REPORT OF THE LEWISHAM PEOPLE'S COMMISSION

AN INQUIRY INTO THE PROPOSALS TO CLOSE LEWISHAM HOSPITAL A&E, MATERNITY AND CHILDREN'S SERVICES

Commission Panel:
Michael Mansfield QC
Baroness Warnock
Professor Blake Morrison

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JUNE 2013

The Save Lewisham Hospital Campaign
c/o Lewisham Pensioners Forum
The Saville Centre,
436 Lewisham High Street,
London.
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On 29 June 2013, in Lewisham, an extraordinary thing happened.
A People's Commission of Inquiry into the proposed changes at Lewisham Hospital took place in the Broadway Theatre, Catford.

What follows is a report of that day and the circumstances leading to the need for an Inquiry, a transcript of what was said on the day divided into sections, and an introduction to each of those sections.

At the end of the report are the conclusions of the Panel after they had considered the oral and written evidence available on the day and the further written information which they asked to be provided to them.

GLOSSARY OF ABBREVIATIONS

A&E	Accident and Emergency Department (often used interchangeably with ED)
CAMHS	Child & Adolescent Mental Health Service
CEO	Chief Executive Officer
COPD	Chronic obstructive pulmonary disease
ED	Emergency Department (often used interchangeably with A&E)
GP	General Practitioner (family doctor)
HASCA	Health and Social Care Act 2012
ICU	Intensive Care Unit
LB	London Borough
LBL	London Borough of Lewisham
LCCG	Lewisham Clinical Commissioning Group
LHT	Lewisham Healthcare NHS Trust
MSLC	Maternity Services Liaison Committee
NCT	National Childbirth Trust
NHS	National Health Service
PRUH	Princess Royal University Hospital, Orpington (LB of Bromley)
QC	Queen's Counsel
QEH	Queen Elizabeth Hospital Woolwich (LB of Greenwich)
QMH	Queen Mary's Hospital, Sidcup (LB of Bexley)
RSPCA	Royal Society for the Prevention of Cruelty to Animals
SLHC	Save Lewisham Hospital Campaign
SLHT	South London Healthcare NHS Trust
SOSH	Secretary of State for Health
TSA	Trust Special Administrator
UCC	Urgent Care Centre
UHL	University Hospital Lewisham/Lewisham Hospital (LB Lewisham)

REPORT OF THE LEWISHAM PEOPLE'S COMMISSION OF INQUIRY

29 JUNE 2013

SUMMARY
LEWISHAM PEOPLE'S COMMISSION OF INQUIRY

The Lewisham People's Commission of Inquiry took place on 29 June 2013, at the Broadway Theatre Catford, half a mile away from Lewisham Hospital.

The Lewisham People's Commission was called to review the Secretary of State's proposals (31 January 2013) to close all major services at Lewisham Hospital in the centre of Lewisham, in South East London.

The borough has a population of 275,000 and is the fourth largest London borough,

Remit of the Lewisham People's Commission

The Terms of Reference of the Lewisham People's Commission of Inquiry were agreed by the Steering Group of the Save Lewisham Hospital Campaign.

They were as follows:

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 Commission Panel

- Michael Mansfield, QC (Chair)
- Professor Blake Morrison, author, poet, journalist and South East London resident
- Baroness Warnock, academic and author of major reports on medical ethics and children with special educational needs

Procedure

- 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. A list of these witnesses can be found on page 165.

- Those not giving live evidence on 29 June provided written evidence and some excerpts from pre-recorded filmed accounts of their evidence were shown. A list of these witnesses can also be found on page 165.

- Witness statements from both live witnesses and those giving written evidence can be found separately online at http://www.savelewishamhospital.com/commission-witnesses/

- During the hearing it became clear that further documents were relevant and these have been provided by the relevant witnesses. They appear online at http://www.savelewishamhospital.com/commission-witnesses/ alongside the statements of the relevant witnesses.

- An audience of 400 people, formed mainly of Lewisham residents but also including those who had travelled from further afield, listened over the course of the day.

- Witnesses were questioned by a team of barristers from Tooks Chambers and the Panel.

- It is to be noted that the Secretary of State for Health, Jeremy Hunt, representatives of the Department of Health and the Trust Special Administrator (TSA) were invited to attend or at the very least submit responses. The People's Commission received apologies from one person, Dr Jane Fryer, Chair of the TSA's Clinical Advisory Group.

- Initial findings from the Commission Panel were published on 4 July 2013. These findings were formulated in general terms without being referenced to the underlying evidence on which they were based. This was done because of the urgency of the situation relating to the TSA recommendations, which had been accepted by the Secretary of State.

- The Judicial Review on 2-4 July 2013 quashed the TSA proposals for Lewisham Hospital on the grounds that the Secretary of State had acted *ultra vires* or 'beyond his powers', in going beyond the boundaries of the South London Healthcare Trust. On 29 October 2013 the three Appeal Court judges, Lord Justice Dyson (Master of the Rolls) and Lords Justice Sullivan and Underhill dismissed the Government appeal.

- On 30 October, it became clear during a House of Commons debate on the NHS in North West London that the Government would not be taking the case to the Supreme Court.

For further information, see Timeline (pp.165-166)

INTRODUCTION
THE NEED FOR A COMMISSION

On 31 January 2013, the Secretary of State for Health, Jeremy Hunt, announced in Parliament that he had accepted the Final Report and recommendations of Trust Special Administrator (TSA) Matthew Kershaw, who had been appointed to remedy the financial failures of the South London Healthcare NHS Trust (SLHT) under Chapter 5A of the National Health Services Act, 2006. This was the first time this emergency process had been used by any government.

The TSA process is intended to provide expedient solutions to remedy a failing trust in a crisis situation. However the hospital for whom Secretary of State's recommendations were *most devastating* was **Lewisham Hospital,** a clinically successful and financially solvent hospital – part of Lewisham Healthcare NHS Trust (LHT), an entirely separate Trust unconnected to SLHT.

Background to the TSA process

The following briefly outlines the TSA process leading up to the Secretary of State's announcement in January 2013.

In **July 2012** the Secretary of State for Health, Conservative MP Andrew Lansley, the predecessor of the current Secretary of State, Jeremy Hunt, appointed a Trust Special Administrator, Matthew Kershaw, to take over South London Healthcare Trust which had developed severe financial difficulties. The Trust consisted of

- Queen Elizabeth Hospital, Woolwich (QEH), LB of Greenwich
- Princess Royal University Hospital, Orpington (PRUH), LB of Bromley
- Queen Mary's Hospital, Sidcup (QMH), LB of Bexley

Staff at Lewisham Hospital and the local community were surprised to discover that Lewisham Hospital had also been included in the plans of the TSA, seemingly going beyond any acceptable remit. As stated earlier, Lewisham Hospital has no organisational connection with SLHT, to which the administrator had been appointed, but was an entirely separate Trust.

From 16 July 2012 to 29 October 2012, the TSA, Matthew Kershaw, worked on preparation of his Draft Report, announced on 29 October. He recommended, in addition to several proposals affecting SLHT, that Lewisham Hospital's newly refurbished A&E (costing £12m), all acute adult and children's admitting wards, adult critical care, emergency and complex surgery units be closed and maternity services closed or severely curtailed. The TSA also proposed the sell-off of 60% of Lewisham Hospital's buildings estate which would be released by the closures. He proposed that Lewisham Hospital become a South East London centre for elective surgery.

During October 2012, as it became clear that Lewisham Hospital would figure largely in the TSA proposals, members of the Lewisham community, LHT health

staff, patient groups and GPs came together to create a campaign group to oppose the recommendations – the Save Lewisham Hospital Campaign. The group also had the support of the Mayor, the Council and the three Lewisham MPs.

Following publication of the Draft Report, the period allowed for consultation was 30 working days **beginning 2 November 2012**. The report's recommendations would have a dramatic impact on Lewisham Hospital, ending its major hospital status and removing all acute and maternity services provision from the local community.

The response from the Lewisham community to the Draft and Final Reports was significant:

- Over 4110 Lewisham residents responded in written form to the draft report, including the online questionnaire, created for the TSA by Ipsos MORI. (*Ipsos MORI Independent Consultation Feedback Report*, Table A3, p.94: Appendix I. TSA Final Report Securing Sustainable NHS Services, 7 January 2013.)
- In response to the question about changes to the Lewisham A&E department, 90% out of over 6000 responses across south east London were 'strongly opposed' while amongst Lewisham residents the level of opposition rose to 96% (*Ipsos MORI*, pp.37 and 42).
- Hundreds of residents attended three consultation meetings with TSA Matthew Kershaw and his panel at different venues in the Borough.
- A petition started by local MP, Heidi Alexander, was handed in to 10 Downing Street in December and the Department of Health 30 January, by which time there were 51,854 signatures in opposition to the proposals.
- 409 GPs opposed the report, including over 90% of Lewisham GPs.
- Two large demonstrations of local people took place: 15,000 people on 26 November 2012 and 25,000 people on 26 January 2013.

The formal consultation process lasted only 30 working days **(2 November - 13 December 2012).**

On **31 January 2013** the Secretary of State announced his decision:

1. that Lewisham Hospital be downgraded from major hospital status;

2. that Lewisham's 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 – a non-admitting 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.

There was little change from the original TSA proposals – except for the 'small but safe' A&E, the midwife-led birth unit, and walk-in paediatric urgent care service. None of these had formed part of the consultation.

The voices of the local community and clinicians had not been heard.

The Secretary of State's arguments

The arguments of the Secretary of State, Jeremy Hunt, formed a central focus for those giving evidence to the Commission so we list them here.

1. **The financial crisis**
   The South London Healthcare NHS Trust was 'the most financially challenged in the country' and 'only by looking beyond the boundaries of the Trust' could Matthew Kershaw, TSA, put forward a 'viable solution'.
   (*Hansard*, 31 Jan 2013: Column 1073)

2. **Ambulance times**
   The 'whole population of South East London will continue to be within 30 minutes of a blue light transfer to an A and E department … with a typical journey time being on average 'only one minute longer'. Maternity services on the QEH site would involve 'an additional 2-3 minutes journey time'.
   (*Hansard*, 31 Jan 2013: Column 1075)

3. **Clinical input**
   The Secretary of State maintained that **'**Sir Bruce [Keogh] was satisfied that there had indeed been sufficient clinical input'.
   (*Hansard*, 31 Jan 2013: Column 1074)

4. **Improved care and patient safety**
   Closures at Lewisham Hospital would result in 'improved care for residents of south-east London'; they were 'underpinned by clear clinical evidence' and 'clinical outcomes would be improved' by the closure of services in Lewisham for acute care. Sir Bruce Keogh had stated that the proposals 'could save up to 100 lives every year'.
   (*Hansard,* 31 Jan 2013: Column 1074)

5. **Emergency care**
   Lewisham Hospital should retain a 'smaller A and E service with 24/7 senior emergency cover'. This unit would see, according to evidence from Sir Bruce Keogh, 'up to three quarters of those currently attending Lewisham A and E'.
   (*Hansard*, 31 Jan 2013: Column 1075)

6. **Maternity services**
   Due to the proposed removal of emergency and intensive care services the expert panel 'was not willing' to support the continued existence of a full obstetrician-led unit at Lewisham Hospital which should therefore be 'replaced with a midwife-led unit that could deal with 10% of current activity, potentially up to 60%'.
   (*Hansard*, 31 Jan 2013: Column 1075)

7. **Maternal deaths**
   'The way to reduce the number of maternal deaths, in which London does not

score well, is to centralise the facilities… It will lead to fewer maternal deaths in Lewisham and south-east London.'
(*Hansard*, 31 Jan 2013: Column 1080).

8. **Paediatric services**
   Having recognised the 'high quality paediatric services' at Lewisham Hospital, any replacement should 'offer even better clinical outcomes and patient experience'.
   (*Hansard*, 31 Jan 2013: Column 1076).

9. **Meeting 'the Four Tests'**

   NHS guidance (Health and Social Care Act 2009), states that four 'threshold tests' should be met for major health service reconfigurations. The Secretary of State asserted that these had been met:

   1.1. Support from GP commissioners (local Clinical Commissioning Groups or CCGs)
   1.2. Clarity on the clinical evidence base for improvement
   1.3. Strengthened public and patient engagement in the consultation process
   1.4. Consistency with current and prospective patient choice, i.e. justification for any restriction of choice.

10. **The issue of CCG support**
    In reply to Dame Ruddock, MP for Lewisham Deptford (Lab): 'Inevitably, when we are reducing the number of sites for complex medical procedures, the people in the areas where those procedures will no longer happen will often be opposed to the changes. That is what has happened here, but the group [Lewisham CCG] supports the principles behind what the trust special administrator has said.'
    (*Hansard* 31 Jan 2013: Column 1080)

The Secretary of State's announcement can be seen in full at http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130131/debtext/130131-0002.htm

[Because of the forthcoming Judicial Review (2-4 July 2013), the Commission did not seek to examine whether the Secretary of State had been *ultra vires* or had gone beyond his powers in intervening beyond the boundaries of the Trust to which he had been appointed.]

The need for a "People's Commission"

In the period following the Secretary of State's announcement it became apparent to hospital clinicians, Lewisham GPs, the community, patients and politicians in Lewisham, that the 'four tests' as well a mass of evidence and opinion had been ignored.

Further questions were raised about the validity of the evidence cited by the Secretary of State to justify his decisions, particularly that '100 lives would be saved', that maternal deaths would be prevented and that the changes would improve clinical outcomes.

For these reasons, reflecting on what else could be done alongside the legal process, the idea of a People's Commission was conceived.

There was a desire for natural justice and for those who had given evidence to be able to 'have their day in court' – a People's Court. The Save Lewisham Hospital Campaign decided to carry out what the Government had failed to do: to establish a proper inquiry to hear the evidence and the voices of those who had been ignored by the TSA.

What is a Commission of Inquiry?

The concept of a People's Commission has a recognised history and precedent not so much in the UK but internationally. Bertrand Russell convened a tribunal of international civic conscience on Vietnam in 1966, which has recently reconvened on Palestine 2010-12. In both cases there was a need to highlight un-redressed violations of international law, by the USA in the first instance and Israel in the second. Another similar tribunal took place in The Hague to focus on human rights abuse in Iran. These initiatives have been entirely motivated and organised by civil society. A permanent international people's tribunal was set up in Bologna in 1979.

This Commission was initiated and promoted by the Save Lewisham Hospital Campaign on behalf of the people of Lewisham.

The terms of reference were extremely important. The Commission did not exist to conduct a public debate. It attempted to conduct a quasi-judicial process. The powers and resources that a proper judicial inquiry would have did not exist but, nevertheless, the proceedings of the Commission equate what the Commission did effectively with what the Government and TSA should have done in the first place.

TRANSCRIPT
INTRODUCTORY MATERIAL AND STATEMENTS

Chair of barristers: Elizabeth Woodcraft (EW) of Tooks Chambers
It is wonderful to welcome you to this People's Commission of Inquiry. I am a barrister at Tooks Chambers and you will see that we have a panel of barristers who are going to be doing the questioning today. But first of all I would like to introduce you to the Panel. We are privileged to be assisted by an eminently qualified panel. The members of the Panel are all experienced in considering and evaluating the sort of matters that we are dealing with today and we are very grateful to them for agreeing to assist the Commission.

Blake Morrison is a writer and journalist. His non-fiction books include the award winning *When did you last see your father?* And he has also written a study of the James Bulger murder, *As if*. He was literary editor of both *The Observer* and *The Independent on Sunday* before becoming a full time writer. Since 2003 Blake has been Professor of Creative and Life Writing at Goldsmiths College and he lives in South East London so he knows Lewisham Hospital very well.

Baroness Warnock: Lady Warnock is a cross-bench life peer and a moral philosopher. She has shaped Government policy on many issues. In 1974 she chaired an inquiry on special education, which brought about radical change by placing emphasis on the teaching of learning disabled children in mainstream schools. From 1979 to 1984 she sat on a Royal Commission on environmental pollution and from 1982 to 1984 she chaired the Committee of Inquiry into Human Fertilisation, which gave rise to the Human Fertilisation and Embryology Act 1990, which led, amongst other things, to the development of policy on IVF treatment.

Chair of Panel, Michael Mansfield, QC (Head of Chambers):
Michael Mansfield has represented defendants in criminal trials, appeals and inquiries in some of the most controversial legal cases the country has seen. He represented the family of Jean Charles de Menezes; and the families of victims at the Bloody Sunday Inquiry. He also chaired an inquiry into the shoot to kill policy in the North of Ireland. He has represented many families at inquests, including the Marchioness disaster, the Deptford/New Cross fire and the Lockerbie bombings and, as you will all know, he represents the family of Stephen Lawrence.

Advocates:
The advocates who will be asking questions of the witnesses are:

- Amanda Weston
- Maureen Ngozi Obi-Ezekpazu
- Di Middleton
- Nicola Braganza

There have been many witnesses who wanted to give evidence to the Inquiry and they have all made statements, but we have only got one day today to hear the oral evidence. But the panel has all the statements: they will have everything that everyone has said.

What we are going to do today is call live witnesses to give the Inquiry the main features of the concerns that have given cause to this Inquiry. In our one day we have tried to arrange the witnesses so you will hear from as many as possible and

that means that people will only speak for a few minutes and I am going to be quite strict with the barristers. You might see me passing pieces of paper saying 'one minute', 'thirty seconds'... In addition there will also be video evidence.

There is also an opportunity for you to give your views to the panel. There is a roll in the foyer that you can write your views on at any stage in the day. You can tweet. I am told that the Tweet address will be on the screen, or you can email and we will be reading out some of the comments during the day, but, in any event, the panel will have them. There is also a letter to Monitor, which is a Government body, which is about the protest to save the hospital and the NHS and you are invited to sign it.

There are several witnesses, who are not here for various reasons:
Jeremy Hunt (JH) was invited, but he has not had the courtesy to reply.

He has an advisor, Sir Bruce Keogh (BK), who is not here. He changed his email address.

Because they are not here, their words, things that they have said or written in Parliament or in letters, for example – those words will be read by an actor, Tim Preece.

And Di Middleton is the person who will be asking questions of JH and BK, so when she rises to her feet you will know what is coming.

Michael Mansfield QC, Panel Chair
Introductory Comments:
I thought it would be useful for you to know a few things before we start. I cannot assume that everyone has the same information and background.

A People's Commission or Tribunal: It is not a novel concept. In fact historically you can trace its origins back to the English Civil War – the Levellers, the Diggers and everything that went on at St Mary's Church, Putney. So if you want to go back that far, you can find out that there is a tradition that is extremely important. But it comes into its own just after the Second World War in an entirely different way which has led to this one. There was a situation where you had the Universal Declaration of Human Rights in 1948 and then you had the Charter for the United Nations and what Bertrand Russell discovered in the wake of those was that actually they were not being implemented; actually they were not being respected. So what he did was to set up the first International People's Tribunal.

I have been sitting on one of the successors to that, but *he* did it in relation to Vietnam and American violations of internatonal law in Vietnam. I have been doing it in relation of Israeli violations of war in relation to Palestine. The importance of them was this: that it was world citizenry saying we want something done, we want the violations highlighted. But of course highlighting is not enough, you need action, and that is what it started and it made a difference. And since then there have been a whole series of them. In fact there is a permanent People's Tribunal set up in Bologna looking at international issues.

But internally there have been similar things to this over the past two decades and do not believe for one moment, despite Government dismissal, or pretending to ignore what is going on, that they actually do not recognise what is happening. They are not

here because they cannot face the music. And I think for a People's Tribunal we face this many, many times over. That the people who are given the opportunity when criticised in the proper way of natural justice, actually do not turn up. So, it's a real arrogance – which of course is the thing we are examining in relation to policy.

The other thing you may not have in the pack and, if I am repeating something please forgive me – you may need to know. Alright, so there's a People's Commission, fine: you now know who the panel is, commissioned by the people in the community of Lewisham. But then, what are the terms of reference? The terms of reference are extremely important. We are not here to conduct a public debate. We are trying to conduct a judicial process. We have not got the powers, we have not got the resources that a proper judicial inquiry would have; but nevertheless we can equate what we are doing effectively with what the Government should have done in the first place.

These are the terms of reference:
The Lewisham People's Commission of Inquiry (LPCI) shall examine the decision of the Secretary of State for Health to downgrade Lewisham Hospital and the context for this: the fundamental changes being made to the NHS over the last 30 years. The Commission will examine two things, but the first is broken into two parts.

Firstly the original vision and principles underpinning the NHS, with particular reference to the community it serves and its accountability to that community. The second part to the first point: 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.

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

The proposals for Lewisham Hospital: it is important that we have in mind throughout the whole of today exactly what it is that is being examined, in other words the proposals themselves. They can be summarised in this way:
A downgrading of Lewisham Hospital from a major hospital status; the closure of the Accident and Emergency facility and all acute admitting wards, including the Children's Wards, Intensive Care, all emergency and complex surgery; a proposed small midwife-led birth unit without, in other words it will not have, obstetric, medical or emergency backup.

The plan in fact is effectively the sell-off of 60% of the Lewisham Hospital estate.

So, those are the proposals that you have to have in mind and may I indicate that this has to be set against an even bigger background. I just want to go back before I finish to the principles that were set out in the United Nations Declaration of Human Rights. We are dealing with a very fundamental human right. It is easy to say – and it slips off the tongue and so on – but this was a framework that was fought for over hundreds of years. Back before that, the League of Nations, and before that. And one of the rights has been enshrined in a subsequent covenant, the International Covenant on Economic, Political and Cultural Rights. This covenant is extremely important because it was brought about in 1966; the United Kingdom signed it in 1968 and they ratified it in 1978 – Article 12. It is important to have these sorts of

texts because if we as a panel are going to be challenged or anyone else is going to be challenged about the fundamental basis or existence of something like this exercise, Article 12 behoves those who signed and ratified – including the United Kingdom – to create conditions to ensure healthcare for all, a very simple proposition, and there are four "A"s that are attached to that.

In other words, if is going to be ensuring access to healthcare for all, it has got to be **available**; it has got to be **accessible**; it has got to be **affordable**; and it has got to be **acceptable**. Those are the four "A"s – they are not the same as the four government criteria that were set down by the Government for their proposals for Lewisham and South East London.

May I just touch on this: next week there is a judicial review where the High Court is going to be examining the legality of the decision and whether it was *ultra vires*, *intra vires* and so on; and also looking at those four criteria set down by the Government, which will be mentioned during the course of today.

For example one of the criteria concerns consultation, so therefore, the judicial review will be looking at consultation; but the other three criteria as well. We are not conducting a judicial review, because we are examining a much bigger context than the judicial review which will be very focused, but the two are obviously allied. They are both related to each other and I obviously would ask any of you here today who have got the time to go to the judicial review and listen to the arguments there. They will also hopefully be as informative as what you hear today.

I will endeavour not to intervene too much because we have excellent advocates who will be trying to focus all the witnesses. We do appreciate and thank all the witnesses for coming and we know there is a lot to say, but obviously we have got to try and keep it within the time constraints.

At the very end of the day I will have a few comments to make and then the three of us will sit down and work out the parameters of a report that will be issued as quickly as we can do it. But we will make some kind of statement at the end of the day once we have heard everything that is going to be presented to us. A lot of it will obviously be in written form.

Thank you *(Applause)*

Simone Boothe from the Save Lewisham Hospital Campaign
Good morning everyone and thank you very much for being here today. First of all I would like to warmly welcome members of the Panel, already introduced by Michael Mansfield, and also we have Baroness Warnock and we also have Blake Morrison as well. Thank you very much to Tooks barristers for being here also. On behalf of the Campaign I would also like to welcome you all for participating and being here today.

My name is Simone Boothe and on introduction, as you have heard, I am a local resident. My family have lived in Lewisham literally metres from the hospital for over 55 years now. Many of my relatives were born in the hospital and some of them had their last moments of life in Lewisham Hospital. Lewisham Hospital has saved my life on a couple of occasions, as an older child and a young adult living in the area, not being very well myself. It saved the life of many of my relatives and many of my friends as well.

This is why, when we heard the proposal to downgrade the hospital, so many of us felt so strongly. 15,000 of us marched after weeks of the campaign launching in November last year, followed by 25,000 of us marching in January of this year in the cold, in the mud, in the rain. 55,000 of us have signed petitions, have marched on Parliament, have written letters to Jeremy Hunt, to the Special Administrator and we have not been heard.

As I said, many of my relatives, many of my friends, my own life have been saved by the services at Lewisham Hospital, A&E and maternity and I would not be here speaking to you today if it wasn't for those services. A lot of us have mentioned quite often that this is Lewisham's hospital. It is the hospital that serves Lewisham Borough, but we need to remember as well, as we just heard from Michael Mansfield, that it is the right for everyone to have NHS healthcare – everyone. Even if you don't live in the Borough. Lewisham Hospital serves people who live on the borders. Lewisham Hospital will serve anyone who happens to fall ill or have an accident on its doorstep. You don't have to be a Lewisham resident. You just have to need them and they will be there.

So, the idea that this service would not be here in the future absolutely terrifies me and I know it terrifies many of you, which is why we are here today, which is why we are all so involved. Because of this we will carry on the campaign until we are heard. We have not been heard as of yet, but we are not going to stop. We have no intention of stopping no matter how tired we are, no matter what other direction we are being pulled in, we will be here until the bitter end. If Jeremy Hunt – not that I'm wishing any ill harm to him at all – but if he happened to have an accident in Lewisham, I'm sure he'd hope that there would be an A&E there, possibly not a maternity, as he is a gentleman, but I am hoping that he would hope there would be an A&E there to serve him, just like we want an A&E there to serve us.

So, I hope you all enjoy what is coming today, I hope you will remain to be involved and I hope I see you all in the future in the future campaign activities. Thank you. *(Applause)*

EW Sir Steve Bullock *(Applause)*

Sir Steve Bullock (Mayor of Lewisham)
Thank you for the opportunity to appear before this Commission. I want to thank those who have put in so much work to make this happen. I have no doubt that it will prove a most useful and productive event. I would also like to place on record my thanks to all the local people who have been involved in the Save Lewisham Hospital Campaign making the case for retaining a full functioning hospital here. As you will know, the Council as well as the Campaign is challenging the decision in the court. I have prepared a short statement which summarises the Council's concerns with the decision made by the Secretary of State.

Lewisham Hospital is a key part of the fabric of public service provision in Lewisham. Its long history in the Borough stretches back before the creation of the NHS to the emergence of Poor Law provisions in South East London. Over the past fifteen years Lewisham Hospital has established itself as a highly effective District General Hospital in both clinical and financial terms, serving a local population of some 300,000 people and with an annual turnover of £240 million. In 2010 the hospital

was commissioned to provide community health services. This has allowed for the vertical integration of acute and community services and has provided stronger links to the Council services and other primary care services.

The hospital's links within the health economy of South East London are positive and strong. Its work with the Council's adult care system is highly effective. It has also played a key role in contributing to Lewisham's collective achievement of an outstanding rating for children's safeguarding.

The strength of clinical and public sentiment evident since the proposals were published reflects the professional and public esteem in which the institution is held, not only for the quality of its healthcare provision, but also its role and place in the local community. In addition to the services it provides, Lewisham Hospital is a well-regarded public institution contributing to the fabric of civic life and a key element of people's sense of place and wellbeing. The hospital is a major local employer and acts as a hub for volunteering and community activities. There are many points that the Council has made in its public statements that the Commission could consider, but I wish to draw a few particularly to your attention.

The basis of our judicial review is that the Trust Special Administrator's powers extend only to making recommendations about the future of the NHS Trust to which they were appointed, in this instance the South London Healthcare NHS Trust. It is our view that the TSA did not have the power to make recommendations which would affect Lewisham Healthcare NHS Trust, nor did the Secretary of State in response to any such recommendation have the power to accept them. Supported by independent analysis, the Council believe that the problem has not been framed correctly. The regime for unsustainable providers was designed to remedy failing hospitals. It was not designed to establish in fine detail the healthcare needs of a given population. It is acknowledged that changes are required for acute healthcare to be organised effectively in South East London. However, such changes need to start with the needs of the population of South East London and not the financial and productivity needs of the healthcare providers. Throughout his draft report the TSA adopted a strict provider focus and failed to take into account or assess any impact of his recommendations on the local population or the extent to which these changes destabilised other local systems and processes.

The Council also considers that the options analysis undertaken by the TSA in respect of the hospitals concerned was unbalanced and that the method for evaluating and weighting the criteria selected by the TSA was flawed. We consider that the TSA failed to recognise the cost effectiveness of local partnership arrangements. These are designed to reduce unnecessary hospital admission and develop community based provision. In the Council's view, these cannot be replicated across four hospitals sites without affecting the quality of provision and incurring additional costs for both health and social care commissioners.

In relation to maternity, children's and older people's services the Council considers that the TSA has failed to address the impact on patient and carer family choice and the need as far as possible for care to be delivered close to home.

Finally, the Council is concerned that, despite the failure of the South London Healthcare Trust which merged three hospitals in 2009, the TSA proposal is to de-merge and then re-merge hospitals without regard to the reasons for the failure of

South London Healthcare Trust; nor any apparent consideration of the risks associated with such new mergers. As both a former Chair of Lewisham Hospital itself and as the Borough's mayor, I am clear that, were these current proposals to go ahead, the residents of this part of London would find the healthcare available to them significantly damaged.
Thank you.
(Applause)

EW: The evidence that is being given today will be recorded and then transcribed, so we will have a note of everything that everybody says. Lord David Owen.
(Applause)

Lord Owen
I've been asked to talk about the wider implications for the NHS.

I was ten years old in 1948 when the NHS started. My father was a GP in Plymouth, my mother was a dentist and that day was a day which my father called 'A day of freedom'. It was the day he no longer had to ask patients to pay for coming to see him with their illnesses. He remembered the twenties and the thirties, the fragmented healthcare service, voluntary hospitals, run by local authorities, private hospitals, a healthcare system which was not matching the needs of the people.

Sadly too many people forget those days. When he gave up having private patients there was one exception and that was the local Roma community who refused to think they had had a real consultation unless silver crossed the palm.

When we look back we must also look forward. Here we are: the NHS – with all the adverse reports that we have been reading in the newspapers and the things that have gone wrong – remains the most popular public service in the whole country. Not only is it popular in this country, it is admired across the world and its record of achievement of cost-effective care is remarkable. We pay a lot less than most countries in a sophisticated world of healthcare and we get a better service.

It is extraordinary really when you look back to this achievement, the greatest social achievement in my view in post war Britain, and here we are in 2013 looking at a situation where the NHS will, unless something changes within the next few years, be completely and totally changed – changed out of all recognition. Don't forget that! This legislation that came in in 2012 – 457 pages worth, 309 clauses, larger than Nye Bevan's original NHS legislation – is a serious sustained attack on the very principles and ethics of the National Health Service.

My wife is American. She came here 43 years ago. She blesses the National Health Service. We, like most families, have had some serious illnesses. I am here in part because my three children all live in South London and use this hospital. We went on the March, my wife and I, with two of our grandchildren, both of whom had used the hospital.

But this is not a NIMBY (not in my back yard) issue, this is not against closures of any hospital. I trained as a doctor at St Thomas' Hospital, I did my midwifery training at the Lambeth Hospital: now closed and thankfully closed. My first job was in the Royal Waterloo Hospital: closed because of new provisions. I am not against the fact that hospitals have to close, that there has to be reconfiguring, but I am very

against the proposals that are being put forward in this way and as it affects Lewisham Hospital.

It is not for me to make here the judgements about this, but I do want to draw attention to an extremely important report that has just literally come out, it is not even finally completed. This is the first objective study of what is being done, or being attempted to be done, here in South London and it is an academic, not a political, document. You will later hear from Professor Allyson Pollock of the Public Health Research and Policy Department at Queen Mary, University of London.

What this shows is that what we are discussing here and what is being evaluated by this Commission has a direct relevance to the National Health Service's future. Are we going to just accept the marketisation of the Health Service? Are we just going to accept that the Health Service can be taken from us? Just remember this: no Conservative prime minister – Winston Churchill right through to John Major – has wanted to change the Health Service. The one that did, Margaret Thatcher, looked at the issue and found it politically too toxic to make the changes. It was only in 2010, after an election in which we were promised by the now prime minister that there would not be another top down re-organisation, have we been faced by this legislation. With no democratic mandate whatever, they are trying to take away a statutory, legal obligation of the Secretary of State for Health to provide a comprehensive healthcare system.

These are fundamental and important changes, but they have repercussions. Those changes are being seen here in South London and what you are trying to assess today, and what the judicial review will start looking at on Tuesday, has profound implications for what will happen to the NHS up and down the country. We have already seen one judicial review in Leeds, mainly about paediatric cardiology and what we did find was that the review threw out the Government's proposals because their facts were wrong. This study shows that many of the 'facts' supposed are fundamentally flawed and wrong and the interpretation and the way that this has been done, if it goes through here, will have profound implications elsewhere. So I hope that the Commission will find some way of getting this document before the Judicial Review on Tuesday, very difficult and very late to be able to do it, but there is a provision for Friends of the Court, but it is up to you.

I say to you today, what you are doing here today is protecting your own hospital, as you have every right as individuals to do, but you are not pursuing just the normal objection to any hospital closure, you are actually pioneering a people's challenge to the fundamental politics that underlie it. It is being greatly changed by this private finance initiative, in my view, it is a political fix and really this overall Government policy which is affecting the issues of your hospital. Good luck to you and I hope you succeed. *(Applause)*

CHAPTER 1

DEVELOPMENTS IN THE NHS, THE SOUTH EAST LONDON HEALTH ECONOMY AND THE PROPOSALS FOR LEWISHAM HOSPITAL

Secretary of State for Health, Jeremy Hunt
On the NHS
'The NHS exists to provide patients with the highest levels of care and compassion, and it does so in a way that is more equitable than the system in any other country in the world—it provides comprehensive care, free at the point of need.

But to be true to those values, different parts of the NHS need to be financially sustainable. Financial problems left unaddressed become clinical problems, not least because money used to fund deficits cannot be used for patient care.'

On the South London Healthcare Trust debt
'The South London Healthcare NHS Trust is the most financially challenged in the country, with a deficit of £65 million per annum.

'It currently spends some £60 million a year, or 16% of its annual income, to service two private finance initiative contracts signed in 1998. For this and other reasons, repeated local attempts to resolve the financial crisis at the trust have failed. As a result, the trust is losing more than £1 million every week. In the three years since it was formed in 2009, it has generated a deficit of £153 million. That figure will rise to more than £200 million by the end of this financial year, a huge amount of money that has to be diverted away from front-line patient care.

'Mr Kershaw had the extremely difficult task of finding a clinically and financially sustainable way forward for the South London Healthcare NHS Trust. Reluctantly, he concluded that only by looking beyond the boundaries of the trust to the wider health community could he put forward a viable solution. I support that analysis.'
(*Hansard*, 31 January 2013)

In Session 1 of the Lewisham People's Commission the panel reviewed ways in which developments in the NHS as a whole might have a bearing on the situation at the South London Healthcare Trust and thus on the Trust Special Administrator's (TSA) recommendations for closures at Lewisham Hospital.

Expert witnesses were invited to give evidence on these points and more particularly on the financial position in the South London Healthcare NHS Trust (SLHT) and the role of private finance initiative (PFI) debts in the SLHT, as referred to in the speech by the Secretary of State on 31 January 2013.

In relation to the terms of reference, the Panel heard that there had been major shifts in the nature of the National Health Service since it was conceived. In 1948 the NHS had been 'universal in the sense of available to all, comprehensive, including all services, both preventative and curative, and free, involving no payment at the point of delivery' (Colin Leys, p.21).

The changing NHS

Expert witness Professor Colin Leys outlined in his evidence to the Commission that from the period of Margaret Thatcher's and John Major's Conservative Governments onwards (the 1980s and 1990s), through the Labour Governments of Tony Blair and Gordon Brown (1997 to 2010), to the current time, there had been at first gradual, then accelerating changes in:

- accountability
- the universality and accessibility of care
- governance i.e. the creation of Trusts and, later, Foundation Trusts run by Chief Executives
- the establishment of internal markets, charges and pricing
- the opening up of clinical services to the private sector.

Things have moved rapidly, stated Professor Leys, from a position where clinicians needed to know how much things cost and to accordingly balance their budgets, to one where the NHS which is run as a series of 'separate businesses'. The current position, he stated, is that NHS providers, as a result of the Coalition Government's Health and Social Care Act (2012), are being forced to adopt 'the motivation and culture of the for-profit companies with which they must now compete'. (Colin Leys, witness statement http://www.savelewishamhospital.com/commission-witnesses/)

Professor Leys also drew the Panel's attention to the increasing proportion of the NHS budget being swallowed up 'simply by the need to operate a market' (10% at a conservative estimate) on top of other management costs. This is a factor, he stated, that is not openly discussed by the Government. (Colin Leys p.24)

While the points raised by Professor Leys affect all NHS trusts and all sectors of the NHS, the Panel felt that they provided the background for understanding how financial pressures, rather than patient care, formed the background to the work and interventions of the TSA in South London and Lewisham.

Accountability

Formal accountability for the provision of healthcare has now moved under the recent Health and Social Care Act (2012) from the Secretary of State, previously accountable 'through elections, through ministers, through Parliament', to bodies such as NHS England and Monitor which are unaccountable through that democratic process. (Colin Leys p.22).

Professor Leys drew to the Panel's attention the fact that MPs and peers who have clear financial interests in private health companies are able to vote on critical areas of legislation which are advantageous to those companies. For example, many peers with those interests voted against annulling regulations which would have moderated the effects of privatisation. These additional points can be found on http://www.savelewishamhospital.com/commission-witnesses/

Private Finance Initiative and the South London Healthcare NHS Trust

Private Finance Initiative (PFI) is a system of private borrowing utilised by consecutive governments in order to finance public sector building projects. PFIs began during the John Major Conservative Government and increased rapidly during the Blair and Brown Labour Governments.

Evidence presented to the Commission revealed both the extent of the PFI impact on the health economy of South London Healthcare NHS Trust and their part role in TSA plans for closure of services at Lewisham Hospital.

The size, extent and terms of the PFIs in the SLHT, argued expert witness Professor Allyson Pollock, were part of national government policy, and thus were not attributable to the actions of individual hospitals in the Trust. She cited evidence to show how widespread the application of PFIs had been nationally:

- 101 of the 133 new hospitals built between 1997 and 2008 were privately financed
- by April 2011 across the public sector more than 700 PFI contracts had been signed in the UK with an estimated capital value of almost £50 billion in England (for every hospital built 'we are actually paying for two, but we are only getting one and in some cases we are paying for three')
- annual repayments stretch for 30 years, even up to 60 years in some cases
- interest rates on the loans were inflated far above current commercial rates – at anything from 6% to 15% – while current interest rates stand at around ½%, and Government borrowing rates at approximately 1½-2%.
  (Allyson Pollock p.26)

Professor Pollock also pointed out to the Panel that PFI contracts are unaccountable and as a result of 'commercial confidentiality' are masked in secrecy.

For the Commission Professor Pollock had produced a report *The TSA regime and the South London Healthcare NHS Trust: A case of blaming the victims.* (The full report which sets out the financial background to the proposed changes can be seen at http://www.savelewishamhospital.com/commission-documents/.)

In her oral testimony Professor Pollock described the situation of the SLHT, which has six PFI schemes drawn up on particularly disadvantageous terms, and explained that it is this factor above all which has led to the current crisis in the SHLT. The hospitals in the SLHT cannot be closed because of the extent and terms of their PFI contracts – thus it was proposed that Lewisham services should be drastically curtailed in order to help fund the PFI payments of a completely separate Trust.

Professor Pollock gave an illustration of just one of the SLHT PFIs:

> '… at the Princess Royal University Hospital in Bromley, the PFI payment… has risen… to £39 million a year and by the contract's close in 2030 – the contracts have been extended – it is £94 million. So… the PFIs just now are taking between 18-20% of the Trust's income.' (Allyson Pollock p.27)

Poor consultation and lack of planning

The rush to put forward these proposals – the Panel was reminded that the consultation period on the draft report was only 30 working days – meant that none of the proper consultations and safeguards were undertaken by the TSA. In focusing almost completely on the financial situation, Professor Pollock stated, the TSA has 'absolutely and irresponsibly' failed to do what is necessary for a major hospital reconfiguration: a needs assessment which asks the question: 'Where will these patients go and how will services be re-provided?' (Allyson Pollock p.28)

John Lister, Director of Health Emergency, a pressure group focused on the NHS, pointed to the lack of necessary analysis, funding and planning for a major service reconfiguration, i.e. the removal of high quality acute services from a busy hospital such as Lewisham and their dispersal over South East London where services are already stretched. He argued such proposals need to contain the following information:

- Where are these services going to be?
- How many people will be employed?
- How will they be recruited, trained and managed?
- What resources will there be?
- How will their work be integrated with existing services in the sector?

(The transcript of his video can be seen online at http://www.savelewishamhospital.com/commission-witnesses/.)

For her part, Professor Pollock made a series of recommendations including:

- the revoking of the TSA recommendations
- the carrying out of a proper needs assessment
- the placing of the PFI arrangements in the public domain
- the renegotiation of PFI contracts.

She also recommended that the TSA regime should not be applied to other trusts where deficits have been significantly contributed to by Government policies. (See http://www.savelewishamhospital.com/commission-documents/)

The Panel has major concerns about both the extent and role of PFI payments in terms of the future of hospitals in the SLHT and the role of PFI debts which had led to the recommendations for closure of services at Lewisham Hospital.

The Panel is also concerned that the evidence highlighted that the NHS is now becoming less universally available, less accountable and currently threatened by extensive marketisation and privatisation.

SESSION 1 TRANSCRIPT

EW We are now about to start hearing evidence from the live witnesses. They will give us some information about the history of the changes in the NHS.

LIVE WITNESSES

Professor Colin Leys (CL) interviewed by barrister Amanda Weston (AW)

AW For the Commission could you just give your full name and your qualifications?

CL My name is Colin Temple Leys. I am a retired professor of political studies. I am attached to Goldsmiths College.

AW What is your specialist area of research?

CL In general we call it political economy. For the last 10 or 12 years I have been heavily focused on the development of health policy and the NHS.

AW Do you have any personal connection with or interest in Lewisham Hospital or the campaign to save Lewisham Hospital?

CL No

AW Could you begin please, Professor, by summarising the principles underpinning the National Health Service?

CL The official historian of the Health Service summed them up by saying the principles were: that it should be universal (in the sense of available to all); comprehensive (including all services, both preventative and curative); and free (involving no payment at the point of delivery). And I would like to just read, if I may, in answer to that, what Bevan himself wrote. He wrote in a pamphlet addressed to the nation:

> 'It will provide you with all medical, dental and nursing care. Everyone - rich and poor, man, woman or child - can use it or any part of it. There are no charges, except for a few special items. But it is not a "charity". You are all paying for it, mainly as tax payers...'
> *Introduction to the NHS Act* (1946)

AW Thank you Professor. What do you say is the importance of accountability to the community in maintaining public confidence in the NHS?

CL Well, I think we had a perfect example of it just now [he is referring to the evidence of Sally and Deion Stephenson, now included later on pp.118-120], so there is really no more to say about that. I would add that the removal of the responsibility of the Secretary of State for providing the service means that the chain of accountability we had – through elections, through ministers, through Parliament – has now been broken.

AW Can you just explain to the Commission how the chain of accountability previously worked?

CL The Secretary of State was responsible to the Parliament for provision of the Health Service and we elect Parliament and, therefore, he was accountable to us in that way. There were other mechanisms built into the Health Service, but that was the principle, the fundamental one.

AW How has that changed?

CL The Secretary of State is only now responsible for 'promoting' the Health Service and the people actually responsible for operating it are NHS England in England – I am speaking now about England and not Scotland, Wales and Northern Ireland. In England the NHS England is a bureaucratic branch in effect of the Department of Health, a body appointed by the Secretary of State, but is not accountable to the Secretary of State; and Monitor, which regulates the market, again is appointed by the Government but not accountable to it. It is an independent monitor like Ofgem and so on.

AW When were those changes introduced?

CL The last changes about accountability came with the Health and Social Care Act of last year. The restructuring of the NHS itself long predates that.

AW To your knowledge, was there informed debate about the fundamental nature of that change to the chain of accountability at the time of the passing of the Bill?

CL I don't think there was. As Lord Owen rightly said, we were promised in the last election no more top down changes. Within months of the election result we had a White Paper proposing this drastic reorganisation. So, there was no debate before the election, there was no mandate, as Lord Owen says. Prior to that, in the stages through which the NHS was broken up and turned into a set of businesses independent of the Department of Health, it was always presented as modernisation or in the name of choice, or patient-led change, patient orientation. At no point was it represented to the public that this was preparation for turning the NHS into a set of organisations competing with private companies. In fact, I would go further and say we should not forget that consistently since 2010 the Government has denied that this is a privatisation measure.

AW Well, you've moved on very neatly to the next subject that I wanted to ask you about Professor, which is: can you tell the Commission when was the first significant introduction of marketisation or adoption of commercial principles into the management of NHS hospitals?

CL It began in the 1980s in the period of the Thatcher Government and the crucial first change was to abolish the management of hospitals by the consensus of senior doctors and senior administrators and replace them by a single person – chief executives – on business lines and, with that, the imposed introduction of outsourcing of non-clinical activities, again on the business model that this would be cheaper. Would you like me to take the story through any further? That's the first time.

AW That's helpful. Yes, if you could move us through in time to the incremental changes.

CL Very quickly, the 90s saw the creation of 'Trusts' so that hospitals ceased to be run essentially from Whitehall. And various structures had their own boards of directors appointed by the Government and were increasingly required to put their finances on a commercial basis. They were given block grants, but they had to balance the books taking one year with another, so this was to train them to think commercially, and you had an internal market in which the money they got was given to them by other branches of the Government.

Finally, in the decade beginning in 2000 you had the transformation of Trusts into Foundation Trusts, which essentially are cut loose from the Department of Health and they are allowed to borrow on the private market, form joint ventures with private companies. And, on the other hand, if they get into financial difficulties they no longer can rely on the Department of Health to plug the gap, so they essentially at that point become independent businesses forced to compete with whoever is offering them competition in the market.

And the market was opened up in the decade 2000-2010 by the introduction of private providers of clinical services that had been an absolute taboo down to that time, and it was introduced under the Labour Government of Tony Blair.

AW The last change relating to commissioning of care by clinical commissioning groups – what impact has that had so far?

CL So far it is early days to say what impact it will have because the Act under which they operate is so recent. It was introduced in April this year. It is not hard to see that they will in fact use the powers they've got to deliver what they consider is 'reasonable' - to meet 'reasonable' needs for care, as opposed to all needs for care such as Bevan proposed. They will have to make decisions as to what is afforded and that will affect the comprehensiveness of the care that is available. They are already doing it in relation to elective, not so serious surgery: so for example, what they do is they tell doctors we have to raise the threshold at which somebody will be eligible for a knee replacement.

AW That's a helpful example. Thank you Professor. Now you've said that the NHS has increasingly become a system of independent businesses. Can you summarise what in your view the impact that has had on the vision and the principles of the NHS?

CL To my mind the most fundamental change is that it replaces patient need as the top priority with the need to meet commercial targets, the need to balance the books, the need to stay solvent. At lot of people think 'well, what's new about that because haven't they always had to be careful about money?' and 'of course the NHS was always short of money, so doctors were never free to do whatever they thought the patients absolutely needed'. But what is new is the shift in the order. Before, you thought 'what do patients need and what can we do with the money we've got?' Now you think 'what must we do to balance the books this year, to balance the competition?' And think about patients separately. And we have already seen the consequences of that at Mid-Stafford and in other places.

AW
Talking as you were about the amount of money we've got, can you give your opinion on how the proportion of the total budget available for clinical care has been affected by the marketisation of the NHS?

CL Yes, I think there are several respects. The most important one to my mind is one the Government never talks about, which is the costs of actually operating a market. A study done by York University in 2004 using the data of 2003 found that the administrative costs of the NHS had risen from 5% in the 70s to over 14% then and changes since then must have increased those costs considerably, particularly the payment by results, which involves independent billing and the whole bidding process for contracts and so on. There are many other costs involved. So, I think, at a conservative estimate, something approaching 10% of the NHS budget is actually being swallowed by the need to operate a market, as opposed to other administrative needs. There are other costs of course that are being imposed, but I think that is the most important one.

AW Why is this happening Professor?

CL This would be a complicated and subjective judgement, but I would say that it is happening as part of a worldwide drive to impose basically market concepts on all areas of life, and that has been especially important in relation to the public sector. The public sector appears to the people who think in market terms as inherently inefficient because it is not above all driven by efficiency concerns, but by the need to meet patient needs.

AW So would you say it is ideological?

CL I would.

AW What impact do you say that these changes have had on accountability?

CL As I said before, I think there is a radical loss of formal accountability because the Secretary of State, who is answerable to Parliament which we elect, can now say 'Well, it's not my work, I didn't do this, look elsewhere.' This is now regulated by a market and the market is supposed to meet your needs by price signals, what people want will get met by the people in the market. We know from a wealth of studies that that does not happen, and indeed Gordon Brown, relying on an important treasury document that has conveniently been forgotten, in 2003 made a speech in which he pointed out that markets will never deliver healthcare if the healthcare is for all. Of course markets can deliver wonderful healthcare for the rich and lousy healthcare, or none, for the poor. To deliver good healthcare for all, which is what Bevan wanted, they can't do it.

AW One last question Professor if I may: What measures have the Government taken in your view to ensure that there is meaningful debate about the fundamental impact of these changes?

CL None.

AW Professor, I am very grateful. *(Applause)*

Panel question from Michael Mansfield (MM) to Professor Leys:

MM You very succinctly described the lack of accountability and the removal of accountability, which was the original concept, from the House of Commons, our supposed representatives. I want to ask a further question on that. The changes that are being advocated and put through, such as the recent Bill, the Health and Social Care Bill, approved by both the House of Commons and the House of Lords – what proportion of the people in both Houses have vested interests in the companies that are going to profit? *(Applause)*

CL I'm sorry I can't give you a figure for the House of Commons, but it is available. I could find it out. If the panel would like to know, I could provide that information. One of the think-tanks that study these things has counted 145 peers who have financial interests in healthcare providers or various types of service providers.

MM And does that cross, as far as you are aware, the political divide?

CL It does

MM Would you be very kind to provide the Commission, if you are able to ascertain, the figures in the House of Commons

CL I shall try, certainly. [This information can be seen online at http://www.savelewishamhospital.com/commission-witnesses/]

MM Thank you *(Applause)*

Professor Allyson Pollock (AP) interviewed by barrister Nicola Braganza

NB Professor Pollock, could you give first of all an outline of your expertise?

AP I am a Professor of Public Health Policy and Research at Queen Mary, University of London. I trained in medicine and then I trained in public health and so for the last 20 years as part of my work I've been looking at the effect and impact of privatisation on the NHS and government policies and one big area of work has been looking at public private partnerships as they are called, or the effect of the private finance initiative across the public sector, but particularly in healthcare.

NB I would like to ask you first about private finance initiatives and in particular a report that you've prepared: *PFI and the National Health Service in England* together with David Price, Senior Research Fellow, and that is dated June this year. In particular the report sets out that by April 2009 101 of the 133 new hospitals built between 1997 and 2008 or under construction were privately financed and it sets out that by April 2011 across the public sector more than 700 PFI contracts have been signed in the UK with an estimated capital value of almost £50 billion in England alone and annual repayments estimated at £8 billion for 30-60 years. What is the consequence of that? How has PFI featured in large NHS projects?

AP Hands up everybody who knows what PFI is? Ok, everybody does, good. PFI: instead of the government doing the borrowing or using taxes – and governments can

borrow very, very cheaply indeed – they go the private sector and they ask the private sector to do the borrowing. So they are borrowing through banks and service operators and equity investors. And the whole problem of going down that route is that it is very, very expensive, so the cost of private finance is incredibly expensive.

So the government borrows the money, but the problem is that the hospital trusts are left with the debt and these are 30 year contracts – and it is often extended to 60 year contracts. So the hospitals have to service the debts from their operating budgets. (Do you want me to say some more?) And this is a very expensive way of borrowing money. Research by Jim and Margaret Cuthbert has shown that for every single hospital designed and built and that is operating for the next 30 years, we are actually paying for two, but we are only getting one - and in some cases we are paying for three. So, if you can imagine two or three: Barts is my hospital: it's a PFI trust – we could have had three of those! But actually at the moment we are only getting one, so that tells you how expensive it is and how lucrative these deals are for bankers and the investors.

NB That brings me to the next point, which is: what is the accountability in the PFI contracts?

AP One of the big problems with PFI is that the contracts are commercial and often they are commercial in confidence, and neither the government nor the commercial contractors have an interest in revealing these contracts to the public, so they remain secret and even Parliament and the select committees have had extreme difficulty trying to get an understanding of how much exactly we are paying. So we don't know quite how much interest we're paying and what the returns are to the investors and all the other beneficiaries. So, they are commercial, in confidence and they have not been open to the public scrutiny.

NB Following on from that, in your report you refer to the fraudulent manipulation. What do you mean about that?

AP Well, one of the ironies is that some of the banks that we bailed out in 2010, like the Royal Bank of Scotland, where we poured in billions of pounds: we poured in hundreds of billions of pounds to these banks, so these banks, which in theory we own, are actually rebuilding their balance sheets on the back of PFI, because they are still continuing to charge the public sector hundreds of millions of pounds in excess interest charges. And many of these banks also have equity stakes, so they are making extraordinary returns on their investment. And the Chair of the Public Accounts Committee, who is a Conservative, called it 'the unacceptable face of capitalism', so high are these returns.

So, this is a really significant issue that the banks have been investing heavily. They are rebuilding their balance sheets, but they were also implicated in some of the fraudulent manipulation of the interest rates. So, if you think about it now, interest rates are about 0.5%. So government borrowing would be about 1.5-2%. And now on these PFI schemes we can be paying anything from 6% to 15%. That's just on the interest and of course there is a real issue as to whether the banks were actually manipulating and fixing the interest rates in the run up to signing of some of these PFI deals; and these are questions that remain there and have to be answered.

NB Thank you. I want to now move on and ask you about the TSA report and the analysis that you've just completed and that's entitled *The TSA regime and the South London Healthcare NHS Trust: a case of blaming the victims.* First of all: TSA – what does that stand for?

AP The Trust Special Administrator.

NB As a result of your analysis, what have you found to be the main consequences of that report?

AP Originally I had started off just looking at the national PFIs, but in the last couple of weeks it became very evident to me there was a bigger story going on in South London. What our report really shows is the way in which the problems of South London are being driven by central government policies, which include the private finance initiative. So the Government has landed South London Healthcare Trust, which included Greenwich and Bromley, with enormous debts, an unaffordable situation that they can't get out of.

On the way here the taxi driver said, 'The problem for Lewisham is that it is going to close, but it is the other hospitals in the area that messed it up.' That is not true. It is not the other hospitals that have messed it up: it's government policies that have messed it up. What the TSA has done is decide to try and resolve the issues locally, when these are national issues. It is not a local issue. So, the national policies include the use of private finance, which is making the whole system unaffordable locally, because South London Healthcare Trust has not one, but six PFI schemes, so if I tell you that for every hospital that is built, you could have had two or three running – that's what you're paying for – you begin to see the scale of the problem. The second problem is that other government policies include a deliberate policy of underfunding trusts, so trust incomes are falling while the PFI charges are rising.

And PFI is *very, very* hungry, because, not only are we paying very high rate of interest, the PFI charge is indexed to the measure of inflation, so the budgets for the NHS are falling, but the PFI charge is rising by about 4 or 5% a year. If I just give you an illustration, at the Princess Royal University Hospital in Bromley, the PFI payment has risen to £39 million a year and by the contract's close in 2030 – the contracts have been extended – it is £94 million. The PFIs just now are taking between 18-20% of the Trust's income.

That's a lot of money because *before*, PFI hospitals paid nothing from their income for capital and then the Government brought in something called a capital charge, which meant they were paying around 4% of their income. So, there is a big difference between non-PFI hospitals, which are paying 4-6% of their income and PFI hospitals which are paying out to the bankers and shareholders anything from 15-30% of their income.

If you remember a hospital's income mainly is spent on the staff, and staff are vital for the quality of care, as you all know; so, if you're paying the PFI and your bankers and your service operators and investors, you've less money to pay for staff, so something has to go.

NB What has the TSA failed to do?

AP The TSA plans are more major service reductions and budget cuts. The TSA's report has focused almost completely on the financial situation, but it failed to give the proper analysis. It has absolutely failed in that respect because it has made this a local problem that can only be solved by closing 15% of the beds across London. That includes beds at Guys and 41% of the beds at Lewisham.

What it absolutely failed to do – and this is totally irresponsible – normally when you have a major service closure, a reconfiguration, you would do a needs assessment, you would say: 'All right, we're going to change our services. Where will these patients go and how will services be re-provided?'

The TSA failed to do that and what we actually show is that there are no significant serious planning details or planning data in the TSA report or indeed in any of the expensive management consultant reports they've commissioned. So they commissioned Deloitte to do the MORI opinion poll, but that's not a measure of access or need; and they commissioned very expensive management consultants to look at travel times and travel access. Travel times are important, but actually the really important thing is – what are the public's needs and how are they going to be met and where are they going to be met and how are services going to be staffed?

Because what we do know from the TSA report is that we are going to see major service closures and major reductions in the staffing budgets, and that doesn't just include Lewisham, that also includes all of the neighbouring Trusts who are going to have to reduce their staff. So, where are patients going to go, how are they going to be treated and who is going to treat them? And the one thing we know from the Francis Report in Mid Staffs was that the focus on financial targets was to the detriment of patient care. The managers put the financial targets before they put the needs of the patients and that meant they cut the services, they cut the staff and there was no good quality of care. We now have lots of Mid Staffs in the making here, not just in South East London, but across the country.

NB Thank you. Finally, your recommendations as a result of your analysis: what are the key recommendations that you make?

AP I am going to read them out, because I think they are quite important.

We found that the TSA report is not evidence-based, its financial analysis is poor and misjudged and they have not conducted a proper needs assessment or planning. Because of that, we recommend:

1. That the TSA regime for South London Hospital Trust should be revoked and the case should be reconsidered afresh, excluding the effect of Government policies.
2. If it's the case that such reconsideration leads to re-jigging of the regime, then our second recommendation is that the TSA recommendations should only occur when a proper needs assessment has been done and when all the data, including the PFI contracts, are placed in the public domain.
3. With a third recommendation that the Government should make public and renegotiate all the NHS PFI contracts, the six South London Healthcare Trust's and the King's Trust's as well; and, in default of which, Parliament should act to require the Government to do so in order that Parliament, and

we the public, can better understand the reasons for the high cost of finance; can take steps to control those costs; and can have confidence in the credibility and fairness of Government decisions made on the basis of them.

4. Our fourth recommendation is that the TSA regime should not in the future be applied to Trusts whose deficits have been significantly contributed to by Government policies, as is the case here in South East London.
5. Finally, the TSA regime in future should not be permitted without a proper needs assessment. It should not be permitted to use productivity measures and targets as a substitute for planning and access. It should not be permitted to use travel times as proxy measure of public's use and need for services. It should not use MORI opinion polls as a substitute for public health planning and it should not use data that has not been put in the public domain. *(Applause)*

Panel question from Michael Mansfield (MM) to Professor Pollock:

MM Thank you very much. I just have one question. When one talks about the financial markets and when one talks about the initiative that you have, and that really the responsibility is not the hospitals', but in fact the Government policy in regard to this, and then you need to assess the needs of a community; has there been any quantification of the needs? In other words, if they go ahead with these proposals, what are the social and economic factors that have really not been quantified? In other words, it is no saving at all or am I wrong?

AP We know that from other hospital closures that there have been really no savings at all that have happened. So we have got past evidence of that; so you can cut services, cut staff and there are no savings. But you are talking also about indirect costs: so – unemployment, people being sick, not getting back to work, not having their operations; and there has been no quantification of that impact, neither in previous hospital downsizing and service closures or in this. And I should say that PFI is a bit of an engine for service closures because every PFI hospital scheme when it opens has affordability problems and it's necessitated going from three hospitals into one, but there has been nothing on the indirect costs and that has never been quantified or analysed at any point.

MM Is there anybody doing it at the moment?

AP Not to my knowledge, but I am sure you could find some management consultants to do it for many millions of pounds.

MM Thank you very much. *(Applause)*

EW Allyson Pollock's report is at this stage in draft form but she will be finishing it over the weekend and on Monday you will be able to access the report from her website www.allysonpollock.com, and the report is going to be called *The TSA regime and the South London Healthcare NHS Trust: a case of blaming the victims.*

Session 1 ends

CHAPTER 2
THE TSA REPORT AND LEWISHAM HOSPITAL

Secretary of State for Health, Jeremy Hunt:

On his main proposals for Lewisham Hospital
'This part of his [the Trust Special Administrator's] recommendation included reducing the number of accident and emergency departments across the area from five to four, replacing the A and E department at University Hospital Lewisham with a non-admitting urgent care centre, reducing the number of obstetrician-led maternity units from five to four and downgrading the current obstetrician-led maternity unit at University Hospital Lewisham to a standalone midwife-led birthing centre. Each obstetrician-led maternity unit would also have a midwife-led birthing centre. The recommendation also included co-locating paediatric emergency and in-patient services with the four A and E units, with paediatric urgent care provided at Lewisham, Guy's and Queen Mary's hospitals. Finally, he recommended that University Hospital Lewisham should become a centre for non-complex elective procedures, such as hip and knee replacements, to serve the entire population of south-east London.'

On saving '100 lives'
'With these caveats, Sir Bruce was content to assert that there is a strong case that the recommendations are likely to lead to improved care for the residents of south-east London and that they are underpinned by clear clinical evidence. He believes that overall these proposals, as amended, could save up to 100 lives every year through higher clinical standards'

On better clinical outcomes
'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.'

On 'No viable alternative plan'
'Yesterday, 30 January, as no viable alternative plan had been put forward, and in light of Sir Bruce's opinion, I decided to accept the recommendations of the trust special administrator, subject to the amendments suggested by Sir Bruce.'

On the 'four tests'
'I believe the amended proposals meet the four tests required for local reconfigurations and I am therefore content for the process now to proceed to implementation. I expect the South London Healthcare NHS Trust to be dissolved by no later than 1 October 2013.'

On maternal deaths
'Let us talk about maternity deaths. London has a higher rate of maternity deaths than most other parts of the country, and that is something that any responsible Health Secretary should try to tackle. The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives agree that the way to reduce the number of maternal deaths, in which London does not score well, is to centralise the facilities that deal with the more complex births in fewer sites, where surgeons can get more experience and deliver better clinical outcomes. That is what this proposal is doing. It will lead to fewer maternal deaths in Lewisham and south-east London.'
(*Hansard*, 31 January 2013)

Lewisham Hospital lies at the heart of a vibrant local community that is ethnically diverse. Its catchment area includes some of the most deprived areas in the UK and also has a high level of morbidity and premature mortality. Lewisham Hospital became Lewisham Healthcare NHS Trust in 2010 when it took over community services. The Trust works in close collaboration with its local partners and provides a broad range of acute and community services from a wide range of locations across Lewisham. This includes a full emergency service and local maternity and children's

services that are, importantly, easily accessible via public transport. Lewisham Hospital is central to the carefully constructed network of healthcare provision in the borough. (Sir Steve Bullock pp.12-13).

The Lewisham Healthcare NHS Trust (LHT) has worked hard to improve the range and quality of services available to local people and can point to evidence of improvements (Tim Higginson, CEO LHT pp.46-49). For example there are increasing numbers of women choosing to have their babies in Lewisham and the performance of the A&E department is improving against national targets. Progress was such that (prior to the Secretary of State's proposals for change) the Trust was moving steadily towards achieving Foundation Trust status. Indeed after extensive assessment the Trust had its Foundation Trust application approved by NHS London and submitted to the Department of Health in June 2012. (Full details of these points can be seen in *Response to the Draft Report of the Office of the Trust Special Administrator for South London Healthcare NHS Trust: "Securing Sustainable NHS Services"*, Lewisham Healthcare NHS Trust (2012) http://www.savelewishamhospital.com/commission-documents/)

In July 2012 the TSA began a process of engagement with those concerned with SLHT and the south east London NHS. However the Panel heard evidence of the failures of the TSA to take on board the submissions of the many concerned stakeholders. LHT itself, in its submissions to the TSA, noted that 'clinicians tell us they have been engaged in the TSA process but not listened to'. (Lewisham Healthcare NHS Trust (2012) op cit p 2)

Clinicians told the Trust that they were presented with a very limited pre-determined range of options by the TSA team, without any adequate opportunity to discuss alternative possibilities. They observed that clinician engagement in this process does not equate to clinician agreement and approval and they are extremely unhappy that it has been presented as such within the TSA's report (Lewisham Healthcare NHS Trust (2012) op cit p 11-12, http://www.savelewishamhospital.com/commission-documents/)

The Panel heard that in January 2013 the Secretary of State for Health announced that the downgrading of Lewisham Hospital's emergency admissions and maternity services could save around 100 lives a year. However it was unclear where the evidence for this claim had come from. In February 2013 eleven clinicians from Lewisham Hospital, led by Dr John O'Donohue, wrote to Professor Sir Bruce Keogh, NHS Medical Director, asking him to provide the evidence for this assertion. It is clear from this correspondence and the report of Dr O'Donohue which the Panel was shown, that the total of 100 lives theoretically saved by downgrading Lewisham Hospital was based on faulty analysis:

1. The unwarranted assumption that patients admitted at the weekend have the same risk of death as those admitted on weekdays. (John O'Donohue p.41) (For correspondence from Dr O'Donohue and colleagues to Professor Sir Bruce Keogh on this point, see http://www.savelewishamhospital.com/commission-witnesses/

2. Since 2011 all patients with strokes have been centralised: already, they are not taken to Lewisham but instead are taken to to King's or to theRoyal in Farnborough '… and we know the centralisation of these has resulted in a better mortality for stroke and heart attack' i.e. these lives have already been saved. (John O'Donohue p.41)

Dr O'Donohue informed the Panel that for other conditions speed of access to emergency treatment is of the essence rather than centralised care: 'It has been shown that what is important for meningitis is the speed you get antibiotics into the patient, not where it is delivered.'. Dr O'Donohue added that the Secretary of State made a 'very surprising claim' in his speech when he announced in his decision that meningitis patients would benefit. 'That is completely contradicted by the specialist societies and the evidence.' (John O'Donohue p.41)

Dr Donal O'Sullivan, consultant in Public Health Medicine for London Borough of Lewisham, told the Panel that, 'One of the main things for me and one of the main risks, as I see, it, in terms of the implementation of the TSA proposals, is the loss of that integration.' He was particularly concerned over the loss of the 'truly integrated children's service' that had been built up in Lewisham, which had led to lower rates of admission for children. (Donal O'Sullivan p.42)

Dr O'Sullivan also queried the introduction of maternal deaths in relation to the proposed reorganisation of maternity services by the Secretary of State in his speech in the House of Commons on 31 January 2013:

> 'Just on the 100 lives argument, I think to bring maternal mortality into this discussion is actually incredibly artificial. Maternal death is a very rare event in this country … I don't believe there is any evidence to support the idea that larger maternity services are safer, are less likely to result in maternal mortality; nor do I believe there is any evidence that they are better quality. In fact there is some evidence to suggest that they are of poorer quality and certainly women are less satisfied with those services. So the idea of moving to a larger service for maternity really comes with no benefit as far as I can see at all.'
> (Donal O'Sullivan, p.44)

Dr Donal O'Sullivan informed the Panel that there had only been one maternal death in seven years at UHL, a mother who had not been known to any service prior to presentation. 'And so during the whole of the rest of that time, that seven year period, there hasn't been a maternal death that's been of a woman known to the service.'

Dr Donal O'Sullivan also raised serious concerns about the quality of patient flow analysis on which the TSA proposals were based, particularly in relation to the question of what would be required to deliver safe and effective services for children and pregnant women in Lewisham and South East London. Dr O'Sullivan drew the Panel's attention to current under-capacity of maternity resources in the region, stating: 'I think we're on the brink of a major problem with capacity in maternity services in South East London.'

Dr Danny Ruta, Lewisham Borough Council's Director of Public Health, noted in later written evidence that where radical reform has been achieved, for example in parts of Spain and the USA, it 'required huge cultural professional change in leadership from within, gradual, incremental integration of clinical pathways across primary and secondary care, and has taken a minimum of 10-20 years to see significant results'. He concluded that such a change could be achieved in South East London but it would take 'clear and genuine Government commitments to clinically led service integration, and to ground-up integration of health and social care; through co-operation rather than competition, this might be achieved within 10 years'. 'The imposition, however', he continues, 'of crude, essentially arbitrary service closures based on wishful financial assumptions, is likely to have completely the opposite effect. It could put health and social care in south east London back 10 years.' (Dr Danny Ruta, http://www.savelewishamhospital.com/commission-witnesses/)

The Panel has found this evidence compelling and troubling.

SESSION 2 TRANSCRIPT

EW We are now going to start Session 2. This session will concentrate on the Trust Special Administrator, the TSA and the "evidence" that was used in considering the proposed changes and was there an alternative plan? First of all we are going to hear some videos from patients and health professionals.

VIDEO STATEMENTS I

Hazel Waters, Lewisham resident, wife of patient with Parkinson's, former librarian

People with Parkinson's have very severe difficulties with mobility, they're very prone to falls. They're prone to infections; and anything else that they have always makes the Parkinson's worse. Now at the moment because of the integration of services if a person with Parkinson's is taken to Lewisham Hospital, if something goes wrong with their medication while they're in there, with their medication regime or if their Parkinson's gets worse, they are also under the neurologist at Lewisham, Professor Chaudhuri, who is a world-class expert in this field can intervene with the staff at Lewisham if something's going wrong with their medication. If our members are taken, say to Woolwich or Farnborough, those links will be lost. People with Parkinson's are prone to falling. How safe is it to take somebody who's had a fall who is dementing, who is immobile, who can't express themself to an Urgent Care Centre? They would have to be taken to an A&E anyway because you know you can't tell from talking to them how badly they're hurt.

My husband has had to go to Lewisham A&E on several occasions and you know I have to be there to interpret for him because the staff can't understand him and so forth. The care we've received at Lewisham has always been excellent. But there's one aspect: Lewisham is much easier for us to get to. I mean this whole thing about *'Woolwich is only 3 minutes further away'* is absolutely ludicrous. There are nine bus routes that go to Lewisham – there are two that go to Woolwich and none of them are direct from our part of the world.

And the other issue relating to trips to A&E is hospital transport, which I don't think anybody has actually considered. Because when we've had to use hospital transport, you have several hours' wait – you've been in A&E for several hours and then you have to wait for hospital transport which I believe is supplied by G4S, with that company's usual efficiency. And you have to wait until the bus or ambulance has got its complement of passengers. So after having waited in A&E and being seen to, by this time you know, a person who is very vulnerable, and very ill, is feeling very tired, really stressed, probably dementing worse than they were before. Then you have a journey of several hours all around the borough to take people back to their homes, you have to wait till there's enough people to fill up the van, then you have to go round the borough so it's at least another hour and a half. That's just from Lewisham Hospital. I mean what's that going to be like? Can you imagine going from Woolwich all round the whole area of South-East London? Have these people ever travelled on public transport in South East London? Or in any mobility vehicle? They don't have a clue, and it makes me very, very angry.

Shannon Hawthorne, Lewisham resident, journalist, campaigner

I'm completely opposed to the Government's proposals to downgrade Lewisham's Emergency Department and maternity services. I believe that they are based on an appalling lack of clinical evidence. I believe that that consultation was a sham. The

final proposals for what the Government has termed 'a smaller A&E' and the midwife-led maternity unit were not in the draft report that was given to the public so I do not believe that we've been consulted on the proposals. And, as one of the four tests that the Government has for NHS reconfigurations is a full and proper consultation, I believe that that test certainly hasn't been met.

I have filed two Freedom of Information requests with the Department of Health. One was to ask what the travel time impact of the proposals would be on Lewisham mums having to go elsewhere for maternity services. I received an inadequate response so I filed an internal review and upon receipt of the response to the internal review the Department of Health admitted that they didn't know what the travel time impact would be and they weren't able to point me to any information about that. I've also got a second Freedom of Information request which as of today, 19th May, is still pending. That requested the clinical evidence behind Sir Bruce Keogh's claim that 75% of current patients to Lewisham's emergency services would still be able to use the department under the new proposals. The response that I got from the Department stated that this claim was based on admissions data. I then filed an internal review saying I wanted more detail on this and as of today, I think it's been 30 working days since I filed that internal review, I haven't received a response and I should have received it within 20 working days.

Anne-Marie Upton, Lewisham resident, RSPCA nurse
I believe that Lewisham Hospital is an integral part of our community. It sits right in the heart of Lewisham and every area in Lewisham converges in towards the hospital. I believe it's a good hospital – it serves our community well.

Carol Brown, Lewisham resident, former ICU patient and social worker
I very nearly died. In January last year 2012 I was admitted via A&E to the Critical Care Unit where they looked after me and somehow with their skills and my determination I'm still here. I've started doing Freedom of Information requests not just about A&Es – and obviously I'm very concerned about them – but also critical care beds, intensive care beds. At the moment approximately 18 are to go in Lewisham alone under the TSA plans and I imagine that's going to be repeated at ten or so other hospitals in the London area. I'm only alive because of having a critical care bed. So me and 200 other patients, something like that, where would we go? And I think honestly, I'd be dead, I know I'd be dead, there's no way I'd survive without the Critical Care Unit. And the other people, the same thing. I think I've had my chance even though I'm only 52 now. You know I've had my chance, I've used my critical care bed but I want others to have that chance should they need it. Other people are parents, or even if they're not they're going to be enjoying their lives, getting on with their life, they should not be condemned to die.

Shakeel Begg, Imam, Lewisham Islamic Centre
I've been the Imam here for 15 years now and part of my work is to teach Arabic, to teach Qu'ran, teach Islamic studies, conduct marriages, give counselling, give advice, also youth work and gang mediation. My connection with Lewisham Hospital is that I'm a volunteer Moslem Chaplain at the hospital which means I engage and deal with staff as well as patients in terms of advising them, in terms of Islamic issues and their religious needs. The Moslem community, as well as the Centre, has built a good relationship with Lewisham Hospital; and the community feels that Lewisham hospital and its staff understand the sensitivities of the Moslem community. And were these individuals from the community to move elsewhere to other hospitals we

feel that they would not be able to understand our sensitivities and concerns as Lewisham Hospital and staff can understand those sensitivities.

The response from the community has been very unified and great. Faith communities as well as other communities have come together against any change in Lewisham Hospital, and any closures to Lewisham Hospital. Sadly, the faith communities and the wider community in the London Borough of Lewisham feel that their concerns have not been taken into consideration by the Government.

Jos Bell, Lewisham resident, blogger, campaigner, former patient
My view of the changes that are proposed is that they are frankly dangerous. They will as far as I can see create a situation where there's going to be thousands of people needing emergency medical help or help with more chronic conditions. There's just not going to be a place for babies to be born, there's not going to be a space or a place for people to have their accident and emergency needs met because, already, the surrounding hospitals are at seemingly breaking point. Already the system is at breaking point and Lewisham is existing; so whatever the term you want to use – 'downgrade it' is I think a kind term, dismantle most of the acute services in Lewisham leaving the borough with nothing but a rump of an Urgent Care Centre with one consultant, that ambulances will not visit. So, the ambulance services are going to have to do longer and longer journeys, which reduces the number of patients they can care for.
(Full statements can be seen at http://www.savelewishamhospital.com/commission-witnesses/)

LIVE WITNESSES

Secretary of State Jeremy Hunt's stand-in, reading excerpts from his speeches, interviewed by Di Middleton (DM)

DM *Minister, we know that the Trust Special Administrator, Matthew Kershaw, has proposed major changes in his report and you have decided to implement those changes. Was that a difficult decision for you?*

JH *It would be totally irresponsible for me as Health Secretary to fail to take a decision that could save as many lives as I believe this decision will save. If we are to save more lives in A&E and reduce the number of maternity deaths in London, it involves taking difficult decisions.*

DM *In real terms, how many lives will be saved?*

JH *These proposals, as amended, could save up to 100 lives every year through higher clinical standards.*

DM *The independent clinical review conducted by Sir Bruce Keogh addressed the issue of local patient care. How significant was the input of that review with regard to the saving of lives?*

JH *In the end, the things that matter the most are the clinical considerations. I thought it was extremely important to take advice from the NHS Medical Director, Sir*

Bruce Keogh, and I have taken that advice. He is absolutely clear that this will save lives, which is my biggest responsibility.

DM *Were there any alternative proposals which could properly address the problems?*

JH *Matthew Kershaw looked extensively at whether there was an option within South London Healthcare NHS Trust to solve the problem. He invited expressions of interest from other people who might run the hospitals in the group, but nobody was able to come forward with a proposal that would solve the problems within the geographical confines of the Trust. Indeed, nobody, not the Labour Party nor any of the people who opposed these changes, has come forward with a proposal that would not impact on the neighbouring healthcare economies.*

DM *Thank you.*

Dr John O'Donohue (JOD), Consultant Physician, Lewisham Hospital, interviewed by barrister Amanda Weston (AW)

AW Could you please, for the Commission, give your name and your qualifications?

JOD Yes, my name is John O'Donohue. I am a physician working at Lewisham Hospital.

AW What is your current role?

JOD As a physician in Lewisham Hospital I am one of a number of senior doctors, consultants, who look after patients admitted through the A&E Department at Lewisham Hospital and these would be cases such as pneumonia, headaches, infections, which come under medicine, rather than surgery or gynaecology.

AW As part of your role, task, overseeing admissions, which departments and professionals would you be dealing with on a regular basis.

JOD When patients come by ambulance or on foot to A&E there is no way of predicting which specialist services they will need. A significant amount would need coronary care, the specialist services there; a significant amount would need intensive care with the back-up of the critical care physicians and also the anaesthetists that that entails. We also have regular need to call the obstetricians or gynaecologists and to see patients who are pregnant.

AW Can you explain to the Commission what in your view would be the impact of the TSA proposals on your Department?

JOD The acute physician role that I undertake would, to all intents and purposes, disappear on the Lewisham Hospital site. We couldn't run acute medical service in the absence of the backup facilities that lie behind the front door of the A&E Department. The slimmed down 'small-but-safe' A&E that was part of the amended proposals – there are no details that have crystallised behind that; but it is likely that this will not involve Intensive Care staying at Lewisham, or those extra specialist services that I mentioned that are so vital to run acute medical emergency services.

AW Would you just like to, in a nutshell, set out what you understand to be the small and safe option?

JOD This stretches the definition of an A&E which would have the support services behind it to support patients who come in by ambulance. It's unlikely that this smaller A&E would be open to ambulances. It's likely that it would be, to all intents and purposes, a Minor Injuries Unit for patients who wouldn't require urgent admission. Like many minor injury departments, patients would only go to it if they knew there was no serious possibility that their condition would need admission. GPs who saw patients at their home would not direct patients to it. So, as it happens in other parts of London, there is a very real possibility that this would lead to a big decline in the hospital and the services it provides and an attrition: of staff who would leave, patients who would be reluctant to use a hospital with only a minor injuries department; because, if you are a patient in the middle of the night with a headache and you fear the worst – and I have done that for my own family – do you want to go to a hospital where staff is an extended nurse practitioner, not an A&E specialist and there is no surgical back up or intensive care back up? Or for a child, paediatric back up? The answer is probably 'no' in many cases.

AW You're saying effectively that people would be turned away?

JOD In a Minor Injuries Unit or a smaller A&E there would definitely have to be rules to limit the severity of illness in the patients who turn up because it wouldn't make sense to have patients having a cardiac arrest with no cardiac arrest team; so patients would be told that this is not a fully-fledged A&E and the London Ambulance Service would be probably not calling at its door.

AW Presumably there would be no access to Intensive Care either?

JOD Those details haven't been completely ironed out. It's a very expensive facility and if patients are not going to be admitted from the A&E Department, or what's called the A&E Department, to the hospital then there would be no rationale to have an Intensive Care to support those patients.

AW Thank you. You have heard the Minister, his claim that proposals will save up to 100 lives a year. Can you explain where this figure comes from?

JOD We did challenge the Secretary of State and Professor Sir Bruce Keogh on this figure and I am disappointed to say that the response from Bruce Keogh contained the phrase: *"This is not an exact science"*. Before I go into the details of the statistical heresy that underpins his claim, events have moved on. We have had Sir Bruce Keogh's other predictions of mortality since then in the Leeds cardiothoracic case. I think that can only serve to undermine his role in this. Also, we have had direct experience of the closure of an A&E Department in England. A Freedom of Information request for Newark A&E showed that the death rate for patients living in Newark who had to be shipped to a neighbouring A&E when Newark A&E closed rose by 25%.

AW Could I just interrupt you there: you are saying you are going to come to what's wrong with those figures?

JOD Absolutely

AW What you are saying is: now there is empirical evidence which undermines that claim?

JOD Since the Secretary of State's decision those two pieces of evidence have come to light. Going back to the Secretary of State's claim that 100 lives would be saved, if you go into the basis for this it all hangs on research from nearly ten years ago from 2004. And this research looked at emergency admissions in England over a period of one year and they found patients coming in at the weekend had a mortality that was higher than patients who were admitted during the week; and they made the heroic claim from that evidence that this meant that patients weren't properly being looked after over the weekend and, therefore, they were more likely to die as a result of that.

If you go into the actual academic paper, the authors themselves actually concede that there is another potential explanation for this and I would ask you to look at data for patients admitted at the weekend. In fact when they looked at the patients admitted at the weekend, in any 24 hour period at the weekend only three-quarters of the numbers of patients were admitted compared to the weekdays. These patients admitted at the weekend were sicker to start with.

AW So you say that one explanation for the figures were that patients were actually sicker when they were admitted. Are there any other specific explanations for figures that you can think of?

JOD I want to expand on that one a bit more, because that's an important one. We take it that emergency admissions aren't always delivered to hospital in an ambulance because in severe cases, such as a severe heart attack or a stroke, you would think that their admission would be spread evenly throughout the week. But they are only a minority of cases.

In fact you are more likely to see admissions who come in from GP practices, who come in from hospital clinics – patients whose decision to admit to A&E is sometimes a little bit marginal; and of course the hospital clinics and the GP surgeries tend to operate during the week. So, patients will often tough it out over the weekend and come in on Monday.

The patients admitted at the weekend are a selective bunch of patients who are often sicker and are quite likely to have a higher mortality to start with. Just to expand on that, I'll take an extreme example: patients admitted on Christmas Day – Christmas Day is a day nobody wants to end up spending in A&E. We know that patients admitted on Christmas Day are of a higher mortality because they are sicker to start with and this is what we are seeing in this paper and this is the basis of the whole premise that *'100 lives will be saved'*.

What the paper showed was that the excess mortality at the weekends was 3,300 for England and they broke this down on the back of an envelope and calculated that for the South East of London pro rata this would be 100 lives and this is the basis for the whole clinical justification that the Secretary of State has made.

AW What arrangements has Lewisham already made to separate off those conditions which would benefit from specialist, rather than speedy intervention?

JOD This brings me back to the other flaw in the argument, which I think you were driving towards since your last question. We do know that for some conditions centralised care is better and that's why since 2011 all patients with strokes have been centralised; they haven't been coming to Lewisham, they have been coming to King's or to Princess Royal in Farnborough. Since 2009 all heart attacks have been diverted, either from A&E in Lewisham or by the London Ambulance Service to specialised heart attack centres and we know the centralisation of these has resulted in a better mortality for stroke and heart attack. But they are the only situations where this applies.

AW Could I just ask you what impact will these changes have on patients for whom speed is of the essence?

JOD An example of that is meningitis, where it has been shown that what is important for meningitis is the speed you get antibiotics into the patient, not where it is delivered. And so the Secretary of State made a very surprising claim in his speech when he announced in his decision that meningitis patients would benefit. That is completely contradicted by the specialist societies and the evidence.

AW You've heard the Government's 'sound bite': what 'sound bite' might you prefer?

JOD I think *'Lewisham lives will be lost by this'*. The fact that you can close a successful, solvent District General Hospital – with care that is deeply rooted in the community as we have seen from the last video and with better than average mortality – and just replace that somewhere else: I think that's a very dangerous leap of faith.

AW Thank you very much Dr O'Donohue. *(Applause)*

Dr Donal O'Sullivan (DOS), Public Health Consultant, London Borough of Lewisham, interviewed by barrister Maureen Ngozi Obi-Ezekpazu (MO)

MO Can I ask you to tell this Commission your name please?

DOS My name is Donal O'Sullivan

MO And your qualifications?

DOS I'm a Consultant in Public Health Medicine

MO Where is your role currently carried out?

DOS I work for the London Borough of Lewisham in the Public Health Department there and I'm responsible for advising the Council and indeed the Clinical Commissioning Group on the quality of maternal and child health services.

MO I'm going to ask you a series of questions around each of those services. First of all, what is said currently about the services that are provided for children in Lewisham?

DOS Firstly, I would say that I think objectively and by however you rate the services for children in Lewisham, particularly the hospital services, but also community child health services, I think they are of a very high standard. I think it's a real boon to Lewisham children that we have a service of this standard in our local Trust. And this service delivers, particularly through community child health services, but also – and critically – through the children's consultant-led A&E service and indeed the hospital service.

MO Can you just expand upon that: an integrated children's service is what Lewisham has currently?

DOS That's absolutely right. One of the developments over recent years is the emergence of a single Trust and a truly integrated children's service. Though always well integrated, the hospital and community services are now part of the same organisation, which does carry an additional advantage. One of the main things for me and one of the main risks, as I see, it, in terms of the implementation of the TSA proposals, is the loss of that integration. And indeed we've also got to bear in mind that maternity services are part of the same Trust.

MO Can you help the Commission with this: what effect has the integrated children's services had on admissions for children to hospital?

DOS One of the first things I discovered when I first took up the responsibility in relation to the public health aspects of child health in Lewisham was that the admission rate for children in Lewisham was much lower than we would expect, particularly given the level of disadvantage in the local population. In fact the admission rate was less than 70% of what we would expect and I was puzzled by this and wondered what the reasons for this might be, because the levels of need locally are quite high.

One of the things I thought might be an explanation was that the consultant-led nature of the service meant that children were much more likely to get a high level of assessment, where junior doctors could be supported by a consultant in a decision to discharge, where the child would actually be managed at home by their parents or carers.

In fact we felt we should explore this a little bit more and we were lucky to have a trainee in our department who was doing her MSc at the time. She did her dissertation looking at admission rates throughout the country and related those to whether or not there was a consultant-led children's A&E Department, and was able to show that there was a significant association between having a consultant-led A&E Department and low admission rates: and that's very clear – it is a very clear association.

MO Can I ask you to just explain to the Commission: under the TSA proposals, what it would look like in the event that Lewisham were to close?

DOS As Dr O'Donohue explained in relation to the adult side, I think the children's side would be very similar. There would be an ambulatory care department for children and that might well be consultant-led. However, the definition of an ambulatory care department is that patients seen there are much less likely to be

admitted, and indeed if somebody who requires admission is seen there, it is almost a failure of the triage by the ambulance service that they've arrived there.

So that then, I think, it would be necessary for the new Trust – the combined Trust – to actually have all the inpatient provision at Greenwich. And therefore, for consultants, I think it would be very inefficient probably to have a consultant-led service just for ambulatory care at Lewisham Hospital, which would in the end mean, I think, that most parents would probably take their children to Greenwich if they could.

MO Would it be an integrated service, or would it be fragmented?

DOS I think it would still be integrated in that the service at Greenwich and the service at Lewisham would be run by the same Trust and would have the same individuals in it, but the local focus in Lewisham would be much less, and parents would find it much more difficult to access a full consultant-led service.

MO Will it be safe for the children of Lewisham?

DOS I'm confident in the people who would be running this that they would make it safe. I'm confident that the people working within the Trust at present, who would be working within these new arrangements, would make these arrangements safe. My worry is that far more parents will find it much more difficult to take their child to a consultant-led full A&E service and that will cause problems for them and for their children.

MO Can I move on to the maternity services within Lewisham: can you tell the Commission what is said about the current service that is provided to would-be mums?

DOS The current service is increasingly popular, I think it is fair to say. I think certainly the new midwifery-led Birth Centre is cherished by local users, local women in particular, and I think over the years a lot has been done to make the service of much higher quality and it is much more highly rated by women.

MO You've been part of that provision under commissioning?

DOS I think we've had a very effective collaboration between the former PCT – now the CCG, the Trust and indeed the Public Health Department to enhance the service that exists in Lewisham.

MO Can I then ask you how that service … what it will look like under the TSA proposals?

DOS My main concern is essentially about capacity generally. I think within the sector at present we are constantly on the bones of not having enough beds, in not having enough capacity to deliver a safe service. That's in the whole sector. So, if you look at all the Trusts in South East London over a period of 18 months where we looked at this, they actually on average each month, at least two of those units had to close on at least one occasion; and that's almost always because of beds, because of a lack of capacity.

We are also as a sector highly dependent on Darent Valley Hospital, where many women from Bexley now go to have their babies, and Darent Valley is itself experiencing problems because of capacity. So I think we're on the brink of a major problem with capacity in maternity services in South East London.

To actually alter that at this time, or to interfere with that, I think, is fraught with danger and I'm not entirely sure that enough thought has been given to that at all in these proposals.

The second issue that I worry about is that the proposals clearly assume that most of the flow will go to Greenwich. There's no evidence for that that I can see. Women in Lewisham historically, if they haven't chosen Lewisham Hospital, have gone to King's or have gone to Guys & St Thomas', with a small number in the south of the borough going to Princess Royal (Farnborough). I'm fairly confident that women will find it incredibly difficult to have to go to Greenwich and most will actually go elsewhere.

So, one of the things we did is we looked in detail at the flows and the potential future flows and we believe that in fact most women will go to King's or St Thomas' and we believe that that will mean that these hospitals will become very large in terms of the size of their maternity service: so large that they will have to, if you like, double up their provision, particularly in relation to their provision of the obstetric rotas, which will make this a much more expensive service. That's also of course assuming that both of these hospitals have the capacity to extend their service. King's, for instance, is on a very restricted site geographically and so there are all sorts of pressures on King's.

MO Has this in fact been looked at by the Government when it came to make these proposals for both children's services and maternity services? Is this evidence based?

DOS I think it's difficult for me to answer that because I've never had a really meaningful dialogue. I've submitted what I feel is reasonable evidence, contrary to the points they've made and the assumptions they are making, and I've not really ever had, in my view, a satisfactory response, so I can't say that they're evidence-based.

MO But will these proposals... is it going to result in a safer system for children and maternity services in Lewisham or is it likely to be less safe?

DOS On the maternity side, as I said, I think there's a huge risk that if we don't manage any change properly it will be unsafe. Children will be born in transit and there are all sorts of problems associated with that.

Just on the 100 lives argument, I think to bring maternal mortality into this discussion is actually incredibly artificial. Maternal death is a very rare event in this country and I think to have even one would be a disaster. I don't believe there is any evidence to support the idea that larger maternity services are safer, are less likely to result in maternal mortality; nor do I believe there is any evidence that they are better quality. In fact there is some evidence to suggest that they are of poorer quality and certainly women are less satisfied with those services. So the idea of moving to a larger service for maternity really comes with no benefit as far as I can see at all.

MO From your experience, and from the work that you've been doing, what do you say the Government should be doing in relation to services for both children and maternity?

DOS I think with children in particular there is a real anxiety amongst many that we are not providing as good a service for our children as a country as we should be. We know that the mortality of children in the UK is higher than in other developed countries. There is some evidence to suggest that that is about the way we organise the provision of our paediatric services and I don't believe that changing services in this way is going to go anywhere towards addressing that issue.

MO Thank you very much. *(Applause)*

Panel question from Michael Mansfield (MM) to Dr Donal O'Sullivan:

MM It might help if you have in front of you the folder we have which has documents in it, because one of the documents – and I don't think those who are here will necessarily have it – it's tab 4, a letter addressed to you from Professor Keogh, NHS Medical Director, dated 13th February. Do you have that?

DOS No, that's addressed to Dr O'Donohue, not me.

MM Can I just ask you about this because you will know about some of the points: did you ever receive a copy of this?

DOS I'm not sure that I have.

MM Well, the points I just want to ask you about are these: first of all it's clear in this letter, and I'm just going to read out a paragraph:

'I want to make it very clear that I was not asked to provide a judgment on the quality of healthcare in your hospital and this has not been called into question either within the TSA report or in any advice I have provided to the Secretary of State.'

Is that your understanding, that there has been absolutely no criticism of any deficiency or any shortcoming in the healthcare provided by the hospital by any single quarter?

DOS Yes

MM Second question: that in fact the decision to trigger the regime was taken in the light of serious concerns that if the financial problems were not tackled there would eventually be significant impact on the quality of care for patients which make up the SLHT. Of course Lewisham is not part of that.

DOS That's correct

MM Is it your understanding that the financial problems not being tackled were created by the Government themselves?

DOS The financial problems are not in Lewisham Healthcare Trust and that's the

strongest point to me: that it seems extraordinary that this Trust is drawn in to the problems of another and certainly those problems were not of Lewisham's creation.

MM The last page, in terms of reconfiguration – what is being claimed here: that it will only happen if clinical colleagues across the different hospital sites are heavily involved in the design and delivery of any changes. Are you aware of anybody across the site being involved in the design and the delivery of the changes?

DOS Certainly not up to the point that the TSA's recommendations went to the Secretary of State. I think we did have consultation days where clinicians were consulted with on the changes, but not in relation to the design of the future changes.

MM Thank you. Another question: I just have a question about maternal deaths. As well as this figure of saving 100 lives a year, Jeremy Hunt says here in the Houses of Parliament that closing the Children's Department here will lead to fewer maternal deaths in Lewisham and South East London. I'm pretty sure I've seen a figure amongst this bundle that says there has not been a maternal death in Lewisham for seven years. I wondered if you could confirm that?

DOS There has been one, but one that hadn't been seen at all by any service and so during the whole of the rest of that time, that seven year period, there hasn't been a maternal death that's been of a woman known to the service.

MM Thank you. *(Applause)*

Tim Higginson (TH), Chief Executive Lewisham Healthcare NHS Trust, interviewed by barrister Nicola Braganza (NB)

NB Could you confirm your full name please?

TH Tim Higginson

NB And, Mr Higginson, what is your role?

TH I'm the Chief Executive of Lewisham Healthcare NHS Trust.

NB Could you please describe what your responsibilities entail?

TH Well, the organisation is in business to provide healthcare so I am accountable for the quality and range of services that we provide and for the resources that we use.

NB Who are you accountable to?

TH: I'm accountable to the Trust Board which consists of executive and non-executive directors, but there are a range of other organisations and agencies to which I am also accountable.

NB Which of those agencies is the Trust held to account to?

TH We're held to account by the National Trust Development Authority, known as

the NTDA, which looks after all Non-Foundation Trusts in England. There is the Care Quality Commission, which licenses us to provide services and can inspect us and our commissioners. And both NHS England and also our local clinical commissioners here in the borough. Last, and not least, in a very important but less formal way, we are accountable to the local community, to the public and to the patients that we serve.

NB You speak about the patients that you serve. Who are those people?

TH They are principally the residents of the London Borough of Lewisham. But in some services we also provide services to a wider range and I think a point has already been made in that, if you are in the Borough and you need urgent or emergency care, then currently the likelihood is that you will come to Lewisham.

NB How would you describe that community? What sort of people make up that community?

TH The Borough has a younger population. It's a very diverse population and it's also a population which has some groups in some areas of deprivation and need.

NB What do you say is at the core of the service that you provide for those people?

TH The core of the service is to meet their local needs which will be expressed by themselves but also by the commissioners who contract with us on their behalf. It is a full range of services for local people. Clearly for more specialised services, we are part of a pathway which sees those patients being treated in other organisations too.

NB In the time that you have been Chief Executive, since March 2008, what is your view as to the change in the range and the quality of services that you provide?

TH In terms of the range of services probably the most significant change was when we were selected as the organisation to provide the Community Health Services in the Borough. The Commission will have heard that earlier. It makes us an integrated organisation providing hospital and out of hospital care. In terms of quality, all the staff in the organisation have worked hard, certainly during my time here, to improve the quality of what they provide.

NB In terms of examples of how that quality has improved and the range of services has improved, women giving birth/women choosing to have their babies, how has that changed over the years?

TH We have seen an increase in the number of mums who want to come and have their baby in services provided by the Trust. They are an extremely discerning clientele and I would regard that as a significant mark of improvement that more mums want to come to have their babies. You will already have heard of the outstanding reputation of children's services, which are actually borough-wide, but the Trust is very proud to play its part in maintaining that reputation.

NB What about the performance of your A&E Department against national targets?

TH During my time in the Trust the hospital has an excellent record of meeting the targets and standards that have been set for it. Those targets and those standards become very difficult at particular times of year, notably in winter, but the team in the department and the backup team throughout the hospital, because a large number of people are involved in supporting this pathway of care, have enabled us to maintain that high standard and hit those targets.

NB Mr Higginson, is it a fair summary to say that you are extremely proud of your excellent record of improving care and meeting targets?

TH I am very proud of that record.

NB Turning to the Trust Special Administrator's appointment and report, what was your response to that decision?

TH We were not surprised that action was taken with regard to the South London Trust because the problems that organisation was facing were well known and well publicised. What we were surprised at was when it became clear during the course of the TSA's work that *we* were regarded as central to the solution in terms of service changes that were being proposed.

NB What was your involvement in the programme of work established by the TSA?

TH I took part in the programme of work along with other senior staff from the organisation and, indeed, other staff from the other six boroughs which together make up what the NHS likes to call South East London.

NB The proposals were issued for consultation and the Trust Board submitted its response on 12th December 2012. What were the main points of your response?

TH The main points were that we were concerned at the proposed service changes and we went through those in some detail. We did recognise that difficult decisions would need to be made to ensure that we could maintain and improve service quality while at the same time keeping within the resource envelope that was available.

We did in fact see merit in joining with Queen Elizabeth Hospital because we felt that would give us a better chance in some areas to meet the standards that we were being set, but in general terms we believed it was important for the local partners in the provision of health and social care to work together to identify how that should be done.

NB Bringing what you have said together, three particular key points I want to ask you about: the first is your view as to the financial viability and how the Trust is doing. What do you say on that?

TH Of the Trust at the point at which the TSA began, we were on course to become a Foundation Trust. We had submitted our application to the then London Strategic Health Authority and it's passing through them to the Department of Health; and certainly at that time perhaps the key consideration was a demonstration of financial viability.

NB In your role as Chief Executive and your experience, how does Lewisham tackle problems, how do you resolve matters?

TH The Borough, the community in Lewisham, has a strong record of tackling its problems together and tackling them successfully. Partnership working means that we don't just agree in the good times, but we also need to work through and agree in the difficult times and I certainly have been very proud to be part of a community which has always prided itself on doing that.

NB Very finally Mr Higginson, were you asked to put forward an alternative plan?

TH We were invited to submit an expression of interest by the TSA as part of the preparatory work and we did express interest. We said that we could see merit in coming together with the Queen Elizabeth Hospital and we outlined, but only in outline, what we would do to ensure that that organisation would be successful, both in terms of providing the right standards of care, but also within the resources available.

NB What happened to that suggestion/ that proposal on your part?

TH It was not taken up.

NB Thank you very much. There may be some more questions for you. *(Applause)*

Panel question from Michael Mansfield (MM) to Tim Higginson:

MM Thank you very much. The expression of interest I think we would be interested in – is that contained in a publicly available document?

TH That was in a letter which I wrote at the time. There was confidentiality because this was seen as a confidential part of the TSA's work. What I will need to check is whether that confidentiality lasted only for the purposes of the TSA exercise and whether that is now available, but I will happily check.

MM I wonder if you could very kindly check that and, if it is available, may we have copy?

TH Indeed.
[The letter was released following a Freedom of Information request to LHT and can be seen online at http://www.savelewishamhospital.com/commission-witnesses/]

MM Thank you. *(Applause)*

Session 2 ends

CHAPTER 3
GPs AND THE COMMUNITY

Secretary of State for Health Jeremy Hunt

On the Lewisham Clinical Commissioning Group
'The public campaign surrounding services at Lewisham hospital has highlighted just how important it is to the local community. I respect and recognise the sense of unfairness that people feel because their hospital has been caught up in the financial problems of its neighbour … Those concerns are echoed by Lewisham clinical commissioning group and many clinicians at Lewisham hospital.'

'With respect to the GP-led clinical commissioning group in Lewisham, of course I understand its opposition to the proposals put forward by the trust special administrator, but it supports the principle that complex procedures should be done from fewer sites. That is an important point. Inevitably, when we are reducing the number of sites for complex medical procedures, the people in the areas where those procedures will no longer happen will often be opposed to the changes. That is what has happened here, but the group supports the principles behind what the trust special administrator has said.'

'Sufficient clinical input'
'As a result of those concerns, I asked the NHS medical director, Professor Sir Bruce Keogh, to review the recommendations and to consider three things: whether there was sufficient clinical input into the development of the recommendations; whether there is a strong case that the recommendations will lead to improved patient care in the local area; and whether they are underpinned by a clear clinical evidence base, as set out in the third of the four tests for reconfigurations.'

'On the matter of clinical input, a highly experienced clinical advisory group, led by local GP, Dr Jane Fryer, and including eight trust medical directors, six clinically qualified clinical commissioning group chairs, the London ambulance service medical director, the local director for trauma and three directors of nursing, supported the trust special administrator. Further scrutiny and challenge was provided by an external clinical panel, which included representatives from the Royal Colleges of Midwives and of Obstetricians and Gynaecologists. The panel was chaired by Professor Chris Welsh, the strategic health authority medical director for the midlands and the east of England. Both groups included respected national and local clinicians. They built on years of previous work in this area and held a series of clinical workshops in August and September last year.'

'Sir Bruce was satisfied that there had indeed been sufficient clinical input.'
(*Hansard*, 31 January 2013)

Session 3 focused on community health, the work of GPs, and the effects on the community of the proposals.

Kathy Cruise is a community nurse, involved in a successful programme with proven outcomes of increased social inclusion. She spoke of the risk to economically disadvantaged young parents of the proposed changes to maternity services. In her video evidence she informed the Panel that this group of young parents has a 25% higher change of having a low birthweight baby. Low birthweight can have a profound impact throughout a child's life. She described how Lewisham Healthcare NHS Trust had increased access for this group to ante-natal services, thus greatly lessening the risk of low birthweight babies. The Panel heard that for young disadvantaged parents the relocation or dislocation of these services to another, more distant hospital could have a "massive impact". An apparently simple thing, like

finding the money for public transport, would be difficult for those on low incomes and might lead to many not accessing services. (Kathy Cruise, p.53)

Cathy Ashley, a Lewisham resident and former carer, described how essential the A&E services were for her husband, given frequent complications from his leukaemia treatments, and how reliance on ambulance services would increase if distance from an A&E were increased. (Cathy Ashley p.54)

This session heard evidence from four GPs, two on video and two oral witnesses. They described how the proposed changes present a significant risk to patients. Pressures from A&E closures lead to more patients being prematurely discharged. More A&E closures will put more pressure on existing services which are already finding it difficult to cope.

Dr Helen Tattersfield, the chair of the Lewisham Clinical Commissioning Group (CCG), described the collaborative spirit and strengths of the community, at the heart of which is the hospital. Dr Tattersfield told the Panel that the TSA proposals did not have Lewisham clinical support. The loss of the hospital would mean great fragmentation: for mental health services, paediatrics and care of the elderly, among others. She felt that the collective expertise of the CCG was ignored by the TSA process. She described meetings where issues were raised by CCG members, but points which went against the view of the TSA and his colleagues were ignored. Those attending were not given advance notice of topics to be discussed, and were not allowed to take documents away afterwards.

Dr Tattersfield told the Panel that that Lewisham Hospital has an important role in maintaining the quality of primary care in the area in terms of teaching and training the next generation of GPs. Almost all GPs in Lewisham have been trained through Lewisham Hospital. Here they learn first-hand what an excellent place Lewisham – this challenging, diverse and underprivileged area – can be to work in. Dr Tattersfield stated that if these changes were to go through, Lewisham Hospital would no longer be able to train GPs, which raises the vital question: where will the next generation of GPs for Lewisham come from?

A patient's journey through the NHS is called a care or clinical pathway, Lewisham GP Dr Brian Fisher told the Panel. The [current] care pathways depend on delicate arrangements, careful planning and relationships at a local level. It is a localized process, but does depend on a national and evidence-based process. Dr Fisher informed the Panel that the TSA proposals would 'smash' these carefully constructed care pathways. The TSA cut across all of these, destroying these crucial links. The Panel heard that, in purely financial terms, this makes no sense as the cost of replacing such services would be enormous. (Brian Fisher p.63)

SESSION 3 TRANSCRIPT

EW We're now moving in to Session 3 where we will be looking, with the witnesses, at the community issues and the work of GPs and the effects on the community of the proposals and broader NHS issues.

But first of all we have some videos of witnesses to the Commission.

VIDEO STATEMENTS 2

Kathy Cruise, Family Nurse Supervisor, Lewisham resident
My job is based on an American evidence-based programme of 30 years standing and it was brought to the UK by the Labour Government in 2006 by the Social Inclusion Unit as it was seen to have proven outcomes to increase social inclusion and reduce things like conduct disorder. And the programme came to Lewisham in January 2010 and has done so well that we have been given money to expand the programme in Lewisham so our team will increase by a further two nurses this year to reach a wider population.

The proposed changes [to Lewisham Hospital] will have a huge effect on the young women and men that we visit in the home. The majority are economically and socially disadvantaged and they do rely on Lewisham Hospital for ante-natal care, for the birth of their children and to use Accident and Emergency when necessary. So relocating to a hospital, for them a hospital that's five miles away – more than an hour on public transport – will have a massive impact on their health. Younger parents can book later than older parents – they have a 25% higher chance of having a low-birthweight baby. Lewisham has worked very hard in the last five years to reduce low birthweight in babies. The effect of low birthweight on babies has a very profound impact, not just in the immediate time after birth but also throughout life. And Lewisham had a very high low birthweight rate compared to the rest of the country but, after five years of hard work, and most of that attributed to booking early and having direct access to midwifery care so that young women don't need referrals, the low birthweight is now greatly reduced and is on a par with the rest of England.

Finding the money to use public transport when you're on a very low income is very, very difficult, so we're very mindful when we run groups for our young parents that it's very hard for them to actually access groups because they can't afford to travel. And it does worry me greatly that young parents having to access care in Woolwich – it will be too far and too costly and may lead to them not accessing those services.

Mrs Kuldeep Seehra MBE, Woolwich Sikh Temple, formerly of HMRC
There are going to be lots of difficulties [if Lewisham Hospital closes] for people who are unemployed paying for taxis, travelling long distances, disabled people needing lots of disabled car parking. Nowadays I find now that lots of disabled people haven't been allowed disabled badges – the Government is just using the test system to take away the badges from them. There are people who have long-term medical conditions who can't stay or travel for a long time and if they have to wait there [at Queen Elizabeth Hospital Woolwich] I think it's going to be very difficult. Sometimes some people have to take their medicines every day after three or four hours so it's going to be very, very difficult for people. Also there's going to be seating arrangements in the hospital, where there are long queues. People don't get a space to sit down, chairs are all full, people can't sit down. People are going to be really unhappy about that, there

are going to be a lot of complaints so there'll be a lot of paperwork generated. I would say that these things have to be considered when they think of closing the services in Lewisham Hospital.

Mrs Avtar Kaur Bilkhu, Woolwich Sikh Temple
Nicholas Hospital, Brook Hospital, Seaman's Hospital, Sidcup Hospital – all those hospitals are closed now.

Cathy Ashley, Lewisham resident, former carer, former systems analyst
I'll tell you a bit about how I managed things with Ray – my husband. He had his first treatment at Lewisham Hospital. Lewisham Hospital identified that he was beginning to develop leukaemia and he had chemotherapy here. And there was a 50:50 chance that it would be successful. Unfortunately it wasn't. And then they proposed that he should be treated by Guys and to see if he would be suitable for a blood stem cell transplant.

All of that worked out to be feasible so he went to Guys and was looked after there. But part of it was that his immune system was compromised, so that meant he was vulnerable to infections and unfortunately a lot of the infections happened late at night. Now when his temperature got up to a certain level I had to ring the on-call haematologist at Guys to be able to find out what to do. Guys is not an admitting hospital so we would have to come to A&E at Lewisham and Guys would ring Lewisham and all the arrangements would be made. He'd have to come in through A&E – they had to identify what the infection was and then work out what the treatment should be.

On most occasions it was late at night and I brought him in by car. I didn't call an ambulance. If this goes ahead were I to be in the same situation again I'd find myself calling an ambulance. I couldn't trust myself to drive late at night when I'd been looking after him all day. So that means I'd have to call an ambulance. Now, the ambulance service is under pressure. The Trust Special Administrator has not looked at what's called the 'unintended consequences': what it means for the other services.

Dr Bob Gill, Bexley GP and Bexley resident
I'm a GP – I've been working in Bexley for the last 10 years. I'm one GP in a two-partner practice: we run a personalised list and I feel a very close connection to my patients because of that. My feelings about the proposed changes are that overall they present a significant risk to patient safety and this is why I've become involved.

We've already witnessed one A&E closure in South East London – Queen Mary's Hospital Sidcup; and I've noticed since the reduction in capacity that followed on from that A&E closure that my patients are being prematurely discharged, they aren't really getting assessed because they're presenting to overstretched A&E departments, either at Queen Elizabeth or Darent Valley or the PRUH in Bromley. And I fear with another A&E closure this will just put on more pressure on existing services which are finding it difficult to cope.

On many occasions I've been 'reassured' that in fact further closures might improve patient care but this is beyond belief. The people in responsible positions are misleading and lying to us about what is obvious to everybody.

Dr Jim Sikorski, Lewisham GP with a special interest in mental health
Spending on mental health has increased hugely in the country over the last five years from I think approximately £77 billion in 2006 to £105 billion in 2009-10. And that reflects increasing mental health needs.

In a young, relatively deprived borough like Lewisham, where the average age is between 30 and 40, there are very large numbers of people suffering from mental health problems – both the common mental illnesses like depression and anxiety, panic attacks, phobias, but also there'll be nearly 3,000 people suffering from a very serious form of mental illness such as schizophrenia or bipolar affective disorder. And in any planning for the health of the local population we need to make sure that services are coordinated because fragmentation of care – and particularly the old dualism between physical health and mental health – is one of the major drivers for increased costs and reduced quality of care and increased health inequalities.

So, it's very important that you coordinate services for our mental health needs and our physical health needs. That's what we have at Lewisham Hospital at the moment: a site where you have physical illnesses dealt with in a good quality district general hospital and the Ladywell Unit, which is a good inpatient mental health facility. And that's going to be desegregated under the new plans. The TSA report shows a typical lack of integration of mental health within physical health planning; indeed it's ignored in a way that no civilised country should ignore it, really.

Dr Somar Segarum, Hindu Temple
I strongly feel the prospect of Lewisham Hospital being closed is shocking news for us because most of our people are on the poor side. They are not wealthy and they depend on the free health service which the whole country provides and, especially locally, is provided by Lewisham Hospital. So I think it is very, very important that vehemently we oppose it [the closure], support the hospital and help in building it even more, rather than closure or making it fully private or something like that.
(Full statements can be seen at http://www.savelewishamhospital.com/commission-witnesses/)

LIVE WITNESSES

Jeremy Hunt stand-in reading extracts from Jeremy Hunt's speeches, interviewed by barrister Di Middleton (DM)

DM *The changes recommended by Matthew Kershaw must satisfy what are called 'the four tests'. Could you explain to us what they are?*

JH *The changes must have the support of GP commissioners; the public, patients and local authorities must have been genuinely engaged in the process; the recommendations must be underpinned by a clear clinical evidence base; and the changes must give patients a choice of good quality providers.*

DM *Although the six Clinical Commissioning Groups expressed some concerns about aspects of the plans, only one of them, Lewisham, came out in direct opposition. What's you view of that group's standpoint?*

JH *Of course I understand its opposition to the proposals put forward by the Trust Special Administrator. But it supports the principle that complex procedures should be done on fewer sites. That is an important point. Inevitably when we are reducing the number of sites for complex medical procedures, the people in the areas where those procedures will no longer happen will often be opposed to the changes. (Laughter) That is what has happened here. But the Group supports the principles behind what the Trust Special Administrator has said.*

DM *Would you say the vocal opposition from the public, patients and local health providers in Lewisham means that they've genuinely engaged with the plans?*

JH *The popular campaign around the services at Lewisham Hospital has highlighted just how important it is to the local community. I respect and recognise the sense of unfairness that people feel because their hospital has been caught up in the financial problems of its neighbour. However, solving the financial crisis next door is also in the interests of the people of Lewisham because they too depend upon the services that are currently part of the South London Healthcare Trust.*

DM *What about the clinical evidence tests?*

JH *We have the benefit of senior people like Sir Bruce Keogh and many of the Royal Colleges that have been involved in the external clinical advisory which had significant input on the proposals. One question I asked Sir Bruce was whether there had been sufficient clinical input, and his conclusion was that yes, there had been.*

DM *Does the opposition of the Lewisham Group (CCG) affect your conclusions?*

JH *I believe the amended proposals meet the four tests required for local reconfigurations and I am therefore content for the process now to proceed to implementation.*
(Audience heckles)

Dr Helen Tattersfield (HT), Chair of the Lewisham Clinical Commissioning Group interviewed by barrister Nicola Braganza (NB).

NB Could you give your full name please?

HT I'm Dr Helen Tattersfield.

NB And, Dr Tattersfield, what is your role

HT First and foremost I'm a GP in Downham, and I have been for about 20 years I think, but for the purposes of today I chair the Lewisham Clinical Commissioning Group.

NB Briefly, could you first of all describe who your patients are, the patients that you see day in day out?

HT I see genuine residents of Lewisham as all the GPs do and I think – one of the things I said right at the beginning – I've been a GP for a long time and that means you build up a really good close relationship with your patients and also you know the

sort of lives they lead and what services they need. And that's why I stood for this position; because I felt I could speak and stand for the people of Lewisham that I work for.

NB What has been the effect of the CCG?

HT The CCG, I mean, we've only been live since the 1st April this year but actually we ran in shadow form last year. And one of the first things we did as GPs when we started was to say what difference can we make immediately: where is Lewisham not doing as well as some other places? And one of the things that Lewisham was not good at was vaccination of their children.

So we looked at this together and we worked with our colleagues in the Council and the hospital community trust and we went from being almost the worst CCG in London to being in the top part of London, and the actual increase was 10%. So we went from something like under 80% of our children being vaccinated to almost 90%; which is in about 6 months, which shows when you work together what you can do. *(Applause)*

NB Now you've read the decision of the Secretary of State in detail, what do you see as the most serious ramifications of these changes?

HT One of the reasons that we continually, throughout the whole process, objected to what we saw was going on, was that we saw what would happen to Lewisham would be a breakdown in services.

One of the things that Lewisham is really, really good at is working together. You've heard lots of speakers today talk about how we work collaboratively. The hospital right at the centre has been a part of that. If you take that hospital out what happens is that we're then having to work with four different hospitals. It doesn't really matter how good or bad they are – you can argue about what the process might do to those hospitals but, even if they're the best hospitals in the world, if I as a GP have patients in four different hospitals, I have to know four different procedures, you have to deal with four sets of social services, it's all incredibly fragmented.

Dr Sikorski was talking about fragmentation in mental health services. This process of fragmentation in paediatrics, in care of the elderly, in all sorts of things: it may be that there are a few certain conditions that are looked after better. We've heard about stroke and heart attack, but the majority of people don't have those sorts of things. They have simple things that just require a day or two in hospital. When my patients end up in King's I get a discharge summary and I don't even know they're there, or when they come home. If they're at Lewisham Hospital I know when they've been there, I get the discharge from the A&E to say they're in hospital, I get a discharge when they come out, in case I need to go and see them so they don't go back in again. That sort of thing is really, really important.

And also I know the doctors at Lewisham Hospital and they know me, so we can work together. There is no way that I can know all those different doctors in all those different hospitals and so my patients absolutely will not get such a good service.

NB And what about travel times? How will the change in travel times impact on residents and their carers?

HT Well I think we've already heard the impact from different individuals about travel time. One of the things that we said clearly throughout the process – we argued intensely about travel times – is that whatever it says on paper, it's what people want to do that's really important. When they do maps for the east of Lewisham and say all those patients are going to go to Queen Elizabeth and it will take them that length of time – whereas if they're actually going to go to King's it's going to take them a whole different length of time.

And we know that's what patients will choose to do. So the impact is huge because the travel is costly, it takes time. You don't necessarily visit your relatives as often so they don't get as well so quickly – so there's an emotional impact. But actually we think the argument about travel times in the TSA report is completely flawed. And we made that point over and over again. It was what *A Picture of Health,* which was the previous manifestation of this, fell down on when they actually looked at it and they realised that the impact of it would be to overburden King's and Guys, and not solve the problem.

NB Now I want to ask you about the process, the TSA process itself. Your particular expertise as Chair of the Clinical Commissioning Group: how was that considered within the process?

HT Well it was considered in that we had to go, we had to be part of many, many meetings. At most of the meetings we were not given advance notice of what was going to be discussed and we certainly had no papers to look at before we got there. So we were presented with documents in a very quick piece in the sense of *this is what has to happen*, without really getting the chance to contest things. If we did contest things we were told that there was no time to discuss that, 'this is the only possible solution', 'there's no time to look at anything else'. That was a consistent statement throughout the whole thing. And often we weren't allowed to take the papers away to look at them afterwards. *(Audience reacts)* It was that type of process.

NB So you were utterly ignored. In reality ignored, your expertise…

HT Oh absolutely – yes.

NB The Secretary of State claims that the proposals have clinical support. What do you say about that?

HT Well I think it's already evident from other people that they certainly don't have Lewisham clinical support. *(Applause)* From my colleagues in other CCGs – the other CCGs are obviously in a very different position, so we shouldn't be surprised if their responses were different. All of those responses clearly stated that they had significant concerns that needed to be answered. And they were also saying that throughout the process. Colleagues in Southwark were concerned about the impact on King's College Hospital; colleagues in Bromley – on the PRUH. And none of those questions have been answered. So, again they've just been brushed over, so no 'everyone's happy, this is the best thing since sliced bread'.

NB Now in your statement you say that we believe that we together could have produced a solution that is both safe and effective. But the one produced by the TSA

is not that. Now could you elaborate on that: what do you mean by that – the solution that you could have come up with?

HT Yes absolutely. Even before the TSA we were sitting down seriously with our colleagues at Lewisham Healthcare Trust to say 'look, we know that the resources are going to go down, we have to manage within our resources. How can we do this? How can we work better so that we can continue to provide even perhaps better services within the same financial umbrella?' We were talking about improving the community services, bringing more things out into the community, helping people to actually avoid going into hospital in the first place. Something you wouldn't expect a Trust to be talking about when you think their income is determined by who goes into hospital. But those are the sorts of conversation we were already having in Lewisham before the TSA came along. We knew there were going to be a few problems with finances, we knew there would have to be some rationalisation of services. But we wanted to make sure that that rationalisation was done in a way that would improve services for the local residents and not make them worse.

My concern with the TSA is that it's been completely financially led. It doesn't take into account the needs assessment, risk assessment of the population and it puts a large number of people at a risk that they are not currently at. And we don't think that's a sensible way forward. *(Applause)*

NB And finally what is your view as to the impact of these proposals on King's and then in turn on GPs?

HT Yes, I think it's quite interesting. We're asked to develop choice and make sure that our patients have choice. One of the things that may well be an outcome of this, if you actually roll it forward a few years, is that the bigger Foundation Trusts – which are great, I've got no problem with them – will actually have more and more share of the market; because patients will choose to use those. People are not clear about whether the quality of Queen Elizabeth Hospital is such that they would feel safe there, they're not sure that they can get there. They know where King's is, they know that's a good, national place to go. So more and more work will shift, I think, to King's. It is more expensive there so from the point of view of commissioning for Lewisham, more of our money will be spent increasingly on secondary care services, so there'll be less money to be available locally.

And what could even happen is that the merger between Lewisham and QE doesn't turn out to be viable if patients don't use it. So you could almost end up with the whole of South East London with one single provider. That's not choice. I don't know that it will happen, but it's potential.

Whereas if you allow Lewisham to build itself up, to build on its reputation, be an effective service along with QE I think patients will have confidence in that. They will use that. It will become a really good, viable alternative to the big Foundation Trust. And the whole economy of the health service will be better, which is a bit of an ironic outcome. *(Applause)*

Just one final point I wanted to make which hasn't really come up today is about the role of the hospital in maintaining the quality of primary care in terms of teaching and also in training up the next generation of GPs. Almost all Lewisham GPs these days have actually come through Lewisham Hospital and that's because they learn

what a great place Lewisham is to work. If you didn't have the experience of working in Lewisham you probably wouldn't think about working in Lewisham. You know, nobody knows about Lewisham! We're sort of the underdog, aren't we, but when you've been trained there, you see what a great place it is – you stay. If these changes go through Lewisham will not be training GPs. Who is going to replace me? Who is going to replace my colleague? Who is there going to be running primary care? We do 90% of the work and if we're not getting good quality GPs into the work, into the situation, what is going to happen to Lewisham?

NB Thank you very much. *(Applause)*

Panel question from Michael Mansfield (MM) to Dr Helen Tattersfield:

MM Thank you very much. I want to ask a question about what the Minister was told by the Medical Director Sir Bruce Keogh. It's maybe a letter you haven't seen so I'll be careful. Tab 2 please of that bundle. I think it's there in front of you. This was written this year, 30 January, where the Director was being asked to consider various aspects of the TSA's recommendations and so on, and consensus was a factor that was being emphasised. And I want to ask you about the second page 'Is there strong evidence of sufficient clinical input?' Do you see that?

HT Yes.

MM Right. Now as a precursor to what he wrote to the Minister, I just want to ask you what is in your statement in detail – and it's on page 85 for those who want to follow it. You've said:

> 'The Secretary of State claims that the proposals have clinical support. We've shown overwhelmingly in Lewisham that there is no local support, 160 GPs signed the petition against the proposals, a further 140 GPs from other CCGs also put their names to this. The hospital clinicians have produced effective clinical arguments against the changes.'

Then you mention 25,000 people marched on the streets. Then you say: 'The other five CCGs have each expressed reservations regarding the outworking of the proposals.' Now you go into more detail.

That's your as-it-were description of the narrative. Now can I just turn to what the Minister was told under this heading 'Is there strong evidence of clinical input?' and I really want you to just make some observations on this if you wouldn't mind. I'll just read it so that everyone in the audience knows what the Minister was being told by this review:

> 'I can confirm that there is strong evidence of wide clinical input. Operationally the TSA programme was supported by a clinical advisory group led by a local GP, Dr Jane Fryer, which built on two [MM to audience: *'I'd ask for a little restraint'*] years of preceding clinical engagement. This group included 8 Trust Medical Directors, 6 clinically qualified CCG Chairs, the London Ambulance Service Medical Director, the local director for trauma and three Directors of Nursing. An additional external clinical panel chaired by Professor Chris Welsh, Medical Director for East of England provided additional scrutiny and challenge, including from the Royal College of Midwives and the Royal College of Obstetrics and Gynaecology.'

Now there is more in this list. I just want to ask whether in fact this is a mis-description or whether there's any truth in it whatsoever?

HT Well first off, I don't know about the two years of previous clinical engagement. It may have happened but it didn't involve me so I don't know anything about that. These people were all at these meetings. I was at those meetings. But the point was that when points were raised which went against the current dialogue they were ignored. So they were *there*. The other point I would make about the external clinical panel is that it was made up of specialists who had specialist interest in specialist areas. There wasn't anybody from the Royal College of General Practitioners, there was nobody talking about integration of services, rather than fragmentation so you could argue, 'yes, you must close the obstetric unit at Lewisham Hospital because you haven't got an ITU and you might get this problem' but what about everybody else who's having normal deliveries, they then have to travel and what are the consequences on them? There's no counter argument. Only the one thing: only a specialist need and money-saving – there was nothing about integration and there was no input from the Royal College of General Practitioners.

MM A final question. Is there a record kept of these meetings?

HT They were all minuted.

MM Are they available as far as you are aware?

HT The TSA must have it, they were all minuted and minutes were circulated.

MM Thank you. *(Applause)*

Dr Brian Fisher (BF), Lewisham GP interviewed by barrister Amanda Weston (AW)

AW Could you give your name and your qualifications for the benefit of the Commission please.

BF I'm Brian Fisher, I'm a local GP, and I do some work with the Clinical Commissioning Group and the PCT before that.

AW Can you tell the Commission a bit about your connection with Lewisham and your length of service in Lewisham.

BF I've been working as a GP in Lewisham since 1983. I live and work in Lewisham. My family lives in Lewisham. So I have a special interest, as so many other people do here, in the healthcare services in this area.

AW We've heard the previous witness refer to integrated and collaborative care: could you please explain to the Commission about care pathways?

BF Yes. The way the NHS thinks about people's journey through care is the idea of a clinical pathway. So if you have breathing trouble or if you have COPD, chronic obstructive airways disease: where are the kinds of places you would go depending on

the severity of your illness? What kinds of treatment and management would you have, throughout your care in the service? And it's a very useful way of thinking about it. What actually should happen is usually determined through clinical evidence. So an organisation called NICE, the National Institute for Clinical Excellence, looks at all the evidence and sees how these things ought to be done and makes formal recommendations, some of which have to be taken up by the CCGs. But how it actually gets implemented on the ground in different places will depend enormously on the relationships and the particular organisations that are involved. So it is a very localised process, but it does depend on a national and evidence-based process.

AW And have you been involved in developing and formulating those localised processes?

BF To some extent I have. So for instance, some years ago I was involved in trying to think about how we could reorganise some aspects of heart disease services. So at that time, to get some relatively simple tests, patient had to go to the hospital to have these things authorised and done. And, through a process of discussion with the hospital and various disciplines involved in primary care, we were able to make the process a great deal simpler and have these things done in the community, so that the hospital didn't have to be involved at all and that was a great deal easier for everybody.

AW And was it cheaper?

BF I don't know! At that time the issue of tracking the money was much less of an issue. And one of the things that I think national policy is going to impact on – this extremely important area of care – is because we have, as other people have said, we have turned the NHS into a market.

And when you think about the way this trajectory of care – going from your own home, through to the GP, into the hospital, back to home and maybe through A&E and so on, through a very complicated set of hand-offs and transactions between the different parts of the sectors – if you turn that into a marketised process, you start beginning to fragment care.

The particular way it happens in this pathway of care process is that through the way the money flows in the National Health Service, if you keep people out of hospital where they want to be, in the community, then actually the hospital loses money. It's a completely crazy way of arranging. It really makes me angry. *(Applause)* So the very sinews of the NHS now are determined by the way this money flows; and the way the money flows actually militates against collaborative cross-sector working.

AW Over what period of time would successful care pathways that avoid the need for costly admission to hospital, over what period of time would those relationships and pathways be developed?

BF Well, developing these pathways is not straightforward. There are many considerations of convenience. What services are available? What extra demand is there on different bits of the sectors of the service? So they're quite complicated to set up. So, there's two relatively simple changes that we introduced which was really about putting [investigative] test access into the community. It took three years –

three and a half years to sort out. And it involved a great deal of discussion and thinking and talking to various people in various ways. So these things are really quite delicate and need to be handled really very carefully.

AW What in your view will be the impact of the TSA proposals on these carefully wrought pathways?

BF It would smash them. *(Applause)* All of these delicate arrangements, all of these careful relationships; because obviously it's about clinical care and it's about organisations working together. But underpinning all of this is a set of relationships between both organisations and people. And what the TSA is doing is basically cutting across all of those. It will destroy the kind of links as other people have said. They will have to be totally rearranged and that will set things back, as you can see – taking three years to organise very simple things. This will have huge opportunity costs, huge resource costs to make, and to make again and re-establish things to work half as well as they did before.

AW Just on the issue of costs then, are you saying there will be more emergency admissions, more crises?

BF I think it's highly likely that that's the case. So overall, again, as other people have said, I think that this re-disorganisation is dangerous for people in Lewisham. So I'm very sure there will be many more emergencies to deal with, yes.

AW Are you aware of any proposals in the TSA plan to recover the community care-based pathways?

BF There is a sort of assumption from the TSA that the sort of pathways I've been talking about will get re-established. But the way all… that level of detail certainly hasn't been discussed at all. What I think is really important is: for these pathways to work, particularly in this highly constrained financial environment, there has to be really significant investment in community services. In fact the TSA report I think was very clear about that. That actually none of this would work if there wasn't very significant investment in community services. So in terms of the care pathways that we've been discussing, that much of it should move – as far as possible, to my mind much more should move – into the community. And that would facilitate this sort of smash and grab of the rest of the NHS in South London. So yes I think there has to be very significant discussion about changes in the community.

AW So, as far as you're aware, is that a discussion – was there any evidence of a plan formed in the TSA to deal with in the long term impact of the destruction of these pathways?

BF There's a long list in the TSA report of things that must happen in the community that would provide better care and I don't disagree with that list. And there is now a process for our people in post who are beginning to think about what good community care would look like. They've hardly started their work, I'm in touch with them, but it does seem a very nebulous kind of process at the moment. And most importantly in the whole of the TSA report there was huge capital expenditure to consider all these changes that were going to be necessary.

There was no money assigned for the community-based plan on which actually everything is based. It's a travesty.

AW So what do you consider will be the impact on local people of the destruction of the pathways?

BF Oh I think it will be … there's a paper in the BMJ this week which shows that clinicians can spend quite a lot of time repairing broken bits of pathways and I think that is what's going to happen. So the way the trajectory of care for our patients is going to be really smashed apart, we're going to have to build them up. And clinicians are going to have to substitute in all sorts of ways, make lots of phone calls to make sure that people go to the right place, double-check tests, do things which duplicate, all sorts of things which have to happen to try and keep things safe when the whole structure around these pathways is beginning to fragment.

AW You've just referred to the need to try and keep things safe. In your view will the safety of service users in Lewisham be at risk?

BF Yes.

AW Thank you very much. The Commission may have some questions.
(Applause)

Panel question from Blake Morrison (BM) to Dr Brian Fisher:

BM I just want to ask you, when Sir Bruce Keogh is recommending his policies to Jeremy Hunt he talks about there being less specialist emergency care at the A&E in Lewisham. But it would retain a 'small but safe' A&E department. I'm finding it hard to imagine what a 'small but safe' A&E department would be. And I'd just be interested in your thoughts on that.

BF Well I think Lewisham has a small and safe A&E now. *(Applause)* What is being proposed is a smaller and unsafer – unsafe – A&E. *(Applause)* And I think that's been clearly expressed by previous speakers. I'm not an expert in A&E and I wouldn't want to say the detail of that. But I think it is very clear that the proposals are not up to the mark and do not offer the services we currently have.

Panel question from Mary Warnock (MW) to Dr Brian Fisher:

MW I want you to say something about what the changes will have on the training of doctors.

BF A little bit like Dr Tattersfield – at the moment the training of doctors is a bit like pathways. There's a whole set of links between parts of the system; and the doctors more or less smoothly go through those pathways now. And Lewisham is a big and important part of that pathway in South East London. So what we see is going to happen is that, with the changes proposed in Lewisham, there will be serious attrition over time to the kind of services that are available. So the training will become more and more difficult to keep going and in fact will almost certainly have to disappear out of Lewisham. *Certainly* the training for GPs. And I think that almost certainly probably applies for the training for specialists as well. So it is going to have a serious impact on the networks of training in our part of London. *(Applause)*

EW We're rapidly heading towards lunch and I think with everyone's agreement we're going to start at 1.45. We're going to hear some tweets now and some comments from people. But one thing I want to make clear before we break for lunch: that Jeremy Hunt is not in the room – it is an actor – who is playing his part as best he can. And I think I should say on his behalf that he's a very ardent member of the campaign. *(Applause)*

So over now to Jill and Olivia who will read some of the comments from people around and about.

Tweets and Messages

Clare Phillips *tweets: 'Moving and powerful video testimonies from all communities in Lewisham which could be repeated across the country'*

This is a **message from the scroll** outside in the foyer. Please add your comments to it as your go for lunch. It reads: 'A mention for the nurses and layers of other staff at the hospital – they are the fabric of Lewisham Hospital and we thank you for your highly professional caring and committed actions, we thank you very much.' That was one comment. *(Applause)*

Two comments here: 'Faux …' (I think it means false) '[False] Jeremy Hunt just booed off the stage #Justice4Lewisham'. And the second one: 'Actor playing Jeremy Hunt being examined by Di Middleton of Tooks Chambers at the People's Commission.'

Okay another one. This is a love letter to Allyson Pollock: 'Allyson Pollock – big red love heart – she tells it like it is. If we follow what she says to the logical conclusion, we have to campaign to cancel all PFI debts in the NHS. Long live Allyson Pollock!' *(Applause)*

Just a final comment – there's lots and lots of comments on Twitter. ***Save our NHS East London*** *tweets: 'Brilliant to be in the audience at Lewisham People's Commission of Inquiry'. And it says: 'Watch here' – because you're probably aware that Obi here is live-streaming this onto our website. So if you do have to go home, please don't miss the afternoon, but you can watch us live. Thanks*

One last comment from the scroll, there are so many brilliant ones, I think I'll be a bit vain. It says ´Lewisham takes a lead again. Question: How good is the Save Lewisham Hospital Campaign? Answer: stunningly brilliant.' *(Applause)*

EW Can I just say before we go to lunch. A big big thank you to all the witnesses who appeared this morning. I think we've had a fabulous morning. See you all at 1.45. *(Applause)*

Session 3 ends

Lunch break

CHAPTER 4
THE DOWNGRADING OF A&E, THE AMBULANCE SERVICE, AND CARE OF THE ELDERLY AND THE MOST VULNERABLE

Secretary of State Jeremy Hunt

On a 'small but safe A&E'
'This part of his recommendation included reducing the number of accident and emergency departments across the area from five to four, replacing the A and E department at University Hospital Lewisham with a non-admitting urgent care centre,'

'Turning to the emergency care proposals, Sir Bruce was concerned that the recommendation for a non-admitting urgent care centre at Lewisham may not lead, in all cases, to improved patient care. While those with serious injury or illness would be better served by a concentration of specialist A and E services, this would not be the case for those patients requiring short, relatively uncomplicated treatments, or a temporary period of supervision. To better serve those patients, who will often be frail and elderly, and would arrive by non-blue light ambulances, Sir Bruce recommends that Lewisham hospital should retain a smaller A and E service with 24/7 senior emergency medical cover. With these additional clinical safeguards and the impact that this is likely to have on patient and clinician behaviour, Sir Bruce estimates that the new service could continue to see up to three quarters of those currently attending Lewisham A and E.'

On journey and ambulance times
'For both emergency and maternity care, Sir Bruce found no evidence that patients would be put at risk through increased journey times. The whole population of south-east London will continue to be within 30 minutes of a blue light transfer to an A and E department, with the typical journey time being on average only one minute longer. Accessing consultant-led maternity services will involve an increase in journey times on average of two to three minutes by private or public transport. Sir Bruce therefore concluded that there should be no impact on the quality of care due to the small increase in travel time.'

(*Hansard*, 31 January 2013)

In Session 4 the Panel heard evidence concerning the Secretary of State's proposal to downgrade Lewisham Hospital's busy A&E department and replace it with a 'smaller' service. Witnesses told the Panel of the effects of the proposed closure on the elderly and most vulnerable sections of the community. The Panel also heard evidence on the impact on ambulance services were Lewisham A&E to close.

The Panel heard from Dr Chidi Ejimofo, Consultant in Emergency Medicine at Lewisham Hospital. He said that he and his colleagues had not been consulted about the proposed changes and that the process was not only 'not transparent, but it was based on data that only they can tell you where they got it from, because they certainly did not get it from us.' (Chidi Ejimofo p.79) The proposals would mean that Lewisham A&E could see only 50% of the number of patients currently seen, rather than the 75% claimed by the Government. He told the panel that there was no such thing as a small but safe A&E as the Secretary of State had claimed. If the proposals were to go through, Lewisham would lose four of the seven essential services needed to support an A&E Department i.e. paediatrics, acute medicine, surgery and intensive care. He said: 'That is not an Emergency Department; that is not an A&E, safe small

or otherwise … This is a model that is known only to the Secretary of State himself and Sir Bruce Keogh'. In Dr Ejimofo's view, without these essential services the A&E Department would be downgraded to an Urgent Care Centre. (Dr Chidi Ejimofo p.79)

Patients with Parkinson's Disease often require admission to A&E due to, for example, frequent falls, and it is crucial that these admissions are linked to the other local services required. Brian Lymbery, a Parkinson's sufferer and Chair of the Lewisham Parkinson's Group, highlighted the importance of the integrated service currently offered at Lewisham Hospital such as physiotherapy, speech therapy and exercise therapy. Contrary to the Government's view the integrated treatment of patients from Lewisham at King's College Hospital would be lost if patients had to go to A&E in Woolwich. Those with chronic conditions, such as Parkinson's Disease, would not get the support they need. (Brian Lymbery pp.71-74)

The serious implications for the elderly, an already very vulnerable group, were addressed by Dr Elizabeth Aitken, Consultant in Elderly Medicine, Lewisham Hospital. She explained to the Panel that when an elderly person falls, even a simple fall will impact on all their functions. There is therefore a particular need for a multi-disciplinary approach as currently enjoyed at Lewisham, where there is a specialist team within the A&E Department. If the proposals are implemented the integrated care currently offered will be destroyed, which will lead to longer and costlier stays in hospital for the elderly. (Elizabeth Aitken pp.74-77)

The closure of the A&E at Lewisham would increase pressures on other hospitals across South East London when the system is already overloaded. This point was illustrated by David Newman whose 92 year old mother had died in the Princess Royal Hospital, Farnborough. He described the overload on that hospital's A&E department on what had been an 'ordinary quiet night'. Ambulances were queuing outside waiting to admit people to A&E. His ill, 92 year old mother had had to wait for an hour before she was even admitted, and had then waited 15 hours on a trolley and wheelchair before a bed had become available. (David Newman pp.80-82)

Evidence of the effect on the ambulance services, were Lewisham A&E to close, was given by Malcolm Alexander, Chair of the London Ambulance Patient User Group, who described the already understaffed and overburdened London Ambulance Service. He told the Panel there had been no study by the Government or the London Ambulance Service into the impact of the proposed changes to Lewisham Hospital on ambulance provision in London. Mr Alexander explained that 'every time you load on the ambulance service additional work, additional waits, you disadvantage somebody else who might die as a result of those longer waits' and 'the more you load an A&E Department the more difficult it is to get the critical patients through the doors'.

He expressed particular concern about the effect of such delays for patients with strokes and heart disease, but there would also be an impact on those with less critical needs:

> '…as you get more emergencies in what is known as Category A – they are the people who are most critically ill – what happens is all the resources are

> moved towards Category A because they are the people who could die or could suffer from serious morbidity. And the Category C patients, those who have fallen, those with fractured hips, those perhaps with bleeds, other conditions, those with mental health problems get neglected, leading to very long waits, deterioration and sometimes people lying on the floor for many hours waiting for an ambulance and suffering considerable harm.' (Malcolm Alexander p.85)

Personal accounts of coping with severely ill partners who required frequent admissions to Lewisham A&E for different conditions came from Cathy Ashley and Hazel Waters. Their testimony highlighted the need for local A&E services able to fully assess, advise and treat their ill partners within an integrated pathway. Loss of the local A&E would lead to greater reliance on ambulance transport and impossible situations such as an elderly carer returning home from a more distant A&E in the early hours with no transport their partner having been admitted.

A number of witnesses who work closely with the most vulnerable sections of the community drew attention to what the closure of A&E and the fracturing of integrated care between hospital, GP, community and council services would mean and what the effect of longer and more costly travel times would entail. These issues, it was felt, had not been taken into account by the TSA process.

Dr Jim Sikorski, a Lewisham GP with a special interest in mental health, reported that in Lewisham 40,000 people a year experience depression, anxiety, panic attacks and phobias and 2900 residents of the borough have Serious Mental Illness (SMI) such as schizophrenia or bipolar illness. Around 160 patients per month attending Lewisham A&E are referred to mental health liaison services. (Jim Sikorski, written statement can be seen at http://www.savelewishamhospital.com/commission-witnesses/). The TSA did not, according to evidence from Dr Tattersfield (p.57), Dr Geraghty (p.131), pay attention to mental health services as being a significant part of service provision, nor properly examine the consequences for these patients of the closure of the hospital. Dr Sikorski told the Commission that currently Lewisham Hospital and the Ladywell Unit, which is an inpatient mental health facility, work together. With the closure of Lewisham Hospital these provisions would be no longer be integrated. And the carefully nurtured network of support and care for these patients would be lost.

The panel also noted the concerns of Captain Nigel Byrne of the Salvation Army

> 'Whether you've mental health issues or not, it doesn't matter because if you find yourself homeless, if you find yourself disconnected from your family, if you find yourself vulnerable and on the streets – and there but for the grace of God go any of us – and you were feeling depressed or suicidal as these folks sometimes do, you would be advised to report to your local A&E Department.' (Captain Nigel Byrne p.88)

He was concerned about what the closure of Lewisham A&E would mean for homeless people, particularly those with mental health problems who may not have the motivation to deal with the extra journeys and delays involved in going to an A&E much further away at QEH or Kings. Even were they to make the journey, those

A&E departments may not have the capacity to see them urgently. Nigel Byrne underlined this concern in his video testimony:

> 'As much as we can talk to them, and we do as much as we can, sometimes people need professional help, they need it quickly and we need to be able to get them to that at the point when they recognise the need for that.'

Concerns were expressed about those who are alcohol and drug dependent should Lewisham Hospital [A&E department] close. Iain Wilson, a nurse from Queen Elizabeth Hospital Woolwich (QEH), raised the difficulties those patients would experience getting to and from the hospital, particularly at night time. He also drew attention to current long waiting times in A&E at QEH, where former Lewisham patients would be expected to go. He queried what would happen to waiting times at QEH. The additional pressure on the QEH A&E would put further pressure on beds, which would make it even more difficult for those with drug and alcohol problems to have their needs assessed and to be admitted. He concluded that these patients would 'end up presenting sicker further down the line, costing more money'. (Iain Wilson p89)

SESSION 4 TRANSCRIPT
LIVE WITNESSES

EW We are now on to Session 4 and we shall be hearing about the hospital closure/proposals, downgrading of the A&E and the effects on the population, the elderly and the ambulance services. But first of all, Jeremy Hunt:

Jeremy Hunt stand-in reading extracts from Jeremy Hunt's speeches, interviewed by barrister Di Middleton (DM)

DM *Minister, Matthew Kershaw's proposals included closure of Lewisham Hospital's A&E, however Dr Bruce Keogh's review recommended that a smaller A&E service should be retained – why is that?*

JH *Sir Bruce was concerned that the recommendation for a non-admitting urgent care centre at Lewisham may not lead in all cases to improved patient care. While those with serious injury or illness would be better served by a concentration of Specialist A&E services, this would not be the case for those patients requiring short, relatively uncomplicated treatments or a temporary period of supervision. To better serve those patients, who will often be frail and elderly, and would arrive by non-blue light ambulances, Sir Bruce recommends that Lewisham Hospital should retain a smaller A&E service, with 24/7 senior emergency medical cover. With these additional clinical safeguards, and the impact this is likely to have on patient and clinical behaviour, Sir Bruce estimates that the new service could continue to see up to three-quarters of those currently attending Lewisham A&E.*

DM *And what did that review say about longer journey times for those seriously ill or injured people that would need acute services of A&E?*

JH *Sir Bruce found no evidence that patients would be put at risk through increased journey times. The whole population of South East London will continue to be within a 30-minute blue light transfer to an A&E Department, with the typical journey time being on average only one minute longer.*
(Laughter)

DM *And what would be the benefit to those patients?*

JH *Well, nowhere in South London currently meets the London wide Clinical Quality Standards. As a result of my decision today, the whole of South East London will meet those standards and it will have some of the highest quality care in London for people who use A&E and maternity services.*

DM *Thank you*

EW Brian Lymbery will now give testimony to the Commission.

Brian Lymbery (BL), patient with Parkinson's Disease, Chair of Lewisham Parkinson's Group, former chair of Lewisham PCT, interviewed by barrister Maureen Ngozi Obi-Ezekpazu (MO).

MO Good afternoon – can you tell the Commission your name please?

BL Yes – my name is Brian Lymbery.

MO And your connection to Lewisham Hospital?

BL I have got various connections; I have lived in Lewisham since 1984 and I was born in Guy's Hospital, so I can regard myself as reasonably local, and I have had a long association with the National Health Service; both as a patient because I was diagnosed 22 years ago with Parkinson's Disease, early-onset Parkinson's Disease, and also in other capacities too.

When I gave up full-time work, which seems a long time ago now, I became the lay member of the Lewisham Primary Care Trust, and then from 2002 I was Chair of the Lewisham Primary Care Trust.

The Lewisham Primary Care Trust had a responsibility for the hospital overall and for funding it, and so we had a lot of contact with them. You would not be surprised to know in 2002, as today, there were concerns about whether A&E could cope and there is nothing new in this case. Except that our Lewisham Primary Care Trust, when it was talking about the University Hospital Lewisham determined that Lewisham Hospital had a case for survival.

It is a large borough that it draws from, and there are not many other good hospitals around. So we knew whatever we were doing in 2002, we would be ensuring that the hospital survived through it, to become bigger and better. And on that basis, we agreed with them a PFI contract for the Riverside complex. But they planned it carefully and so there were not the unfortunate circumstances that arose in the current case.

MO Can you please inform the Commission about the services that sufferers of Parkinson's Disease require?

BL Yes – Parkinson's Disease is an insidious disease; it affects most of the areas of movement in a person's body – voluntary and involuntary movement – and you never know what is going to come next. It creeps up on you and when you think you have beaten one thing, another will come and take its place. And so it is a never-ending battle against the factors which are trying to slow me down, stop me, prevent me from getting on with my life.

MO Does Lewisham provide Parkinson's sufferers with an integrated service?

BL Yes it does, and that is very important because a Parkinson's Disease patient might need physiotherapy and speech therapy and exercise; I have had all of those this year, all in Lewisham. They might need help with getting about; they ultimately become immobile and need a wheelchair. So there is a great collection of different things that together encompass Parkinson's Disease.

MO And does Lewisham work closely with another hospital to provide this service?

BL Yes – Lewisham neurology staff are provided from King's; and King's oversees the neurology at Lewisham . King's College Hospital has a specialist nurse relating to Lewisham and she deals with lots of Parkinson's patients in the borough of Lewisham. A specialist nurse is a very good thing – but not every hospital has them;

not every hospital with a neurology department has one – because they know more than the consultants. The consultants only see their patients twice a year, but the specialist nurse can see patients whenever they need. And so she can give advice on medication usually; she can give advice on dressings if dressings are needed; on exercise; on the various therapies which are part of the treatment package that the Parkinson's patients might have. She can do all of that and she does it well in Lewisham, and this has a tremendous effect on Parkinson's patients when they need help and it prevents some of them from going in to hospital.

MO Can you please inform the Commissioners what your view is about proposals of the Trust Special Administrator; how that is going to affect people who suffer with Parkinson's in Lewisham?

BL Yes – I will concentrate on how it affects people, but I would like to say before that I rapidly grew concerned as I read the documentation. There was no evidence worth looking at being provided to us. And so I find myself getting more and more strongly against the idea and I do not see how an Accident and Emergency Department in Greenwich/in Woolwich Hospital can provide the support that Parkinson's patients need when they are not linked so closely to King's College Hospital.

MO So the links that currently exist with King's will disappear, is that right?

BL Well I think so, actually because there will not be the unity of purpose there is now, because King's will not want to send specialists out to Woolwich all the time. It is much further to go than Lewisham, from King's anyway. Much more than a minute and they will not have the same knowledge of Parkinson's patients as they would have if it was Lewisham and King's.

I go to the National Hospital for Neurology in Queen's Square where they have a specialism in Parkinson's Disease and I go there because I know I have got a long haul, 35 years or more of Parkinson's Disease and I want to be abreast of the most up to date medicines. But I use many of the clinical services, the therapy services in Lewisham and, as I have said, particularly to cope with my falls apart from anything else and if I went to Woolwich I would not know anybody there and they would not know me, and yet in Lewisham, because I use Lewisham for much of my therapy ...

MO What would you say is going to be the impact on the actual health of those Parkinson sufferers if the A&E is closed?

BL It will be bad because if you have anything wrong with you at any one time it affects the rest of your systems; so if you have got a cold your Parkinson's gets worse, if you fall over a lot Parkinson's gets worse. And so Parkinson's patients – it is not untypical of neurological patients – Parkinson's patients do not have it easy and they would not be able to establish the same sort of rapport with Woolwich that they now have with King's.

MO Can I ask you about consultation – can you inform the Commission what your view is about the consultation?

BL When I was Chair of the Lewisham Primary Care Trust we had a policy that we wanted to involve the patients in everything that was going on and we succeeded

fully in implementing and achieving that policy. And we had had a six year run at it, during the time that I was Chair. So it is not easy to do, but we felt it was important to consult as much as possible, even when we were closing down a nursing home or something like that. We had to take the flack. But the TSA seems neither to have taken any flack nor to have put a set of proposal together which makes sense. So I think that gives my view.

MO Can you say whether it is your view that Lewisham Hospital did or did not have to adhere to the Trust Special Administrator's time frame for the consultation?

BL No – as I understand it in the legislation, I hesitate to say this in present company, but as I understand the legislation, it specified health trusts that needed that attention. And Lewisham was never included in the designation of the three-hospital trust - Greenwich, Woolwich and Bexley. [South London Healthcare Trust]

MO So is it your view there should have been much more time given over the consultation for Lewisham?

BL Yes – much more time, because without time you cannot get a sense of what all the people of Lewisham want and it is only with time or with long knowledge of the borough that you realise they are committed to having a hospital and making it a good one. That is a good way for people to live I think.

MO Well I am very grateful to you, thank you very much indeed.
(Applause)

Dr Elizabeth Aitken (EA), Consultant in Elderly Medicine, Lewisham Hospital interviewed by barrister Amanda Weston (AW)

AW Could you, for the Commission, give your name and qualifications please.

EA I am Dr Elizabeth Aitken. I am a Consultant Physician with a special interest in elderly medicine.

AW And how long have you been practising in Lewisham?

EA Since 1997 when I was first appointed.

AW What are the particular needs of your client group in the local population?

EA Clearly although Lewisham, as has been said this morning, is a young borough we still have many, many elderly people who have complex care. There are many within the borough that live on their own and are very frail, with very high levels of both social care and of health needs.

AW Are you saying they are at risk of social isolation?

EA They are very much at risk of social isolation, which can impact on their health needs as well. They are a very vulnerable group. And obviously in addition to those people living on their own, we have a high number of care homes within the

borough, so a lot of patients in nursing homes and residential homes, who also need at times an acute hospital for acute hospital care.

AW Can you talk a little about the general principles which apply in delivering care to a vulnerable elderly group?

EA So, vulnerable elderly people – often they can have a simple fall as has been talked about very many times this morning and just now again by Brian; that elderly people will fall and it may be a very simple fall, but that will impact on all their functions. So that they lose confidence, their mobility is decreased. And they therefore will need both physiotherapists and occupational therapists to go into their homes and give adaptations – see how they manage; social care to help them with some of their care needs; and also a period, potentially, a period of rehabilitation – possibly in their home, possibly in hospital; or else we also have some rehabilitation beds within Lewisham in our intermediate care facility which the Trust manages – all of those beds. So there is a whole team and then there is the other, there is the speech and language and everything else.

AW So you are saying there is a need, a particular need, for a multi-disciplinary approach?

EA Yes – in the elderly, with older people – yes.

AW And so what are the principles that you would apply in the context of independent living and restrictive or least restrictive forms of caring for the elderly?

EA We want to maintain people in their own homes for as long as possible if that is what they want and it is safe for them. And obviously those principles require all the agencies working together and it is a multi-agency approach. We have extremely good relationships with social care, because in Lewisham the social workers work with us on the wards to deliver that care, and extremely good relationships with the occupational therapists who work in the community and within the hospital; and many of our therapists work across the hospital and the community to give a streamlined approach so that the patients are seeing the same person [therapist] both in the hospital and in their own homes.

AW What is the positive impact of that integrated approach in protecting vulnerable members of the elderly community?

EA I think it gives patients confidence, seeing people across the divide between acute and community and also we have seen a decreased number of people being admitted since we have integrated with our community colleagues. Hospital is not the best place for elderly people to be, we know that; they will pick up infections and have falls and there are huge numbers of risks in hospital. So the ideal place is to have people functioning in their own homes, because they will recover more rapidly. Particularly also, for patients with cognitive impairment and dementia, the hospital is clearly the worst environment for them to be in, and even if they live alone with some mild dementia they can manage independently in their own surroundings if we give them the right support. And also their partners as well.

AW How, how is Lewisham doing in maintaining that integrated approach?

EA I think, I believe we are doing really well. Particularly since we have integrated with the community providers; we have more and more of these pathways. We have a team within the Emergency Department who will see patients who have come in and we work as a team, myself, all the therapists and social workers, to get people home rather than admitting them, or to our rehab beds. So that we actually have seen a decrease in our admissions.

We have a Stroke Service; acute strokes, as we have heard, go up to King's or down to the PRUH to have urgent treatment, but are then transferred back to our Stroke Unit within 24-48 hours for their rehab. And we have an integrated team so that the therapists come in from the community, help rehab the patients on the Stroke Unit and then take these patients out earlier than they would in other Trusts. So we have a much more streamlined approach.

Similarly, for patients who have a hip fracture. Obviously, the average age of a patient with a hip fracture now is 85; so there is a very frail part of our population. We have an extremely good community rehabilitation team, who will see, again, come in to the hospital and take those patients out, and continue their care in the community.

AW Thank you – how much time and work and effort and co-ordination goes in to organising those networks?

EA As we have heard already, it takes a long time; it has taken several years for all of these pathways to be developed and be streamlined and we are still working on making sure they run smoothly. And there is always things we can improve, but it takes a lot of time, a lot of discussions, a lot of meetings and planning.

AW Now I would like to move on, if I can, to the issue of the impact of the TSA's proposals on integrated care and care delivery for this vulnerable group. Could you give the Commission your views?

EA I think the integrated care will be destroyed because we won't be seeing these patients in Lewisham. The barriers will be much more difficult to get across, they'll be going to Woolwich A&E or even to King's, and if they end up in King's or Guy's & St Thomas' it is much more difficult to implement those integrated pathways. They are certainly not going to see the same therapist or same doctor in the hospital as they would do in the community, as they do now. So I think all those pathways we have spent the last few years building will be destroyed.

AW And when you are looking at discharge planning and liaising with social services, will all those links and connections be destroyed?

EA Absolutely, I mean we have very good relationships with our social care colleagues in Lewisham. What we have found, patients in Lewisham Hospital from other boroughs have a longer length of stay; potentially up to two and a half days. So it is a significant relationship.

AW So it would be right to say, in your view, it is likely to lead to more costly longer stays in hospital?

EA Yes – and the potential to get further infections and further acute illnesses if they stay longer.

AW Thank you – I do not have any further questions; the Commission may have some.

MM Thank you very much – no. *(Applause)*

Dr Chidi Ejimofo (CE), Consultant in Emergency Medicine, Lewisham Hospital interviewed by barrister Nicola Bragana (NB)

NB Could you give your full name please.

CE My name is Chidi Ejimofo.

NB And what is your role?

CE I am a Consultant in Emergency Medicine at University Hospital Lewisham.

NB And what is your connection and your background in Lewisham and Lewisham Hospital

CE I have been a Consultant in the Emergency Department since 2009. Prior to that I was a registrar in training at Lewisham. Prior to that I worked as senior house officer – in other words, a junior doctor and also in a non-training position in the same hospital.

In addition my family have attended as patients, my wife works within Lewisham borough and has an organisation that works with disadvantaged youth within the area.

NB And for the purpose of this People's Commission what is your specific expertise and how can you assist?

CE Hopefully I can provide the Commission with some insight as to the workflows we have within the A&E Department, how we work within borough and how we work with the patients we have; and also some insight in to the process or lack of process that the TSA engaged with the Emergency Department regarding those workflows and information.

NB So if we take that in stages: first of all people of Lewisham, the patients. How will these proposals affect those people?

CE Right – our department sees over 115,000 attendances every year. This is a number that's going up fairly dramatically as well. The proposals allege that what is left in place will be able to see approximately 75% of those patients still. This has been challenged, without any response to our challenges. We, and by 'we' I mean the Consultants within the Emergency Department and also with the backing of our College, believe that actually it would be closer to about 50%. So you are going to see in excess of 50,000 attendances having to go to other Emergency Departments within the area.

NB And what is the profile of the service users of the patients; how would you describe them? What are the most common complaints and needs that are called for?

CE I am fairly sure that it has been stated earlier on in the Commission. Lewisham is an area of high deprivation, has areas of high deprivation. It is a young community but similarly has a lot of patients who are elderly, are frail, have multiple co-morbidities. We have a lot of commonly occurring conditions seen throughout the nation; things such as COPD, heart disease, diabetes. We also have a lot of conditions because it is an area of – it's a very multi-cultural area. We have a lot of conditions that are native to our population, so you see a lot of patients with sickle cell disease. You have patients who come back to the area with imported diseases such as malaria. These are all conditions that we treat very well within our Department because we are used to treating these; again you would be looking at exporting these patients to areas that would be less well set up to treat them.

NB So in reality where will these people go with no A&E at Lewisham?

CE Well it's interesting: previously, I believe the gentleman who was first here speaking on behalf of Parkinson's patients. There had been a previous enquiry where the so called 'A Picture of Health' for South East London, where they had looked at where patients would go if there was no A&E in Lewisham and all of the modelling they showed pointed out that patients would, in order to take advantage of the public transport links, would have to go more centrally. They would need to go to places like King's, they would possibly to St Thomas', that's where all of the links are.

However, the TSA seems to take an opposite view: that people would easily be able to go to Queen Elizabeth Hospital, Woolwich. My understanding is that they believe that would only involve a journey of on average one minute more. I think there are, I think the people's personal understanding of that, and, sorry to site YouTube links, might beg to differ.

NB So in your view, where are they most likely to go?

CE They are most likely to go more centrally, they will most likely to go King's College Hospital and when 'A Picture of Health' was carried out previously, King's College Hospital were quite clear they would not be able to, quote, "to be able to deal" with that increase in volume. And that volume has only gone up since then.

NB Okay – what about the ambulance service?

CE We've a very good relationship with the London Ambulance Service. We are – our Emergency Department has pretty much been – a stalwart force within South East London. It's been the place that has been known both by NHS London and by the control services in London Ambulance Service as the department you can fall back on when other places are overwhelmed. And taking us out would probably lead to a meltdown.

NB Can I ask you about the process the TSA – what is your view as to the extent of transparency in the process?

CE Oh dear: with regards to transparency, I was not personally brought in or privy to the meetings. Colleagues who were, were essentially told this is what is going to happen, your comments may be invited but they are not necessarily going to be taken in to consideration and they are not necessarily going to be taken as part of the final considerations either. In addition the most interested parties, the various departments such at the A&E, Maternity Services, Paediatrics and the rest; decisions appear to have been taken on data that none of these departments had actually presented to them. So you had a process that not only was not transparent, but it was based on data that only they can tell you where they got it from, because they certainly did not get it from us.
(Applause)

NB And finally – I know that you want to say something about the planning of the changes and you describe them as a sea change – what do you want to say about that?

CE I think it is really important to state the Secretary of State for Health had stated that we would be left with a 'small, but safe A&E'. I think it is really important to say there is no such thing, it does not exist. We know what an A&E is: the College of Emergency Medicine has a fairly thick booklet, which describes the services, the role, and the organisation of an Emergency Department. One of the major things there is that you would have to be able to see, 24/7, undifferentiated patients; patients no matter where they are coming from, whether they come in via ambulance, whether they walk in by themselves and for the full spectrum of medical problems and in addition you need to have seven essential services in support of that A&E Department.

What they have stated is that Lewisham would lose four of those essential services: paediatrics, acute medicine, surgery and, in addition, intensive care. That is not an Emergency Department that is not an A&E, safe, small or otherwise. So this is a model that is known only to the Secretary of State himself and Sir Bruce Keogh.
(Applause)

NB Thank you very much, there may be some more questions for you.

Panel question from Michael Mansfield (MM) to Dr Chidi Ejimofo:

MM Yes, just to correlate that: if it is not an A&E what is it?

CE That's a very good question. It had been put to them that what you were describing was an Urgent Care Centre; I note that they are loath to describe it as such because that would, I hate to use this term, would put a lie to the term that the Secretary of State has saved our A&E.
(Applause)

MM I just wanted to make sure I understood you correctly. You are a Consultant in Emergency Medicine. One would expect when radical proposals to an A&E Department are being proposed that a Consultant would be consulted.

CE One would expect so.

MM You were not consulted, your opinion was not sought; the opinion of your colleagues was not addressed and listened to.

CE No – we were informed what would happen.

MM Thank you

CE Thank you *(Applause)*

Dave Newman (DN) interviewed by barrister Maureen Ngozi Obi-Ezekpazu (MO)

MO Can you inform the Commission of your name?

DN Yes – I'm David Newman.

MO And your connection to Lewisham Hospital and why you want to give evidence to this Commission?

DN I am a resident in the London Borough of Lewisham, in New Cross, and I work in Forest Hill; but the main reason I wanted to give evidence was because of an experience we had with my mother earlier this year.

MO Can I take you then to that time: it was March 2013 – can you just explain to the Commission and enquiry what happened with your mum. If I just might say this, she was ill, she became ill with a chest infection is that correct?

DN That's right – yes.

MO And she was 92-years of age?

DN That's right – yes.

MO So can you please inform us what happened?

DN Sure – so mum became ill in March and her situation deteriorated quite rapidly one evening so I was with her, and needed to call an ambulance. She was unable to get out of the chair and couldn't eat or do anything else so we decided she needed an ambulance – despite her resistance. And, as was said, she was 92 at Christmas. She was born in Bermondsey in 1920 and that kind of meant that she grew up in between the wars and during the Second World War, so she knew exactly what it was like to live without an NHS.

Her father, who died – my granddad – died when he was about 50; he had stomach cancer but that went undiagnosed until it was too late because in those days if you did not have much money the last thing you wanted to do was get a doctor they couldn't afford, so they didn't until it was too late.

Anyway, going back to my mum. The ambulance came and they agreed she needed to go to hospital. She lives in Sidcup, which is about 10 miles out from here.

MO Sorry to interrupt you, but can you just inform the Commission whether there was a local hospital?

DN Yes I was coming to that. A few years previously she would have gone straight to Queen Mary's Hospital, which is in Sidcup about 5-minutes from where she lived. But that A&E – which is obviously very significant – was closed down a couple of years ago. So the choices the ambulance crews gave us were Queen Elizabeth in Woolwich, Princess Royal in Farnborough near Bromley or in fact Lewisham. We thought that the Princess Royal was the easiest for her friends and relations to get to visit and she had been there before, so we went there.

MO How long – how far away?

DN It takes about 40-minutes to drive there, for an ambulance half an hour or so. She wasn't being blue lighted, but that's the sort of time it takes to get there.

They set off and I arrived shortly after. We couldn't get into the A&E Department, it was too busy. We were told that we would have to wait. Subsequently I found out that there were 74 people in the A&E Department. This is 10 o'clock on a Wednesday night in Farnborough. So we were put in a cubicle, mum was in a chair, they had given her oxygen to help her breathe. The ambulance crew have to wait with you until you are actually admitted to Accident and Emergency; they are not allowed to leave you, they are still responsible for their patient. So we had an ambulance crew with us for over an hour or so, which meant they weren't able to go and do their valuable job. They were just minding my mum.

Then eventually we were moved in to the A&E Department there. We weren't seen by a doctor just had to sit in the A&E Department, this is obviously getting quite late. Mum was very unwell, very tired and was dozing off, then she would come round, and she was quite distressed and asked to be taken home. Normally, she was very alert and a bright person, but she wasn't aware of what was going on then and I think we waited there until about 1:30am or so before they put us in to a bay, put her on to a trolley and we got to see a doctor.

MO Sorry can I just ask you what time did you arrive at?

DN We arrived about 10 o'clock in the evening

MO So it was 1:30 before she was seen?

DN Before we were actually seen by a doctor, yes, and he ran some tests and blood tests and she went for an x-ray and he was very kind. While we were waiting I was talking to him and he told me that they had actually stopped ambulances coming to Princess Royal. So I asked him where they would divert them to and he named a few other hospitals and of course one of them was in fact Lewisham A&E that they were diverting the ambulances to and the irony was not lost on us.

So anyway eventually they found that my mum needed to stay in the hospital so at about 3:30 or so I left, she was falling asleep and the nurse in charge said they would find a bed for her. And the next day my sister was going to go up there - she lives in Epsom - so before she made the journey she would phone, but each time she phoned they hadn't found a bed for her and she was still in A&E on the trolley.

MO So how many hours is this then – about 12 hours?

DN Well, yeah it got up to about 12 hours. I finished work about 4:30 and went straight to the hospital and by then they had just found a bed for her. So in all she was either in a porter's chair or on a trolley for over 15 hours and it's not only that that was awful for her and traumatic for her, but that meant that bay she was in, in the A&E could not be used because she was in it and they could only examine people in the bays so that just exacerbated that situation.

So my mum was very angry, but tired; and really over the next few days she did not improve very much and she passed away the following Monday. So she was there for five days. We promised her we would put in an official complaint, which we did, but I have to say here and now that we did not put in a complaint against the care that she received. Everybody from the ambulance, the nurses everyone, the doctors were great and she got good care. It was just the system that kept her on a trolley for that length of time.

MO Did you get a response – a formal response?

DN We did, I have a formal response, eventually we got a response and it was an apology and an acceptance that that was a bad situation, unacceptable for anyone and they were going to investigate but the reality is there was nothing they could do, they had 74 patients in A&E on a Wednesday night in Bromley of all places, Farnborough, and we found out that they closed the hospital to ambulances for 90 minutes.

We also found out there were 12 patients waiting to be offloaded from ambulances that night. There was nothing particularly interesting about that night; it was just a night in the middle of March. So the A&E was virtually overwhelmed that night and it meant patients were on the trolleys for a long time.

MO Can I ask you what your view would be about what the situation would have been following, if the TSA proposals were implemented for Lewisham, closing Lewisham A&E?

Well – I just can't understand how any argument can be made for closing any A&E Department here in this area. If that situation on a Wednesday night in a suburban hospital is typical, with all those people waiting and ambulances queuing up, I can't see how closing an A&E or downgrading it or whatever they choose to say it, is going to possibly help the situation; it can only be worse. So that more people will find themselves in that situation, with loved ones being in very traumatic and stressful situations.

MO Thank you very much – there may be questions. *(Applause)*

Malcolm Alexander (MA), Chair London Ambulance Patient User Group interviewed by barrister Amanda Weston (AW)

AW Could you please give your name and your particular area of interest?

MA Yes – I am Malcolm Alexander and I'm Chair of the Patient's forum for London Ambulance Service, which is an independent group that monitors the ambulance service and has done for about 10 years. In the past I also ran a project called

Casualty Watch, which monitored A&E Departments and actually started because King's A&E was a devastating and dangerous place for patients.

AW And how long have you been involved in these activities?

MA Well, in public involvement work since 1987.

AW So you have seen a lot of changes in the time you have been involved.

MA Yes – I was the Chief Officer of Southwark Community Health Council so I monitored services in the borough of Southwark.

AW And so in your current role how long have you been involved in Lewisham ambulance matters?

MA I haven't been involved specifically in Lewisham; the work we do with London Ambulance Service is to monitor their work for the whole of London.

AW And have you had cause to have particular interest in problems faced by the London Ambulance Service in South East London?

MA Yes – well, there are considerable problems with the London Ambulance Service because they are understaffed to a very significant degree; and the number of patients is increasing rapidly. In fact over the last year there have been massive increases in the number of patients. There has been a cut of staff over a number of years of about 500 and now the situation is so desperate there is an attempt to recruit about 250 new staff, but that is because the conditions have become so bad for patients, especially patients who are more vulnerable.

AW Are you able to say what, in your view, are the pressures driving more increased admissions to A&E in London?

MA It is very difficult to say, I mean nobody seems to understand the reason why there is such a significant increase in the number of patients who are dialling 999 requiring ambulances. But what has become clear is that whilst the focus on those most seriously ill, people with heart conditions, stroke, major trauma is quite efficient, for patients who are suffering from falls, who are vulnerable, who are in precarious state of health, they can sometimes wait many hours for an ambulance despite the fact the target for that category of patients should be about 20 minutes – 90% of the time.

AW Now you have talked about understaffing, underfunding and an upward surge in demands on the London Ambulance Service: what has been the Government response thus far to those pressures?

MA The Government response?

AW Yes

MA Well the Government hasn't made a specific response. What has happened is that the Ambulance Service – in relation to particular pressures, which resulted from changes in North East London with Chase Farm, because of similar problems there –

they called on a company called OHR to do a study and that company has finished its study recently and has recommended there should be a significant increase in the number of staff in relation only to there, not in relation to Lewisham.

And that is a very important issue: there has been no study by the London Ambulance Service or the Government in relation specifically to the emergency care demands on the ambulance service in relation to Lewisham.

So what OHR have recommended is an increase of funding, which would pay for an increased number of staff and a change in the model, so that every ambulance would have a paramedic and an A&E support worker. The problem being that at the moment many ambulances, well the good thing is, many ambulances now have two paramedics or a paramedic and a technician. In the future it will be one paramedic, who is the most highly trained member of staff and an A&E support worker who is a member of staff who is not registered as a paramedic and has much lower qualifications.

AW So you are saying, if I can just summarise, that the Government is aware there are significant problems with the London Ambulance Service, it has received recommendations in respect of ...

MA The London Ambulance Service.

AW In respect of one part of London Ambulance provision?

MA Yes.

AW Are you aware that any of these matters have been taken into account before making the claim that only one minute's difference would be caused?

MA I must say that is absurd. There has been no study by the Government or the London Ambulance Service in relation to the increased pressures that would result from a change to Lewisham Hospital. There has been none. I have questioned the Secretary of State for Health and I have questioned the Chief Executive of the London Ambulance Service persistently for the pastnine months and I am absolutely certain there has been no study whatsoever in relation to the impact of increased pressures on the London Ambulance Service should there be changes to Lewisham Hospital.

And if I might add, the really significant thing that I think is not quite well understood is that across London there are many long waits – it was mentioned by the previous witness – of ambulances queuing outside A&E Departments. And just as an example at Bromley, The Princess Royal University Hospital in Bromley: in April there were 172 periods when an ambulance waited more than half an hour outside the A&E Department; and in May there were 152 occasions when an ambulance was more than half an hour outside the A&E Department just to get the patient in to the A&E Department. And I have got figures for the whole of London.

Lewisham does not appear on these figures, there is not one single incident where Lewisham Hospital, where there was an ambulance waiting more than half and hour outside Lewisham Hospital to bring a patient in, although there may be instances of lower waits.

AW So to your knowledge have the authors of these proposals made any attempt to deal with these concerns or address these matters before making their claims?

MA Not that I am aware of and the significant thing is every minute that somebody waits in an ambulance in addition to what they should be waiting, every longer journey actually disadvantages another person who may have had a heart attack or stroke or major trauma. Because every time you load on the ambulance service additional work, additional waits, you disadvantage somebody else who might die as a result of those longer waits.

AW So how would you summarise the key impact on the ambulance service and on care provisions, emergency care provision, in light of the TSA proposals?

MA Well I would say that the downgrading of the A&E Department in to an Urgent Care Centre would result, probably, in a very significant increase in pressure on King's College Hospital, which has got no room to expand. And I would imagine there would be significant ambulance queuing outside the A&E department at King's College Hospital and there would be a crisis in terms of admission, because they wouldn't have enough beds.

So I think actually, I think it is quite likely people from Lewisham would go towards King's or perhaps Guy's and St Thomas' and I think the pressure would be enormous and referring back to Casualty Watch, when we started the Casualty Watch programme there was very significant queuing inside King's A&E Department. I have got pictures of the time and it was unbelievable to see the number of patients that were loaded in to that A&E Department for a very similar situation; because nobody would invest appropriately in to the development of that A&E Department.

AW So in general terms then, would you say that the proposals would exacerbate the existing and well known recognised difficulties?

MA I think that it would exacerbate, it would increase morbidity and mortality. I think it would have a negative impact on people with heart disease and stroke, because of the difficulty of, not that they aren't a priority, but the more you load an A&E Department the more difficult it is to get the critical patients through the doors in to appropriate places. The more the beds are full there will be consequent problems. And already, if we look at the situation, there is already inadequate attention to some people with stroke and heart disease, because resources are currently insufficient and that situation would become exacerbated with very negative consequences to patients.

AW In other words many more examples of the very sad story that Mr Newman told the Commissioners.

MA I think so and the particular issue, which is so important, is that as you get more emergencies in what is known as Category A – they are the people who are most critically ill – what happens is all the resources are moved towards Category A because they are the people who could die or could suffer from serious morbidity. And the Category C patients those who have fallen, those with fractured hips, those perhaps with bleeds, other conditions, those with mental health problems get neglected, leading to very long waits, deterioration and sometimes people are lying on the floor for many hours waiting for an ambulance and suffering considerable harm.

AW So you are saying then that this is not only the time-critical patients that we have to be concerned about but also the impact on those with less time-critical needs?

MA Consequences for less time critical patients are grave.

AW Have you communicated your concerns to the TSA?

MA Not directly: to the Secretary of State and to the Ambulance Service, not to the TSA directly no.

AW You've communicated to the Secretary of State – what response have you received?

MA Well, we've received two letters, which I have submitted to you, which … really the first letter I thought was pretty shameful in that it answered very few questions. The second letter attempted to give data to answer our questions, but I thought the data was very inadequate and it finished off with a sentence that said 'we cannot answer any more of your questions because of the Judicial Review, which is imminent', which I understand legally is actually not correct.

AW What confidence do you have in the response you've received from the Secretary of State?

MA I think the response from the Secretary of State is shameful.

AW I have got no further questions unless the Commission might have some. *(Applause)*

Panel question from Michael Mansfield (MM) to Malcolm Alexander:

MM Yes, it is on that same topic – you wrote three letters and we have got the dates and we have got copies of them, as well as the responses as you have just mentioned. You really wanted to find out what impact assessment had been made by the Department of Health with regard to the area you are concerned in; not just for Lewisham but for the South East area, so I make that clear.

I want to deal with one of the replies that came to you, the last one I think on 2nd May – do you have it there, as it is better if you have got it?

MA Somewhere probably.

MM It's page 162 and the reason I am asking the question is: we do have to consider – just while you're turning it 162, middle paragraph – what it is the TSA and others are saying and make an assessment about that as well. Now they are saying in this letter to you this – have you got it, 162?

MA It starts *'You also mention the impact …'*

MM Yes that's right – and it's the third paragraph down:

'Your letter suggests …' – I just want your observations on this: 'Your letter suggests there has been no impact assessment of the TSA's recommendations. The TSA commissioned a Health and Equalities Impact Assessment, which appeared at Annex l of the Final Report. An equalities screening document was published alongside the TSA's consultant and final report, then considered the feedback from the TSA's consultation. The TSA's final report traces how it considered these various aspects before he made final recommendations'

Does this make any sense?

MA Well it doesn't because I questioned the Chief Executive, London Ambulance Service persistently and raised questions in their public board meetings on this matter and they have repeatedly told me, and I have also spoken to Fiona Moore, the Medical Director who is a member of clinical team for the TSA, I had a meeting with her in fact last week on the subject. And I have been persistently told that there has been no study by the Ambulance Service, by the London Ambulance Service, in relation to the impact should the Lewisham proposals by the TSA take place. So I am absolutely confident that although there may have been a study, that study is not specific to the impact on the London Ambulance Service. That has not been done.

MM A serious misrepresentation?

MA I think it is a very serious; it's a generalisation which doesn't deal specifically with the pressures on the London Ambulance Service.

MM Might I ask what an Equality Screening document would be?

MA I don't think I can really answer that question – I can't tell you specifically what that means. I think it is probably an equalities impact assessment that looks to see if any particular groups of the community would be [impacted] – people from an ethnic minority or people with a disability and so forth, I think that is what they are referring to.

MM Thank you

MA Thank you so much
(Applause)

EW We now have some more videos from witnesses who are not giving oral evidence today.

VIDEO STATEMENTS 3

Dorthe Swaby-Larsen, Consultant Nurse, Lewisham Hospital Urgent Care Centre

I think we deliver an incredibly high quality of care to our patients. We're amongst the fourth, fifth, busiest in London and we do so with less resources than some of the others do. I think we have real commitment around creating different roles for people and one of the things that really got me back to Lewisham is the way everyone works together across professional boundaries; and that includes out into the community, so

not just doctors and nurses, but the whole range of staff and patients together.

I think there are several risks to this proposal – some of them are obvious and I think a lot of people have talked about them. I think some of them are a little bit more hidden.

I think the consultation failed to engage with certain parts of the community. I'm sitting right now in the middle of New Cross, it's one of our more deprived areas. There's a big gang culture down here and their voices no one will ever hear because they don't engage, generally speaking, with any services. But we see them in our department. And I think just for those people, they couldn't travel up to Queen Elizabeth, they would be travelling too many boundaries. I know 12 years olds who hardly can't go to their local school without taking a big detour because of gang culture so I think that's really been lost.

I think some of the other risk is around the training. I run – and I'm very proud of it – a very successful nurse practitioner team. We treat around 25% of all patients coming to the Emergency Department, adults and children with injuries but we can only do so being part of that major team. What I can't see, if we keep chopping services away and splitting them up is: where's the next generation coming from? How are they going to train?

Eleanor Beardsley, Lewisham resident, mother of child with urgent care needs

My experience of Lewisham Hospital goes back to 2006 when I was pregnant with my daughter who was born at Lewisham Hospital. She had significant health problems and was very much under their care for a significant amount of the first two years of life. My son was born in 2010 and has more severe health problems and has also been a regular at Lewisham Hospital. He has a significant and very rare and complex set of health problems – one is a complex congenital heart defect and his second significant health problem is a liver-related diagnosis. Unfortunately the second one has meant that he spontaneously vomits blood in quite a dramatic way and it's happened three times in his life. That situation's been stabilised and managed by a special unit at King's College Hospital now; but at the time when this happened we got an ambulance to Lewisham Hospital and they saved his life and three months later he bled again and they did it again. And there is a risk that that may happen in the future. And there is a need for him to be treated very, very quickly and the team at King's have said that we should be near an A&E – not beyond 20 minutes.

Nigel Byrne, Captain, Lewisham Salvation Army

Now if you're homeless, you haven't necessarily got connections to the area you find yourself in and you aren't necessarily registered with a GP. That means if you find yourself with a health crisis on your hands – you're on the streets perhaps, perhaps you're homeless – you need to present to the local A&E department. Indeed I can say that some of the folk that we meet will have had or have mental health issues. Whether you've mental health issues or not, it doesn't matter because if you find yourself homeless, if you find yourself disconnected from your family, if you find yourself vulnerable and on the streets – and there but for the grace of God go any of us – and you were feeling depressed or suicidal as these folks sometimes do, you would be advised to report to your local A&E Department. And I think that has a huge bearing on what we're talking about today. Because if you haven't got a local A&E Department to report to, nor the resources to get to one, where exactly does that

leave you? It leaves you a bit more vulnerable than you were to start with. So I think our unique positioning in the community gives us access to such people and I have a deep concern for them.

The A&E Deportment is the first port of call. If you have to say to them, 'Well we're going to put you on a bus to Bexley' or 'We're going to have to put you on a bus to somewhere else', will they go? I don't know. Will they have the motivation to go? I don't know. Will they then be seen as quickly as they need to be? I'm not sure. If somebody's suicidal and they've got that thought in their mind immediately, that that's their only course of action, what difference will the delay make? Well, it might make a tremendous difference to that particular individual. As much as we can talk to them and we can do as much as we can, sometimes people need professional help, they need it quickly and we need to be able to get them to that at the point when they recognise the need for that.

And it just feels like something's been taken away in the support for us and the work that we do.

Iain Wilson, Lewisham resident, Psychiatric Nurse, Queen Elizabeth Hospital, Woolwich
In terms of Queen Elizabeth Hospital I'm based in A&E, that's where my job is. And the A&E is just wildly overwhelmed – as it is, *before* Lewisham shuts. It's one of those things where I don't want to be scaremongering, or damaging morale of a good lot of staff there, but it's just too much work.

There was one day alone where there were 102 patients who waited 4 hours or more in A&E to get out – so that's for their length of treatment – that's not waiting to see a doctor. But you're meant to only be in A&E for 4 hours. There was a 98 year old lady who came in with a fall and she was there for 33 hours. She came in 8 o'clock in the morning one day, didn't go up to the ward till 8 pm the next day. And A&Es aren't equipped to deal with older people for long periods of time.

Specifically to my job which is drugs and alcohol, the main risks I would see is that the pressure on bed space in the hospital means that the vulnerable people I see, drug and alcohol patients, they'd fall down the list of people who were likely to get hospital admissions. So the typical kind of repeat presenter at A&E who might be someone with ongoing liver or stomach problems, frequently relapsing with alcohol, who needs inpatient hospital care: when the bed pressure's on, they're going to, you know, gradually marginalise and stop admitting those sorts of people and stop treating them as fully as they can because the staff are under pressure to see other people. So specifically for my patients they're less likely to get in. They're more likely to be left to sit in a waiting area in A&E until they get pissed off and go home. You know that's the sort of thing where they end up presenting sicker further down the line, costing more money.

It's difficult to know what'll happen, whether Lewisham patients will struggle to get to the hospital. If they are mobile they will struggle with getting home from the hospital at 3 o'clock in the morning because they're not going to get patient transport.

Maggie Palmer, Child mental health specialist team, Kaleidoscope (CAMHS)
I want to assist the inquiry because I think it's crucial that child mental health services are linked to Lewisham Hospital. We have a very important role with

helping young people who are suicidal and also young people who are referred from various departments within the hospital such as dermatology, diabetes, oncology, various departments, paediatric departments that are there. And the problem is if Lewisham Hospital closes then the link will be lost to our service.

If young people are forced to go to Woolwich, to go on a bus six miles away when they feel suicidal … and there's a problem with that because what we would do if a young person is suicidal if it's out of hours? Then, we have to tell them to go to the hospital, rather than contact us if it's out of hours. So the problem is partly getting to Woolwich, and then – what happens if they're turned away, if they had to go to another hospital? But there's also a continuity of care with our service which is then lost, because we may not be able to. There's a discussion: would we then go over to Woolwich and assess them or would that then be with Greenwich Child and Adolescent Mental Health Service? So there's a problem of the continuity of care that's lost.

Father William Chatterton, All Saints Church, Blackheath
What impresses me most is the staff in Lewisham Hospital actually listen to you, you can see them listening to you, they're taking it in, they're thinking 'what do I need to do as a result of this information? Do I need to refer to someone else or is this within my competence?' And you can actually see it ticking, see the process ticking. They're hugely committed and I'm full of admiration for them. And in a sense that's not just me as a parish priest speaking and someone who knows this parishioner really well, it's also as a manager. I can see, as a manager that this is a system that really works. This is a system that motivates people, it runs intelligently. And, I'm lost in admiration of it.

This campaign is one of the most broadly based campaigns I think I've ever come across. It's got people who know about the changes in the NHS in great detail and in a sense who are more professionally involved. It's got people from the hospital and it's got a groundswell of popular support. I think that makes it extraordinary. And it's right and proper that the Church be involved in that as well.
(Full statements can be seen at http://www.savelewishamhospital.com/commission-witnesses/)

Session 4 ends

CHAPTER 5
MATERNITY SERVICES

Secretary of State for Health Jeremy Hunt

On the proposal for a midwife-led birthing centre at Lewisham Hospital
'This part of his recommendation included reducing the number of accident and emergency departments across the area from five to four … downgrading the current obstetrician-led maternity unit at University Hospital Lewisham to a stand-alone midwife-led birthing centre. Each obstetrician-led maternity unit would also have a midwife-led birthing centre.'

'On the issue of maternity services, the expert clinical panel advising the TSA was not willing to support the increased risk to patients of having an obstetrician-led unit at Lewisham without intensive care services. As achieving the London-wide clinical standards will be possible only with the consolidation of the number of sites with these facilities, Sir Bruce supports the proposal for this unit to be replaced with a free-standing, midwife-led unit at Lewisham hospital. This will continue to deal with at least 10% of existing activity and potentially up to 60%, and £36 million of additional investment has been earmarked to ensure that there is sufficient capacity at other sites.'

On travel times
'The whole population of south-east London will continue to be within 30 minutes of a blue light transfer to an A and E department, with the typical journey time being on average only one minute longer. Accessing consultant-led maternity services will involve an increase in journey times on average of two to three minutes by private or public transport. Sir Bruce therefore concluded that there should be no impact on the quality of care due to the small increase in travel time.'

On maternal deaths
'Let us talk about maternity deaths. London has a higher rate of maternity deaths than most other parts of the country, and that is something that any responsible Health Secretary should try to tackle. The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives agree that the way to reduce the number of maternal deaths, in which London does not score well, is to centralise the facilities that deal with the more complex births in fewer sites, where surgeons can get more experience and deliver better clinical outcomes. That is what this proposal is doing. It will lead to fewer maternal deaths in Lewisham and south-east London. It will also mean that, for the first time, south-east London will do something that it does not do at the moment, which is to meet the London-wide clinical quality standards. That must be the most important thing for the people of south-east London.'
(*Hansard*, 31 January 2013)

In this Session the panel first heard from Ruth Cochrane, the most senior Consultant Obstetrician and Gynaecologist at Lewisham Hospital and also a clinical teacher. She had worked for the NHS for 32 years, since qualifying, and at Lewisham for over 16 years. She described the team at Lewisham as a highly efficient, experienced team which provides a safe service with choices for women.

Currently Lewisham Hospital offers the choice of home birth, supported by members of the Lewisham team; and at the hospital itself, a midwife-led unit, co-located with the obstetric unit and the adjacent labour ward.

Ms Cochrane explained that Lewisham currently delivered the babies of over 4000 women each year and the birth rate is increasing. Only approximately 12% of those 4000 women would be considered safe to deliver in a stand-alone midwifery-led unit. She highlighted the essential nature of maternity work: that emergencies are inevitable and unpredictable. At present in those emergencies women are moved immediately along a corridor to the labour ward. The TSA proposals would involve

an ambulance being called to transfer the woman to another hospital. None of the nearby hospitals have sufficient capacity to deal with all the women transferred if the Lewisham Obstetric unit closed. Thus, frightened, high risk women would travel to a hospital they didn't know to be looked after by people not aware of their history and in a unit that is already overstretched. That will impact on quality of care and endanger not only Lewisham women and babies but also women who are delivering in those other hospitals and already suffering because the service is overstretched.

She also referred to the vital links which Lewisham has with the community midwives and local GPs. Those links are in real danger under the proposals. Ms Cochrane informed the panel that in June 2013, the week before the Commission, Lewisham Hospital's maternity services had been inspected by the Clinical Negligence Scheme for Trusts, the CNST. Lewisham had formerly been at level 1 of CNST, equivalent to the standard version, but on their recent CNST inspection had risen to level 2, a vote of confidence in current practice:

> 'The assessors were very complimentary on the standard of note keeping and clinical care that they have reviewed. They were impressed with the live records they saw on the post natal ward and from the birth centre and they received so much assurance from those live records of our high standards [that the inspection was finished in half the usual time]...'
> Letter to staff re: Lewisham maternity inspection findings from Mr Dhiraj Uchil, Consultant Obstetrician and Gynaecologist, University Hospital Lewisham. (Can be seen at http://www.savelewishamhospital.com/commission-witnesses/)

Jessica Ormerod, a mother and Lay Chair of the Lewisham Maternity Services Liaison Committee (MSLC), a multi-disciplinary forum, gave evidence. She said Lewisham Hospital and the NCT (National Childbirth Trust) provide excellent care within the community. During the consultation period her committee was invited by Lewisham Hospital to attend a consultation. She described the TSA team as failing to consider women's concerns. They were "absolutely not interested". (Jessica Ormerod p.102)

She told the panel of her input to a later TSA meeting, organised belatedly for the evening of the last day for consultation and attended by Dr Jane Fryer for the TSA. Dr Fryer's response to Ms Ormerod's safety concerns about the proposal was that, for example, the risk of post-partum haemorrhage – a relatively frequent, potentially dangerous occurrence – could be addressed with 'putting in a drip'. (Jessica Ormerod p 105 (Dr Fryer was invited to give evidence to the Commission but was unable to attend and sent apologies.)

Most women, Ms Ormerod told the Panel, want to give birth safely at their local hospital, rather than travelling miles and hours out of their area. Even if they could afford it, taxis will not take women in labour to hospital, so women would have to walk or get a bus or hope that an ambulance will actually arrive. The proposals do not take that into account, as well as doing away with choice of maternity services, as currently offered by Lewisham Hospital.

Ms Omerod was asked about a long and detailed letter she had sent to Jeremy Hunt, SOSH setting out her concerns. She confirmed she had received no reply beyond a standard acknowledgment. There had been no attempt to answer her concerns.

(These letters can be seen at http://www.savelewishamhospital.com/commission-witnesses/)

Toyin Adeyinka explained that she was a Lewisham resident and the mother of one son and wished to speak on behalf of women, mothers and vulnerable people of the borough. Her story highlighted the specific services which would disappear if the proposals were put in place. Her son was born at Lewisham Hospital in 2011. Hers was a complicated pregnancy which meant that at 37 weeks she had to be admitted for a Caesarian section. She remained in hospital for eight days. None of the complications could have been predicted in advance. At Lewisham she was able to be visited by her family and friends, whom she relied on heavily for support and help. Following delivery, and because of both Ms Adeyinka's blood pressure and her son's weight, they had to remain another three days to be monitored.

If the proposals were to go through, in the event of another pregnancy, Ms Adeyinka would not be permitted to use the proposed midwifery led unit, because of the past obstetric history. She would have to travel to another hospital. Currently she can take one bus to Lewisham Hospital, a 10-15 minute journey. To get to QEH would take her over an hour requiring two or three changes of bus, or two buses and a train. For a heavily pregnant woman with health issues this could be dangerous.

The Commission heard evidence of the potentially great impact on the health of economically and socially disadvantaged young parents and their children of relocating maternity services to QEH, five miles away from Lewisham. Kathy Cruise, a highly experienced community nurse who works on a special programme targeted on needs of this group of young parents, spoke of the predictable impact on them and their children of long and costly journeys on public transport. (Kathy Cruise p.53) The Commission heard from this witness too, that low birthweight in babies was often associated with poor early attendance at ante-natal provision and that the effects of this were often 'lifelong' for children. Lewisham had successful addressed this issue, raising early attendance rates in line with national norms. However Kathy Cruise expressed her concern that shifting services to QEH could reverse this progress, because the journeys would be 'too far and too costly and may lead to them not accessing those services'.

Toyin Adeyinka expressed similar concerns (Toyin Adeyinka p.110). She stated that transferring maternity services would have a 'really negative impact'. She felt that some young mothers may feel that they 'don't have the energy' to travel the longer distance of over an hour to QEH and may feel more reluctant to attend because they 'won't possibly understand the importance of these appointments'. She stated that for her a return journey to QEH from Lewisham would be £26 which would clearly be far beyond what those on low incomes could afford.

SESSION 5 TRANSCRIPT

LIVE WITNESSES

EW Jeremy Hunt

Jeremy Hunt stand-in reading extracts from Jeremy Hunt's speeches, interviewed by barrister Di Middleton (DM)

DM *Minister, you intend to keep the birthing centre at Lewisham but you'd disperse Lewisham pregnant women to other hospitals. Why is that?*

JH *London has a higher rate of maternity deaths than most other parts of the country and it is something that any responsible Health Secretary should try to tackle. The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives agree that the way to reduce the number of maternal deaths in which London does not score well is to centralise the facilities that deal with the more complex births in fewer sites where surgeons can get more experience and deliver better clinical outcomes. This is what the proposal is doing. It will lead to fewer maternal deaths in Lewisham and south east London.*

DM *What financial provision has been put in to place to provide for those pregnant women who will be moved out to those other hospitals?*

JH *We have allocated £36m to expanding the capacity at those other hospitals that will take on more complex and high risk births as a result of the proposals and we will work closely with those Trusts to ensure that capacity is in place.*

DM
And what did Sir Bruce Keogh's review say about travel times for those transferred women?

JH *Accessing consultant-led maternity services will involve an increase in journey times on average of two to three minutes by private or public transport. Sir Bruce therefore concluded that there should be no impact on the quality of care due to the small increase in travel time.*

DM *And is this small increase in travel time something that those patients are likely to object to?*

JH *The Royal College of Obstetricians & Gynaecologists has established that women with high risk pregnancies would prefer to travel a little bit further if that means they will get better clinical outcomes, which is what this is all about.*

DM *Thank you. (Applause)*

Ruth Cochrane (RC), Consultant Obstetrician and Gynaecologist, Lewisham Hospital, interviewed by barrister Nicola Braganza (NB)

NB Could you give your full name please.

RC I am Ruth Cochrane

NB And what is your role?

RC I am a Consultant Obstetrician and Gynaecologist at University Hospital Lewisham.

NB How long have you held that post?

RC I've been there over 16 years now.

NB And where are you in terms of your seniority in that post?

RC Well, I'm afraid I am the oldest. I've been there the longest. I am the most senior consultant. I am the one my colleagues come to when they have a problem.

NB What is your particular expertise?

RC I am a generalist so I do both obstetrics and gynaecology. I have a major role in terms of labour ward management and the management of high risk obstetric cases. I see a lot of women who have had previous troubles in pregnancy, particularly still birth and recurrent miscarriage, and I do my best to look after then in their future pregnancies. I also have a major gynaecological interest in doing major gynaecological surgery.

NB How long have you worked for the NHS?

RC 32 years since I qualified.

NB And, how would you describe your connection with University Hospital Lewisham?

RC I feel a very deep connection because of the way in which my consultant post came about. I was looking for a consultant job at the time that my predecessor Miss Mary Anderson was retiring from Lewisham and I applied for the post never thinking for a moment that I would be able to step into her shoes, but I was fortunate enough to be appointed. Mary Anderson was the Vice President of the Royal College of Obstetricians & Gynaecologists and very much a hero to many obstetricians and gynaecologists of my generation. And she was extremely proud of being the senior clinician at Lewisham and I am very, very proud to have followed her.

NB And how do you feel about the service that you provide?

RC I think we provide a fair and safe service and I like to think that we provide choices for women. We have a very interesting mixed borough which makes the work fascinating and challenging. As other witnesses have said we have a high level of deprivation in our borough, we have a very wide range of people who present a very wide range of clinical problems and I, with my colleagues, I hope, are able to offer a good and competent and safe service to those people.

NB You are also a clinical teacher.

RC That's right. I am the lead for undergraduate teaching in obstetrics and gynaecology at Lewisham. We receive a tranche of medical students from King's Medical School every term so we have a major role in terms of clinical teaching. The students who come to Lewisham enjoy it thoroughly, not just in our department, but in other departments run by my colleagues. They feel the inclusiveness of our place, they feel that they are involved, they feel part of the team and that's often a nice surprise for them when they have been used to a bigger campus.

NB What do you understand the central ethos of the NHS to be?

RC It is the provision of good clinical care that is free at the point of access.

NB And how do you see the internal market as having affected that?

RC I think it has been very worrying because it has set up competition amongst colleagues that wasn't really there before. We of course all like to do well and we like to think that we do the best that we can, but that shouldn't mean that there are problems between departments and between hospitals. I think that the danger of any market-led force in the NHS is that it takes away the original ethos of the service and it takes away the instinctive goodwill which is what makes the NHS so popular and so successful where that goodwill is allowed to flourish.

NB To what extent do you take the view that the changes in the NHS have been openly debated?

RC They may have been openly debated in our hospital bar and in our common rooms! I don't think they have been openly debated nationally. I feel that many of us hoped that with various governments over the last few years, that because members of the higher echelons of that Government had personal interest and connections in the NHS that they would understand instinctively that it was worth saving. There has been a lot of talk about the NHS being safe in various senior politicians' hands and I'm afraid I trust none of them. *(Applause)*

NB What do the proposals mean for maternity patients?

RC It is going to be very interesting because we currently deliver just over 4000 women at Lewisham each year. I did a 'back of the envelope' calculation of women who would be considered safe to deliver in a stand-alone midwifery-led unit – which is what Mr Hunt has proposed for us – and it would be approximately 12% of those 4000 women. They could only have women who had had a baby successfully normally before, who weren't overweight, who had no scars on their uterus from a caesarean section or any other surgery, who didn't have any other co-morbidity, who didn't have a yen for an epidural for example, who didn't have any other medical problems and in whom no emergency could be foreseen.

One of the problems for maternity work is that emergencies are inevitable and unpredictable and that is why you need people like me and my colleagues because you cannot always look at somebody and say you are going to have a problem, say with bleeding excessively after your baby is born, or you are going to have a sudden rise in your blood pressure, or your baby's heartbeat is suddenly going to become abnormal unexpectedly quickly in labour.

I don't have second sight, I've just got 30 years' experience and I know that even women who are purported to be low risk can often change very quickly and whilst at the moment women who deliver in our Birth Centre who need immediate obstetric help can be transferred quickly along a corridor and up to our labour ward, in Mr Hunt's vision they will be transferred, as we have heard, slowly in an ambulance to another hospital. I would be terrified if that was me or if that was my daughter.

NB So taking that a stage further in Mr Hunt's vision, what is going to happen to these mothers and what is going to happen to these babies?

RC I think the word that Mr Hunt used was 'dispersed'. *(Laughter)*

The idea, as we have heard from other witnesses, is that they will all go to Queen Elizabeth Hospital, Woolwich. And we all know that that is not the case. Some might go to Woolwich if they live on the Blackheath side of the borough. But most would gravitate towards King's or possibly even to St Thomas' and some of those in Catford down to the PRUH. None of these places have sufficient capacity to deal with all the women that they would be expected to deal with if the Lewisham obstetric unit closed. And I have real concerns about people who have formed an attachment, a trust with our own department, with our community midwives in Lewisham, who might be looked after in the borough ante-natally but then will be expected to deliver in another hospital where nobody knows them and where they haven't formed that professional rapport. Certainly many of the women I looked after, who are terrified because of their past history, find great comfort in knowing the people who are going to look after them. And there is a wealth of evidence about the importance of continuity of carer in people who have complex pregnancies with difficult past histories. This proposal would shatter that.

NB And how is that going to manifest itself in terms of these individual mothers and their babies? What is actually going to happen? What are the dangers?

RC The dangers are that frightened, high risk women will travel to a hospital they don't know, to be looked after by people who aren't aware of their history, in a unit that is already overstretched. My colleague from London Ambulance Service talked about waits in A&E. There would be similar waits in the maternity services in all of these hospitals.

We already run very often with a full labour ward and with our neighbouring hospitals doing the same, and then when more women come in in labour some of our local hospitals say we can't take any more, we'll have to send you to Lewisham. If that's the case now, what's it going to be like when Lewisham obstetrics closes. The people of Lewisham are not going to stop having babies. They have got to be delivered somewhere safely and the worry is not only will it add the risk for Lewisham women and babies, it will significantly increase the risk for women who are delivering in those other hospitals who are already suffering because the service is overstretched. We will make it even worse.

NB What about the birth rate in Lewisham: how do you see that changing?

RC I think it is likely to increase. You'll have noticed all the building work going on up around Lewisham station. This is going to be affordable housing for young families; most of those will be fertile and have babies so I suspect the birth rate here

would increase. There's also other developments in the Thames Gateway area which are expected to increase the birth rate in our neighbouring hospitals and so we really should be improving the provision for obstetric patients rather than reducing it.

NB What about the integration between hospital services and the community? What do you want to say about that?

RC I think that is something that is currently done well and something that is valued by not just the maternity services. We clearly have a good link with our community midwives and with our local GP colleagues, but this is true across the board in various departments. You heard Liz Aitken earlier, talking about the community arrangements with regard to Care of the Elderly. My paediatric colleagues who will talk later will say the same thing about community-based paediatric services. It is something that Lewisham does well but not something that you can generate very quickly. It grows gradually with people who stay in the same job for a long time forging those links with colleagues from outside of the hospital and those links are in real danger with these proposals.

NB Now, you have been a patient yourself at Lewisham hospital?

RC Yes

NB And in respect of that, what have you found?

RC I was looked after very well. I had major surgery about three years ago and ended up in HDU [high dependency unit] where they looked after me beautifully and as you can see I've recovered. I know that that was because they are extremely good at their job – it wasn't just because I was one of their colleagues and they were being nice to me.

NB So if you fast forward in time to these proposals being put in place, how would that have affected your circumstances?

RC I'm sure if I went to Guy's for my surgery they would have looked after me well. It made a big difference to my family being able to just come down the road to visit. It made a huge difference to me to be looked after by people that I knew and who were familiar with me and were able to explain to me the severity of my situation and help me through it. The same could be said for everybody in the borough who has had major treatment at the hospital. If you are looked after well you form a bond and you don't want that bond broken by somebody who quite frankly who doesn't understand the details.

NB Now we've heard about the reorganisation only supposedly taking place if four tests are satisfied. Those four tests are:

1. That there must be sound evidence that it would be clinically sensible.
2. That there must have been genuine public consultation.
3. There must be agreement from primary care.
4. The changes should enhance rather than reduce choices for patients.

What do you want to say about that?

RC Well I think this proposal fails all four. Many of us were involved in the so-called public consultation. The public consultation consisted of Mr Kershaw standing

up in front of a bunch of angry Lewisham residents and them all shouting at him, and him having to be hustled out of a back door by security guards. If that is consulting the public then I don't recognise it. But that was the scene at the Calabash Centre shortly before the publication of the [final] proposal.

The clinical evidence base I think has been roundly demolished by my colleagues from the hospital and myself in terms of the evidence we have been able to provide. But when we tried to explain about the clinical evidence to Mr Kershaw he didn't really listen. One example really would be the way in which he tried to say to me that it would be okay to have a low-risk obstetric unit at Lewisham, which is what his draft proposal originally suggested. When I said to him I don't know what low-risk obstetrics is, he then of course amended his proposal to take away obstetrics altogether and just have a midwifery-led unit with no obstetric support. So that shows you how much he listens to clinical evidence. The choice element of it, the final point, I think is roundly ruined because at the moment people have the choice to go to their local hospital in Lewisham and we like to feel that we provide a choice for them about how they are cared for and if you take Lewisham out of the picture their choices are diminished rather than increased.

NB And finally, there's been a particular development in the last few days that I know you want to comment about.

RC That's right: in the last week, Lewisham Hospital's maternity services have been the subject of an inspection by an organisation called the CNST, which is the Clinical Negligence Scheme for Trusts. This is a national organisation that inspects hospitals to make sure we are practising in a safe and efficient manner and there are various levels at which you can pass the CNST inspection. There are standards for hospitals in general and there are more stringent standards for maternity units in particular. We were at level 1 of CNST until this week, level 1 being if you like the standard version. But we have achieved level 2 on our recent CNST inspection because they were so impressed with us and I would like to just read what the inspectors had to say:

> "The assessors were very complimentary on the standard of note keeping and clinical care that they have reviewed. They were impressed with the live records they saw on the post-natal ward and from the Birth Centre and they received so much assurance from those live records of our high standards that when a CNST inspection for level 2 normally takes 2 days, they finished ours after just one because they liked so much what they saw. They were particularly complimentary on the detailed documentation of all staff in the care of high risk staff in particular post-partum haemorrhage."

So it is not just the good people of Lewisham who think that we are alright and it is not just my consultant colleagues who believe that, but national inspectors who come and look at us and judge us very carefully believe it too.

NB Thank you very, very much. *(Applause)*

Panel question from Michael Mansfield (MM) to Dr Ruth Cochrane:

Yes, I have one question and that comes again out of this, if you like, Government response. Could you look at Tab 2 of the document? We've seen it before in relation

to other witnesses. It is Bruce Keogh's provision of material to the Secretary of State. I want to deal with what he says in relation to your particular topic. I'm afraid it is not paged, it will be the 4th page of that letter at the bottom. There is one paragraph dealing with your particular specialism. Have you got the fourth page – 'I am satisfied …'? I'd better read it: it is a very short paragraph so everybody knows what the background to the question is. This is what he is telling the Secretary of State:

> "I am satisfied that there was substantial clinical input and external scrutiny of the maternity options. The Expert Clinical Panel was not willing to endorse the risk, be it small, for an obstetrician-run unit at Lewisham in the absence of intensive care services. This is because obstetrician-run units attract higher risk mothers and babies. However, in the light of the recent *Birthplace* research study I support the proposal for a free-standing midwifery-led birthing unit at Lewisham."

So, question: he seems to have had a certain amount of criticism of this but he has overridden that because of a recent *Birthplace* research study. Can you help us, what is that study?

RC The *Birthplace* research study was looking at the safety of various options for place of birth depending on the kind of mothers who were being delivered. And what it found was that obviously if you were a high risk obstetric patient you would need a high risk obstetric unit. If you were low risk then you might be okay in a midwifery-led unit, but ideally you would be best served by a midwifery-led unit that was co-located with an obstetric unit.

So in other words you would be looked after by midwives unless your case became complicated and then you could be moved along the corridor and the obstetricians could help you. Free-standing midwifery-led units are really only endorsed by our Royal College for women who have had babies before – who pose no other risk. And so we felt that this paragraph was slightly odd, because it was saying that we are taking away obstetrics from Lewisham because we are also taking away intensive care. Surely a more logical thing to have done would be to have kept both. *(Applause)*

MM Will you ensure that we have copies of the assessment you have referred to.

RC Of course. (An email citing this evidence can be seen at http://www.savelewishamhospital.com/commission-witnesses/)

NB Thank you very much. *(Applause)*

Jessica Ormerod (JO), Lay Chair of the Lewisham Maternity Services Liaison Committee, interviewed by barrister Amanda Weston (AW)

AW Could you give your name and your particular area of interest to the Commission please?

JO Yes, I am Jessica Ormerod. I am the lay chair of the Lewisham Maternity Services Liaison Committee – snappy title. Basically we are a multi-disciplinary forum; we work with Lewisham Hospital, the London Borough of Lewisham and the core membership of the committee are mums, and I am a mum.

AW What does your role entail in that organisation?

JO Basically what we do is we look at the service that is being provided at the moment and we look at ways in which it can be improved.

AW And how long have you been involved with looking at maternity services in Lewisham?

JO I've been involved for three and a half years.

AW And what do you understand to be the current proposal regarding maternity services at Lewisham hospital?

JO My understanding is that we pretty much won't have a maternity service locally provided in Lewisham.

AW Was your committee involved in the process by which that proposal was made?

JO Well, we were sort of involved. I was invited by Lewisham Hospital to attend a consultation with senior clinicians and managers and commissioners.

AW Sorry, who invited you?

JO Lewisham Hospital invited me to attend with them a maternity workshop with the TSA.

AW And do you have a good working relationship with Lewisham Hospital?

JO I have an excellent working relationship with Lewisham Hospital, yes.

AW And how do you find their responsiveness to your committee's concerns?

JO They are really excellent. We have made huge changes to Lewisham Hospital since my first daughter was born eight years ago when Lewisham maternity services didn't have quite the same reputation they have now. Lewisham Hospital and the PCT and now part of the Council have responded to women brilliantly. They have opened the midwife-led unit. We have excellent care within the community and the MSLC is a vital part of everything that happens with maternity services in Lewisham.

AW And how supported do you feel as a mother and as a member of the committee by Lewisham Hospital?

JO Hugely supported.

AW Now you have said that Lewisham Hospital invited you to attend a meeting with the TSA team.

JO Yes, this is during the so-called consultation period. It was a maternity workshop hosted by the TSA and the TSA had invited senior clinicians, managers and commissioners from Lewisham, Guy's and St Thomas' from King's, from Bromley, from Darent Valley and Woolwich.

AW And how did the TSA team react to your attendance at that meeting?

JO They were – 'rude' doesn't really quite cut it. I arrived – the meeting had been planned for two or three weeks and somebody asked me what I was doing there, so I explained to them what I was doing there.

AW Was that a member of the TSA team?

JO That was a member of the TSA team, and at which point they all went into disarray, and were horrified that I could be at this meeting and they asked me to leave. I said: 'Absolutely not, I represent all maternity users in Lewisham, I can't understand why you wouldn't want me here.'

AW And you were invited?

JO 'And I was invited and I've got a babysitter so I am staying.' So I sort of walked past them and went into the meeting and sat down and I thought they will have to pick me up to get rid of me.

AW What reasons were you given why it wasn't appropriate for you to stay?

JO Well somebody suggested that I might not be able to follow the clinical discussion and I said I didn't really think that was any of her business and it was my decision if I could follow it or not. At that point, I was sort of ignored. Then my colleagues at Lewisham Hospital were told that if I didn't leave, I could stay, but that is because they would have had to obviously cart me out, so they said I wasn't allowed to speak.

AW Were you provided with any documentation in advance of the meeting?

JO Nobody was provided with any documentation before the meeting. There was no agenda, there was nothing. This was really senior members of staff across many Trusts.

AW Was there any meaningful consultation at that meeting?

JO Absolutely not.

AW Describe how the meeting went.

JO The meeting was quite horrifying. Obviously I had been told not to speak. I didn't know if that was true of anybody else at the meeting. It was extraordinary. doctors, midwives, commissioners, managers all tried to get their concerns across to the TSA team who were absolutely not interested. They were not interested in any of the models that anybody had brought along with them for patient flows or anything at all really. Because what they were attempting to do was start afresh and have a completely new model of care. And that was it. And they said: 'If you have a problem with this you can leave.'

AW So there was no clinical or patient input into that model?

JO Not as far as I could see.

AW Certainly not at that meeting?

JO Certainly not at that meeting.

AW Was there any discussion of the issues arising from that model?

JO There was no discussion at all. There was no discussion allowed. We were broken into groups and the group I was at, we were broken into groups of Lewisham, King's, Guy's, Darent Valley across the Trusts. And everybody tried to say: 'We haven't been consulted with yet, we would like to use this opportunity to consult with you.' And they were told that wasn't on the agenda for this meeting and they weren't interested in them providing their expertise. There was a young woman desperately writing boxes about people's ideas and totally: 'Come on, think now what would you add?'

AW Hasty?

JO It was hasty and it was absurd.

AW It was absurd. On reflection what considerations do you feel the TSA process failed to take into account as a result of this meeting or failed consultation exercise?

JO I think they failed to take into account women's concerns. I then, after this meeting, attempted to have a consultation with the TSA again because I felt that I hadn't been able to represent my views.

AW Did you write them a letter?

JO I wrote Matthew Kershaw a letter straight after the meeting; what I thought about his consultation process and demanding to have a meeting with one of his team.

AW Did you write to the Secretary of State?

JO I've written to the Secretary of State many times.

AW The commission has that letter at 172. So, you've said there was a failure to take on board women's concerns.

JO Women's concerns, but also clinicians', managers', commissioners' across the board.

AW What about the views of those with particular needs? What about diversity in the community?

JO Yes, this is something that we in our committee feel very strongly about and we have a representative from the Lewisham Migrant and Asylum-Seeking Network who comes to our meetings and we consult with those maternity users quite frequently.

AW Just before you go on to talking about that, can you tell the commission a little bit about the kinds of groups and the kinds of needs there are in the Lewisham community.

JO As it has been said before, Lewisham is a complex and deprived borough. We have maternity users who have very complex needs, socially and economically, and also with high-risk health needs and it is the job of our committee to make sure that we represent those women and make sure that they have fair access to maternity services.

AW So you were going to go on and tell us those matters that you felt the process had failed to take into account.

JO When we finally got a meeting with Dr Jane Fryer, who kindly agreed to come to my house the evening that the consultation was closing, they'd agreed that I could have a one to one meeting but I decided it would be only fair to let other maternity users to come to the meeting with me. Jane Fryer was quite upset about this. But she didn't really have a choice so that's fine.

AW What was the timing of that meeting?

JO The timing was 8 o'clock in the evening on the night that the consultation closed.

AW So you didn't have a chance to feed in … ?

JO That was our first opportunity to actually have a proper conversation with Jane Fryer. There were eight of us in total and we made very clear that we felt that the models that had been used by the TSA were actually nonsense. We didn't know where they could have found them.

AW Presumably you had had an opportunity to consider them by then?

JO I had considered them because I had been so involved with Lewisham Hospital and Public Health in Lewisham and they had shared a lot of their data and models with me so I could see that the TSA's models were completely ridiculous. And also because I live in the borough I know how long it takes me to get to Lewisham Hospital. My second child was actually born at St Thomas' and I nearly had her in the car! – so it doesn't take a genius to work out that what the TSA was suggesting was just rubbish.

So at the meeting with Jane Fryer we talked about our concerns: about women not being able to access maternity care at all because they wouldn't be able to afford to receive the care in Woolwich or elsewhere; that women would be confused; and also that when you are in labour – I don't know how many people know this – but taxis won't take you to hospital, so you have to walk or get a bus or cross your fingers that the ambulance is actually going to arrive; so that is highly dangerous and an outrage.

AW And what were the ultimate fears and concerns of you and your group?

JO As Ruth has just said, childbirth is really unpredictable and for many women things can happen late on and post-delivery that are very life threatening such as

post-partum haemorrhage. What we were trying to get across to Jane Fryer was that post-partum haemorrhage is a relatively frequent occurrence; and if a woman who has had a low-risk delivery starts to bleed, it requires somebody to notice it first of all. If you are in a very highly pressured busy ward you are not necessarily going to notice it until quite late, and then you have to organise a transfer to a hospital who can deal with you. So this woman can be bleeding to death in the back of an ambulance and is that is really something that they could countenance really? Jane Fryer said to us that there were things you could do for post-partum haemorrhage such as putting in a drip, which I have never heard of before, and she tried to reassure us that that wouldn't happen, but …

AW You are not convinced?

JO No.

AW And what about the issue of maternal choice?

JO Well obviously, if you lose your local hospital, your choice is significantly reduced. Most women want to give birth safely at their local hospital. They don't want to be travelling miles and hours out of their area and at the moment we have a safe hospital where we can have our babies and we have a choice of different services that we can use. There is home birth, which is very well supported at Lewisham; there is the midwife-led unit; there is the obstetric unit; they have also just opened two home-from-home rooms within the acute labour ward. Lewisham Hospital are very good at responding to women's choice and the TSA are closing those doors to women.

AW And is that a choice which is supported throughout the pre-natal period: a part of a process?

JO I don't understand.

AW I'm sorry, the act of birth doesn't simply take place on the day of the birth; there is a whole process which leads into that, support choices are made during that process and relationships can develop with midwives.

JO Absolutely. And at the moment one has a midwife team that you get to know in your community and who are often the midwives who deliver you when you have your baby.

AW How important are those relationships?

JO Hugely important: when you are giving birth, trust is essential. You are in a very vulnerable position often, particularly for a lot of Lewisham residents, and you have to have trust in your midwife and doctors, obstetricians because they are going to save your life if something goes wrong.

AW I don't have any further questions, but the Commission may have some.

Panel question from Michael Mansfield (MM) to Jessica Ormerod:

MM Yes, Jessica thank you. I'm looking at a document which indicates you wrote to Mr Kershaw.

JO I did.

MM Pointing out that there is a very diverse community here in this area with very different needs and you pointed out the elements of that community: is that right?

JO Yes.

MM This was totally rejected as being necessary for consultation it seems from what you said.

JO Yes absolutely. The TSA team contacted the local NCT branch who contacted me to ask me to help the TSA set up two focus groups for women. It was an extraordinary process. They basically promoted these groups to the NCT, which are hardly known for their ethnic diversity or social diversity and they were planning not to provide a crèche even. I asked them to do that. They didn't promote it within the community – in libraries, in the hospital. It was two meetings. Women were given about three maybe four days' notice to take part; and there was no attempt other than by asking me if I could particularly ask black women to attend – which I found to be really offensive.

MM Now, one other thing, and that is you have written as you have said to Jeremy Hunt, quite a long and detailed letter with various headings of the deficiencies and one of them being that 'maternity Matters have been completely disregarded'. I am not going to read the letter out – we have it – but did you get a reply?

JO I got a standard reply saying thank you for my letter, but I actually wrote to him four times during that period because I had so much to say. And we also submitted our own response – the MSLC submitted our own response – to the TSA as well. The first one wasn't acknowledged at all although it was cited in the Royal College of Midwives response which I was very pleased about. But I wrote up the minutes of the Jane Fryer meeting, and they were submitted to the TSA – she submitted them actually on our behalf.

MM Right, a point of information really – maybe others do? – I don't seem to have any of the letters back from Mr Hunt or anyone on his behalf so I would quite like eventually to get copies of that, do you have them?

JO I think so.

MM Don't worry if you haven't.

JO They were fairly bland.

MM More particularly, do you have what you submitted? I would like a copy of that please.

JO All of it?

MM Oh, how much is it? *(Applause)* Well, we are providing wheelbarrows so it is fine.

JO That's great. (This correspondence can be viewed online at http://www.savelewishamhospital.com/commission-witnesses/)

MM Can I just say, I am reducing it to this: most mothers want a safe birth and in your view a midwifery-led unit as proposed by Jeremy Hunt, whatever the skills of midwives, will strike most mothers as potentially risky and therefore in effect what he is proposing will mean the end of maternity services in Lewisham.

JO I do and I think it is also important to say that women will not choose to give birth in a stand-alone midwife-led unit. They recognise that it is not safe in their view and so it will not be used. Women are saying that again and again and again. That is not just in Lewisham, that is nationally. *(Applause)*

Toyin Adeyinka (TA), mother and Lewisham resident interviewed by barrister Maureen Ngozi Obi-Ezekpazu (MO)

MO Good afternoon.

TA Good afternoon.

MO Would you kindly tell the commission your name please?

TA My name is Toyin Adeyinka

MO And your connection to Lewisham Hospital and the reason why you are giving evidence to this Commission of Inquiry?

TA I am a Lewisham resident and the mother of one son – who I believe you heard earlier! [Toyin's son had been crying audibly earlier in the proceedings.] And I am here to speak on behalf of women, mothers and vulnerable people of this borough.

MO If I might, I want you to describe your experience of having had a baby within Lewisham – your own personal experience. First of all I'll set the background. Your son was born at Lewisham Hospital in 2011. Is that correct?

TA That's right.

MO Is it also correct that you were a first time mum?

TA Yes.

MO But there were some health issues?

TA That's correct.

MO So there was therefore increased risk of blood pressure; and other issues arose as your pregnancy developed. Is that correct?

TA I already had blood pressure prior to being pregnant but I was on no medication or anything like that but because of my pregnancy my blood pressure rose which then led to it being a high risk pregnancy.

MO At 35 weeks there were some difficulties that arose within that pregnancy.

TA That is correct.

MO Can you explain to the commission what those difficulties were?

TA Yes: due to the blood pressure, I was monitored on a weekly basis, then a two-weekly basis which also meant that I had increased scans and at the 35 week scan my son's abdomen had shown no growth. And it was a concern that they would have had to perform a C-section for him and I wouldn't have been able to carry on the pregnancy.

MO What happened to you?

TA Thankfully I had a scan a week later and there was growth but it still meant that because of the blood pressure I had to be induced at 37 weeks.

MO Who made that decision?

TA I actually came under Ruth's care and it had been decided that because of the blood pressure he needed to get out, because the placenta then begins to shut down.

MO So you were admitted?

TA That is correct.

MO And you stayed in the hospital for a period of eight days?

TA Yes.

MO What happened then? You were in hospital for eight days: what type of delivery did you have?

TA We tried for a natural delivery but my body wasn't responding. I had scans. My baby was monitored to make sure his heartbeat was ok. There were a couple of scares where his heartbeat levels had dropped but thankfully they picked up again. But a decision was made on 18th April that he needed to come out. So because they had tried everything in terms of the inducement, my body wasn't working, responding to it, so they decided that I was going to have a C-section.

MO And all of that could not have been predicted in advance?

TA No, absolutely not.

MO Whilst you were in hospital, were you able to be visited by members of your family and friends.

TA Thankfully I was. Because of being local and family being local, it was 15 minutes on the bus for my sister in particular to be able to come and bring me breakfast, anything I needed; she was able to do that, yeah.

MO And following the birth, were there any difficulties that you had that required you to stay in hospital?

TA Because of the blood pressure and because of my son's weight we did have to be monitored through the night, constant blood sugar levels being tested; and because of my blood pressure being quite high, that needed to be monitored just to make sure me and my son were doing well.

MO So following the birth, how long did you remain in hospital?

TA Another three days.

MO You had a total of 11 days in hospital or thereabouts?

TA Yes.

MO I would like to talk to you or ask you to inform the Commission about how far or close is the hospital to where you live. How long does it take you in travel time to get to Lewisham?

TA Right now, it takes 20 minutes walking and 10 to 15 minutes by bus.

MO And do you know what the cost would be of taking a minicab?

TA Yes. It would cost £5.

MO Now you know what the proposals are of the Trust Special Administrator.

TA Yes

MO First of all, do you believe that you would be a mother that could use the proposed midwifery-led unit?

TA I know I wouldn't be able to.

MO So where would you go?

TA I would have no choice but to use King's. That is what I would have to do if they decide to go through with this, which isn't what I would want. I couldn't even consider using QE Hospital, because it is just way too far.

MO Tell us why you say that.

TA At the moment, it could take one bus to get to Lewisham Hospital: like I said, a 10-15 minute journey. To get to QE would take well over an hour and that's two to three buses or two buses and a train. Who wants to do that when they are pregnant? Nobody. I don't imagine anybody would want to do that.

MO And what do you say the use of the midwifery-led unit would have on young mothers in terms of travel times, cost, and desirability of going elsewhere?

TA I think it would have a really negative impact because at the moment Lewisham Hospital – obviously where it is – is very local. If someone is referred there it [QEH] is not *that* hard to get to, but as possibly a younger mother you may not feel that you have the energy or you really want to have to travel that far. You won't possibly understand the importance of these appointments as it is and the thought of having to face an hour-plus journey – I mean, the cost of it is ridiculous. A one-way journey by cab, from near where I live, would be £13. Now, if you are someone who is on a low income, or somebody who – you come from a family where there isn't much coming in – that obviously … two ways is £26 and not everybody can afford that, so it is not going to have a good effect.

MO And so, were you, if in the future, to become pregnant again, would you use the proposed maternity-led unit yourself?

TA No

MO Why would you not use it?

TA I wouldn't be allowed to, as Ruth has just explained. I've had a C-section, I'm overweight; my pregnancy was not the easiest pregnancy. They wouldn't take me, so no.

MO What would you do then?

TA I would have to … it's a horrible question when you think about it. When you plan to have a family you don't sit there thinking, where is my nearest hospital going to be? Who thinks about that? But this is something you will actually start to think about in the future, which is wrong when you have a perfectly good, fantastic midwifery, it is just wrong.

MO I am extremely grateful to you. I don't have any further questions for you. *(Applause)*

EW
This is a very, very long and intense day. But we are now about to have a break. We have made incredibly good time, I think, but if you would be back between 4.05 and 4.10 that would be very helpful as we go into our last session. Thanks.

Session 5 ends

CHAPTER 6
PALLIATIVE CARE AND CHILDREN'S SERVICES

Secretary of State Jeremy Hunt

On paediatric care
'The recommendation also included co-locating paediatric emergency and in-patient services with the four A and E units, with paediatric urgent care provided at Lewisham, Guy's and Queen Mary's hospitals.'

'On the issue of paediatric care, Sir Bruce recognised the high-quality paediatric services at Lewisham and that any replacement would have to offer even better clinical outcomes and patient experience. His opinion is that this is possible, but dependent on very clear protocols for primary ambulance conveyance, a walk-in paediatric urgent care service at Lewisham, and rapid transfer protocols for any sick children who would be better treated elsewhere. He is clear that this will require careful pathway planning and will need to be a key focus of implementation.'

(*Hansard*, 31 January 2013)

The Health Care Commission rated the Children's Services provided by Lewisham Hospital as providing 'excellent care'. The Lewisham Mayor, Sir Steve Bullock described to the Commission how Lewisham Healthcare NHS Trust had contributed to 'Lewisham's collective achievement of an outstanding rating for children's safeguarding';

Dr Donal O'Sullivan, Public Health Consultant for Lewisham Borough told the Panel earlier in the Commission

> 'Firstly, I would say that I think objectively and by however you rate the services for children in Lewisham, particularly the hospital services, but also community child health services … they are of a very high standard … It's a real boon to Lewisham children that we have a service of this standard in our local trust.'
> (Donal O'Sullivan p.42)

It is against this background that the Panel considered the decision of the Secretary of State to downgrade paediatric provision at Lewisham Hospital. The children of Lewisham represent some 20% of its population. There are 63,000 children in Lewisham, over 300,000 children [0-19] across the whole South East London area. And yet the Panel was concerned to hear from Dr Tony O'Sullivan, Consultant Paediatrician and Director of Children's Services that, during the consultation process, children and young people had not featured in the thinking of the TSA, either in the time leading up to the TSA's confirming his decision to propose the downgrading of Lewisham Hospital or during the subsequent consultation process. There was no consultation with the Lewisham community, or with the key professionals running the integrated children services. Nor was an impact

assessment undertaken as to how the proposed changes would impact on the child population of Lewisham. (Tony O'Sullivan pp.123-124)

Dr Tony O'Sullivan told the panel about the integrated service for children which had developed over his 20-plus years of working in Lewisham. The service had built:

> 'Networks of care for children, often very vulnerable children, in a way that was actually in advance of government policy, government policy that was escalated after the Victoria Climbié death and the inquiry. But we'd already started building up networks across health agencies and across local authority agencies, and indeed the voluntary sector, to build that very necessary set of supportive environments for different groups of children, and doing that also with the hospital'.
> (Tony O'Sullivan p.120)

The Panel reminded themselves that a failure to register the interests of children could be seen as a clear violation of the commitment the Government has made to children's rights, which of course includes their health under the provisions of the United Nations Convention on the Rights of the Child 1990.

In this Session the Panel heard from witnesses who, through their direct experiences, were able to paint a vibrant and clear picture of what the well-integrated services provided by Lewisham Hospital offer to the children and young people of Lewisham and other children and, indeed, young people not living within its borders. These provisions allow children to move from specialist to specialist with ease where the need arises. The resulting effect on the children's population is that admissions to hospital have been reduced, leading to better outcomes for children overall. (See Dr Donal O'Sullivan pp.41-45)

Dr Tony O'Sullivan's conclusion to the Inquiry was that the TSA proposals and decision making showed a clear lack of consideration, consultation and planning.

Dr Wendy Geraghty, Lead, Child and Adolescent Mental Health Services (CAMHS) has worked in Lewisham since 1996. She told the Inquiry about the complexities of the mental health of children and adolescents and stressed the importance of the Children's A&E at Lewisham Hospital. She described how it provides for a child or adolescent suffering a crisis a clear and effective pathway to services needed, to assist both the children concerned and their families. It had taken 20 years to develop and maintain the integrated children's services. The loss of this gateway – the inevitable result she stated, of the proposed closure of the Children's A&E and the downgrading of Lewisham – will create very clear dangers for the children of Lewisham. Her view was that the TSA proposals were short-sighted. Whilst at first glance the proposals look to save money, they were in fact more likely to increase workloads, hospital admissions and costs. Her chilling conclusion was that these proposals will inevitably lead to poorer outcomes for children and adolescents and consequently to a huge impact on the adult population "from children who will develop chronic patterns of inappropriate ways of managing their emotions leading to a higher use of the adult

mental health service and prisons". An increase in the dysfunctional adult population would impact adversely on society. She informed the Inquiry that the mental health of children had not been a consideration in the TSA decision about closure of children's A&E Lewisham Hospital. (Wendy Geraghty pp.127-131)

Sally and Deion Stephenson a mother and patient, at the start of the day, spoke powerfully of the support offered them by the well organised network of services between community and hospital. (Sally and Deion Stephenson p.118)

Joan Brown, a resident of Lewisham and mother to Drew, a sickle cell disease sufferer spoke movingly about her daughter and the disease. She spoke of the importance of being close to the Children's A&E; of the need to access the hospital quickly; and the benefit of working with a team of professionals who know Drew and her condition well and can treat her without delay. She described how a sickle cell crisis can lead to immediate hospital admission for treatment by way of blood transfusion or morphine to ease the excruciating pain Drew suffers when in crisis. Her use of the Children's A&E is high, reflecting the health needs of her daughter. Her anxiety about the proposed closure of the Children's A&E was clear to the Panel, because of the devastating impact it will have on Drew and the remainder of her family.
(Joan Brown pp.125-127)

The Panel was astonished, listening to this story and the testimony of the professional witnesses, that a decision to close Lewisham Hospital children's A&E could be undertaken without a full and detailed assessment of the needs of children.

The Panel could only conclude at this stage that the TSA and Secretary of State simply had not counted the children and young people of Lewisham as important enough to be included in their plans to the downgrade A&E services at Lewisham.

SESSION 6 TRANSCRIPT

EW
This session will be dealing with Palliative care and also children's services.

Tweets and messages

This is the first one I've chosen off the scroll. It's worth, if you've got 5 minutes at the end, to have a read of these wonderful comments from you good people here.
'This People's Commission needs to be shown on national TV.' *(Applause)*
'We need a People's Commission for all the cuts that are taking place in our society.'
'We need to show the world what is happening to our public sector.'
'Well done Lewisham for leading the way.' *(Applause)*

Here's a tweet: '@MillwallFC. When you think you've seen it all #LewishamPeoplejustgetbetter. JusticeforLewisham' (Applause)

So this is going to sound like a 'bigging it up' session but – hey!
'A historic day, a memorable day'
'This is a crucial part of campaigning to save our NHS and to save our hospital. Well done for getting all this startling and vital evidence out into the public arena.'
(Applause)

Another tweet: 'Thanks Toyin for sharing personal experience of maternity services and the impact of losing them at Lewisham' (Applause)

I'll be a bit naughty now and read out an obviously political one:
'Rebuild the NHS, tax the rich and banks to pay for it' *(Applause)*

And finally from Pete Sullivan: 'If Jeremy Hunt loses this fight, he should do the honourable thing and resign' (Cheers and Applause)

LIVE WITNESSES

Anita Downs (AD), Palliative Care Nurse, interviewed by Barrister Maureen Ngozi Obi-Ezekpazu (MO)

MO Good Afternoon. Can you tell the Commission of Inquiry your name please?

AD Yes my name is Anita Downs.

MO And your qualifications?

AD I'm a registered nurse. I work as a Palliative Care Clinical Nurse Specialist at Lewisham Hospital.

MO And can you tell the Commission of Inquiry why it is that you are giving evidence today to this Commission of Inquiry?

AD Okay. My role in Lewisham Hospital: I'm a Community Palliative Care Nurse Specialist – that's my side of the team and part of my team works in Lewisham Hospital. I think that the TSA proposals are going to have a massively detrimental effect on patients in hospital and also in terms of how we link up services in the community.

MO Sorry to interrupt you but I would like you to help the Commission by explaining what a Palliative Care Nurse is and whom within the community you serve.

AD Okay. Palliative care is a term I have to explain quite frequently. Palliative care is focusing on patient comfort so we're not looking at curative measures we're looking at controlling symptoms like pain, nausea, breathlessness; but also looking at – particularly in the community role – supporting people at home, to try and plan for care at home and to make sure that the patient's needs are met there. And a lot of the patients that I'm dealing with, in fact the majority of patients I'm dealing with, are terminally ill.

MO Now currently Lewisham Hospital has a team who deal with both patients within the hospital and within the community. Please explain how it works and the number of patients your team covers.

AD I don't have exact figures for our referral rates but the ballpark figure which I got from our consultant is that we see across the pathway approximately 500 new patients each year, 300 of which are patients in the community. As I said, our team is split into the hospital palliative care side and also community palliative care; and we take referrals from GPs, from hospital doctors and other clinical nurse specialists.

The patients that we see are all under Lewisham GPs; it's a part of the borough, we don't cover the whole borough, and if a patient is known to us in the community and they're admitted to hospital, then our hospital palliative care team then sees them while they're an inpatient but we also have hospital patients that are directly referred to our hospital team. Has that covered everything?

MO Yes thank you. Now it's a joined up service isn't it: – integrated and joined up – so the care that is given meets specifically the needs of the individuals. Is that right?

AD Yes. So in the community as I said part of our role is to help to facilitate, to make sure patients are receiving the care they need. And we liaise very much with District Nurses, with social services, with GPs – with a variety of different teams; to make sure that patients are getting what they need in the community. And I think I was making a point about the fact that they're based in the Borough of Lewisham; and our dealing with patients in the Borough of Lewisham helps things to be joined up because we've got a rapport with the GP practices that we cover, we meet them regularly. We're also familiar with the District Nursing service in Lewisham and what it does and doesn't provide, and so we've got, especially now, neighbourhood teams. We're having more joined up working with social services particularly covering areas of Lewisham. So the fact it's all kind of in one area helps join things up in the community. But the fact that our team covers both the community and the hospital means that when people then come into hospital we can foresee a lot of the

problems that there might be on discharge and help the ward make sure that those appropriate services are set up when that patient goes home.

We can also, at the other end, try and help prevent unnecessary admissions to hospital by making sure that patients have got the care that they need, so that they can stay at home for as long as that is suitable.

MO Thank you very much for that. Is there a need for palliative care patients to access the Accident and Emergency Department at Lewisham?

AD Yes. Out-patients, even patients that are known to us, that we are supporting at home, they quite frequently do need to come to A&E. And a common reason for that is our patients are very ill, they often have a lot of pain morbidities, quite a lot of our patients have got cancer and get lots of acute complications as that disease progresses.

And some of those complications can be successfully treated by admission to hospital, so in those instances it's very medically appropriate for them to attend the A&E. Unfortunately there's also instances where patients have to go to A&E because, despite the best will in the world, things are not working out at home and they're not getting the support they need at home. And for those patients the hospital can be a safety net to make sure that they're kept safe.

MO So can we turn then to the Trust Special Administrator's proposals: what would that mean for your patients? What would it look like for them?

AD I think it will affect our patients on a number of different levels. For our patients who do need to go to A&E to have a hospital admission it's very, very stressful for our patients to have to go into hospital; because they're often very poorly and coming towards the end of life, and their families of course want to be with them as much as possible. And if they've got a hospital which can provide comprehensive care, which is very geographically close to them, it's very important as it reduces a lot of the stress that the families face, in terms of making sure they've got the things they need in hospital to make them comfortable and being able to spend as much time as they can with their loved ones. That would be a lot more difficult and a lot more stressful if they had to go to Queen Elizabeth in Woolwich, partly because of the travel distance; but also I think because, if the Lewisham A&E closes, that's already an already busy A&E and they may have to wait for longer periods of time before getting settled and getting comfortable in hospital. And it's further then for relatives to have to travel to see them. And there's other issues …

MO Can I just stop you? They may arise from the question. The hospital team that currently exists: would that team exist under the proposals of the TSA?

AD During the TSA consultation process – we've got two hospices that provide care for Greenwich and Bexley in Greenwich and Bexley, and St Christopher's [Hospice] provide some care as well. And there are proposals for those organisations from Greenwich and Bexley to take over the inpatient service and for St Christopher's to take over the community service. I mean, I think on one level these are voluntary organisations who don't have full funding from the NHS so I think there's an issue of funding – funding there – so that's one issue.

In terms of the hospital, the proposals from the TSA would mean that there would be virtually no medical admitting wards at all in Lewisham Hospital anymore. So we wouldn't really have a hospital team to do what they're doing now because the patients wouldn't be there to be seen.

MO If there is no hospital team would that mean that your team, the community team part, would go as well?

AD I think it wouldn't carry on as it is, and we're quite a small team as we are. We've got administrative support, we've got a consultant, we have a dietician, we have a counsellor: we have all those people supporting our team. If we didn't have a hospital team there'd just be a few people working the community and I don't think it would be a viable team.

MO So what would that mean for the patients or the service users – what would that mean for them, the people whose lives are coming to an end? How will they be supported?

AD I think as it stands it's not clear who would be providing palliative care if the TSA's proposals go ahead. That's something I think that nobody in the Trust is quite clear about: who would carry on doing that. From a practical point of view, probably, a lot of that service will be coming out of the QEH in Greenwich and that would cause problems in terms of that then being in the Borough of Greenwich instead of in the Borough of Lewisham. So if you have Lewisham patients in a Greenwich hospital then you immediately have a whole different set of forms to fill out; people are not going to be as familiar with working with Lewisham social services, working with Lewisham GPs and Lewisham District Nurses.

And we face a bit of that problem sometimes because some of our patients live just over the border in Greenwich and it creates real problems around who's funding what and are people being referred to the right place. I think administratively that will increase the risk, massively.

MO I'm very grateful to you and I don't have any further questions for you. Perhaps the panel does? Thank you
(Applause)

CHILDREN'S SERVICES

LIVE WITNESSES

EW You've heard his name and now you can hear his evidence. Professor Sir Bruce Keogh (BK)

Professor Sir Bruce Keogh stand-in

DM *Sir Bruce, just one question in fact: Matthew Kershaw has accepted that his report had assumed that the children's unit at Lewisham would close alongside the current A&E department. What recommendations did you make in your review regarding this area of provision?*

BK *A full provision of paediatric services has been made in the plan, but is dependent on adoption of clear protocols of conveyance of ambulance provision, an ambulatory paediatric urgent care service at Lewisham and rapid transfer protocols for ill self-presenters. This must be considered a priority by the TSA for implementation.*

DM *Thank you*

Tim Preece (actor who played the stand-in for Jeremy Hunt and Sir Bruce Keogh)
I know this isn't scheduled but now I've finished being other people *(Laughter)* I do need to say as 'me' that my daughter and my granddaughter might not be alive today if it hadn't been for the expertise of Lewisham maternity services. *(Applause)*

Sally (SS) and Deion Stephenson (DS), interviewed by barrister Nicola Braganzia (NB) [Originally included in Session 1]

NB Could you both give us your name please?

SS I am Sally Stephenson

DS I am Deion Stephenson

NB And in what capacity have you come here today to give evidence to this Inquiry?

SS I am here as a parent and Deion is here as a patient and we have been using Lewisham Hospital and the healthcare system for about 22 years.

NB Could you tell us first please about your eldest son and how it is that your experience of Lewisham Hospital has gone back so many years?

SS My eldest son was born with a very rare syndrome and he used probably every department in Lewisham Hospital and the healthcare system. He had a progressive illness, he sadly passed away seven years ago, but in that time we used Lewisham healthcare a lot and at one point, because he had a self-injury problem, we were down

in the A&E every week, probably two or three times every week from school and from home so we have well used the services.

NB And what about now? How do you rely on the services now?

SS We rely on it quite a lot. Deion has quite complex needs. He sees OTs, physios, paediatricians, the speech and language therapists, dieticians (he has got a gastrostomy). So he uses a lot of the services still. What do you think Deion?

DS I have to use a lot of that staff because it's important. Let's face it, if Lewisham gets closed down – King's College …

NB Can you tell us about why it is important for you to be close to Lewisham Hospital?

SS Because we need to be able to get somewhere quickly. It is not even just about being close to the hospital, it's when you are in the community and when you live close to a hospital, the same people you see in the community you see in the hospital, so it's the continuity of care. We know the doctors, we've got trust in the doctors. If Deion is ill I can ring his doctors and everything is seen to and I am two minutes away. If I need to get down to the hospital quickly and I'm two minutes away that's fine. If I've got to do an hour's journey it is going to be impossible to do that with a child that's unwell and could deteriorate. So, we live close: we live walking distance if we have to be and parking is an issue at lots of hospitals, especially King's. So if we have to walk it we can walk it.

NB What will the impact be on you and your family and Deion if these proposals are put in place?

SS It will be like starting all over again I guess because we know the doctors now and the doctors know Deion and if we have got to go somewhere else we've got to start relationships all over again. Also, if I do have an emergency, then I'm a long way away and its taking away a safety net really, having somewhere close is what makes you feel safe and secure, knowing the doctors as well, but being close by matters a lot. What about you Deion?

DS If you don't know the doctors then how are they meant to know if you're not well or if it's serious or not? How can they judge if you don't know them?

NB How do you get on with the doctors that you work with and that help you at the moment and any particular doctors?

DS It is basically trust, that's all it is. You trust the doctors. That's how you know what they are saying is right, because you know them.

SS He has got a very good relationship with the doctors he knows. They have a very good relationship where they can banter and they know each other so Deion feels safe and secure. If I have to take him somewhere and he doesn't know a doctor, he has lots of questions about who it is going to be and everything else, whereas if we are going to Lewisham to a doctor he knows he obviously doesn't have to ask those questions. He feels safe and I feel safe.

NB Finally, if Jeremy Hunt were here today or is watching this, what do you want to say?

SS I would like to say that he should stop putting money before my children. I think the last thing I worry about when I'm rushing one of my children to the hospital is whether or not it is going to stretch NHS resources. We do our jobs as parents. We look after our children. We make sure they are well. We do what needs to be done. He should do his job and make sure that they've got adequate, close-by healthcare should we need it.

NB Deion, is there anything that you want to say?

DS He just needs a reality check. *(Applause)*

Dr Tony O'Sullivan (TOS), Community Consultant Paediatrician, Director Children's Services, Lewisham NHS Trust, interviewed by barrister Nicola Braganzia (NB)

NB Could you give your full name please?

TOS Tony O'Sullivan

NB And what is your clinical job?

TOS I'm a consultant community paediatrician mainly working in the arena of childhood disability.

NB So could you explain about that – what does that involve? What does that entail?

TOS We work in our community child development service based at Kaleidoscope Children's Centre up the road from here. For the last three years we've been united with the hospital, providing integrated care for children across the hospital and community. Kaleidoscope offers a whole range of services for children with disability including motor disability, cerebral palsy, autism, learning disability, sensory impairment and also services for children who need safeguarding, children in the care system, placed for adoption. And we work with a range of therapists and nurses. And we also have co-located with Social Care – the disability social work team, the education and mental health services – which is actually unique in England.

NB And what is your other role?

TOS That's my day job. My other role is Director of Children's Services across the hospital and the community for the last two and a half years.

NB For the purpose of this People's Commission what is your expertise?

TOS My expertise comes from working in Lewisham for 20 years and having been part of building up the networks of care for children, often very vulnerable children, in a way that was actually in advance of government policy, government policy that was escalated after the Victoria Climbié death and the inquiry. But we'd already

started building up networks across health agencies and across local authority agencies and indeed the voluntary sector to build that very necessary set of supportive environments for different groups of children and doing that also with the hospital.

You hear a lot about community-based care, which is a sort of 'kick in the face' to hospitals. But Lewisham – to me – Lewisham Hospital *is* part of community-based care. It's certainly at the centre of our community and as Anita has just said it underpins safe community-based care.

NB I want to go back in time. What was your first experience of the NHS?

TOS Well, that would be as a child. My father worked in the NHS, he's Irish, well he was Irish, he's no longer with us, and he came to work in England before the war as a hospital consultant, no, as a hospital doctor in training, sorry. And then he was in the war for six years which he regarded as something that, although he's Irish, was a democratic issue against Fascism and then when he came out of the army the NHS was, fantastically, formed and he was a GP in Manchester for the rest of his professional career.

And my first experience – which I vividly remember – is: he would be a GP in Manchester. He had a list of vulnerable patients and just one example: we would have our Christmas dinner ready and we would go out to one of the very elderly bed-ridden women in Gorton and give her her Christmas dinner before we started at home. And I thought that was pretty good! That was part of the NHS – it was one meal at least that was better than meals-on-wheels. *(Applause)*

NB And what is your commitment to the NHS?

TOS My commitment is total to it because I think it's the most democratic achievement that we have in this country. It is the greatest contribution to health equality that we have and although people talk about it as being free, it's not free: it's paid democratically out of taxation and it's free at the point of need. So those that don't have money either at the time or at all, get exactly the same care. I think that's the right thing to do. *(Applause)*

NB And Dr O'Sullivan, why did you become a community paediatrician?

TOS Well I did thoroughly enjoy hospital training – newborn babies and general paediatrics, but I thought that the expertise that was generally centred around hospital in terms of specialisms – I don't mean GPs: that is a different specialty in its own right – but that expertise should be brought into the community. And so, along with others, where community paediatrics was a developing specialty I thought we should be continuing to work with hospital but build up a network of services that would actually facilitate children, for example with disability, achieving in their homes, their nurseries, their schools and bringing specialist therapy, specialist nursing skills, specialist paediatrician skills out into the community – and therefore working with GPs, with schools, and the hospital as well.

NB I want to ask you now about the TSA proposals. What are your main concerns about the proposals?

TOS The main concern about services, as opposed to objections morally about what they've done, is that for 15 to 20 years we've been building up a set of networks in children's – and you've already heard similarly in Care of the Elderly and Mental Health and all these other areas – and we've been doing it partly because we knew we should and later on because it's part of government policy – and then that is going to be destroyed because a major hospital is going to be taken out of the equation and we'll be relating one set of hospital in-care services to a different set of social services, a different set of mental health services from three or four different boroughs and it will just return to the chaos which we had 20 years ago. So we'd be starting all over again. And the colleagues, if they are colleagues, that we talked to in the TSA process, actually know they've done that.

NB So what does this mean for the children of Lewisham?

TOS Well it means that children in Lewisham, and in Greenwich I should say – are two of the most deprived boroughs in London – and they're in the top 8% most deprived Local Authorities throughout England, so the top 8% out of 325 Local Authorities. And that's not a statistic alone: it's vulnerability – lots of issues around it – one of the youngest populations, one of the most vulnerable populations, one of the highest populations of young children with Sickle Cell Disease for example; lots and lots of risk factors that exist with deprivation are visited in Lewisham.

Lewisham and Greenwich have the two highest numbers of very, very critically ill children that have to be retrieved from the hospital and taken to a paediatric intensive care unit, in the whole of the South East sector.

So I'm starting from the fact that we have vulnerable, ill children in a deprived population. They're taking out the local hospital, they're reducing access to a deprived population with all the things we've heard and it will lead to worse care, absolutely lead to worse care.

NB So what provision has been made by the Secretary of State to deal with that fact?

TOS Well he's not told the truth but he's basically made a statement that in the aftermath of his decision – somebody must have regard to it in the ensuing period. And that's not the way you plan for serious service planning changes. So he's given us the decision and sort of said: 'Sort it out'.

NB So there is no plan?

TOS There is no plan. I mean Sir Bruce Keogh has eloquently said that children's services were well provided for by Matthew Kershaw – and they weren't provided for in any shape or form! There was no analysis of need, there was no description of current service, there were no proposals for this or that proposal, there was no risk assessment – you can't risk assess a proposal that you haven't made and children were used, were assumed as, the term I've used is 'collateral damage' of the major decision to close the hospital.

NB So what was the consultation on behalf of the Secretary of State – with respect of children?

TOS Including the TSA process?

NB Yes.

TOS The consultation from Matthew Kershaw and the Trust Special Administration process was virtually zero.

They set off last July with a structure of having forums for hospital-based care and community-based care – and I was unfortunate enough to go to four of these – and in the first one I went to, there was an analysis of the community's needs, in terms of mortality, hospital attendance, number of procedures and so on, and there wasn't a single piece of data about children. They'd been forgotten. So, we raised this vigorously, and said 'We think you've forgotten 20% of the community …'

NB Sorry, if you could hold your thought, how many children are we talking about?

TOS In Lewisham there are 63,000 children under 19 and across the six boroughs over 300,000. In Greenwich it's about the same so approximately 120,000 in Lewisham and Greenwich.

NB So to go back to … I hope you haven't lost your thread, with respect to the 300,000 children.

TOS I have lost my thread, I'm sorry.

NB The consultation, what was said about them?

TOS Thank you, sorry. So they huddled together and then they said they would arrange a meeting. So they arranged a consultation meeting at the last minute, and it was also maternity, which they also seemed to have forgotten. It was thrown together into one meeting, hastily convened along with children as well.

As in the other meetings that you've heard about, we weren't discussing any details about actual children's needs and it was led by the consultants McKinsey who got £5million for it, and they were telling us to do 'blue-sky thinking' at a time when the storm clouds were gathering across South London, and the only blue sky was McKinsey consultancy's fees, I think. *(Applause)*

And so we were unable to get into the actual detail which is absolutely necessary if you're going to talk about a wide range of diseases and conditions that children have. Children are often regarded as a disease – you have diabetes work groups, and oncology work groups, then you have a children's work group, as though they are a disease.

But they're precious and they're complicated and there was no planning at all done for it. And when that was raised with the TSA team they were actually shamefaced about it.

NB So what was the data that was used?

TOS Well there isn't any data about children in the report. The only data is the births and the numbers of children that exist.

And they had the birth rate wrong as well. I was at the same meeting as Jessica [JO – an earlier witness, see pp.101-103] on maternity and we challenged the birth figures they had because they were modelling it in such a way as to justify closing down Lewisham maternity. And they were at least two or three thousand births out for the sector, because they were over two years behind in their data. We said 'Your data's wrong' and they said: 'You can't discuss the data, that's been agreed' *(Laughter).* This was a 'risk analysis' work group! So I said: 'Do you think it's a risk that the data's wrong?' *(Laughter)* And they said: 'We're not discussing data' and then they finally agreed to put it down on the risk register that their data may be wrong. And they subsequently changed the data, because they were wrong.

NB So to what extent has there been any professional analysis?

TOS Of children's needs? Zero. I would absolutely say zero. And, senior people in the TSA process confessed to that in private.

NB That's my last question to you. It concerns your experience of those key players and what they have said to you.

TOS Well, stop me if I'm going on too long, but the first episode was one of the public consultation meetings. And I raised the issue of the Health Equalities Impact Assessment not having been completed. And that's an essential requirement of major change, analysing proposals and risks. And Matthew Kershaw at the end of that meeting came up to me and he apologised that the Health Equalities Impact Assessment hadn't been done but there was no time, because of the timescale of the TSA process, *which he had suggested being used in the first place* – last April [April 2012].

The second example was: Matthew Kershaw, he's the TSA I'm sorry, not to be personal, the TSA, the Medical Director of London NHS and the Medical Director of the sector – the six boroughs – came to a meeting of consultants at Lewisham Hospital and the Medical Director of NHS London is actually a paediatrician. So the colleagues in the audience gave him quite a hard time – how could he forget children when he's a paediatrician? And at the end of the meeting we had a conversation with a couple of those people present and they actually said the TSA process should not have been used in the circumstance that they were facing; it was unjust for Lewisham; they recognised that networks would be shattered for children; but it was too late: pardon the expression – they said 'Lewisham Hospital has been shafted'.

NB Thank you. I don't have any other questions for you but there may be some from the panel. *(Applause)*

Panel question from Michael Mansfield (MM) to Dr Tony O'Sullivan:

MM Yes I've been going through this document all day and I'm going to finish off with this same document, Tab 2 and it is Sir Bruce Keogh's provision of information to the Secretary of State, which led to the decision. This time we are dealing with your area. It comes right at the end of the letter. It was written this year, earlier.

But since we're going to have to deal with what they're claiming, then I'm very interested. You've covered a lot of this ground.

Anyway this is the paragraph:

> 'The only other area of clinical risk I wish to highlight relates to paediatric care. Over the years Lewisham has developed a respected, high quality paediatric service. Any alternative should be designed to be even better in terms of clinical outcomes and patient and parental experience. This is possible but is dependent on very clear protocols for primary ambulance conveyance and ambulatory paediatric Urgent Care services in Lewisham and rapid transfer for any sick children who may want to be treated elsewhere. This will require careful pathway planning particularly with the ambulatory paediatric service. This need is recognised in the proposals but must be considered a priority by the TSA in the next stage of implementation.'

Then: 'With these caveats I would be content to assert there is a strong case that the recommendations are likely to lead to improved care.'

I've read that all out because: do I understand – do we understand – what you're saying in fact, is that this is entirely speculative what he's put here, there's absolutely no evidence base for any of the assertions?

TOS Well I would have to agree with you. *(Applause)*

MM Well you don't have to ...

TOS I would have to agree with you from my professional experience and judgement and conscience that it's just disgraceful to say: 'We've made a decision about children and the planning comes later.'

MM Okay, thank you. *(Applause)*

EW Joan Brown. *(Applause)*

Joan Brown (JB), parent of child with Sickle Cell Disease, interviewed by Maureen Ngozi Obi-Ezekpazu (MO)

MO Good afternoon.

JB Hello

MO Can you tell the Commission who you are and your connection to this inquiry?

JB My name is Joan Brown. I live and work in Lewisham. I have a child who has Sickle Cell Disease, who's nine years old.

MO Please would you explain something about Sickle Cell Disease?

JB Sickle Cell Disease is a life-threatening disease. It is a disease that causes pain. It's a blood disorder, that's in your child's blood. The cell is a sickle shape so that sickle shape gets trapped in the vein and it causes pain. That pain can be

anywhere in the body. And that pain can be extremely excruciating to the point where your child is screaming and at that point, well, even prior to that, we have to take our child down to the hospital.

MO And how close does the hospital have to be to help your child, your daughter?

JB Now the hospital for us is a five minute drive. So my husband and I and our daughter Drew – my daughter's name is Drew and I will use her name – it is five minutes away so we will rush her down in the car to A&E where she will be basically seen immediately.

MO So she doesn't have to wait in a queue or anything like that?

JB No, no – she doesn't have to wait in a queue.

MO And where in the A&E does she go to?

JB 'As soon as': sometimes, because of the pain she's visibly in – you can visibly see that pain that she's in – we are immediately taken through and the thing is sorted out.

MO Is it the children's A&E?

JB Yes, the children's A&E. On one occasion when my husband hasn't been at home and she's had a crisis, I've had to call an ambulance and I've had to wait up to half an hour for an ambulance with my child. All I can do is cuddle her and console her. I can't take the pain away from her, waiting for that ambulance to come. If we had to go further away then we would not be able to jump in the car and quickly get her to an A&E. We would have to wait for an ambulance because we couldn't really trust the traffic. We wouldn't have that right of way to get her to hospital.
When a child … there are certain crises like a chest crisis that a child can have with sickle cell, which is very life-threatening – because she could have a stroke – and the emergency for her to get to a hospital is really, really urgent.

MO How many times in the last year has your daughter been in A&E?

JB Drew's been in eight times and she's been admitted three times. Last night she was admitted and I came out of hospital at 12 o'clock today. She was at the point where at home – we have a series of pain relief – and when the codeine is not able to stop that pain, we have to take her into hospital where she has to have morphine. First she'll have oral morphine and if that's not enough we have to go with intravenous morphine.

MO How many times has your daughter had to have a blood transfusion?

JB Drew has had four blood transfusions in her life. She's had to have her spleen and her gall bladder taken out. When Drew's admitted to hospital it can be for days, but it can also be for weeks. And when she was diagnosed with gall stones, she had to spend over two weeks in hospital, and eventually she had to have an operation.

MO If Lewisham closes, what will be the position? What will be the position for your daughter, for her care?

JB I intentionally, because I'm a teacher, got a job in this borough so I could be near to the hospital and near to where Drew's school is. If the hospital were not as close to us as it is now, I'm not sure what would happen to Drew if we had to wait for a long period of time to get her to hospital. Lewisham being right on our doorstep and Drew being treated right from eight weeks there, we've got to know all the nurses. Drew knows the nurses. Drew knows the nurses know how to take care of Drew. When there are situations where she's been so poorly that they cannot find a vein, and she's been injected 10 times, the nurses know me and they know Drew and they can help support me, to comfort her, for that cannula for her blood to be taken.

MO So if Lewisham closes… ?

JB If Lewisham closes there will be no continuity of care. Also if I'm at home and I feel there's a problem that I'm not quite sure of, I can email the consultant but I also have the consultant's number that I can ring and she will give me the right advice on what to do.

MO Thank you very much, I have no further questions. *(Applause)*

EW On the timetable for the next witness, we should be hearing from Tina Sajjanhar who is the Children's A&E Consultant and the Deputy Director of Children' Services, but unfortunately she is today on call and she's not able to be here. As I said earlier, all of the witness statements are in the bundle, so the panel will have those statements.

So we shall go straight on to hear from Wendy Geraghty. *(Applause)*

Dr Wendy Geraghty (WG), Lead, Child and Adolescent Mental Health Services (CAMHS), interviewed by barrister Amanda Weston (AW)

AW Could you give your name and qualifications for the Commission please.

WG I'm Dr Wendy Geraghty. I'm a consultant clinical psychologist and I'm the lead clinician for Lewisham CAMHS. I work for South London & Maudsley NHS Trust and I'm responsible for the mental health services in Lewisham; and as such I'm also responsible for the services that liaise with Lewisham Hospital around emergency psychiatric presentations of children and young people.

AW Can you tell people what CAMHS stands for first of all?

WG Yes it stands for Children and Adolescent Mental Health Services.

AW Thank you. And how long have you been providing mental health services to children in Lewisham?

WG I've worked in the London Borough of Lewisham since 1996. I became Lead Clinical Psychologist in 2003 and lead overall clinician in 2012.

AW What kinds of vulnerabilities and needs do the children and young people in Lewisham have in respect of mental health services?

WG Well there's a broad range of mental health needs. Only a small percentage of those are the urgent ones that they would deal with at the hospital but when children present in a psychiatric emergency, this is usually at a level that is serious. So it can be when they're feeling suicidal; it can be in relation to very serious self-harm; it can be the first onset of psychosis which is incredibly frightening for the children themselves, the young people themselves and their families; or it can be other very serious presentations of mental health problems that aren't dealt with on an outpatient basis.

AW What particular groups of children give cause for concern in Lewisham: I'm thinking particularly of looked after children and other children from at risk groups: what is the profile?

WG Well, as has already been said, Lewisham is a young borough and a deprived borough. We have specialist services for looked after children because there is a much higher incidence of mental health problems for that population. We have also specialist provision that's co-located with the youth offending team because there's a lot of undetected problems in that group, as well as learning difficulties. And there's a big incidence of mental health problems in learning disabled and autistic children. And all of those more complex presentations need considerable inter-agency working and, just commenting on Dr Tony O'Sullivan, and I've known him back till 1996 due to a joint interest in autism, and he's developed the autism services for instance. And it's those kind of inter-agency links that are vital for very, very vulnerable children.

AW So when you talk about inter-agency working, what range of agencies might be involved in providing the care pathways for children and young people with mental health problems?

WG It is very complicated and it is very important that they are done right because otherwise we end up creating more work. So having said that, the agencies involved would be children's social care, the paediatric service, obviously child mental health services, increasing numbers of voluntary agencies as well; and we're working very hard to develop good pathways of care that will mean that there can be a step up in terms of need for children with mental health problems.

AW Now you've given an indication of the kinds of disorders that may be affecting children and young people, what risks arise for them as a consequence of these kinds of disorders?

WG Well the risks – if you're thinking of those in critical situations that would take them to A&E – are quite high. I mean for children who have a psychiatric crisis it might mean that they might very significantly self-harm. I know a young person that describes it as 'A&E deep' [i.e. deep cut self-harm] which means that they definitely need medical attention – swallowing batteries – so there are lots of ways with self-harming that are very serious for health. Taking overdoses of pills is a way of coping with feelings or demonstrating a situation of how bad they're feeling, without necessarily thinking about the consequences. And this can be very serious and there needs to be a very serious medical intervention at that point.

AW What about less acute risks?

WG The risk is that they present … they develop a pattern of coping with emotions

by self-harming or by presenting at A&E and, unless they get the right psychological intervention, they can develop this as a way of coping with their feelings. And that can eventually lead to more and more presentations, maybe more expensive presentations at inpatient units where they learn more and more inappropriate ways of coping, which can lead in adulthood to developing problems that will be seen as personality disorders. Yes and that can be expensive for our country.

AW I'm going to come on to that shortly – I know you have a lot to say about that. How key are the interventions in these cases?

WG I think it's key obviously for the children themselves; because if we work with them and their families then that works to find more appropriate ways of coping, of dealing with some of the real problems that can be around, you know, that their self-harm can be evidence of. I mentioned social care and sometimes we pick up very serious issues of safeguarding. Children have been sexually abused and therefore are self-harming. So it's important to have good networks of care around these children and we have good relations with Lewisham Social Care so we can very quickly offer to make a 'team around a child' and we can make sure that children are made safe early on.

AW In this way you're able to identify groups of children at risk of mental health problems and intervene early?

WG Yes. And intervene with the other agencies. With most of the complex cases you need to have inter-agency working.

AW What in your view would be the loss of the paediatric A&E facility? And I'd like you to start with the more immediate effects and then go on to the longer term.

WG Just to say – I don't know, I would imagine a lot of people in the room have been to the paediatric A&E. It's a very impressive establishment, run by very professional, dedicated staff. And we have done a lot of work with them to make sure there's good pathways of care for the children that we see.

AW Could I just ask how long has it taken to build up these networks and pathways?

WG It's an ongoing process over years. And you know it's important that the local A&E and the local child mental health services can work together and have relationships. And it's ongoing. And we would lose that if we didn't have a local A&E to relate to, it could be 'dispersed' – is the term that's been used – in various other agencies. So I can't see that it would have that same relationship.

AW Some of the witnesses that have given evidence about the impact on adult services have talked about the loss of ability to avoid admissions to hospital. Is that something that would arise in this field?

WG Yes, that's a worry: that the unintended consequence of this could be more expensive - you know we can't afford it at the moment. We can't afford to have less lean services and this would be a really expensive proposal the TSA has put forward as far as child mental health goes, because it will lead, I think, to more admissions and to children and young people developing ways of coping that are not helpful to

their mental health in the long run; and will put more emphasis on inpatient services which would be obviously disastrous for those young people and also disastrous for the public purse.

AW So in a nutshell then the appropriate way forward is to front load the cost of supporting children who may be vulnerable to developing health problems?

WG That – and to have good clear care pathways for these children. At the moment someone from the local CAMHS will go to the local A&E and assess and make a relationship with young people. And then they'll link with CAMHS and we'll be able to intervene. We won't be able to do that if they're sent to all sorts of other A&Es. There won't be that relationship, we won't pick them up at that point.

AW So there'll be disruption to services available to children?

WG Yes. I'm also worried that the children won't present and that'll either mean that there's an effect in terms of their physical health and their mental health not being dealt with. Or if they do present, there won't be a continuity of care from whichever A&E they present at.

AW Why won't the children present?

WG The young people that we see are young people who are very deprived, they come from very difficult backgrounds: you know if you come from families – and this is a huge generalisation – who wouldn't be able to get it together to go on two buses or two buses and a train ride to …

AW To where?

WG To Woolwich or more probably more likely, as everyone has said, to go to King's where it would be very overcrowded. There isn't a specialist paediatric A&E there. They would be there in the adult A&E with all the problems that adult A&E has to cope with, including adult mental health and adult alcoholism and all the rest of it, which isn't a safe place for children. And they'll be waiting around, they wouldn't bother to wait around. A lot of our young people are very impulsive.

AW Do these general adult facilities have any specialist expertise in psychiatric services for children and young people?

WG The expertise comes from the local CAMHS going out. And we work alongside. Because, for the older young people, we do go into adult A&E to do exactly that. They call on us and they call on our expertise – sometimes we will pay for nurses to go who specialise in young people if children have to be held in an adult setting. But it's our services going out and it's that relationship that will be destroyed.

AW And what about the long term impact of failing to address and support children and young people with developing mental health problems?

WG Well longer term it doesn't make any financial sense as much as anything else, because they will develop chronic patterns of inappropriate ways of managing their emotions and they are more likely to end up in the adult mental health service and in other institutions such as prison.

AW You're talking about an increase in juvenile crime which could be avoided?

WG Yes.

AW And how would you describe how far-sighted the proposals are?

WG I have problems with the documents. As I've said, I haven't been part of the negotiations at all: I've been reading the documents with interest. I haven't seen anything which addresses child mental health in the thinking of the TSA and there's been very little in terms of mental health generally; which again – the Government thinking in terms of the NHS' *Mandate* – these plans should be holistic and take account of mental as well as physical health and I haven't seen that in the thinking behind the TSA document.

AW Thank you very much. I don't have any further questions. The Commission may do. *(Applause)*

EW Now our final witness, Louise Irvine. *(Applause)*

Dr Louise Irvine (LI), GP and Chair of the Save Lewisham Hospital Campaign, interviewed by barrister Nicola Braganza (NB)

NB Could you give your full name please.

LI It's Louise Irvine.

NB And what is your role?

LI I'm a GP in North Lewisham and I've been a GP there since 1995. I'm also Programme Director for GP specialist training in Lewisham. And I'm also Chair of the Save Lewisham Hospital Campaign.

NB I want to ask you first of all about your practice. Where is your practice?

LI I practice in New Cross, Deptford which is the North of Lewisham in a practice called the Amersham Vale Practice.

NB Who are your patients?

LI We have about seven and a half thousand patients and they're people who live in the area in which I practice which is in some of the most deprived wards in Lewisham. And Lewisham itself is one of the most deprived boroughs in England.

NB And how long have you worked as a GP in Lewisham?

LI I've been a GP since 1988. I started working in Lewisham first around 1990, and I've been a partner in my practice since 1995.

NB Why do you want to assist this inquiry?

LI As a GP it matters to me the quality of care my patients can access. Obviously the parts that are within my control, within my practice, I try with my colleagues to create as good a service as we possibly can for our patients. But we also depend on other services. We depend on hospital services and community services and therefore it matters to me because every single day I'm dealing with patients and I'm trying to help them, help solve their problems. And some of those I can do within the context of our practice in primary care, but many times I need to link up with and use other services, refer patients into other services, etc. So the whole health economy has to work well for my patients to get a good service.

NB What are your main concerns about these proposals?

LI Many of the concerns have been expressed already. First of all we have a very deprived population which actually have low income but also higher than average health needs. It's really important to them to access good care. They do get good secondary care and community care from Lewisham NHS Trust. In terms of journey times it's just outrageous to suggest that it's just as easy or almost as easy for patients to access care beyond Lewisham. Many of my patients will use public transport: they can get to Lewisham Hospital in about 15 minutes. We've tested as part of the campaign the journey to Queen Elizabeth A&E and on two different occasions it's taken nearly 2 hours for people to get there by public transport.

So that's one thing. I think if patients are admitted to hospital – because if A&E closes you're talking about closing the acute medical, surgical and children's wards – then sick patients will be admitted to hospital further away. It will be very hard for patients from my area to travel, to visit their relatives; it'll cost them a lot more. It will probably reduce the amount of visiting. I think visiting is a really important thing, for people to recover.

We also have a very young population in the practice, with a lot of women having babies. At the moment they really value the maternity care they get at Lewisham. They do have choice. They can use the midwife-led unit, knowing it's co-related with an obstetric unit; or for the majority who are actually higher risk they can go to the very good local obstetric unit. They won't have that care. They'll have to go further away – Queen Elizabeth or King's or St Thomas's. And that will disrupt relationships that have been built up, care pathways and actually fragment the care that they get.

And that leads on to the other about the whole – as GPs we've been working in Lewisham, certainly formally for the last eight years as a federation of GP practices. This pre-dated Clinical Commissioning Groups and we've been working closely with Lewisham Hospital and with social and community care and built up relationships, networks and knowledge about how all these things can work together well for the benefit of patients. That's something I'm really concerned about, that's all going to be broken up if these proposals go through.

NB We've heard a lot about the process and the absence of process – what do you want to say about that?

LI About the consultation process?

NB Yes.

LI First of all the public consultation was only 30 days, which is really short. Most people found it really difficult to complete the consultation documents because they were very dense, they didn't explicitly say that they were proposing a closure of Lewisham Hospital A&E and acute services and Lewisham Hospital maternity. They hid the map that showed they were going to sell off 60% of the Lewisham site – it was buried in the appendices which most people in Lewisham didn't see.

I went to one of the so-called consultation meetings – before the consultation process they had these sort of workshops with clinicians and I went to the community care one because all of the TSA proposals are based on the notion that 30% of the hospital-based services will be replaced by community-based care.

When I went to that it wasn't possible to really express any dissent. When one person asked the leader of the workshop what was the evidence that community care could replace the need for hospital care, the person who was asked was Dr Penny Dash, who was a senior McKinsey's executive who was a senior member of the King's Fund, and Dr Penny Dash's reply to that question was 'There is no hard evidence'. So they're basing a whole strategy on something where they, even McKinsey's who was behind the whole consultation process, admits that's there's no hard evidence.

And whatever evidence there is does not show that improved community-based care does reduce hospital admissions – although it might be a good thing in its own right but it doesn't necessarily reduce admissions nor does it reduce costs. But in the workshop we went to we weren't allowed to talk about specifics in fact Lewisham Hospital wasn't even mentioned. We were just asked to indulge in 'blue-sky thinking' *(Laughter)* and 'aspirations' and 'visions'. That was all we could talk about – aspirations and visions.

NB I want to ask you now about the campaign, the Save Lewisham Hospital campaign. How has that developed?

LI It's been the most amazing experience. When we first heard that Lewisham was going to be included in the TSA proposals, which was some time in September 2012 – when I say 'we' I mean clinicians and patients, people from Lewisham Pensioners Forum for example – we all discussed this and said: 'This sounds dreadful, we need to do something about it'. And we had had a meeting of just 12 people and we said 'well, we're going to have to have a public meeting to tell people what's happening and while we're at it we should have a march to protest'.

So we pencilled in the dates, we organised the public meeting. We thought it would be great to have it in the Hospital. The Hospital very kindly let us have their auditorium. It soon became clear that the auditorium was going to be far too small for our public meeting. Not only did the Hospital have to provide two overflow venues in the Hospital for the meeting, we had to organise at short notice an entire other venue at the Calabash and even *that* people couldn't get into. So the public meeting had at least 600 people who turned up and these were ordinary Lewisham people, people from across the borough, from all walks of life and also Lewisham [Healthcare] staff. And the feelings of anger, kind of disbelief basically and determination to fight it, were huge.

Then a demonstration: we were liaising with the police and originally thought there might be about 2000 people, which we thought would be a good turnout, and we began

to get the feeling from the street – because we were leafleting and having street stalls and talking to people – that a lot more people were going to come. So we said to the police: 'We'd better cater for 4000'. They said: 'No, no, don't worry, that's not going to happen; that doesn't happen in Lewisham'. *(Laughter)* On the day it was bucketing! – windy cold and bucketing in November – and I thought 'oh dear!'. Well we had 15,000 people on that demonstration. *(Applause and cheers)*

And just talking about the demonstrations, that built up to the – Jeremy Hunt was going to announce his consultation decision at the end of January. And we organised a second demo in the snow and it had 25,000 people on it! *(Applause and cheers)* But as well as demonstrations we had public meetings, we did a lot of petitioning, we helped people to take part in the consultation process because, as I said, it was quite a difficult document to understand and we facilitated that. There were protests of mums and dads with babies in buggies in the snow – they went to the Department of Health to try to talk to Jeremy Hunt. He was in the building: he would not come down to talk to these 120 mothers and babies in the snow. He wouldn't come and talk to them.

As well as that we produced a very detailed critique of proposals as well. We as a campaign did a detailed analysis but we were also overwhelmed by the contributions from the Lewisham clinicians. So each department produced amazingly detailed evidence-based critiques of the proposals from - the emergency department to paediatrics and maternity to medicine, to surgery to ENT, to care of the elderly. And they're all on our website. But we also had contributions from the churches, from the Diocese, we had contributions from Lewisham [Council] – we had support from across the borough, from every possible part of it. And that's why we had such a huge impact.

NB And just one final thought on that, because I'm being reminded of our time: as Chair of this campaign, what has this campaign shown you about the people of Lewisham? What has it shown you, what does it reveal to you?

LI What it reveals about the people of Lewisham is that they really value the NHS and they're prepared to fight. They don't take things lying down. I think they're prepared to show passion – also intelligence. You know the whole level of critique we've had today and the evidence; it's been amazing and I think people here are very determined. That's why whatever happens we're going to keep on fighting to defend our hospital! *(Applause)*

NB Thank you very much

Panel question from Blake Morrison (BM) to Dr Louise Irvine:

BM Can I address one question to you as the Chair and as a GP. Bruce Keogh says that the case for change is predominantly financial; he almost seems to admit that it's wholly financially since there's not criticism of the standards of care and excellence at Lewisham Hospital which is offered. So the financial motive has been commented on by a couple of people: that Lewisham Hospital would be cheaper to close down than other hospitals lumbered with the PFI debt. But, the other thing that hasn't really come up today – and perhaps you could help me with this – is: as I understand it, there's quite a lot of land that goes with Lewisham Hospital. Were it to shrink in size or close altogether, there's a potential release and sale of that land. And I wondered

whether you had any thoughts on whether that might be motive behind some of the TSA thinking? *(Applause)*

LI Yes, I think you're right to say this is a financially motivated plan and the role of PFI has been totally iniquitous because PFI has to be constantly fed and you have to divert patients to the PFI hospitals to bring the money into the hospitals. And that means that financially viable hospitals like Lewisham are having to close to feed the beast of the PFI. And that also means selling off land. You know if they sold off 60% of the site to developers to develop, I don't know how they would do it, whether it would be used for healthcare, and that money to be made from that is supposed to go to pay off the PFI debts of the neighbouring South London Healthcare Trust.

I think it's totally immoral to start with, it doesn't make sense financially to close a financially viable hospital to help to sort out problems which were not caused by the hospital. But then again, as Allyson Pollock said, not even caused by the South London Trust but caused by Government policy. And if you look at the costs of the whole reorganisation it looks as if it's going to cost £196 million to do all the reorganisation and to rebuild some services in other hospitals, and that's only going to save about £19 million per year so it will take 10 years to pay off the costs of the money they're going to spend on this reorganisation of services across South East London. And we've been shown those sums are wrong – it could take even longer than that. It doesn't make sense financially, in fact I don't know why they want to close the hospital. It just doesn't make sense.

EW Thank you very much. And before I hand over to our Chair Michael Mansfield to sum up I'd just like to say on behalf of the advocates it's been an honour to be involved in this Commission of Inquiry *(Applause)* and we are thankful. We want to express our thanks to all the witnesses who've given such moving and powerful testimony today. Thank you very much.

TRANSCRIPT: SUMMING UP BY PANEL CHAIR

Michael Mansfield QC

I realise the time. I realise you've been very patient. And I must say I've been involved in many inquiries of different kinds and this has been one of the most disciplined, most focused and most efficient inquiries generated by public conscience. Effectively, that's what a people's tribunal is about. And you've demonstrated that time and again today through the quality of the witnesses, the quality of the evidence as well as the organisation and obviously the advocates that sit to my left. And I want to thank the two judges who are sitting with me. We're going to retire – and in my case not actually! – but to a room, to discuss aspects of what we've heard; because we do need the various documents you've heard about which we've asked for today and I hope we will get them in the near future. We will have interim conclusions because there is a Judicial Review next week and we need to ensure that the public at large, well beyond the boundaries of Lewisham recognise what is going on. It's going on in all the welfare services of course, what is going on with their National Health, and we don't want them suddenly to wake up – which at the moment they may do if they're not careful – to find that what they depended on since 1948 has disappeared.

Now I just want to say this about 1948. We will bear in mind what I've talked about, the United Nations Declaration of Human Rights and the Right to Health. But in 1948, a letter went through everybody's letter boxes, and the letter said this about the inauguration of the National Health Service:

> 'It will provide you all with medical, dental and nursing care, everyone rich or poor, man, woman or child, can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. It's not a charity, you're paying for it through tax. But it will relieve your money worries in times of illness.'

So in a sense that was the gold standard that was set in 1948 alongside the Declaration of Human Rights. None of this should be forgotten. And none of it should be forgotten in the context of what had happened in the Second World War. You were dealing with the ashes and embers of a nation that had been battered, a nation that had had its industry knocked out. But an industry that stood together, in one sense, within those ashes, the phoenix was arising. It shows what is possible, whatever the economic exigencies.

And so we're very conscious of the background when we come to consider everything that has happened today.

I just want to light upon another South London resident that you all know about – it was in the news this week – Doreen Lawrence. And her example's the same as yours. It's Lewisham in a sense once again. Because what she has demonstrated is the possibility of change, the possibility that she's going to be told, time and again, by the authorities: 'It's all right, we're looking after your best interests' when actually behind her back – behind her back! – they're trying to undermine her. And that's only just come out this week. But she and Neville (who's not in the country anymore but was) fought very hard for the principle of public conscience being laid out and being effective. And in my view she has led the way on that. And we today, and you today,

are giving us the opportunity to follow in those footsteps by what we want to look at here.

We're looking at the National Health Service, but with particular concerns. I just want to highlight now – if there are press here or anyone else wants to know – what our concerns are. We've had time to speak but briefly, so I say this is only preliminary. They're not conclusions yet but they are concerns.

The first concern is the absence of democracy. *(Applause)* The democratic element as you've heard today was removed effectively, so the Minister now concerned can just, as it were, slough it off and say 'well it's nothing to do with me, it's the market and all the rest of it'. So we know that point.

Second point in relation to democracy is those that are still in Parliament, those who still, as it were, reserve the right to devolve responsibility: of course those are decisions taken by – and you've seen how that House of Lords and the House of Commons (we'll get the figures for the House of Commons because I've been given one figure today) – a very substantial proportion of those deciding this in our so-called democratic organs are part of the very vested interest that is going to profit from what is going on. So, it's pretty clear that this is profit before people no question. Yes treachery even. And if there were a criminal offence attached to that I'd be in the forefront of trying to prosecute it. But however … *(Applause)*

And just bringing up to date, with all the evidence that you've heard today, another concern that we're going to have is that when ultimately they decide, perhaps they ought to talk to you – a bit? But they ought to consult. It's an insult and a travesty to call it a consultation, as far as I can see from the evidence.

And our concern is that whenever a reasoned argument was put to the TSA on the various occasions, when more than one witness is saying effectively they were dismissed, no opposition was trucked.

Now what kind of democratic state is that or would it be called an oppressive state? We have an oppressive situation in which they're not, effectively, wanting to listen. So that whole element of democracy I think concerns all three of us: that it is missing from this whole process.

But then you have to ask the second question. The second question is why is it happening and of course you have heard the answers today. In fact they've provided the answer very clearly and Blake just asked the question a moment ago and I think we started the day with the same question. Namely, it's not about Lewisham, in case you wondered: according to them, it's about two other hospitals in another area; and as people rightly pointed out it's not the fault of those hospitals – it's the fault of the system that has produced, in a sense, a set-up-to-fail system, in which it's the private sector that once again is going to profit.

And the Pollock Report – if I may call it that shortly, that's being leaked or released today and going to be published formally on Monday – makes it very clear that it is in

fact a problem that has been created by successive Governments. It's not just this one but previous ones, going back to a Labour Government, with the Private Finance Initiatives. Which means that hospitals; some – there are now 700 contracts we learned today – are locked into an impossible situation in which they cannot possibly pay it off unless of course this Government were prepared to go really back to first principles, that this should be a properly, publicly funded resource and (as the recommendation of that report is) that these Private Finance Initiatives have to be revoked, they have to be re-negotiated. *(Applause)*

So our concern will be examining that process by which those contracts have come into place and have essentially rebounded onto Lewisham. And therefore it isn't really just about Lewisham. They're not the fault of the staff, as far as we can see today, at all. The quality of care has not been questioned, it hasn't really been questioned in Lewisham at all. The recent report relating to obstetrics shows that they're not only good, they're getting better all the time. So once again it's a remarkable situation which we'll have to look at as to why on earth they are looking at closing or at least that was the original intention – downgrading – and we will look at the various aspects of the downgrade whether it's the elderly, maternity, the travel prospects, the paediatric resources, and A&E which as the witness said today: what is it? Well it certainly isn't A&E – Urgent Care is actually not going to meet the needs of this community which extends beyond Lewisham.

And therefore once you begin to look at all the component parts of what is failing here, which we will have to look at one by one; and there is the point about the land grab [which] is of interest because – when you look at, there's a statement: I'll just mention her name – you can look it up – it's a quite remarkable piece of research by Kathy Ashley who's a systems analyst and who has worked as a district auditor. She went to one of the consultation meetings and found they weren't remotely interested in what she or anyone else had to say, and she was pretty horrified as you may imagine, so we're back to that same point. But she took the trouble to get the draft report, she took the trouble to actually look through and look at the maps, which take a little bit of looking at. A lot of detail: I won't read out what detail she came up with, but I'll just read you her conclusions. This is going to be another of our undoubted concerns. 'Look at the site,' she says: 'The TSA wants to leave the buildings that are close to the river for hospital use, but to sell off all the land fronting Lewisham High Street. There is no means to get into this hospital, no cars, no ambulances, and no pedestrians.

Well that sounds interesting, I think that's the ideal hospital that the Government wants with nobody in it (Laughter) Nobody in it and no way of getting to it. (Applause) And that's her conclusion. The fact that there's not even a means of getting into the site in this plan suggests that it's nothing more than a land grab to fund the failures of South London Healthcare Trust. And of course as I've said, we're not blaming the Trust we're blaming the system and that is going to be another further area of concern.

Finally the other area – sorry it's taking a little time to say that we're examining this very, very closely. Finally what is the basis, what is the evidence basis. As a lawyer I'm always concerned to see what is the evidence. Not what is the speculation but what the evidence is. If you're going to have far-reaching reconfiguration which sometimes takes up to 10 years, you've got to do it properly. Which means not only consultation but you actually have to know what the impact is going to be. And you don't know the impact until you've discovered what it is you're serving. What is the community? What are their needs? Well it's perfectly clear from today, and also from the written material we have, this is an area that we'll examine very, very closely because it so far appears: there was absolutely no evidential basis and the basis that they did come up with – the 100 saved lives – nobody knows where they got it from. They haven't been able to reply in any of the letters that we've so far got from the TSA or anyone else. This is the evidential basis. No research.

And perhaps the height of that was the paragraph I put to Tony O'Sullivan in the paediatric sector. It is a complete misrepresentation, it is complete speculation, and they take decisions on the back of it.

Well we want to demonstrate through this report, that the public are no longer going to put up with being misled, with false information. The public are no longer going to put up with oppressive dictatorial dictats essentially, *(Applause)* from a Government not interested – they always say lawyers take four minutes to cough; never mind, I haven't got one don't worry, doctors don't rush.

I just want to say thank you very much for your patience and thanks to everybody including the Mayor for allowing us to use this Theatre today, because it's been a wonderful experience, one which I'm sure very few of us will ever forget.

(Applause)

Olivia O'Sullivan, coordinator

Before we go, I think it's self-evident that we owe great thanks to Michael Mansfield. We've just had to watch the news over the last two weeks to see how busy he is. And we've shamelessly used his name throughout building for this event, and he's given his time and support, but also his great authority, to the event. So you've thanked him, but let's thank him again. *(Applause)*

I'd also really like to thank on behalf of the campaign Baroness Warnock and Blake Morrison. I'm not sure that they knew what they were letting themselves in for but I know that the Baroness has lots of training in the House of Lords, sitting for long periods and listening. *(Applause)*

I'd also like to thank Lord David Owen, I mean he gave a belting speech this morning and really got us off to a good start. *(Applause)*

My very warmest and sincerest thanks go to Elizabeth Woodcraft, Amanda Weston, Nicola Braganza, Di Middleton and Maureen Ngozi Obi-Ezekpazu. They've been the

most fantastic women to work with over the last two or three months, and I think today they've just been amazing. So thank you. Stand up! *(Applause)*

I'd like to thank Lewisham Council who have generously supported this event. *(Applause)*

And the witnesses – it's all been said – 50 witnesses and more who have given their evidence. It's all been videoed, and they've given their time so generously and opened themselves up professionally and also in terms of talking about themselves individually and their children. It's just been an amazing experience. And you've only seen a small glimpse of the material we've got today. Thank you to those witnesses. *(Applause)*

I won't be long, don't worry, but talking about video, you've no idea how Stuart Monro has spent so much time – he doesn't even live in Lewisham – but he's spent days and weeks going up and down; and spent so much time videoing for this event. And it just takes hour and hours and hours of work at home as well. So I just want to thank Stuart Monro. *(Applause)*

I'd really like to thank our actor today, Tim Preece. *(Applause)*

And finally I'd like to thank Martin Costello and the theatre staff. And I'd really like to thank members of the campaign and the Commission working group team because they've been an amazing group of people. It's such a privilege to work with them and to have produced this event, and to all the stewards that have taken part. So thank you very much. *(Applause)*

Commission ends

CONCLUSIONS

The Commission of Inquiry took place on 29 June 2013.

The panel gave impromptu conclusions on the day and prepared an interim report setting out our concerns more fully which was published on 14 July 2013. The interim report was formulated in general terms because of the urgency of the situation relating to the TSA recommendations which had been accepted by the Minister. Since then a transcript of the day's evidence has been prepared and we have received the further written information which we requested.

We were impressed by all the witnesses, by their commitment to the community and to Lewisham Hospital. We were impressed by the thoughtfulness of the professional witnesses and their genuine concern about the implication for the health and welfare of the people of Lewisham should the proposals go through. And we were impressed by the careful and thoughtful testimony of the users of the service. The evidence of their experiences was enormously useful to us as it presented a vivid picture of how the needs of the people of Lewisham are being met, the pride which exists in the current system, and the current fears – unheeded by the Secretary of State – as to the future.

As has been said before the Minister, representatives of the Department of Health and the TSA were all invited to the Commission or at the very least submit responses. Nothing was received save from the chair of the TSA subgroup, the Clinical Advisory Group. This failure to engage with the community is reflective of the approach we found permeating the consultation process.

The Panel was assisted in obtaining a fuller picture of the background by hearing the words of the Secretary of State and of Professor Sir Bruce Keogh, NHS Medical Director, read by an actor.

As we heard and considered the evidence we bore in mind the four tests for major hospital reconfigurations (listed in NHS guidance in the Health and Social Care Act 2009) which the Secretary of State asserted had been met in Lewisham's case:

1.5. Support from GP commissioners (local Clinical Commissioning Groups or CCGs)

1.6. Clarity on the clinical evidence base for improvement

1.7. Strengthened public and patient engagement in the consultation process

1.8. Consistency with current and prospective patient choice ie justification for any restriction of choice

A Judicial Review was listed to be heard two days after the Commission of Inquiry, to review the legality of the decisions taken by the Secretary of State for Health, Jeremy Hunt based on the recommendations of the Trust Special Administrator (TSA). For this reason the Commission did not consider the question of legality. The JR was granted by the single judge 31 July, a decision upheld by the Court of Appeal on 29 October 2013.

A Service for the 21st Century

At the start of the day we reminded ourselves of the principles of the NHS as stated at its beginnings in 1948: the promise that it would provide the whole population 'with medical, dental and nursing care, everyone rich or poor, man, woman or child, can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. It's not a charity, you're paying for it through tax. But it will relieve your money worries in time of illness.'

We are now in 2013, some 65 years later and the world has changed immeasurably. And clearly an NHS for the 21st Century will be different from that of 1948. We have been conscious of this throughout the workings of the Commission. However, we need to be clear that changes required as a result of an ageing population, the increase in drug abuse, the development of new and sometimes radical treatments, are very different from changes required due to the demands of the market and debts incurred through excessive Private Finance Initiative payments or cuts.

We have also borne in mind that Lewisham is a vibrant, ethnically diverse borough with very specific qualities and needs. It is also a financially disadvantaged area.

Hospital quality and the need for change

Dr Chidi Ejimofu, a Lewisham A&E consultant, said,

> '(Lewisham) is a young community but similarly has a lot of patients who are elderly, are frail, [who] have multiple co-morbidities. We have a lot of commonly occurring conditions seen throughout the nation; things such as COPD, heart disease, diabetes. We also have a lot of conditions because … it's a very multi-cultural area. We have a lot of conditions that are native to our population … a lot of patients with sickle cell disease … [and] patients who come back to the area with imported diseases such as malaria. These are all conditions that we treat very well within our Department because we are used to treating these ...' (p.78)

And there is no question but that Lewisham Hospital is a good hospital. Over the years, the hospital and the Trust have worked hard to improve the range and quality of services available to local people and the Panel's attention was directed to evidence of improvements. Tim Higginson, CEO Lewisham Healthcare NHS Trust said this:

> 'During my time in the Trust the hospital has an excellent record of meeting the targets and standards that have been set for it … the team in the [A&E] department and the backup team throughout the hospital ... have enabled us

to maintain that high standard and hit those targets.'
(Tim Higginson p.48)

Mr Higginson described increasing numbers of women choosing to have their babies in Lewisham and the performance of the A&E department which is improving against national targets. Progress has been such that (prior to the Secretary of State's proposals for change) the Trust was moving steadily towards achieving Foundation Trust status. Indeed after extensive assessment the Trust had its Foundation Trust application approved by NHS London and submitted to the Department of Health in June 2012. (See http://www.savelewishamhospital.com/commission-documents/

In a letter dated 13 February 2013 Professor Sir Bruce Keogh, NHS Medical Director acknowledged the good clinical care at Lewisham Hospital. See http://www.savelewishamhospital.com/commission-documents/

Dr Helen Tattersfield, Chair of the Lewisham Clinical Commissioning Group made it clear to the panel that there was a recognition that change was always in the minds of the Trust:

> 'Even before the TSA we were sitting down seriously with our colleagues at Lewisham Healthcare Trust to say 'look, we know that the resources are going to go down, we have to manage within our resources. How can we do this?'… We were talking about improving the community services, bringing more things out into the community, helping people to actually avoid going into hospital in the first place … Those are the sorts of conversation we were already having in Lewisham before the TSA came along … But we wanted to make sure that that rationalisation was done in a way that would improve services for the local residents and not make them worse.' (p.59)

The Trust Special Administrator (TSA) had been appointed to South London Healthcare Trust in July 2012 with a brief to sort out the financial difficulties of that trust, which comprised three hospitals in Bromley, Bexley and Greenwich. Two of these were major PFI hospitals and could not be closed. Notwithstanding the reputation of Lewisham Hospital, its essential role in the Lewisham community and that LH was part of an entirely different trust, it soon became clear that the TSA intended to focus on LH as a key financial solution in his plans. (It was this issue which formed the basis of the Judicial Review brought by the Council and the Save Lewisham Hospital Campaign) In his opening remarks the Mayor reflected on the need for change:

> 'Such changes need to start with the needs of the population of South East London and not the financial and productivity needs of the healthcare providers …´ (p.13)

Throughout his draft report the TSA adopted a strict provider focus and failed to take into account or assess any impact of his recommendations on the local population or the extent to which these changes destabilised other local systems and processes.'

Lewisham Borough Council's Director of Public Health, Dr Danny Ruta, pointed out that many western healthcare systems require a complete radical redesign to achieve the quality of care and health outcomes expected by their patients and the public, and

it may well be that reform is needed in healthcare provision in the area and indeed in London and beyond.

Dr Ruta also noted that where this reform has been achieved, for example in parts of Spain and the USA, it 'required huge cultural professional change in leadership from within, gradual, incremental integration of clinical pathways across primary and secondary care, and has taken a minimum of 10-20 years to see significant results'. He concluded that such a change could be achieved in South East London but it would take 'clear and genuine government commitments to clinically led service integration, and to ground-up integration of health and social care; through co-operation rather than competition, this might be achieved within 10 years'.

> 'The imposition however', he continued, 'of crude, essentially arbitrary service closures based on wishful financial assumptions, is likely to have completely the opposite effect. It could put health and social care in South East London back 10 years.' (p.34)

The Panel is aware of the financial constraints and the need for evolutionary change in all major institutions but the evidence before the Commission made clear that the ill-thought-out, major reconfiguration proposed by the TSA, without adequate needs assessment or consultation, was financially driven and is not the way to achieve improvements in the quality of care and health outcomes.

Professor Colin Leys made the following points

> 'To my mind the most [recent] fundamental change is that it replaces patient need as the top priority with the need to meet commercial targets, the need to balance the books, the need to stay solvent. At lot of people think "well, what's new about that because haven't they always had to be careful about money?" and of course the NHS was always short of money, so doctors were never free to do whatever they thought the patients absolutely needed. But what is new is the shift in the order. Before, you thought "what do patients need and what can we do with the money we've got?" Now you think "what must we do to balance the books this year, to balance the competition?" And think about patients separately. And we have already seen the consequences of that at Mid-Stafford and in other places.' (p 23)

While the points raised by Professor Leys affect all NHS Trusts and all sectors of the NHS, the Panel felt that they provided a useful background for understanding how financial pressures rather than patient care, formed the background to the work and interventions of the TSA in South London and Lewisham.

Professor Leys also drew the Panel's attention to the increasing proportion of the NHS budget being swallowed up simply 'by the need to operate a market' (10% at a conservative estimate) on top of other management costs. This is a factor, he stated, that is never discussed. We start that discussion now.

Professor Leys highlighted for us a significant change in accountability. The Secretary of State is now only responsible for 'promoting' the Health Service and the people actually responsible for operating it are NHS England and Monitor in England. He was speaking here about England and not Scotland, Wales and Northern Ireland. NHS England is 'a bureaucratic branch in effect of the

Department of Health, but is a body appointed by the Secretary of State, but is not accountable to the Secretary of State.' He went on to describe 'Monitor which regulates the market, which again is appointed by the Government but not accountable to it. It is an independent monitor like Ofgem and so on.' (p.22)

This immediately poses issues for democratic opposition to aspects of healthcare policy.

For example, opposition to the TSA and the Secretary of State in Lewisham has been extensive: 15,000 and 25,000 people have marched in protest on the streets of Lewisham on two occasions, more than 50,000 signed a petition, 6000 responded to the written consultation, 160 (nearly all) Lewisham GPs and large numbers of hospital clinicians opposed the closures, as did local elected MPs, the Mayor and councillors – but this was seen as being of no material account by the TSA and Secretary of State.

Professor Leys drew to the Panel's attention to the fact that MPs and peers who have registered financial interests in private health companies are able to vote on critical areas of legislation which are advantageous to those companies. For example, many peers with those interests voted against annulling regulations in the debate on Section 71 of the Health and Social Care Act, which would have moderated the effects of competition and privatisation. These additional points from Professor Leys can be found at http://www.savelewishamhospital.com/commission-witnesses/.

The decision to downgrade Lewisham Hospital has nothing to do with the provision of healthcare in SE London. Lewisham Hospital's good level of clinical care is admitted by the authorities. The panel finds the decision deplorable.

The evidence pointed strongly to the fact that the NHS is now becoming less universally available, less accountable and currently threatened by extensive marketisation and privatisation.

The Panel is concerned that the areas of the NHS which remain for Parliament to decide upon 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.

Private Finance Initiative

Evidence presented to the Commission revealed both the extent of the impact of PFIs on the health economy of South London Healthcare NHS Trust and their role in the TSA plans for closure of services at Lewisham Hospital.

Expert witness Professor Allyson Pollock cited evidence to show how widespread the application of PFIs had been nationally:

- 101 of the 133 new hospitals built between 1997 and 2008 were privately financed
- by April 2011 across the public sector more than 700 PFI contracts had been signed in the UK with an estimated capital value of almost £50 billion in

England and the cost of every PFI hospital built could have paid for two hospitals financed through government lending

- annual repayments stretch for 30 years, even up to 60 years in some cases
- interest rates on the loans were inflated far above current commercial rates - at anything from 6% to 15% - while current interest rates stand at around ½%, and government borrowing rates at approximately 1½-2%.

The SLHT has 6 PFI schemes, which were drawn up on particularly disadvantageous terms and the Panel understands that it is this factor above all which has led to the current crisis in the SHLT. The hospitals in the SLHT cannot be closed because of the extent and terms of their PFI contracts – thus it was proposed that Lewisham services should be drastically curtailed in order to help fund the PFI payments of a completely separate Trust.

The size, extent and terms of the PFIs in SLHT, Professor Pollock argued, were part of national government policy. Thus they could not and should not be attributed to the actions of individual hospitals in the Trust.

Professor Pollock gave an illustration of how PFI contracts can become unaffordable for individual trusts over time.

She clarified the position in this way:

> 'So the Government borrows the money, but the problem is that the hospital trusts are left with the debt and these are 30 year contracts – and it is often extended to 60 year contracts. So the hospitals have to service the debts from their operating budgets … And this is a very expensive way of borrowing money. Research by Jim and Margaret Cuthbert has shown that for every single hospital designed and built and that is operating for the next 30 years, we are actually paying for two, but we are only getting one and in some cases we are paying for three. So, if you can imagine two or three: Barts is my hospital, it's a PFI trust – we could have had three of those! But actually at the moment we are only getting one, so that tells you how expensive it is and how lucrative these deals are for bankers and the investors.' (p.26)

She highlighted yet another difficulty for accountability in that it is extremely difficult to discover how much exactly is being paid. The PFI contracts are commercial and often bound by commercial confidentiality. Information about how much interest is being paid, and what returns investors and other beneficiaries are receiving, has not been open to public scrutiny.

She described the irony that some of the banks that were bailed out in 2010, such as the Royal Bank of Scotland, where hundreds of billions of pounds were poured in by the Treasury, with public money, are still continuing to charge the public sector hundreds of millions of pounds in excess interest charges.

We found her next comments extremely shocking

> '… not only are we paying very high rate of interest, the PFI charge is indexed to the measure of inflation, so the budgets for the NHS are falling, but the PFI charge is rising by about 4 or 5% a year. If I just give you an illustration, at the Princess Royal University Hospital in Bromley, the PFI payment has risen

to £39 million a year and by the contract's close in 2030 – the contracts have been extended – it is £94 million. So we've gone to £94 million and the PFIs just now are taking between 18-20% of the Trust's income.' (p.27)

Many of these banks also have equity stakes, so are making extraordinary returns on their investment. So high are these returns that the Chair of Committee of Public Accounts, who is in fact a Conservative, called it 'the unacceptable face of capitalism'.

The Panel had major concerns about the extent and role of PFI payments for the future of hospitals in SLHT and the role of PFI in the recommendations for closure by the TSA of services at Lewisham Hospital.

The Panel's view is that the decision to downgrade Lewisham Hospital is based entirely on economic considerations.

The health of the nation is now a secondary consideration to the vested interests of the bankers, shareholders and corporate stakeholders who, having been invited by Government to invest in the health service, now seek increasing returns thereby draining the health service of vital resources.

Planning and consultation

Professor Pollock also spoke about the TSA plans. She highlighted the lack of any proper planning. She said, 'What [the TSA] absolutely failed to do – and this is totally irresponsible … [is ask] "Where will these patients go and how will services be re-provided?"'

Professor Pollock summed up as follows: 'We found that the TSA report is not evidence-based, its financial analysis is poor and misjudged and they have not conducted a proper needs assessment or planning.' (p.28)

- This point was also made by John Lister, the Director of Health Emergency, a pressure group focused on the NHS (the transcript of his video can be seen on p xx). He argued proposals for change should contain answers to the following questions: Where are these services going to be?
- How many people are going to be employed?
- How will they be recruited and trained?
- How will they be managed?
- What resources will there be?
- How is their work to be integrated in with the existing services across the NHS in South East London?'

He said: 'Until there are firm answers to all of those questions, a timescale and the first building programme actually started, and a prospect of these services coming into action, it's irresponsible to start running down and closing hospitals or even deciding to do so.'

Professor Pollock made a series of recommendations:

1. that the TSA regime for South London Healthcare Trust should be revoked and the case should be reconsidered afresh, excluding the effect of Government policies;
2. any TSA recommendations should only occur when a proper needs assessment has been done and when all the data, including the PFI contracts, are placed in the public domain;
3. that the Government should make public and renegotiate all the NHS PFI contracts, the six South London Healthcare Trust's and the King's Trust's as well;
4. that the TSA regime should not in the future be applied to Trusts whose deficits have been significantly contributed to by Government policies, as is the case here in South East London.
5. the TSA regime in future should not be permitted without a proper needs assessment. It should not be permitted to use productivity measures and targets as a substitute for planning and access. It should not be permitted to use travel times as proxy measure of public's use and need for services. It should not use MORI opinion polls as a substitute for public health planning and it should not use data that has not been put in the public domain.
(pp.28-29)

The lack of any proper planning, the absence of proper research and the failure to ask simple common-sense questions as referred to by Professor Pollock and John Lister led the Panel to the conclusion that the basis of the proposals was not about improving patient care.

Consultation

The TSA undertook what they described as a process of consultation with those concerned with the SLHT and the TSA's proposals. The consultation period was 30 working days. Professor Pollock said, 'This meant that none of the proper consultations and safeguards were undertaken by the TSA.'

The Panel heard evidence of the failures of the TSA to take on board the submissions of the many concerned stakeholders. Lewisham Healthcare NHS Trust itself, in its submissions to the TSA, noted that '[our] clinicians tell us they have been engaged in the TSA process but not listened to'. LHT's submission to the TSA made it very clear that clinician engagement in this process does not equate to clinician agreement and approval and they were extremely unhappy that it has been presented as such by the TSA (Lewisham Healthcare NHS Trust, 2012 op cit pp 11-12, Appendix).

There are over 60,000 children in Lewisham, over 20% of the population. It was clear to the Panel that the needs of children and the effect of the proposals had not formed any part of the planning or consultation process at all. (Dr Tony O'Sullivan p.123).

Dr Chidi Ejimofo, Consultant in Emergency Medicine at Lewisham Hospital told the Panel that he had not been consulted about the proposed changes. He said that the process was not only 'not transparent' but the proposals were 'based on data that only

they can tell you where they got it from because they certainly did not get it from me and my colleagues.'

Dr Helen Tattersfield, Chair of the Lewisham Clinical Commissioning Group answering questions about GPs' involvement in the consultation process said:

> '… We had to go, we had to be part of many, many meetings. At most of the meetings we were not given advance notice of what was going to be discussed and we certainly had no papers to look at before we got there. So we were presented with documents in a very quick piece in the sense of *this is what has to happen*, without really getting the chance to contest things. If we did contest things we were told that there was no time to discuss that, "this is the only possible solution", "there's no time to look at anything else" ... And often we weren't allowed to take the papers away to look at them afterwards. It was that type of process. I think it's already evident from other people that they certainly don't have Lewisham clinical support.' (p.58)

She said:

> 'The other point I would make about the external clinical panel is that it was made up of specialists who had specialist interest in specialist areas. There wasn't anybody from the Royal College of General Practitioners.' She added, 'there was nobody talking about integration of services, rather than fragmentation … Only the one thing: only a specialist need and money-saving …'

She went on:

> 'The TSA doesn't take into account the needs assessment, risk assessment of the population and it puts a large number of people at a risk that they are not currently at.' (p.59)

She made the interesting point that the expressed aim of giving patients choice will be meaningless. Patients will choose to use the bigger foundation trusts – because they have heard of them, because they are easier to get to, they would feel safe there. So there is a possibility that everyone will want to use King's Hospital. She said:

'It is more expensive there so from the point of view of commissioning for Lewisham, more of our money will be spent increasingly on secondary care services, so there'll be less money to be available locally … So you could almost end up with the whole of South East London with one single provider. That's not choice.'

She offered another view:

> 'Whereas if you allow Lewisham to build itself up, to build on its reputation, be an effective service along with QEH I think patients will have confidence in that. They will use that. It will become a really good, viable alternative to the big foundation trust. And the whole economy of the health service will be better, which is a bit of an ironic outcome.' (p.59)

The clinical engagement and public consultation exercises in respect of the decisions regarding Lewisham Hospital were a sham. In many cases there was none and where it did take place notice was inadequate and objections

were overruled or dismissed. The Panel was left with the strong sense that decisions had already been made.

Poor data and the misuse of data

The panel was told that the Secretary of State's recommendations combined poor clinical data with a misuse of data in his proposals for Lewisham. We were given several examples.

The '100 lives' argument

The actor Tim Preece read the words of the Secretary of State concerning the basis of the decisions:

These proposals, as amended, could save up to 100 lives every year through higher clinical standards

The panel heard from John O'Donohue, Consultant Physician at Lewisham Hospital:

> 'We did challenge the Secretary of State and Professor Sir Bruce Keogh on this figure and I am disappointed to say that the response from Bruce Keogh contained the phrase: *"This is not an exact science"* …'
>
> '… If you go into the basis for this it all hangs on research from nearly ten years ago from 2004. And this research looked at emergency admissions in England over a period of one year and they found patients coming in at the weekend had a mortality that was higher than patients who were admitted during the week; and they made the heroic claim from that evidence that this meant that patients weren't properly being looked after over the weekend and, therefore, they were more likely to die as a result of that.
>
> 'If you go into the actual academic paper, the authors themselves actually concede that there is another potential explanation for this … when they looked at the patients admitted at the weekend, in any 24 hour period at the weekend only three-quarters of the numbers of patients were admitted compared to the weekdays. These patients admitted at the weekend were sicker to start with.' (p.40)

He explained this phenomenon, that most people avoid going to the doctor or attending hospital at the weekend. If they can they will 'tough it out' until Monday. So those that feel they must go to A&E are inevitably those who are more unwell. He said:

> 'Just to expand on that, I'll take an extreme example: patients admitted on Christmas Day – Christmas Day is a day nobody wants to end up spending in A&E. We know that patients admitted on Christmas Day are of a higher mortality because they are sicker to start with and this is what we are seeing in this paper and this is the basis of the whole premise that "*100 lives will be saved".*' (p.40)

He described how the figure was arrived at:

> 'What the paper showed was that the excess mortality at the weekends was 3,300 for England and they broke this down on the back of an envelope and calculated that for the South East of London pro rata this would be 100 lives and this is the basis for the whole clinical justification that the Secretary of State has made.'

He also referred to other, chilling, information which has come to light since the Secretary of State's decision.

> 'We have had Sir Bruce Keogh's other predictions of mortality since then in the Leeds cardiothoracic case. [Data, later shown to be invalid, had formed the basis for an emergency decision by Sir Bruce Keogh to suspend children's heart surgery at Leeds General Infirmary in March 2013 to the distress of parents and potential damage to patient care.] … I think that can only serve to undermine his role in this.' (p.39)

On the effect of department closures he said

'[W]e have had direct experience of the closure of an A&E Department in England. A Freedom of Information request for Newark A&E showed that the death rate for patients living in Newark who had to be shipped to a neighbouring A&E when Newark A&E closed rose by 25%.' (p.39)

Maternal deaths

Dr Donal O'Sullivan was troubled by the spectre of maternal deaths introduced unnecessarily by the Secretary of State in a speech concerning the proposed reorganisation of maternity services, in the House of Commons on 31 January 2013. Dr O'Sullivan said:

> 'Just on the 100 lives argument, I think to bring maternal mortality into this discussion is actually incredibly artificial. Maternal death is a very rare event in this country and I think to have even one would be a disaster … I don't believe there is any evidence to support the idea that larger maternity services are safer, are less likely to result in maternal mortality; nor do I believe there is any evidence that they are better quality. (pp.44-45)

He said that in seven years there had only been one maternal death and that was of a mother who had not engaged with any service prior to presentation in labour.

Poor data on the impact on ambulance services of closure of Lewisham Hospital

Referring to consideration of how the changes would affect the ambulance service, the Commission heard from Malcolm Alexander Chair London Ambulance Patient User Group:

> 'The Ambulance Service … called on a company called OHR to do a study [re: Chase Farm Hospital, North East London] and that company has finished its study recently and has recommended there should be a significant increase in the number of staff in relation only to there, not in relation to Lewisham.
>
> '… There has been no study by the Government or the London Ambulance Service in relation to the increased pressures that would result from a change to Lewisham Hospital. There has been none.' (p.84)

A response to Mr Alexander's letter to the SOSH said:

> *'Your letter suggests there has been no impact assessment of the TSA's recommendations. The TSA commissioned a Health and Equalities Impact Assessment, which appeared at annex l of the final report. An equalities screening document was published alongside the TSA's consultation and the final HEIA report, then considered the feedback from the TSA's consultation. The TSA's final report traces how it considered these various aspects before he made final recommendations' (Letter from Malcolm Jones, Department of Health to Mr Alexander, May 2013. This letter can be seen at* http://www.savelewishamhospital.com/commission-witnesses/)

The panel pursued this issue with Mr Alexander, asking if that response made sense to him. Malcolm Alexander replied:

> 'Well it doesn't because I questioned the Chief Executive, London Ambulance Service persistently and raised questions in their public board meetings on this matter and … I have been persistently told that there has been no study by the Ambulance Service, by the London Ambulance Service, in relation to the impact should the Lewisham proposals by the TSA take place. So I am absolutely confident that although there may have been a study, that study is not specific to the impact on the London Ambulance Service. That has not been done.' (p.87)

Misleading clinical data on the centralisation of services

Dr O'Donohue also assisted us with the Secretary of State's assertion that services should be centralised to save lives. We noted particularly the dates in his explanation of the treatment accorded to stroke and heart attack patients. He said:

> 'We do know that for some conditions centralised care is better and that's why *since 2011* all patients with strokes have been centralised; they haven't been coming to Lewisham, they have been coming to King's or to Princess Royal in Farnborough. *Since 2009* all heart attacks have been diverted, either from A&E in Lewisham or by the London Ambulance Service to specialised heart attack centres and we know the centralisation of these has resulted in a better mortality for stroke and heart attack. But they are the only situations where this applies (Panel's emphasis).' (p.41)

In other words, *these changes were already in place before* the Secretary of State's proposals came into being.

Dr O'Donohue made a distinction between the centralised and thus improved care for stroke and heart patients, and other conditions where speed is also of the essence in terms of treatment:

> 'An example of that is meningitis, where it has been shown that what is important for meningitis is the speed you get antibiotics into the patient, not where it is delivered. And so the Secretary of State made a very surprising claim in his speech when he announced in his decision that meningitis patients

would benefit [from centralised care]. That is completely contradicted by the specialist societies and the evidence.' (p.41)

Poor analysis of patient flow

Dr Donal O'Sullivan, consultant in Public Health Medicine for London Borough of Lewisham described his 'grave concerns about the TSA's proposals'. In relation to the question of what would be required to deliver safe and effective services for children and pregnant women in Lewisham, Dr O'Sullivan pointed to evidence of overstretched maternity resources in the South East area overall.

> 'My main concern is essentially about capacity generally … Within the sector at present we are constantly on the bones of not having enough beds, in not having enough capacity to deliver a safe service. That's in the whole sector.' (p.43-44)

He described research carried out over a period of 18 months, looking at all the trusts in South East London, which showed that 'on average each month, at least two of those units had to close on at least one occasion; and that's almost always because of beds, because of a lack of capacity.'

He said 'I think we're on the brink of a major problem with capacity in maternity services in South East London.' (p.44)

He was concerned about the assumptions of the TSA that women would go to one specific alternative hospital if they could not go to Lewisham Hospital to give birth:

> '… the proposals clearly assume that most of the flow will go to Greenwich. There's no evidence for that that I can see. Women in Lewisham historically, if they haven't chosen Lewisham Hospital, have gone to King's or have gone to Guys & St Thomas', with a small number in the south of the borough going to Princess Royal (Farnborough). I'm fairly confident that women will find it incredibly difficult to have to go to Greenwich …' (p.44)

He described the effect on the hospitals that women would choose to go to:

> '….we believe that in fact most women will go to King's or St Thomas' and … that will mean that these hospitals will become very large in terms of the size of their maternity service: so large that they will have to, if you like, double up their provision, particularly in relation to their provision of the obstetric rotas, which will make this a much more expensive service. That's also of course assuming that both of these hospitals have the capacity to extend their service. King's, for instance, is on a very restricted site geographically …' (p.44)

We shared the concerns expressed about the lack of analysis in to the effect of the changes, in particular where pregnant women will actually choose to go to have their children, and the impact on the chosen hospitals, already struggling with capacity. This omission we consider has implications for costs – it is clear that many of the proposed changes will in fact be more expensive as well as less safe than the current provision.

We queried the Secretary of State's purpose in introducing the emotive subject of maternal death when that clearly was not a concern in this situation.

The Panel found the lack of proper statistics in this debate was astonishing.

Where data existed, its quality and relevance was questionable. On the whole the panel found there simply had been no proper examination of the needs of Lewisham residents or consideration of the impact the proposals might have.

The closure of Lewisham A&E

The Panel heard from Dr Chidi Ejimofo, Consultant in Emergency Medicine at Lewisham Hospital as to the effect of the TSA proposals on the service offered by Lewisham A&E. The department currently sees over 115,000 attendances every year and that figure is rising. The Secretary of State asserts that the changes would mean that 75% of patients currently seen would continue to be seen but this figure has been challenged – with no response. The Consultants in the A&E Department believe the figure would be more like 50% of current numbers would be seen. 'So you are going to see in excess of 50,000 attendances having to go to other Emergency Departments within the area.' (p.77)

He said that there is no such thing as a 'small, but safe' A&E as the Secretary of State had claimed. If the proposals were to go through, Lewisham would lose 4 of the 7 essential services needed to support an A&E Department ie paediatrics, acute medicine, surgery and intensive care. Dr Ejimofo stated 'that is not an Emergency Department, that is not an A&E, safe small or otherwise.' In Dr Ejimofo's view without these essential services the A&E Department would be no more than an Urgent Care Centre. (p.79)

The closure of the A&E at Lewisham would increase pressures on other hospitals across South East London when the system is already overloaded. Dave Newman, whose 92 year old mother had died in the Princess Royal Hospital a few days after experiencing lengthy delays and overcrowding in the A&E, described the overloading of that department on what had been an ordinary quiet night with, even then, ambulances queuing outside waiting to admit people to A&E.

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

The Ambulance Service

In addition to hearing the individual testimony of David Newman, the Panel was also informed of the wider issue of how the London Ambulance Service would be affected by the closure of Lewisham. Fewer, already extremely pressed A&Es would be under intolerable pressure. Malcolm Alexander, Chair of the London Ambulance Patient User Group, described the inevitably increased risks to those 'time-critical' patients with strokes and heart disease taken through the A&Es of the centralised specialist services, by then under pressure from swollen numbers; but there would also be the

knock-on effect on those with less critical needs attending those same pressurised A&Es.

He spoke of the situation of ambulances queuing outside A&E Departments. He had collated the performance figures on delays for the whole of London:

> 'Lewisham does not appear on these figures, there is not one single incident … where there was an ambulance waiting more than half an hour outside Lewisham Hospital to bring a patient in, although there may be instances of lower waits.' (p.84)

In none of the proposal documents is it clear that any consideration was given to this front line service, already under great pressure, and the effects the proposals would have on its vital role in ensuring the safe passage of very ill patients to hospital.

Maternity Services

Ruth Cochrane Consultant Obstetrician, an exceptionally experienced clinician, described the efficient and effective working of Lewisham Hospital Maternity Unit.

Currently Lewisham Hospital offers the choice of home birth, supported by members of the Lewisham team, and at the hospital itself, a midwife-led unit, co-located with the obstetric unit and Labour Ward, with its recently opened two home-from-home rooms. The reduction of this choice of high quality services to a single midwife-led unit in Lewisham Hospital without medical backup raised pressing concerns for Ms Cochrane.

She highlighted that it is in the nature of maternity work that emergencies are inevitable and unpredictable, especially in the population served by LHT. The TSA proposals would result in women with those emergencies being transferred mid-emergency to another hospital. She repeated the concern that none of the nearby hospitals has sufficient capacity to deal with all the women transferred if the Lewisham obstetric unit closed. She too was of the view that this will endanger not only Lewisham women and babies but also women who are delivering in those neighbouring hospitals already under great pressure because the service is overstretched. (p.97)

She referred to the vital links which Lewisham has with the community midwives and local GPs, which in a borough such as Lewisham, with many young or vulnerable mothers, are vital to ensure proper care for them and their babies. Her concern was that those links are in real danger under the proposals.

Kathy Cruise, a highly experienced community nurse who works on a special programme successfully targeting the needs of vulnerable young parents, spoke of the possible impact on them and their children because the journeys would be 'too far and too costly and may lead to them not accessing those services.'

Jessica Ormerod, a mother, former patient and Lay Chair of the Lewisham Maternity Services Liaison Committee (MSLC), a multi-disciplinary forum, told the Panel that Lewisham Hospital provides excellent maternity care. Ms Ormerod emphasised the popularity of the range of choices offered to mothers by Lewisham maternity services.

During the TSA consultation period her committee was invited by Lewisham Hospital professionals to join them in attendance at a TSA consultation meeting, She described the TSA team as failing to consider women's concerns. They were "absolutely not interested". (p.102)

The Panel was extremely troubled by the evidence given in relation to maternity services, evidence that highlighted some of the evident dangers for women giving birth. These dangers exist even for the ostensibly healthy 12% of women who meet the low-risk criteria of the Secretary of State's proposals for a midwife-led unit without emergency backup. Women throughout the borough will be put at risk by the implementation of the TSA proposals.

The panel was also concerned that choice for pregnant women in Lewisham, would be seriously reduced, contrary to the Government's 'fourth test' – patient choice.

Children's Services

Public Health Consultant for Lewisham Council Dr Donal O'Sullivan talked about 'the truly integrated children's service' in Lewisham, whereby hospital and community services are part of the same organisation. This had led to lower rates of admission for children, he said, 'less than 70% of what we would expect'. Dr Donal O'Sullivan told the Panel that, 'One of the main things for me and one of the main risks, as I see, it, in terms of the implementation of the TSA proposals, is the loss of that integration.' (p.42)

Dr Tony O'Sullivan, consultant paediatrician and Director of Children's Services at LHT, told the panel about the integrated service for children which had developed over his 20 years of working in Lewisham. The service had built:

> 'networks of care for children, often very vulnerable children, in a way that was actually in advance of government policy, government policy that was escalated after the Victoria Climbié death and the inquiry … we'd already started building up networks across health agencies and across local authority agencies, and indeed the voluntary sector, to build that very necessary set of supportive environments for different groups of children and doing that also with the hospital'. (p.120)

Sir Bruce Keogh in his advice to the SOSH had recommended to the Secretary of State a walk in paediatric urgent care centre, removing the highly effective paediatric A&E and children's ward. In her written statement, Dr Tina Sajjanhar, a paediatric A&E consultant, LHT and Deputy Director of Children's Services commented:

> 'The most disturbing thing about the TSA is that children's services are not specifically considered. Whatever happens to children's services will be by default. If A&E goes there will be a house of cards effect, other services that rely on A&E will collapse. 60,000 children are now unplanned for in Lewisham. The review hasn't joined all the dots. Because of the deprivation in the area many people don't have cars or the means to travel easily on public

> transport. There has been no consultation with the Ambulance Service. There is no planning to deal with what has been taken away. There is a sizeable minority of people in Lewisham living on £35 a week. They can't take a cab to hospital. It's hard to even pay the bus fare.'
> (See http://www.savelewishamhospital.com/commission-witnesses/)

Parents and a young patient spoke very movingly about their use of the excellent paediatric A&E services at Lewisham Hospital and about the excellent continuity of care between hospital and community services, and the effect the changes will have on their children if the changes go through

The Panel was appalled that children who form over 20% of the Lewisham population were not planned for at all in the TSA proposals.

The Panel was unanimous in its view that the current system of care offered by the paediatric services in the Hospital and in the Community has been developed over many years so that the care it offers to the children of Lewisham responds exactly to their needs.

The Panel agreed that the walk-in paediatric urgent care service suggested by the TSA has no clear parameters, is unsafe and unsustainable. Any such unit needs to be co-located with an Emergency Department for which there are no plans. Stand-alone paediatric ambulatory care will predictably result in higher costs – a clinically suspect and more expensive downgrading of what exists.

Community care and fragmentation of care pathways

Dr Brian Fisher, Lewisham GP, gave evidence to the Panel about the workings of a care or clinical pathway. This describes the different sorts of care which might be needed: GP, hospital, other services in the community, such as physiotherapy, or occupational therapy. The TSA proposals 'cut across all of these, destroying these crucial links.' Dr Fisher told the panel 'One of the reasons that we continually, throughout the whole (consultation) process, objected to what we saw was going on, was that we saw what would happen … would be a breakdown in services'. He highlighted how expensive this would be, both financially and in terms of patients' health:

> '… if you keep people out of hospital where they want to be, in the community, then actually the hospital loses money. It's a completely crazy way of arranging. '… So the very sinews of the NHS now are determined by the way this money flows; and the way the money flows actually militates against collaborative cross-sector working.' (p.62)

The effects of fragmentation in services was addressed by Dr Helen Tattersfield, GP and Chair of the Lewisham Clinical Commissioning Group.

> 'We've heard about stroke and heart attack, but the majority of people don't have those sorts of things. They have simple things that just require a day or two in hospital. If they're at Lewisham Hospital I know when they've been there, I get the discharge from the A&E to say they're in hospital, I get a discharge when they come out, in case I need to go and see them so they don't go back in again. That sort of thing is really, really important.' (p.57)

The effect on the most vulnerable sections of the community

Evidence presented to the Commission demonstrated that for the general population of Lewisham, the effects of removing a high quality major hospital with its A&E and acute services would be disastrous. In terms of the more vulnerable sections of the population, even graver concerns were raised by witnesses with direct experience of the problems. These witnesses drew attention to the implications of the division of integrated care between hospital, GP, community and council services and what the effect of longer and more costly travel times would entail.

Mental illness
In this deprived inner city borough the population experiences high levels of poor mental health. 40,000 people a year experience depression, anxiety, panic attacks and phobias and 2,900 residents of the borough have Serious Mental Illness (SMI) such as schizophrenia or bipolar illness. And yet, the Panel learned through evidence from Dr Jim Sikorski, GP (p.55) that despite the significance for such a large proportion of the Lewisham population, the Trust Special Administrator did not mention mental health services as being a major/important part of service provision, nor properly examine the consequences for these patients of the closure of the hospital.

The elderly
The serious implications for the elderly, an already very vulnerable group, were addressed by Dr Elizabeth Aitken, Consultant in Elderly Medicine, Lewisham Hospital. She explained that when an elderly person falls, even a simple fall, will impact on all their functions. There is therefore a particular need for a multi-disciplinary approach as currently enjoyed at Lewisham:

> 'Both physiotherapists and occupational therapists to go into their homes and give adaptations – see how they manage; social care to help them with some of their care needs; and also a period, potentially, a period of rehabilitation'. (p,75)

If the proposals are implemented the integrated care currently offered will be destroyed, which will lead to longer and costlier stays in hospital.

The Panel noted the concerns raised by Captain Nigel Byrne of the Salvation Army in his video testimony, about the effect closure of Lewisham A&E would have on homeless people, particularly those with mental health problems, who may not have the motivation to deal with the extra journeys and delays involved in going to an A&E much further away Captain Byrne reflected on the work of the Salvation Army itself:

> 'As much as we can talk to them, and we can do as much as we can, sometimes people need professional help, they need it quickly and we need to be able to get them to that… ' (p.88)

The Commission also heard about concerns for those who are alcohol- and drug-dependent if Lewisham Hospital were to close. A nurse from QEH pointed out that these patients would 'end up presenting sicker further down the line, costing more money'. (p.89)

The Commission heard evidence from Kathy Cruise, community nurse, on the impact on the health of economically and socially disadvantaged young parents and their

children of relocating maternity services to QEH, 5 miles away from Lewisham, and the risk that such parents would fall through the cracks of the fractured system, with life-long implications for the children and society generally. (p.53)

The Panel was astonished at the lack of consideration given by the Secretary of State to the effect of the TSA proposals on the vital, carefully developed, integrated network of care in Lewisham, which will almost certainly disappear if the proposals go through. The excellent care provided, developed over years, will be impossible to replace. The impact on the most vulnerable residents of Lewisham will be incalculable.

Any replacement system will not be as good and will be absurdly and unnecessarily costly, contrary to the assertion of the Secretary of State that these measures need to be taken to save money.

Reliance on the good work of charities will clearly be an inadequate alternative.

Training

We heard evidence about the training carried out at Lewisham Hospital, which maintains the quality of primary care through training the next generation of GPs and nurses, and the very real risk that losing this function will lead to a dearth of doctors willing to work in Lewisham.

Dr Helen Tattersfield (HT), Chair of the Lewisham Clinical Commissioning Group told the panel

> 'Almost all Lewisham GPs these days have actually come through Lewisham Hospital … If you didn't have the experience of working in Lewisham you probably wouldn't think about working in Lewisham ... We do 90% of the work and if we're not getting good quality GPs into the work – into the situation – what is going to happen to Lewisham?' (pp.59-60)

Dorthe Swaby-Larsen Consultant Nurse, Lewisham Hospital Urgent Care Centre, who as part of her duties is involved in the training of nurse practitioners, reiterated the point: 'If we keep chopping services away and splitting them up, where's the next generation coming from? How are they going to train?' (p.87)

The Panel was extremely concerned about this evidence and the total lack of consideration given to this vital area – finding the future health professionals to work in Lewisham. An admirable record of training will fall victim to these proposed changes.

OVERALL CONCLUSIONS

The Panel was unanimous in its views about the approach taken by the TSA, the NHS Medical Director Bruce Keogh, and the Secretary of State Jeremy Hunt in its dealings with and decisions about Lewisham and Lewisham Hospital.

- 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 – 'the four tests' – 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 you with all medical, dental, and nursing care. Everyone - rich or poor, man woman or child - can use it or any part of it. There are no charges … no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve you of your money worries in times of illness.' *(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 mot
- That patient needs and care are the paramount and determinative factor in healthcare provision.

SUMMARY OF SPECIFIC FINDINGS

The proposal to downgrade Lewisham Hospital

- The decision to downgrade Lewisham Hospital has nothing to do with the provision of healthcare in SE London. Lewisham Hospital's good level of clinical care is admitted by the authorities. The Panel finds the decision deplorable.
- The evidence before the Commission made clear that the flawed attempt at major service reconfiguration, bypassing proper consultation, as conducted by the TSA, is not the way to achieve improvements in quality of care and health outcomes.
-

The NHS

- The evidence pointed strongly to the fact that the NHS is now becoming less universally available, less accountable and currently threatened by extensive marketisation and privatisation.

- The Panel is concerned 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.
- The health of the nation is now a secondary consideration to the vested interests of the bankers, shareholders and corporate stakeholders who, having been invited by Government to invest in the health service, will now seek increasing returns thereby draining the health service of vital resources.

The role of PFI

- The Panel had major concerns about the extent and role of PFI payments for the future of hospitals in the SLHT Trust and the role of PFI in the recommendation by the TSA for closure of services at Lewisham Hospital.
- The Panel's view is that the decision to downgrade Lewisham Hospital is based entirely on economic considerations.

Lack of consultation

- The consultation exercise in respect of the decisions regarding Lewisham Hospital was a sham. In many cases there was none and where it did take place notice was inadequate and objections were overruled or dismissed. The panel was left with the strong sense that decisions had already been made.

Lack of analysis and poor data

- The Panel is extremely troubled by the evidence given in relation to the lack of proper statistics in this debate, which was astonishing.
- Where data existed, its quality and relevance was questionable. On the whole the Panel found there simply had been no proper examination of the needs of Lewisham residents or consideration of the impact the proposals might have.
- The Panel shares the concerns expressed about the lack of analysis into the effect of the changes, in particular where pregnant women will actually choose to go to have their children, and the impact on the chosen hospitals, already struggling with capacity. This omission we consider has implications for costs – it is clear that many of the proposed changes will in fact be more expensive as well as less safe than the current provision.
- The Panel queries the Secretary of State's purpose in introducing the emotive subject of maternal death when that clearly was not a concern in this situation.

Maternity services

- The Panel was extremely troubled by the evidence given in relation to maternity services. Evidence from an exceptionally experienced clinician demonstrated some of the evident dangers for women giving birth, even for ostensibly healthy women who meet the criteria of the Secretary of State's proposals for a midwife-led unit without emergency backup.
- The Panel was also concerned that choice would be seriously reduced for pregnant women in Lewisham, where there are 5000 births per year, 0ver 4000 in Lewisham Hospital. This is contrary to the 'fourth test' for major

hospital configuration which speaks about 'consistency with current and prospective patient choice'. (p.7)

Children's services

- The Panel agreed that the 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 stand-alone paediatric ambulatory care will be expensive.
- The Panel was shocked that children who form over 20% of the Lewisham population were not planned for at all in the TSA proposals.

A&E

- The proposal for a small and safe A&E, with the loss of key supporting services, is a contradiction in terms and clearly does not accord with basic clinical requirements, or the needs of this disadvantaged community. It is not a concept recognised by the College of Emergency Medicine. It places the patient at risk and involves travel to more distant facilities already under intolerable pressure

- In none of the proposal documents is it clear that any consideration was given to this front line service, already under great pressure, and the effects the proposals would have on its vital role in ensuring the safe passage of very ill patients to hospital.

Community networks

- The Panel was astonished at the lack of consideration given by the Secretary of State to the effect of the TSA proposals on the vital, carefully developed, integrated networks of care in Lewisham, between Primary Care, the local authority, LHT's integrated hospital and community services, and the voluntary sector – these will almost certainly disappear if the proposals go through. The excellent care provided, developed over years, will be impossible to replace. The impact on the most vulnerable residents of Lewisham will be incalculable.
- Any replacement system will be less efficient, not as good and will be absurdly and unnecessarily costly.
- Reliance on the good work of charities will clearly be an inadequate alternative

Training

- The Panel was extremely concerned about this evidence and the apparent total lack of consideration given to this vital area – finding the future medical professionals to work in Lewisham.
- An admirable record of training will also fall victim to these proposed changes.

APPENDIX A
LIVE WITNESSES (IN ORDER OF APPEARANCE)

Colin Leys	Professor of Political Economy
Allyson Pollock	Professor in Public Health
Dr John O'Donohue	Consultant Physician, Lewisham Hospital
Dr Donal O'Sullivan	Public Health Consultant, LB Lewisham
Tim Higginson	CEO Lewisham Healthcare NHS Trust:
Dr Helen Tattersfield	GP,, Chair Clinical Commissioning Group (CCG)
Dr Brian Fisher	Lewisham GP
Brian Lymbery	Chair Lewisham Parkinson's Group
Dr Liz Aitken	Consultant for the Elderly, Lewisham Hospital
Dr Chidi Ejimofo	A&E Consultant, Lewisham Hospital
Dave Newman	Son of a patient at the PRUH
Malcolm Alexander	Chair London Ambulance Patient User Group
Ruth Cochrane	Consultant Obstetrician, Lewisham Hospital
Jessica Ormerod	Mother, patient, Lay Chair Maternity Liaison Committee
Toyin Adeyinka	Mother, patient
Anita Downs	Palliative care nurse, LHNT
Sally & Deion Stephenson	Mother and son (patient)
Dr Tony O'Sullivan	Consultant Paediatrician, Director Children's Services, LHT
Joan Brown	Mother of sickle cell patient
Dr Wendy Geraghty	Clinical Lead, Child and Adolescent Mental Health Services (CAMHS)
Dr Louise Irvine	Lewisham GP, Chair Save Lewisham Hospital Campaign

WITNESSES PROVIDING VIDEO TESTIMONY (IN ORDER OF APPEARANCE)

Hazel Waters	Carer
Shannon Hawthorne	Lewisham resident, journalist
Anne-Marie Upton	Lewisham resident, RSPCA nurse
Carol Brown	Former ICU patient
Shakeel Begg	Imam, Lewisham Islamic Centre
Jos Bell	Patient, blogger, campaigner,
Kathy Cruise	Family Nurse Supervisor, Lewisham resident
Mrs Kuldeep Seehra, MBE	Woolwich Sikh Temple
Mrs Avtar Kaur Bilkhu	Woolwich Sikh Temple
Cathy Ashley	Lewisham resident, former carer
Dr Bob Gill	Bexley GP and Bexley resident
Dr Jim Sikorski	Lewisham GP
Dr Somar Segarum	Hindu Temple representative
Carolyn Emmanuel	Counsellor, Campaigner
Dorthe Swaby-Larsen	Consultant Nurse, Lewisham Hospital UCC
Eleanor Beardsley	Lewisham resident, Mother
Nigel Byrne	Captain, Lewisham Salvation Army
Iain Wilson	Lewisham Resident, Psychiatric Nurse, QEH
Maggie Palmer	Child specialist,(Lewisham CAMHS),
Father William Chatterton	All Saints Church, Blackheath

OTHER WITNESSES PROVIDING EVIDENCE

Dr Tina Sajjanhar	Director Paediatric A&E, Deputy Director Children's Services, LHT
Dr Danny Ruta	Director of Public Health, Lewisham Borough Council
Andy Ambler	CEO Millwall Football Club
Bobby Bacic	Chief Physiotherapist Millwall Football Club
David Rome	Rabbi
Sylvia October	Patient

APPENDIX B

TIMELINE OF THE TSA PROCESS JULY 2012 to OCTOBER 2013

July 2012	
13.07.12	**Secretary of State for Health Andrew Lansley appoints Trust Special Administrator to South London Healthcare NHS**
16.7.13	Unsustainable Provider Regime (UPR) enacted. Trust Special Administrator, Matthew Kershaw, put in place. SLHT Trust Board suspended.
16.7.13 - 29.10.12	**Preparation of Draft Report begins** *'The* TSA must rapidly assess the issues facing the organisation, engage with a range of relevant stakeholders, including staff and commissioners and develop a draft report including draft recommendations for consultation.' 75 working days Stakeholder engagement workshops take place: Community based care, acute services, maternity and paediatrics, joint community based care and acute.
October 2012	
29.10.12	**TSA draft report published and proposals announced**
Nov - Dec2012	
2.11.12	**Consultation** The TSA begins a consultation over 30 days to 'validate and improve' the draft recommendations in the draft report. 30 working days
8.11.12	**Save Lewisham Hospital Campaign Public meeting at Lewisham Hospital:** including two overflow venues. 500-700 people **3 TSA public meetings**
24.11.12	**First Save Lewisham Hospital Campaign march**10,000 people
28.11.12	**Save Lewisham Hospital Campaign Public Meeting, Catford Broadway Theatre** 500+ people
5.12.12	**TSA Maternity Model meeting:** called as extra meeting in view of concern re: models in Draft and concern on numbers. Attended by LHT staff and lay-chair of Maternity Services Liaison Committee. Attempt to exclude lay chair & some LHT staff
7.12.12	**Petitions to 10 Downing St** Heidi Alexander MP's petition/Lewisham Healthcare Trust staff petition SE London clinicians, including GPs from the 6 CCG areas
12.12.12	**Matthew Kershaw TSA, Andy Mitchell (Med Direct, NHS London) and Jane Fryer (MD SE London Cluster)** met LHT consultant staff at Lessof Centre, Lewisham Hospital
13.12 12	**Consultation ends** **Save Lewisham Hospital Campaign evening vigil outside the Hospital 4-7pm**
14.12.12	**Final Report** The TSA must use consultation responses to inform the final report to the Secretary of State.
7.1.13 To 1.2.13	**Secretary of State decision period** The Secretary of State has to determine what action to take in relation to the organisation. He must then publish and lay in Parliament a notice containing the final decision and the reasons behind it. The SoS's decision is final with **no right of appeal**; this final decision must be within 20 working days Published by 1 February 2013.

January 2013	
10.1.13	**BBC Question Time:** major discussion on Lewisham Hospital and TSA, with major national interest in media subsequently
14.1.13	**London Ambulance Service PPE forum:** concern expressed and PPE chair agreed to write to SoS Health
16.1.13	**First Bexley meeting of GPs in Bexley CCG**
22.1.13	**First Lewisham Mums, Dads and Buggies protest at the Department of Health**
26.1.13	**Second Save Lewisham Hospital Campaign march** 25,000 people
30.1.13	**Petitions to SoS Health, Dept of Health** Heidi Alexander MP's petition. 51,854 signatures, London and SE London GPs from the 6 CCG areas: 409 signatures
31.1.13	**SoS Health announcement in parliament: Secretary accepts TSA proposals**
February 2013	
14.2.13	**Valentine's Day Mums, Dads and Buggies protest at the Department of Health**
15.2.13	**Friday Lunchtime Rally outside Lewisham Hospital**
16.2.13	**Town centre rally and leafleting, Lewisham shopping centre**
March 2013	**Submission of the legal challenges of LB of Lewisham; and Save Lewisham Hospital Campaign requesting Judicial Review**
7.3.13	**Roll out the red carpet for Boris Johnson, at Catford Broadway, People's Question Time**
16.3.13	**Born in Lewisham event, hands around the hospital**
26.3.13	**Meeting between Boris Johnson, Mayor of London and campaigners, clinicians and Mayor of Lewisham**
June 2013	
29.06.13	**Lewisham People's Commission takes place at Broadway Theatre, Catford, chaired by Michael Mansfield QC**
July 2013	
2-4.7.13	**Expedited hearing of application for permission to apply for JR and substantive application (estimate of 3 days)**
31.7.13	**Mr Justice Silber rules against Secretary of State in favour of Lewisham Council and Save Lewisham Hospital Campaign.** Finds that the proposals for Lewisham Hospital were 'ultra vires' and the views of Lewisham CCG, main commissioners, ignored.
August 2013	
21.08.13	**SoS announces decision to appeal High Court Decision**
14. 09.13	**Save Lewisham Hospital Campaign holds Victory Parade and Party in Ladywell Fields at the back of the Lewisham Hospital**
27.09.13	**Fundraising Victory Dance at Rivoli Ballroom**
28/29.10.13	**Appeal takes place: government appeal turned down**
30.10.13	**Government announces will not take case to Supreme Court**
November 2013	
24.11.13	**Publication of Lewisham People's Commission Report at House of Lords**

APPENDIX C
THE PROCESS OF THE COMMISSION

Given that others may be interested in the process of the Commission – how it was organized and run – we have outlined this briefly. The Commission process was facilitated by a working group of campaign members and a barristers group from Tooks Chambers.

The first step was to approach the Panel Chair and to create the Terms of Reference of the inquiry.

The Commission Panel was formed. It was chaired by Michael Mansfield, QC and included Professor Blake Morrison, author, poet, journalist and South East London resident and Baroness Mary Warnock author of prestigious reports on medical ethics and the education of children with special educational needs.

Terms of reference
The terms of reference of the Lewisham People's Commission of Inquiry were as follows:

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.

A team of barristers from Tooks Chambers volunteered to help pro bono with the work of the Commission in a variety of ways:

- interviewing witnesses and taking statements
- acting as counsel on the day
- assembling and collating documents and statements
- reviewing the evidence

Over 50 witnesses were approached including:

- Lewisham Healthcare Trust staff: doctors and nurses, both hospital- and community-based staff
- Staff from other hospitals
- GPs

- Mental health staff
- Community health workers
- Patients and patient group representatives
- Parents and carers
- Campaigners
- Community representatives and faith leaders
- Expert witnesses

Witness interviews, mostly carried out by trained barristers, took place over a period of 2 months, at suitable locations in Lewisham, where statements could be taken and videoing of statements could be done. A format for statements was provided (see http://www.savelewishamhospital.com/commission-documents/)

On each of four separate days, up to 10-12 witnesses were interviewed and videoed. Statements were written up, checked with the witnesses and signed. A full archive of witness statements can be viewed online at http://www.savelewishamhospital.com/commission-witnesses/

The barrister team of four for the day was identified and a barrister chair appointed. Witnesses were allocated to barristers. A schedule for the day was drawn up. This can be seen at http://www.savelewishamhospital.com/commission-documents/

In addition, campaign member Simone Booth, the Mayor of Lewisham, Sir Steve Bullock and Lord David Owen were invited to speak at the beginning of the Commission.

On the day, all witnesses except one – a hospital doctor on duty – were able to appear. One parent came to give evidence despite having been in hospital with her sick child that very morning.

During the Commission, barristers questioned 22 witnesses on the basis of their written statements, from the 50 who had provided written testimony. Members of the Panel also asked additional questions of some witnesses, and some were asked to provide additional written information.

Excerpts from the video testimony of a further 25 witnesses were heard by the Commission.

Immediately following the Commission, the panel members met and agreed initial conclusions and a draft initial report was published on 4 July 2013.

The entire day was recorded on audio and video.
A DVD of most of the proceedings is being produced. For further information see http://www.savelewishamhospital.com/lewisham-peoples-commission-of-inquiry-2/

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The National Council for Independent Action

Panel Members:
Michael Mansfield QC (Chair)
Baroness Mary Warnock
Professor Blake Morrison

Barristers:
Elizabeth Woodcraft
Nicola Braganza
Di Middleton
Maureen Ngozi Obi-Ezekpazu
Amanda Weston
Bronwen Jones
Abi Moore
James Mehigan
Andrea Becker
Jenny Boswell
Andrea Chute
Melanie Gingell

All the witnesses (listed separately on p.164)

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