Overview and Scrutiny

Review of 'A Picture of Health for Outer South East London'

Statutory Joint Health Overview and Scrutiny Committee

May 2008

Membership of the Statutory Joint Health Overview & Scrutiny Committee:

1. Councillor Sylvia Scott, London Borough of Lewisham (Chair)

2. Councillor Robert Banks, London Borough of Lambeth

3. Councillor Roger Charsley, London Borough of Bromley

4. Councillor Graham D'Amiral, London Borough of Bexley

5. Councillor Janet Gillman, London Borough of Greenwich

6. Councillor Mick Hayes, London Borough of Greenwich

7. Councillor David Hurt, London Borough of Bexley

8. Councillor Adedokun Lasaki, London Borough of Southwark

9. Councillor Chris Maines, London Borough of Lewisham

10. Councillor Helen O'Malley, London Borough of Lambeth

11. Councillor Charles Rideout, London Borough of Bromley

12. Councillor Dr Tony Robinson, Kent County Council

13. Councillor Martin Seaton, London Borough of Southwark

Preface by the Chair

This report represents the formal response of the Joint Health Overview and Scrutiny Committee to the Joint Committee of Primary Care Trusts with regard to their proposals for the reconfiguration of health services in Outer South East London, known locally as 'A Picture of Health for Outer South East London'.

The nature of these proposals is such that there are very significant implications for all of the hospitals and residents in the seven areas covered by Bexley, Bromley, Greenwich, Kent County, Lambeth, Lewisham and Southwark Councils.

The proposals have attracted significant public attention and local opposition. The Committee wishes to make clear its gratitude to all who have contributed evidence, in person or in writing. The Committee would like to thank the 'A Picture of Health' team for their regular attendance and interest in meetings of the Committee.

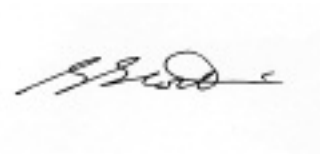
The Joint Health Overview and Scrutiny Committee accepts the need for change in the delivery of health services in Outer South East London and did not spend time questioning this. The view was expressed that it is wrong not to change services when they currently are not the best they could be. Whilst we accept the need for change in the location and delivery of health services across our four boroughs, we are aware that the three options presented will impact differently on different communities in Outer South East London.

We were keen to establish if there was a strong clinical case for change and that the proposals were not financially driven. We also wanted to ensure that any change will be carefully managed and that implementation will happen only when all aspects of the reconfiguration are fully in place. Finally, we wanted to ensure that the residents of our boroughs had been fully and properly consulted, and that their views and the outcome of the Integrated Impact Assessment (IIA) were fed into the decision-making process. We have expressed our concern about the inadequacy of the consultation and the unavailability of the IIA as we completed our work.

We are not yet fully convinced of the merits of the options and therefore do not support any of the options presented by the NHS and look to further information about enhancements that are planned to our primary health care, transport infrastructure, reduction in health inequalities and patient information before commending any of the change options. A detailed implementation plan is required.

This report makes a series of recommendations to the Joint Committee of Primary Care Trusts and the Joint Health Overview and Scrutiny Committee will consider their response and decisions at its meeting on 24th July 2008.

This has been a challenging task, bringing together elected members from seven different local authorities to scrutinise wide ranging proposals. I am grateful to all members of the Committee for their commitment and contribution to this report and the recommendations to the PCTs.



Cllr Sylvia Scott
30th May 2008

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NB Appendices are availably separately at www.lewisham.gov.uk

Executive Summary

This report sets out the results of the work of the Joint Health Overview and Scrutiny Committee (hereafter the JHOSC) on the Joint Primary Care Trusts' consultation on 'A Picture of Health for Outer South East London'.

The JHOSC accepts the need for change in the delivery of health services in Outer South East London (hereafter OSEL) and did not spend time questioning this. We accept that the status quo is not an option.

However, we conclude that the A Picture of Health proposals (hereafter APOH) have been heavily driven by financial pressures.

Instead, as a priority, we look to APOH to deliver improvements in the standard and quality of patient care and improved patient safety, and to enhance the primary care provision that will enable most residents to be treated closer to home.

We welcome the proposal not to close any of the four local district general hospitals, but are concerned at the impact on our residents and health inequalities of the options presented for a reconfiguration of services provided at our hospitals. We perceive that the impact of the reconfiguration of hospital services will vary according to borough, and would want to minimise the negative impact of these changes, especially on the socially excluded and more disadvantaged.

We are concerned at the inadequacy of the consultation and the exclusion of many residents from this process. The presentation of the materials was poor, the options were obscured and the coincidence of the Healthcare for London consultation caused confusion. We are extremely concerned that the Integrated Impact Assessment was not made public at an appropriate time or in sufficient time for the JHOSC to undertake adequate scrutiny.

We need reassurance about capacity, the mix of hospital care, patient flows, transport issues, patient choice and enhanced community provision, including staffing issues and costs, before we can agree the merits of any option.

The JHOSC also seeks a lot more work around projections of capacity, including data from neighbouring hospitals and population projections.

Maternity services need to be addressed in the context of the Healthcare for London (HfL) review before taking forward any APOH proposals in this area. Implementation must take into account the particular needs of excluded and disadvantaged groups.

We commend an integrated approach across primary and secondary care, and between health and social care. However, we believe that more detail is required regarding the proposals around primary care, that there should be more coordination across the health service and adult social care in our boroughs, and that a thorough implementation plan is required. We strongly urge APOH to develop more detailed work at a pre-implementation stage, especially around the development of local health services and public transport.

The JHOSC will scrutinise the integrated impact assessment and make further comment when it is available in July and would welcome the opportunity to consider a detailed implementation plan in due course.

Conclusions and recommendations

R1 The Joint Health Overview and Scrutiny Committee (JHOSC) has significant reservations about the decision of NHS London to allow the Joint Committee to proceed with consultation on these proposals whilst 'consulting the capital' on Healthcare for London. The JHOSC therefore recommends that NHS London outlines the rationale for allowing A Picture of Health (APOH) to proceed. This should be in the form of a report to the next meeting of the JHOSC

R2 The JHOSC recommends that NHS London revisits its protocol for authorising consultations of this scale

R3 The JHOSC recommends that NHS London does not permit two significant consultations affecting the same area to run concurrently

R4 The JHOSC recommends that views expressed on the inadequacy of the consultation document are used to inform future consultations

R5 The JHOSC is extremely disappointed with the distribution of consultation documents and recommends that the Primary Care Trusts (PCTs) develop more robust mechanisms to ensure that consultation documents are delivered to each household and those likely to be affected by the proposals

R6 The JHOSC recommends that all future consultation documents and their questionnaires must achieve the Crystal Mark award for plain English

R7 Given the inadequacy of the consultation documents and initial engagement plans, the JHOSC recommends that NHS London revisits its role and considers how best to ensure that consultation processes reach the intended recipients whilst reflecting best practice

R8 The JHOSC recommends that the views expressed at public meetings and in petitions submitted to local authorities, marches and protests organised by concerned groups, MPs and others are analysed by Imperial College as part of the response to the consultation document

R9 The JHOSC recommends that Local Authorities ensure that all petitions and correspondence received on APOH are submitted to Imperial College for analysis as part of the response to the consultation document

R10 The JHOSC recommends that PCTs refer the development of Urgent Care Centres to local Overview and Scrutiny Committees. If the proposals go ahead, the PCTs should develop a publicity campaign to inform the public of the different range of services available at each site. The campaign should also address the difference between an Urgent Care Centre and Accident and Emergency

R11 The JHOSC is concerned about the fragmentation of children services and the loss of the excellent rated service at University Hospital Lewisham. The JHOSC therefore recommends that children services are retained on all four sites

R12 The JHOSC recommends that the Joint Committee outlines how the reconfiguration of services in APOH will realise further efficiencies

R13 The JHOSC recommends that the reconfiguration of services are driven by the needs of patients and carers as opposed to finance and Private Finance Initiatives (PFIs)

R14 The JHOSC recommends that the Joint Committee provides adequate assurances that the options arrived at were not financially driven

R15 The JHOSC strongly recommends that more detailed work on capacity is carried out before implementation of any option should go ahead. The JHOSC particularly recommends that there should be greater clarity about the services that will be provided by Urgent Care Centres and whether they will be available on all four sites 24/7

R16 The JHOSC requests further information on the workforce requirements of the APOH proposals and how these requirements differ from existing staffing configurations in South East London. This should include detail on the additional skills and training that may be needed to help existing staff to undertake the proposed new ways of working and the expected timescales for recruiting additional staff and to undertake any re-skilling and additional training of existing staff

R17 The JHOSC recommends that proposals are put in place to address particular issues that have been highlighted such as the shortage of midwives before proceeding further with the reconfiguration of services, especially the migration to community based services

R18 The JHOSC recommends that a workforce training and development strategy is developed in consultation with staff, and that a full briefing exercise is conducted with those working in the OSEL health services

R19 The JHOSC recommends that there be some double running of services for some time whilst the transition takes place and the publicity campaign takes effect

R20 The JHOSC is not convinced that the proposals will deliver better choice and services for expectant mothers. The JHOSC therefore recommends the Joint Committee revisits the proposals for Maternity Services in the seven boroughs and requests that the Joint Committee provides additional evidence that illustrates how these proposals will deliver better midwifery services to expectant mothers in Outer South East London (OSEL). This additional evidence should be provided for the next meeting of the JHOSC

R21 The JHOSC is not convinced about the case for and how the changes will impact on the London Ambulance Service. The JHOSC recommends that more detailed work and costings is made available, including how patients will be transported to Darent Valley

R22 The JHOSC recommends that the PCTs ensure that clear protocols are developed to provide guidance to the London Ambulance Service on what can be accepted on each hospital site

R23 The JHOSC recommends that further work is carried out to identify and mitigate the implications of longer journey times for patients especially those using public transport and living in the more deprived wards. The JHOSC seeks details regarding car parking capacity and charges, and travel times between communities and health facilities

R24 The JHOSC recommends that the Joint Committee at the pre-implementation stage have discussions with public transport providers to ensure that routes are available where footfall will increase between communities in OSEL and the range of health and social care providers

R25 The JHOSC would like information on which hospitals patients are likely to use if it is not the local hospital, so that a better assessment could be made on travel times, public transport routes, car parking capacity and car parking charges. The JHOSC also is concerned about patient information, issues around who decides on referrals and transport times should a patient require referral to an acute hospital on a different site

R26 The JHOSC recommends further discussions and the development of more detailed proposals between local authorities, social care providers and the health service around capacity and financial implications of changes to community based care

R27 The JHOSC finds it unacceptable that the Integrated Impact Assessment (IIA) was not made available during the public consultation and recommends that the IIA is presented as an integral part of all future NHS consultations so that the public and stakeholders can make

an informed choice on the proposals presented by the NHS

R28 The JHOSC recommends that an IIA is completed for Lambeth and Southwark and that the outcome of this is used to inform the decision on the reconfiguration of services outlined in APOH

R29 The JHOSC recommends that the APOH team outlines the rationale for limiting the ability of the JHOSC to scrutinise the contents of the IIA. This should be addressed in the Joint Committee response to the JHOSC report

R30 Whichever option is chosen, the JHOSC recommends that the Joint Committee provides evidence about how the decision will tackle health inequalities and provide better services for all residents in OSEL. This should be in the form of a report to a future meeting of the JHOSC

Additional recommendations

R31 The JHOSC recommends that the Joint Committee provides additional evidence to demonstrate that the plans are deliverable. This evidence will assist the JHOSC in reviewing the decision of the Joint Committee

R32 The JHOSC recommends that APOH review its proposals in light of the principles and models agreed through Healthcare for London (HfL)

R33 The JHOSC recommends that the Joint Committee develops a detailed implementation plan which clearly outlines the timescale for delivery. This plan should be easy to read and understand

R34 In the event that local residents are not supportive of any of the options outlined, the JHOSC recommends that the Joint Committee revisits and re-consults on alternative options

1. Background

1.1 The project to redesign health services in the London Boroughs of Bexley, Bromley, Greenwich and Lewisham commenced in December 2005 and is called A Picture of Health for Outer South East London. The review focuses on hospital and out of hospital services and is led by the Joint Committee of the Primary Care Trusts of these four London boroughs in South East London. There has been involvement from West Kent and the London Boroughs of Lambeth and Southwark as their population and hospitals will be affected by these changes.

1.2 The proposals that form the basis of the public consultation carried out between January and April 2008 were set out in a Pre-Consultation Business Case (PCBC) (December 2007.)

1.3 This traces the origins of the project to advice from local clinicians to Primary Care Trusts that the current pattern of service provision would lead to services becoming increasingly unviable, both clinically and economically. This was fuelled by the impact of initiatives such as "Modernising Medical Careers" (2004) and the European Working Time Directive, both of which would restrict the hours the doctors would be available for clinical work. Advances in clinical care and technology mean that more patients can be treated in community settings, and there is an urgent need to address the pattern of hospital care. The PCBC states that some hospital services will need to be consolidated on fewer sites to ensure patient safety and improved patient outcomes, although there is also a commitment that none of the four major hospital sites in the consultation area will be closed. This approach to hospital care will need to be combined with greater partnership with primary, community, mental health and social care services to reduce the need for patients to use hospital based services.

1.4 Although the PCBC emphasises that there is a strong clinical basis for the proposed changes, it also tries to make a strong financial case for change. It argues that while a range of cross-cutting financial initiatives could be implemented under the current arrangements, this will not be enough to bring hospital services in South East London back to financial health. Currently the hospitals are spending £400,000 a week more than they have, and they are spending £5.4 million a year just paying the interest on their £218 million debt. (APOH consultation document p 13). The overspend is increasing daily with the prospect of it reaching almost £57 million every year (by 2010/11), despite planned efficiency savings. Private Finance Initiatives have funded building developments on three of the four hospital sites, introducing additional significant fixed costs for the health economy in Outer South East London. The individual Primary Care Trusts and acute hospital Trusts are separate financial entities, but in developing options for health care provision across four boroughs, there will be a knock on effect of the financial situation of each Trust. The PFI initiatives on three of the four hospital sites have added to the debt servicing burden of the Trusts, and will have influenced the proposed options. The JHOSC concludes that the APOH proposals therefore inevitably have been heavily driven by financial pressures.

2. The proposals

2.1 The four acute hospital trusts in OSEL are the Queen Mary's Sidcup in Bexley; the Princess Royal University Hospital in Bromley; the Queen Elizabeth Hospital in Greenwich; and University Hospital Lewisham. They work closely together, and their medical directors led the discussions to develop options for the design and reconfiguration of services across OSEL but without being site specific.

2.2 APOH states that these plans for radical changes were led by clinicians not accountants, and sought a shift from secondary to primary care, expressing a view that there was too much hospital activity in Outer South East London and that patients could be better dealt with in the community (should facilities be available).

2.3 It argued that approximately 100 clinicians had a high level of consensus on having specialist acute services on two main sites in the interests of patient safety and to ensure that they would see enough patients per year to achieve better results. Alongside this they proposed that urgent care centres and out-patients would be located on all four sites, with community services being developed to support people nearer home.

2.4 A Picture of Health was designed to integrate suggestions from the acute trusts with the development of out of hospital services. Clinical and economic issues in OSEL meant that APOH seeks to secure a *"stable platform of acute hospital service provision"*, whilst ensuring that general practice and community services provide robust high quality services. The intention is that urgent care centres and other alternatives would offer patients *"improved access to the health professionals and services that can best treat them"* whilst reducing the need for and pressure on Accident & Emergency (A&E). Priorities were quality of care, patient safety and service improvement. In providing health services and social care for people in their home through to highly specialised care, it was understood that it might mean travel within or outside OSEL to receive optimal care and that integration of care would be critical. APOH agreed that there was not an option to do nothing, for both clinical and financial reasons. Efficiency drives are underway, but are not enough to address the financial deficit.

2.5 The proposals stressed that there would not be hospital closures but the redesign, redistribution and improvement of hospital services. APOH is clear that urgent changes are needed now, alongside a five to ten year vision, with an integrated plan to optimise resources.

"Changes in the hospital sector will be extremely difficult without appropriate changes in the community, some of which will need to precede changes in hospital services". *Alberti Review*

2.6 Initially 23 options were considered and after clinical and financial modelling and preliminary consultation were reduced to three options. These were set out in a business case by the Joint Committee of the PCTs (hereafter the Joint Committee).

2.7 In October 2007, the London Strategic Health Authority asked the National Clinical Advisory Team through Professor Sir George Alberti to review the project and advise if the three models and the options within them would be clinically safe and feasible, before consultation would begin. He concluded they were clinically sound, even though the environmental issues and the specific needs of the boroughs were not taken into account by the clinicians.

"Each of the options identified in the proposals have travel implications for most patients and carers" *Alberti Review*

2.8 Under all three proposals, Accident and Emergency services would be closed at Queen Mary's Hospital, Sidcup, but retained at the Queen Elizabeth Hospital and the Princess Royal Hospital (the hospitals with the largest PFIs).

2.9 The largest variations within the three options affect University Hospital Lewisham, which would retain full Accident and Emergency services in only two of the three options. One of the options would lead to the loss of the A&E and non-surgical emergencies. In two of the options, UHL would not carry out emergency and complex surgery or trauma surgery. In two options, the excellent rated children's services would close, being reduced merely to more limited assessment and treatment services. In two options, the doctor-led maternity unit with intensive care for babies would go, and there would not even be a mid-wife led birthing unit.

2.10 QMS would lose its A&E, its non surgical emergencies, its emergency and complex surgery, its trauma surgery, its children's services and its doctor led maternity unit with intensive care for babies and its midwife led birthing unit.

2.11 PRU and QEH would lose planned surgery and planned orthopaedic surgery, and children's assessment and treatment services.

2.12 The proposals, including the three options, were put out to public consultation between 7 January and 7 April 2008. Imperial College has been asked to evaluate and report to the Joint Committee in June on the findings from the consultation. Alongside this, the proposals are being evaluated through an Integrated Impact Assessment, which will report to the Joint Committee. At this point, the Joint Committee will make its decision on the most appropriate way forward.

2.13 Alongside this work, the JHOSC was taking evidence, consulting on and evaluating the proposals on behalf of the residents of the four London boroughs most affected by APOH. Members became particularly concerned about the consultation process, the impact of the proposals on emergency and urgent care, planned and emergency surgery, maternity and newborn care, children's services, health care in the community, the financial case for change, capacity issues and patient flows, workforce issues, patient choice, transport and accessibility, the interface between adult social care and health care, and health inequalities.

3.Joint Health Overview and Scrutiny Committee (JHOSC)

3.1 The NHS is compelled by the Health and Social Care Act 2001, the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002, and the Secretary of State for Health's Direction of July 2003 to consult local overview and scrutiny committees about any planned substantial developments and variations to NHS Services. OSCs seek to examine thoroughly the nature of the proposed changes in order rigorously to assess whether the changes would result in a more effective health service for the local community.

3.2 The Joint Health Overview and Scrutiny Committee was set up under the Health and Social Care Act 2001 to act as the statutory consultee for the NHS public consultation on the future of health services across outer South East London. It operates for a limited time and will end when the NHS formally reports its decision on the outcome of consultation, unless the Committee chooses to refer the service reconfiguration to the Secretary of State for Health.

Specifically the terms of reference of the JHOSC are:

1) To undertake the functions of a statutory joint health overview and scrutiny committee in accordance with sections 7 and 8 of the Health and Social Care Act 2001 and associated regulations and guidance.

2) To consider and respond to NHS proposals for the reconfiguration of health services in Outer South East London (A Picture of Health).

3) To scrutinise the consultation process.

The JHOSC has the power to refer to the Secretary of State for Health on the following grounds:

- Where the JHOSC is not satisfied with the content of the consultation or that sufficient time has been allowed for the consultation or;
- Where the JHOSC considers that the proposals are not in the interests of the health service in the area.

There is no right of appeal against the decision of the Secretary of State.

The JHOSC was based on the following assumptions:

a) That the need for change in the delivery of health services in Outer South East London is established and generally accepted and that the Joint Health Scrutiny Committee need not spend further time in examining the need for change.

b) That the Joint Health Scrutiny Committee is constituted to respond to the NHS consultation document and the proposals it contains, as well as comment on the public and patient involvement activity in which the NHS has engaged in relation to this matter.

c) That the Picture of Health Project Board and Project Council (henceforth 'the Project Board') will permit the Joint Health Scrutiny Committee access to the outcome of the public consultation phase prior to the formulation and submission of the Joint Committee's response to the public consultation.

3.3 The JHOSC comprised of two Members from each of the London Boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark. West Kent participated in the APOH process because of the number of residents using Queen Mary's Sidcup Hospital. Similarly the London Boroughs of Lambeth and Southwark were involved because of patient flows to and the possible impact on Guys and St Thomas' and Kings College Hospitals.

3.4 On 30 October 2007, the JHOSC requested early access to information to enable full scrutiny of the proposals and consultation to be possible. The JHOSC expected the APOH Project Board and Council to give it access to the outcome of public consultation before the JHOSC has to formulate and submit its response.

3.5 Meetings took place in public and received briefings and updates from:

- Professor Sir George Alberti, National Director for Emergency Access, NCAT
- Dr William Cotter, GP Group
- Gill Galliano, Chief Executive, Lewisham PCT
- Oliver Lake, Communications and Engagement Lead, APOH
- Simon Robbins, Responsible Officer, A Picture of Health and Chief Executive of Bromley PCT.
- Michael Chuter, Chair of the Joint Committee
- Professor Rifat Atun, Imperial College, London
- Professor Sue Atkinson, Matrix Insight
- Paul Murray, Operational Research in Health Ltd
- Usman Khan on behalf of AEA Technology Ltd

The JHOSC heard evidence from the following witnesses:

- Greg Russell, Programme Director for Adult Social Care & Health Modernisation, LB Lewisham
- London Ambulance Service
- London Region of the Royal College of Nursing (Operational Manager)
- Patient and Public Involvement Forums
- Royal College of Midwives

3.6 Written information also was supplied to the JHOSC. Information was shared with the local OSCs who in turn passed information to the JHOSC as appropriate, enabling cross borough joint scrutiny. Boroughs shared their own responses to the APOH and raised questions for clarification. The JHOSC has taken into account the views of the boroughs' local health overview and scrutiny committees. It recognises that the proposals contained in APOH will impact differently on different areas and communities, and therefore offers a commentary on those different impacts, whilst coming to a joint conclusion about the proposals and consultation overall. In addition, key points from local health overview and scrutiny reports are appended to the JHOSC final report.

4. Consultation Process

4.1 Whilst responding to the NHS consultation document and the proposals within it, the JHOSC also comments on the public and patient involvement in the consultation and proposals.

4.2 An expert panel of public participation and involvement advisers had been appointed to prepare materials for consultation, and a series of events were held to test the approach. Imperial College was commissioned to examine the consultation materials and analyse the results. Consultation was to be on more than one model.

4.3 It was intended that the main materials for the consultation would be easy to understand and that detailed working papers also would be available. A commitment was made that the consultation document would be in plain English, but the Crystal Mark was awarded for the questionnaire only and not the document. It also was tested with PPI groups before going out to public consultation. A range of materials was produced including a booklet, newspaper advertisements advising from whom the public could obtain the consultation documents and the website. The business case and the consultation draft were available for public consultation.

4.4 The JHOSC is aware that PCTs in London were holding a consultation during the winter of 2007/8 on Healthcare for London : A framework for action. It covers the principles and models of care for London's health service over the next ten years. The JHOSC is aware that NHS London had been clear that no consultation on changes to services should proceed during HfL's consultation unless there is an "urgent need to resolve clinical and/or financial pressures". However, both the Joint Committee and NHS London agreed that consultation could proceed on both grounds. Given the duty to ensure safe services by local hospitals, the clinicians view had been given that changes were necessary and urgent. They felt that if APOH was put on hold until the HfL consultation was concluded and implementation of models proceeded, they could risk making services less safe and be forced to make unplanned emergency changes. Aware of the deteriorating financial position of hospitals, they feared more unplanned changes. They felt that no change at this point was not an option, so sought to ensure appropriate consistency between the two consultations. It understood that local PCTs are working closely with the HfL team to ensure that models of care that APOH are proposing are aligned to the HfL principles.

4.5 However, the JHOSC is concerned about the parallel consultations and feels that presenting both consultations together has caused confusion and a lack of clarity about the options. A council leader expressed the view that the parallel consultations have been confusing and inappropriate and that residents have been unclear about the implications of the separate consultations. The validity of APOH service and site specific proposals were questioned when Healthcare for London principles and models of care and delivery for the next ten years have not been agreed. We suggest that this confusion has resulted in far too few responses to both consultations, with just over 5,000 responses to Healthcare for London and 7,500 to APOH.

4.6 An example of the confusion that this could cause to residents is the lack of clarity of language, such as the unclear distinction between the polyclinics advocated by HfL and the borough hospitals proposed by APOH. The JHOSC has sought clarity as to whether polyclinics and borough hospitals are the same. Responses included the distinction between a borough hospital being on one site, whereas a polyclinic may not be, but could be a number of 'networked' GP practices linked to a 'hub'. Similarly, the borough hospital would have beds and would care for patients with more complex conditions including beds for

intermediate care. A polyclinic would carry out only minor procedures, whereas a borough hospital could carry out planned surgery and would have a more sophisticated range of clinical support services. The staff types would be quite different. These changes will require further scrutiny by the JHOSC and local overview and scrutiny committees as details emerge.

4.7 The JHOSC understands that planning to implement the outcomes of HfL was due to start in the spring/summer of 2008, and feels that further consultation is needed on detailed local plans arising out of the HfL consultation and that have a bearing on APOH.

Recommendations:

R1 **The JHOSC has significant reservations about the decision of NHS London to allow the Joint Committee to proceed with consultation on these proposals whilst 'consulting the capital' on Healthcare for London. The JHOSC therefore recommends that NHS London outlines the rationale for allowing APOH to proceed. This should be in the form of a report to the next meeting of the JHOSC**

R2 **The JHOSC recommends that NHS London revisits its protocol for authorising consultations of this scale**

R3 **The JHOSC recommends that NHS London does not permit two significant consultations affecting the same area to run concurrently**

Pre–formal consultation phase

4.8 Prior to the formal public consultation of the proposals arising from APOH, there had been informal consultation and liaison on the principle of changes in local health services. Providers had listened to local people's views on health services, their current experience and their priorities for service development. Hospital based clinicians and doctors and nurses in the community were involved in considering how services can be developed to treat more people closer to home and to keep them healthy, thus reducing the need for hospital admission. Informal consultation took place with the chairs of borough overview and scrutiny committees and Patient and Public Involvement (PPI) groups. There were local stakeholder briefings and discussions. Patient access and experience were considered through consultations and meetings with the public. The JHOSC understand that the public were involved in setting criteria to help to short-list the options, but the lack of PPI involvement in workstreams was criticised.

4.9 Issues of the fit between hospital and community based health services, capacity and budget were considered at public meetings and a workshop for members of the public. These outcomes were used to inform the final options to go out to public consultation. These preliminary conversations were not site specific but addressed the question of how to meet the hospital needs of the one million people resident in the Outer South East London area as a whole.

4.10 As author of the LSHA commissioned review of proposals, Professor Sir George Alberti offered to talk to patient groups and medical staff after the report was published.

4.11 The JHOSC was not invited to comment on the draft consultation materials before they were approved by the Joint Committee .

4.12 The JHOSC received the Joint Committee's APOH initial engagement plan on 14 January, and reviewed the consultation plan on 22 January and 4 March 2008. The consultation document and questionnaire had been published on the web and printed before that meeting on 7 January. The JHOSC heard that the engagement plan evolved due to feedback received eg filling gaps and responding to

phone requests and placed newspaper adverts to publicise from where to obtain the consultation literature.

Formal Consultation

4.13 The JHOSC is concerned that the consultation on APOH was inherently flawed and questions the ability of this consultation to offer a clear representation of the views of residents of South East London.

Public Engagement

4.14 Local PCTs developed consultation and engagement plans which guided activity during the formal consultation period. The plans covered engagement activity across the four Boroughs and included individuals and groups from a range of key stakeholders. Core to this activity were four consultation events held in each of the Boroughs. A dedicated office, phone line and email address for the APOH project team were also established as key communication links. However, it became evident as scrutiny continued that many people did not know about the public meetings and stakeholder events.

4.15 The JHOSC supports the attempts to engage with local stakeholders through workshops, road shows, attendance at public meetings and briefings with specific groups and individuals. An update of the progress in implementing the plans was reported to the JHOSC on 4 March.[1] Further clarification is sought on the ways in which the PCTs have sought to engage with under represented groups such as people with low literacy, single parents, homeless people and asylum seekers and refugees,[2] as part of the formal consultation process.

4.16 The JHOSC's main concerns rest with the consultation documentation as a key component of public engagement.

Consultation Documents

4.17 The JHOSC has significant concerns about the clarity of the consultation document and the questions posed in the accompanying questionnaire, which are the basis for the public consultation on APOH. In evidence submitted to the JHOSC, similar observations have been made by the Children and Young People Select Committee (LB Lewisham), Delivery of NHS Services Scrutiny Sub-Group (LB Bexley), Greenwich and Lewisham Pensioners Forum, the National Childbirth Trust (Lewisham and Greenwich Branch), and a group of 23 consultants from QMS[3]. The JHOSC is not convinced that meaningful conclusions can be drawn from these consultation materials.

Questionnaire

4.18 A key aspect of any consultation is choice. However, there is only a single choice for the future delivery of services at the PRUH, QEH and QMS and the outcomes for these hospitals have been pre-determined. The consultation document further states that no change is not an option. The actual existence of public consultation on the future delivery of services at these hospitals can therefore be questioned. Additionally, there is limited space on the questionnaire for respondents to detail any concerns they may have, or to propose alternative options.

4.19 The JHOSC notes that a number of questions in Part One of the questionnaire are leading. They are worded to promote the positive aspects of the proposals, but do not set out the less positive aspects which may be associated with them. People could respond to these questions without realising the implications of their response. In 1.2 for example, people might wish to see a separation of planned and emergency surgery, but not if this means the loss of A&E services from their

local hospital. The question does not make this link clear.

4.20 The JHOSC also remains concerned that the questionnaire does not readily relate to the options detailed on pages 10-15 of the Picture of Health consultation document. The consultation document presents the options in terms of the services that will be delivered on each site. However, part 3 of the questionnaire focuses on a number of issues such as transport and hospital infection. It is difficult for respondents to link the choices they are invited to make in the questionnaire to the consultation options and the subsequent impacts on the delivery of services across the four acute sites in Outer South East London.

4.21 Professor Rifat Atun, representing Imperial College, gave evidence to the JHOSC[4]. Imperial College had been commissioned to produce a consultation questionnaire and to analyse the responses to the consultation. Professor Atun explained that Imperial College had not drafted the consultation document, which had been produced separately to the questionnaire. Professor Atun acknowledged that the questionnaire instead *"…worked with the implications of the scenarios presented by clinicians"* and was not based on the specific detail included in the consultation document.

4.22 The JHOSC feels that this evidence confirms its reservations about the efficacy of the consultation documents. It is difficult to understand how residents can be asked to complete a questionnaire which bears little resemblance to the consultation material accompanying it, and how any meaningful conclusions can therefore be drawn from this consultation.

Complexity of consultation materials

4.23 The JHOSC further notes that a number of local residents contacted their ward councillor as they did not understand the consultation document and were unsure how to complete the questionnaire. Members of the JHOSC representing LB Bromley reported the need to hold ward meetings with local residents to go through the consultation document. Other JHOSC Members reported similar contacts from residents. The APOH project team reported a number of contacts from residents who had found the document complex and confusing.

4.24 It is noted that following the number of concerns which had been raised, including a letter sent by the Leader of the London Borough of Bexley to the Chair of the Joint Committee and the Secretary of State, the APOH project team took steps to make available an 'easy to read' version of the consultation document. This attempted to clarify and offer an alternative explanation of the options. However, this was only available on the 'A Picture of Health' website and thus its accessibility was limited.

4.25 Furthermore, the JHOSC does not find it satisfactory that the consultation document, upon which respondees would base their responses to the questionnaire, did not receive a Crystal Mark approved by the Plain English Campaign. The document's lack of clarity appears to be reflected by comments that the JHOSC, local councillors and the APOH team have received from local residents. It is also possible to suggest that residents' confusion and the complexity of the document led to the low response rate.

Delivery Issues

4.26 Whilst the JHOSC has been assured by the APOH project team that robust delivery mechanisms were in place alongside effective quality assurance of distribution, the JHOSC remains unconvinced that all households in Bexley, Bromley, Greenwich and Lewisham (and parts of Southwark and West Kent) have had access to the consultation document.

4.27 The JHOSC was informed in a written report that as of 20 February 2008, 485 enquiries had been received via the dedicated consultation phone line and email account and that *"A large majority of these contacts were document requests or issues with document distribution"*.[5] As of 12 March 2008, the number of enquiries totalled 1,020.[6] Similar delivery issues were reported by all Members of the JHOSC.

4.28 The JHOSC was also aware of cases where deliveries of consultation documents had been left by communal entrances to flats (for example Coylers ward in Bexley) and of significant areas within South East London (for example Orpington) which did not appear to have received deliveries of the consultation documents. As an example, at a meeting in Mottingham of 220 residents, only five appeared to have received the consultation documents[7].

4.29 This is contrary to the assurances given to the JHOSC. It is noted that where such cases were reported to the APOH project team, re-deliveries of consultation materials were arranged. However, the JHOSC remains unconvinced that the delivery process was robust and notes that the reported cases of missed delivery may only be a small fraction of the actual total.

Responses and Analysis of Consultation Outcomes

4.30 At a meeting on 24 April, Professor Rifat Atun (Imperial College) reported that 7,500 postal questionnaires had been returned[8] as part of the formal consultation. This equated to a 0.79% response rate, which was low but in line with similar consultations.

4.31 Whilst it is recognised that 0.79% is comparable to similar consultations, it is not acceptable that such a response rate is merely dismissed as 'the norm'. This consultation has clearly either not reached the people it was aimed at, or people were not engaged in such a way that they felt able to respond to the consultation.

4.32 The JHOSC queried how the responses to the consultation would be analysed and whether the responses were weighted to take into account the different sizes and socio-economic compositions of the boroughs. Professor Atun stated that this was not done, but the responses for each borough could be analysed. Responses could be broken down by postcode (down to the first three or four numbers) to be analysed ward by ward[9].

4.33 Imperial College would be analysing responses objectively and in detail and establishing why people chose particular options. Professor Atun noted his aim was to present an objective picture of the public's views[10].

4.34 Professor Atun noted that formal responses to the questionnaire should be considered as part of a larger process of consultation and engagement. Individual written responses would be analysed word for word. Petitions and other materials that had been sent to Imperial College would be analysed and would form part of the report.

4.35 Following these comments, the JHOSC observed that marches had been held in Bexley and Lewisham and that a petition of 8,000 signatures had been gathered in Bexley. Also many public and ward meetings had been held across the boroughs where members of the public had voiced their views. The JHOSC is concerned that the outcomes of these activities are fed into the analysis of public opinion and seeks assurances that they will be given appropriate weighting in the report that is produced by Imperial College.

4.36 The JHOSC concurs with the view expressed by Professor Atun that, whilst this was not his decision, *"if people did not agree on a way forward then the project might have to go back to the drawing board"*[11].

4.37 The JHOSC had been advised that the Integrated Impact Assessment would be published in early May and would inform the decision-making on the options being taken forward. However, it was not available at the time intended and the extracts considered on 20th May arrived too late for the JHOSC to give full consideration to the issues before having to respond to the Joint Committee. We find it completely unacceptable that the completed IIA will be published in July.

Recommendations:

R4 **The JHOSC recommends that views expressed on the inadequacy of the consultation document are used to inform future consultations**

R5 **The JHOSC is extremely disappointed with the distribution of consultation documents and recommends that the PCTs develop more robust mechanisms to ensure that consultation documents are delivered to each household and those likely to be affected by the proposals**

R6 **The JHPSC recommends that all future consultation documents and their questionnaires must achieve the Crystal Mark award for plain English.**

R7 **Given the inadequacy of the consultation documents and initial engagement plans, the JHOSC recommends that NHS London revisits its role and considers how best to ensure that consultation processes reach the intended recipients whilst reflecting best practice**

R8 **The JHOSC recommends that the views expressed at public meetings and in petitions submitted to local authorities, marches and protests organised by concerned groups, MPs and others are analysed by Imperial College as part of the response to the consultation document**

R9 **The JHOSC recommends that Local Authorities ensure that all petitions and correspondence received on APOH are submitted to Imperial College for analysis as part of the response to the consultation document**

5. The Future of Services in South East London – Impact of the Proposals

5.1 The pre-consultation business case assembled the argument on the type of change proposed for Outer South East London. Whilst options will not result in any hospital closures, there will be a redesign and change in usage across the four sites.

5.2 The JHOSC agrees with the no closure proposal, but is concerned at the prospect of a reduction of services provided at two of the hospitals. We are concerned about issues to do with access, journey times, cost and inconvenience to residents, confusion, capacity, reductions in service and subsequent pressures on remaining services. We are also concerned about the lack of detail or costings for the development of community based services or the proposals to integrate further health and social care.

"Plans should encompass the principle that no fewer people should be treated in their local hospital than at present, but the services offered will be different and safe". *Alberti Review*

Emergency and Urgent Care

5.3 The APOH proposals will result in an overall reduction in A&E services in Outer South East London. This will lead to even greater pressure at sites already stretched and struggling to meet the standard of 98% of patients seen within four hours. The loss of A&E at QMS and possibly at UHL, which are easily accessible to local residents, will therefore have a negative impact and will not provide a better A&E service for all residents of South East London. The A&E service at UHL for example currently receives the highest number of patients of the acute trusts forming part of the APOH review. It is difficult to conclude that remaining sites could cope with the displacement of patients from this site should the A&E service be removed. Furthermore, the proposals will have a significant impact on the role of the London Ambulance Service (LAS).

5.4 The JHOSC asked that if there is a minimum number of 450,000 people to be served by an A&E service, is there also a maximum? We heard that the Royal College of Surgeons advises a preferred catchment population of 450,000 to 500,000 but recognises that 300,000 is more realistically achieved. There is no maximum. Reducing the number of acute hospitals to two or three for a combined four borough population of one million would be in line with that catchment number. However, we are concerned at the impact on journey times and patient awareness if A&E is removed from two sites.

5.5 The JHOSC similarly has reservations about the downgrading of A&E services and what this might mean for residents seeking emergency care, particularly out of hours. Whilst we would wish to ensure that care pathways are developed which help to prevent patients making unnecessary journeys to an A&E, there needs to be a very clear public understanding of the appropriateness of services delivered at an Urgent Care Centre. To self refer to the right location requires individuals to be well informed and able to obtain good information. The variation in hours of opening and different availability of services has the potential only to create confusion.

5.6 There is not sufficient understanding amongst the public of the differing role and functions of A&E and urgent care. In many cases, if a person is unsure they will present themselves to the nearest A&E department. Conversely, if a person with chest pains arrives at an urgent care centre because it is located on a hospital site closest to them and upon assessment has to be transferred to another hospital site for emergency care, one could question whether this route provides the best clinical outcomes for that patient.

5.7 If a person is taken to an A&E and then requires admission to hospital, this itself will create further pressures. Young families and

older people may struggle to visit family members in a hospital that is not easily accessible and local to them. The costs of accessing an appropriate level of care will be transferred onto patients and their families, and will have a particular effect on those already less able to meet those costs. It is difficult to see how this provides a better service.

5.8 The location of Urgent Care Centres (UCCs) on each hospital site is noted and welcomed. However, there is little detail available on the types of services that will be available at each site. Moreover, no detail is available on the staffing mix, when particular types of staff would be available and access to specialists. Further detail is required to allow the JHOSC to understand the proposals in more detail and to make a judgement as to whether they will offer an improved service to residents of South East London.

5.9 It is difficult to see how the proposals for urgent and emergency care will provide an improved service for South East London residents. Evidence suggests that they will lead to a reduction in services and increase pressure on those that remain. Urgent Care Centres may not always be a viable alternative and confusion as to their role and the services they offer may not lead to the required reduction in A&E attendances upon which the proposals are based.

5.10 It could be suggested that these proposals are based more upon medical staffing and financial considerations than the desire to provide improved services for residents in Outer South East London.

Planned and Emergency Surgery

5.11 The argument used as the basis for these proposals is that the separation of planned and emergency surgery will help to reduce the spread of hospital acquired infections and the number of cancelled operations. These arguments are noted and any steps that can be taken to reduce these incidents are welcomed, such as robust infection control procedures. However, the consultation suggests that these things can only be reduced by splitting planned and emergency surgery across hospital sites. This then has implications on the accessibility of A&E services, as under the proposals, A&E services will not be provided at sites alongside planned surgery. The possibility of splitting planned and emergency surgery on each acute site does not appear to have been explored[12] and the JHOSC seeks further clarification on this as an option.

5.12 There is no detail on whether specific hospital sites would focus on different specialities and thus where people might go for different forms of surgery and how this could be accessed. This information is needed for the JHOSC and any other respondents to this consultation to be able to make a judgement as to whether the proposals will deliver improved local services and better quality care for the residents of South East London. The JHOSC requests that further information on the site specific details of surgical services is provided.

Maternity and Newborn Care

5.13 The proposed cross-borough concentration of maternity services is depicted in the consultation documents as providing only benefits. It is promoted as enabling twice the number of senior doctors to be located at the one unit. As this would follow the closure of another unit, however, the numbers of women attending the combined unit could similarly double and therefore counterbalance the expected advantage of additional consultants. Local maternity services are already under pressure but whilst the modelling for maternity is predicated on hospital developments being accompanied by developments in out of hospital care and local provision, the APOH

Programme Team has not yet been able to provide an iteration that takes into account the number of expectant mothers choosing a home birth, a key component of the model.

5.14 Evidence submitted by the Royal College of Midwives (RCM), states that the removal of services *"will reduce the quality and accessibility of maternity care, which will limit the choices available to women and their families [in South East London]"*[13]. Based on the evidence it has received, the JHOSC is unconvinced that the proposals will provide higher quality care and better services for all residents of South East London and believes that the proposals will only serve to exacerbate the inequalities experienced by some residents.

5.15 The demographics for OSEL do not easily support the concentration of hospital maternity services proposed under APOH. For example the JHOSC heard that there has been a 40% increase in births in Lewisham since 2000; and Lewisham and Greenwich have the highest fertility rates in the sector, reflective of the high levels of deprivation and diversity in those boroughs. It is not surprising therefore that the Royal College of Midwives is *"alarmed at the proposal to leave women in Lewisham with no maternity unit"* and is supportive of some form of maternity unit in each borough. Nor did RCM in its evidence to the JHOSC consider that the proposals will address the midwifery recruitment and retention difficulties, so making us question how the Trust might deliver on increased community provision and home births. With an ongoing population increase forecast and the current shortage of midwives in South East London there is inadequate assurance that services in other local hospitals would not be pushed beyond the demands on current limits.

5.16 Moreover, the proposals appear to be in contention with a range of national and local policies. Fundamentally, the proposals remove local choice for women in Bexley and possibly Lewisham of where they give birth. This contradicts the vision for maternity services set out in *Maternity Matters* and the *National Service Framework for Children, Young People and Maternity Services (NSF) and Healthcare for London*[14], which all promote local choice. The proposals for maternity services will not provide better services for people in South East London. Choices will be limited for women who want to give birth in a local hospital and there will be no local choice for women in Bexley and possibly Lewisham.

5.17 There is also concern that these proposals are based on financial medical staffing considerations rather than improving services for local people[15]. The proposals in APOH appear solely based on the perception of giving birth as a medical event, which is a core argument running through the submissions from the RCM and the National Childbirth Trust (NCT). Evidence received by the JHOSC suggests that Midwife Led Units (MLUs) give an opportunity for low risk mothers to give birth in their local hospital and for continuity of care before and after birth. It appears that other, perhaps financial and staffing, constraints are preventing MLUs as a local birthing choice being available on the four acute sites in South East London. It is not based on aspirations to provide higher quality care or 'normality' for the majority of women who are low risk and will experience a normal pregnancy and child birth and will not require medical intervention.

5.18 Evidence also suggests that the proposals could have a negative impact on health inequalities, a view that is expressed by the RCM and the NCT in their submissions to the consultation. It should be noted that Lewisham in particular is an area of relatively high social and economic deprivation. There are links between high levels of deprivation and increased mortality, morbidity and more complex births and the RCM believes that *"the loss of consultant obstetric services at*

Lewisham will have a negative impact on tackling health inequalities in the borough…centralising services at Bromley and Greenwich will transfer social costs…and economic costs…to women and their families"[16]. It is therefore difficult to see how the options seek to provide a better and more equitable maternity service for all residents across South East London.

Children's Services

5.19 These proposals will see a reduction in children's inpatient services, which will be delivered at PRUH and QEH, and possibly UHL. Children's assessment and treatment services will be available at QMS and possibly UHL depending on the option implemented. The pre-consultation business case offers many reasons as to why this reconfiguration should occur and the arguments will not be rehearsed here[17].

5.20 The JHOSC needs more assurances about children's health services, and whether services overall would be enhanced or reduced and seeks detailed implementation plans to work out the size of the paediatric A&E available in neighbouring hospitals.

5.21 There is concern that the proposals would reduce the availability and quality of services to children in South East London. Well regarded paediatric provision exists on those sites which may see a downgrading of the children's services they provide.

5.22 Although it is recognised that some centralisation of specialised inpatient care may be advantageous, it is noted that not all children require specialist inpatient care. Sometimes that may need to be admitted for simple observation. Moving all paediatric inpatient provision to fewer sites may restrict families' ability to visit their children and in non-specialised cases, may not provide any better clinical outcome. It is difficult to conclude therefore that this provides a better local service.

5.23 Without being site specific, the proposals to offer Paediatric Ambulatory Care and Child Development Centres could be regarded as a positive aspect of this consultation. However, it is important that this does not mean that children and their families will see a reduction in the availability and quality of service provision across South East London. QMS have already expressed their astonishment at the description of the assessment and treatment services planned for the hospital as an improvement to existing paediatric services.

5.24 Furthermore, the JHOSC has no assurance that experienced paediatric staff cover will be available 24 hours a day, so that parents can feel confident that quality paediatric care is available at their local hospital. Concerns that this level of care is not available locally could create further pressures on the ambulance service and already pressured and consolidated A&E units, as parents seek assurance that their children will receive the same or improved level of care as they do now.

Better Care in the Community

5.25 The pre-consultation business case provides some detail as to the types of services that might be delivered in community settings. As a principle, the JHOSC welcomes such proposals to bring care closer to residents, at times and locations more convenient to them. This could help to create better quality, local care for residents of South East London. However, there are a number of concerns that the JHOSC feels should be highlighted as they may impact on the success of the proposals in offering improved services to local people.

5.26 The consultation document states that the NHS is proposing to increase local hospital services **and** improve care provided in the community[18]. This is clearly not the case across

South East London, as there are proposals to consolidate key hospital services on fewer sites. Therefore it could be suggested that there will not be improved care overall, but rather the same or fewer services delivered in different settings.

5.27 It is recognised that the success of the APOH proposals for hospital services relies strongly on effective joint working with local authorities to deliver care in community settings. It is somewhat surprising therefore that local authority social care departments appear to have had limited involvement in the APOH project from the outset. The JHOSC would expect that links will be strengthened as and when any proposals are taken forward. The JHOSC would anticipate that there will be close collaboration on working up more detailed options, financial modelling and needs analysis leading to a joint project plan, developed by local authority social care departments and the local health service providers.

5.28 Although there is some information on the types of services that might be delivered in community settings, there is little detail as to how identified services will be developed and put in place. It is imperative that these services are put in place and their success monitored before services are taken out of hospital settings. There should be no service gaps during transition.

5.29 The success of community services requires the right workforce to deliver them. In evidence received by the Royal College of Nursing (RCN), it was noted that workforce training development will be required[19]. The JHOSC requests assurances about how the existing workforce will be equipped with the skills required and estimates of anticipated additional workforce requirements for the expansion of community based services.

5.30 The JHOSC is supportive of steps to make intermediate care more accessible to those who need it. However more information is required as to how this would be provided across South East London. It could be suggested that intermediate care located on one hospital site (as suggested in the consultation) could be regarded as a reduction in service rather than an enhancement.

5.31 Steps to bring more outpatient clinics into local hospitals and other settings would assist in providing high quality care locally. However, the JHOSC has yet to see further detail on proposals, including what outpatients' services might be delivered and where. This information is needed for the JHOSC to be able to make a judgement as to whether the proposals will deliver improved local services and better quality care for the residents of South East London.

5.32 The JHOSC notes Professor Sir George Alberti's recommendation[20] that a five to ten year plan is required to see how the proposals in APOH fit into plans for longer term service delivery. The JHOSC supports this recommendation in reassuring itself of the longer term viability of both the APOH proposals and district general hospitals in South East London.

5.33 The JHOSC raised concern about extra bed provision in specialist stroke centres rather than local centres. Both Healthcare for London and APOH have agreed the need for specialist stroke services at fewer hospitals across London, with rehabilitation provided through intermediate support at a local hospital setting, followed by transfer to further rehabilitation at home. This is out for consultation. The JHOSC raised concerns about how and when the local transfer would be managed, and how patients would be supported at home. The JHOSC sought information on whether there are enough speech and language therapists and physiotherapists to support home-based rehab. Members expressed support for the retention of a stroke unit at QMH, and wanted more detailed planning regarding how services would

operate and staffing requirements, and that is not yet available.

Recommendations:

R10 **The JHOSC recommends that PCTs refer the development of Urgent Care Centres to local Overview and Scrutiny Committees. If the proposals go ahead, the PCTs should develop a publicity campaign to inform the public of the different range of services available at each site. The campaign should also address the difference between an Urgent Care Centre and Accident and Emergency**

R11 **The JHOSC is concerned about the fragmentation of children services and the loss of the excellent rated service at UHL. The JHOSC therefore recommends that children services are retained on all four sites**

Finance

5.34 The consultation material for APOH sets out the financial pressures that exist in South East London. The JHOSC notes the significant investment in new hospitals in Outer South East London in recent years, but believes that there has been poor financial planning and management, which have contributed to budgetary pressures. We are aware that debt is increasing by approximately £400,000 per week, and that overspends could reach almost £57 million a year by 2010/11.

5.35 Mindful of the current financial situation of the acute hospitals, the JHOSC has challenged APOH on whether patient safety and choice are really the key drivers for the proposals to reconfigure services, rather than finance. We heard from Michael Chuter, Joint Committee Chair, that the OSEL Trusts had known since 2005 that there had been too much investment in acute services and too little in primary care, so a reconfiguration of services would be needed.

5.36 The investment in new acute facilities in South East London over recent years has seen significant cost pressures for the NHS Trusts in OSEL. This has been further exacerbated by the introduction of national policy changes such as payment by results and the change in direction from delivering care in the acute sector to moving care closer to home, delivered more cheaply in the Primary Care setting. Of the four hospitals that are part of the reconfiguration of services in South East London two are in new Private Finance Initiative (PFI) accommodation (the PRU and QEH), one has a new PFI block (UHL) and one does not have a PFI (QMS). The JHOSC understands that due to the complexity of the PFI contracts, there is little scope to reduce these payments.

5.37 In a briefing to the Overview and Scrutiny Committee chairs in April 2007, members read *"other issues which will play into our business case is the PFI which has given us higher than average running costs at BHT and QEH"*. The APOH project team released a paper in April 2007 *"The Implications of Fixed Costs and PFI Schemes for Service Redesign in South East London"*. This paper stated that due to the PFI contracts at three hospitals (BHT, QEH and UHL) there is much less scope to reduce activity on these sites due to the fixed costs incurred. The paper therefore outlined the following:

- To increase the utilisation and capacity at sites where there is little scope to reduce fixed costs;
- To reduce activity at sites where there is greater scope to reduce fixed occupation costs by selling or leasing surplus estate

We fear that the financial burden of servicing the PFIs has driven the options, leading to a significant reduction in hospital based services

in some parts of OSEL rather than others eg the view was expressed that QMS is the only site with an option to reduce services and is being penalised due to the cost of the PFIs and overspends at other sites. The JHOSC seeks reassurance that the decision is not financially led and designed to protect the hospitals which have PFIs and much less scope to reduce activity on their sites.

5.38 We are aware that efficiency savings are being planned but are not enough, and that APOH expects to find further savings through the reconfiguration of services. The JHOSC is also aware that other savings initiatives such as Project SARK are underway across the Trusts in South East London, looking at shared service arrangements that will produce efficiencies. The JHOSC seeks assurance that the plans are robust enough to deliver stable financial future services, that the plans are led by a desire to improve services rather than save money and that we are not going to be subjected to further reconfigurations of services in the near future because this project and other associated projects have not delivered the anticipated level of savings.

5.39 The LAS and APOH both suggested that half of ambulance journeys could be saved by reducing the need to access A&E and by providing urgent care centres on all four sites. However, the LAS pointed to a need for more emergency ambulances and crews for any of the three options, namely two additional ambulances and crew for options 1 and 3, and one additional ambulance and crew for option 2. Additional costs ranged from £600,000 to £1.2 million, but the JHOSC heard that the proposals have not yet been costed in detail. The LAS told us that LAS commissioners are likely to approve funding for new programmes as they always have, and it was reported that the pre-consultation business case allocated £10.5 million to cover any capital requirements of the reconfiguration.

Recommendations:

R12 The JHOSC recommends that the Joint Committee outlines how the reconfiguration of services in APOH will realise further efficiencies

R13 The JHOSC recommends that the reconfiguration of services are driven by the needs of patients and carers as opposed to finance and PFIs

R14 The JHOSC recommends that the Joint Committee provides adequate assurances that the options arrived at were not financially driven

Capacity and Patient Flows: Increased Pressures on Services

5.40 The JHOSC has significant concerns about the capacity levels within the acute sector in south east London to cope with the impact arising from the proposed changes and associated patient flows. Nor have members received little beyond 'aspirational' evidence to be assured that there will be sufficient capacity developed in primary care and in the community to cope with increased numbers of patients and ensure the delivery of key services outside the hospital setting. Where acute units are reduced, financial and human resources will need to be available to expand associated facilities. Too frequently answers to questions posed by the JHOSC have required further modelling or determination or are dependent on assurances from Trusts outside the OSEL sector.

5.41 In all three options, some services would be removed from a local hospital. In all cases the JHOSC is concerned about the capacity of other hospitals to take on new patient flows. We asked questions about A&E modelling if options to reduce A&E sites are implemented. The JHOSC seeks reassurance about the PCT developed projections for the numbers needing A&E rather than UCCs or alternatives to

hospital admission, and whether those projections reflect anticipated changes in the population or address health inequalities in the area. If a decision about pathways to care is made to refer patients to an UCC regardless of whether A&E was on site, the JHOSC seeks assurances that specialist nurses and GPs would be on hand; no detail has been made available about the number or mix of staff yet.

"… a decrease in acute admissions and/or bed occupancy needs to be demonstrated". *Alberti Review*

5.42 It is clear that local A&Es are already under pressure and we had to challenge the initial evidence presented on achieving against the four hour target: subsequent figures showed that there is variation across the trusts and some underachievement against targets. However it is not clear that the closure of two A&Es in the sector will deliver a better service for local residents.

5.43 We were told that options in APOH and its business case accept that developments have the imperative to meet the standard, while performance issues should be referred to local OSCs by the PCTs and Trusts.

5.44 APOH makes the argument that a major driver for the project is to ensure that A&E is safe and effective into the future. By reducing the number of sites with A&E, it argues, there would be larger more specialist teams and better consultant cover. These would be dedicated A&E clinicians who would not cover elective surgery too, and so would be specialist, providing safer care for serious cases. A&E pressures would be lessened as more appropriate care for those currently using A&E would be provided through the UCC ie for where a condition was not life threatening or a serious trauma. These would be fully linked into support outside hospital so that there would be proper follow up care in place. The JHOSC seeks more detailed information about implementation and the development of community based services to be satisfied that this reconfiguration can work.

5.45 The APOH options to reconfigure services in Bexley, Bromley, Greenwich and Lewisham include changes that would increase demands on some services based in the London Borough of Lambeth, the London Borough of Southwark and Kent, to an extent in certain cases that would require significant extra capacity and new build at these locations.

5.46 The JHOSC has heard that rather than travel across boroughs for hospital care with problematic connecting transport links, it is more likely that residents in all four boroughs will find it easier to travel into central south London and seek services at Kings College Hospital, Guys Hospital and St Thomas' Hospital. In particular the proposals for University Hospital Lewisham (UHL) are likely to impact on Kings - Lewisham is generally considered to be an inner London borough and many Lewisham residents would be more inclined to travel locally to services at Kings College Hospital rather than towards outer London services.

5.47 It is clear that the modelling implications of the proposals on King's College Hospital and Guys and St Thomas' hospitals have not yet been effectively worked through and the JHOSC considers it unfortunate that a seemingly abrupt decision was taken to omit from the project the inner south London PCTs and the acute providers in those boroughs when the emerging options clearly impacted more widely than outer south east London.

5.48 The JHOSC received the initial observations made by the Chief Executive of King's College Hospital and the activity implications for the Trust relating to the three options, including the requirement for investment in infrastructure and the need for an extra 138 beds under option 3. In a subsequent submission the Academic Health Sciences Centre partners have similarly emphasised in

the combined response to the consultation their significant concerns related to such increased patient flows, and in particular those arising from the UHL proposals and state that *"such flows would cause serious capacity difficulties, particularly at KCH, with the potential to require significant capital investment either to adapt/re-equip existing areas for change of use (such as maternity) or potentially for new build, if services for our local populations in Lambeth and Southwark are not to be affected".*

5.49 We seek assurances that APOH has consulted fully other hospitals used by residents in OSEL eg with regard to extra bed provision if required. We are aware that the LAS already transports patients to Darent Valley Hospital in Kent, and are concerned about the additional impact of flows of patients to Dartford and Gravesham if the proposed reduction in services at QMS especially goes ahead. We do not feel that there have been adequate detailed discussions nor reassurances given that there will be sufficient capacity across all the hospitals used by our residents should the proposed reconfigurations go ahead. The JHOSC recommends strongly that more detailed work is carried out before implementation of any option should go ahead. We particularly want more information on the impact on Guys and Kings, and feedback from clinicians there.

5.50 We also need to know whether UCCs would have 24 hour cover and adequate staffing if they are to take the pressure off A&E. The JHOSC believes that patients should receive the same standard of care regardless of when they present at a hospital. Careful protocols will be needed with the ambulance service and GPs to ensure appropriate referrals. Careful calculations are required regarding capacity, with a particular focus on the size of the medical assessment units.

5.51 Should the Joint Committee decide to proceed with any of the three options it is imperative that appropriate levels of additional capacity are agreed, financed and achieved, before critical services are reduced in neighbouring boroughs and with an impact that threatens to register beyond the immediate boundaries of the OSEL boroughs.

5.52 We heard the concerns of Lewisham Pensioners on capacity issues, and their view that the consultation document did not fully explore the capacity issues presented in the pre-consultation business case.

5.53 The JHOSC also is concerned about demographic trends in OSEL and whether anticipated population growth has been adequately addressed in redesigning hospital services, particularly around elders care and maternity services. The PCT assured members that in predicting future numbers of patients requiring care they have considered changes in population, and that the modelling indicates that there will be sufficient total acute bed capacity at each of the four hospitals in the borough if accompanied by developments in out of hospital care. That detail has not been made available yet, and with regard to maternity services, further work is needed regarding the changes in the number of deliveries at each site and the number of specific care and neonatal beds, as well as detailed staffing plans.

5.54 Whilst we agree that an expansion in community based health services should improve care options and patient choice, and reduce hospital admissions, we believe that conservative estimates of the reduction in capacity required is needed in the short term whilst new services are developed.

5.55 We accept that outpatients can be located in the community and do not have to be on acute sites. We accept the principle that patients will be transferred back as soon as possible and will attend outpatients locally. This will move services closer to the patients and reduce journeys.

5.56 Regarding older people, the JHOSC would expect to see better integration of services eg between urgent care centres and older people's assessment, with rapid assessment and diagnostics, as well as joined up health and social care. Multi-disciplinary teams and integrated services are important for their health and social care needs.

Recommendations:

R15 The JHOSC strongly recommends that more detailed work on capacity is carried out before implementation of any option should go ahead. The JHOSC particularly recommends that there should be greater clarity about the services that will be provided by Urgent Care Centres and whether they will be available on all four sites 24/7

Workforce issues

5.57 The JHOSC was particularly concerned about the impact of the APOH proposals on staff and the proposed changes to maternity services which will have a particular impact on nurses and midwives. The JHOSC received evidence from the RCM who advised that the proposals needed to take more account of mid-wife vacancy levels. Most maternity units do not have enough midwives to provide the one to one care promoted in the 'Maternity Matters' report. It is estimated that 36 midwives per 1,000 births are required to provide one to one care in labour. Some of the worst ratios in the capital can be found in South East London. There are 28 midwives per 1,000 births at University Hospital Lewisham (UHL) and 23 midwives per 1,000 births at the Princess Royal (PRUH).

5.58 Midwifery vacancy rates in south east London are currently running at 8.5% and this probably represents an underestimate as a vacancy is defined as such when it has been advertised for at least three months. Only Lewisham has a vacancy rate below that level.

5.59 Maternity services in London will experience a 'retirement bulge' with 30% of midwives eligible to retire in the next five years. The age profile of midwives in Bromley, Bexley and Lewisham is similar; Greenwich has a slightly younger age profile[21].

5.60 The RCN recognised that there were powerful financial and clinical arguments for change and they would always want to see patients cared for closer to home. However they had a number of concerns regarding capacity, skills and workforce issues.

5.61 The RCN were concerned whether, with the reduction in A&E sites and the introduction of Urgent Care Centres (UCCs), there would be sufficient capacity to meet the demand. They supported the idea of UCC but were not convinced that they could act as a replacement to a full A&E service.

5.62 The proposals require workforce training and development and having a skilled workforce in place is absolutely paramount. The proposals involved a shift from acute to community settings and this change will require different skills for nurses. It was important that proper workforce planning, training and development were in place to facilitate and support nurses in this.

5.63 The RCN representative, in response to a question, explained that not all members felt that they had been consulted well enough and that morale was not great.

Recommendations:

R16 The JHOSC requests further information on the workforce requirements of the APOH proposals and how these requirements differ from existing staffing configurations in South East London. This should include detail on the additional skills and training

that may be needed to help existing staff to undertake the proposed new ways of working and the expected timescales for recruiting additional staff and to undertake any re-skilling and additional training of existing staff

R17 The JHOSC recommends that proposals are put in place to address particular issues that have been highlighted such as the shortage of midwives before proceeding further with the reconfiguration of services, especially the migration to community based services

R18 The JHOSC recommends that a workforce training and development strategy is developed in consultation with staff, and that a full briefing exercise is conducted with those working in the OSEL health services

Patient Choice

5.64 By proposing to concentrate specialist services on two main sites in Outer South East London, the JHOSC feels that patient choice will reduce. However, a key tenet of APOH is that by reorganising A&E and expanding UCC, patients can access urgent care in a more timely fashion, especially as 40-60% of patients using A&E do not need it. Instead patients will be encouraged to use other community based settings and receive more support to self-care, especially if they have a long term condition. By offering urgent care and other options for those who do not require A&E services, it will help to ensure that those who do need A&E access it more quickly. The JHOSC seeks clarity about the services provided by Urgent Care Centres and whether the same services would be available on all four sites 24/7.

5.65 The JHOSC understands that the exact specification may vary according to the needs of residents and the breadth of services. We also enquired about referral between UCCs and A&E, and understand that such a referral is unlikely to be necessary but that if it was a UCC would be able to stabilise the condition before the transfer. APOH stated that *"It is not envisaged that ambulances would deliver patients to a UCC that is not linked to an A&E department"* again indicating the responsibility of the LAS for pathways to care so that patients access the most appropriate or specialist care as needed.

5.66 We understand that proposals are in hand for a telephone triage system to ensure appropriate routing of patients including one single out of hours service, and the JHOSC would expect close working and integration between all levels of the health service and social care. The PCTs advised that they and practice based commissioning clusters have well developed proposals to establish urgent care centres on other sites, not just on hospital sites; eg Bexley plans to have a UCC up and running from October 2007, and each PCT plans to develop UCCs with the local district general hospital and will plan for a carefully managed transition. However as the JHOSC has not seen detailed proposals, we feel there may be an interim requirement for some double running of services for some time.

5.67 The JHOSC wished to assess whether the proposals would enhance the patient experience, especially in terms of patient choice. The RCM gave evidence in terms of women's choices regarding maternity services. The RCM welcomed the commitment within the consultation to establishing mid-wife led birthing units, promoting an increase in home births and providing more antenatal and post natal care nearer to women's homes. However they were concerned about the proposal to close the consultant led unit at Queen Mary's hospital without replacing it with a mid-wife led unit. The RCM also completely opposed any option that would leave residents in Lewisham without a local maternity unit. The RCM believe that that these closures would

reduce the quality and accessibility of maternity care and limit the choices available to women.

5.68 The RCM was particularly concerned that the proposals will reduce the choices available to local women, particularly those in Bexley and Lewisham, when deciding on where and how to give birth. They currently are able to access four maternity units or choose to have a home birth. Under these proposals women in Bexley and Lewisham will either have to give birth at home or outside the borough.

5.69 The proposals go against the grain of current national and local policy drivers such as Maternity Matters, the NSF Maternity Standard and Healthcare for London, which aim to ensure that:

- Women are able to exercise informed choice about where and how they give birth, and that
- Some options are available locally

5.70 The RCM highlighted the fact that the reconfiguration will be taking place at a time when maternity services in London and OSEL face a number of demographic challenges:

- Nearly 20% of all births in England were to women in London in 2006
- London has the fastest rising birth rate in England: births in London increased by 16% between 2001 and 2006 (12.8% across England in same period)
- Fertility rates in Greenwich and Lewisham are among the highest in England
- Queen Elizabeth hospital has seen a 40% increase in births since 2000
- The populations in Greenwich and Lewisham are also likely to increase as a result of the Thames Gateway development
- Lewisham has the second highest teenage pregnancy rate in London

5.71 They were also particularly concerned about the impact of the closure of the units in Bexley and Lewisham on the capacity of the units at Bromley and Greenwich as well as Kings College Hospital and St Thomas's Hospital.

5.72 The RCM emphasised the importance of choice and local maternity services for women and their families and were not convinced that the proposals would enhance this in OSEL.

Recommendations:

R19 The JHOSC recommends that there be some double running of services for some time whilst the transition takes place and the publicity campaign takes effect

R20 The JHOSC is not convinced that the proposals will deliver better choice and services for expectant mothers. The JHOSC therefore recommends the Joint Committee revisits the proposals for Maternity Services in the seven boroughs and requests that the Joint Committee provides additional evidence that illustrates how these proposals will deliver better midwifery services to expectant mothers in Outer South East London. This additional evidence should be provided for the next meeting of the JHOSC

Transport and Accessibility

5.73 The JHOSC stressed that it is important to model transport requirements accurately and to reflect patient journeys within and beyond Outer South East London. It will be important at the pre-implementation stage to have discussions with public transport providers to ensure routes are available where footfall will increase between communities in OSEL and the range of health and social care providers.

5.74 The JHOSC heard from representatives of the London Ambulance Service. It heard an

assessment that half of patients transported by ambulance do not require care in an accident and emergency centre but could be seen at an urgent care centre. The JHOSC was advised that through paramedic assessment patients are more likely to be routed to appropriate care eg specialist hospitals outside South East London for heart attack and major trauma patients. The view was also expressed that with the introduction of UCCs on all four sites patients would be seen more quickly than if they waited in an A&E when they did not require that level of care. However, if specialist patient care is accessed through a longer journey, care is available from trained paramedics in the ambulance and on arrival the care should be safer because it is provided at a specialist acute hospital.

5.75 The JHOSC raised a number of concerns with the London Ambulance Service (LAS) around the extent of their involvement in the proposals and the implications for their service and patients. They focused on the potential for more and longer ambulance journeys due to hospital sites taking on a specialist role. It was also clear that there was a need for more ambulance vehicles which would involve significant resources.

5.76 The LAS assured the JHOSC members that there would be no training implications as paramedics already are trained in diagnostics and have to make decisions about where to take the patient. The JHOSC also heard that there had been referral pathways modelling in order to predict capacity requirements and care options. The LAS also reported that they could better utilise vehicles, carry out more treatment on the spot and make better use of district nurses. They have a strategic plan to see 200,000 fewer patients taken to A&E across London by 2013 with alternative care options being treatment at home, referral to a GP or social care, referral to minor injury units or walk-in centres, or help over the phone (the ambulance service could do 150,000 calls per year).

5.77 However, the LAS conceded that support would be needed for extra resources due to the longer journeys set out in the options. Whilst they and the APOH programme director were confident that funding would be forthcoming for this, the JHOSC is less confident since a key driver of the reconfiguration is financial savings.

"Transport is also key to many of the changes proposed. The impact on the ambulance service should be carefully assessed. Close examination of the impact on public transport is also necessary, with possible modifications negotiated with the appropriate authorities".
Alberti Review

5.78 The Alberti report referred to patients and the public's concerns about travel times especially in terms of emergencies[22]. The report accepted the need for better focussing services so that quality and safety of care is improved and LAS is aware of the challenges involved. However they recognised the necessity to model accurately the implications for the number of ambulances and crews to meet the challenge and also to allow for patients travelling outside OSEL, as some already do, for example after heart attacks.

5.79 The Alberti report supported a substantial increase in Emergency Care Practitioners who have the skills and experience to deal with patients problems or take them to out of hours' services or a UCC[23]. They also believe that discussions will be necessary with public transport companies to ensure that travel across the area is possible and reasonably convenient.

5.80 The JHOSC were concerned about the lack of evidence of detailed planning regarding the transport implications for patients. The proposals will inevitably involve patients, their families and medical staff having more journeys. There was an important issue in terms of accessibility as many patients and their families may struggle to afford the cost of these

added journeys. Older Peoples groups have expressed concerns regarding the feasibility of their families visiting them in hospital sites that were further away from home.

5.81 The proposals would also involve many patients and their families relying on public transport occasionally in the evenings. Allied to this were issues of more and reasonably priced parking provision at each of the hospital sites.

5.82 The work on patient flow and accessibility carried out by ORH Ltd, as part of the Integrated Impact Assessment, has shown that under all options the average journey time for all affected patients within the catchment area will increase by between nine to ten minutes. Furthermore patients using public transport are more adversely affected than those using ambulances or private transport.[24]

5.83 Professor Sue Atkinson's work on Health Inequalities and Equalities Impact Assessment highlighted *"the risks are that some members of some 'inequality groups" in some areas will be affected in terms of increased travel for some services"*[25].

5.84 LAS provided the JHOSC with further evidence regarding the development of its services, in particular the introduction of a single response approach. This involved a response vehicle being sent to emergencies first to carry out an assessment, with ambulances following if necessary. However, this had not yet been implemented and needed further consultation.

5.85 LAS emphasised that the vast majority of calls did not involve life-threatening situations, and only around 10% of calls involved transporting a patient who needed to lie down. More than one vehicle was often needed in circumstances where there was a serious condition, such as cardiac arrest, where there might be heavy lifting or where there was a potential risk to staff.

5.86 A large part of the workload involved situations where there was an exacerbation of a pre-existing condition. In many circumstances, the LAS needed to refer patients to other services (ie GP or District Nurse) rather than take them to A&E. The aim of the LAS was to put resources into well-trained staff rather than into expensive vehicles.

5.87 The JHOSC recognised that significant changes were planned in the way the LAS operated and that these would have to fit with the proposals. However it was not clear how these changes would be communicated to patients, whether patients would see this as an improvement and how the additional demands/ challenges facing LAS will be resourced and to what timescale.

5.88 The JHOSC seeks further information about the concerns outlined above and whether APOH have adequately researched and addressed these matters. We consider they have a significant impact on reducing health inequality since many residents depend upon public transport or would have limited means to pay high parking charges. The JHOSC was assured that APOH has commissioned a company to consider the impact on travel times of proposed changes in clinical services, including the identification of the wards that would be most adversely affected and the implications of using cars and parking.

5.89 The JHOSC also was informed that Transport for London will provide information about distances between the hospitals and accessibility issues, and the Integrated Impact Assessment will look at car parking capacity in A&Es and assess the number of car users attending each hospital site each day and how this might change. The JHOSC would like to see further work conducted on car parking needs and capacity, and on improving public transport to hospital and other health service sites.

5.90 The JHOSC would like information on which hospitals patients are likely to use if it is not the local hospital, so that a better assessment

could be made on travel times, public transport routes, car parking capacity and car parking charges. The JHOSC also is concerned about patient information, issues around who decides on referrals and transport times should a patient require referral to an acute hospital on a different site.

5.91 The JHOSC raised the issue of carbon footprints, and asked if this had been taken into account in consolidating acute services on two sites eg leading to longer journeys and increased travel for patient visitors. Members raised the issue of environmental as well as clinical and financial sustainability, and whether this is being addressed eg in facilities management. The JHOSC understands that environmental impact assessments are being undertaken through the Integrated Impact Assessment but is concerned that the IIA will report too late for the JHOSC to consider it fully.

Recommendations:

R21 The JHOSC is not convinced about the case for and how the changes will impact on the London Ambulance Service. The JHOSC recommends that more detailed work and costings is made available, including how patients will be transported to Darent Valley

R22 The JHOSC recommends that the PCTs ensure that clear protocols are developed to provide guidance to the London Ambulance Service on what can be accepted on each hospital site

R23 The JHOSC recommends that further work is carried out to identify and mitigate the implications of longer journey times for patients especially those using public transport and living in the more deprived wards. The JHOSC seeks details regarding car parking capacity and charges, and travel times between communities and health facilities

R24 The JHOSC recommends that the Joint Committee at the pre-implementation stage have discussions with public transport providers to ensure that routes are available where footfall will increase between communities in OSEL and the range of health and social care providers

R25 The JHOSC would like information on which hospitals patients are likely to use if it is not the local hospital, so that a better assessment could be made on travel times, public transport routes, car parking capacity and car parking charges. The JHOSC also is concerned about patient information, issues around who decides on referrals and transport times should a patient require referral to an acute hospital on a different site

Interface with Local Authorities' Adult Social Care

5.92 The Programme Director for Adult Social Care and Health Modernisation of the LB Lewisham provided a perspective to the JHOSC. We were told that each PCT has been working through the issues with its council regarding services for older people, developing borough specific plans. However, there was limited evidence of the close collaboration between health and social care providers that would be necessary eg to do the modelling of community based services based upon needs analysis and available resources. It seems that adult social care departments have only recently been made aware of the possible financial and resource implications for their boroughs. Consequently, the JHOSC seeks far more detail about the role that social care departments and local authorities generally will fulfil in developing the details of the options on which there has been consultation.

5.93 Although the JHOSC heard that all local authorities and PCTs should put forward proposals to enhance services as alternatives to

hospital admission, we strongly feel that details have not been worked out across the service providers. We therefore seek more information about proposals for community based services, and believe that primary care needs to be enhanced and community health services put in place with an upfront investment in and even double running of services, before reconfiguration of acute and other hospital services.

5.94 The JHOSC supports the principle of bringing care closer to home, but is concerned about how this would be resourced eg addressing the shortage of midwives. We also expressed a need for more details about how care would be delivered and services expanded, and how the PCTs and local authorities would develop better integrated care and pathways to care. We have seen that in Bexley there are already enhanced services and GPs with special interest schemes which give local access to high quality services and good value for money. The Bexley Care Trust with QMS already delivers primary care based physiotherapy and plan to expand on at least two more sites. The Bexley Cardiac Diagnostic Service is fully operational out of four primary and one secondary (hospital) site, and Bexley Primary Care Diabetes service was to be introduced into the community in April 2008. However, we feel that this pattern needs to be extended and in place before hospital reconfiguration if the shift from hospital to community based care is to work.

Recommendations:

R26 The JHOSC recommends further discussions and the development of more detailed proposals between local authorities, social care providers and the health service around capacity and financial implications of changes to community based care

Health Inequalities and Integrated Impact Assessment

5.95 The APOH project suggests the discussion should be not around which site(s) but the overall provision of services. However, concerns have been expressed forcefully around the site specific impact of the provision of public information on services available, transport access and cost, capacity, and patient choice. For example, the reduction of services at UHL will hit hardest on the more disadvantaged residents who mainly live in the catchment area of University Hospital in Lewisham.

5.96 The APOH proposals did not explore the options in relation to their contribution to reducing health inequalities. They later commissioned an integrated impact assessment by a consultancy to carry out this evaluation, but it has taken place late in the process. This has prevented such information from being included in the consultation and in the JHOSC's detailed work.

5.97 We are aware that a workshop with traditionally under-represented groups was held in Charlton on 7 May as part of the Integrated Impact Assessment. Issues raised included the selection of participants for the workshop, many having participated in similar events before and few being involved for the first time; capacity; specialist care; travel times; the additional cost of travel for patients and their visitors and carers and accessibility. A particular concern was around raising awareness of health care options for those with disabilities or learning disabilities who would be adversely affected by any change in configuration; they would need to become familiar with new routes or new arrangements to access particular care if the mix of provision as sites changed. Whilst a consultancy is looking at the likely impact of reconfiguration on those at risk of exclusion or facing disadvantage (the Integrated Impact Assessment), the JHOSC remains concerned that it is reporting too late for us fully to

consider its findings and present our response to them. The JHOSC would prefer to evaluate the findings in case corrective action would be needed to address those concerns with the revision or replacement of options as necessary, but this option has been denied to us.

5.98 One of the major expressions of concern heard by the JHOSC was of the impact on maternity services. There was a strong feeling that longer journeys would be unpleasant for women in labour and that there is a poor uptake of home delivery. Questions were raised about who was consulted about maternity modelling, capacity, staffing, and future population forecasts. It was also recognised that maternity services form part of the overall review in Healthcare for London, and its conclusions should not be anticipated but awaited before options are agreed for OSEL.

Recommendations:

R27 The JHOSC finds it unacceptable that the Integrated Impact Assessment was not made available during the public consultation and recommends that the IIA is presented as an integral part of all future NHS consultations so that the public and stakeholders can make an informed choice on the proposals presented by the NHS

R28 The JHOSC recommends that an IIA is completed for Lambeth and Southwark and that the outcome of this is used to inform the decision on the reconfiguration of services outlined in APOH

R29 The JHOSC recommends that the APOH team outlines the rationale for limiting the ability of the JHOSC to scrutinise the contents of the IIA. This should be addressed in the Joint Committee response to the JHOSC report

R30 Whichever option is chosen, the JHOSC recommends that the Joint Committee provides evidence about how the decision will tackle health inequalities and provide better services for all residents in Outer South East London. This should be in the form of a report to a future meeting of the JHOSC

6. Conclusion

6.1 We accept that the status quo is not an option and that there needs to be a reconfiguration of services in OSEL. Whilst we welcome the recommendation not to close any of the four hospitals in OSEL, we remain concerned about the mix of hospital care proposed on each site and the proposed loss of significant services from particular hospitals in the options. We are not convinced that the proposals are clinically rather than financially driven.

6.2 Whilst the APOH team highlight improved patient safety and the importance of clinicians seeing enough patients per year to achieve better results (by specialising), the JHOSC has not been reassured that those messages are reaching the public and fears that the fundamental motivation in proposing hospital changes has more to do with patient numbers at the PFI hospitals to meet their higher running costs.

6.3 The JHOSC were asked to support a judicial review by a pensioners' forum. We explained our particular remit and specific duties that do not include a judicial review. The JHOSC therefore noted the request but asked the forum to keep us informed.

6.4 We are aware that Imperial College will feed back on the responses from the public consultation, after which further studies and a refreshed activity and financial analysis will be undertaken. If a new option emerges it will be evaluated. The JHOSC would want to consider any such developments and scrutinise the new proposals or revised options.

6.5 The Integrated Impact Assessment was carried out too late for the JHOSC to consider it fully, but we want to scrutinise it and respond to its findings.

6.6 The JHOSC believes that much of the detail on the operational aspects of services is yet to be determined and we would want to undertake scrutiny of the implementation phase as specific plans and details are developed.

6.7 The JHOSC understands that APOH offers a complete health service redesign in OSEL, but feels that the proposal only can succeed if implementation of the community services support proceeds ahead of hospital reconfiguration. A thorough implementation plan and more detailed proposals for expanded community services are required before any hospital reconfiguration is acceptable.

6.8 The JHOSC identified a need for a month by month implementation plan. Should any of the options be implemented, the reconfiguration of services should have a long enough lead time for the development of alternative services, the improvement of public transport, and a public information campaign.

6.9 In conclusion, the JHOSC accepts that the status quo is not an option. However:

- We are concerned at the extent of, quality of and feedback to the consultation and await the findings of it with interest
- We welcome the proposal not to close any of the four local district general hospitals. However, we perceive that the impact of the reconfiguration of hospital services will vary according to borough, and would want to minimise the negative impact of these changes, especially on the socially excluded and more disadvantaged
- We commend the importance of an integrated approach across primary and secondary care, and between health and social care
- The JHOSC seeks a lot more work around projections of capacity, including data from neighbouring hospitals and population projections
- Maternity services need to be addressed in the context of HfL review before taking forward any APOH proposals in this area.

Notes

Implementation must take into account the particular needs of excluded and disadvantaged groups

- We strongly urge APOH to develop more detailed work at a pre-implementation stage, especially around the development of local health services and public transport

- The JHOSC would welcome the opportunity to scrutinise the integrated impact assessment and a detailed implementation plan

Additional recommendations

R31 **The JHOSC recommends that the Joint Committee provides additional evidence to demonstrate that the plans are deliverable. This evidence will assist the JHOSC in reviewing the decision of the Joint Committee**

R32 **The JHOSC recommends that APOH review its proposals in light of the principles and models agreed through HfL**

R33 **The JHOSC recommends that the Joint Committee develops a detailed implementation plan which clearly outlines the timescale for delivery. This plan should be easy to read and understand**

R34 **In the event that local residents are not supportive of any of the options outlined, the JHOSC recommends that the Joint Committee revisits and re-consults on alternative options**

1 Written report *'NHS Consultation Update'* – JOSC Agenda, 4 March 2008 (Appendix 5 – Public Engagement Comparison Table)

2 Gaps in engagement with these groups are highlighted in the above update (Appendix 4).

3 www.bexleytimes.co.uk 'Top Medic Slams Health Consultation' – 26 March 2008

4 Oral Evidence – 24 April 2008

5 Written report *'NHS Consultation Update'* – JOSC Agenda, 4 March 2008

6 Written Report *'Consultation Update'* – JOSC Agenda, 1 April 2008

7 (Draft) Minutes of the JOSC Meeting held on 24 April 2008, Minute 5.3

8 Oral Evidence – 24 April 2008

9 Oral Evidence – 24 April 2008

10 Oral Evidence – 24 April 2008

11 Oral Evidence – 24 April 2008

12 As noted by the Children and Young People Select Committee of the London Borough of Lewisham in their response to the Picture of Health consultation.

13 Response to the Consultation *"A picture of health for Bexley, Bromley, Greenwich and Lewisham"* Pg 3, Royal College of Midwives (April 2008)

14 Response to the Consultation *"A picture of health for Bexley, Bromley, Greenwich and Lewisham"* Pgs 4 and 5, Royal College of Midwives (April 2008)

15 As above – pg 6

16 As overleaf – pg 14

17 *Outer South East London NHS Pre-Consultation Business Case*, pgs 46-47 (7 January 2008)

18 A Picture of Health consultation questionnaire – Q 1.3

19 Minutes of the JOSC meeting held on 1 April 2008 – Minute 15.12

20 *Outer South East London Service Reconfiguration* Recommendation 13, KGMM Alberti on behalf of the National Clinical Advisory Team (18 December 2007)

21 Healthcare Commission Review of Maternity Services 2007

22 Outer South East London service reconfiguration. Review of Clinical Case for Change: KGMM Alberti on behalf of the National Clinical Advisory Team pg 12.

23 Ibid pg 12

24 Presentation to the JHOSC on 20 May on the draft flow and accessibility modelling by Paul Murray, ORH Ltd.

25 Presentation to the JHOSC on 20 May on the draft health inequalities impact assessment and equality assessment by Professor Sue Atkinson.

Appendix 1

To: A Picture of Health
FREEPOST RRSL-BSTX-AKYS
Centre for Health Management
Tanaka Business School
Imperial College
London
SW7 2AZ

Copy sent by email to APOH@lewishampct.nhs.uk

Dear Sir/Madam,

London Borough of Bexley's Response to the 'A Picture of Health' Consultation

I write to you to present the London Borough of Bexley's response to the 'A Picture of Health' consultation, which has been developed by a sub-group of Bexley's Health and Adult Social Care Overview and Scrutiny Committee.

We will be sharing our response with the Joint Overview and Scrutiny Committee reviewing A Picture of Health, so that it can be used to inform the deliberations of the Joint Committee.

We have responded to each of the consultation questions individually. Should you require any clarification or further information on our response, please contact the London Borough of Bexley's overview and scrutiny team.

Yours faithfully,

Councillor Ian Clement

Leader, London Borough of Bexley

A Picture of Health for South East London

Introduction

This document sets out the response to the Picture of Health Consultation from the London Borough of Bexley. Overall, the Consultation is disappointing in terms of the structure of the consultation material, the leading nature of the questions and the lack of meaningful choice for Bexley residents in the options for the reconfiguration of future services. We set out these concerns in writing to both the Secretary of State and to Michael Chuter at the beginning of the consultation process, requesting that the consultation be withdrawn and reconsidered. This request was refused and we were informed by Michael Chuter that the consultation process would proceed unaltered.

Therefore this response has been developed from the comments made in response to the Questionnaire, drawing on the views expressed by Members at the Delivery of NHS Services Scrutiny Sub Group, Members of the Council and the public who fed in their views via public meetings. It aims to answer each part of the questionnaire accompanying the 'A Picture of Health' consultation document.

Although the overall reduction in key services is something we feel will have a negative impact on the Borough's health services there are some positive aspects to the proposals. We were pleased to hear Sir George Alberti state that there is a future for Queen Mary's and that there will still be a variety of services available there. We are also encouraged by the commitment to out of hospital care in Bexley and some of the positive work that has already commenced to develop enhanced services at local GP surgeries.

Enabling patients, especially the elderly, to receive treatment at home will be a welcome development for many residents and we recognise this. The creation of virtual wards is an exciting development. Supporting people to return to their own home after a hospital admission is important and we are encouraged by the work of the Bridging Team in achieving this. The extended number of intermediate care beds and the development of a community

stroke rehabilitation facility are again positive proposals and we are keen to see how these proposals develop. Locally there are concerns that there are not sufficient facilities locally to support patients recovering from strokes and this is vital to ensure that specialist facilities such as Kings are not placed under more pressure.

We are encouraged by the level of commitment to continuing a quality local service for children. Although we would like to the see an inpatient facility included in the proposals for Bexley, the Child Development Centre and the Paediatric Ambulatory Care Unit will enable an integrated approach to dealing with children's health and social care needs across the Borough and this is something we support and would like to see developed further.

Finally a commitment to resources for the management of long-term conditions in Bexley is important. A new diabetes model of care and community based anticoagulation monitoring and management service is a great benefit to patients, some of whom have already expressed their satisfaction with the services that have been developed to date. A dedicated Older Persons Assessment Unit within the Medical Assessment Service will be a valuable service in the Borough.

Although we are clear that there are some positive aspects to the Picture of Health proposals, we find ourselves unable to support any of the options for the future of services in Outer South East London as they present no choice for Bexley residents, except the downgrading of some key local services that they rely on.

Part 1

Bringing together specialist care in a smaller number of hospitals. Providing specialist care in a smaller number of hospitals will mean better and safer care services for patients, but these services could be further away from your home. Please tell us whether you agree with this proposal for the following services:

- Emergency Services, including accident and emergency services and emergency surgery: **Disagree**
- Maternity and newborn care: **Disagree**
- Children's inpatient services: **Disagree**

Comments:

Emergency Services:

In reality these changes will have a negative impact on the lives of the residents of Bexley. Firstly if an elderly person in Bexley has a fall and needs emergency treatment, out of hours, under these proposals they will be taken to A&E at Princess Royal or Queen Elizabeth hospitals. They will be treated and possibly admitted to hospital. Quite often there is an elderly partner who will have to travel to visit the patient and this is difficult and often daunting for both the patient and the visitor. At present these needs are met by their local hospital. Under the options for the future of these services planned orthopaedic surgery and inpatient and day surgery are still to be provided at Queen Mary's but for those who have emergency needs they will be treated further away because of the separation of emergency and planned care. For many of our residents, the proposals for out of hours emergency care do not present a better service.

We have received information regarding the difference between the services that would be delivered by an Urgent Care Centre and a main A&E department. However it states that the services provided at Urgent Care Centres will be different from Borough to Borough. Our main concern is how the general public will understand what services are on offer and at which location. Educating the public and communicating the services that are available across the Borough will be a significant challenge. Adequately staffed 24 hour Urgent Care is essential if the A&E department is to be removed and we would have expected to see more information about the number and mix of staff and the times that various specialist staff would be available at the Urgent Care Centre. Also we are unsure whether services such as psychological assessment would be available, as

patients currently receive referral through A&E. We consider that patients will simply attend A&E if they are not clear about the level of service available at each location.

Maternity and new born care:

We feel strongly that the removal of the midwifery led unit and doctor led maternity unit from Queen Mary's Hospital will be a huge loss for the people of Bexley. There will be no healthcare facility for those wishing to give birth in the Borough leaving home birth as the only option for Bexley residents. If a woman chooses to give birth in hospital then she will have to travel to the Princess Royal or Queen Elizabeth Hospitals. Women giving birth to a second or third child would be at a further disadvantage with partners having to travel further with other children to visit them in hospital. We have heard from the Care Trust and in the press nationally about the promotion of choice for women in deciding where to have their baby. The Royal College of Midwives has stated that the options set out in these proposals limit the choices of the women of Bexley if they want to give birth at their local hospital, which is against national and government service drivers. The RCM also believe that if the maternity unit is withdrawn from Queen Mary's Hospital then a midwife led birthing unit should remain on the site.

For babies who need special care, which can often last for a number of weeks after a baby is born, this will present a further challenge to family life in balancing a journey to a hospital in another Borough to visit a newborn baby with juggling the care of other children in the family. We understand that level 2 Neonatal Intensive Care Units are currently operating at Queen Mary's and Lewisham Hospitals. The London Perinatal Network has currently only designated level 2 services at Lewisham Hospital. This implies there must be a need for more capacity across the sector if Queen Mary's Hospital is currently delivering Level 2 services when it is designated as level 1. Under the options for reconfiguration level 2 services will be delivered at hospital sites (PRUH and QEH) that are currently delivering level 1 care and lost at the sites currently delivering level 2 care. We would like to understand why an option for continuing these services at Lewisham and Queen Mary's has not been proposed.

We currently have a maternity unit that delivers approximately 3000 babies per year. We would like to receive further information regarding the modeling of maternity services across Outer South East London as we are currently unsure that the assumption that patients will use the next available service is a robust one. The proposals need to be clear where, and in what proportion, it is anticipated that patients will go to have their babies. We would like to understand how this work was developed and also to understand whether there are any capacity issues at the alternative units and how these have been considered and will be overcome. We understand that surrounding NHS Trusts were asked about capacity issues as part of the consultation process. We are concerned that detailed discussions about capacity should have taken place prior to the options being developed and that the proposed options should have been developed and signed up to by the neighbouring NHS Trusts that will be receiving an increased number of patients.

We understand that the Care Trust expect the number of women choosing home birth to rise in future. The Royal College of Midwives has expressed some doubts about this projected rise in home births, even if there is not a maternity service in the Borough. We would suggest that the fact that there is not a maternity unit close by may impact on women feeling comfortable with home birth as the security of support from a main maternity department will take longer to reach. We would like assurances that there are adequate staff available to deliver this service and that the future of maternity services across Outer South East London will be sustainable against future growth.

Children's Inpatient Services:

We are very supportive of the proposal to develop a Child Development Centre and are encouraged by the intention for this service to work alongside the Paediatric Ambulatory Care Unit (PAC). The Child Development Centre would enable a more integrated approach to dealing with the health and social care

needs of children in the Borough and we look forward to understanding more about this. We hope that an environment conducive to meeting the needs of children can be created. We are encouraged by the services that are proposed for the PAC.

We would like to know whether there are any outpatient and day-case services that are currently available at Queen Mary's but are not proposed for the PAC and how the level of service currently will actually compare with the service we will have in the future. The Care Trust stated in a response to a clarification question raised by the Delivery of NHS Services Scrutiny Sub Group that the PAC will mean that "better experienced staff will be available for extended periods, which is an improvement on current services". However in a response to this statement Queen Mary's hospital expressed dismay at this description and outlined the excellent range of Paediatric services that are currently provided at the hospital i.e. specialist cover available 24 hours a day 7 days a week in a dedicated Paediatric A&E unit, as well as a consultant-led inpatient ward. The hospital stated firmly that the future provision of services at the PAC should not be described as an improvement on existing services. Although we have been assured by the Care Trust that the future proposal presents an enhanced service, it appears that Queen Mary's disagree. Though we are pleased with the development of the PAC we would not wish to see any reduction in the extensive services that are currently available.

The consultation says that Children's Urgent Care needs will be dealt with at any of the four Urgent Care Centres. Firstly in terms of the assessment and treatment of children at the Urgent Care Centre, it is important that there are experienced staff available 24 hours a day to deal with children's needs effectively. Residents have raised their concerns on this issue, saying that if there are not sufficient staff, experienced in paediatric healthcare available at all times they will be uncomfortable with attending such a unit and will go to a main A&E instead. Further to this point there have been concerns raised that the size of paediatric A&E departments in neighbouring hospitals and even the parking facilities are insufficient already. Faced with a longer journey and the stress of uncertainty and cost of car parking, parents may choose to call an ambulance to get their child the care they need. The Children's Trust meeting were concerned about schools having to determine whether a child needed Urgent Care (QMS) or A&E (PRU/QEH) and it was agreed that the schools would still call "999" and the paramedics would determine the level of service that is required and deliver the child to the relevant centre, meaning that ambulances would still go to QMS. However the guiding principles on urgent care centres provided by the Care Trust appears at odds with this, stating that *"it is not envisaged that ambulances would deliver patients to an urgent care centre that is not linked to an A&E department"* . We therefore do not feel that there is sufficient clarity on this issue.

We are disappointed that there is no option for a Children's In-patient service locally. Our highly regarded children's ward is under threat of closure under the Picture of Health Consultation in order to concentrate services onto a smaller number of sites in order to provide more specialist care. Not all child illnesses require 'specialist care' so a children's inpatient unit should be retained at QMS. Often being closer to friends and family so they can visit regularly will have a very positive impact on a child's recovery. Families can struggle if they have other children at home and added travel will make the pressure harder.

Separating planned surgery from emergency surgery.

> The local NHS also proposes to separate planned surgery from emergency surgery. This will reduce the spread of hospital-acquired infections and the number of operations that need to be cancelled. Please tell us whether you agree with this proposal.

Comments:

It is difficult to answer this question as it is presented because the implications are that the answer will be used to promote a course of action that we do not agree with. In essence we would agree that minimising hospital acquired infections and reducing the number of cancelled operations are important issues to address and would be important to the residents of Bexley. The information contained in the consultation material states that this can be achieved by separating planned and emergency care and we follow this logic. However the only proposal that is suggested to achieve this separation is closing the A&E and emergency surgery services that are currently provided at Queen Mary's Hospital. It is this outcome that we would strongly disagree with. The question does not make clear that by agreeing or strongly agreeing to a separation of services to achieve the positive outcomes outlined in the question, effectively respondents are agreeing to the loss of a service. The consultation offers no choice in the course of action that could achieve the reduction of hospital acquired infections and reduce cancelled operations – if we say this is important to us, we are saying that we are happy to lose our key emergency services, which we are not. Visitors as well as patients can carry MRSA. Infection control procedures being more rigorously enforced will have an impact in reducing infections.

There are a high number of A&E attendances across all four of the hospitals in Outer South East London. We would like to understand more about the capacity issues that these changes will present across South East London and how they will be dealt with. Professor Sir George Alberti stated at a previous meeting that if the numbers do not stack up then changes will not be made. We would like to work closely with our partners to understand the capacity issues further and how they will be overcome with regard to the option that could be taken forward. The Care Trust have confirmed that they are seeking assurances from surrounding Trusts regarding capacity. However we received this assurance in March 2008 and feel strongly that this information should have been sought, in the months prior to consultation beginning so as to inform the proposals from the outset. Are the assumptions about patients attending other hospitals robust and have neighbouring Trusts given clear assurances that they can effectively manage the extra capacity?

Better Care in the Community

> The local NHS is proposing to increase local hospital services and improve care provided in the community. These developments will support the changes in specialist hospital services. This will mean outpatients tests, as well as antenatal and postnatal care, will continue to be provided as before and some services will be further developed. There will also be more home-based community nursing and therapy services.
>
> Please tell us whether you agree with these developments.

Comments:

The consultation questionnaire refers the respondent to pages 8 and 9 of the consultation document for information that will enable them to say how strongly they agree or disagree with the statement made in this question. Some of the information contained on these pages explains how patients want more care delivered closer to their home. It explains the issue of the spread of MRSA when hospitals carry out both emergency and elective care and explains some of the recent developments in community care, for example community matrons and extended services at GP surgeries. At face value the statement itself, if answered inline with the information given would be difficult to disagree with.

However, implications will be drawn from this answer that respondents may not agree with if the question were posed more clearly. For example the first sentence is very misleading. For the residents of Bexley their local NHS is not proposing to increase local hospital services. Comparing the range of services provided at Queen Mary's Hospital today against what is proposed under the Picture of Health

options, overall, demonstrates a reduction in key services. The question implies that more services will be delivered closer to home, yet it is not clear that this will be instead of the services that can be accessed currently at the local hospital. An example here is the reference to antenatal and postnatal care. The document does not explain clearly that providing these services at more convenient locations is an alternative to maintaining a maternity unit at your local hospital.

We are pleased that there is a commitment to developing community services in Bexley as these services have declined over recent years. However, as yet, there is not sufficient information about how local services will be developed before key services at our local hospital are closed.

There are significant staffing implications for delivering more services in the community. The Royal College of Nursing has expressed concerns about the implications on the workforce and having the right skills and training in place to deliver the kinds of services proposed in A Picture of Health. They are concerned that nurses need different skills to work on their own in community settings as opposed to being in a larger organisation with the back up of clinical staff in a hospital setting. The Royal College of Nursing feels that many nursing staff are apprehensive about the changes. A workforce development strategy will be needed to ensure staff are trained and supported through these changes.

The infrastructure of well developed community services and accessible extended GP services should be in place before major changes are made to our hospital services. There are a number of established enhanced services available in GP surgeries currently and we are pleased that there is a considerable commitment to developing this further. We are also encouraged by the development of a satellite renal dialysis service that is being developed. Many GP surgeries in Bexley do not provide extended opening hours and extended services, perhaps because they are small and do not have the space or capacity. However these local GPs can be highly valued by the residents because they are small and provide a more personal service. Bexley Care Trust explained that a federated model could be used to enable GPs to access wider services for their patients. This is very much inline with the options set out in the Healthcare for London consultation which closed in March. Although the Picture of Health consultation is taking place at the same time, the models of care in the Healthcare for London consultation document are already being proposed here. A federated model is referred to in the Healthcare for London Framework for Action document as "a federation model that would provide common services to existing practices". However this is in relation to the setting up of polyclinics. The document then goes on to state that "it is envisaged that over time polyclinics will become the site of most GP care".

The services of a Borough Hospital as listed in A Picture of Health appear the same as those of a polyclinic in Healthcare for London. We would like to understand more about the long term prospects of a Borough Hospital as a model of healthcare delivery as it does not appear in the strategic plan for the delivery of healthcare as set out in the Healthcare for London consultation. The options for services at Queen Mary's appear to match the description of a polyclinic with the only real difference between the two being elective surgery. We are therefore concerned about the future of elective surgery at QMS and would appreciate a long term commitment to the continuation of these services. We would not want to see a further consultation to re-locate this service to another site in a few years time. Will elective surgery continue to be delivered by the NHS? Our key concern is that the term Borough Hospital may be a transitional name for downgrading Queen Mary's to a Polyclinic over time or developing an Independent Sector Treatment Centre and losing other services altogether.

A cynical mind may consider that "Borough Hospital" is simply a more publicly acceptable term than polyclinic. We have been assured that the options for A Picture of Health are in line with the models of care that are set out in Healthcare for London. However, a Borough Hospital is not mentioned in the models of care set out in the Framework for Action so the

assumption must be that effectively the proposal involves a polyclinic as the main centre for the delivery of health services in Bexley. Statistics presented in the Healthcare for London Framework for Action document regarding the future of polyclinics and the services they will deliver, state that "the majority of healthcare activity will take place here – just under 60%. 50% of current A&E attendances would be dealt with in polyclinics and 41% of outpatients. It is acknowledged that new or more suitable sites for polyclinics may have to be found". From this information we could draw various conclusions, for example we have a hospital that currently deals with almost all of our healthcare needs with the exception of more specialist services, yet it will be replaced with a facility that will deal with at most just under 60% of them. It is proposed that this clinic will be supported by services in the community and GPs who will link seamlessly with it to provide wider services such as testing and various clinics, under a federated model. This raises many concerns, not least:

- The extended community services are not yet described or in place. Accessibility of GP surgeries to make bookings is often difficult. Residents in Bexley still have problems accessing their GP service resulting in attendance at hospital instead.
- Is there a commitment from local GPs to provide extended services?
- The IT infrastructure is not yet in place to support this
- Vast improvements in the relationship between Primary and Secondary care will need to be seen if the patient is to receive a seamless service between healthcare organisations

This is not an improvement on the services we have at present and does not offer residents more from their healthcare services overall.

Community services such Chiropody and Podiatry have been reconfigured over recent months in order to meet efficiency targets. We have seen reductions in budgets for community services to meet efficiency savings so we are naturally concerned by these proposals that promise so much with regard to enhanced community services. The Care Trust have acknowledged that current community services are not sufficient and are looking at services across the whole Borough. George Alberti has also stated that there is a need to look at the whole Borough in terms of where other services could be accommodated and this is encouraging. We are keen to be reassured that there will be investment in local facilities to make the delivery of these local services possible. We have mentioned previously the apparent close relationship between the services in a Borough Hospital and a polyclinic, however the Framework for Action document explains that a polyclinic would service a population of around 50,000, implying at least 4 would be needed in Bexley. Will there be investment in more facilities across the Borough, or plans to invest in GP surgeries across the Borough to enable them to deliver more services?

There are examples in the consultation document of some services already available in GP surgeries. Although this is encouraging, we strongly feel that plans for the delivery of community services in Bexley should have been included with the consultation material. We are being asked to support an option that presents a major reduction in our key services without any clear blueprint for the future of community services or clear commitment to the amount of investment that will be made.

Part 2

It is difficult to see how the questions in this section are relevant to the options for reconfiguration set out in A Picture of Health. Respondents are asked to rank the following statements in order of preference from 1-5.

- **Patients should have hospital services that are easy to get to by public transport**
- **Patient should be treated out of hospital**

unless going to hospital is really necessary

- **The local NHS should reduce the risk of patients catching hospital infections**
- **The local NHS should make best use of the hospital buildings it has available**
- **The local NHS should make the best use of specialist doctors and nurses**

These are all statements that a majority of people will agree are important and the ranking of their importance would be a matter of personal preference. How will the answers to these questions be used to determine a meaningful outcome that relates to what is proposed for our local services? Feeling strongly about being treated out of hospital and only going to hospital if really necessary is not the same as a preference for your local hospital to be downgraded. Reducing the risk of infections will be important to most patients but this does not necessarily mean they would agree with the removal of emergency services from their local hospital to achieve it. If a respondent strongly agrees that the NHS should make the best use of the hospital buildings it has available, it does not mean they would agree to local hospital land being sold off because services have been withdrawn from these sites.

The consultation does not include detailed information regarding access and public transport. This is an issue of major concern for residents of Bexley. As our current Public infrastructure is inadequate, often overcrowded for commuters and disjointed when travelling across the borough, with travel geared towards commuting into central London rather than around the Boroughs or to neighbouring Boroughs. The access to hospital task force set up by Travelwatch identifies issues with accessing both Darenth Valley Hospital (non-validity of the freedom pass) and Princess Royal University Hospital (lack of bus stands and stops) by public transport. We are pleased that an Integrated Impact Assessment will be carried out that will look at the issue of travel to various sites, however we would have liked to have seen this analysis as part of the information contained in the consultation material. Having the analysis available after the consultation has closed will not enable people to make informed comments as part of the consultation process.

The role of London Ambulance Service in delivering the options set out in the consultation is not fully explored in the consultation. George Alberti stated that the challenge for ambulance staff will be knowing when to leave a patient at home and envisaged ambulances becoming "mobile A&Es". The Pre-consultation Business Case states that all options will require the provision of additional emergency ambulances, we are pleased to see this has been considered. Also from information provided by the Care Trust and London Ambulance Service it seems that LAS are embracing the changes and a lot of collaborative work has taken place. The residents are still concerned about sufficient staffing and equipment, though communication and education will be essential to provide the public with confidence that the ambulance services can manage these changes effectively.

Part 3

Questions 3.1-3.3

This section uses the same five questions as part two but asks the respondent to indicate whether they agree or disagree with them in relation to the three options for the reconfiguration of services. Our response to part two above makes clear our view that these questions do not relate to the implications for the future delivery of services. We have also highlighted in part four of this response how for the residents of Bexley, there are effectively no options or choices for the future of their local services. Therefore in answering this section a respondent could easily imply satisfaction with a course of action that they don't agree with, whilst having no real platform for expressing any preference for something else. For these reasons we feel that this consultation, and section 3 in particular, is flawed.

Part 4 – Which option do you prefer?

We cannot support any of the options presented as part of the Picture of Health consultation. We have outlined a number of our concerns throughout this response and have listed here some of the key issues;

- For the residents of Bexley there is nothing to be consulted upon. All options for the future of healthcare services in the Borough are the same, therefore this is a process of providing limited information, not a meaningful consultation.

- The consultation documentation itself is flawed, misleading and does not give the residents of Bexley all of the information they need to express an informed opinion. This has been explained in the earlier points raised in relation to each specific question.

- There is not enough detailed information in any of the consultation documentation to give us the confidence in the options for Bexley. Community services need to be strengthened and established in the Borough and detailed plans set out for how and where these services will operate before we can support any changes to our hospital services. This is also essential if services are going to complement the move to more specialist centres as step down care both at healthcare facilities and in the community would need to be well established for the whole system to work. The Pre- Consultation Business Case sets out diagrams with options such as specialist support in the community. However, we need to understand the detail of this support, who will provide it, where it will be and how will it be accessed and booked.

- We feel there is a lack of clarity around the role and services of a Borough Hospital. Our concerns here have been set out previously in this response. We need there to be more clarity and transparency around what the role of a Borough Hospital is and where it fits into the wider models of care being set out as part of Healthcare for London.

- We feel strongly that the outcome of this consultation is pre-determined and that the changes are being driven by finance rather than patient care. It appears that the future of Queen Mary's Hospital has been sealed because of the inflexible PFI contracts that are in place across South East London. The Pre-Consultation Business Case states that "Given the long-term nature of PFI contractual commitments, it is important to achieve service dispositions that achieve optimum use of PFI capacity to enable cost reductions on sites with greater cost reduction flexibility". It would seem from this statement that as the only non-PFI hospital in Outer South East London, the fate of Queen Mary's Hospital is sealed with any options for its future as a fully admitting hospital discounted.

Appendix 2

Statutory Joint Health Overview and Scrutiny Committee

A Picture of Health for Outer South East London

A joint response to the consultation from the Health scrutiny committees of the London Boroughs of Lambeth and Southwark

April 2008

We note the considerable impact through extra pressures on healthcare provision in Lambeth and Southwark with major issues as yet unquantified.

1 Following a review by the Office of Government Commerce in early July 2007, the focus of the 'A Picture of Health' review (APOH) was narrowed to address the acute financial and clinical issues facing the four outer South East London boroughs. The governance arrangements for the project were consequently restructured and earlier options of direct relevance to the Lambeth and Southwark Trusts and PCTs were discarded. It was therefore proposed that the joint scrutiny committee no longer include representation from Lambeth or Southwark.

2 Health scrutiny councillors from both authorities saw merit in remaining involved with the JHOSC, as a minimum to maintain a watching brief. This decision was particularly based on the initial absence of the APOH clinical models and correlative patients flows, which are anticipated to impact Lambeth and Southwark health services.

3 The three options outlined in the subsequent consultation document do not include proposals to reconfigure services provided by hospitals local to Lambeth and Southwark. As acknowledged in the pre-consultation business case, however, the APOH options to reconfigure services in Bexley, Bromley, Greenwich and Lewisham include changes that would increase demands on certain Lambeth and Southwark based services, to an extent in certain cases that would require significant extra capacity and new build. Lambeth and Southwark residents are therefore susceptible to these changes and we are critically concerned that while additional modelling is currently being prepared to provide further detail, the consultation documents fail to adequately quantify or address such impact.

4 The absence of more refined modelling prompts extreme doubt that potential issues for Lambeth and Southwark service users will be averted. We support the request from the Academic Health Science Centre (AHSC) partners for an urgent piece of work, prior to the PCT decision, that would enable a proper assessment of the likely impact on these providers' services.

Our key concerns include as follows:

Transport

5 Each of the APOH options proposes the concentration of various services that are currently located across different borough sites. This would compel patients to travel greater distances to access healthcare currently provided locally. The forthcoming Integrated Impact Assessment (IIA) is expected to provide further detail on the predicted increases to travel times (and costs), but such information is currently unavailable and so hinders further comment.

6 The APOH options focus on acute care. However travel factors may also be influenced by an increase in the provision of community primary care services combined with certain secondary services, such as those outlined in the 'Healthcare for London' proposals. As the outcomes of the pan-London review are as yet unknown, further information gaps remain that prevent a complete assessment of the transport issues within the APOH proposals.

7 The APOH options would also place greater demands on the London Ambulance Service (LAS) and compel additional funding. While

the LAS claim to have no concerns in obtaining new monies, they have not yet costed the proposals. Moreover, Guy's and St Thomas' (GSTT) transport services for out patients are significantly stretched. It is not unusual for patients to be collected several hours prior to their scheduled appointment in order to fit with transport arrangements, and similarly to wait hours afterwards to be returned home. We are consequently concerned that increased patient flows will only exacerbate such challenges and further compromise service provision for Lambeth and Southwark residents.

Maternity

8 The proposed cross-borough concentration of maternity services is depicted in the APOH consultation documents as providing only benefits. It is promoted, for example, as enabling twice the number of senior doctors to be located at the one unit. As this would follow the closure of another unit, however, the numbers of women attending the combined unit could similarly double and therefore counterbalance the expected advantage of additional consultants.

9 It is not surprising that the Royal College of Midwives is "alarmed at the proposal to leave women in Lewisham with no maternity unit". In view of the 40% increase in births in the borough since 2000; the forecast ongoing population increase; and the current shortage of midwives in South East London (conservative estimates indicate 8.5% vacancies), there is inadequate assurance that matching services at King's College Hospital (KCH) and GSTT would not be pushed beyond the demands on current limits.

Accident and Emergency Services

10 The proposed closure of the A&E unit at University Hospital Lewisham (UHL) prompts particular concern about the potential impact for current KCH and GSTT emergency services. Evidence indicates that many Lewisham residents would be more inclined to travel to alternative services at the Lambeth and Southwark hospitals, than to Bromley. It is imperative that appropriate levels of additional capacity are agreed, financed and achieved, before such critical services are reduced in neighbouring boroughs. As emphasised in their combined response to the consultation, the AHSC partners similarly have significant concerns related to such increased patient flows.

There is an urgent need for the financial implications to be further clarified.

11 The APOH project has a ring-fenced budget of £10.5 million to cover capital costs of possible building work. There is inadequate information, however, as to how this would be apportioned to neighbouring hospital trusts that would be affected by increased user numbers.

12 Specific investment in infrastructure and possible new build would be a prerequisite to accommodate increased patient flows at KCH under both options 1 and 3. Moreover, any scaled increase would require additional investment: While option 2 would likely incur a less significant impact, the proposed changes could compel increased service efficiencies. Any decline in the quality of healthcare to Southwark and Lambeth residents due to an increased foot flow, should not be permitted. To emphasise, as mentioned, it would therefore be necessary that building improvements and extended service capacity be achieved prior to the decommissioning or relocation of healthcare services in neighbouring boroughs.

13 Queries regarding the proposals' expected impact on social care budgets have been raised on several occasions at the JHOSC meetings. In response, representatives of the APOH team have indicated that the reconfigured services should effect improved outcomes for patients, reducing the need for care following a hospital stay. However, it was also explained that the

possible impacts on social care services would need to be worked through via close collaboration between PCTs and local authorities. This indicates that the potential impact on such services is yet to be quantified or assessed.

14 Members anticipate that the proposals to combine or concentrate certain services will challenge social care budgets, as this is expected to compel cross-borough working for the provision of intermediate care, in a context where authorities have discrepant budget allocations and service policies.

That the existing cross-trust co-operation within Southwark, Lambeth and Lewisham be noted.

15 It is evident that the supporting and enhancing of services as a result of cross-trust cooperation could bring significant benefits, and members welcome the steps already taken by the AHSC consortium to explore such advantages with UHL. On the other hand, it would not be acceptable for any amalgamation of services or collaborative measures to result in the averaging of services or a quality compromise over a broader area, due to financial restrictions. In the absence of more refined modelling to determine what is financially viable, it is not feasible for members to properly comment further.

The four borough APOH proposals should not be advanced before the 'Darzi' consultations have taken their course.

16 That the APOH consultation has run concurrently with that of Healthcare for London compels uncertainty and prevents clarity. This is particularly so, when the first stage of the Healthcare for London review, which is designed to establish the models and principles for the re-configuration of pan-London services, has not yet concluded and thus the outcomes remain unknown.

The completion of a full Equality Impact Assessment is integral to an adequate assessment of the proposed changes and should have been provided with the core consultation documents.

17 At the January 22 meeting, a member of the JHOSC questioned the role of APOH in tackling health inequalities. A representative of the APOH team responded that health inequalities were not a key focus for the reconfiguration proposals and that these were issues being addressed by the Healthcare for London consultation. This position may account for the relatively late preparation of the APOH Integrated Impact Assessment (IIA), which is first due to be available to the joint scrutiny committee a few days prior to its May 20 meeting, when members are due to finalise their joint response.

18 Several organisations that have provided evidence to the JHOSC, however, highlight the potential impact on health inequalities as a significant concern. The Royal College of Midwives, for example, doubts the feasibility of the APOH proposals to tackle such issues: Changes to maternity care under options 1 and 3 are expected to adversely affect women who are the most vulnerable and socially excluded.

19 While it may not be a key objective of the APOH project to pro-actively alleviate health inequalities across the affected boroughs, it is critical that the proposals would not exacerbate inequalities and result in services that negatively and unfairly impact certain groups, - particularly those already characterised by vulnerability and/or deprivation. The failure to include a thorough equalities impact assessment with the core consultation documents prevents confidence that the APOH options will preclude such adverse outcomes.

(*These last points may need to be amended following provision of the IIA.*)

Appendix 3

9 April 2008

FREEPOST RRSL-BSTX-AKYS

A picture of health
Centre for Health Management
Tanaka Business School
Imperial College
London
SW7 2AZ

Dear Sirs,

Thank you for the opportunity to comment on the proposals set out in the consultation paper "A picture of Health". On the 23rd of January Lewisham Council discussed the proposals and concluded that the options in the consultation document would lead to a reduction of services in Lewisham. The proposals have also been considered by the Council's Healthier Communities Select Committee, the Children and Young People's Select Committee and by key Partnership Boards. I have attempted to capture the views expressed alongside those which I have heard directly from residents of Lewisham and reflect them in this response.

The investment made in the NHS over recent years has seen a marked improvement in the health services experienced by citizens. Advances in technology and medicine have revolutionised approaches to health care and treatment. Inevitably, the NHS needs to change and reform to take full advantage of these advances. However, as the NHS modernises it is vital that new improvements are in place and working before existing high quality provision is decommissioned. It is also essential that change benefits all of our citizens and that new models of health care are effective, efficient and responsive to local circumstances and the personal needs of individuals.

Lewisham is very much a part of inner-London. There are good transport links connecting our citizens to services within Lewisham and to provision in the centre of London. When choosing a hospital, I believe that residents will consider University Hospital Lewisham (UHL), which is on their doorstep, and Kings' and Guy's and St. Thomas' in central London, rather than the other hospitals set out in the consultation. It is vital that this important aspect of any future change is fully explored before any radical changes are made to provision at UHL. It is also essential that forecast population growth in Lewisham and the wider region are factored in to future plans.

Health care is not just about clinical need – particular social factors require personalised provision. For our new and emerging communities, who often fall outside the radar of care, UHL often offers vital support and health care provision. Any changes to current provision need to take account of these issues to ensure that existing health inequalities in this part of inner-London are not exacerbated.

We are fortunate in Lewisham to have a local hospital which provides high quality services to Lewisham's residents and beyond. Some of the provision is exemplary. UHL's paediatric care unit is rated as excellent, the only district general hospital in London to have such a rating. The Accident and Emergency (A&E) department at UHL is highly regarded, easily accessible and one of the busiest in South East London. The fact that UHL has separate children's theatres, dedicated paediatric anaesthetists and a separate children's emergency department play a significant role in ensuring excellent provision. UHL also contributes to the training and development of medical and allied professionals throughout the region. I am not at all persuaded that the removal of these services will meet the NHS objectives of providing higher quality care and better local services.

Lewisham's highly effective teams of nurses and doctors work with a supporting network of local health, social care and community sector providers to deliver personalised and wrap around care for our citizens. This holistic approach ensures joined-up services are focussed on patient's needs. As we move into the future it is vital to test and model fully new approaches to delivery to ensure improved services and better health outcomes for our citizens. Shifting key services out of the borough to different parts of

outer-London could compromise these effective networks and the excellent relationships that have been forged over time.

The consultation paper emphasises the importance of providing more services in the community and treating patients closer to their home. In order to achieve this, clinics, local GP surgeries, Urgent Care Centres, health centres and appropriate community support will need to be in position and fully capable of delivering extra care before provision at UHL is moved or reduced. For instance, it is questionable whether there will be a sufficient shift to home births to support any removal of maternity services at UHL. The consultation does not clearly demonstrate how this will be achieved.

All the public agencies and partners in Lewisham are working to ensure the environmental sustainability of the borough for future generations. The significance of the transport issues associated with these proposals need to be fully considered. The excellent transport links available in Lewisham ensure that UHL is accessible from virtually any part of the borough by bus, train or on foot. Any proposals to shift provision should explore fully the impact on citizens in terms of increased travel, transport capacity and on the environment in general as part of the overall considerations. This impact assessment is not set out in the consultation document.

Many of the proposals in the consultation emphasise the importance of modernising services and adapting them to meet the changing needs of our diverse communities. The drive to improve both primary and acute services, whilst empowering patients and citizens to participate in their own health care, is an objective we all share. The specific proposals in the paper do not set out clearly enough how new community care services and basic care pathways will evolve. The failure to adequately consider patient flows to inner-London hospitals also make it difficult to assess any of the options comprehensively but certainly rule out options 1 and 3 at this stage. As a result, I believe option two is the only option which provides an opportunity to further explore and secure an appropriate balance between primary and acute care in the future without damaging existing excellent provision.

I look forward to seeing the response to the consultation once you have had an opportunity to consider all the views expressed.

Yours sincerely,

Sir Steve Bullock

Mayor of Lewisham

Cc Gill Galliano, Chief Executive of Lewisham PCT
Michael Richardson, Chair of Lewisham PCT
Bala Gnanapragasam, Lewisham Hospital
Tim Higginson, CEO of the Lewisham Hospital
Oliver Lake, PCT

Appendix 4

Response by the Children and Young People Select Committee of the London Borough of Lewisham to the Picture of Health consultation

The Children and Young People Committee wishes to make the following points in response to the Picture of Health consultation:

1 We feel that the consultation document is difficult to understand. The information is laid out in dense columns and the implications of the different options are not spelt out sufficiently. There is little space in the comments boxes of the questionnaire for respondents to give their views.

2 We are concerned that people with poor levels of literacy are highly unlikely to respond. This is likely to result in a skewed response rate between different communities. It also means that people on low incomes, who do not have cars and are most likely to suffer as a result of services being provided at more distant locations, are the least likely to be involved in the consultation process.

3 The consultation events have not been well advertised. There have been some newspaper advertisements but many people do not receive these papers.

4 We understand that, although groups of clinicians were consulted at the pre-consultation stage, this was in general terms and no site specific information was given at that time.

5 The basis of the consultation is flawed. No account is taken of historic links between the Lewisham area and hospitals in inner south-east London, i.e. King's, Guy's and St Thomas'. These hospitals are connected to our area by rail routes and so more accessible to those people who do not have cars, and to many who do, than most of the hospitals in the consultation area. Even GP's close to the Bromley border told us that their patients identify more strongly with hospitals such as King's than with Bromley hospitals. Lewisham's population make-up has more in common with that of Southwark, which is not included in the consultation area, than with that of Bromley, which is.

6 Other complexities in relation to existing services do not appear to have been considered. Lewisham Hospital is a regional centre for paediatric and neo-natal surgery. It takes patients from all over the South-East of England. We understand that six paediatric services at Lewisham are shared with Guy's and St Thomas'. These cannot be moved to Queen Elizabeth without consultation with the other hospitals. Lewisham Hospital works well with SLAMH and, again, there are well-established links. These are just a few examples.

7 The committee is very concerned about the possible loss of maternity and children's services from Lewisham Hospital. Members of the committee recently visited these units and were impressed by the dedication of the staff we met and by the services provided. Children's services at Lewisham have an excellent reputation.

8 There is much concern that if services were moved to Woolwich, skilled and experienced members of staff would not necessarily move with them. Some would look for posts elsewhere.

9 No mention is made of gynaecology within a Picture of Health. Some doctors who deliver obstetric care discover gynaecological issues e.g. internal bleeding. Lewisham has a dedicated gynaecological ward.

10 The maternity and children's services at Lewisham have long-established links with the community. There are concerns that elements of the excellent service this enables would become fragmented and lost.

11 Lewisham's 24-hour A&E service is one of very few fully-staffed with children-trained

nurses. It also has a dedicated play therapist. We understand that when Sydenham Children's Hospital was closed in 1991 the promise was made that a separate children's A&E department would be maintained in the area.

12 Lewisham's neo-natal unit has three in-patient bedrooms for new mothers to stay overnight so that they can learn to care for their baby on their own but with support available. These are very well used and there clearly is a need for this service in Lewisham.

13 Lewisham provides level 2 beds. However, its paediatric intensive care unit offers both surgical and medical care and provides services which would otherwise go to level 3 beds at King's. Occasionally there is a shortage of such beds.

14 The Hospital school also has links with the community and provides outreach services for children who are out of school.

15 Lewisham Hospital currently takes a significant number of medical students for paediatric placements.

16 It is suggested in the consultation document that to prevent cross contamination it is preferable for there not to be emergency and planned surgery on the same site. However, we understand that it is perfectly possible to separate these functions completely within one site.

17 Clearly all options would result in some patients having to travel greater distances to hospital. It is not clear where increased money for patient transport will come from.

18 Many people in the Lewisham area live on low incomes or benefits. To travel greater distances for hospital appointments or to visit family members or friends in hospital would present financial difficulties for those living on very tight budgets.

19 The committee would prefer not to support any of the options outlined in the report because of the flawed basis for the consultation. However, of the three options, clearly option 2 is the only one that would preserve Lewisham's existing maternity and children's services.

20 To summarise, Lewisham Hospital has long-established maternity and children's services which are well-embedded with other local services e.g. safeguarding, GP's, health visitors etc. There are other historic connections which would be very difficult to disentangle. It would very clearly not be in the best interests of children and families in Lewisham to lose these important services from the local area.

Members of the Children and Young People Select Committee:

Councillor Julia Fletcher (Chair)

Councillor John Paschoud (Vice-Chair)

Councillor Godfried Gyechie

Councillor Ami Ibotson

Councillor John Muldoon

Councillor Marion Nisbet

Councillor Ian Page

Councillor Pete Pattisson

Councillor Romayne Phoenix

Councillor Alan Smith

Gail Exon (Church of England, Southwark Diocesan Board of Education)

Monsignor Nicholas Rothon (Roman Catholic Archdiocese of Southwark, Commission for Schools and Colleges)

Jonathan Montes (Parent Governor Representative – Primary Schools)

Patricia Howell (Parent Governor Representative – Secondary Schools)

Lewisham

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