IRP

Independent Reconfiguration Panel

ADVICE ON PROPOSALS FOR CHANGES TO THE DISTRIBUTION OF SERVICES BETWEEN BROMLEY HOSPITALS, QUEEN ELIZABETH HOSPITAL GREENWICH, QUEEN MARY'S HOSPITAL SIDCUP AND UNIVERSITY HOSPITAL LEWISHAM AND THE ASSOCIATED DEVELOPMENT OF COMMUNITY SERVICES

Submitted to the Secretary of State for Health

31 March 2009

IRP

Independent Reconfiguration Panel

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RECOMMENDATIONS

1 **The Panel supports the need for change in the location and delivery of the health services reviewed in Bexley, Bromley, Greenwich and Lewisham.**

2 **The Panel strongly believes that its Recommendations Three to Thirteen for the location and delivery of services will only be effectively implemented to provide sustainable care if Recommendations Fourteen to Nineteen are rigorously applied. The actions described in these recommendations must be undertaken before any major changes to the services at Queen Mary's Hospital Sidcup (QMS) take place.**

3 **The Panel supports the proposals to meet the emergency care needs of the population by concentrating services on three sites at Princess Royal University Hospital (PRUH), Queen Elizabeth Hospital (QEH), and University Hospital Lewisham (UHL), and the closure of emergency care services at Queen Mary's Hospital (QMS), subject to Recommendations Four, Five and Six below.**

4 **The Panel supports the proposals to meet the urgent care needs of the population through urgent care centres integrated with the A&E departments and medical assessment services at PRUH, QEH, and UHL, together with the urgent care centres already planned in the community and a 24-hour urgent care centre at QMS, integrated with a medical assessment service.**

5 **The Panel supports the proposals to concentrate emergency surgery on three sites, PRUH, QEH and UHL. The Panel does not support 12-hour differentiated take (8am to 8pm) at UHL and recommends that this locality retains 24-hour emergency surgery.**

RECOMMENDATIONS

6 **The Panel recommends that further work be undertaken with the London Ambulance Service to confirm the number of additional emergency ambulances required to support the proposals. The appropriate commissioners should also undertake further work on non-emergency patient transport provision to support the proposals.**

7 **The Panel supports the proposals to concentrate planned surgery on the QMS and UHL sites and, as modified in the Joint Committee of PCTs (JCPCT) decision, the continuation of adult day case surgery at PRUH, QEH, QMS and UHL.**

8 **The Panel supports the proposals to relocate planned surgery from Orpington Hospital to QMS. However, the Panel recommends that the plans for the future of the Orpington Hospital site be clarified urgently and that Orpington Hospital staff be fully involved in all further considerations.**

9 **The Panel recommends the development of detailed plans for critical care to support the proposals and the engagement of the South East London Critical Care Network to ensure that the proposals meet capacity requirements and the required standards across the network.**

10 **The Panel supports the proposals for maternity services that will provide local community midwifery, antenatal and postnatal services in all four boroughs with consultant-led maternity units at PRUH, QEH, and UHL. The Panel also supports the establishment of midwife-led units in these trusts and recommends the retention of the midwife-led unit at QMS, which should become a stand-alone unit.**

RECOMMENDATIONS

11 The Panel supports the proposals to concentrate neonatal services in support of consultant-led deliveries at PRUH, QEH, and UHL, and recommends that the South East London Perinatal Network Board ensures the compliance of each site with relevant standards prior to implementation.

12 The Panel supports the proposal to concentrate paediatric inpatient services at PRUH, QEH and UHL, with the closure of all paediatric inpatient beds at QMS. It recommends, however, that consideration be given to continuing day case cancer care for children and young people at QMS. In addition, the Panel recommends that the children currently utilising the Paediatric Oncology Shared Care Unit (POSCU), their parents and guardians are thoroughly involved and informed throughout the change process.

13 The Panel does not support the current proposals for non-complex paediatric surgery. The Panel recommends that a further examination of the suitability for non-complex paediatric surgery at PRUH, QEH, QMS and UHL be undertaken.

14 The Panel recommends that urgent work takes place to agree the clinical and patient pathways to achieve a seamless service across primary, secondary, community and social care, taking a whole systems approach. This must include liaison with local authorities and detailed agreement as to which community and social services need to be in place and operational before changes are made to hospital services. The Panel also recommends that estates and facilities planning work to accommodate the proposals be undertaken as a matter of urgency.

15 The Panel recommends that a rigorous review of the workforce implications of the proposals be conducted as soon as possible, based on agreed patient pathways, ensuring the full involvement of staff representatives.

RECOMMENDATIONS

16 The Panel recommends that a clear process is immediately put in place that will allow the financial viability of the proposals to be reassessed and assured through the lifetime of the programme, and that this should be overseen by NHS London.

17 The Panel recommends the immediate operation of the newly established Transport Group comprising staff, patients, members of the public and representatives from the London Ambulance Service, Transport for London and Travelwatch, with a specific requirement to work together to mitigate the effects of the proposals on those individuals most affected.

18 The Panel recommends that a comprehensive and inclusive public engagement strategy relating to the implementation phase of the proposals be specifically agreed with both the Joint Health Overview Scrutiny Committee (JHOSC) and Bexley Overview and Scrutiny Committee (Bexley OSC) prior to commencement of implementation.

19 The Panel recommends that NHS London oversees the implementation of the proposals within an achievable and agreed timescale, through the work of commissioning groups and project boards already established.

OUR REMIT

What was asked of us

1.1 The Independent Reconfiguration Panel's (IRP) general terms of reference are set out at Appendix One.

1.2 Two referrals were made to the Secretary of State for Health, The Rt Hon Alan Johnson MP, the first of which was on 28 August 2008 by Councillor David Hurt, Chairman of the London Borough of Bexley's Health and Adult Social Care Overview and Scrutiny Committee (OSC) who wrote exercising powers of referral under Section 7 of the Health and Social Care Act 2001. The second referral was made on 19 November 2008 by Councillor Sylvia Scott, Chair of the Joint Health Overview and Scrutiny Committee (JHOSC) consisting of members from the local authorities of Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark and Kent County. This referral was made pursuant to regulation 4 (5(a)) and 4 (7) of the Local Authority (Overview and Scrutiny Committee Health Scrutiny Functions) Regulations 2002 (S.I. 2002 No 3048), made under s.7 of the Health and Social Care Act 2001 (now consolidated in s.244 of the National Health Service Act 2006).

1.3 Both referrals concerned proposals developed by the Bexley, Bromley, Greenwich, Lewisham and West Kent Primary Care Trusts (PCTs) about the location and delivery of services currently provided at Bromley Hospitals (including the Princess Royal University Hospital and Orpington Hospital), Queen Elizabeth Hospital Greenwich, Queen Mary's Hospital Sidcup and University Hospital Lewisham, together with associated developments in community services. The proposals had been set out in a consultation document *A Picture of Health*, launched on 7 January 2008 by the Bexley, Bromley, Greenwich, Lewisham and West Kent PCTs.

1.4 The Secretary of State for Health requested advice on the referrals from the IRP, which undertook an initial assessment and subsequently advised the Secretary of State that the Panel wished to consider the issues further and would be willing to undertake a full review if requested. Terms of reference for the review were set out in a letter from the Secretary of State to Dr Peter Barrett, IRP Chair, on 29 December 2008.

1.5 Copies of correspondence are included at Appendices Two, Three and Four.

1.6 The IRP was asked to advise the Secretary of State by 31 March 2009:

a) *Whether it is of the opinion that the proposals for changes to the distribution of services between Bromley Hospitals, Queen Elizabeth Hospital (Greenwich), Queen Mary's Sidcup and University Hospital Lewisham and the associated development of community services will ensure the provision of safe, sustainable and accessible services for local people, and if not why not;*

b) *On any other observations the Panel may wish to make in relation to the proposals; and*

c) *On how to proceed in the interests of local people in light of a) and b) above and taking into account the issues raised by Bexley HOSC and the Joint HOSC in their referral letters of 28 August 2008 (and additional commentary of 19 December) and 19 November 2008 respectively.*

It is understood that in formulating its advice the Panel will pay due regard to the principles set out in the Independent Reconfiguration Panel general terms of reference.

OUR PROCESS

How we approached the task

2.1 The NHS London Strategic Health Authority (SHA) and the Bexley, Bromley, Greenwich, Lewisham and West Kent PCTs were asked to provide the Panel with relevant documentation for the review and to help arrange site visits, meetings and interviews with interested parties. The *A Picture of Health* (APOH) team, on behalf of the PCTs, carried out these tasks.

2.2 The JHOSC and Bexley OSC were also invited to provide documentation and suggest other parties to be involved in meetings and interviews. The Panel identified additional sites to visit and stakeholders to interview. Details of all visits, meetings and interviews are at Appendix Six.

2.3 The IRP Chair, Dr Peter Barrett, wrote an open letter to editors of local newspapers on 5 January 2009 informing them of the Panel's involvement (see Appendix Five). The letter invited local people, especially those who either felt they had new information that was not submitted during the formal consultation process or believed that their voice had not been heard, to contact the Panel. A press release was issued to local media on 5 January 2009, publicising the review process and inviting people to contact the Panel. A further press release providing information on progress was issued during the review (see Appendix Five).

2.4 Visits and evidence gathering were carried out by an IRP sub-group, consisting of seven Panel members; Peter Barrett who chaired the sub-group, Fiona Campbell, Sanjay Chadha, Ailsa Claire, Nick Coleman, Jane Hawdon and Ray Powles. Other Panel members attended on a number of days during the review. All of the evidence received was shared with sub-group members who were supported and accompanied throughout by members of the IRP Secretariat.

2.5 Panel members visited the four acute hospitals included in the APOH proposals, namely Princess Royal University Hospital, Queen Elizabeth Hospital, Queen Mary's Hospital Sidcup and University Hospital Lewisham, as well as Orpington Hospital, Darent Valley Hospital, the proposed site of Eltham Community Hospital, and a number of community health facilities including the Waldron Health Centre in New Cross, the Kaleidoscope

Centre in Lewisham, Beckenham Beacon and Lakeside Health Centre in Thamesmead, for six days in total (see Appendix Six).

2.6 The Panel also heard oral evidence over a total of nine days. A list of the people and organisations seen during these sessions is at Appendix Six.

2.7 Informal 'drop-in' sessions for staff took place at the four acute hospital sites on the evenings of 10, 11, 17 and 18 February 2009 (see Appendix Six).

2.8 Meetings were held with five local MPs over a period from 11 February to 4 March. Written evidence was also received from five other local MPs and the Mayor of London.

2.9 A list of all written evidence received from the SHA, PCTs, NHS Trusts, the JHOSC, Bexley OSC, MPs and all other interested parties is at Appendix Seven.

2.10 Throughout its consideration of the proposals, the Panel's focus has been the needs of patients, their relatives, public and staff, taking into account the issues of safe, sustainable and accessible services for local people as set out in the IRP's general terms of reference.

2.11 The Panel wishes to record its thanks to all those who contributed to the review, either by providing written or oral evidence or by contacting the IRP offering their views. Particular thanks are due to the staff of the Waldron Health Centre, Bexley Borough Council, and Sidcup Leisure Centre for the use of their buildings and facilities, and the APOH team for arranging the large number of site visits and assisting with overall arrangements. The Panel was also impressed by the documentation provided by the SHA, PCTs and Overview Scrutiny Committees.

2.12 The advice contained in this report represents the unanimous views of the Chair and all members of the IRP.

THE CONTEXT

A brief overview

3.1 The services that are the subject of the proposals and review by the IRP are provided by four south east London acute trusts, namely Bromley Hospitals (Princess Royal University Hospital (PRUH) and Orpington Hospital), Queen Elizabeth Hospital (QEH) Greenwich, Queen Mary's Hospital Sidcup (QMS) and University Hospital Lewisham (UHL). Their services are commissioned mainly by five primary care trusts, namely Bexley, Bromley, Greenwich, Lewisham and West Kent. The PCTs are the sponsors of the APOH proposals, for which a Joint Committee of Primary Care Trusts (JCPCT) was created.

3.2 The stated aim of the APOH programme is twofold: first, to improve health services for approximately one million people living in the four boroughs of Bexley, Bromley, Greenwich and Lewisham, and parts of West Kent; second, to address urgent financial issues. The four acute trusts had a combined deficit of £20.4m in 2007/8 and an accumulated debt of £121.5m in 2007/8, forecast to rise to £205.9m in 2010/11.

3.3 Pre-consultation engagement with the public began in October 2006 and ran until March 2007. Across south east London, 180 meetings took place with community groups. In December 2006, the first briefing of the HOSCs[1] and patient forum members took place and, in July 2007, a review was carried out by the Office of Government Commerce to provide quality assurance. At this stage, APOH was formally refocused on to the urgent clinical and financial issues affecting the acute trusts in outer south east London. Consequently, Lambeth and Southwark PCTs left the formal APOH programme structure, although they remained closely involved. A total of 23 options for reconfiguration of services was reduced to three for public consultation and, on 7 January 2008, a 14-week consultation exercise was launched.

3.4 The consultation document states that "*the purpose of* A Picture of Health *is to address the urgent clinical and financial issues that are preventing your local NHS from providing better, safer and affordable care. We believe that our health services cannot continue as they are and that we have to change them"*. The document further states that

[1] Consisting of the Health Overview and Scrutiny Committees from Lewisham, Greenwich, Lambeth, Southwark, Bexley, Bromley and West Kent. These subsequently became the Joint HOSC.

the proposed changes would enable the NHS to *"treat more patients closer to their homes"* and *"better organise hospital services, especially emergency care, maternity and children's services and planned surgery, so that patients are treated more safely and quickly in units that are designed to meet their particular needs"*. The document also states that the options consulted on would allow the NHS to *"manage ... money better in the future"*.

3.5 All three options presented for consultation proposed that all four hospitals would provide outpatients and tests, an urgent care centre, children's assessment and treatment centres and a medical assessment service for older people.

In all three options, it was proposed that other services at **PRUH, QEH and QMS** would be:

- **PRUH and QEH** would become specialist emergency centres providing accident and emergency (A&E), surgical and non-surgical emergencies, trauma surgery, inpatient maternity services and inpatient children's services. Planned surgery would not be provided.

- **QMS** would specialise in planned surgery and would become a base for community healthcare services. A&E, surgical and non-surgical emergencies, trauma care, inpatient maternity and inpatient children's services would not be provided.

The proposals for other services to be provided at **UHL** were different in the three options:

- **Option 1**. UHL would provide A&E, non-surgical emergencies and planned surgery. Surgical emergencies, trauma surgery, inpatient maternity and inpatient children's services would not be provided.

- **Option 2**. UHL would become a specialist emergency centre providing A&E, surgical and non-surgical emergencies, trauma surgery, inpatient maternity and inpatient children's services as for PRUH and QEH. It would also provide planned surgery.

- **Option 3.** UHL would specialise in planned surgery similar to QMS. A&E, surgical and non-surgical emergencies, trauma surgery, inpatient maternity and children's services would not be provided.

3.6 Consultation documents were distributed to over 500,000 households and 46,000 businesses. 145,000 documents were placed in public outlets such as libraries, pharmacies and GP surgeries. 309 public meetings were held including 111 with traditionally under-represented groups. More than 8,500 people attended meetings and public events, and 1,306 telephone calls, emails and letters were received in response to the consultation document. There was also a series of press adverts and releases, together with regular website updates. The consultation document was accompanied by a questionnaire produced by a team from Imperial College.

3.7 On 10 June 2008, a workshop took place to review the criteria upon which the decision on the options would be made and, on 20 June 2008, Imperial College presented an analysis of the consultation responses at a public feedback event. 8,374 questionnaires, 79 letters, 71 voice messages, four petitions and 22,534 telephone texts were analysed. This was interpreted as representing 8.40 respondents per 1,000 inhabitants.

3.8 Information from an Integrated Impact Assessment (IIA) was made available to the JHOSC at a presentation given by the APOH team on 20 May 2008, after the consultation had been completed. The presentation, which was termed *"work in progress and therefore draft"*, reported on the setting up of an IIA Steering Group with an independent chair, a sponsor PCT chief executive, and a local authority and user representative. The work considered and addressed the impact of travel access and equalities for traditionally under-represented groups, as well as the environmental impact and carbon footprint of the proposals.

3.9 The JCPCT decision-making meeting took place on 21 July 2008. At the meeting, the JCPCT agreed to adopt Option 2, but added two variations to form the selected option known as Option 2d. The variations provided for day case surgery to be retained on all four acute hospital sites, together with establishing a 12-hour 'differentiated take' for emergency surgery at UHL, whereby emergency surgical admissions would be accepted between 8am and 8pm.

3.10 On 4 August 2008, the Bexley OSC decided to refer the proposals to the Secretary of State for Health and referral was made on 28 August 2008. The key components of the **Bexley OSC** referral were:

- Adverse impacts of the Joint Committee of Primary Care Trusts' decision on services and local residents
- Undue influence of financial factors and PFI schemes on reconfiguration
- Flawed and inadequate consultation
- Lack of public support for Joint Committee of Primary Care Trusts' preferred option
- Limited assurance of deliverability

3.11 On 10 September 2009, the JHOSC, which included members of the Bexley OSC, met and also decided to refer the proposals to the Secretary of State. A referral letter was subsequently sent on 19 November 2008. The **JHOSC's** reasons for its referral were:

- The consultation process was flawed
- The late completion of the Integrated Impact Assessment
- Loss of services at Queen Mary's Hospital
- Inadequate financial modelling
- Lack of Integrated Impact Assessment for the geographical areas covered by Lambeth and Southwark Councils

3.12 However, the JHOSC letter also stated that the referral was not seeking a review of the decisions about the configuration and delivery of services at Greenwich and Lewisham - a statement that required clarification during the IRP review. The JHOSC confirmed it was not contesting the proposals in respect of Lewisham but, subsequent to the submission of its referral, recognised that the proposals relating to Greenwich were inextricably linked with those relating to Bromley and Bexley. The referral letters are at Appendices Two and Three.

3.13 Between the date that the JHOSC decided to make a referral (10 September 2008) and the formal referral being made to the Secretary of State (19 November 2008), the APOH team produced a paper for the JHOSC dated 23 October 2008 titled *Service developments to be progressed alongside referral to Secretary of State*. The purpose of the paper was for the JHOSC and JCPCT to agree which service changes were outside the scope of the referral and thus could move forward immediately to implementation. The paper was considered by the JHOSC on 27 October 2008. During the review, the IRP was informed that agreement had been reached in some areas, although the minutes have only been produced in draft form and have not been formally ratified[2].

3.14 On 3 December 2008, the Bexley OSC met to agree an *additional commentary*, relating particularly to decisions agreed at the JHOSC meeting on 27 October 2008.

3.15 The Secretary of State for Health asked the IRP for an initial assessment of the two referrals. Following receipt of that advice, the Secretary of State requested on 29 December 2008 that the IRP undertake a full review.

[2] This document and the subsequent discussion and apparent agreement, although undertaken with the best of intentions by all parties, has led to some confusion and uncertainty for staff, public, stakeholders and some managers and contributed to the ambiguous wording in the JHOSC referral letter.

INFORMATION

What we found

4.1 The Panel received a substantial volume of written and oral evidence, which has been of great assistance in enabling it to reach its conclusions and subsequent recommendations. The Panel is most grateful to those people who took the trouble to give evidence and for the care taken by those who made presentations, especially those members of the public who were coping with difficult personal and family circumstances at the time. The Panel considers that the documentation received, together with the information obtained during oral evidence gathering sessions and other meetings, provides a fair representation of the views from a variety of perspectives. The evidence submitted to the Panel is summarised below under headings that emerged during the review. The tables and map have been taken from documentation submitted to the IRP by the NHS.

4.2 Population profile

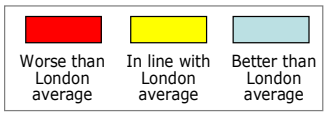
4.2.1 Approximately one million people live in the four south east London boroughs of Bexley, Bromley, Greenwich and Lewisham. This is set to rise over the next 10 years, due to factors such as the Thames Gateway regeneration. There is a dividing line locally between the north and south of the area in terms of the health status of the population overall. The health of residents closer to the Thames in the northern wards of Bexley, Greenwich and Lewisham is generally worse than in the south of these boroughs and than in the borough of Bromley. People's health in these areas is also generally worse than the rest of London and national averages. In Greenwich and Lewisham, people live about two years fewer than most Londoners (77 for men and 81 for women)[3] whereas in most parts of Bexley and Bromley, people have better health and live up to two years longer than people in many places in London. There is an increasingly elderly population in Bexley and Bromley and, although people in Bexley and Bromley are largely more affluent and in better health, there are also pockets of inequality and poorer health status in these boroughs.

[3] Life expectancy in South East London 2003-2005

4.2.2 Greenwich and Lewisham both have high levels of deprivation, Greenwich ranking 24 and Lewisham 39 out of 354 of the most deprived boroughs in the UK. There are also areas of deprivation in the boroughs of Bexley and Bromley.

Population profiles and health needs

(Source: DH Community Health Profiles)



Health Indicator	Lambeth	Southwark	Lewisham	Greenwich	Croydon	Bromley	Bexley
Deprivation							
Children in Poverty							
Homelessness							
GCSE Achievement							
Life expectancy							
Infant Mortality							
Early deaths: cancer, heart disease & stroke							
Deaths from smoking							
Alcohol admissions & drug misuse							
Mental Illness & Violent crime							
Physically active adults							
Binge drinking adults							
Healthy eating adults							
Obese Adults							
Obese Children							
Teenage Pregnancy							
Tuberculosis							

4.2.3 The following table shows the number of people in the four boroughs who are from Black and Minority Ethnic (BME) groups.

	Bexley	**Bromley**	**Greenwich**	**Lewisham**	**Total Sector**
Total Population	221,000	298,000	222,000	253,000	994,000
BME Groups	18,800	24,800	49,100	84,800	177,500

4.3 **Service profile**

4.3.1 The table below summarises the current activity at the four hospitals most affected by the proposals.

	BHT (PRUH, Orpington, Beckenham)	**QEH**	**QMS**	**UHL**
Total acute, critical care and maternity beds	537	468	338	501
No. of acute beds in 2008	492	414	299	439
No. of critical care	15	17	10	20
No. of maternity beds	30	37	29	42
Bed occupancy	95.0%	94.8%	90.0%	85.3%
A&E attendances 2007/08	93,434	99,900	66,339	124,890
Non-elective inpatient spells 2007/08	25,742	32,876	20,008	31,843
Total elective (inpatient and day case) 2007/08	33,110	23,440	18,752	20,958
Outpatient attendances 2007/08	249,708	186,225	150,802	187,927

4.3.2 *Bromley Hospitals Trust (BHT)*

Bromley Hospitals Trust consists of the Princess Royal University Hospital and Orpington Hospital.

4.3.3 Princess Royal University Hospital (PRUH) is located at Farnborough Common in the London Borough of Bromley (population 298,000). It is a 30-year Private Finance Initiative (PFI) funded hospital, costing £155m and completed in 2003. BHT entered into an additional £10m PFI agreement to supply, maintain and/or replace certain medical equipment. At present, PRUH provides accident and emergency (A&E) services, general medicine, emergency and planned surgery (the latter in both the main hospital building and in a purpose built day surgery unit), trauma and orthopaedic surgery, a critical care unit providing both level 2 and level 3 care, children's services (inpatient, assessment and treatment), consultant-led maternity services and a level 1 neonatal unit and outpatient services.

4.3.4 Orpington Hospital contains a 66-bedded treatment centre opened in 2003, which provides planned surgery (located on the top floor). Additionally, the hospital provides

intermediate care managed by the PCT, a range of therapies and specialist rehabilitation, together with outpatient clinics and diagnostic facilities (located on the ground floor). Rooms are also leased to independent organisations.

4.3.5 In 2005, BHT was invited to proceed to its second phase of application for foundation trust status. However, the Panel noted that BHT, QEH and QMS are included in the list of 20 hospital trusts that have been identified as unlikely to achieve FT status by 2010.

4.3.6 The Healthcare Commission's assessment of BHT for each of the last three years is set out in the table below.

	2007/08	**2006/07**	**2005/06**
Quality of services	Fair	Good	Fair
Meeting core standards	Almost met	Fully met	Almost met
Existing national targets	Partly met	Fully met	Fully met
New national targets	Good	Good	Weak
Use of resources	Weak	Weak	Weak
Maternity	Least well performing	Least well performing	

4.3.7 *Queen Elizabeth Hospital (QEH)*

QEH is located in Woolwich in the London Borough of Greenwich (population 222,000) on the site of a former military hospital. It is PFI-funded and opened in 2001. There is a separate 15-year PFI contract for certain medical equipment, which began in 2002. QEH currently provides A&E services, general medicine, emergency and planned surgery, trauma and orthopaedic surgery, level 2 and 3 critical care, children's services (inpatient, assessment and treatment), consultant-led maternity services and a level 1 neonatal unit, a medical assessment service for older people and outpatient services. It also provides urology and dermatology services for the boroughs of Greenwich and Bexley. An urgent care centre (UCC) pilot scheme was initiated within the A&E department in February 2009.

4.3.8 The Healthcare Commission's assessment of QEH for each of the last three years is set out in the table below.

	2007/08	2006/07	2005/06
Quality of services	Good	Good	Fair
Meeting core standards	Almost met	Almost met	Almost met
Existing national targets	Fully met	Fully met	Fully met
New national targets	Good	Excellent	Fair
Use of resources	Weak	Weak	Weak
Maternity	Fair performing	Fair performing	

4.3.9 *Queen Mary's Hospital Sidcup (QMS)*

QMS is located at the southern extremity of the London Borough of Bexley (population 221,000). It was extensively rebuilt in the late 1970s and early 1980s. QMS currently provides A&E services (including a UCC managed by the PCT), general medicine, emergency and planned surgery, trauma and orthopaedic surgery, level 2 and 3 critical care, children's services (inpatient, assessment and treatment and the paediatric oncology shared care unit (POSCU)), consultant-led maternity services and a level 2 neonatal unit, a midwife-led birthing unit, a medical assessment service for older people and outpatient services.

4.3.10 The Healthcare Commission's assessment of QMS for each of the last three years is set out in the table below.

	2007/08	2006/07	2005/06
Quality of services	Fair	Fair	Good
Meeting core standards	Fully met	Almost met	Fully met
Existing national targets	Partly met	Fully met	Fully met
New national targets	Good	Weak	Good
Use of resources	Weak	Weak	Weak
Maternity	Least well performing	Least well performing	

4.3.11 *University Hospital Lewisham (UHL)*

UHL is located in the London Borough of Lewisham (population 253,000). The inpatient beds are in the modern Riverside Building and in A Block (the women's and children's block) which opened in the 1980s. The Riverside Building is PFI-funded and the hospital is in discussion with its PFI partner about a fifth operating theatre. Services currently provided include A&E (with a stand-alone paediatric-staffed children's A&E department), general medicine, emergency and planned surgery (the latter in both the main surgical ward and theatres and in a treatment centre), trauma and orthopaedic surgery, level 3 intensive care unit, children's services (inpatients, assessment and

treatment), consultant-led maternity services and a level 2 neonatal medical and surgical unit, a medical assessment service for older people and outpatient services.

4.3.12 The Healthcare Commission's assessment of UHL for each of the last three years is set out in the table below.

	2007/08	**2006/07**	**2005/06**
Quality of services	Fair	Good	Good
Meeting core standards	Almost met	Fully met	Almost met
Existing national targets	Partly met	Fully met	Fully met
New national targets	Good	Good	Good
Use of resources	Fair	Weak	Weak
Maternity	Least well performing	Least well performing	

4.3.13 *Community Services*

The following is a brief description of those community services and facilities visited by the Panel during the review.

4.3.14 *Beckenham Beacon*, managed by Bromley Care Trust, is a new facility providing outpatient and diagnostic services for the population of north Bromley. These include antenatal care, physiotherapy and genito-urinary medicine. There is also an adjoining new minor injuries unit with a UCC due to open later in 2009.

4.3.15 *Kaleidoscope* is the Lewisham Centre for Children and Young People, located in Catford. The Centre provides a comprehensive range of services for children and young people who have a disability or other specialist health, mental health, social care or education needs.

4.3.16 *Eltham Community Hospital* is a proposed development with a service specification in Greenwich PCT's Outline Business Case, confirmed by both *Healthcare for London* and APOH. Services envisaged include 40 intermediate care beds; GP services; a range of community services; outpatient services; a UCC; diagnostics; and interactive health information.

4.3.17 *Lakeside Health Centre* is located in Bexley and provides: family planning; antenatal clinics; maternity care; well baby clinics; postnatal care; parentcraft classes; smear tests;

minor surgical procedures; asthma clinics; diabetes clinics; travel clinics; dietetics; high blood pressure and heart disease clinics; blood testing; mental health services; chiropody; speech therapy; and audiology.

4.3.18 *Other hospitals affected by the APOH proposals*

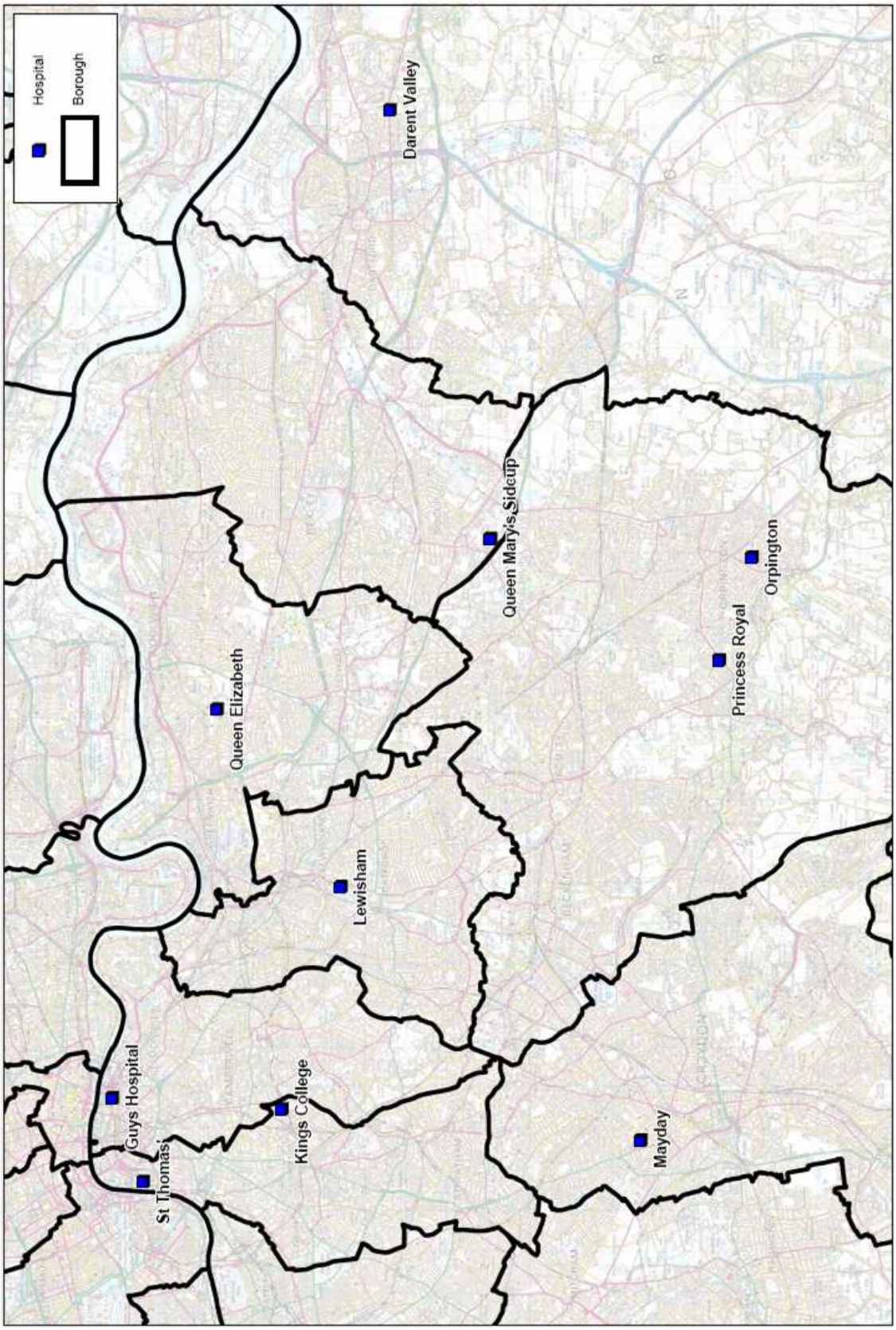
A number of other hospitals are affected by the proposals.

4.3.19 *Darent Valley Hospital* is a PFI-funded acute general hospital trust serving a population of approximately 300,000 people living in Dartford, Gravesham, Swanley and Bexley. Activity undertaken at Darent Valley relating to Bexley residents increased by 17 percent in 2008/09. Besides a range of acute services already in place, a *Heart Centre* was established in 2007, and a *Stone Centre* in 2008. Darent Valley has a level 1 neonatal unit and takes maternity and neonatal cases when QEH is at capacity.

4.3.20 *The King's Health Partners Academic Health Sciences Centre (AHSC)* comprises Guys and St Thomas' NHS Foundation Trust (GSTT), King's College Hospital NHS Foundation Trust (KCH), South London and Maudsley NHS Foundation Trust (SLaM) and King's College London. The AHSC works closely with UHL, including an initiative to improve maternity service standards in line with *Healthcare for London* and *Maternity Matters* guidance.

4.3.21 *Networked Services* - neonatal services at PRUH, QEH, QMS and UHL, together with those at Darent Valley Hospital, GSTT and KCH, form the South East London Perinatal Network - one of five such networks in London reporting to the London Perinatal Steering Group. GSTT and KCH provide level 3 neonatal units for the South East London Perinatal Network. Babies requiring level 3 treatment are transferred to GSTT or KCH and then returned to the local unit for continuing care.

4.3.22 *Location of hospitals*



4.3.23 The distances between the hospitals is set out in the table below.

Hospital	Hospital	Distance in miles
UHL to	**QEH**	4.50
UHL to	**QMS**	7.00
UHL to	**PRUH**	8.00
QEH to	**PRUH**	10.75
QEH to	**QMS**	6.00
QMS to	**PRUH**	6.25

4.4 Financial profile

4.4.1 As the Healthcare Commission assessments show, the four acute trusts have had financial problems for some years. At the point of the JCPCT's decisions about APOH in July 2008, the income and expenditure position for the outer south east London NHS was as described in the table below.

No change (Baseline) Income & Expenditure statement - Nominal prices

£ million

		2007/08	2008/09	2009/10	2010/11
OSEL PCTs					
Bexley	Funding	355.9	360.1	378.8	398.7
	Commissioned services & costs	(355.8)	(357.1)	(375.6)	(395.3)
	Contingency	0.0	(3.0)	(3.2)	(3.4)
	NET POSITION	*0.1*	*(0.0)*	*(0.0)*	*(0.0)*
Bromley	Funding	403.5	429.6	448.9	473.1
	Commissioned services & costs	(403.5)	(426.5)	(445.7)	(469.8)
	Contingency	0.0	(3.1)	(3.2)	(3.3)
	NET POSITION	*0.0*	*0.0*	*0.0*	*(0.0)*
Greenwich	Funding	372.4	404.9	423.3	444.0
	Commissioned services & costs	(373.3)	(400.6)	(420.0)	(439.6)
	Contingency	0.0	(4.3)	(4.4)	(4.5)
	NET POSITION	*(0.9)*	*(0.0)*	*(1.1)*	*0.0*
Lewisham	Funding	426.3	453.3	472.1	496.5
	Commissioned services & costs	(426.2)	(448.3)	(466.1)	(489.5)
	Contingency	0.0	(5.0)	(6.0)	(7.0)
	NET POSITION	*0.1*	*0.0*	*0.0*	*0.0*
Net PCT in year surplus / (deficit)		(0.7)	(0.0)	(1.1)	0.0

Note: The in-year PCT deficits in 2007/08 and in 2009/10 are driven by Greenwich tPCT in-year positions. These in-year positions are, however, funded by a surplus carried forward by Greenwich tPCT and therefore are not a resource pressure on the health economy.

OSEL Trusts					
BHT	Income	158.5	172.2	176.1	180.2
	Expenditure	(176.4)	(172.0)	(175.8)	(179.8)
	NET POSITION	*(17.9)*	*0.2*	*0.3*	*0.4*
QEH	Income	148.1	149.0	147.4	151.5
	Expenditure	(151.5)	(154.5)	(152.7)	(158.0)
	NET POSITION	*(3.4)*	*(5.5)*	*(5.3)*	*(6.5)*
QMS	Income	101.3	95.6	94.3	93.2
	Expenditure	(104.2)	(109.7)	(113.7)	(119.6)
	NET POSITION	*(2.9)*	*(14.1)*	*(19.4)*	*(26.4)*
UHL	Income	171.1	163.2	165.5	168.8
	Expenditure	(167.3)	(162.9)	(165.8)	(171.1)
	NET POSITION	*3.8*	*0.3*	*(0.3)*	*(2.3)*
Net Trust in year surplus / (deficit)		(20.4)	(19.1)	(24.7)	(34.7)
OSEL health economy in year net surplus / (deficit)		(21.1)	(19.1)	(25.8)	(34.7)

4.4.2 The deficits incurred by the acute trusts up to the end of 2007/08 had accumulated into a combined debt of £121.5m.

4.4.3 In addition, to the acute sector's deficits and accumulated debts, the Panel was advised that Bexley Care Trust is required to repay over the next two financial years an overspend of £10.7m.

4.4.4 As part of the NHS London-wide agreement to fund the repayment of legacy debt accumulated by certain trusts (including those in outer south east London), the Panel was informed that Bromley, Greenwich and Lewisham PCTs will contribute nearly £22m in total from their resource allocations over the next two years.

4.5 The need for change

4.5.1 The purpose of APOH, as stated in the consultation document, is *"to address the urgent clinical and financial issues that are preventing your local NHS from providing better, safer and affordable care"*, and this was reinforced in the evidence given by the APOH team who stated that *"APOH was founded on an overwhelming clinical case for change"*. Emphasis was placed on the way in which clinicians across the acute trusts had worked together and that it was intended to *"put clinicians in the driving seat for a change"*. There was agreement between those in the NHS and the JHOSC that *"no change was not an option"*. It was stated in the consultation document that *"without making changes, services will become increasingly unsafe, unaffordable and unable to meet national standards and clinical best practice"*.

4.5.2 Further reasons given by the APOH team for why change is necessary:

- *Hospital services* spread too thinly; need to create critical mass to deliver 'quality with efficiency'; current service failing to provide quality of service structure and outcome; current service configuration an obstacle to improvement; impact of all of these factors most evident in the smallest unit, QMS
- *Out of hospital services* currently insufficient; do not sufficiently support people in the community; inappropriate admissions to hospital; review by the National Clinical Advisory Team (NCAT) in 2007 stated that "A Picture of Health *is not*

about hospital closure but rather the redesign, redistribution and improvement of hospital services"

4.5.3 Not everyone agreed with the need for change. The Panel heard from a number of people who wished to see services remain as at present and some who felt that the proposals were driven only by financial issues rather than clinical quality as well.

4.6 **Emergency and urgent care**

4.6.1 The Panel heard evidence that the Royal College of Surgeons (RCS) recommends a catchment population of 450,000 – 500,000 for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency medical and surgical care. Whilst recognising the circumstances of rural populations, the RCS suggests smaller hospitals should be reorganised to achieve a catchment population of at least 300,000. At present, in outer south east London, there are four acute hospitals serving a population of around one million people.

4.6.2 There are currently insufficient consultants and staff to staff four A&E departments properly. The proposal under Option 2 would provide for A&E departments at PRUH, QEH and UHL, while the A&E department at QMS would close. At present, QMS only has two A&E consultants. The Panel heard that the College of Emergency Medicine recommends a minimum of four consultants for a small department and eight for a medium sized department. It was argued by the APOH team that this overall situation would be resolved through the revised configuration, which would create a critical mass of patients, bring consultant numbers up to strength, enable relevant clinical skills and experience to be maintained and would take account of the European Working Time Directive.

4.6.3 In addition to the three A&E departments, there are plans to have UCCs at each of the four hospital sites. One has already been operating at QMS for the past year. UHL has a Primary Care Centre adjacent to its A&E. It is estimated by APOH that up to 80 percent of people currently attending A&E could be seen in primary care. Besides the four UCCs located at the hospitals, the minor injuries unit at Beckenham Beacon will be extended to become a UCC and Eltham Community Hospital is also planned to have a UCC in 2010. The aim is that those arriving at an A&E department would be diverted through triage, if

appropriate, to the co-located UCC. Those arriving at a UCC who need emergency care would be transferred to an A&E department - by ambulance if the UCC is not co-located.

4.6.4 The Panel received a substantial volume of written and oral evidence, from members of the public and from the JHOSC and Bexley OSC, expressing concerns over the proposed loss of A&E services at QMS. Some believed that their removal might lead to a domino effect of other services being withdrawn, whilst others consider that QMS is ideally sited to deal with road traffic accidents from the nearby A2, A20 and M25. Concern was expressed over the difficulty of accessing alternative A&E facilities at PRUH or QEH, and the Panel heard many requests for retention of the A&E department at QMS. The Panel was told of potential confusion amongst the public of what a UCC was and what services it offered. One member of the public described his visit to the A&E department at QMS, but had not realised that he had been triaged into the UCC. The Panel heard from many that, in their opinion, the case for closure of the A&E department at QMS had not been made in the consultation document, although there was broad support for the proposed older person's and children's assessment units to be established there.

4.6.5 The Panel visited the A&E facilities at the four acute hospitals and found them all to be busy. The department at QEH was cramped and unable to provide staff teaching or changing facilities and the Panel heard of the need for expansion from clinicians. The facilities at UHL were most in need of modernisation and development. The cubicles at UHL's A&E department are sub-divided by curtains in order to accommodate the volume of patients being treated and this has resulted in a lack of privacy. The Panel heard of outline plans to expand the facility, which would include a UCC, but substantial capital finance would be required.

4.6.6 The Panel heard in evidence that the majority of admissions to the four acute hospitals are medically related. A critical mass is required to create an acute medical unit, which is the model of care recommended by the Royal College of Physicians. The Panel was told that it was intended to implement such a unit partially at PRUH, QEH and UHL, but not at QMS where, due to insufficient staffing, it was not considered possible. This would mean the redistribution of medical beds from QMS across the other three acute hospitals.

However, under the proposals, a Medical Assessment Service for older people will be in place at all four locations.

4.6.7 The APOH team described the future emergency medical care pathway, which would be initiated through either self-referral via A&E/UCC or GP referral direct to a Medical Assessment Unit where appropriate. A&E and Medical Assessment Unit medical arrivals would be handled by a single team and a consultant physician would be present in the emergency admitting area for 12 hours per day. Patients would be streamed - either to a specialist unit if required or to remain on a medical short stay ward or in short stay elderly care beds. Those patients needing level 1 intensive care would be taken to a medical high dependency unit.

4.7 **Emergency surgery**

4.7.1 The Panel was told by the APOH team that systems of emergency surgery that have centralised treatment into larger units offer significantly improved care and treatment outcomes. Currently, all four acute hospitals provide emergency surgery for a combined population of just under one million people.

4.7.2 Under the APOH proposals, emergency surgery would no longer take place at QMS. The Panel heard that the reconfigured services would be consultant-based, with consultants personally involved rather than distant from the delivery of care. In terms of a vision for the clinical care pathway, it was stated that, initially, the patient would be triaged by a senior A&E nurse and then examined by an experienced A&E doctor who would decide on the next stage of treatment. If the patient was to be transferred to the Surgical Assessment Unit and a surgical procedure was necessary, then they would be operated on within 12 hours and the consultant would be part of the decision-making process. The Panel was also told that the APOH model would deliver consultant-led orthopaedic trauma lists seven days a week.

4.7.3 One of the variants of the selected option, Option 2d, involves what is termed ‘differentiated take’ - restricting emergency surgery to 8am to 8pm at UHL. In giving evidence to the Panel, senior representatives from UHL disagreed that the ‘differentiated take’ model is in the interests of patient safety, accessibility and service sustainability, when applied to the population served by UHL. The Panel was told that local clinicians

were not involved in the work to examine the suitability of this model of care in the context of UHL's service, and the surgical clinicians seen by the Panel were not familiar with how the model would work in practice. It was further stated that UHL's ability to deliver other services agreed by the JCPCT would be compromised, should 'differentiated take' be adopted, with potentially serious consequences for the local population. The Panel was told of some potential practical difficulties associated with the set hours, including the necessity to complete surgical procedures by 8pm of patients admitted during the day; the care of patients already admitted but subsequently requiring surgery out of hours; and the effect of lack of surgical cover at night on other clinical services.

4.7.4 The 'differentiated take' arrangement is relatively unusual, although it is in place in a small number of UK hospitals. The Panel was told that the Royal Colleges of Physicians and of Surgeons have expressed reservations about this model, on the basis that some patients need both medical and surgical assessment and treatment at the same time. Very little support was presented to the Panel for 'differentiated take' amongst those who gave evidence, though it had support from the APOH Clinical Advisory Group and Lewisham PCT. However, the latter stated in evidence that it would only support a safe and deliverable model.

4.7.5 The evidence about emergency surgery at UHL exemplified a theme raised by the JHOSC, and heard by the Panel throughout its review, about the critical interdependence of this locality and its hospital with King's, Guy's and St Thomas's hospitals.

4.8 **Ambulances**

4.8.1 The consultation document states that *"we will need more emergency ambulances to take patients directly to the right hospital for the best care"*. In giving evidence to the Panel, London Ambulance Service (LAS) stated that it had been involved in APOH at an early stage and felt that its views had been represented in the proposals. A description was given by LAS of the service provided by emergency ambulances, approximately half of which carry paramedics with all staff now joining the emergency service entering as student paramedics.

4.8.2 Whilst acknowledging that journey times to hospital are very important to patients, LAS stressed that it was more important for a patient to be taken to the most appropriate, as opposed to the nearest, hospital. For example, staff are trained in ECG interpretation and can recognise certain heart conditions, enabling patients to be taken to one of eight hospitals that specifically treat the condition. Furthermore, emergency ambulances carry a computer decision support system which aids decision making, and it is the crews themselves who make the judgement on where to take a patient. This conforms to information contained in the *Healthcare for London* and *High Quality Care for all* documents.

4.8.3 Evidence given to the Panel established that implementation of APOH would require additional ambulance support, particularly through the closure of the A&E department at QMS and the consequent increased 'blue light' journey times. For Options 1 and 3, this was calculated as two extra ambulances whilst, for Option 2, it was stated by the APOH team that only one extra ambulance would be required. Some divergence of opinion exists on whether Option 2 requires one or two extra ambulances, but the Panel was informed during evidence giving that one ambulance was sufficient. Meanwhile, the PCTs have already given a commitment to fund one extra ambulance. The Panel received no evidence of any planned increases in the non-emergency patient transport service associated with the proposed changes.

4.8.4 The Panel heard anxieties expressed by those in the catchment area of QMS as well as members of Bexley OSC that ambulance provision would be insufficient in the event of the closure of the A&E department at QMS.

4.9 Planned surgery (also termed elective surgery)

4.9.1 Planned surgery is provided by all four acute trusts and presently takes place at five NHS sites, including Orpington. The consultation document states that, by separating planned and emergency care, fewer operations would be cancelled and infection rates could be reduced. Under Option 2d, routine planned inpatient surgery would no longer take place at PRUH and QEH, but would be concentrated at UHL and QMS. The planned surgery unit at Orpington Hospital would move to QMS. However, one of the variations resulting from the consultation phase, as a response to access issues raised, was that day case surgery would take place at all four hospital trusts, rather than at only two as

originally proposed. The Panel heard that, when patients for planned surgery may require level 3 critical care, that is, when the surgery is complex or the patients have significant medical co-morbidities this surgery would continue to be performed at PRUH and QEH. This would mean that more patients may require planned surgery at PRUH and QEH than was thought under the original proposals, potentially limiting the effective separation of planned and emergency surgery.

4.9.2 During the review, the Panel was informed that BHT had decided to move the elective surgery unit from Orpington Hospital to PRUH in October 2008 because of financial reasons. This decision had been reversed, though the Panel heard from staff that they had been told it had been postponed for one year and that they now expected it to move in October 2009. Other staff felt there was a question mark over the whole future of Orpington Hospital.

4.10 Critical care

4.10.1 There are critical care units at all four hospitals (but not at Orpington Hospital, where emergencies are covered by a resident doctor and nursing staff, all of whom are acute life support trained). At QEH and UHL, which provide level 3 care, there is an estimated need for three to four additional beds each to accommodate the increase in emergency workload from QMS and these have been identified within the existing Intensive Therapy Unit and High Dependency Unit accommodation. Similar expansion requirements at PRUH seem to be less easy to accommodate. The critical care unit at QMS delivers level 2 and 3 critical care and achieves good outcomes**.** However, there are only three consultants, one of whom returned from retirement and does not participate in out of hours work. The current medical staffing arrangements are, therefore, fragile and, the Panel was advised, unsustainable. Under the APOH proposals, QMS would provide only level 2 care for surgical patients and would cease to admit level 3 patients.

4.11 Maternity and neonatal services

4.11.1 Between 2002 and 2006, there was a three percent increase in births across the four boroughs. In 2006, there were 14,261 births, and this is predicted to increase to more than 18,000 births by 2010 and 21,000 births by 2016. The predicted rise in births is expected to affect Greenwich and Lewisham more than Bexley and Bromley, although it

is not clear whether recent increases in births due to migration will continue at the same rate. The Panel heard that, of the Bexley and Bromley populations, 70 percent of pregnant women are considered to be at low risk whereas, in Lewisham and Greenwich, 70 percent are considered to be high risk.

4.11.2 The number of deliveries at each of the acute hospitals is shown in the following table:

Hospital	**Deliveries 2006/7**
PRUH	3,731
QEH	4,180
QMS	2,951
UHL	3,399
Total	14,261

4.11.3 Under the APOH proposals, PRUH, QEH and UHL would continue to provide a consultant-led obstetric service, together with midwife-led units (MLU), whilst the QMS consultant-led obstetric service and its MLU would close. However, Decision 39 at the JCPCT meeting on 21 July 2008 *"confirmed that a decision regarding the stand-alone Midwifery-Led Birthing Unit at QMS would be made in light of the* Healthcare for London *report, due in 2009."*

4.11.4 The Panel heard that maternity strategies exist for each of the four PCTs, but that APOH will influence working towards a single strategy. The Panel also heard that UHL intends to work closely with GSTT and KCH to develop its own maternity strategy. In terms of overall numbers of births predicted for the future, it was considered that three consultant-led units would be sufficient. Furthermore, with the expansion of the home birth service and MLU deliveries, three consultant-led units would be more than adequate. On choice, it was stated that, at present, the only MLU was located at QMS, whereas in future there would be MLUs at the other three hospitals to benefit women in outer south east London. QEH and BHT have identified potential sites for their MLUs, whilst UHL is considering off-site options as placing it on the main hospital site may not necessarily meet the needs of its population. Additionally, APOH would see antenatal and postnatal care established in new community settings. It was stated that many women of overseas

origin are not registered with GPs, so the extension of facilities in the community would benefit them.

4.11.5 The APOH team had sought advice from the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) about the proposals for maternity services and, with appropriate protocols in place, there was agreement about the desirability for centralisation, and both Colleges would have accepted a plan for two consultant-led obstetric units. However, the JCPCT ultimately decided to opt for three units, rather than two.

4.11.6 The Panel heard that the argument for closure of the obstetric unit at QMS was primarily on safety grounds because there are insufficient consultants to staff all four obstetric units and they are not meeting the standards for consultant presence on labour wards, currently 40 hours. RCOG guidance in *Safer Childbirth* for units delivering between 2,500 and 4,000 births per year is 60-hour consultant presence by 2009. There is an aspiration under APOH to provide 98-hour consultant presence, which is the presence recommended by the guidance for births exceeding 4,000. An increased consultant presence was also needed in recognition of the fact that less experienced junior doctors would be emerging from the revised training scheme.

4.11.7 The Panel heard a variety of views from consultants, midwives and members of the public about MLUs. Opinions were divided about whether MLUs should be co-located with consultant-led obstetric units or be stand-alone units. The majority preferred co-located MLUs but that they should have separate entrances. The Panel heard that the intention was to increase midwife numbers in line with Birthrate Plus[4]. It was also informed by the APOH team that, across all the units, they were approximately 50 midwives short when assessed against National Practice Guidelines although it was stated that there is no problem in terms of recruitment. It was also stated that skill mix is more critical than purely numbers in midwife to patient ratios.

4.11.8 The Panel heard much criticism from the JHOSC, Bexley OSC, MPs, members of the public and some staff of the plan to close consultant-led obstetrics and the MLU at

[4] Ratios for Midwifery Workforce Planning at National, SHA and local level

QMS. There was praise for the quality of service at QMS and concerns were expressed about difficulty in accessing either PRUH or QEH. The Panel was informed that the fabric of the building housing the QMS maternity unit was in poor condition and that there were concerns about the building's fitness for purpose. Many people were concerned about the ability of PRUH and particularly QEH to absorb the extra numbers of births that would occur with the closure of the QMS unit. However, the Panel heard that, should the proposals proceed, Darent Valley Hospital, which also has an MLU, is anticipating an extra 800 to 1,200 obstetric admissions per year, including an additional 500 to 750 births per year from the borough of Bexley.

4.11.9 All the hospitals have had episodes of labour ward closure and instigated maternity diverts for a variety of reasons. In 2007, QEH closed on 14 occasions, UHL closed five times and QMS and PRUH each closed twice.

4.11.10 Neonatal services are provided at all four hospitals at present, with PRUH and QEH designated level 1 units, and QMS and UHL level 2 units. All the hospitals are currently operating above the designated level in the network and not all babies requiring high dependency or intensive care are transferred out from level 1 units. All are at, or are above, their funded capacity either by stretching staff or by using bank staff. UHL is the only unit that has medical staffing appropriate for the levels of care actually provided. Physical capacity is very constrained, with all units other than QMS overcrowded, though parents' facilities at all units are good. QMS currently acts as an overflow for QEH. QEH had not yet identified where additional babies would be cared for, should the plan to close the neonatal unit at QMS proceed.

4.11.11 All units other than UHL have shared paediatric/neonatal rotas and there is a risk that middle grade doctors who are covering paediatrics out of hours may not be immediately available for neonatal duty, as required by the British Association of Perinatal Medicine (BAPM) 2001 standards. Furthermore, BAPM 2001 requires that, for units providing intensive care, there should be 24-hour cover by a middle grade doctor or that an advanced neonatal nurse practitioner, whose only responsibilities are to the neonatal and maternity services, should be provided. Currently, no unit other than UHL meets this standard.

4.11.12 The Panel heard evidence questioning the effectiveness of the neonatal network, particularly in relation to capacity planning, auditing and setting standards.

4.12 **Paediatric services**

4.12.1 The Panel heard that, for paediatrics, medical staff are spread too thinly and that there is significant variation in the quality of service across the four hospitals. The service is critically dependent upon key individuals, and therefore vulnerable. One of the aims of APOH is to respond to the changing patterns of care requiring shorter lengths of stay in hospital and greater care in the community. This leads to a model with fewer beds but enhanced ambulatory care. The Panel heard that there is a *Children and Young People's Strategy* developed by the four PCTs, with the Bexley strategy being the most advanced.

4.12.2 Paediatric surgery takes place at all four hospitals at present and, under the chosen Option 2d, it is proposed that this will continue, though complex surgery currently undertaken by UHL will move to the tertiary centre at the Evelina Hospital, GSTT. The Panel heard that the provision of paediatric surgery is a complicated issue and the view of PRUH, QEH and QMS representatives appeared to be that planned non-complex surgery for children should be concentrated on one site. However, the Panel heard there was uncertainty as to how to deal with emergency paediatric surgery and detailed proposals were not available to the Panel.

4.12.3 In anticipation of the implementation of the proposals**,** Darent Valley Hospital is planning on between 300 and 850 emergency children's admissions and between 20 and 50 planned admissions from children from the borough of Bexley.

4.12.4 Evidence was heard about the Paediatric Oncology Shared Care Unit (POSCU) at QMS, which supports some 40 to 50 children in Bexley, Greenwich and Dartford, with care provided by six paediatricians. The Panel was told of the intention to move the unit to either PRUH or QEH. PRUH is at present the preferred location but a decision has not yet been made. UHL also provides shared care for children with cancer. Concerns were expressed by members of the public, in particular parents of children receiving treatment at the POSCU, about accessibility to PRUH and the time to take a sick child for urgent treatment for a potentially life-threatening condition. In addition, concern was expressed that more routine oncological care for children currently provided at QMS, such as blood

and blood product transfusion, could not continue without the facility for an overnight stay. An example of this was blood transfusions, which can take up to five hours and, therefore, patients could have to wait until the following day unless attended to by mid-morning. It was stated that no specific mention was made in the consultation document of the intention to move paediatric oncology inpatients away from QMS. The Panel heard that a meeting between parent representatives and Trust staff to discuss the proposed model had been cancelled at short notice.

4.13 **Primary care and community services**

4.13.1 The consultation document stated the intention to provide more services in the community so that people do not have to go to hospital to get simple tests done or to see a consultant; that they can better manage a long-term condition to avoid an emergency journey to hospital or the condition getting worse; or that they have more support when coming back from hospital. Detailed information about services to be provided in the community was not available to the Panel, particularly in demonstrating how care would be delivered closer to people's homes. Currently, variable experiences were reported by members of the public who gave evidence, though it was clear to the Panel that there was significant ongoing development by the PCTs, including new buildings and use of existing facilities as well as new initiatives.

4.13.2 The Panel, however, heard from the APOH team that one of the principles of pathway design would be a seamless service for patients moving between primary/community and secondary/tertiary care with appropriate links into social care. In terms of avoiding hospital admissions, there would be urgent assessment covering many specialities in support of GPs and community teams including community matrons and chronic obstructive pulmonary disease nurses. There would also be follow-up outpatient clinic appointments for early discharges, enhanced community services for hospital at home, physiotherapy and intravenous therapies, together with access to intermediate care. Additionally, specialist input would be provided to nursing homes including respite and end of life care.

4.13.3 The APOH team described plans for early discharge, including expansion of community provision, improvement of cross-boundary flows, better integration between health and social care on all hospital sites, and consistent, effective and agreed care pathways. The

Panel was told of current developments in the four boroughs, including step-up/step-down units, increased provision of intermediate care and "virtual" wards. The APOH team described the risk of failing to change, which would mean that community developments would be isolated from specialist care and the patient pathway would remain fragmented. The Panel heard that cost-effective care in the community could be developed, but that it needs careful coordination. The importance of GP engagement was stressed.

4.13.4 The Panel also heard that practical difficulties are being encountered in some areas and that there are limitations on the speed at which infrastructure can be established.

4.13.5 The Lewisham GP Federation spoke about the relationship between primary and secondary care in Lewisham. It was stated that there was a tradition of healthcare workers committing long term to the area and becoming part of the community, with co-operative working between GPs and UHL. Additionally, the Panel was told that UHL has traditionally provided the next generation of Lewisham GPs. Patients, in general, are unwilling to travel any distance outside their community. Because of ease of access, the alternative to UHL is seen by many people to be GSTT or KCH - not QEH or PRUH. Enthusiasm was expressed for the intention to place GPs in the UCC planned at UHL and also for *joined-up* community working, although there was recognition that sufficient GP practices would need to be available throughout the community. The importance of this was stressed, with Lewisham having a substantial ethnic minority population that sees their GP as a 'safe' person and one whom they can trust.

4.13.6 The Panel was told about a proposal for the QMS site to become a 'Health Campus'. This would be provided in a *polyclinic* environment and would consist of GP and practice nurse appointments over extended hours, with primary care being delivered to both registered and non-registered patients. District nurses, health visitors and social services staff would work together to support local patients' needs. There would also be secondary care clinics, such as outpatient appointments, community clinics for blood testing and for patients with long-term conditions, therapy sessions, counselling, physiotherapy and diagnostics. Minor surgery would also be undertaken. The Panel heard that the 'Health Campus' would provide a greater range of comprehensive care all in one place. Some members of the public expressed the view that the 'Health Campus'

proposal would affect the future viability of GP services locally as younger people were more likely to visit polyclinics, while older people would still wish to see a GP in their locality. Some members of the public were concerned that *polyclinics* could deplete GP surgeries in the community, which again would disadvantage older people in particular. The Panel also heard evidence expressing support for services close to people's homes.

4.14 Capacity, estate and capital projects

4.14.1 The current estate of the four hospitals varies in condition. Under the Land and Property appraisal criteria[5], PRUH and QEH are assessed to be at Estate condition 'B', UHL at 'B/C' and QMS at 'C'. Orpington Hospital is at Estate Condition 'B'.

4.14.2 The capacity planning for APOH prior to the JCPCT decision shows a baseline acute bed capacity (excluding day case beds) of 1,782, of which 189 are currently closed. The Panel heard evidence that under the APOH proposals, the number of acute beds required is projected to fall to 1,459, mainly through shorter hospital stays and the provision of services that will prevent hospital admissions. Consequently, implementation will involve shedding the capacity for over 300 acute beds across outer south east London.

4.14.3 The Panel heard evidence that the following key estate issues are subject to review by the APOH team:

- A&E capacity at QEH/PRUH and UHL
- ICU capacity at QEH/PRUH
- UCCs at UHL/PRUH/QEH
- Location of ward and support services
- Layout changes
- Maternity and neonatal capacity at QEH/PRUH/UHL and location of MLUs
- Elective centre layout at QMS
- Bexley campus content and layout
- Out of hospital facilities developed

[5] *Definitions:* *B – Sound, operationally safe and exhibits only minor deterioration*

C - Operational but major repair or replacement will be needed soon, that is, within three years for the building elements and one year for the engineering elements.

4.14.4 The table below is a summary of indicative capital costs at the Decision Stage of APOH (21 July 2008).

Organisation	**Indicative Capital**
QEH	£12.4m
BHT	£7.75m
UHL	£1.25m
QMS	Subject to Campus development
PCT for UCC x3	£7.6m Based on UHL figures
KCH	£12.0m
GSTT	£7m-£15m depending on option

4.14.5 The Panel heard evidence that some of the capital spend would occur through adjustments to PFI contracts. Additionally, the Panel was told that most *out of hospital* facilities would be funded by Local Improvement Finance Trust (LIFT) and that this would, for example, apply to certain facilities on the Bexley Campus. The Panel understands that offset finance could be achieved through initiatives such as disposals, although no specific detail was given.

4.15 Workforce

4.15.1 The Panel received little evidence of any workforce planning, other than information on transitional costs associated with the APOH proposals. There was, however, an outline plan to undertake this workstream through joint working with the service redesign and finance and capacity workstreams. This area of work included education and training issues, organisational development and human resource management, as well as workforce planning. The Panel heard that very little joint working between management and staff side had taken place, although some briefing sessions had been undertaken. An acute sector management and staff side group termed the Outer South East London Partnership Committee has now been established.

4.16 Finance

4.16.1 By the end of 2007/8, the four acute trusts had a combined accumulated debt of £121.5m. Under the 'no change' option, this was projected to increase to £205.9m by the end of 2010/11. The in-year deficit in 2010/11 was projected to be £34.7m before

savings initiatives. The Panel was told that adoption of Option 2d would produce an overall surplus of £10.8m in 2010/11, taking into account £5m of cross cutting initiatives.

4.16.2 The single biggest change in financial position is at QMS, whereby a projected deficit of £26.4m in 2010/11 is projected to turn into a £0.5m surplus as a result of the proposed major changes in location and delivery of services. The Panel understands, however, that much of the saving is related to staffing costs, although it is further understood that staff would be needed to relocate with their services to other sites, so the net saving to the acute trusts would be reduced. The large reduction occurs because the new cost is based only on the activity in the planned treatment centre with associated clinical services and overheads. This reflects a reduction compared to the existing site and overhead costs, and part of the released capacity would be used by the Bexley Care Trust and QMS to deliver integrated health services on the Bexley Campus. The capital costs for this development have not been finalised.

4.16.3 As a result of day case surgery continuing to be provided at all four hospital sites under Option 2d, £10.7m worth of day case activity - that would have flowed out to other providers – will be retained. In addition, activity would be rearranged so that QMS and UHL would both be projected to lose income, whilst PRUH and QEH would be projected to gain income. The net improvement in income and expenditure across the newly formed South London Healthcare Trust (see 4.20.2) and UHL is projected to be £7m.

4.16.4 Because they are either wholly or partially PFI-funded, PRUH, QEH and UHL all pay an annual availability payment and facilities management payment as part of their PFI contract extending over either a 30 or 35 year period. The Panel heard that it is very difficult and costly to amend the terms of the PFI. This fact had been identified at an early stage of the APOH programme and contributed to the feeling expressed in some quarters that the presence of PFI buildings and the associated fixed costs were the main problem and had been used to predetermine the outcome of APOH against QMS. The Panel also received evidence about the analysis done prior to the JCPCT decision to compare the relative costs to the NHS of option 2d and an option that would substitute QMS for PRUH in the proposed configuration of services. This analysis captures the

effect of a number of relevant factors including capital costs, optimal use of buildings as well as PFI commitments. Overall, Option 2d is significantly less costly and, therefore, more affordable than the alternative using QMS.

4.16.5 As part of APOH, reduction in length of stay is an important factor in being able to deliver improvements in efficiency, particularly a reduction in the use of acute hospital beds and the associated costs. APOH is aiming to achieve top quartile performance (as at 2005/06) by 2010/11. On staffing cost reductions, the main reduction would be at QMS where there is a projected reduction of £43.9m in 2010/11 under Option 2d, which would represent a reduction of 55 percent.

4.16.6 During the review, changes to the NHS payment by results regime for 2009/10 were being modelled for their impact on the financial position of outer south east London. The Panel was told by the NHS that the impact of these changes on previous financial projections used in APOH would be marginal.

4.16.7 A Challenged Trust Board was set up to deal with those trusts with the worst historic deficits in the NHS in England. PRUH, QEH, QMS and UHL are all subject to this regime.

4.17 **Consultation process**

4.17.1 The referrals by the JHOSC and the Bexley OSC relate to the period of activity after 7 January 2008 and specifically to the content and manner in which the information was presented to the public and stakeholders. In considering the performance and compliance of the APOH consultation, the Panel was impressed with the level of pre-consultation engagement and activity undertaken in the preceding 15 months, together with the preparation and production of associated pre-consultation documents.

4.17.2 The finalised APOH proposals were set out in the *A Picture of Health* consultation document launched on 7 January 2008. (The levels of distribution and supporting events are outlined in section 3.6). A recurring theme during evidence from the public and stakeholders was that it was not possible to understand fully both the proposals themselves and what the proposals meant for each particular district within the review area. The Panel heard differing views as to whether the information was easy or difficult

to understand. However, there was concern over the lack of detailed explanatory information on such issues as transport and travel, access and the provision of additional emergency ambulances, together with a clear description of which hospital services would be provided for people living in each of the boroughs. Additionally, it was strongly argued by Bexley OSC that the case for change, specifically for QMS, was not made in the document. The same point was made by a number of members of the public, and the Panel was told on a number of occasions that people believed the loss of services at QMS was a 'done deal' prior to any formal decision being made, because QMS was the only non-PFI hospital in the proposals. However, the Panel heard in evidence from the APOH team that, as a potential option, QMS had been modelled as a fully admitting hospital, with one of the other acute hospitals simultaneously modelled as a borough hospital. The analysis demonstrated an adverse cost of £358m altogether and the Panel was told that it would have made no sense to incur this extra financial burden when higher quality clinical services could be achieved by implementing the selected option.

4.17.3 The document itself states that it presents "*a summary of our plans*" and that further information, signposted in the document, is available on its website. The Panel found little evidence that the groups, stakeholders or public it met were either able to or in a position to do this, that is, access and analyse the extensive and complex information on the website.

4.17.4 The Panel also noted the absence in the consultation document of any reference to the Cabinet Office Code of Practice on Consultations and of any statement on the consultation criteria. Similarly, there was an absence of assessment criteria in the document.

4.17.5 The JHOSC, Bexley OSC, and many individuals made reference to the lack of availability of the document, citing examples of large sections of the community that did not receive anything. The evidence provided by the APOH team shows a significant effort to ensure that all sections of the community were informed and consulted. The Panel also heard from the JHOSC and Bexley OSC that, when problems in distribution occurred, the APOH team acted swiftly to rectify the situation. There were numerous examples evidenced by the Panel where the APOH team had taken actions to correct

problems, particularly in relation to information and where the team was learning from and responding to the process.

4.17.6 Concern was expressed by many people, including staff, about the wording of the questionnaire - specifically about the relevance and linking of the five question areas. The Panel noted the 'crystal mark' awarded to the questionnaire, presumably for its use of the English language rather than its clarity of purpose. The Panel also noted that the document and the questionnaire were two separate documents compiled by two different organisations. In its referral, Bexley OSC claimed that the questionnaire had *"leading questions"***.** Members of the public, in evidence, referred to the 'test tube diagram' in the document, which indicated that the chosen option is the 'least safe' of all the options.

4.17.7 The Panel noted the report produced by the Centre for Health Management, Tanaka Business School, Imperial College London, which was presented to the decision-making meeting on Monday 21 July 2008. Concern was expressed to the Panel about the meeting being held at London Bridge rather than within the four boroughs, together with only three days notice being given to the public and stakeholders; also that press releases and advertisements only being published on Friday 18 July 2008. The Panel was told that the London Bridge location, which is out of the consultation area, was chosen as the most easily accessible location for all and that the JCPCT operated under Greenwich PCT Standing Orders which allow for three clear days' notice of meetings. The arrangements for this important meeting may have affected the numbers of people attending and could have been handled in a more inclusive and accommodating manner.

4.17.8 Significant pre-consultation and analysis work was undertaken by the APOH team, including the *Big Ask* campaign and the involvement of patient groups in the development of the options. This emphasis on involvement was not carried into the consultation period itself and was not fully reflected in the evidenced information presented to the public. There is, though, evidence that significant information, for example, assessment criteria, costings, transport maps etc was made available at meetings and events throughout and following the consultation period, with the APOH team attempting to specifically act to rectify shortfalls in understanding.

4.18 **Transport and travel**

4.18.1 Whilst recognising that people rarely travel between hospitals, instead travelling from where they live to the hospitals, the distances between the current healthcare facilities in outer south east London are relatively short. Closer examination of the transport infrastructure, particularly the roads and bus travel, indicate that some locations and areas have greater adverse transport issues than others. During the course of the review, concern was expressed by people in the centre and south of the four boroughs, particularly in Sidcup and parts of Bromley, that they would have difficulty in travelling by public transport to other hospitals. However, the Panel found that overland railway services between all of the main areas of population were good.

4.18.2 The APOH team commissioned a study and report on transport by Operational Research in Healthcare (ORH), the results of which were presented to the Panel. The information available included details of patient flows, journey time impacts on affected patients, an analysis on the most adversely affected patients and public transport users by ward. However, there was little or no evidence of the use of this information during the consultation period or that any meaningful engagement or activity had taken place with stakeholders and the public to identify where the most affected areas might be, particularly the development of a strategy to mitigate any detrimental impact.

4.18.3 The variant in Option 2 – Option 2d - to continue day case surgery on all sites would reduce the adverse impact of travel. In addition, the Panel recognises that the proposed clinical areas of change would also by their nature lessen the impact, as also would the overall strategy of moving care out of hospital settings, provided that this really was closer to people's homes. However, the proposals would involve additional public bus journeys for those without access to private vehicles and additional distances of travel for those visiting children, new mothers and others in hospital receiving emergency care. Car parking on all of the hospital sites appears to be problematic. Bus services throughout the four boroughs appear to be plentiful and timely. Journey times, however, are lengthy and access by bus from the south of Bexley to QEH is time consuming and currently involves at least two buses.

4.19 **Integrated impact assessment**

4.19.1 The referral from the JHOSC expressed concern over the late completion of the integrated impact assessment and the lack of such an assessment on the geographical areas covered by Lambeth and Southwark councils. In evidence, the JHOSC said it was disappointed at the failure of APOH to make such information available to it in order to inform their response, particularly as in their view, the proposals had failed to show how they would address health inequalities. The Panel subsequently heard no evidence from any source relating to people living in the boroughs of Lambeth or Southwark about how they might be affected by the proposals. This did not, therefore, appear to be an issue.

4.19.2 APOH did not produce an integrated impact assessment prior to the consultation process but undertook significant activity in this area both during and after to ensure some information was available prior to the decision-making meeting on 21 July 2008. The 'work in progress' was presented to the JHOSC on 20 May 2008. The information presented to the Panel in February 2009 by the APOH team, encompassing health inequalities, travel implications and carbon footprint, whilst still not complete, shows progress in establishing impacts and gives examples of mitigation requirements. For example, there is an acknowledged need to develop a "*cross borough model of integrated care between health and local authority services to ensure streamlined and flexible discharge planning*".

4.20 **Management capacity and merger of trusts**

4.20.1 The hospital trusts have suffered from a lack of stability amongst senior management in recent times. For example, PRUH has had five chief executives over the past two years, and the chief executives at both QMS and UHL are interim managers as are many of the executive directors. Notwithstanding the challenges of APOH, the Panel received evidence that the capacity to lead and manage the hospitals was stretched in a way that is unsustainable for the future and that this is being addressed by the merger of PRUH, QEH and QMS.

4.20.2 Although the merger of BHT, QEH and QMS into a single trust on 1 April 2009 is separate from the APOH proposals, the Panel recognises that its formation will have an effect on the implementation of APOH. The merger relates to the leadership and

management of the proposed trust and does not directly impact upon clinical services, whereas the proposals in APOH are about the redesign, redistribution and improvement of hospital services. Whilst the issues facing health services in south east London have, in different ways, prompted both APOH and the merger, the merger process is not dependent upon the implementation of APOH.

4.20.3 During the taking of evidence by the Panel, it was evident that, in some areas, the focus of staff in particular was on the merger, whereas the APOH proposals had receded into the background. Elsewhere, a number of people were confused over the difference between the merger and APOH.

OUR ADVICE

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5.1 Introduction

5.1.1 The Secretary of State for Health asked the IRP to advise whether it is of the opinion that the proposals for changes to the distribution of services between Bromley Hospitals, Queen Elizabeth Hospital (Greenwich), Queen Mary's Sidcup and University Hospital Lewisham and the associated development of community services will ensure the provision of safe, sustainable and accessible services for local people, and if not why not.

5.1.2 The proposals for the changes were developed by the Bexley, Bromley, Greenwich, Lewisham and West Kent PCTs and set out in the consultation document *A Picture of Health* (APOH) launched in January 2008. The principal elements of the proposals relate to A&E, non-surgical emergencies, emergency and planned surgery, maternity and neonatal services, and paediatric services.

5.2 The Need for Change

5.2.1 The Panel heard that APOH was founded on urgent clinical and financial issues that are preventing the local NHS from providing better, safer and affordable care.

5.2.2 Prior to the consultation, clinicians, patients and the public were engaged in articulating what changes might lead to better services. The conclusions from this work were subsequently reviewed and supported overall, both internally and externally, including by the National Clinical Advisory Team (NCAT) and NHS London. The Panel heard ample evidence**,** including many contributions from senior clinicians working in all four hospitals that, without change, the quality of services would deteriorate**.** The JHOSC, in its letter of referral to the Secretary of State, stated that it *"is not against change where it is necessary and in our report we expressed the view that it is wrong not to change services where they are currently not the best they could be and we accepted the need for change in the location and delivery of health services in South East London."*

5.2.3 Financial issues have been present for many years in outer south east London, resulting in an accumulated debt for the four acute trusts of £121.5m at the end of 2007/08. Even with recent turn-round initiatives, the 2008/09 in year deficit of the four acute trusts combined is projected to be £22.2m and, with no change, their accumulated debt is projected to be £221.1m by the end of 2010/11. This level of debt is undermining the quality and sustainability of local services.

5.2.4 The Panel heard much evidence during the review either in support of, or in recognition of, the need for change. However, it was *how* such change was to be effected that caused a divergence of opinion. For example, the Panel heard from a substantial number of people who strongly opposed the proposed closure of the A&E and maternity departments at QMS. The JHOSC, in its letter of referral to the Secretary of State, stated that *"the JHOSC is of the view that some of the decisions arrived at by the JCPCT do not represent the right decision for 'outer' South East London and there are potential alternatives which should be fully considered."* However, there appears to be widespread acceptance of the need for change itself and the Panel also supports the need for change.

5.2.5

Recommendation One

The Panel supports the need for change in the location and delivery of the health services reviewed in Bexley, Bromley, Greenwich and Lewisham.

5.2.6 Throughout its review, the Panel heard how the proposals had been derived and modified in response to consultation. Taken together, the Panel believes that its recommendations about changes in location and delivery of services should provide safe, sustainable and accessible services for the population of the four boroughs. However, the changes involved are both large in scale and complex in their detail, involving many interdependencies across services and organisations. Building on the clinical redesign work started by the APOH programme, and reflecting some of the concerns expressed by both scrutiny committees, the Panel has identified further preparatory work that must be addressed in realistic timescales to ensure the delivery of safe, sustainable and accessible services for the people of south east London.

5.2.7 **Recommendation Two**

The Panel strongly believes that its Recommendations **Three to Thirteen** for the location and delivery of services will only be effectively implemented to provide sustainable care if Recommendations **Fourteen to Nineteen** are rigorously applied. The actions described in these recommendations must be undertaken before any major changes to the services at Queen Mary's Hospital Sidcup (QMS) take place.

5.3 **Location and Delivery of Services**

5.3.1 *Emergency care*

The Panel received evidence from clinicians and others that continuing to run a full range of emergency care services from four separate hospital sites was not sustainable. There are not enough medical staff to provide four separate services properly and a critical mass of skills and experience is needed to ensure the safe and sustainable delivery of services. People have a reasonable expectation of seeing and being treated by clinical staff with the necessary skills and experience to provide high quality care. The Panel accepts that the current configuration of four separate services is not sustainable.

5.3.2 In terms of the APOH proposal to concentrate emergency care services on three sites, the strong views expressed in favour of retaining QMS were not matched by evidence of sustainable, alternative options. In addition to the clinical quality argument, the Panel considered the evidence relating to catchment populations, access, the availability of suitable facilities and affordability, as well as the introduction of additional UCCs and medical assessment services across the four boroughs. Taking all these into account, the Panel agrees that emergency care services should, in future, be concentrated at PRUH, QEH and UHL with a UCC and medical assessment services at QMS.

5.3.3. **Recommendation Three**

The Panel supports the proposals to meet the emergency care needs of the population by concentrating services on three sites at Princess Royal University Hospital (PRUH), Queen Elizabeth Hospital (QEH), and University Hospital Lewisham (UHL), and the closure of emergency care services at Queen Mary's Hospital (QMS), subject to Recommendations Four, Five and Six below.

5.3.4 *Urgent care*
The Panel heard evidence about plans to establish UCCs at PRUH, QEH and UHL in addition to the UCC established at QMS in the past year. The Panel was told by APOH that up to 80 percent of people arriving at A&E could be seen in a fully functioning UCC, as set out in the core specification presented to the Panel. The Panel agrees with the proposals for UCCs to be established at PRUH, QEH and UHL.

5.3.5 The Panel believes that retention of the UCC at QMS is important for the local population. The Panel heard that the APOH team had been working with LAS concerning future arrangements for emergency ambulances once the A&E department at QMS closes. These arrangements will need to ensure that transfers from the UCC at QMS for emergency admission to other hospitals are clinically safe and appropriate. The presence of a medical assessment service at QMS is considered to be an integral and essential part of the proposed model of care.

5.3.6 The Panel noted that the JHOSC recommended *"that PCTs refer the development of Urgent Care Centres to local Overview and Scrutiny Committees."* This was accepted by the JCPCT, which stated that each PCT would continue to involve its local population as well as their overview and scrutiny committee. Furthermore, in their recommendation, the JHOSC stated, *"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"*. The JCPCT agreed with this and the Panel strongly supports both of the JHOSC's recommendations and their implementation.

5.3.7 On availability, the Panel heard of the intention that the UCC at QMS would be open 24 hours a day, seven days a week, whilst the opening hours of the other UCCs would be considered as part of the implementation plan.

5.3.8 In addition to the UCCs at the four acute hospitals, the Panel supports the development of UCCs in the community closer to people's homes, which would provide easier access to services. These include the UCCs at Beckenham Beacon and the proposed site of Eltham Community Hospital, both of which the Panel visited.

5.3.9 Whether there is a need for further UCCs across the four boroughs is the subject of further consideration by the PCTs that needs to be brought to a conclusion.

5.3.10 **Recommendation Four**

The Panel supports the proposals to meet the urgent care needs of the population through urgent care centres integrated with the A&E departments and medical assessment services at PRUH, QEH, and UHL, together with the urgent care centres already planned in the community and a 24-hour urgent care centre at QMS, integrated with a medical assessment service.

5.3.11 *Emergency surgery*

At present, emergency surgery, including trauma care, is provided separately by the four acute hospitals. The Panel accepts that the clinical factors relating to critical mass, skills and experience set out in paragraph 5.3.1 also apply.

5.3.12 The Panel heard that implementation of a 12-hour differentiated take (8am to 8pm) would potentially undermine the JCPCT's main decision to adopt Option 2. The Panel concluded that, with respect to limiting the emergency surgery hours at UHL, neither the effect on surgical patients nor the implications for other clinical services that require surgical input have been fully considered. UHL is as busy, if not busier, than the Kings Health Partners Foundation Trust in terms of emergency surgery. Furthermore, in gynaecology, orthopaedics and ENT, all of which are planned to be provided at UHL, the critical mass of the service is large enough to sustain a 24-hour emergency service. The Panel was concerned that, in adopting the 12-hour differentiated take model, the sustainability of the emergency service at UHL would potentially be at risk. Weighing up all the evidence received about the 12-hour differentiated take proposal for UHL, the Panel considers that 24-hour emergency surgery to be conducted by UHL in collaboration with Kings Health Partners is in the best interests of the local population.

5.3.13 **Recommendation Five**

The Panel supports the proposals to concentrate emergency surgery on three sites, PRUH, QEH and UHL. The Panel does not support 12-hour differentiated take (8am to 8pm) at UHL and recommends that this locality retains 24-hour emergency surgery.

5.3.14 *Ambulance provision*

In giving evidence, the APOH team stated that the proposals would require one additional emergency ambulance and this was confirmed by LAS. However, because the patient pathways had not yet been defined, the Panel heard doubts that one extra ambulance would suffice and that two might be needed instead. Once all the work is completed on patient pathways, the Panel considers that verification of the ambulance requirement must be undertaken.

5.3.15 The Panel did not receive evidence indicating that any work is being carried out to determine the level of non-emergency patient transport required to satisfy the requirements of APOH. This is important in ensuring that future services are patient-centred and accessible.

5.3.16 **Recommendation Six**

The Panel recommends that further work be undertaken with the London Ambulance Service to confirm the number of additional emergency ambulances required to support the proposals. The appropriate commissioners should also undertake further work on non-emergency patient transport provision to support the proposals.

5.3.17 *Planned surgery*

One of the stated aims of APOH is to split emergency and planned surgery. The Panel agrees that this is desirable, where it can be achieved, bringing the benefits of reduced cancellations and waiting times and reduced risk of cross infection. The Panel supports the concentration of planned surgery on the QMS and UHL sites and the retention of adult day case surgery at all four hospital sites, which was a specific response to the public's call during the consultation phase for better access to hospital services.

5.3.18 **Recommendation Seven**

The Panel supports the proposals to concentrate planned surgery on the QMS and UHL sites and, as modified in the JCPCT decision, the continuation of adult day case surgery at PRUH, QEH, QMS and UHL.

5.3.19 *Orpington Hospital*

During the taking of evidence, the Panel heard a divergence of views over plans for Orpington Hospital. Despite the consultation document stating that, under all options, Orpington Hospital would continue to provide services other than planned surgery, there appears to be considerable uncertainty amongst staff about the hospital's long term future. The Panel supports the decision to transfer planned surgery from Orpington Hospital to QMS. It also supports the view given in evidence that Orpington Hospital would be valuable as a back-up facility during the implementation phase of APOH, not least because the redistribution of a significant number of beds from QMS is a major undertaking. A clearly set out plan for Orpington Hospital, including timescales, is required and staff should be fully involved and kept informed of developments.

5.3.20 **Recommendation Eight**

The Panel supports the proposals to relocate planned surgery from Orpington Hospital to QMS. However, the Panel recommends that the plans for the future of the Orpington Hospital site be clarified urgently and that Orpington Hospital staff be fully involved in all further considerations.

5.3.21 *Critical care*

In considering the provision of critical care within APOH, the Panel had concerns about whether the critical care facilities at PRUH, QEH and UHL would be able to expand, particularly at PRUH, to undertake the work currently done at QMS. In addition, the clinical case for a stand-alone level 2 unit at QMS was not convincing. The future absence of emergency services on this site, together with the proposed concentration elsewhere of complex surgery and surgery on patients with serious co-morbidities, would suggest that there would not be sufficient patients requiring genuine level 2 care to make the unit viable. The Panel considers that a surgical unit able to deliver

augmented care to surgical patients and provide additional organ support prior to transfer to one of the other units is the most appropriate option.

5.3.22 **Recommendation Nine**

The Panel recommends the development of detailed plans for critical care to support the proposals and the engagement of the South East London Critical Care Network to ensure that the proposals meet capacity requirements and the required standards across the network.

5.3.23 *Maternity care*

Under the proposals, there is overall agreement by clinicians that the needs of the population are best met by three consultant-led obstetric units, taking into account the number of births predicted for the future. Besides the consultant-led units, the plan to add a MLU at each of the three hospital sites, together with initiatives to increase the homebirth numbers across the four boroughs, should ensure that three units are more than adequate to meet the demand. Having seen a number of facilities during visits, the Panel acknowledges the good work being undertaken in relation to the establishment of community-based maternity services and the intention to increase the number of babies born either in a MLU or at home. In terms of which unit would close, the Panel accepted the evidence that closing QMS provides the more sustainable service in the future. However, the Panel strongly supports the retention of the MLU at QMS as a stand-alone unit. This would provide an additional choice for women in the borough.

5.3.24 **Recommendation Ten**

The Panel supports the proposals for maternity services that will provide local community midwifery, antenatal and postnatal services in all four boroughs with consultant-led maternity units at PRUH, QEH, and UHL. The Panel also supports the establishment of midwife-led units in these trusts and recommends the retention of the midwife-led unit at QMS, which should become a stand-alone unit.

5.3.25 *Neonatal care*

At present, neonatal services are provided at all four acute hospitals. Under the proposals, they would continue at PRUH, QEH and UHL, but not at QMS. The Panel was concerned to hear that level 2 work is undertaken at PRUH and QEH, which are only level 1 units. Additionally, because they are level 1 and not staffed for or accredited at level 2, a large number of babies are transferred away from PRUH and QEH to receive treatment elsewhere. The Panel was also concerned to hear that, except for UHL, the other hospitals have shared paediatric/neonatal rotas, with the risk that middle grade doctors who are covering paediatrics out of hours may not be immediately available for neonatal duty. The Panel concluded that, currently, the hospitals appear to be working independently and it heard no evidence indicating that the South East London Perinatal Network is functioning effectively in a co-ordinated way. Neonatal services do not appear to be underpinned by a strategy and the Panel believes that urgent engagement of the perinatal network is essential to ensure that the proposals meet both the required standards and capacity requirements as part of the wider south east London network arrangements.

5.3.26 **Recommendation Eleven**

The Panel supports the proposals to concentrate neonatal services in support of consultant-led deliveries at PRUH, QEH, and UHL, and recommends that the South East London Perinatal Network Board ensures the compliance of each site with relevant standards prior to implementation.

5.3.27 *Paediatric care*

During visits to the four acute hospitals and whilst taking evidence, the Panel heard much about the current and proposed models of ambulatory care, paediatric assessment and integrated care for children with complex needs and it commends the work done in this area of care.

5.3.28 Evidence was heard concerning the current distribution of inpatient paediatric services at PRUH, QEH and QMS, with a need to concentrate inpatient care, given the declining rate of inpatients nationally, so that clinical skills can be safely maintained and enhanced. This is in accordance with the Royal College of Paediatrics and Child Health's plans for the increase in paediatric care in the community. The Panel heard that

the preferred option was the closure of all paediatric inpatient beds at QMS and the optimisation of resources at PRUH and QEH. The Panel accepts the evidence that this option offers a more sustainable future than the alternatives.

5.3.29 On services for children with cancer (15 percent of the paediatric activity at QMS), the South East London Children's Cancer Network and the Young Persons' Cancer Working Group were agreed that maintaining the inpatient POSCU beds at QMS was not an option and that this activity should move to either PRUH or QEH.

5.3.30 The future of the POSCU was raised in evidence by a number of people whose children attend the unit. It appears that, during the consultation phase, the future of POSCU itself was not overtly brought to the attention of the public. The plan under APOH is to relocate the main service to either QEH or PRUH, with PRUH as the preferred option. The Panel has established that the main service must be located within general inpatient/day care paediatrics with the requisite associated 24-hour infrastructure, but that there is potential to have a satellite site, provided that general paediatric ambulatory services are also located at that site. The Panel therefore believes that consideration should be given to establishing a satellite day case care service at QMS for the benefit of children and their families.

5.3.31

Recommendation Twelve

The Panel supports the proposal to concentrate paediatric inpatient services at PRUH, QEH and UHL, with the closure of all paediatric inpatient beds at QMS. It recommends, however, that consideration be given to continuing day case cancer care for children and young people at QMS. In addition, the Panel recommends that the children currently utilising the POSCU, their parents and guardians are thoroughly involved and informed throughout the change process.

5.3.32 *Paediatric surgery*

Under Option 2d of the proposals, it is intended to continue non-complex paediatric surgery at all four acute hospitals. During evidence taking, the Panel heard that that there was uncertainty as to how the proposals would be taken forward, particularly in the case of emergency surgery. The Panel, therefore, cannot support the proposals as they stand and believes that a further examination of non-complex paediatric surgery is urgently

required. However, it does support the recent decision taken in respect of UHL for complex paediatric surgery to be undertaken at GSTT.

5.3.33 **Recommendation Thirteen**

The Panel does not support the current proposals for non-complex paediatric surgery. The Panel recommends that a further examination of the suitability for non-complex paediatric surgery at PRUH, QEH, QMS and UHL be undertaken.

5.4 **Next Steps**

5.4.1 *Capacity planning*

In assimilating the huge volume of documentation associated with APOH, the Panel was impressed by the methodology and work carried out to determine, in principle, the capacity requirements to implement the proposals successfully. However, the subsequent work is somewhat opaque and the Panel did not see or hear evidence of the detailed workings of how the capacity requirements would be implemented in practice, based on a detailed understanding of how patient care and pathways would be organised. The Panel was, therefore, concerned to ensure that this crucial element of the process be undertaken.

5.4.2 **Recommendation Fourteen**

The Panel recommends that urgent work take place to agree the clinical and patient pathways to achieve a seamless service across primary, secondary, community and social care, taking a whole systems approach. This must include liaison with local authorities and detailed agreement as to which community and social services need to be in place and operational before changes are made to hospital services. The Panel also recommends that estates and facilities planning work to accommodate the proposals be undertaken as a matter of urgency.

5.4.3 *Workforce*

The Panel were told that many of the clinical quality benefits of the proposals would flow from skilled and experienced clinicians being more available and directly involved in patient care at critical times. From the information and evidence presented, the Panel considered workforce planning to be the weakest area of activity within the project. The

work appeared to focus on 'transitional' arrangements and little else, with those involved in this area of work seemingly resigned to the fact that they could not plan ahead until "*the way in which we are going to work is known*". This in turn arises from there being no apparent planning around new patient pathways. The Panel recognises the difficulties in mapping workforce requirements, but believes that more could and should have been done.

5.4.4 **Recommendation Fifteen**

The Panel recommends that a rigorous review of the workforce implications of the proposals be conducted as soon as possible, based on agreed patient pathways, ensuring the full involvement of staff representatives.

5.4.5 *Finance*

As recognised by the APOH team and stated in the consultation document, the purpose of APOH is to address the urgent clinical and financial issues. During the review, the Panel heard evidence about both revenue and capital costs, and it recognises that significant detailed work was put into modelling the options. However, by necessity, the costings were calculated based on a 'top down' approach for the business case and the Panel has considerable unease that there has not yet been a shift to detailed 'bottom up' work to establish firm costings. Additionally, costings were based on assumptions prior to the determination of individual care pathways. Once these pathways have been formulated, the associated physical capacity and staffing will need to be assessed which, in turn, will need conversion into the costing requirement.

5.4.6 In terms of the capital cost requirement of APOH, the Panel has a number of misgivings, including that no sum had been allocated to the QMS site and that, other than bed numbers, little was known about how and at what cost key facilities would be provided. It also heard conflicting evidence relating to potential capital receipts at the UHL site and how they are to be handled in the overall capital calculations.

5.4.7 **Recommendation Sixteen**

The Panel recommends that a clear process is immediately put in place that will allow the financial viability of the proposals to be reassessed and assured through the lifetime of the programme, and that this should be overseen by NHS London.

5.4.8 *Transport*

The Panel acknowledges that much work has been undertaken to establish the public transport issues arising from the APOH proposals. The Panel also recognises the impact of the day case decision on travel and access. It remains concerned, however, that much of the outcome of the work has not been openly presented to patients and the public.

5.4.9 From the evidence heard by the Panel in relation to geography, access and current transport provision, and from the Panel's own experiences throughout the review, it is satisfied that the adverse impacts on travel to hospital will affect a minority of people. However it also recognises that, when transport difficulties do occur for patients and families, they will be at critical times, relating to accessing emergency, paediatric and maternity care. All practical steps must, therefore, be taken to mitigate these difficulties.

5.4.10 In addition, the Panel recommends that the work already undertaken be extended to take account of the current proposals being formulated in respect of the Bexley Health Campus and other GP and community facilities.

5.4.11 **Recommendation Seventeen**

The Panel recommends the immediate operation of the newly established Transport Group comprising staff, patients, members of the public and representatives from the London Ambulance Service, Transport for London and Travelwatch, with a specific requirement to work together to mitigate the effects of the proposals on those individuals most affected.

5.4.12 *Consultation*

The Panel has considered the concerns of both the JHOSC and the Bexley OSC in relation to the conduct of the consultation. Whilst not concurring with the JCPCT decision on 21 July 2008 that the consultation had met, in full, the Cabinet Office Code of Practice, particularly in relation to clarity of the consultation document, the Panel is

satisfied that appropriate actions were taken in the pre-consultation phase and then throughout the process as a whole.

5.4.13 The Panel is pleased to note the continuation of the Consultation Advisory Panel but believes that greater emphasis must be placed on effective and meaningful engagement with both staff and public during the implementation phase.

5.4.14

Recommendation Eighteen

The Panel recommends that a comprehensive and inclusive public engagement strategy relating to the implementation phase of the proposals be specifically agreed with both the JHOSC and Bexley OSC prior to commencement of implementation.

5.4.15 *NHS London*

Taking into account the magnitude of the proposed changes, together with additional factors such as the creation of the new South London Healthcare Trust and the implications of *Healthcare for London*, the Panel believes that NHS London must be more closely involved in the preparations for and implementation of the proposals.

5.4.16

Recommendation Nineteen

The Panel recommends that NHS London oversees the implementation of the proposals within an achievable and agreed timescale, through the work of commissioning groups and project boards already established.