Additional comments for People's Inquiry

Dear colleagues

As promised, we are sending you some further comments and some background information following our meeting with you on 23 October. **As discussed with some of you after the panel session, we would be very happy to talk to the panel again** (collectively or individually) about our proposals and our view that the current configuration of NHS services needs to change if we are top provide safe, high quality and sustainable services – **please let us know if this would be helpful.**

1. We welcomed the opportunity to speak to the 'People's Inquiry into the NHS' as we thought it was important to set a number of facts straight about our programme, which is often misrepresented by campaigners.

2. Dr Marilyn Plant referenced a number of evidence sources that the panel may want to consider and we have attached these to this document, along with a summary of our proposals and the reasons for them.

3. The panel has asked for clarification of what the difficulties are under the Health and Social Care Act of developing a common strategy for south west London. The legal advice we have received is as follows:

   "Responsibility for consultation under the NHS Act 2006 (as amended by the Health and Social Care Act) lies with NHS England and the seven CCGs who have duties of public involvement and consultation (sections 13Q and 14Z2 respectively). Unfortunately, the Act does not allow CCGs to form joint committees with themselves or other bodies in the way that primary care trusts could. For that reason, it is proposed that the governing body of each CCG should form its own committee, as should NHS England. The seven CCG committees will then meet in common, but each will take the necessary decisions in relation to the BSBV programme on behalf of its CCG. The NHS England Committee will meet separately to take its own decisions with regard to the relevant BSBV matters."

Under the Act, the statutory duty of a CCG is to serve the interests of its population, but the population served by a single hospital may cover many CCGs and certainly more than one. Where one CCG declines to agree a change across a wider area, involving many CCGs, the

change may be impossible under the 'four tests'. So, in effect, one CCG, pressured by its local stakeholders, can have a veto on changes which will benefit the wider population.

Many of the problems that reconfigurations address cover wider areas than a single CCG, involve some trade-off between travel times and safety, or between hospital and community-based care. These trade-offs become much more difficult to negotiate when collective decision-making to benefit a whole population – even if some have to travel slightly further for some services – is difficult. This seems to contradict the premise that we should provide services locally where possible and centralise where necessary.

4. We also wanted to correct a number of inaccuracies and misconceptions that were put forward about BSBV when we were present and we have responded to these points below.

5. **Suggestion that we propose to close St Helier Hospital.** In fact, up to 80% of patients would continue to go there of most of their care. BSBV proposals clearly state we will need five hospitals providing NHS services, three of them major acute hospitals and two of them local hospitals.

6. **Siobhain McDonagh referenced the difference in life expectancy between the St Helier catchment and that of Wimbledon, arguing that this was a reason for a hospital at St Helier.** This completely misses the point that the difference will not be improved by acute hospitals, it is a public health issue and needs addressing through better community care, public health and social measures – supporting our case rather than the opposite.

7. **Ms McDonagh also suggested we do not know when urgent care centres in local hospitals would be open.** While this would be a decision for local commissioners, it is not a question we have not considered. We modelled for a range of possible options including 12, 16 and 24 hours a day. All patients would have access to an urgent care centre and A&E on a 24/7 basis, though it is true that some will have to travel further. The evidence from existing urgent care centres suggests very few attendances after midnight, so commissioners would need to take a decision based on local need and affordability. As we do not yet know where the local urgent care centres will be, as the future configuration of services won't be agreed until after a public consultation has taken place, it would be impossible to ask local commissioners to make such a decision now.

8. **Dr Howard from St Helier talked about the need for training of clinicians**. BSBV proposals would benefit training – planned care centres are recognised by the Royal College as an excellent training locus, and having consultants on site for longer hours again improves training.

9. **Dr Howard also stated that patients would not be prepared to travel to an elective surgery centre.** This is an extraordinary statement considering the success of the existing elective care centre at Epsom Hospital. Another statement from Dr Howard called into question whether the other trusts would allow their patients to go to the centre – we would respectfully point out that i) the patients are not trust

property, commissioners can decide where to buy services, ii) the trust chief executives are on record as saying they will send activity there and iii) the trusts do not lose money by doing so as our proposed planned care centre is based on a profit sharing agreement (as the current elective centre is).

10. **Local evidence around excess mortality at weekends at ESTH was cited by Dr Howard.** This is non-peer reviewed 'evidence' which has never been shared with the programme – whereas the national evidence (and BSBV proposals) are subject to the highest levels of assurance. We know that at population level, the mortality rate at weekends and at night is around 12% higher. There is a mass of evidence emerging that differential mortality is a national issue for all hospitals. This means that even if local figures are better than average, there are still excess deaths that can be avoided. We must all strive to improve and save more lives and there is no room for complacency. National commissioning intentions are addressing this by signalling a seven-day service, so no change is clearly not an option.

11. **A campaigner suggested we don't engage with the public**. This is a remarkable claim. BSBV's pre-consultation engagement has gone way above and beyond any similar programme, we have attended over 500 meetings with members of the public and stakeholders and our pre-consultation engagement has been specifically commended by the Consultation Institute, the Office for Government Commerce and the National Clinical Advisory Team (NCAT). The JHOSC has endorsed our consultation plan, as have local councils, including those opposed to the proposals. We have never refused an invitation to speak and explain our plans unless there are too many requests at the same time for us to cover

12. **The same campaigner claimed we don't answer questions on Twitter.** Again, our social media activity far outstrips any similar programme and most NHS organisations. It is possible that campaigners don't get the answers that they want to hear as they often then repeat the same questions continually, but we do try very hard to answer their questions honestly or refer them to people who can. We have had a series of Twitter chats with our medical directors, who have also blogged extensively in response to specific questions that keep coming up. Unfortunately, the debate is often side-tracked a handful of anti-BSBV campaigners impugning the integrity of clinicians, misrepresenting their words and even refusing to read some of the information we send to them on the basis of wanting yes/no answers in 140 characters to every question. Symptomatic of this - as Polly Toynbee highlighted during our presentation – is the confusion in some quarters about the relationship between BSBV and the Health and Social Care Act. The case for change in south west London predated the Act and the current government and, as we accepted when questioned, elements of the Act have made necessary reconfigurations more difficult. BSBV certainly did not arise as a result of the Act and certainly has nothing to do with privatising NHS services.

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