Office of the Trust Special Administrator

Securing sustainable NHS services:

the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London

Securing sustainable NHS services

Final report
Volume 2 of 3
7 January 2013

The Trust Special Administrator
Appointed to the South London Healthcare NHS Trust

Securing sustainable NHS services: the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London

Volume 2 of 3

Presented to Parliament pursuant to section 65I of the
National Health Service Act 2006

Appendix A

Explanatory memorandum to the South London Healthcare NHS Trust (appointment of Trust Special Administrator) order

Securing sustainable NHS services

EXPLANATORY MEMORANDUM TO

THE SOUTH LONDON HEALTHCARE NATIONAL HEALTH SERVICE TRUST (APPOINTMENT OF TRUST SPECIAL ADMINISTRATOR) ORDER 2012

2012 No. 1806

AND

THE SOUTH LONDON HEALTHCARE NATIONAL HEALTH SERVICE TRUST (EXTENSION OF TIME FOR TRUST SPECIAL ADMINISTRATOR TO PROVIDE A DRAFT REPORT) ORDER 2012

2012 No. 1824

1. This explanatory memorandum has been prepared by The Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instruments

2.1 The South London Healthcare National Health Service Trust (Appointment of Trust Special Administrator) Order 2012 ("the Appointment Order") authorises the appointment of a trust special administrator (TSA) to exercise the functions of the chairman and directors of the South London Healthcare National Health Service Trust ("the Trust"), and makes provision for the appointment of the TSA to take effect on 16 July 2012.

2.2 Appended to this memorandum is a report produced in accordance with the requirement set out in section 65B(5) of the National Health Service Act 2006 ("the 2006 Act") stating the reasons for appointing a TSA to the trust.

2.3 The South London Healthcare National Health Service Trust (Extension of Time for Trust Special Administrator to Provide a Draft Report) Order 2012 ("the Extension Order") extends one of the time periods within which the TSA appointed for the Trust must carry out certain duties.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None

4. Legislative Context

4.1 Section 16 of the Health Act 2009 inserted a new chapter 5A into the 2006 Act to provide for the Secretary of State to appoint trust special administrators (TSA) to failing NHS trusts and NHS foundation trusts. The legislation also sets out the functions of the TSA during the period of the appointment, in particular, provision is made for the TSA to prepare a draft report making recommendations to the Secretary of State on the action he should take in relation to the Trust, for consultation by the TSA with staff of the trust, commissioners of services and other interested parties on the draft report, for the preparation by the TSA of a final report to the Secretary of State, and a final decision by the Secretary of State in relation to the trust. These functions are to be carried out within time periods prescribed in the 2006 Act. During the administration, the TSA will also be responsible for ensuring

that the trust continues to operate effectively, delivering quality health care promptly to its patients.

4.2 Section 65B(1) of the 2006 Act gives the Secretary of State the power to make an order authorising the appointment of a TSA to run an NHS trust if the Secretary of State considers it is appropriate in the interests of the health service. An order can only be made after consulting that NHS trust, any Strategic Health Authority in whose area the trust has hospitals, establishments or facilities, and any other person who commissions services from the trust where the Secretary of State considers it appropriate.

4.3 A TSA is only likely to be appointed after previous performance interventions have been unsuccessful. The TSA is appointed by the Secretary of State and holds and vacates office in accordance with the terms of their appointment. When the TSA's appointment takes effect the chairman and directors of the trust are suspended from performing their duties as members of the board.

4.4 Section 65J(2) of the 2006 Act gives the Secretary of State the power to, by order, extend certain of the time periods prescribed in the 2006 Act within which the TSA must carry out specified duties if the Secretary of State considers it is not reasonable in the circumstances for the TSA to be required to carry out a specified duty in that period.

4.4 These Orders are the first orders that have been made under sections 65B(1) and 65J(2) of the 2006 Act.

5. Territorial Extent and Application

5.1 These Orders apply to England.

6. European Convention on Human Rights

As these instruments are not subject to either the affirmative or the negative resolution procedure and do not amend primary legislation, no statement is required.

7. Policy background

7.1 The Secretary of State is exercising his powers under section 65B of the 2006 Act to trigger the Trust Special Administrator's (TSA) regime ("the regime") with regard to the South London Healthcare NHS Trust by means of appointing a TSA to the Trust pursuant to the Appointment Order. The hospitals in the Trust have faced multiple problems for many years. The Trust lost over £1 million a week last year. Whilst there have been some recent improvements in care, patients still face some of the longest waits for operations in London.

7.2 The Trust is a significant outlier in respect of referral to treatment times being one of only two trusts in London failing to meet 90% admitted standard and the only trust to fail the non-admitted standard at the end of 2011/12. The Trust has a record of weak accident and emergency performance failing to achieve the 4-hour standard in 2010/11 and 2011/12.

7.3 Financially, the Trust is the most challenged in the country and had a £65 million in-year deficit for 2011/12 - the third consecutive year of deficits (£42million in 2009/10 and £36million in 2010/11). It has not yet had its plan for 2012/13 accepted by the Strategic Health Authority that includes an 8.3% cost improvement target. This is considered above the achievable threshold. There is also no plan underpinned by a clinical and organisational strategy that demonstrates long-term sustainability. The most recent downside model developed by the Trust reflecting a more realistic set of assumptions suggests it will achieve a deficit, before support for its PFI scheme, of between £45million and £70million a year over the next four years. This is not sustainable.

7.4 Strenuous efforts have been made to tackle the problems in the South London health economy. South London Healthcare NHS Trust was established in April 2009 as a merger of three challenged hospitals – Queen Elizabeth in Woolwich, Queen Mary's Sidcup, and Princess Royal in Bromley. Over the past two years the Trust has worked hard to deliver improvements in the standard of the quality of care, demonstrated by a considerable fall in mortality rates and the opening of a new stroke facility. Nevertheless, the merger has not delivered long term financial and clinical sustainability.

7.5 The Government is committed to all remaining NHS trusts achieving foundation trust status. Every NHS trust has agreed a Tripartite Formal Agreement with its Strategic Health Authority and the Department of Health that sets out a clear plan and timetable for achieving foundation trust status. The trust has been red rated on its Tripartite Formal Agreement since it was agreed due to the lack of a credible plan that demonstrates how the Trust can be clinically and financially sustainable. There is no realistic prospect of the Trust achieving foundation status in its current configuration.

7.6 The regime was created to deal decisively with trusts in difficulties. The Appointment Order will enable the Trust to be put under the control of a TSA, with powers to make recommendations on how to make the Trust sustainable. The chairman and directors of the Trust are suspended at the point the TSA's appointment takes effect. The TSA's draft recommendations to the Secretary of State on what action should be taken in relation to the Trust must be consulted upon, after which the TSA produces a final report for the Secretary of State and the Secretary of State will then take the final decision on what action to take in relation to the Trust.

7.7 The regime sets out a timetable that produces final recommendations to the Secretary of State within a usual timeframe of 120 days. In this case, the Secretary of State has exercised his powers under section 65J(2) of the 2006 Act to make the Extension Order to extend the time period within which the TSA must produce a draft report from 45 working days to 75 working days.

7.8 The reason for the Secretary of State considering that it is not reasonable in the circumstances for the TSA to produce a draft report within 45 working days is that the issues affecting the Trust are particularly complex, being long standing and being built on a history of trust mergers, changes in commissioning arrangements and affecting a range of providers in the Trust's area. In conjunction with this, this is the first use of the regime, and the TSA appointed to the Trust will have to deal with the very challenging situation at the Trust

without being able to draw on processes and learning developed by previous TSAs. The TSA will need to develop these processes from scratch. In addition, the future of Orpington services are about to be consulted upon. Assuming this goes ahead, the extension will give the TSA the opportunity to take the output from this consultation exercise into account when developing his recommendations. The complexity of the situation at the Trust, combined with this being the first use of the regime, and the opportunity to take into account responses to the planned consultation on Orpington, have led the Secretary of State to consider it to be appropriate to extend the 45 working day period in the Extension Order by an additional 30 working days.

7.9 The first administration of an NHS trust is expected to attract significant levels of public and media interest. The Government will be issuing a press notice to accompany the appointment of the TSA, which will cover the extension to the timetable.

8. Consultation outcome

8.1 Pursuant to section 65B(4) of the 2006 Act, there is a statutory requirement for the Secretary of State, prior to making the Appointment Order, to consult the trust, any Strategic Health Authority in whose area the trust has hospitals, establishments or facilities, and any other person who commissions services from the trust where the Secretary of State considers it appropriate.

8.2 The main commissioners wrote to say that they shared the Secretary of State's concerns about the financial sustainability of many of the services provided by the Trust. They acknowledged evidence of rapid improvement in the accessibility and quality of care, but noted that the Trust is not financially viable beyond the short term. The commissioners advised that any strategy aimed at resolving the financial issues at the Trust needs to look at the whole health system for potential solutions. Looking at issues in the Trust alone will not resolve the factors causing the financial challenge. The commissioners offered their full support should the Secretary of State decide to trigger the unsustainable provider regime in relation to the Trust.

8.3 The Trust in its response, stressed the importance of the TSA having the remit and authority to look beyond the Trust and to maintain current standards of care. It stressed that the Trust now provides high quality services, but acknowledged that it is not able through its own actions to secure financial viability. The Trust accepts absolutely the timeliness of the intervention, but cares deeply that it is done in a way that solves the problem. The Trust is concerned that uncertainty created by the administration regime could reverse the recent gains that have been achieved. The Trust said that, if appointed, the TSA needs to have the powers and authority to look at a sufficiently wide range of options beyond the Trust itself. They also urged that the TSA should operate in such a way to safeguard current standards of care and retain the commitment of staff.

8.4 The SHA commented that applying the administration regime now – with its broad remit and timetable to which the TSA will work – is the best opportunity there is for securing access to high quality, financially viable health services for the people of south east London. The SHA emphasised that as part of his directions to the TSA, the Secretary of State should emphasise the need to take a broad strategic view, involving the whole of the south east London health economy.

8.5 The Government welcomes the generally supportive response to the consultation. The need for a solution to go beyond the Trust and involve the entire health economy was raised by all respondents to the consultation. The Secretary of State has powers to issue directions to the TSA under section 65H of the 2006 Act, to ensure that key stakeholders across the health economy are consulted on the draft report. The 2006 Act requires the TSA to attach to the final report a summary of all responses received to the draft report during the consultation. The Government notes the Trust's concern that the TSA should maintain the high standards of care and retain the commitment of staff. This has informed our decision to appoint a TSA with extensive experience of holding senior management posts within the NHS. This background will help to ensure that the Trust remains focussed on continuing to deliver high standards of care, and staff engagement will be a priority.

9. Guidance

9.1 There is guidance for TSAs on the DH website at http://www.dh.gov.uk/health/2012/07/statutory-guidance-tsa/

10. Impact

10.1 The urgency of the situation requires the Government to act promptly. There has not been time to produce an impact assessment on £3million to £4 million of external costs that are expected to be incurred on this administration. However, the Department of Health took into consideration the costs associated with the TSA administration as compared with the very large costs explained earlier in this Explanatory Memorandum associated with Trust as it stands.

10.2 The impact on public sector costs is not considered to be significant. The TSA is employed by the SHA, and where possible staff employed by the SHA and the Trust will be used to provide support to the TSA, in order to minimise costs.

11. Regulating small business

11.1 The legislation does not apply to small business.

12. Monitoring & review

12.1 The Department of Health made a commitment to review the operation of the administration regime after five years in the impact assessment that accompanied the Health Act 2009.

12.2 The TSA appointed pursuant to the Appointment Order is under a duty to provide the Secretary of State with a final report (after having developed and consulted on a draft report) about the action it recommends the Secretary of State should take in relation to this Trust, as provided for in Chapter 5A of the 2006 Act. If the Secretary of State's final decision is that the Trust is not to be dissolved, the Secretary of State has a duty to make an order specifying when the appointment of the TSA will come to an end. If the Trust is to be dissolved, then the TSA's appointment will end when the Trust is dissolved. In either case, the appointment authorised by the Appointment Order will end once implementation of the decision that follows the trust special administration process occurs.

12.3 This Extension Order provides for the time period in which the TSA appointed to the Trust must provide a draft report to be extended. Once this period has passed, and the trust special administration process for this Trust has ended, the Extension Order will have no ongoing effect, and can be revoked.

13. Contact

John Guest at the Department of Health Tel: [0113 254 6369 or email: John.Guest@dh.gsi.gov.uk can answer any queries regarding the instrument.

South London Healthcare NHS Trust

The Case for Applying the Regime for Unsustainable NHS Providers

July 2012

Executive Summary

1. The NHS is guided by the principles set out in *The NHS Constitution.* These include an aspiration to attain the highest standards of excellence and professionalism in delivering high quality care to all and, in doing so, a commitment to provide best value for taxpayers' money and the most sustainable use of finite resources[1].

2. All NHS Trusts have a duty to deliver these principles, however, for a variety of reasons, a small number of NHS Trusts across the country fall short. This is unacceptable and action must be taken to address Trusts that are failing to deliver clinically and financially viable services to patients.

3. South London Healthcare NHS Trust (SLHT) is one such Trust. Despite recent improvements in the quality of services, there is a long-standing history of underperformance, particularly around financial management and access standards, and a consistent inability to deliver high quality services whilst balancing income with expenditure.

4. A number of solutions have been implemented to try to resolve these problems and ensure the NHS in this area is able to provide consistent, high quality services to local patients and the public, within the designated budget. None have delivered the scale of change required to ensure clinically and financially viable services for patients and the people of south east London.

5. In the three years since its formation, SLHT has generated a total deficit of £154m. In the financial year 2011/12 it reported a deficit of £65m making it the most financially challenged Trust in the NHS. SLHT has no coherent and sustainable plan to resolve these issues. Over the next five years, from 2012/13 to 2016/17, the Trust projects a total accumulated deficit of £196m.

6. One of the major pressures on SLHT's financial position is the £89m annual cost of servicing the debt of its five PFIs, 18% of the Trust's annual turnover is spent on PFI contracts. Whilst key, even addressing this financial challenge will not be enough to deliver the Trust's long-term financial sustainability.

7. Despite SLHT's hospitals having, for many years, a number of performance issues in respect of delivery of clinical services, the Trust has made a number of improvements since 2009, including recently. However, the Trust still struggles to meet a number of key standards and with the significant financial challenges sustaining these improvements is unlikely.

8. The challenges facing SLHT are vast and complex. There is no clear and robust strategy in place to ensure that the Trust is able to secure a sustainable future for its services to patients within its existing configuration and organisational form.

9. It is therefore recommended that the Regime for Unsustainable NHS Providers, in which a Trust Special Administrator (TSA) is required to develop a solution within a prescribed timeframe, is applied to SLHT. Once appointed, the TSA will work across conventional or established stakeholder and organisational boundaries to develop a health economy-wide solution. This will bring about the transformational level of change needed to ensure clinically and financially viable services are secured for the people of south east London.

[1] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132958.pdf

Introduction

1. This paper provides an overview of the history and context, outlines previous attempts to resolve SLHT's challenges, analyses SLHT's financial and clinical performance challenges and concludes with why the UPR is the most suitable option for addressing SLHT's problems.

History and context

Overview of south east London health economy

2. SLHT operates largely out of three sites: Princess Royal University Hospital (PRUH), Queen Elizabeth Hospital (QEH) and Queen Mary's Sidcup (QMS). The Trust serves a population of approximately one million people, employs around 6,300 people and has an annual income of c. £440m, making it the 16th largest NHS Trust, by income, in the country.[2]

3. The wider south east London health economy comprises:

- One PCT Cluster, NHS South East London, that consists of six primary care Trusts (PCTs):
  - Bexley Care Trust
  - Bromley PCT
  - Greenwich PCT
  - Lambeth PCT
  - Lewisham PCT
  - Southwark PCT
- NHS South East London works with six proposed clinical commissioning groups (CCGs) (made up of 277 GP practices), each coterminous with their local authority. It has a commissioning budget of £2.3bn (of which £1.3bn is spent on acute care) for a population of c.1.8 million people.
- Two major teaching and research Foundation Trusts (FTs): Guy's and St Thomas' Hospital NHS Foundation Trust (GST) and King's College Hospital NHS Foundation Trust (KCH), operating from three sites.
- Two mental health FTs: South London and Maudsley NHS Foundation Trust (SLaM) and Oxleas NHS Foundation Trust.
- Two acute NHS Trusts: SLHT and Lewisham Healthcare NHS Trust (UHL).
- Four community services providers across the six boroughs: Southwark's and Lambeth's community services are provided by GSTT; Greenwich's and Bexley's by Oxleas NHS Foundation Trust; Lewisham's by Lewisham Healthcare NHS Trust; and Bromley's by Bromley Health Community Interest Company, a social enterprise.

[2] Audit Commission analysis of audited NHS financial statements

- One Academic Health Science Centre, Kings Health Partners (KHP), which is a partnership between GSTT, KCH, SLaM and King's College London.

4. Figure 1 shows the acute hospital sites across south east London. All hospital sites are easily accessible, as they are located on well-developed public transport routes. There are also significant patient flows from Bexley to Darent Valley Hospital (part of Dartford and Gravesham NHS Trust) in north west Kent. In the financial year 2011/12 Bexley Care Trust spent £190m on acute services, of which Dartford and Gravesham NHS Trust received £25m and SLHT received £90m.

Figure 1: Map of acute hospitals in south east London

5. In 2010/11 the two major teaching hospitals - GSTT and KCH - generated revenue of c. £940m[3] and c. £570m[4] respectively. Both organisations tend to generate a surplus. Given their size and clinical specialisms, GSTT and KCH create significant competition for SLHT, particularly in elective care.

6. No acute Trust in south east London has made a net surplus of more than 3.3% in the past three years and SLHT consistently reports the greatest deficit (see figure 2). In the next few years, in light of the constraints on public sector finances and the changing pattern of healthcare, it is anticipated all south east London acute Trusts will have financial challenges to address.

Figure 2: Summary financial position for SEL acute Trusts[5]

Currency: £ m	Guy's & St Thomas'			King's College Hospital			Lewisham			South London Healthcare			Total Health Economy		
	Income	Surplus / (deficit)		Income	Surplus / (deficit)		Income	Surplus / (deficit)		Income	Surplus/ (deficit)		Income	Surplus/ (deficit)	
2010/11	992	18	1.8%	586	1	0.1%	222	0	0	438	(44)	-10%	2,239	(26)	-1.1%
2009/10	943	2	0.2%	556	(1)	-0.2%	224	(1)	-0.4%	463	(44)	-9.4%	2.196	(44)	-2.0%
2008/09	845	19	2.2%	518	11	2.1%	174	6	3.3%	446	(21)	-4.8%	1.982	14	0.7%

[2] GSTT FT Annual Report and Accounts 2010/11(note: 2011/12 information not available for Guy's and St. Thomas and King's College Hospital)
[3] KCH FT Annual Report and Accounts 2010/11 and 2011/12
[4] Individual Trust report and Accounts 2008/09 – 2010/11

7. Local commissioners have also been managing financial pressures. In particular, Bexley Care Trust has struggled to deliver its statutory duty to break even. A recent NHS London review of PCT expenditure indicated that for the financial year 2012/13 NHS South East London will spend 45% of its planned income on acute care. This compares to the London average spend of 42%. (In contrast, in England, acute services account for 40% of total spend). The figures for the three PCTs that are SLHT's main commissioners are Bromley 47%, Bexley 45% and Greenwich 38%. This would indicate that the commissioners are not under-investing in acute services.

Figure 3: Summary of financial position of commissioners[6]

Currency: £ m	Lambeth		Southwark		Lewisham		Bexley		Bromley		Greenwich		Total Health Economy	
	Income	Surplus / (deficit)	Income	Surplus / (deficit)	Income	Surplus / (deficit)	Income	Surplus / (deficit)	Income	Surplus / (deficit)	Income	Surplus / (deficit)	Income	Surplus / (deficit)
2011/12	687	7	558	6	553	5	357	2	520	6	492	5	3,168	31
2010/11	667	6	546	1	537	5	347	0	513	7	476	5	3,086	26
2009/10	4	1	523	1	508	0	322	0	478	0	448	1	2,913	3
2008/09	562	3	455	0	450	0	287	0	429	0	404	2	2,586	5

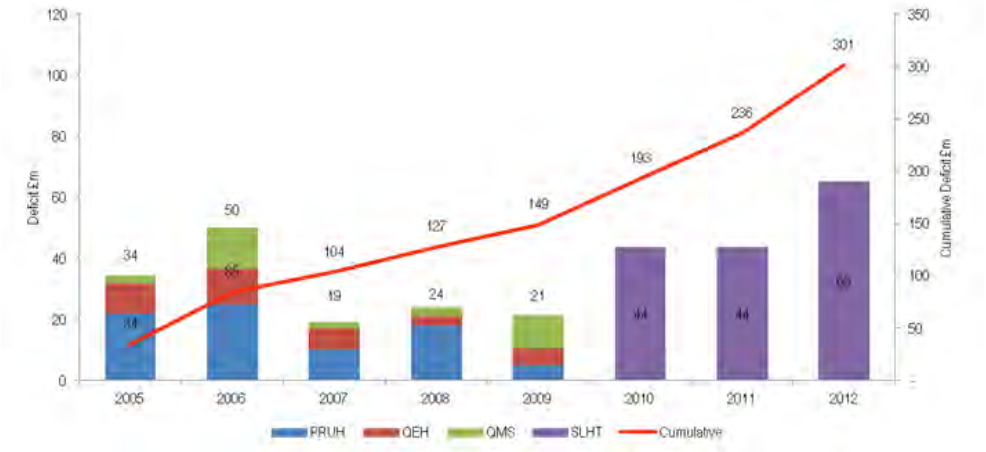
8. The consequence of the financial pressures in south east London is that each organisation adopts strategies that contain and resolve their own financial pressures, with insufficient regard to the impact on others. This has had a negative impact on SLHT and has strained relationships between organisations that need to work together effectively if they are to secure the best services for patients.

9. The pressures also act as a disincentive for organisations to engage with key strategic issues, since the cost of engagement and change can be viewed as prohibitive when seeking to contain short-term expenditure.

Overview of the history of SLHT

10. There is a long-standing history of underperformance (see figure 4), particularly around financial management and key access targets, within the hospitals that now make up SLHT, with a consistent inability to deliver high quality services within budget over the last eight years.

Figure 4: Normalised deficit[7] of SLHT and its three predecessor Trusts for 2004/05 to 2011/12[8]



[6] South East London Cluster FIMS returns 2008-09 to 2010-2011

11. Over the last five years there have been repeated attempts, involving different types and scale of intervention, to address the deep-rooted challenges facing SLHT. Thereby ensuring that the NHS in south east London provides local patients with clinically and financially sustainable services into the future.

12. These interventions started with *A Picture of Health* (APOH) - a substantial commissioner-led service reconfiguration programme to transform health services. Starting in 2006, the original aims of the programme were to "examine how to ensure improved, affordable and sustainable health services across the six boroughs in south east London - Lambeth, Southwark, Lewisham, Bexley, Bromley and Greenwich". The review work was undertaken in the context of an underlying and growing financial deficit projected for the south east London health economy.

13. In 2007, in light of a lack of progress, NHS London and south east London's PCTs changed the scope of the programme so that it only covered the outer boroughs - Lewisham, Bexley, Bromley and Greenwich - recognising that it was this part of the health economy that faced the most pressing challenges.

14. Prior to public consultation, the preferred option for change that emerged - with the options endorsed by the National Clinical Advisory Team - would have seen the outer south east London provider landscape rationalised to create a 'borough' hospital (ie. QMS), a 'medically admitting' hospital (ie. UHL) and two 'admitting' hospitals (ie. PRUH and QEH). The 'borough' hospital would not have provided a full A&E service, but with the service re-modelled as a primary care-led urgent care centre. The 'medically admitting' hospital would have an A&E department that can admit patients who may need some emergency monitoring, but would not provide inpatient maternity or inpatient paediatric services.

15. Public consultation on the APOH proposals for change took place in early 2008. The considerable challenge of managing stakeholders' responses to these reconfiguration proposals - most significantly those who opposed the proposed changes to services at UHL, including a significant number of the Trust's clinicians - was a major factor in the decisions following consultation. In the summer of 2008, the PCTs decided that PRUH, QEH and UHL were to become specialist emergency centres with 24-hour A&E, maternity units and children's inpatients; QMS was to focus on planned surgery and become a base for community healthcare services, with a 24-hour urgent care centre (with the site losing its A&E, obstetrics unit and all children's inpatient beds).

16. Despite the implementation of the APOH decisions, the south east London health economy still faces some significant challenges. One of the reasons for the continued challenges in this area of London is that, despite being implemented more quickly than other agreed reconfiguration programmes in London, arguably APOH did not go far enough to transform services. Services were rationalised, which meant movement between sites; but without being able to reduce capacity at any sites and therefore no significant efficiencies have been realised.

17. On 1 April 2009, SLHT was established as a merger of three NHS Trusts: QEH, QMS and PRUH. The merger was then seen as a solution to achieve cost and operational synergies amongst three Trusts facing their own significant, individual challenges.

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[7] Adjusted for non-recurrent income and expenditure
[8] SLHT Annual Report and Accounts 2008/09 – 2010/11 and draft annual accounts 2011/12 (note for 2011/12 management accounts 2011/12 have been used, reported under UK GAAP)

18. Whilst the merger, alongside the service changes implemented through APOH, has delivered some improvements to the quality of care that patients receive, the financial benefits anticipated have not been realised[9]. Given the organisation is in such profound financial distress it is questionable that the improvements in the quality of care are sustainable.

19. The anticipated improvement in clinical and operational performance has not materialised from the merger, partly due to the failure to operate as a single, consistent organisation across all three sites, including maximising the efficiency of Trust estate. Furthermore, the expected stimulus to make wider changes in the health economy has not been brought about. SLHT's relationships with commissioners remains strained.

20. More recently, the Trust has had significant traditional financial turnaround support from external consultancies and turnaround specialists. Over the past 18 months alone, SLHT has engaged three different sets of management consultants, including McKinsey & Company, Ernst & Young and PricewaterhouseCoopers to advise on devising turnaround plans and performance improvement strategies. SLHT has been unable to implement these plans effectively, resulting in continued operational and financial inefficiency.

21. Decision-making also remains variable and distinct across the three sites, with many examples of where Trust-wide policies have not been standardised. HR policies remain in place from the three pre-merger Trusts. As such, there are variations in payments and terms and conditions across SLHT. These variations continue to undermine attempts to streamline corporate-level reporting.

22. In a recent analysis undertaken by NHS London[10] the productivity opportunity at SLHT was assessed to be considerable, at between £67m and £97m over four years when benchmarked against comparable NHS Trusts in England. However, even if SLHT's productivity opportunity is realised in full, it would still not be sufficient to close the financial gap and deliver financially sustainable services. The gap is estimated at just over £51m.

23. Lastly, and in addition to all of the interventions and support outlined above, the Trust has also seen a number of senior management changes and, whilst some of these have resulted in short-term improvements, these have not been embedded and have failed to deliver the long-term change required.

Detailed analysis of SLHT

Overview

24. The disposition of key services at the Trust's three main sites is outlined in figure 5. SLHT also operates from three further sites - Orpington Hospital, Beckenham Beacon and Erith Hospital - at which the Trust mainly delivers outpatient care.

[9] The King's Fund Report: Reconfiguring Hospital Services, Lessons from South East London, Keith Palmer 2011
[10] Acute Hospitals in London: Sustainable and Financially Effective, February 2012

Figure 5: Key services by main three sites[11]

PRUH	QEH	QMS
Full admitting A&E	Full admitting A&E	Non-admitting urgent care centre
24/7 surgical emergency admissions	24/7 surgical emergency admissions	
Obstetrics and midwife-led birthing unit	Obstetrics	Antenatal and postnatal outpatient care
Routine elective care	Routine elective care	Routine elective care
Inpatient paediatric service	Inpatient paediatric service	Outpatient paediatric service
Complex inpatient surgery	Complex inpatient surgery	Elective day surgery
Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics
		Intermediate/ rehabilitation beds

Financial performance and reporting

Overview

25. Financial underperformance in SLHT and its predecessor Trusts has been a persistent issue over the last eight years. In the three years since its formation, SLHT has generated a total deficit of £154m. In the financial year 2011/12, only 10 of the 104 NHS Trusts in England reported a deficit; of these, SLHT had the largest at £65m (14.8% of the Trust's turnover) making it the most financially challenged Trust in the NHS. This was an increase of nearly 50% from £44m in the financial year 2009/10.

26. The Trust has constructed a Long Term Financial Model (LTFM) that projects SLHT will not achieve financial viability in the next five years. In every year of the model the Trust delivers a deficit (see figure 6), with a cumulative deficit over the five years totalling £196m. This is after an assumption that efficiency improvements totalling £113m per annum can be delivered. Achievement of this would require efficiency and productivity improvements beyond those made by the top performing organisations in the country. The downside case, which includes reasonable assumptions - CIP delivery of £84m, a reduced income assumption and a reduced assumption regarding transition financial support - projects a total accumulated deficit position of £343m.

27. The continued delivery of deficits with no plan for resolution is unsustainable and means that vital resources are, and will continue to be, diverted away from other parts of the NHS to maintain safe and high quality services at SLHT. In order to deliver long-term sustainable services for patients, the Trust, as part of the wider health economy, must work with its partners to develop models of care and clinical pathways that are both clinically and financially viable.

[11] http://www.slh.nhs.uk/?section=aboutus&id=84

Figure 6: SLHT Long term financial model 2012/13 – 2016/17[12]

Currency:£ m	2012/13	2013/14	2014/15	2015/16	2016/17	Total
Base case Income	429.7	449.8	456.6	456.6	456.6	**2,249.3**
Expenditure	(488.5)	(491.5)	(491.5)	(487.1)	(487.1)	**(2,445.7)**
Surplus / (Deficit)	(58.8)	(41.7)	(34.9)	(30.5)	(30.5)	**(196.4)**
Surplus / (Deficit) as a % of income	(13.7%)	(9.3%)	(7.7%)	(6.7%)	(6.7%)	**(8.7%)**
Downside case	(101.8)	(80.1)	(80.7)	(78.7)	(81.2)	**(343.8)**

Summary financial performance for the last three years

28. To understand fully the underlying financial challenges facing the Trust it is necessary to consider the recent financial performance of the Trust, how it has responded to the challenges it has faced since its establishment and its current financial position.

29. Figure 7 outlines the financial performance of SLHT since its formation on 1 April 2009 and shows a deterioration over the period. The key points are:

- Total revenue has declined by £23.7m (5.1%) over the three years. This decline took place between 2009/10 and 2010/11 and was linked to changes in commissioning intentions, the pace of which is likely to accelerate as CCGs assume control of commissioning.

- Operating costs have reduced by £32.2m (6.2%) over the three years. However, they increased between 2010/11 and 2011/12 by £40.9m (9%). This is a real terms increase and demonstrates that the Trust's cost base has risen, despite income remaining constant.

- Finance costs, which principally relate to the two whole hospital PFIs located at PRUH and QEH, have increased by £5.3m (25.2%) over the last three years.

- The total deficit has increased by £21.3m (49%) over the three years. Adjusting to reduce the impact of the impairment[13], the net deficit in 2009/10 and 2010/11 was c. £44m and in 2011/12 was £65m.

[12] Source: SLHT Long Term Financial Model 2011/12 – 2016/17 (31 December 2011)

[13] The 2009/10 deficit of £90.5m includes an impairment in the value of fixed assets of £46.8m, which relates to a reduction in the value of assets at SLHT's operational sites resulting from the impact of changes in the economic environment. In 2011/12, a similar impairment was £21.6m. Impairments are directly related to the value of the Trust's estates and they are not considered to be of a material nature when considering the overall financial performance of any Trust, since they are not related to the year-on-year delivery of patient services.

Figure 7: SLHT financial performance 2009/10 – 2011/12[14]

Currency: £ m	2009/10	2010/11	2011/12[15]	%change
Revenue from patient care activities	421.7	407.8	408.8	(3.1%)
Other operating revenue	40.9	30.0	30.1	(26.4%)
Total revenue	462.6	437.8	438.9	(5.1%)
Employee costs	(306.9)	(293.8)	(301.7)	1.7%
Non pay costs	(216.1)	(156.1)	(189.1)	(12.5%)
Total costs	(523.0)	(449.9)	(490.8)	(6.2%)
Investment revenue	0.0	0.0	0.0	
Other gains and losses	0.0	0.0	0.0	
Finance costs	(21.0)	(23.3)	(26.3)	25.2%
Surplus / (Deficit) for the financial year	(81.4)	(35.4)	(78.2)	(3.9%)
Public dividend capital dividends payable	(9.1)	(8.4)	(8.4)	(7.7%)
Retained Surplus / (Deficit) for the financial year	(90.5)	(43.8)	(86.6)	4.3%
Less 2009/10 and 2010/11 impairment and IFRS adjustment	46.8	0.0	21.6	53.8%
Normalised position	(43.7)	(43.8)	(65.0)	(48.7%)

Income

30. The majority of SLHT's income comes from the Bexley, Bromley and Greenwich PCTs. The Trust has seen its income reduced by £24m (5.1%) over the last three years (see figure 8), due to:

- tariff deflation;
- a reduction in other operating income of £10.8m; and
- some reduction in activity related income as commissioners developed services away from the acute hospital environment.

Figure 8: Breakdown of income 2009/10 – 2011/12[16]

Currency: £ m	2009/10	2010/11	2011/12[17]	%change
Primary Care Trusts	419.9	404.2	405.6	(3.4%)
Non NHS: Other patient care	1.8	3.6	3.2	77.7%
Total income from Patient Care Activities	**421.7**	**407.8**	**408.8**	**(3.1%)**
Other operating revenue	17.7	12.2	8.3	(53.1%)
Education, training and research	16.5	15.7	15.2	(7.9%)
Non-patient care services to other bodies	1.7	2.1	5.7	235.2%
Income generation	5.0	0.0	0.9	(82%)
Other operating income	**40.9**	**30.0**	**30.1**	**(26.4%)**
Total operating income	**462.6**	**437.8**	**438.9**	**(5.1%)**

[14] SLHT Annual Report and Accounts 2009/10, 2010/11 and draft annual accounts for 2011/12
[15] There may be a difference between the management accounts and audited accounts
[16] Source: SLHT Annual Report & Accounts 2009/10, 2010/11 and 2011/12.
[17] draft annual accounts 2011/12 – note, there may be a difference between the management accounts and audited accounts, but it is the latest available information

31. In line with the NHS elsewhere in England, south east London commissioners have developed plans that will see the delivery of care transferred from acute hospital settings to community settings, where appropriate. In parallel, a plan for developing and improving overall public health is being pursued, which potentially further reduces the need for hospital care and therefore may reduce SLHT's income further.

32. In addition to this, and building on evidence-based service change already undertaken across the capital, there is a powerful case for treatment of some complex conditions to be consolidated at 'centres of excellence'. It is therefore unrealistic for SLHT to expect to be able to generate significant additional income to support its underlying financial position. In reality, the Trust's income is likely to reduce and, therefore, SLHT has to look to reducing its cost base to match its income structure and the expected level of activity in future years.

33. Any organisation would find it challenging to react to changes in demand for services but, coupled with the other challenges facing SLHT, it is virtually impossible that this organisation can respond to these challenges in its current form.

Operating costs

34. SLHT's operating costs have fallen 6.2% overall in the last three years. However, all of the reductions were made in 2010/11. In 2011/12 costs rose by £40.9m, increasing the Trust's deficit.

35. In 2011/12, 61.5% of total expenses incurred related to employee costs (see figure 9). This puts SLHT in the top 20% of large acute Trusts in terms of proportion of total costs relating to employees. An independent report concluded SLHT has significant inefficiencies within its employment cost structure[18], which it has been unable to address.

Figure 9: SLHT Employee costs[19]

Currency: £ m	Staff cost			Number of employees		
	2009/10	2010/11	2011/12	2009/10	2010/11	2011/12
Total, excluding bank staff, locums and agency staff	268.1	259.4	262.4	5,771	5,431	5,367
Bank staff	17.8	18.5	22.2	432	741	789
Locum staff	2.7	3.1	4.0	11	24	20
Agency staff	18.2	12.7	13.3	299	302	187
Total bank, locum and agency staff	**38.7**	**34.3**	**39.5**	**742**	**1,067**	**995**
Total	**306.9**	**293.7**	**301.8**	**6,513**	**6,498**	**6,363**
% of expenses	58.7%	65.3%	61.5%			
% of bank, locum and agency staff	12.6%	11.7%	13.1%			

36. From 2010/11 to 2011/12 headcount costs increased by £8.1m (2.8%) to £301.8m. £3m of this increase was from the permanent staff base. The remainder was

[18] PwC Report, South London Healthcare NHS Trust, Workforce Review, 8 September 2011
[19] SLHT Management Accounts 2009/10, 2010/11, 2011/12

generated by additional spend on bank, locum and agency staff. Given the Trust's financial position, these additional pressures are unsustainable.

37. Temporary staff expenditure continues to be a problem for SLHT. For example, in 2011/12, agency staff costs were budgeted to be under £3.4m the actual cost was £13.3m; SLHT's target for agency usage is 1% of total workforce and yet, in 2011/12 it delivered 4%. Compared to its peers, SLHT has consistently underperformed on its levels of usage of temporary staff.

38. The Trust's inability to contain temporary staff costs suggests a broader problem: a combination of the challenges of planning, rostering, staff utilisation and staff recruitment and retention. It demonstrates short-term operational planning, with permanent positions being removed, only to be replaced with more costly temporary staff. This has been a recurrent issue and one which SLHT has been unable to address. The lack of a clear plan for financial and operational viability and the worsening financial position compounds this issue, making the Trust an unattractive organisation for potential recruits.

39. Non-pay costs, before taking into account impairments, increased by 1.2% over the last three years (see figure 10); this is despite an £11.5m reduction in 2010/11.

Figure 10: Non-pay costs[20] 2009/10 – 2011/12

Currency: £m	2009/10	2010/11	2011/12[21]	% change
Supplies and services – clinical	68.9	70.9	83.3	(20.9)%
Premises	38.4	31.4	35.8	6.8%
Clinical negligence	10.6	11.2	13.3	(25.5)%
Supplies and services – general	13.3	12.7	12.8	3.8%
Establishment	5.2	5.2	5.1	2.0%
Other	19.8	13.3	7.8	60.1%
Total operating expenses excluding employee benefits and non-trading expenditure	**156.2**	**144.7**	**158.1**	**(1.2)%**
Impairments and reversals	44.1	(1.7)	17.5	
Depreciation	16.0	13.2	13.5	
Total operating expenses excluding employee benefits	**216.3**	**156.2**	**189.1**	

40. In 2011/12 non-pay costs, before taking into account impairments, returned to levels above those seen in 2009/10. The £13.4m (9.3%) increase was driven by a £12.4m increase in clinical supplies and services. Such an increase could either indicate a lack of control over the purchasing of such supplies, high inflation, or a failure to turn additional activity into income. It should be noted that income was constant between 2010/11 and 2011/12.

[20] SLHT Annual Report & Accounts 2009/2010, 2010/2011 and draft annual accounts for 2011/12
[21] There may be difference between the management accounts and audited accounts

Cost Improvement Plans (CIP)

41. In the last three years SLHT has generated CIP savings of £91.5m, equal to 19% of total costs. Despite these significant cost reductions, SLHT has a history of underperformance against budget for its CIPs (see figure 11). In 2011/12, only 68% of cost savings were achieved. The key reasons for this underperformance have been SLHT's limited ability to deliver successfully against plans that it has developed or to reflect long-term changes in demand. In such circumstances, plans are often short-term reactions to pressures and demonstrate a lack of planning and / or awareness of the impact of shifts in activity to the cost base.

Figure 11: Summary of CIP savings[22]

Currency: £m	2009/10	2010/11	2011/12
CIP – Forecast	30.4	51.5	30.6
CIP – Actual	24.1	46.7	20.7
% CIP actual vs forecast	79.3%	90.7%	67.6%
Actual CIP as % total costs	4.6%	10.4%	4.2%

42. The key drivers for CIPs in each year have been[23]:

- In 2009/10 61% of savings were generated from clinical cost reduction, half of which were from clinical headcount and staffing costs. This area was also one of the key drivers for the underperformance against the CIP (£3.4m). This indicates that in this area, a large target was set but the Trust was unable to deliver this target whilst ensuring that all services were safe for patients.

- The 2010/11 saving plan was the largest (as a proportion of total costs) in London. Key areas of focus were restrictions on temporary / agency staff and controls on discretionary spending.

- In 2011/12 SLHT underperformed by £9.9m against its CIP. The primary reason for this was the changing nature of activity and the desire to ensure services remain safe.

43. The absence of a clear long-term strategy for the Trust is reflected in the SLHT's CIP schemes. These tend, in the main, to be comprised of high numbers of low-value schemes, which are intrinsically harder to manage than a small number of high-value schemes. A recurrent theme of these programmes is a lack of success in tackling the strategic and transformational issues and requirements of the Trust based on overall productivity and efficiency, with instead a repeated focus on short-term savings'

Operational efficiency

44. NHS London analysis of productivity opportunities for acute NHS Trusts[24] concluded that SLHT had an opportunity of between £67m and £97m over a four-year period. Efficiencies were identified across all parts of the operations, including:

[22] SLHT Long Term Financial Plan 2011/12 – 2016/17 (31 December 2011)
[23] SLHT Long Term Financial Plan 2011/12 – 2016/17 (31 December 2011)
[24] Acute Hospitals in London: Sustainable and Financially Effective, February 2012

- Theatre utilisation - Day case rates consistently below the Trust's peer group average and national target at only 70% against a national theatre utilisation benchmark of 90%, making theatre utilisation at SLHT one of the lowest nationally. Internal analysis suggests that SLHT could potentially deliver current levels of activity with between two to nine fewer theatres.

- Medical productivity - SLHT's job planning process in relation to programmed activity (PA) for its consultant workforce does not correspond directly to demand. As such, there are significant operational inefficiencies with respect to additional PAs being contracted for and remunerated but not being fully utilised. An external review undertaken last year[25] estimated that over 200 PAs could be released by restructuring the demand planning framework and reducing unnecessary PAs.

- Nursing and midwifery productivity - SLHT's nursing and midwifery levels are 3.5% higher than comparator Trusts, which equates to a potential annual recurrent saving of between £4m and £13m. The Trust has higher than benchmark staffing levels for *Agenda for Change* bands 6 to 8d (the most senior nurses). The average number of nurses per shift, nurses per bed ratios and bank use figures are high across certain wards, and exceed recommended staffing levels set-out by the Royal College of Nursing[26].

- Length of stay and bed management - Work undertaken by the Trust suggests SLHT's current bed configuration is not effectively managed. The Trust's internal analysis suggested that the bed requirement could potentially be reduced by between 100 and 300 beds if managed more effectively and length of stay was reduced.

45. However, NHS London's analysis also[27] concluded that even if the Trust, in its current configuration, achieved 'best in class' productivity across its operations, it would still not be able to achieve a sustainable financial position in its current form. This shows that the underlying fixed cost base is too high and significant change is needed to the Trust's operational structures as well as to its productivity.

Cash flow

46. The operating cash position has deteriorated since 2009/10, with a £30.5m reduction in operating cash flow in 2011/12 to £64.4m (outflow) (see figure 12). This was driven by the significant deficit generated by SLHT during the year.

[25] EY Report, SLHT Financial Improvement Support, September 2011
[26] EY Report, SLHT Financial Improvement Support, September 2011
[27] Acute Hospitals in London: Sustainable and Financially Effective, February 2012

Figure 12: Cash flow 2009/10 – 2011/12[28]

Currency: £ m	2009/10	2010/11	2011/12
Net cash inflow / (outflow) from operating activities	(27.0)	(33.9)	(64.4)
Net cash inflow / (outflow) from investing activities	(12.6)	(14.3)	(16.3)
Net cash inflow / (outflow) before financing	(39.6)	(48.2)	(80.7)
Net cash inflow / (outflow) from financing	40.1	46.7	80.6
Net increase / (decrease) in cash and cash equivalents	0.4	(1.4)	(0.1)
Cash and cash equivalents at the start of the year	7.6	8.1	6.6
Cash and cash equivalents at the end of the year	**8.1**	**6.6**	**6.5**

SLHT would be insolvent without the significant additional public dividend capital that it has received (£182.9m in the three years to 2011/12).

Quality of financial information

47. As with all NHS providers, effective management is dependent on timely and accurate financial information which the Trust struggles to deliver. This is a key operational risk. For example, the Trust has had difficulty identifying detailed site-specific financial information and has not been able to implement a robust Service Level Costing information system.

48. The weakness of SLHT's financial information can be evidenced by the issues uncovered during the close and audit of the 2010/11 accounts. The draft financial statements for the 2010/11 audit were provided late, incomplete and contained a number of errors. The most pressing concern was the completeness and valuation of assets on SLHT's fixed asset register.

49. Upon initial review, the audit team found a number of significant errors within the fixed asset register. In order to avoid qualification of its accounts, SLHT carried out a second review of its asset register and the audit team returned to re-test in September 2011. High levels of errors were still identified, showing inadequate monitoring and control of financial information despite the serious concerns already raised by the auditors. Additional errors were also found and are documented in SLHT's Annual Governance Report.

50. In addition, during the 2010/11 financial year end close the 2009/10 accounts needed to be re-stated. This was due to a number of material errors relating to asset disposals and re-valuations. These highlight severe weaknesses in SLHT's data and control environment. SLHT also has a history of inaccurate budgeting. In 2010/11, whilst the figures presented in figure 13 show a difference of £2.8m, this is a revised forecast, with the original forecast projecting a c. £25m lower deficit than was actually achieved.

[28] SLHT Annual Report & Accounts 2009/10, 2010/11, Management Accounts 2011/12

Figure 13: Accuracy of budgeting[29]

Currency £m	2009/10 Actual	2009/10 budgeted	Variance	2010/11 Actual	2010/11 budgeted	Variance	2011/12 actual	2011/12 budgeted	Variance
Total revenue	**462.6**	**440.4**	**22.2**	**437.8**	**438.9**	**(1.1)**	**438.9**	**410.4**	**28.5**
Operating expenses	(523.0)	(438.5)	(84.5)	(449.9)	(450.3)	(0.4)	(490.8)	(446.4)	(44.4)
Operating surplus (deficit)	**(60.4)**	**1.9**	**(58.5)**	**(12.1)**	**(11.4)**	**(0.7)**	**(51.9)**	**(36.0)**	**(15.9)**
Finance costs	(21.0)	(19.0)	(2.0)	(23.3)	(20.6)	(2.7)	(26.3)	(25.4)	(0.9)
Surplus/(Deficit)	**(81.4)**	**(16.4)**	**(65.0)**	**(35.4)**	**(32.0)**	**(3.4)**	**(78.2)**	**(61.3)**	**(16.9)**
Public dividend capital dividends payable	(9.1)	(13.3)	4.2	(8.5)	(9.0)	0.5	(8.4)	(8.5)	0.1
Retained Surplus/(Deficit) for the financial year	**(90.5)**	**(29.7)**	**(60.8)**	**(43.8)**	**(41.0)**	**(2.8)**	**(86.6)**	**(69.8)**	**(16.8)**
Less 2009/10 and 2010/11 impairment	46.8	0.0	46.8	0.0	0.0	0.0	21.6	0.0	21.6
Normalised position	**(43.7)**	**(29.7)**	**(14.0)**	**(43.8)**	**(41.0)**	**(2.8)**	**(65.0)**	**(69.8)**	**4.8**

51. The Audit Commission concluded[30] that there was inadequate challenge to the financial information at Board level, including:

- no discernible consideration given to a plan to reduce the historic Trust deficit;
- an unidentified £4m of cost savings inserted into the annual cost improvement programme, with no explanation as to how it would be achieved; and
- no evidence of a medium term financial plan, indicating a short term approach to financial planning.

52. In an environment where there are concerns about data quality, such a lack of challenge is concerning. A broader review of governance structures and reassessment of the role of the current Board members is required to build the necessary understanding of the problems affecting the Trust and what needs to be done to introduce a more robust approach.

PFI and estate management

53. One of the major pressures on SLHT's financial position is the £89m annual cost of servicing the debt of all its PFIs. The main PFI contracts are based at PRUH and QEH.

54. The cost of capital incurred by having financed QEH and PRUH through PFI schemes was assessed in the 2011 DH analysis of all PFI contracts that were deemed as potentially adversely impacting on a Trust's journey to long-term sustainability. This analysis found that 18% of SLHT's turnover was spent on PFI contracts. This was the largest percentage identified in the analysis compared to the average rate of 10.3%.

55. The cost of PFI contracts is significantly higher than if these were funded through standard government rates. Accordingly, SLHT's ability to control its cost base is

[29] SLHT Annual Report & Accounts 2009/10, 2010/11, Management Accounts 2009/10, 2010/11, 2011/12
[30] http://www.slh.nhs.uk/media/documents/slht-annual-report-and-accounts-1011.pdf

impacted, reducing the proportion of the cost base over which the Trust has direct control.

56. In February 2012, SLHT was one of seven NHS Trusts highlighted by the Secretary of State for Health as being potential candidates for access to a new £1.5bn fund, to provide a package of support. The DH analysis concluded that the PFI arrangements at SLHT meant costs of £21m were being incurred over and above what would be the case had the hospitals been constructed in the traditional manner and operating to an appropriate level of efficiency.

57. Whilst this is not, in itself, the only reason for the size of the Trust's financial deficit, it is a key factor as the commitment to these sites is fixed until at least 2030.

58. The additional funding is vital for the overall local health economy to become financially viable and stable. The challenge is for those funds to be made available as soon as possible to support the local health economy's developments in quality improvements. Otherwise, there is a high risk of cross-contamination whereby commissioners are obliged to act for the short term financial benefit, to support SLHT further, as opposed to supporting the much needed health economy wide service development. (The NHS South East London plan for 2012/13 proposes £10m overall support to SLHT from the non-recurrent resource allocation).

59. SLHT will only be able to access the £1.5bn if it can demonstrate an answer to the overall financial issue, as the PFI funding is key but insufficient on its own to deliver sustainability long term. As currently there is no plan in place, access to this additional funding is therefore at risk.

60. In addition to the overall PFI burden there are a number of areas of inefficiency in SLHT's estate management. These include:

- Lack of consolidation of clinical services across sites. The same services are provided across various sites rather than being reviewed and reconfigured to reduce inefficiencies.

- Lack of centralisation of back-office functions such as medical records. Currently a number of basic services are replicated across three sites, taking up excess space across the estate.

- Significant overlap between the PFI contracted facilities management and SLHT's own in-house facilities management staff. There are still 288 'full time equivalent' staff employed in relation to the in-house facilities management operation, despite 70% of SLHT's estate being operated under PFI schemes[31].

- Excess freehold space held by SLHT. Despite owning the freehold for a wide variety of properties, leasehold buildings are still being used. Similarly, a number of SLHT buildings are currently leased to social services (95 staff) for no income. The estimated annual rent, rates and utilities for these additional rented buildings totalled approximately £0.5m in 2011/12.[32]

[31] EY Report, SLHT Financial Improvement Support, September 2011
[32] Estates review – initial findings for discussion dated 2 September 2011

61. There has been no significant progress on reducing or rationalising the estate footprint. In view of the size of the Trust's PFI contracts and high 'buy out' costs, its estate rationalisation plan has focused on maximising activity at its two primary sites while reducing activity at QMS.

Clinical performance

62. SLHT currently meets 16 of the 23 key standards in the DH National Performance Framework. In the Dr Foster Hospital Guide published in November 2011[33], SLHT was one of a number of Trusts in London to perform well on three of the four mortality indicators - Hospital Standardised Mortality Ratio, Summary Hospital-level Mortality Indicator and deaths in low-risk conditions.

63. The positive sustained improvement in mortality rates may be attributed to service redesign, senior clinical involvement in decision-making and systematic scrutiny of mortality, as well as leadership and focus in this area, among other factors[34].

64. Despite SLHT's hospitals having, for many years, a number of performance issues in respect of delivery of clinical services, the Trust has made some improvements since 2009 and especially more recently. However, the Trust still struggles to meet a number of key standards and the sustainability of these improvements is unclear.

65. Referral to treatment time (RTT) (admitted and non-admitted performance) continues to be an area of weakness for SLHT. It was the only Trust in London that failed to meet both the 90% and 95% standard for admitted and non-admitted waits throughout most of 2011/12. However, the Trust has made progress in clearing backlogs in recent months and data for May 2012 shows that the Trust is now meeting the RTT standards for admitted, non-admitted and incomplete pathways[35] and is on track to achieve the standards at speciality level by October 2012. Continuing to reduce backlogs will come at a financial premium that will be challenging to sustain in view of the wider financial pressures faced by the Trust.

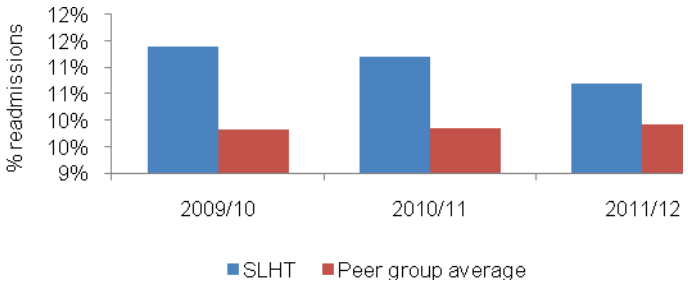
66. SLHT has a historical record of poor A&E performance and is consistently ranked in the bottom 10% of NHS Trusts for A&E wait times nationally. SLHT has consistently underperformed against its peer group for A&E wait times, reaching a low of 89% in Q3 of 2010/11 against the four-hour wait target. The Trust failed to meet the A&E 'all type' operational standard for 2011/12 - with 'all type' performance of 93.5% against the 95% standard.

67. Since February 2012 there has been a gradual improvement in A&E performance as a result of action taken to strengthen ambulatory care, elderly care support to the emergency care pathway and weekend medical cover, as well as ongoing support from the Emergency Care Intensive Support Team, all of which have had a positive impact on performance at both PRUH and QEH. The Trust met the A&E standard in Q1 of this financial year.

68. Re-admission rates, against a national peer group of comparable Trusts, have remained consistently high (as shown in figure 14):

[33] Hospital Guide 2011: Dr Foster Health, 28 November 2011
[34] SLHT Trust Board papers, 25 January 2012
[35] SLHT Trust Board papers, 25 April 2012

Figure 14: Comparable SLHT re-admission rates, 2009/10-2011/12[36]



69. The comparably high level of re-admissions at SLHT would lead to a significant amount in marginal tariff payments, estimated at c. £4.5m. There is little evidence to demonstrate that leadership arrangements to improve performance against this standard have led to any material improvements, or the necessary changes.

70. The prevention and treatment of Venous Thromboembolism (VTE) is a key safety priority and is a measure of the level of care in a hospital. SLHT has been one of the worst Trusts in the country for VTE. Its performance in Q3 of 2011/12, in which it delivered a 32% score, was the worst of all Trusts in the country against the standard of 90%. The Trust is still below the national benchmark and is performing well below its peers for this clinical measure, due to both recording and clinical process issues, but is expected to achieve the target in June 2012.

71. In 2010/11, SLHT was found by the Care Quality Commission (CQC) to be non-compliant with essential standards of quality and safety in eight areas. Since this review, further CQC visits have been made to all three of SLHT's sites, which have found that improvements have been made in most areas. All essential standards were met at QEH and PRUH, with all but one at QMS. The CQC had minor concerns across a number of areas at all three sites.

72. The efforts of the current leadership team in delivering improvements across key performance standards and the quality and safety of care should be acknowledged and commended.

73. However, there is clearly a significant risk that recent clinical and performance improvements cannot be sustained unless the financial challenge is addressed. As the root causes of the challenges are complex, site-specific and both internal and external to the Trust, any solution will require action across the whole local health economy to secure long-term financially and clinically sustainable services.

Why enacting the Regime for Unsustainable NHS Providers at SLHT is necessary

74. Over the last five years there have been repeated attempts, involving different types and scale of conventional intervention, to address the deep-rooted challenges faced not only by SLHT but the wider health economy in south east London. This has included a major commissioner-led review of service configuration, the merger of the three previous Trusts into one and numerous organisational reviews and management changes. None have succeeded in bringing about the required level of change to

[36] *Dr Foster website*

secure financially and clinically sustainable services for local patients. Furthermore, there is no strategic plan in place to address these significant and far-reaching challenges for the future.

75. Fundamental and transformational change is needed. This is change that would stretch beyond the organisational boundaries of SLHT, as the conventional options for addressing the complex, long-standing challenges faced by the Trust and the wider health economy have all been tried, but have failed to deliver the scale of change required.

76. It is therefore recommended that the Regime for Unsustainable NHS Providers (UPR) is applied to SLHT. The purpose and drive behind the regime is to have a resolute focus on implementing rapid, fundamental and transformational change within a significantly challenged Trust and across the whole health economy to ensure long-term sustainability, so that local people's access to high-quality healthcare services is protected.

77. The scope of the UPR, the ability to work across conventional or established stakeholder and organisational boundaries and the timeframe in which the Trust Special Administrator is required to develop a solution, means that it is the best mechanism to bring about the required level of change. This is needed now to secure long-term financially viable services and access to high-quality health care for the people of south east London.

Appendix A

Abbreviations	
A&E	Accident & Emergency
AHSC	Academic Health Sciences Centre
APOH	A Picture of Health
C. Diff	Clostridium difficile
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
COO	Chief Operating Officer
CQC	Care Quality Commission
DGH	District General Hospital
DH	Department of Health
EY	Ernst & Young LLP
FT	Foundation Trust
KHP	Kings Health Partners'
LTFM	Long Term Financial Model
McKinsey	McKinsey & Company
MRSA	Methicillin-resistant Staphylococcus Aureus
NTDA	NHS Trust Development Authority
PA	Programmed activities
PCT	Primary Care Trust
PFI	Private Finance Initiative
PRUH	Princess Royal University Hospital, Bromley
PwC	Pricewaterhouse Coopers
Q1	Quarter ending 30 June
Q2	Quarter ending 30 September
Q3	Quarter ending 31 December
Q4	Quarter ending 31 March
QEH	Queen Elizabeth Hospital, Woolwich
QMS	Queen Mary's Hospital, Sidcup
RTT	Referral to treatment
SEL	South East London
SoS	Secretary of State
SLHT	South London Healthcare NHS Trust
TFA	Tripartite Formal Agreements
Trusts	NHS Trusts
TSA	Trust Special Administrator
UHL	Lewisham Hospital NHS Trust
UPR	Unsustainable Provider Regime
VTE	Venous Thromboembolism

Appendix B

Trusts included in the Peer Group (per NHS London analysis)

1. East Kent (FT)
2. Gloucestershire (FT)
3. Heart of England (FT)
4. North Bristol
5. Portsmouth
6. SLHT
7. South Tees (FT)
8. Ashford and St Peter's
9. Aintree (FT)
10. Barnet and Chase Farm
11. BHRT
12. Blackpool, Fylde & Wyre (FT)
13. Bradford (FT)
14. Calderdale and Huddersfield (FT)
15. Colchester (FT)
16. County Durham and Darlington (FT)
17. Epsom and St Helier
18. Heatherwood and Wexham Park (FT)
19. Lancashire Care (FT)
20. Maidstone and Tunbridge Wells
21. Mid Essex Services
22. Morecambe Bay
23. Northern Lincolnshire and Goole (FT)
24. Northumbria (FT)
25. NWLH
26. Peterborough and Stamford (FT)
27. Royal Berkshire
28. Royal Bournemouth and Christchurch (FT)
29. Royal Cornwall
30. Sandwell and West Birmingham
31. Sherwood Forest (FT)
32. Stockport (FT)
33. West Hertfordshire
34. Worcestershire
35. Wrightington, Wigan and Leigh (FT)
36. Western Sussex

Appendix B

Directions to the Trust Special Administrator

Securing sustainable NHS services

NATIONAL HEALTH SERVICE, ENGLAND

Directions to the Trust Special Administrator appointed to the South London Healthcare National Health Service Trust in relation to Consultation during the Preparation of a Draft Report 2012

The Secretary of State, gives the following Directions in exercise of the power conferred by sections 65F(2)(b) and 272(7) of the National Health Service Act 2006(**a**).

Citation and commencement

1. These Directions may be cited as the Directions to the Trust Special Administrator appointed to the South London Healthcare National Health Service Trust in relation to Consultation during the Preparation of a Draft Report 2012 and come into force on 20th July 2012.

Consultation when preparing a draft report

2. When preparing the draft report under section 65F(1) of the National Health Service Act 2006, the trust special administrator appointed to the South London Healthcare National Health Service Trust(**b**) must consult the following—

(a) Bexley Care Trust(**c**);

(b) Bromley Primary Care Trust(**d**);

(c) Croydon Primary Care Trust(**e**);

(d) Greenwich Teaching Primary Care Trust(**f**);

(e) Lambeth Primary Care Trust(**g**);

(f) Lewisham Primary Care Trust(**h**);

(g) South East Coast Strategic Health Authority(**i**);

(h) Southwark Primary Care Trust(**j**);

(i) Surrey Primary Care Trust(**k**);

(j) West Kent Primary Care Trust(**l**).

Signed by authority of the Secretary of State for Health

Name

(a) 2006 c. 41. Section 65F was inserted by section 16 of the Health Act 2009 (c.21).
(b) The Trust Special Administrator was authorised for appointment pursuant to the South London Healthcare National Health Service Trust (Appointment of Trust Special Administrator) Order 2012 (S.I. 2012/1806) and the South London Healthcare National Health Service Trust was established by S.I. 2009/772.
(c) Established by the Bexley Primary Care Trust (Establishment) Order 2000 (S.I. 2000/1962), amended by S.I. 2002/1405 and 2003/2168 (which changed the name of the trust to Bexley Care Trust).
(d) Established by the Bromley Primary Care Trust (Establishment) Order 2001 (S.I. 2001/248), amended by S.I. 2002/1405.
(e) Established by the Croydon Primary Care Trust (Establishment) Order 2002 (S.I. 2002/1007).
(f) Established by the Greenwich Primary Care Trust (Establishment) Order 2001 (S.I. 2001/528), amended by S.I. 2002/1405 and 2004/1643 (which changed the name of the trust to Greenwich Teaching Primary Care Trust).
(g) Established by the Lambeth Primary Care Trust (Establishment) Order 2002 (S.I. 2002/999).
(h) Established by the Lewisham Primary Care Trust (Establishment) Order 2002 (S.I. 2002/1001).
(i) Established by the Strategic Health Authorities (Establishment and Abolition) (England) Order 2006 (S.I. 2006/1408).
(j) Established by the Southwark Primary Care Trust (Establishment) Order 2002 (S.I. 2002/1003).
(k) Established by the Primary Care Trusts (Establishment and Dissolution) (England) Order 2006 (S.I. 2006/2072).
(l) Established by the Primary Care Trusts (Establishment and Dissolution) (England) Order 2006 (S.I. 2006/2072).

Member of the Senior Civil Service
Department of Health

Date

19.7.2012

Sebastian Habibi

NHS

Office of the Trust Special Administrator

Appendix C

Programme Governance in the development of recommendations

Securing sustainable NHS services

Contents

Introduction

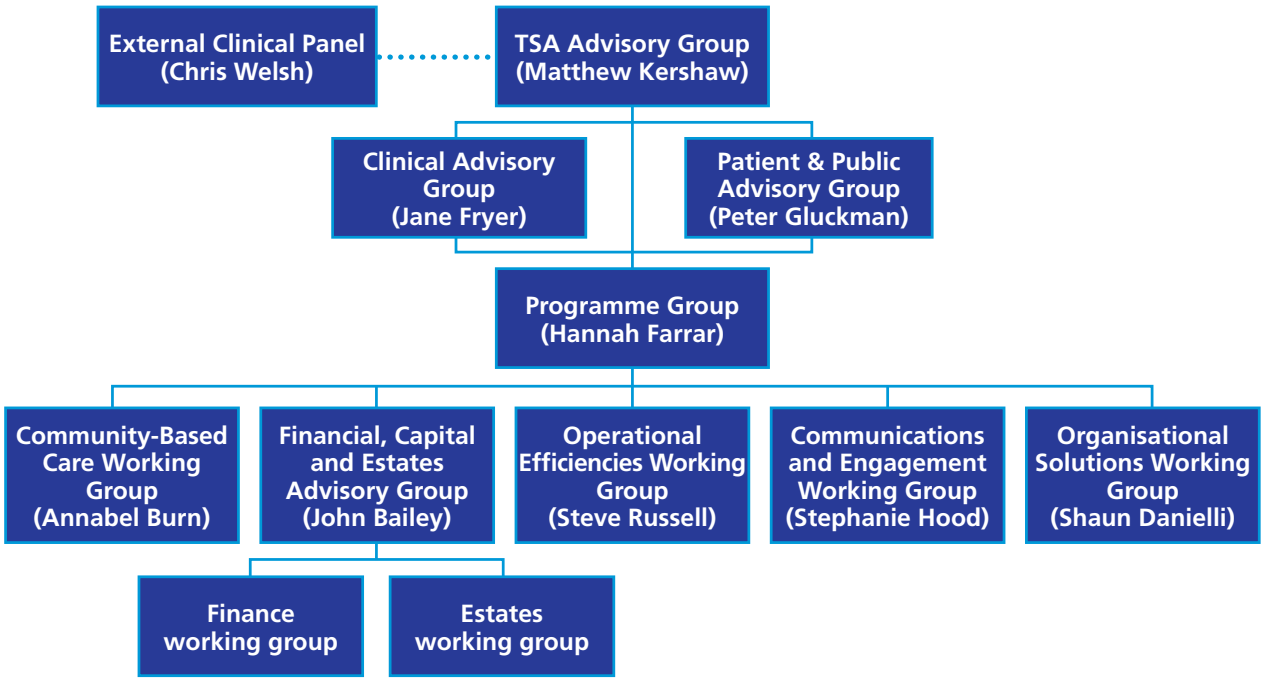
The organisation and governance arrangements to support the Trust Special Administrator were designed to reflect the two distinct phases of the Regime for Unsustainable Providers.

Phase 1	16 July – 29 October 2012	Development and publication of draft report
Phase 2	2 November - 7 January 2013	Consultation and engagement on recommendations detailed in draft report followed by development and publication of final report

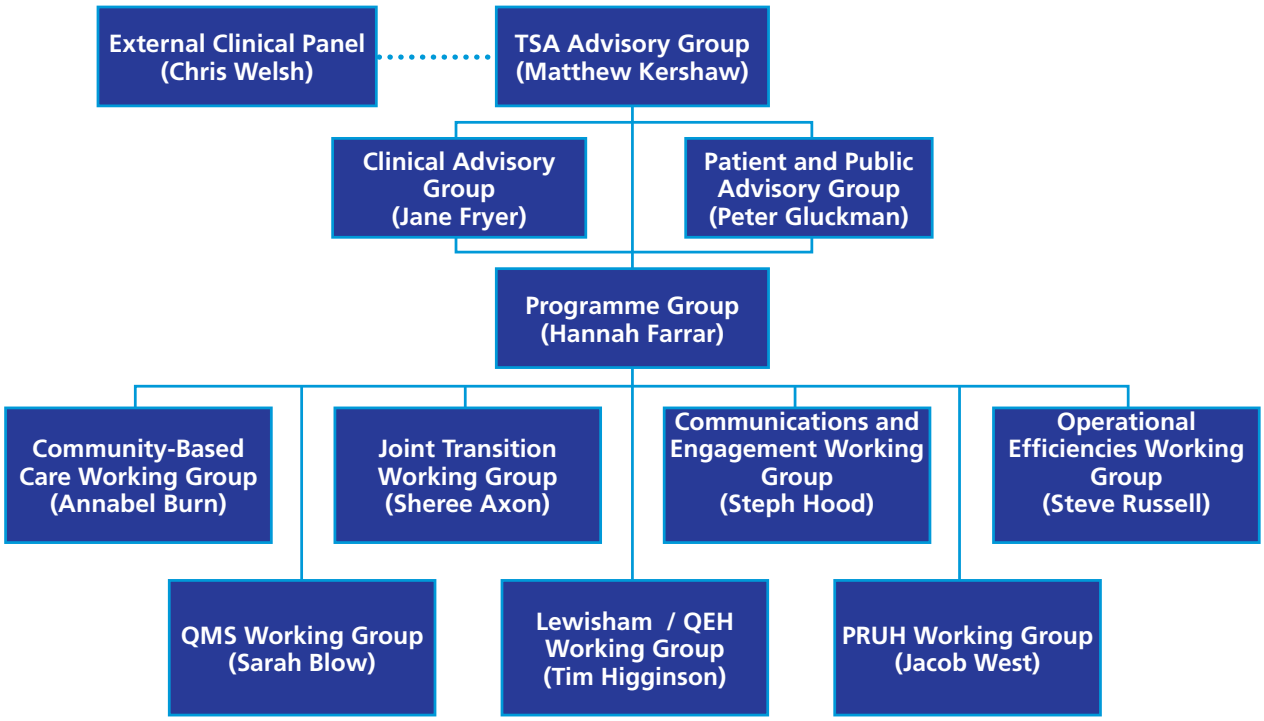
The focus of phase 1 was to develop a set of initial recommendations that would resolve the challenges faced by South London Healthcare NHS Trust. The advisory and working groups were instrumental in supporting the development of the potential recommendations across a range of issues and offering advice to the TSA.

During phase 2 the working and advisory groups were established to support the responses required during consultation, as well as facilitating further development of the recommendations and plans for to enable efficient implementation.

Phase 1 governance and advisory group arrangements



Phase 2 governance and advisory group arrangements



TSA Advisory Group

Pattern
Approximately 3-weekly

Summary of Purpose
To advise the TSA on the robustness and openness on the development, evaluation and refinement of potential recommendations

Members

TSA (chair)	Matthew Kershaw	Patient and Public Advisory Group Chair	Peter Gluckman
Strategic Advisor to TSA	Hannah Farrar	Communications and Engagement Working Group Chair	Stephanie Hood
NHS Bexley CCG Chair	Dr Howard Stoate	Medical Advisor to the TSA and Clinical Advisory Group Chair	Dr Jane Fryer
NHS Bromley CCG Chair	Dr Andrew Parson	NHS Greenwich CCG Chief Office and Community-based Care Working Group Chair	Annabel Burn
NHS Greenwich CCG representative	Dr Rebecca Rosen	Finance Capital and Estates Advisory Group Chair	John Bailey
NHS Lambeth CCG Chair	Dr Adrian McLachlan	Organisational Solutions Working Group Chair	Shaun Danielli
NHS Lewisham CCG Chair	Dr Helen Tattersfield		
NHS Southwark CCG Chair	Dr Amr Zeineldine		
SLHT Chief Operating Officer and Chair, Operations Working Group	Steve Russell	**In Attendance**	
NHS London Chief Executive Officer (CEO)	Ruth Carnall	Bexley Local Authority CEO	Will Tuckley
NHS Commissioning Board representative	Penny Emerit	Bromley Local Authority CEO	Doug Patterson
Oxleas NHS Foundation Trust CEO	Stephen Firn	Greenwich Local Authority CEO	Mary Ney
Lewisham Healthcare NHS Trust CEO	Tim Higginson	Lambeth Local Authority CEO	Derrick Anderson
Guys and St Thomas's NHS Foundation Trust CEO	Ron Kerr	Lewisham Local Authority CEO	Barry Quirk
Kings College Hospital Foundation Trust CEO	Tim Smart	Southwark Local Authority CEO	Eleanor Kelly
Dartford and Gravesham NHS Trust CEO	Susan Acott	Legal Advisor to the TSA	David Mason
NHS South East London CEO	Christina Craig		
Bromley Healthcare CEO	Jonathan Lewis		

External Clinical Panel

Pattern
Meetings clustered towards the end of each phase of the programme (i.e. three meetings in October and three in December) to allow for the panel to interrogate and shape emerging recommendations.

Summary of Purpose
To provide clinical assurance and advice to the TSA, ensuring robust clinical proposals are developed and to make recommendations to the TSA

Members

Medical Director at NHS Midlands and East and Health Education England Medical Director (Chair)	Mr Chris Welsh	**Ad hoc members invited where appropriate:**	
NHS London Medical Director and NHS Commission Board London Medical Director	Dr Andy Mitchell	Head of Policy at the Royal College of Midwives	Dr Sean O'Sullivan
National Director for Trauma Care	Prof Keith Willett	Strategic Maternity Advisor at NHS London	Margaret Richardson
London Clinical Commissioning Council Chair	Dr Howard Freeman	General Secretary of the Royal College of Midwives	Cathy Warwick
Homerton University NHS Foundation Trust Medical Director	Dr John Coakley	Kingston Hospital NHS Trust Medical Director	Miss Jane Wilson
NHS North East London and the City Director of Nursing and Quality and NHS Commissioning Board London Chief Nurse	Caroline Alexander	Imperial College Healthcare NHS Trust Director of Midwifery and Head of Nursing	Jacquie Dunkley-Bent
NHS South of England (Central) Scientific Director	Chris Gibson	Royal College of Obstetricians and Gynaecologists London Regional Advisor	Mr Anthony Hollingwood
NHS London Allied Health Professionals Lead	Lesley Johnson		
Royal Free London NHS Foundation Trust Medical Director	Prof Stephen Powis	**Attendees:**	
London Deanery Director of Medical and Dental Education Commissioning	Dr Fiona Moss	Medical Advisor to the TSA and Clinical Advisory Group Chair	Dr Jane Fryer
NHS London Lead Scientist	Dr Fiona Carragher		
		Ad hoc attendees invited where appropriate:	
		Lewisham Healthcare NHS Trust Medical Director	Miss Jane Linsell
		Lewisham Healthcare NHS Trust Director of Operations and Nursing	Claire Champion
		Lewisham Healthcare NHS Trust Director of Business Planning and Development	Lynn Saunders

Clinical Advisory Group

Pattern
Approximately fortnightly

Summary of Purpose
To advise the TSA on the clinical robustness of the process and robustness of development of clinical proposals as part of the TSA recommendations

Members

Medical Advisor to the TSA and NHS South East London Medical Director (Chair)	Dr Jane Fryer	King's College Hospital NHS Foundation Trust Medical Director	Mr Mike Marrinan
NHS Bexley CCG Chair	Dr Howard Stoate	King's College Hospital NHS Foundation Trust Clinical Director for Trauma	Mr Rob Bentley
NHS Bromley CCG Chair	Dr Andrew Parson	King's College Hospital NHS Foundation Trust Deputy Medical Doctor	Dr TJ Lasoye
NHS Bromley CCG Chief Officer (Designate)	Dr Angela Bahn	Guy's and St Thomas' NHS Foundation Trust Medical Director	Dr Ian Abbs
NHS Greenwich CCG Chair	Dr Hany Wahba	Guy's and St Thomas' NHS Foundation Trust Chief Nurse and Director of Infection Prevention and Control	Eileen Sills
NHS Lambeth CCG Chair	Dr Adrian McLachlan	London Ambulance Service Medical Director	Dr Fionna Moore
NHS Lewisham CCG Chair	Dr Helen Tattersfield	Dartford and Gravesham NHS Trust Medical Director	Miss Annette Schreiner
NHS Southwark CCG Chair	Dr Amr Zeineldine	Oxleas NHS Foundation Trust Medical Director	Dr Ify Okocha
South London Healthcare NHS Trust Medical Director	Dr Chris Palin		
South London Healthcare NHS Trust Deputy CEO and Director of Nursing	Jennie Hall	**In Attendance**	
South London Healthcare NHS Trust Divisional Director Emergency Care and Specialist Medicine	Dr Liz Sawicka	Strategy Advisor to the TSA	Hannah Farrar
Lewisham Healthcare NHS Trust Medical Director	Miss Jane Linsell	Director, Office of the TSA	Shaun Danielli
Lewisham Healthcare NHS Trust Director of Operations and Nursing	Claire Champion	Consulting Programme Director	Penny Dash
Lewisham Healthcare NHS Trust Director of Clinical and Academic Strategy	Dr Gabrielle Kingsley	Office of the TSA	Katie Horrell
Bromley Healthcare Clinical Director	Andrew Hardman	Office of the TSA	Patrice Donnelly

Patient and Public Advisory Group

Pattern
Approximately monthly

Summary of Purpose
To advise the TSA from a patient and public perspective on the development of the recommendations and the approach to consultation

Members

Patient and Public Advisory Group Chair	Peter Gluckman
Bromley Local Involvement Network (LINk)	Angela Harris
Bexley LINk	Sandra Wakeford
Greenwich LINk	Sheila Freeman
Greenwich LINk	Francis Hook
Southwark LINk	Barry Silverman
Southwark LINk	Fiona Subotzky
Lambeth LINk	Nicola Kingston
Lambeth LINk	Aisling Duffy
Lewisham LINk	Val Fulcher
Lewisham LINk	Sally Nisbett
Lewisham Community Development Officer	Elaine Osborne
Southwark Engagement and Patient Sub Group representative	John King
South Greenwich Forum	Judy Smith
Bexley Patient Council	Ron Brewster
Bromley Patient and Public representative	Lyn Wheeler

Programme Group

Pattern
Weekly

Summary of Purpose
To manage programme delivery in line with the scope, aims and timescales set out by the Order

Members

Strategy Advisor to the TSA (Chair)	Hannah Farrar	**Ad hoc attendees invited as appropriate:**	
TSA	Matthew Kershaw	Stephen Moran	
Medical Advisor to the TSA and Clinical Advisory Group Chair	Dr Jane Fryer	Steve Quinlan	Richard Storer
Operational Efficiencies Working Group Chair	Steve Russell	Eoin Leydon	Charles Hooper
NHS South East London CEO	Christina Craig	Ian Devlin	Christian Norris
Director, Office of the TSA	Shaun Danielli	Praveen Sharma	Martin Marcus
Finance Advisor, Office of the TSA	John Bailey	Penny Mitchell	Bashir Arif
Communications Advisor, Office of the TSA	Stephanie Hood	Dominic Harris	Sharon Lamb
Associate Director, Office of the TSA	Emily Hough	Phil Lobb	Jamie Cuffe
Legal Advisor	David Mason	Lisa Goldstone	Patrice Donelly
Consulting Programme Director	Penny Dash	Agnes Krygier	Katie Horrell
Programme Manager	Neil Beer	Charlie Paterson	Amy Darlington
Consulting workstream lead	David Meredith	Dominic Firth	John Drew
Consulting workstream lead	Altaf Kara	Alexandra Philpott	Nigel Durman

Finance, Capital and Estates Advisory Group

Pattern
Fortnightly

Summary of Purpose
To advise the TSA on the development of recommendations in the areas of finance, capital and estates and the implications of potential recommendations on finance, capital and estates

Members

Finance Advisor, Office of the TSA (Chair)	John Bailey	Lewisham Healthcare NHS Trust Estates Director	Keith Howard (co-opted)
Strategic Advisor to the TSA	Hannah Farrar	Oxleas NHS Foundation Trust Estates Director	Rachel Evans
Strategy Advisor, Office of the TSA	Dominic Harris	NHS London Head of Strategic Investment	Peter Brazel
South London Healthcare NHS Trust Finance Director	Rob Cooper	Bromley Healthcare Finance Director	Jacqui Scott
South London Healthcare NHS Trust Deputy Finance Director	Simon Worthington	Guy's and St Thomas' NHS Foundation Trust Finance Director	Martin Shaw
NHS Bexley CCG Chief Financial Officer (CFO)	Theresa Osborne	King's College Hospital NHS Foundation Trust Finance Director	Simon Taylor
NHS Bromley CCG CFO	Mark Cheung	Essentia Executive Director	Steve Maguire
NHS Greenwich CCG CFO	Chris Costa	Dartford and Gravesham NHS Trust Estates Director	Colin Gentile
NHS Lambeth CCG CFO	Christine Caton	South London Healthcare NHS Trust Estates Director	Jonathan Pearce
NHS Lewisham CCG CFO	Tony Reed		
NHS Southwark CCG CFO	Malcolm Hines		
Lewisham Healthcare NHS Trust Director of Finance	John Hennessey		
Oxleas NHS Foundation Trust Director of Finance	Ben Travis		
NHS South East London Director of Finance	Richard Chapman		
NHS South East London Estate Director	James Eaton		

Community-Based Care Working Group

Pattern
Fortnightly

Summary of Purpose
To support Clinical Commissioning Groups in developing a Community-Based Care strategy that will inform the TSA recommendations for a robust and sustainable health economy in South East London

Members

NHS Greenwich CCG Chief Officer (Designate)(Chair)	Annabel Burn	The work of this group was supported by a series of workshops which had a much wider attendance, including from:
NHS Bexley CCG Chief Officer (Designate)	Sarah Blow	**Bexley** CCG Local Authority Care Trust Community Nursing GPs GP practice managers
NHS Bromley CCG Chief Officer (Designate)	Dr Angela Bhan	**Bromley** CCG Local Authority Healthcare Trust GPs GP practice managers
NHS Lambeth CCG Chief Officer (Designate)	Andrew Eyres	**Greenwich** CCG Local Authority Bexley & Greenwich Hospice Community Nursing GPs GP practice managers
NHS Lewisham CCG Chief Officer (Designate)	Martin Wilkinson	**Lambeth** CCG Local Authority Community Nursing GPs
NHS Southwark CCG Chief Officer (Designate)	Andrew Bland	**Lewisham** CCG Local Authority Community Nursing
Medical Advisor to the TSA and Clinical Advisory Group Chair and NHS South East London Medical Director	Dr Jane Fryer	**Southwark** CCG Local Authority Community Nursing GPs
NHS South East London Director of Primary Care	David Sturgeon	
NHS South East London CEO	Christina Craig	
Strategic Advisor to the TSA	Hannah Farrar	
GP representative on behalf of Helen Petterson	Dr Marc Rowland	
Associate Director Office of the TSA	Emily Hough	

Ad hoc attendees invited as appropriate:	
NHS Commissioning Board London Delivery Director (South)	Penny Emerit
NHS Commissioning Board London Head of Service Redesign (Out of Hospital Transformation)	Rachel Bartlett
Consulting Programme Director	Penny Dash
Consulting workstream lead	Stephen Moran

Operational Efficiencies Working Group

Pattern
Weekly

Summary of Purpose
To identify and realise operational efficiency opportunities in South London Healthcare NHS Trust and support the development of TSA recommendations

Members

South London Healthcare NHS Trust Chief Operating Officer (Chair)	Steve Russell
South London Healthcare NHS Trust Medical Director	Dr Chris Palin
South London Healthcare NHS Trust Finance Director	Rob Cooper
South London Healthcare NHS Trust Deputy CEO and Director of Nursing	Jennie Hall
South London Healthcare NHS Trust Director of Human Resources	Louise McKenzie
South London Healthcare NHS Trust Director of Communications	Carl Shoben
South London Healthcare NHS Trust Care Group Director for Medicine	Dr Liz Sawicka
Associate Director, Office of the TSA	Emily Hough
Consulting Workstream Lead	John Drew
Consulting Workstream Lead	Altaf Kara
External Support to the TSA	Lisa Goldstone
External Support to the TSA	Joseph Gottfried

Communications and Engagement Working Group

Pattern
Three-weekly

Summary of Purpose
To advise the TSA on communications and engagement activity required to support the programme, including advice on communicating and engaging with a wide ranging audience of staff, stakeholders, patients and the public, and the development of a consultation plan and consultation materials

Members

Director of Communications, Office of the TSA (Chair)	Stephanie Hood	Lewisham Healthcare NHS Trust, Head of Communications	David Cocke
London Borough of Bexley, Head of Communications	John Ferry	Lewisham Healthcare NHS Trust, Director of Knowledge, Governance and Communications	Joy Ellery
Assistant Director, Communications and Corporate Services, NHS Bexley CCG	Jon Winter	NHS South London Commissioning Support Unit, Director of Communications, Governance and Marketing	Oliver Lake
London Borough of Bromley, Corporate Communications	Susie Clark	London Ambulance Service, Head of Communications	Angie Patton
Bromley Healthcare, Communications and Marketing Lead	Paula Larder	NHS London, Director of Communications and Public Affairs	Stephen Webb
Dartford and Gravesham NHS Trust, Head of Communications	Glyn Oakley	NHS South East London, Deputy Director of Communications & Engagement	Yvette London
The Royal Borough of Greenwich, Head of Communications	Stuart Godfrey	Oxleas NHS Foundation Trust, Head of Communications	Russell Cartwright
Guy's and St Thomas' NHS Foundation Trust, Director of Communications	Anita Knowles	South London and Maudsley NHS Foundation Trust, Head of Communications	Dan Charlton
King's College Hospital NHS Foundation Trust, Director of Communications	Sally Lingard	South London Healthcare NHS Trust, Director of Communications	Carl Shoben
Lambeth Council, Director of Campaigns & Communications	Julian Ellerby	Southwark Council, Head of Communications	Robin Campbell
Lewisham Council, Head of Communications	Adrian Wardle	NHS Southwark CCG, Head of Communications and Engagement	Rosemary Watts

Organisational Solutions Working Group

Pattern
Fortnightly

Summary of Purpose
This group worked to identify and evaluate potential organisational solutions that would support the implementation of the recommendations

Members

Director, Office of the TSA (Chair)	Shaun Danielli
Strategy Advisor to the TSA	Hannah Farrar
Director of Communications, Office of the TSA	Stephanie Hood
NHS London Procurement Advisor	Kyn Aizlewood
Associate Director, Office of the TSA	Emily Hough
Strategy Advisor, Office of the TSA	Alexandra Philpott
TSA Programme strategic solutions workstream lead	David Meredith
Consulting workstream lead	Martin Marcus
Legal Advisor	Sharon Lamb

Queen Mary's Hospital Sidcup Programme Board

Pattern
Pre-established group that had an existing meeting schedule

Summary of Purpose
To conduct due diligence on current activities on QMS and develop plans for transition to the proposed service model

Members

Bexley CCG Chief Officer (Designate) (Chair)	Sarah Blow	Bromley CCG Chief Officer (Designate)	Dr Angela Bhan
Strategy Advisor to the TSA	Hannah Farrar	Bexley Local Authority CEO	Will Tuckley
Associate Director, Office of the TSA	Emily Hough	NHS South East London CEO	Christina Craig
Finance Lead, Office of the TSA	John Bailey	NHS London Head of Strategic Investment	Peter Brazel
Dartford and Gravesham NHS Trust Deputy CEO	Gerard Sammon	External advisor to NHS South East London	Nick Auer
Oxleas NHS Foundation Trust CEO	Stephen Firn	External advisor to NHS South East London	Ross Graves
Oxleas NHS Foundation Trust Director of Finance	Ben Travis		
Oxleas NHS Foundation Trust Deputy CEO and Director of Service Delivery	Helen Smith		
London Borough of Bexley Deputy Director of Neighbourhoods and Communities	Maureen Holkham		
South London Healthcare NHS Trust Acting Director Access and Queen Mary's Hospital site director	Clare Baldwin		

Lewisham Healthcare Trust and Queen Elizabeth Hospital Working Group

Pattern
Fortnightly meetings

Summary of Purpose
To conduct due diligence on current activities and develop plans for transition to the proposed service model

Members

Lewisham Healthcare NHS Trust Chief Executive (Chair)	Tim Higginson	Lewisham Healthcare NHS Trust Director of Clinical and Academic Strategy	Dr Gabrielle Kingsley
Strategy Advisor to the TSA	Hannah Farrar	Lewisham Healthcare NHS Trust Medical Director	Miss Jane Linsell
Transition lead, Office of the TSA	Sheree Axon	Lewisham Healthcare NHS Trust Director of Operations and Nursing	Claire Champion
Medical Advisor to the TSA	Dr Jane Fryer	Lewisham Healthcare NHS Trust Director of Business Development and Planning	Lynn Saunders
Finance advisor, Office of the TSA	John Bailey	South London Healthcare NHS Trust Chief Operating Officer	Steve Russell
Director, Office of the TSA	Shaun Danielli	South London Healthcare NHS Trust Medical Director	Dr Chris Palin
Lewisham Healthcare NHS Trust Finance Director	John Hennessey	South London Healthcare NHS Trust Clinical Director of Stroke Medicine	Dr David Sulch
South London Healthcare NHS Trust Finance Director	Rob Cooper	South London Healthcare NHS Trust Deputy Director of Finance	Simon Worthington

King's College Hospital NHS Foundation Trust and Princess Royal University Hospital Working Group

Pattern
Fortnightly meetings

Summary of Purpose
Conduct due diligence on current activities and develop plans for transition to proposed acquisition of Princess Royal University Hospital by King's College Hospital NHS Foundation Trust

Members

King's College Hospital NHS Foundation Trust Director of Strategy (Chair)	Jacob West	Finance Advisor, Office of the TSA	John Bailey
King's College Hospital NHS Foundation Trust Chief Operating Officer	Roland Sinker	South London Healthcare NHS Trust Medical Director	Dr Chris Palin
King's College Hospital NHS Foundation Trust Medical Director	Mr Mike Marrinan	South London Healthcare NHS Trust Deputy Director of Finance	Simon Worthington
King's College Hospital NHS Foundation Trust Project Director	Tony Johnson	Associate Director, Office of the TSA	Emily Hough
King's College Hospital NHS Foundation Trust Chief Financial Officer	Simon Taylor	King's College Hospital NHS Foundation Trust Human Resources Director	Angela Huxham
King's College Hospital NHS Foundation Trust Director of Nursing, Midwifery and Infection Control	Geraldine Walters	King's College Hospital NHS Foundation Trust Director of Corporate Affairs	Jane Walters
South London Healthcare NHS Trust Chief Operating Officer	Steve Russell	External advisor to King's College Hospital NHS Foundation Trust	Jane Walters
Strategy Advisor to the TSA	Hannah Farrar	Legal Advisor to the TSA	Sharon Lamb
Director, Office of the TSA	Shaun Danielli		

Meetings of advisory groups

Clinical Advisory Group	TSA Advisory Group	External Clinical Panel	FCE Advisory Group	Patient and Public Advisory Group
25-Jul-12	08-Aug-12	11-Sep-12	30-Aug-12	14-Aug-12
08-Aug-12	05-Sep-12	01-Oct-12	30-Aug-12	29-Aug-12
29-Aug-12	19-Sep-12	15-Oct-12	27-Sep-12	13-Sep-12
05-Sep-12	02-Oct-12	22-Oct-12	04-Oct-12	03-Oct-12
19-Sep-12	17-Oct-12	06-Dec-12	04-Oct-12	22-Oct-12
26-Sep-12	17-Oct-12	12-Dec-12	25-Oct-12	22-Oct-12
03-Oct-12	21-Nov-12	18-Dec-12	25-Oct-12	04-Dec-12
10-Oct-12	12-Dec-12		23-Nov-12	
17-Oct-12	07-Jan-13			
31-Oct-12				
14-Nov-12				
28-Nov-12				

Office of the Trust Special Administrator

Appendix D

Operational efficiency opportunities within South London Healthcare NHS Trust

Securing sustainable NHS services

Introduction

1. This appendix to the final report of the Trust Special Administrator (TSA) appointed to South London Healthcare NHS Trust relates particularly to chapter 4 of the report. It provides an overview of the detailed work that has been undertaken by the TSA and his team to identify potential operational efficiency improvements that could be made to the services provided by South London Healthcare NHS Trust.

2. South London Healthcare NHS Trust incurs significantly more cost in the way it provides services than the income it receives from its commissioners. As a result of these higher costs the Trust is in a very poor financial position, spending in excess of £1m more each week than it receives in income. For the year 2012/13 South London Healthcare NHS Trust is forecast to have a normalised deficit of £59.5m.

3. To understand better the reasons for these high operational costs, a programme of detailed work has been undertaken with the aim of identifying how much of the financial challenge faced by South London Healthcare NHS Trust could be resolved by improving the efficiency of the current services. This work has been completed in two phases.

4. Phase one was undertaken prior to the publication of the TSA's draft report on 29 October 2012 and concluded that a significant proportion of the Trust's financial problems could be solved through improved productivity and efficiency gains of £79m over a three-year period.

5. Phase two took place over a five-week period between November and December 2012. The work validated the findings of phase one by converting the identified productivity and efficiency opportunity into detailed cost improvement programme schemes (CIPs). This process generated £74.9m of CIPs, which form the recommended three-year operational efficiency programme outlined in chapter 4 of the final report. It also identified £7.7m of efficiencies which could be realised through merger synergies, outlined in chapter 6 of the final report. These opportunities are a fundamental requirement for achieving financially sustainable services in south east London.

6. This appendix outlines:

   - the approach used in phase one to determine the size of the operational efficiency improvement that could be made within the Trust's services;
   - the identified operational efficiency opportunity and the specific areas with the greatest opportunity for improvement;
   - the approach taken in phase two to develop detailed plans to close the existing efficiency 'gap' over a three-year period and the impact of this on the cost base of the services;
   - the assessment of what South London Healthcare NHS Trust can deliver as it is currently constituted; and
   - what is recommended to ensure that the full efficiency opportunity is captured.

Phase one approach: determining the operational efficiency improvement opportunity

7. Over a six-week period, a team of senior leaders and clinicians from within South London Healthcare NHS Trust worked with external consultancy advisors to review the Trust's current operational efficiency to identify the potential size of the improvement opportunity. The involvement of internal and external leads in this work was deemed essential to the identification of credible opportunities based on innovative best practice.

8. An executive-led working group was established, with the remit to bring together senior leaders and clinicians to assess, challenge and validate the findings of the work.

9. To strengthen further the clinical involvement in the operational efficiency workstream and the above working group, a workshop was held during the process with clinical leads, directors and heads of nursing to provide additional challenge to the process.

10. Two different methods of analysis were used to identify the operational efficiency opportunity: an external benchmarking in which the Trust was compared to 18 similar NHS organisations; and a detailed, internally focused review of the current cost base of the Trust.

Benchmarking

11. In benchmarking South London Healthcare NHS Trust, a similar approach was taken to that used by NHS London in its recent report *Acute Hospitals in London: Sustainable and Financially Effective*[1] *(SaFE)*. The methodology compared the Trust with a peer group of 18 multi-site trusts of a similar size with a similar income and a similar mix of elective and non-elective workload. The peer group of 18 trusts was selected and agreed by the operational working group.

1 http://www.london.nhs.uk/webfiles/SaFE%20repoer/SaFE%20report%20February%202012.pdf

12. Figure 1 shows the 18 trusts - and their relative size, income, case mix and quality of services - against which the Trust was compared.

Figure 1: Peer group of 18 trusts against which South London Healthcare NHS Trust was benchmarked

Trust Name	FT	Trust Type	Trust income £m	Number of spells '000	Non elective spells %	Total beds	Income per bed £000	Quality Score	Monitor FRR
South London Healthcare NHS Trust	N	Large	438	173	50.0%	1,444	303	55%	n/a
Barking Havering and Redbridge University Hospitals NHS Trust	N	Large	407	119	58.9%	1,152	405	29%	n/a
Calderdale and Huddersfield NHS Foundation Trust	Y	Large	321	114	55.1%	837	384	80%	4
County Durham and Darlington NHS Foundation Trust	Y	Large	341	134	57.0%	944	361	74%	4
Derby Hospitals NHS Foundation Trust	Y	Large	423	145	44.3%	1,139	371	54%	3
East Kent University Hospitals NHS Foundation Trust	Y	Large	490	151	50.3%	1,165	421	53%	4
Gloucestershire Hospitals NHS Foundation Trust	Y	Large	423	154	40.5%	1,042	406	43%	3
Heart of England NHS Foundation Trust	Y	Large	561	221	59.8%	1,543	364	14%	3
Mid Yorkshire Hospitals NHS Trust	N	Large	430	140	55.8%	1,152	373	34%	n/a
North Bristol NHS Trust	N	Large	493	112	46.9%	1,114	443	71%	n/a
North West London Hospitals NHS Trust	N	Large	370	101	57.0%	641	577	18%	n/a
Northumbria Healthcare NHS Foundation Trust	N	Large	320	113	55.0%	1,263	253	88%	4
Pennine Acute Hospitals NHS Trust	N	Large	557	210	52.8%	1,626	343	41%	n/a
Portsmouth Hospitals NHS Trust	N	Large	446	122	55.0%	961	464	51%	n/a
Sandwell and West Birmingham NHS Trust	N	Large	388	133	50.5%	912	425	27%	n/a
South Tees Hospitals NHS Foundation Trust	Y	Large	474	147	47.0%	1,127	421	73%	3
United Lincolnshire Hospitals NHS Trust	N	Large	392	156	49.0%	1,350	290	32%	n/a
University Hospital of North Stafford NHS Trust	N	Large	418	139	52.1%	1,054	397	23%	n/a
Western Sussex Hospitals NHS Trust	N	Large	362	121	53.5%	997	363	35%	n/a

13. This benchmarking analysis compared the Trust against the peer group operational efficiency measures within the key cost categories outlined in the NHS Costing Manual[2]. To identify the improvement opportunity for each category, the Trust's performance was initially compared with a peer on the top quartile threshold.

14. In further developing the methodology the TSA team were keen to ensure that benchmark comparisons were made between South London Healthcare NHS Trust and other whole and comparable acute NHS trusts or foundation trusts, rather than by seeking to benchmark performance on each cost element and performance metric with a different trust. This was deemed essential to ensuring the credibility of the benchmarking work with clinical teams and removed the potential for variation in other trusts' cost apportionment approaches to skew the findings. To ensure sufficient ambition in the benchmarking, it was agreed that the Trust would be compared with the average of the top three highest performing peer trusts overall - which are Mid Yorkshire Hospitals NHS Trust, County Durham and Darlington NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust - on their operational efficiency.

15. Operational efficiency is one contributor to overall financial performance, which is also influenced by other factors such as income, fixed costs and capacity and therefore may not always directly correlate to a trust's in-year I&E.

16. In keeping with this approach, the final benchmarking considered what the cost base of the Trust would be if it were able to provide its services as productively as at the average level of these top three highest performing peer Trusts.

17. In undertaking the benchmarking, South London Healthcare NHS Trust's operational efficiency in 2011/12 was compared with that of its peers for 2010/11. This was because a full set of 2011/12 public data on other trusts was not available for all metrics across the peer group. It was noted that the opportunity identified using this approach was likely to be conservative, as many of the peers (and particularly the top performers) would have further improved their performance between 2010/11 and 2011/12. An exception to this was clinical supplies, where 2010/11 data was used for the Trust as well as the peer group, because the Department of Health changed the definition of clinical supplies in 2011/12.

18. In comparing the Trust's operational efficiency and using this as a basis to determine potential levels of savings that could be made, the operations working group wished to understand the relative quality of care in those other organisations.

19. A quality score was calculated for each of the 18 Trusts in the peer group, which is a composite measure of 20 clinical indicators of quality of services that are collected nationally. Each of these indicators is weighted and shown in figure 2 (see overleaf).

2 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132398.pdf

Figure 2: Metrics included in Diagnostics, which make up the quality score

Dimension	Sub-dimension	Sub-dimension weight	Metric	Units	Metric weight	Source	Period
Quality	**Safety**	1	Litigation claims rate	Claims per 10,000 bed days	1	NHSLA	2010/11
			Rate of written complaints	Cases per 1,000 bed days	1	NHS IC	2010/11
			Medication errors	Claims per 1,000 bed days	1	NPSA	2010/11
			Patient accidents	Cases per 1,000 bed days	1	NPSA	2010/11
			Treatment procedure	Cases per 10,000 bed days	1	NPSA	2010/11
			All other categories	Cases per 1,000 bed days	1	NPSA	2010/11
			C.diff infection rate	Cases per 1,000 bed days	1	HPA	2010/11
			MRSA infection rate	Cases per 10,000 bed days	1	HPA	2010/11
			Rate of surgical site infections	Cases per 10,000 bed days	1	HES	2010/11
			SHMI	Ratio	1	NHS IC	2010/11
Quality	**Patient Experience**	1	Overall IP experience	Rating	1	Patient Survey	2012
			Overall OP experience	Rating	1	Patient Survey	2011
			Overall A&E experience	Rating	1	Patient Survey	2012
			Mother's satisfaction	Rating	0.5	Patient Survey	2010
			Mixed sex accommodation breach	Rate	0.5	DH	2010/11
			18 week target	%	0.5	DH	2010/11
			Delayed transfer of care	Patients per 1,000 spells	0.5	DH	2010/11
			Delayed transfer of care	Days per 1,000 spells	0.5	DH	2010/11
Quality	**Clinical outcome**	1	Readmission rate for elective spells	%	0.5	HES	2010/11
			Emergency readmission of Babies within 30 days of birth	%	0.5	HES	2010/11
			Readmission rate for non-elective spells	%	0.5	HES	2010/11
			Emergency readmission Total	%	0	HES	2010/11
			% patients discharged to usual place of residence	%	0.5	HES	2010/11
			Stroke patients spending >90% time in stroke unit	%	0.25	National Stroke Audit	2011
			Stroke patients receiving CT scan within 24 hours	%	0.25	National Stroke Audit	2011
			Patients receiving #NOF surgery within 48 hours	%	1	HES	2010/11
			Admitted patients risk assessed for VTE	%	0.5	DH	2010/11
			C-sections	%	0	HES	2010/11
			Mothers with 3rd/4th degree tear	%	0.5	HES	2010/11
Quality	**Patient reported outcome**	1	PROMS: Groin hernia	Score	1	HES online	2010/11
			PROMS: Hip replacement	Score	0.5	HES online	2010/11
			PROMS: Knee replacement	Score	0.5	HES online	2010/11
			PROMS: Varicose vein	Score	1	HES online	2010/11
			Pre-op Questionnaires Participation rate: All Procedures	%	0	HES online	2010/11
			Post-op Questionnaires Issue rate: All Procedures	%	0	HES online	2010/11

Note:	NHSLA	NHS Litigation Authority
	NHS IC	NHS Information Centre
	NPSA	National Patient Safety Agency
	HPA	Health Protection Agency
	HES	Hospital Episode Statistics
	DH	Department of Health
	HES online	Hospital Episode Statistics online

20. The quality score for each of the 18 peer Trusts is shown in figure 1. The score describes the position of the Trust relative to all other acute trusts in England. South London Healthcare NHS Trust was assessed across the weighted 20 measures as being at the 55th percentile. This means that 45% of trusts perform better than South London Healthcare NHS Trust across these quality indicators, whilst 55% of trusts perform less well.

21. As shown in figure 1, a number of Trusts perform either similarly, or better, to the Trust on the quality score. Importantly, two of the top three highest performing peer Trusts overall – County Durham and Darlington NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust – both have quality scores that are much higher than the Trust. This is evidence that the services offered by the Trust can be delivered at a reduced cost, whilst maintaining or improving quality of care.

22. Having benchmarked the Trust against the average of the top three highest performing peer Trusts and having ensured that these peer Trusts were of sufficient quality to be considered appropriate comparators, the phase one benchmarking identified a total cost gap of £57m with the largest opportunities in medical spend (£12m), nursing spend (£17) and clinical supplies (£14m). This is described in further detail later.

23. There are limitations to this type of analysis, not least the different mix of clinical work between peers, the quality and accuracy of the data as reported and the potential for discrepancies in income to skew the analysis. A second assessment of the operational efficiency opportunity was therefore undertaken to supplement and validate the benchmarking.

Internal review and validation of benchmarking

24. The second methodology used to identify the opportunities within the Trust was a more detailed internally-driven bottom-up analysis that reviewed the variable cost base and looked to validate the benchmarking using internal data.

25. Having identified a cost gap to peers of £57m, the next step was to validate this figure by identifying specific savings opportunities within the Trust based on a bottom-up analysis that reviewed individual categories comprising the variable cost base. These categories included: medical pay; nursing pay; scientific, therapeutic and technical staff (ST&T) pay; non-clinical pay; clinical supplies cost; costs attributable to length of stay; and other variable costs (eg. catering and cleaning).

26. The analysis made use of internal data, on-site interviews and direct observations of ways of working. For example, under medical pay, the Trust was found to have the lowest income per consultant in its peer group, a high ratio of junior doctors to consultant staff, and a greater proportion of locums and agency personnel than its peers. The opportunity in this area was broken down into two components: one, savings from aligning clinical income per permanent medical full time equivalent at the Trust with top-quartile peer performance (by specialty), and two, savings from aligning the Trust's locums / agency spend (obtained from payroll and the finance department) with that of top-quartile London trusts.

27. In the case of nursing pay, the Trust was discovered to have high nursing spend relative to its number of occupied bed days, with a £12m opportunity from raising operational efficiency (including of temporary staff) to that of top-quartile peer levels. At the suggestion of key stakeholders, analysis was also undertaken to demonstrate that other hospitals manage to combine high nursing efficiency with good outcomes and patient experience. The Trust was found to have a more senior nursing skill mix than its peers (even accounting for the Trust's latest establishment / vacancy figures), with an additional estimated £2m savings from aligning nursing paybands with peer median distribution.

28. The benchmarking and internal analysis were reviewed on a weekly basis by the operations working group composed of senior leaders of the four Care Groups of the Trust, including clinicians and managers. This group provided input and challenge to the work, which took account of feedback received and suggestions that were put forward. As mentioned above, analyses and conclusions were further tested and validated through conversations with relevant staff and key stakeholders during on-site interviews. The operations working group meetings also considered the most recent internal Trust data (2012/13) to look for any potential departures from earlier-year benchmarking and trends.

The size of the operational efficiency opportunity

29. In benchmarking the operational efficiency improvement opportunity for South London Healthcare NHS Trust, three possible models were identified and considered. The first was based on comparing the Trust with the Trust at the top quartile threshold of all 18 peer Trusts. The second was based on comparing the Trust with the average of the top three performing Trusts. The third involved determining the opportunity by matching the Trust's performance to the top quartile performing Trust on each individual metric.

30. As described above, it was deemed that the second of these models was the most appropriate as it increased the credibility of the benchmarking with clinical teams and removed the potential for variation in other Trusts' cost apportionment approaches to skew the findings.

31. Matching the Trust's level of operational efficiency to the average of the top three highest performing peer Trusts and by providing services in a similar way to them offers the opportunity to reduce costs in the Trust by £57m. Matching the different levels of productivity in these three organisations offered a range of efficiency opportunities of between £56m and £67m. The detailed breakdown of the £57m opportunity is shown in figure 3.

Figure 3: Operational efficiency opportunities by cost category based on benchmarking

Cost category	2011/12 cost base (£m)	Matching peer at top quartile threshold (£m)	Matching average of top three peers (£m)	Matching peer at top quartile for category of spend (£m)
ALOS[1]	N/A	0	**0**	0
Medical pay	90	-11 (-13%)	**-12 (-13%)**	-23 (-25%)
Nursing pay	98	-18 (-19%)	**-17 (-18%)**	-14 (-14%)
ST&T pay	37	-2 (-4%)	**-2 (-5%)**	-9 (-23%)
Non clinical pay (back and middle office)	50	-7 (-15%)	**-8 (-17%)**	-12 (-23%)
Supplies[2]	72	0	**-14 (-19%)**	-11 (-16%)
Other variable costs[3]	15	-7 (-46%)	**-4 (-26%)**	-7 (-44%)
Costs not benchmarked[4]	164	n/a	**n/a**	n/a
Total	526	-46 (-9%)	**-57 (-11%)**	-75 (-14%)

Trust analysis performed using 2011/12 data, but benchmarked to peer analysis performance using 2010/11 data. Opportunity for Trust (gap to peers) is even greater if peer Trusts made efficiency improvements themselves between 2010/11 and 2011/12.

[1] Bed day opportunity estimated at £150/day. Note that average length of stay (ALOS) is assumed to stay at current rate or move to target, whichever is shorter.
[2] Clinical supplies opportunity calculated using 2010/11 data for South London Healthcare NHS Trust as well as peers, given differences in definitions of "Clinical supplies" between 2010/11 and 2011/12 FIMS returns
[3] Other variable costs include catering, cleaning and laundry
[4] Cost categories not benchmarked include: other clinical income (due to inconsistency in reporting), premises, establishment cost and non-operating costs (ie. PDC, interest, depreciation, etc.)

32. The analysis undertaken internally to validate the benchmarking and identify specific operational savings came up with a slightly larger savings profile, with a total savings opportunity of £62m. The breakdown of this is shown in figure 4. As with the initial benchmarking the greatest opportunities were identified to be in medical pay, nursing pay and clinical supplies.

Figure 4: Productivity opportunity identified through internal review of the cost base

Cost category	2011/12 cost base (£m)	Improvement opportunity identified from internal review (£m)
ALOS	-	**-6**
Medical pay	90	**-20 (-22%)**
Nursing pay	98	**-14 (-14%)**
ST&T pay	37	**-4 (-11%)**
Non clinical pay (back and middle office)	50	**-4 (-8%)**
Supplies	72	**-9 (-12.5%)**
Other variable costs	15	**-5 (-34%)**
Total	526	**-62 (-11.8%)**

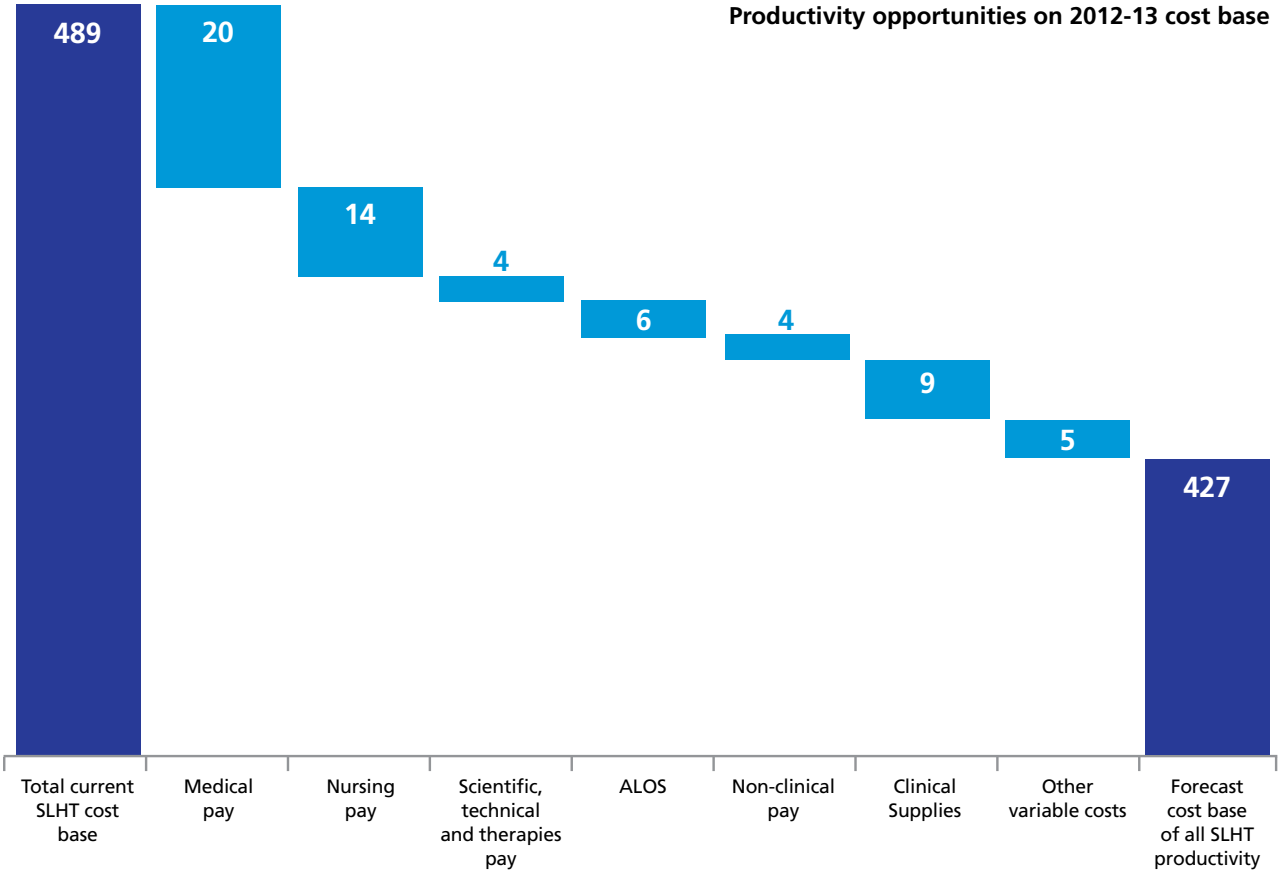
33. Figure 5 compares the benchmarking assessment and the outcome of the internal review.

Figure 5: Comparison of operational efficiency opportunity identified through benchmarking and the internal review of the cost base

Cost category	2011/12 cost base (£m)	Improvement opportunity identified from benchmarking (£m)	Improvement opportunity identified from internal review (£m)
ALOS	N/A	0	**6**
Medical pay	90	12	**20**
Nursing pay	98	17	**14**
ST&T pay	37	2	**4**
Non clinical pay (back and middle office)	50	8	**4**
Supplies	72	14	**9**
Other variable costs	15	4	**5**
Total	526	57	**62**

34. Having considered the current improvement opportunities identified by both the benchmarking (£57m) and the detailed internal review (£62m), the operational efficiency working group recommended that the size of the current improvement opportunity for the Trust was £62m. This is shown in figure 6.

Figure 6: Breakdown of cost savings by type (£m on 2012/13 cost base) from detailed internal review



35. It is implausible to deliver £62m of efficiency improvement in a single year. The TSA team has, therefore, assumed improvements should be made over a three-year period. Alongside this an assumption has been set that the Trust should not only improve to the level of high performing peers as they were in 2010/11, but also recognise that all trusts will need to continue to improve performance.

36. Therefore, the TSA has applied an additional 2% savings per annum to the £62m opportunity identified by the operational efficiency working group to reflect the continuing improvement of the Trust's peer group. This is consistent with the methodology used in *SaFE*. Application of this 2% figure identifies an additional £17m of savings, making a total operational efficiency requirement of £79m. This reflects the expectation that there will be a spread of performance compared to the average, with the highest performing trusts having less scope to improve as they have already delivered reductions in their cost base in recent years.

37. The key areas where the operational efficiency opportunity can be realised, as shown in figure 6, are considered to be:

- *Medical productivity (£20m):* the Trust has the highest spend on medical staff relative to total clinical income compared to its peer group, which means it spends much more on medical staff than other trusts would to do the same level of work. This suggests that the level of activity currently delivered by the Trust could be achieved with a lower number of medical staff, if the productivity of other trusts was matched. The Trust also has a very high proportion of non-consultant doctors (for every consultant there are three non-consultant grade doctors) and has a high use of locum and agency staff. Bringing the number of medical staff in line with high performing comparator trusts, by redesigning the way in which services are provided, will reduce costs, with a 16% reduction in the size of the workforce and a reduction in the level of locum and agency use.

- *Nursing productivity (£14m):* the Trust has a high nursing spend relative to the number of occupied bed-days (the sum of all the days spent in hospital by patients), which indicates the efficiency of nursing could be improved. The Trust also has an expensive skill mix compared with peers, with a higher proportion of senior staff and a high spend on bank and agency staff – specifically within theatres and A&E. High-level analysis has also shown that, compared with peers, the Trust has a lower number of A&E attendances per A&E nurse and does fewer operations per theatre nurse, supporting the view that there is a productivity opportunity.

38. Given the size of the opportunity in medical and nursing productivity and the fact that doctors and nurses spend a high proportion of their time working in 'settings of care' – such as outpatients and in theatres – consideration was given to the level of productivity in each of these areas. In particular, improving the efficiency of the overall operations within outpatients or theatres will improve both medical and nursing productivity. This work provided additional insight into how to improve efficiency in the cost categories of medical and nursing productivity.

- *Outpatients:* In total across the Trust nearly 75,000 appointment slots are unused due to patients not attending. Two-thirds of specialities within the Trust have 'did-not-attend' (DNA) rates in the worst 25% of trusts in the country and none are in the best 25% of Trusts. Nearly 30,000 fewer outpatient slots would be needed if the average DNA rate were achieved. In other words, the Trust could treat the same number of patients with many fewer clinics if outpatient slots were better utilised compared to how they currently are and the number of patients seen per clinic matched the top performing trusts. Reducing the DNA rate will mean fewer clinics are required and could save the Trust up to £2m.

- *Theatres:* The Trust's utilisation of staffed theatre time (the amount of time spent operating on patients) currently ranges from 67% to 76%. The main drivers of this are shown in figure 7.

Figure 7: Drivers of active theatre utilisation in South London Healthcare NHS Trust

Site	% of time lost due to late starts	% of time lost due to early finishes	% of time lost to turnaround between cases	% Active theatre time/utilisation
QMS	6	12	7	76
PRUH	8	16	9	67
QEH	13	10	5	72

Late starts and early finishes (indicating that lists are not fully booked or are not staffed in a way that matches staff time to the required operating time) result in significant amounts of time being paid for but not used.

There is also considerable variation between consultants in the average time it takes them to complete the same procedures (eg. the variation in the time taken to carry out a knee operation ranges from 103 to 200 minutes). Achieving 85% utilisation of theatres and improving the number of cases on theatre lists by reducing the procedure time by 10% would unlock significant capacity by reducing the number of paid theatre hours required by approximately 8,000 per year. This would save at least £2m across medical and nursing spend, while still allowing the same number of patients to be treated. This would also reduce the amount of premium spend the Trust incurs on waiting list initiatives. The work has identified three key specialities that have the greatest scope for improvement - general surgery, gynaecology and trauma and orthopaedics - which account for 62% of the potential opportunity as shown in figure 8.

Figure 8: Opportunity by specialty arising from improved theatre productivity

Specialty	Current utilisation % (and hours)	Potential hours freed up per annum	Equivalent theatre sessions per annum
Cardiology	25 (180)	50	16
ENT	58 (1,074)	662	120
General Surgery	75 (7,959)	1,945	382
Gynaecology	75 (4,344)	1,085	248
Ophthalmology	74 (3,094)	819	203
Oral Surgery	58 (593)	266	89
Pain Management	69 (959)	341	86
Plastic Surgery	59 (122)	72	18
Orthopaedics	73 (7,353)	2,109	417
Urology	62 (1,886)	960	160

39. Improving the way in which services are delivered in these settings of care will have a significant impact on the medical and nursing productivity in particular, although other changes are also needed to the overall workforce structure within these professional groups to close the total efficiency gap.

40. The areas of identified opportunity in other categories of spend are detailed below:

- *Average length of stay (ALOS) in in-patient wards (£6m):* in many areas the Trust performs in line with, or even above, the average of its peers. However, there is still opportunity for improvement. Comparisons of overall length of stay can be misleading, given differences in case-mix between Trusts. To estimate the opportunity in this area,

the ALOS for individual groups of patients (HRGs) in each specialty were benchmarked to peer values. The work found that, at a more detailed level, there is an opportunity to improve care for patients with specific conditions and to reduce the amount of time patients need to stay in hospital. Matching peer median average length of stay, for example by making a small improvement for longer-stay patients, would reduce the number of beds the Trust needs to treat the current number of patients. This would allow the Trust to operate with up to 100 fewer beds. The main specialities where there is the potential for improvement are general and elderly medicine, paediatrics, trauma and orthopaedics and general surgery.

This opportunity in ALOS is supported by the work that showed the significant variation in patient length of stay between consultants in the same specialty and for the same condition (HRG), and by estimating the considerable impact of mild reductions in ALOS for longer-stay patients. Realising this opportunity will require changes both to the internal medical model as well as improved joint working across the wider health system, to reduce the time patients spend in hospital. The aspirations for this are set out in the Community Based Care Strategy (see appendix O).

- *Scientific, therapeutic & technical (ST&T) productivity (£4m):* The Trust has a high number of permanent ST&T full-time equivalent staff relative to the clinical income in multiple professional groups. These include pharmacy, speech and language therapy and various sub-specialities of pathology. By bringing the number of full time equivalent staff in line with top performing peers, the Trust could realise around £2m in savings. As with other areas of the Trust, there is also a high bank and agency spend on ST&T staff, specifically within pathology and pharmacy.

- *Non-clinical pay (£4m):* The £50m non-clinical pay spent on 'back office' staff (eg. HR, IT and procurement) and 'middle office' staff (eg. medical secretaries, ward clerks and receptionists) was reviewed. This cost base represents approximately 1,300 full time equivalents. Opportunities for more efficient and effective running of the processes performed by these staff groups have been assessed, using outsourcing as the primary alternative. This assessment took account of the areas that can be most easily addressed and used benchmarks for outsourcing benefits achieved in other hospitals, public sector bodies and private sector organisations. Discussions were held with potential suppliers (both on- and off-shore) for outsourced services.

- *Supplies (£9m):* A detailed review of addressable non-pay spend at category level (eg. prosthetics, laboratory reagents and other consumables) was undertaken and concluded that there was the potential for a saving of £9m across the Trust. This could be achieved through a combination of supplier consolidation, better negotiation, managing demand and reducing stock levels. In order to realise this saving, a significant strengthening of the capacity and capability of the in-house procurement and contracts management teams, which are responsible for £92.5m of the Trust's spend, is required. Alternatively, this function could be outsourced.

- *Other variable costs (£5m):* A high-level review was carried out to establish the savings potential from outsourcing clinical support functions. Pathology and pharmacy were identified as offering the greatest benefit. An estimate of around £5m - based on current Trust operating volumes - was arrived at by making reference to benchmarks and by having discussions with potential suppliers.

Conclusion from phase one

41. The first phase of work concluded that operational efficiency improvements totaling £79m could be made over the three years 2013/14 to 2015/16, which is equivalent to 5.4% a year. The expected site split of the savings was £34m at Princess Royal University Hospital, £34m at Queen Elizabeth Hospital and £11m at Queen Mary's Hospital.

42. However, a risk assessment of capability within South London Healthcare NHS Trust assessed the Trust as only being able to deliver 55% of these savings with the current clinical and managerial leadership. Further detail on this is set out in paragraphs 63 to 68.

43. This formed the basis for the draft recommendation that the operational efficiency of the services provided by South London Healthcare NHS Trust should be improved over a three-year period such that costs were reduced by £79m by the end of 2015/16 and that, to achieve this, enhanced leadership capability would be required to drive it forward.

Phase two approach: developing detailed plans to realise the identified operational efficiency improvement opportunity

44. Following the publication of the draft report a second phase of work was undertaken in which detailed CIPs were developed to test and validate the £79m total operational efficiency improvement expectation for the three-year period 2013/14 to 2015/16 as outlined in the draft report.

45. To aid the focus of the development of the CIPs, the £79m of opportunity was allocated to each of the care groups as a target by each of the cost categories used in phase one. This ensured that CIPs broadly reflected the main areas of opportunity identified and thus would be credible.

46. All of the cost improvement schemes were developed over an intensive five-week period in which the external advisors from phase one continued to work with the leadership teams of the four care groups and corporate services. Dedicated finance, workforce and information management resources were provided to work alongside each group to develop and validate all CIPs.

47. The governance arrangements for this phase of the work included the following weekly pattern of development and review:

- a weekly meeting of the operational working group to review progress, test and challenge the work completed;
- internal Trust leads were identified and freed up to match the external consultancy support on a one-to-one basis. The external advisors and the Trust leads also met twice a week to co-ordinate the programme of work;
- a weekly internal leads meeting to ensure schemes that cut across care groups were coordinated;

- three meetings per week between the care group team and the consultancy support team; and
- throughout the five-week period there was clinical and finance engagement to ensure clinical rigour was applied and finance input incorporated.

48. In the fourth and fifth weeks the process included a review of the schemes by the Medical Director, Chief Nurse and Deputy Director of Finance to provide executive review and sign off. The CIPs were also reviewed by an independent firm who undertook a due diligence exercise on the proposed schemes and the underlying analysis.

49. The process for developing the CIPs was driven by a number of principles:

- the scale and location of improvement opportunities should be based on the cost categories identified in phase one;
- senior management and clinical engagement throughout, so that schemes would be credible and deliverable;
- internal and external clinical assessment of proposed schemes, so that patient safety and quality of care can be maintained and, where possible, improved; and
- robust internal governance processes, so that the work is undertaken with sufficient quality, scale and pace to meet the needs of the TSA process.

50. Teams from each of the four clinical care groups and corporate services developed detailed CIPs to full business case standard for year one (2013/14) and to outline business case standard for years two and three (2014/15 and 2015/16). This level of detailed planning over a three-year time period is considered to be excellent practice and beyond that routinely done in other NHS organisations.

51. The year one full business case standard CIPs all follow a similar very detailed format showing:

- the cost category that the CIP will reduce, and by how much in each of the three years;
- how costs will be reduced through specific actions in each of the three years;
- the underlying analysis that details the feasibility of the scheme;
- the impact on headcount and spend over the three years; and
- the implementation costs of the schemes, a site level split and an assessment of risk.

52. All CIPs were developed at hospital site level on the basis of the clinical and non-clinical services that are currently provided by the Trust. They therefore focus on improving the efficiency of the services as they are currently configured within the Trust. The implications of other recommendations are addressed in the relevant sections elsewhere in the report and build on the position for the Trust post this CIP work.

53. In total, £74.9m of CIPs were developed during phase two, covering the three-year period 2013/14 to 2015/16 (see figure 9). This represents 95% of the £79m total operational efficiency improvement expectation set out in the draft report.

54. In addition to CIPs developed to reduce costs based on the current configuration of South London Healthcare NHS Trust, a high-level piece of work was undertaken to assess the potential further cost savings that could be made to corporate services within the Trust if the proposed new organisational arrangements (see chapter 6 of the final report and appendix F) were implemented. This work identified £7.7m of savings could be achieved in corporate services by streamlining functions and shaping and sizing the workforce in line with the corporate services of other merged high-performing NHS trusts.

Figure 9: Total CIPs 2013/14 – 2015/16

		Improvement opportunity (phase one)		Cost Improvement Programme Schemes developed (phase two)			
Cost category	2011/12 cost base (£m)	Improvement opportunity identified from external benchmarking (£m)	Improvement opportunity identified from internal review (£m)	CIP identified year 1 (£'000)	CIP identified year 2 (£'000)	CIP identified year 3(£'000)	Total CIP identified (£'000)
ALOS	N/A	0	**6**	1.9	1.4	0	**3.3**
Medical pay	90	12	**20**	6.1	6.1	2.6	**14.8**
Nursing pay	98	17	**14**	7.3	2.5	3.9	**13.7**
ST&T pay	37	2	**4**	0.9	1.4	2.0	**4.3**
Non-clinical pay (back and middle office)	50	8	**4**	1.9	2.6	5.7	**10.2**
Supplies	72	14	**9**	4.9	5.1	5.0	**15.0**
Other variable costs	15	4	**5**	3.4	5.7	4.5	**13.6**
Total	**526**	**57**	**62**	**26.4**	**24.8**	**23.7**	**74.9**

55. Figure 9 outlines the major elements of the CIPs for the three-year period. The key components of this are:

Average length of stay (ALOS): £3.3m of CIPs developed against an identified improvement opportunity of £6m

- Inpatient bed capacity should be reduced over the three-year period as the Trust reduces its current ALOS. This should be achieved through improvements in internal working, consolidation of key inpatient areas into single geographical spaces and maximising the opportunity to reduce the number of people who stay in hospital after they are fit for discharge.

- The provision of beds should be matched to the demand, through further use of day-case wards and with bed capacity in high cost areas better aligned to patterns of demand, so that there are not more beds being staffed than are needed.

- Inpatient capacity should be reduced by approximately 90 beds across the sites over the three-year period.

Medical productivity: £14.8m of CIPs developed against an identified improvement opportunity of £20m

- The medical workforce should be redesigned to match the number of consultants to the workload, ensuring that appropriate numbers of patients are treated in each session.

- A significant component of this should be achieved by improving elective theatre utilisation to 90% over the three-year period and by increasing the number of cases per list. This will mean fewer expensive theatre sessions are needed.

- A redesign of the number of non-consultant doctors and their working patterns will realise further reductions in cost.

- Several schemes reduce the reliance on waiting list initiatives and premium spend in areas such as theatres, endoscopy and radiology and, as changes are made to working patterns, expensive locum and agency spend will reduce.

- Most of the apparent remaining opportunity in medical productivity relates to clinical income opportunities, which are captured under the non-clinical pay section (see below).

Nursing productivity: £13.7m of CIPs developed against an identified improvement opportunity of £14m

- Improved rostering control and improved management of sickness should further reduce the requirement for expensive bank and agency staff.

- The current model of nursing in theatres and wards should change, and over the three-year period a number of elements should come together, resulting in a differently structured nursing workforce.

- A different model of staffing theatres should be introduced, alongside a reduction in the number of theatre lists.

- The senior nursing structure that supports inpatient wards should be redesigned and there should be a reduction in the number of non-ward based senior posts.

- A change to the model and skill mix within midwifery should be introduced over the period.

Scientific, therapeutic & technical (ST&T) productivity: £4.3m of CIPs developed against an identified improvement opportunity of £4m

- A coherent programme of automation should enable the size of the workforce to be reduced over the three-year period, alongside the use of outsourcing of areas such as outpatient dispensing.

- The replacement of expensive on-call systems with standard terms and conditions and a modernised way of working in pathology and radiology should take place.

Non-clinical pay and income based schemes: £10.2m of cost and income schemes developed against an identified cost improvement opportunity of £4m

- The use of technology to replace current manual processes should be introduced in a number of areas across the Trust.
- Corporate services and management costs should be reduced as those functions are 'right-sized' to the activity being undertaken.
- Some of the CIPs in this area relate to income growth across clinical areas and are captured here to ensure that cost and income based schemes are not confused within the main clinical cost groupings.

Clinical supplies: £15.0m of CIPs developed against an identified improvement opportunity of £9m

- Standardising the supplies that are used by the Trust, ranging from less expensive disposable items to expensive prosthetics used in surgery, will result in significant cost savings, whilst better stock control and management should mean that the Trust will be able to carry out its activities by holding and wasting fewer stocks of supplies.
- Drug spend should be reduced through a variety of schemes and contracts for support services should be rationalised.

Other variable costs £13.6m of CIPs developed against an identified improvement opportunity of £5m

- Aligned to the CIPs to automate scientific and technical services, the outsourcing of some clinical support functions should be introduced in certain areas of the Trust.
- A different model of managing the Trust's outpatient dispensing through the provision of a non-NHS supplier should reduce cost while also delivering an improved quality of service and reduced waiting times.
- A revised managed service model for pathology should achieve further cost reductions through strengthened purchasing power.
- Further opportunities have been identified to improve the quality of patient care, which will attract best practice tariff payments.

56. During phase 2, £74.9m of CIPs were identified for the three-year period which represents 95% of the £79m target. The target is composed of a £62m productivity gap identified in phase 1 and an additional £17m of savings required to match the predicted future improvement of top performing trusts during the next three years. Thus, the CIPs identified will deliver the full £62m of productivity gap and £12.9m out of the £17m required to match ongoing improvement of top performing peer trusts. By regularly benchmarking performance and by developing a culture of continuous improvement, further opportunities should be identified over the three-year period.

57. The scale and phasing of the CIP savings for the Trust as a whole are shown in figure 10.

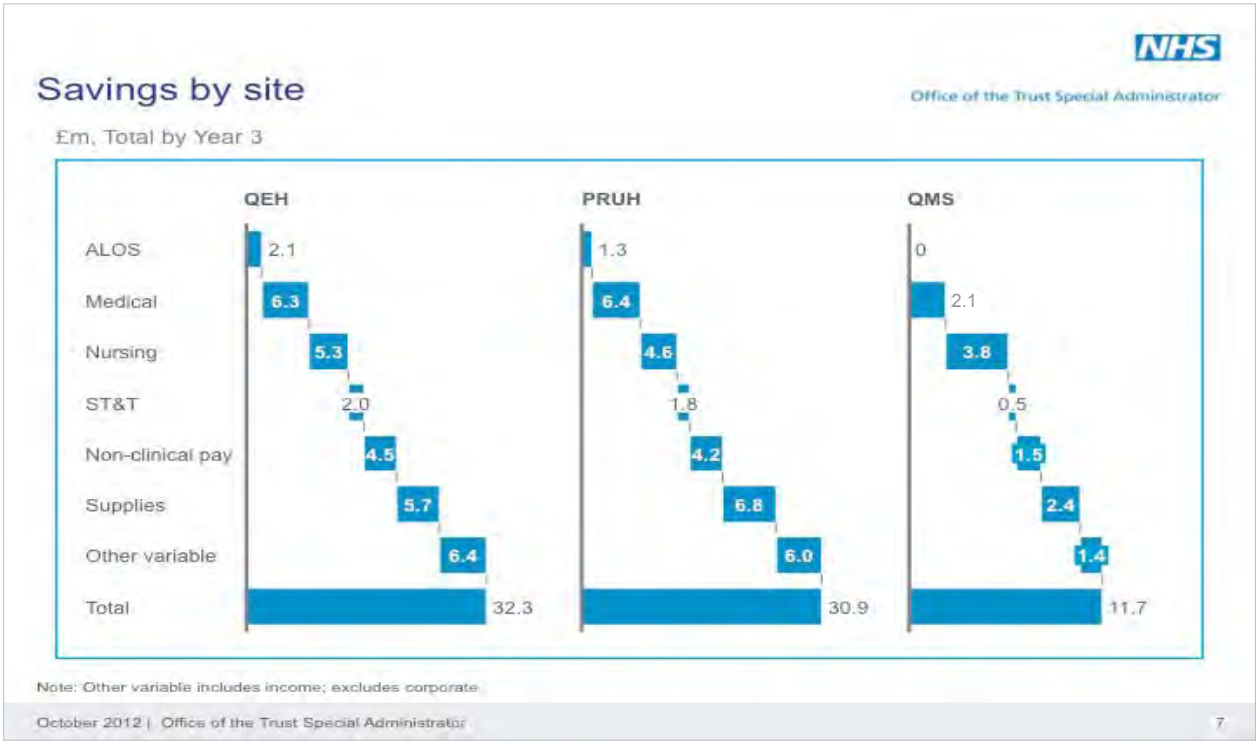
Figure 10: Total planned CIPs by year for South London Healthcare NHS Trust's services overall

Year	CIP (£m)	CIP[2] (%)
2013/14	26.4	5.4%
2014/15	24.8	5.4%
2015/16	23.7	5.4%
Total	**74.9**	**15.3%**

58. Assuming no change in configuration of services and the profile of these opportunities, the cost of operating the services at Queen Elizabeth Hospital will reduce by £32.3m over three years, at Princess Royal University Hospital the reduction will be £30.9m and at Queen Mary's Hospital the reduction will be £11.7m. The profile of the savings across the three years is shown in figure 11.

Figure 11: Planned CIPs by site and year

Year	QEH £m (%)	PRH £m (%)	QMS £m (%)
2013/14	11.2 (5.6%)	10.9 (5.3%)	4.2 (5.1%)
2014/15	10.9 (5.7%)	9.7 (5.0%)	4.3 (5.4%)
2015/16	10.2 (5.6%)	10.3 (5.6%)	3.2 (4.3%)
Total	**32.3 (16.0%)**	**30.9 (15.1%)**	**11.7 (14.1%)**
Equivalent % per annum	**5.6%**	**5.3%**	**5.0%**



2 The CIP % in year relates to the % saving on the forecast cost base at the start of the year.

59. Figures 12 to 14 show the planned CIPs by year for each of South London Healthcare NHS Trust's three main sites and the split of the planned savings across the cost categories in each of the three years.

Figure 12: Total planned CIPs by year at Queen Elizabeth Hospital

Year	CIP	CIP[3] (%)
2013/14	£11.2m	5.6%
2014/15	£10.9m	5.7%
2015/16	£10.2m	5.6%
Total	**£32.3m**	**5.6%[4]**

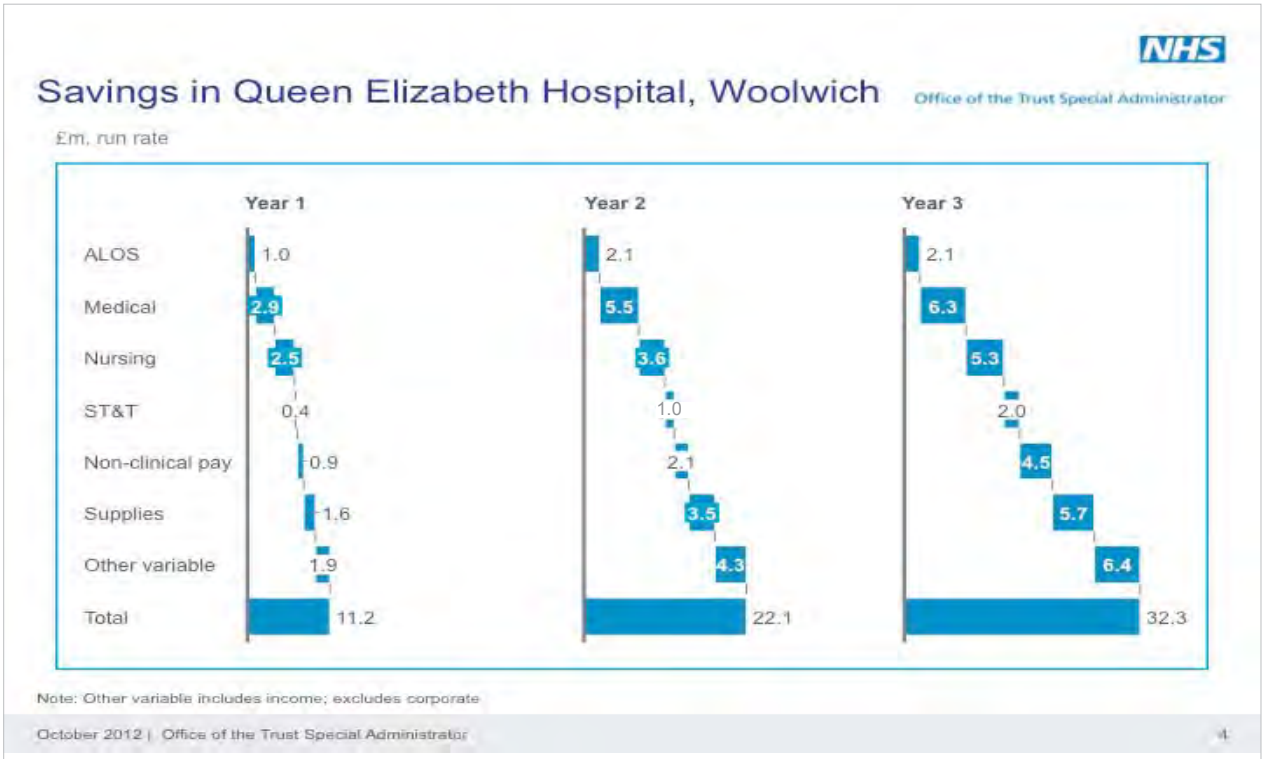


Figure 13: Total planned CIPs by year at Princess Royal University Hospital

Year	CIP	CIP[5] (%)
2013/14	£10.9m	5.3%
2014/15	£9.7m	5.0%
2015/16	£10.3m	5.6%
Total	**£30.9m**	**5.3%[6]**

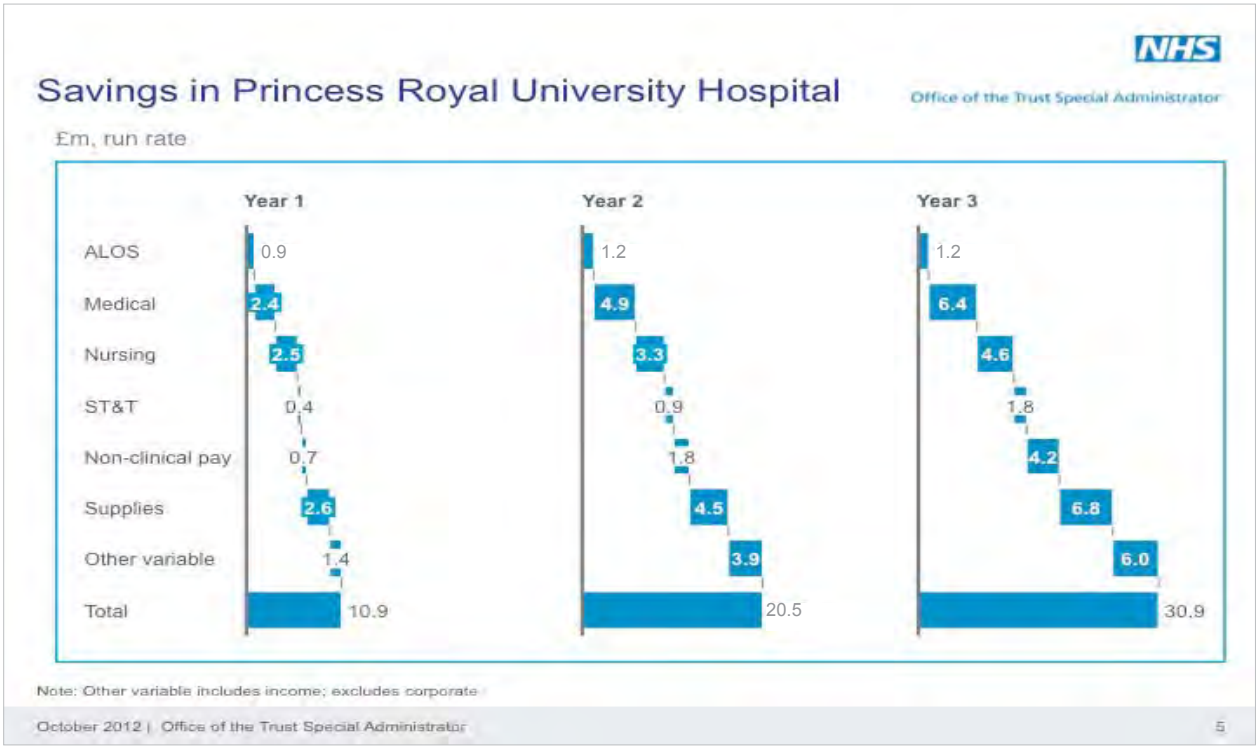
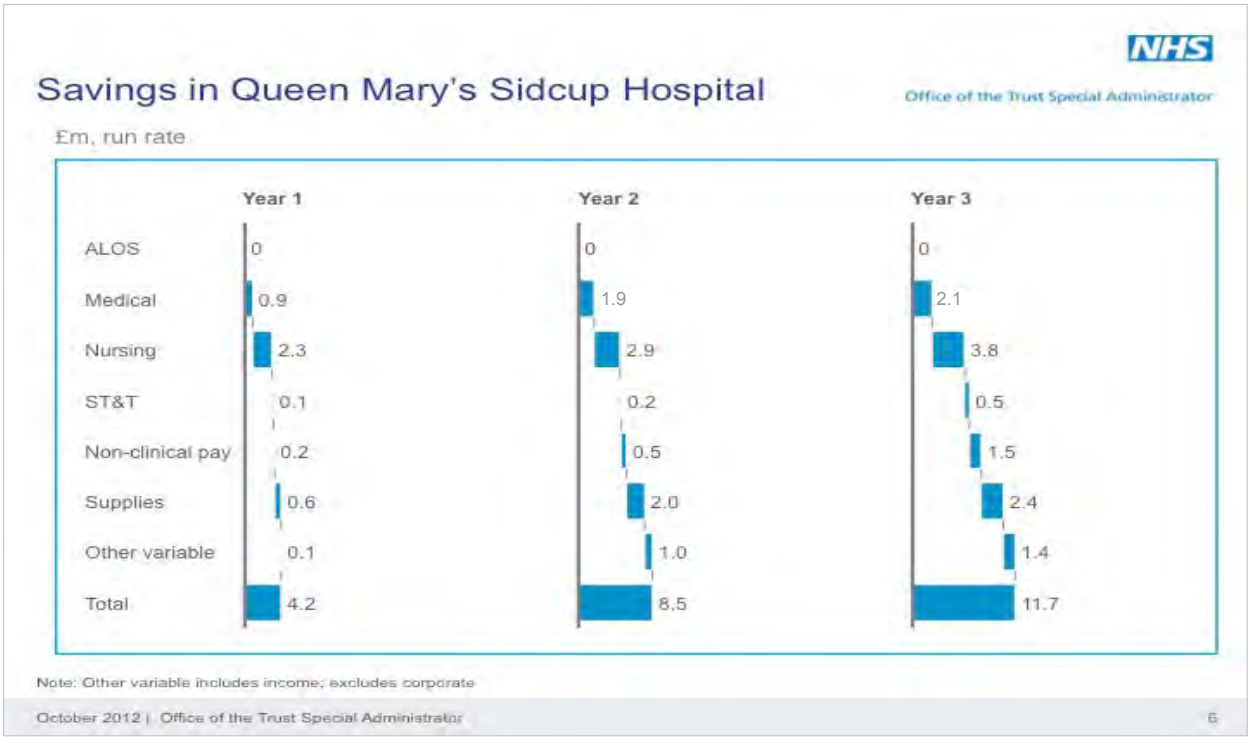


Figure 14: Total planned CIPs by year at Queen Mary's Hospital

Year	CIP	CIP[7] (%)
2013/14	£4.2m	5.1%
2014/15	£4.3m	5.4%
2015/16	£3.2m	4.3%
Total	**£11.7m**	**5.0%[8]**



60. Throughout the work, the importance of safeguarding the quality and safety of service delivery has been recognised and is paramount. A combination of internal clinicians from the key professional groups and external clinicians have been involved in the development of many of the schemes. An initial review of the schemes has been undertaken by the Trust's Chief Nurse and Medical Director and the external clinical panel. It was noted during this process that there is a very significant scale of change proposed in totality when the combined effect of all the schemes is considered. As such, a further review of the timing of the schemes should take place prior to implementation to ensure all the interdependencies, which have been mapped out, are carefully managed.

61. Four key recommendations were made following the internal and external clinical review:

- CIPs that reduce the overall bed base should be phased over two years to mitigate any risk to delivery;
- further work should be undertaken on those individual schemes where they relate to existing local and pan-London service networks;
- a robust implementation programme and safety impact assessment should be developed, to provide assurance during the delivery of schemes; and
- further assurance should be undertaken through the implementation period, so that changes do not compromise other recommendations.

62. Clinical leadership and engagement in implementing schemes will be critical to ensure successful delivery. The CIPs for all three years have been broken down by year, by site and by cost category and have been collated into a single programme plan to describe the recommended sequence for implementation. The further work recommended by the review will take place early in 2013, prior to the implementation of any schemes.

Assessment of current capacity and capability to deliver the required efficiency improvements

63. Based on the work described in the previous section, the TSA's assessment is that the opportunity exists to reduce the cost of South London Healthcare NHS Trust's current services by £79m over a three-year period and that the TSA has identified £74.9m of CIP schemes in the development of this final report.

64. Linked to the identification of the savings that could reasonably be expected by improving the productivity of the services provided by the Trust is the important question of how these improvements could be delivered that, if unanswered, would have meant that the opportunity would not be translated into actual savings. Paragraph 56 of chapter 4 describes the TSA's assessment of the culture, capacity and capability within the Trust, indicating that significant change is likely to be needed.

65. Based on the experience accumulated over the two phases of work, the analysis which underpinned it and the review of the output by the operational efficiency working group, an assessment of what levers would be required to ensure successful delivery of the CIPs has been completed. The major barriers to effective delivery identified within the Trust included:

- inadequate and insufficient consistent clinical leadership, clinical management and a lack of clinical engagement and ownership;
- inadequate consistent general and operational management capability and a lack of senior management leadership within the care groups;
- insufficiently strong board leadership;
- a lack of partnership working between clinicians and managers and a lack of collective responsibility and ownership for the services provided by the Trust; and
- inadequately developed systems and processes to provide timely and accurate information that provides insight into performance and productivity relative to peers.

66. It was therefore considered that the Trust would not be able to deliver the full operational efficiency opportunity identified through the TSA process. The capacity and capability of the Trust to reduce costs in each of the major areas identified was considered and the assessment is shown in figure 15.

Figure 15: Assessment of capacity and capability of South London Healthcare NHS Trust to deliver the required productivity improvement

Cost category	2011/12 Cost base (£m)	Validated estimate of savings (£m)	Trust capability to deliver opportunity	Risk adjusted estimate of delivered savings (£m)*
ALOS	N/A	6	Medium	4
Medical pay	90	20	Low	12
Nursing pay	98	14	Medium	8
ST&T pay	37	4	Medium – High	3
Non clinical pay (back and middle office)	50	4	Low – Medium	2
Supplies	72	9	Low	2
Other variable costs	15	5	Medium	3
Total	**526**	**62**		**34**

* Risk adjusted calculation based on:

Low capability:	20% of opportunity will be delivered
Low – Medium capability:	40% of opportunity will be delivered
Medium capability:	60% of opportunity will be delivered
Medium – High capability:	80% of opportunity will be delivered
High capability:	100% of opportunity will be delivered

67. Figure 16 details the rationale for the level of risk adjustment that was applied to each area of opportunity, based on the specific levers that were associated with each opportunity.

Figure 16: Basis for the risk adjustment to the savings opportunity by category

Cost category	Trust capability to deliver opportunity	Summary rationale for risk assessment
ALOS	Medium	Lower level of clinical engagement in the need to modernise radically the model of care delivery within hospital. Out-of-hospital systems' capacity and capability represents a significant barrier.
Medical pay	Low	Lack of co-ordinated medical management, inconsistent approach to job planning and individual performance review and a lack of clinical engagement and ownership.
Nursing pay	Medium	Lack of previous evidence-based approach has hindered leadership taking this forward. Inability to identify clearly where opportunity exists.
ST&T pay	Medium – High	Willingness amongst workforce to modernise ways of working and take advantage of technology.
Non clinical pay (back and middle office)	Low – Medium	Requires significant commercial capability, which the Trust does not have
Supplies	Low	Detailed review of procurement function showed a low level of clinical engagement in standardisation / non-pay control and a lack of commercial ability within the procurement function.
Other variable costs	Medium	Requires significant commercial capability, which the Trust does not have

68. Based on this detailed consideration, it was concluded that the Trust could deliver 55% of the £79m total opportunity – in other words £43.3m over the three-year period – and the base case was developed on this basis.

Conclusion

69. A significant and validated operational efficiency opportunity exists by improving the way in which South London Healthcare NHS Trust's services are provided. This should reduce costs by at least £74.9m over a three-year period.

70. There are significant barriers to achieving this improvement within the Trust in its current form. The barriers identified during the TSA's assessment do not exist in all trusts or, at least, not to the same extent that has been found in the Trust and, as such, it should remain possible to deliver the full level of CIPs that have been developed.

71. However, to achieve this will require cultural change across the Trust with the following elements being critical to success:

- strong board-level and local management to drive productivity changes at the clinical service line;
- significantly strengthened clinical leadership and clinical management of the medical workforce;
- significantly strengthened general and operational management;
- improved clinical and, specifically, medical engagement;
- stronger partnership working between clinicians and managers;

- strengthened job planning;
- timely and accurate information that provides insight into performance and productivity relative to peers;
- improved systems and processes to support clinicians to perform to their maximum potential; and
- significantly strengthened procurement capability.

72. This will be a challenging task that requires committed leadership. It is, however, essential if the Trust is to provide sustainable services that are value for money. Fundamentally, an engaged and aligned clinical workforce and a capable clinical and managerial leadership structure are the critical success factors. New organisational arrangements will need to facilitate and lead this change. Without this, the scale of transformation that is required will not be achieved.

Footnotes

1 £164m of 2011/12 cost base not benchmarked, including other clinical income (due to inconsistency in reporting), premises, establishment cost and non-operating costs (ie. PDC, interest, depreciation, etc.)

2 The CIP % in-year relates to the % saving on the forecast cost base at the start of the year.

3 The CIP % in-year relates to the % saving on the forecast cost base at the start of the year.

4 The total cost reduction over the three years is 16.0%, which is equivalent to 5.6% per year over the period.

5 The CIP % in-year relates to the % saving on the forecast cost base at the start of the year.

6 The total cost reduction over the three years is 15.1%, which is equivalent to 5.3% per year over the period.

7 The CIP % in year relates to the % saving on the forecast cost base at the start of the year.

8 The total cost reduction over the three years is 14.1%, at a rate of 5.0% per annum over the period.

NHS

Office of the Trust Special Administrator

Appendix E

Hospital Service Change Proposals

Securing sustainable NHS services

Introduction

1. Recommendations 1 to 4 will enable a significant improvement to the financial position at South London Healthcare NHS Trust. However, implementing them neither bridges the financial gap entirely nor responds to the need to deliver the quality improvements in health services, recommended following a recent review of emergency and maternity care in London. The Trust Special Administrator (TSA) was therefore required to look more broadly at the financial and clinical state of the whole health system of south east London.

2. The development of recommendations for service change is in response to working with clinicians, commissioners, patients and the public and other stakeholders to understand how the quality of service provision in the NHS in south east London could be improved and secured in light of a growing and changing population and within available resources.

3. This work included the development of a strategy by the six Clinical Commissioning Groups (CCGs) in south east London for how care will be delivered in the future, so that the population of south east London receives the best possible care in the community supporting people to live healthier and more independent lives. These aspirations are essentially a set of shared standards of care, which will be delivered locally as determined by each CCG. Details on some of the opportunities to improve the quality of care, outcomes, patient experience and performance on health inequalities are detailed in annex 1.

4. For hospital-based care the TSA‘s clinical advisory group and external clinical panel both recommended that any future configuration of hospital services in south east London must meet the London-wide clinical quality standards for hospital-based acute emergency and maternity services, which have been agreed in response to the recent London review (appendix P). CCGs have further committed to ensuring all future hospital-based care in south east London is commissioned in line with these standards. The benefits of implementing these are outlined in annex 1.

5. To respond to both the Community Based Care Strategy (appendix O) and the clinical quality standards (appendix P), a number of potential hospital configuration options were developed to secure clinical sustainability. Key clinical and non-clinical stakeholders were then engaged to develop a set of robust criteria to evaluate these configuration options. The clinical advisory group evaluated each option before recommending how hospital-based acute emergency and maternity services should be configured in south east London. These draft recommendations were then subject to a financial value for money assessment.

6. This appendix sets out the approach taken; the configuration options considered; the process for developing and agreeing the criteria to evaluate each option; the process for the application of the criteria; and the outcome of the evaluation.

7. Further to this, the appendix details the development work and engagement that was subsequently undertaken on the recommendations during the consultation period. Consultation responses and the Health and Equalities Impact Assessment are then detailed for each recommendation with detail of the external clinical panel's consideration of this and their recommendation to the TSA.

Approach

Agreeing clinical quality standards

8. A number of reports over many years - including those from the National Confidential Enquiry into Patient Outcome and Death, the Royal College of Physicians and the Royal College of Surgeons - have identified issues relating to the provision of emergency care services. The message from these reports has been consistent, namely that there is often inadequate involvement of senior medical personnel in the assessment and subsequent management of many acutely ill patients. Outcomes are therefore not as good as could be achieved - and not as patients should expect - particularly at the weekend.

9. In 2011, on behalf of commissioners in London, London Health Programmes undertook a review of adult emergency services across the capital. This review demonstrated that patients admitted as an emergency at the weekend have a significantly increased risk of dying compared to those admitted on a weekday. Across London it suggested around 520 lives could be saved every year - within south east London this equates to around 100 lives. Reduced service provision, including fewer consultants working at weekends, was associated with this higher mortality rate. In London, consultant cover at the weekend was found to be half of what it was during the week - the same was found in south east London.

10. Clinical expert and patient panels developed evidence-based minimum clinical quality standards for adult emergency services – acute medicine and emergency general surgery – to address these variations in service arrangements and patient outcomes.

11. This work was expanded in 2012 to cover all hospital-based acute emergency services – adults and paediatric – and maternity services to address the variation found in these services. Clinical quality standards for these services have now been developed (appendix P) and were endorsed by the London Clinical Senate in September 2012 and the London-wide Clinical Commissioning Council in November 2012.

12. The clinical advisory group and external clinical panel considered these clinical quality standards and further endorsed them and advised the TSA that any future models of acute care in south east London should consistently meet these standards to secure long-term clinical sustainability. Clinical commissioners have committed to

ensuring all future hospital based care in south east London is commissioned in line with the clinical quality standards. This was echoed in the commissioners' responses to the consultation, stating the any future configuration of services in south east London would need to meet the London clinical quality standards for emergency and maternity care and supported the need for consolidation of services to achieve this.

Evaluation of the options

13. Considering the impact of delivering the clinical quality standards and Community Based Care Strategy alongside the financial challenges to be addressed, a number of options for the future configuration of services across south east London were put forward for evaluation.

Establishing hurdle criteria

14. An exhaustive list, taking into account every possible combination of service configuration of hospital sites in south east London, created 16,384 permutations to evaluate. To ensure only options that were clinically and financially viable were considered fully; hurdle criteria were agreed and applied to this long list. These hurdle criteria were agreed by the clinical advisory group and the TSA advisory group on 8 August 2012 and were further endorsed by the patient and public advisory group and external clinical panel. The agreed hurdle criteria are shown in figure 1.

Figure 1: Long-list hurdle criteria

Hurdle criteria	High quality care, Realistic time frame, Affordable to commissioners	▪ capable of meeting all applicable standards, ensuring patient safety ▪ deliverable within a 3 year timeframe ▪ affordable to health and social care commissioners

Application of hurdle criteria

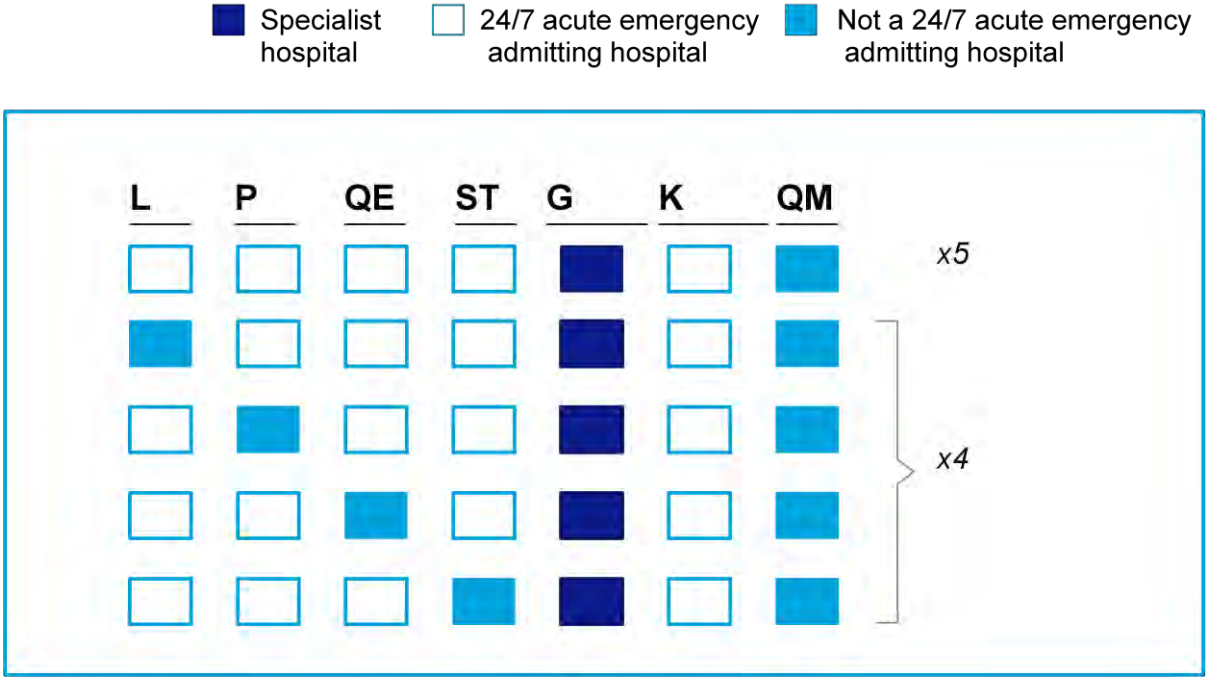
15. Application of the hurdle criteria immediately removed from consideration the vast majority of possible configuration options: solutions that would need the creation of new hospital sites were ruled out on the grounds that they were neither affordable nor deliverable in a realistic time frame; and solutions that would see the reversal of decisions taken recently about the reconfiguration of services that had improved outcomes were also ruled out.

16. In the application of these criteria, a number of ~~fi~~xed points" were also established by the clinical advisory group. For these sites, the clinical advisory group decided their designation should be ~~fi~~xed" on the grounds that changes would result in a deterioration of services. These ~~fi~~xed points" and the rationale for each are as follows:

- *Guy's Hospital*: It was agreed that Guy's Hospital would not be considered for development as a 24/7 acute emergency admitting hospital as it is well established as a specialist and elective centre for a range of standard, complex and specialist services.
- *King's College Hospital*: As one of London's four major trauma centres for seriously injured patients within the trauma networks in London, which are working successfully, it was agreed that this site would not be considered for significant service reconfiguration and should be developed as a 24/7 acute emergency admitting hospital.
- *Queen Mary's Hospital*: It was agreed that this site should not be considered for development as a 24/7 acute emergency admitting hospital as it was felt that re-opening A&E and associated emergency services on the site would be a retrograde step in light of the changes that had recently been made under the *A Picture of Health* programme.

17. With these ~~fix~~ed points" agreed, a short list of five configuration options were agreed to be evaluated against the full evaluation criteria (figure 2).

Figure 2: Potential configuration options



Key: L - University Hospital Lewisham; P - Princess Royal University Hospital; QE - Queen Elizabeth Hospital; ST - St Thomas' Hospital; G - Guy's Hospital; K - King's College Hospital; QM - Queen Mary's Hospital Sidcup

18. The term ~~fix~~ed point", used by the clinical advisory group, did not mean that the site would be exempt from some changes. It was recognised by the clinical advisory group that all sites would need to change in response to the impact of the Community Based Care strategy and to meet the agreed minimum clinical quality standards for hospital-based acute emergency and maternity services.

Establishing full evaluation criteria

19. The next stage in the process involved defining the full criteria to evaluate the short list of configuration options further. The evaluation criteria were agreed by the clinical advisory group and the TSA advisory group and covered five key areas:

    - Quality of care
    - Access to care
    - Value for money
    - Deliverability
    - Research and education

20. Sub-criteria and indicators on which analysis could be provided to support the evaluation were defined at a number of workshops attended by a wide range of clinicians, clinical commissioners and patients and the public. The indicators chosen were to provide an overview of the criteria that would allow clinical advisory group members to make informed decisions based on their professional judgement and the information presented to them. The list of indicators chosen was not exhaustive, but rather to provide quantitative analysis to support the discussion and decision making of the clinical advisory group.

21. The approach adopted for evaluating the options, including the evaluation criteria, were reviewed in various advisory groups including the clinical advisory group, the patient and public advisory group, the finance, capital and estates advisory group and the TSA advisory group. The approach and the criteria were refined on the basis of feedback. The final set of criteria, sub-criteria and description indicators is shown in figure 3.

Figure 3: Final evaluation criteria, sub-criteria and description indicators

Criteria			Description indicators
1	Quality of care[1]	• Clinical effectiveness • Patient experience and estate quality	• Standardised mortality rates (in and out of hours), time to operatefor FNOF, infection rates, readmission rates, conversion rates of A&E attendance to admission • Consultants on rota (emergency surgery, pediatrics) • Key patient satisfaction scores, complaints, patient safety, medication error rate • Age and quality of the estates
2	Access to care	• Distance and time to access services • Patient Choice • Access to integrated services	• Impact on population weighted average travel (blue light travel, off-peak car, peak car, public transport) • Number of sites delivering emergency, obstetrics, elective, outpatients, diagnostics • Number of Trusts with major hospital sites • Delayed transfers of care in vs out of borough; length of stay >75s, readmission rates trend
3	Value for money	• Capital cost to the system • Transition costs[2] • Fixed cost & operational savings • Net present value • Provider viability	• Up front capital required to implement acute reconfiguration • Non-recurring costs (excluding capital build and receipts) to implement changes • Estimate of fixed cost savings derived from cost rationalisation initiatives • Overall value to the system • Assessment of the on-going viability of the individual sites
4	Deliverability	• Workforce • Expected time to deliver • Co-dependencies with other strategies	• Workforce experience/quality e.g., turnover, sickness, satisfaction • Scale of change (bed movements) • Assess strategies impact e.g., cancer, stroke, King's Health Partners merger
5	Research and Education	• Conducive to education • Conducive to research	• GMC national training survey and staff training survey • Disruption to education and research spend • Qualitative assessment of impact on existing strategies (alignment with GMC training plans)

1. Patient safety is considered before this stage of evaluation in the hurdle criteria for options. All options must meet required patient safety standards
2. Costs of transitioning from the current to the proposed option

Full evaluation of the configuration options

22. Each short list option was then clinically evaluated against the criteria by the clinical advisory group on 26 September 2012. At this stage, the group recommended that St Thomas' Hospital should be developed as a 24/7 acute emergency admitting hospital and should not be considered for the evaluation. This decision was made on the grounds that:

- The Evelina Hospital – a purpose-built children's hospital alongside St Thomas' Hospital – is critical to delivering tertiary paediatric services to the local population (including South London, Kent, Surrey and Sussex). The Evelina Hospital's specialist paediatric services are both interdependent with and share the support infrastructure with general paediatrics and the wider acute hospital services of St Thomas' Hospital.
- It is a receiving centre for high-risk obstetrics services for a wider population, which would be difficult to re-provide elsewhere.

- St Thomas' Hospital is one of the designated complex vascular centres in London making the unit the largest centre by operating volume in Europe. One in three emergency referrals to this service is via the A&E department and loss of this service would cause a significant challenge to the delivery of the arterial model of care. Moreover, it is the only unit in the country that runs an emergency rota for acute aortic surgery.
- St Thomas' Hospital is one of five extracorporeal membrane oxygenation (ECMO) sites in the United Kingdom. As a designated centre for tertiary severe respiratory failure, it provides a critical care service for tertiary cardiology and vascular service for the region. These services would be difficult to re-provide elsewhere.

Application of the full evaluation criteria

23. Using the indicators that were agreed, information on each sub-criteria was considered by the clinical advisory group for the non-financial evaluation of the options. Using this information, members of the clinical advisory group were asked to use their professional judgement and clinical expertise and opinion to reach consensus on a single score for each criteria as a whole.

24. Each option of four 24/7 acute emergency admitting hospitals was scored compared to the option of five 24/7 acute emergency admitting hospitals. This enabled each of the short-listed options to be ranked in terms of impact. The nature of the exercise, evaluating the impact that potential changes to the configuration of health care services in south east London would have on the system in 2015/16, does not lend itself to a precise scoring system. Instead, it was agreed that each potential configuration of services should be rated in terms of whether the clinical advisory group felt it would lead to an improvement or deterioration in that specific category compared to the option to deliver five 24/7 acute emergency admitting hospitals, awarding a "+" or "-" as appropriate.

25. In order to have a process that could distinguish between varying degrees of improvement or deterioration, without creating a system forcing the evaluators to be impossibly specific in their predictions, a second tier of scoring was introduced simply as "++" or "--" to indicate a significant improvement or deterioration. Using this methodology, the scoring for each criteria is outlined in the following sections.

26. Similarly, the finance, capital and estates working group - formed of the directors of finance and directors of estates from the four trusts and the chief financial officers from the six clinical commissioning groups across south east London - agreed a set of criteria and used it to evaluate each option in term of its value for money.

1: Quality of care

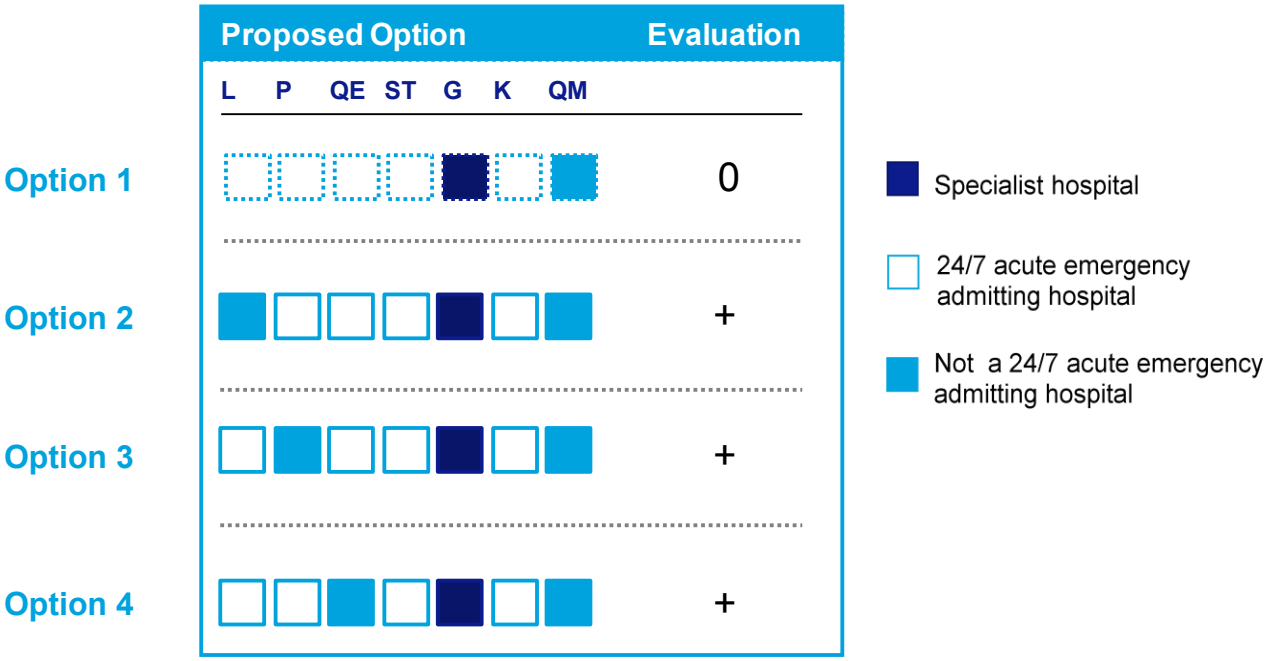
27. To evaluate the impact that each option would have on the quality of care that patients would receive, data on each of the description indicators were considered by the clinical advisory group for the two sub-criteria of clinical effectiveness and patient experience and estate quality.

1A: Clinical effectiveness

28. For clinical effectiveness, the metrics chosen were well recognised national indicators of overall current quality of care.

29. After consideration of the data for each indicator, the clinical advisory group reached a consensus that each of the options to develop four 24/7 acute emergency admitting hospitals were to be rated equally – and more positively than the option to develop five 24/7 acute emergency admitting hospitals.

Figure 4: Evaluation of sub-criterion 1A – Clinical effectiveness



Key: L - University Hospital Lewisham; P - Princess Royal University Hospital; QE - Queen Elizabeth Hospital; ST - St Thomas' Hospital; G - Guy's Hospital; K - King's College Hospital; QM - Queen Mary's Hospital Sidcup

30. The clinical advisory group noted that it would be difficult to prove empirically that one hospital in its entirety would have a higher overall quality of care than another. The variation by particular service line or dimension of quality was too high. In addition, the group advised that data on current indicators would not indicate the quality of care that would be provided in the future. Potential changes in organisational form, a potential reconfiguration of services and a drive towards higher standards therefore made it difficult to distinguish between options.

31. The clinical advisory group highlighted that quality was of the upmost importance in considering any changes to the way services were delivered and had already advised that any future configuration of services in south east London would need to meet the London-wide clinical quality standards.

32. Hospitals in south east London were audited from July to September 2012 for compliance with the already commissioned acute medicine and emergency general surgery services clinical quality standards. The audit results were not made available to the clinical advisory group at the point of evaluating the service change options, but they do demonstrate the challenges facing hospitals in south east London. With regard to compliance with the quality standards, no hospital met all of the standards as shown in figure 5.

Figure 5: Quality and Safety Programme Audit in south east London, 2012

No	Standard	KCH		SLHT-PRUH		SLHT-QEH		GSTT-ST		UHL	
		Medicine	Surgery	Medicine	Surgery	Medicine	Surgery	Medicine	Surgery	Medicine	Surgery
1	All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital.	✗	✗	✓	✗	✓	✗	✓	✗	✗	✗
2	A clear multi-disciplinary assessment to be undertaken within 12 hours and a treatment or management plan to be in place within 24 hours (for complex needs patients see 23 and 24).	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
3	a) All patients admitted acutely to be continually assessed using a standardised early warning system (EWS).	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	b) Consultant involvement is required for patients who reach trigger criteria. Consultant involvement for patients considered 'high risk' to be within one hour.	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.	✓	✓	✓	✗	✓	✗	✓	✓	✗	✗
5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical/ surgical unit to cover extended day working, seven days a week	✗	✗	✓	✗	✓	✗	✓	✗	✗	✗
6	All patients on acute medical and surgical units to be seen and reviewed by a consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate.	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
7	All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: • Critical – imaging and reporting within 1 hour; • Urgent – imaging and reporting within 12 hours; • All non-urgent – imaging and reporting within 24 hours.	✗	✗	✗	✗	✗	✗	✓	✓	✗	✗
8	All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week: • Critical patients – 1 hour; • Non-critical patients – 12 hours.	✓	✓	✗	✗	✗	✗	✓	✓	✗	✗
9	Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical or surgical unit. Subsequent transfer or discharge must be based on clinical need.	✗	✓	✓	✗	✓	✗	✓	✓	✓	✓
10	A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialties throughout the emergency pathway.	✓	✓	✗	✗	✗	✗	✓	✓	✗	✗
11	Patients admitted for unscheduled care to be nursed and managed in an acute medical or surgical unit, or critical care environment.	✓	✓	✓	✗	✓	✗	✓	✗	✓	✗
12	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. A policy is to be in place to access social services seven days per week. Patients to be discharged to their named GP.	✗	✓	✓	✗	✓	✗	✓	✓	✗	✓

No	Standard	KCH		SLHT-PRUH		SLHT-QEH		GSTT-ST		UHL	
		Medicine	Surgery	Medicine	Surgery	Medicine	Surgery	Medicine	Surgery	Medicine	Surgery
13	All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night.		✗		✓		✓		✗		✓
14	All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.		✗		✗		✗		✗		✓
15	All patients considered as 'high risk' to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. High risk is defined as where the risk of mortality is greater than 10%.		✓		✗		✗		✗		✓
16	All patients undergoing emergency surgery to be discussed with consultant anaesthetist. Where the severity assessment score is ASA3 and above, anaesthesia is to be provided by a consultant anaesthetist.		✗		✓		✗		✗		✓
17	a) The majority of emergency general surgery to be done on planned emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded.		✓		✗		✓		✗		✓
	b) Any operations that are carried out at night are to meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.		✗		✗		✗		✗		✓
18	All referrals to intensive care to be made from a consultant to a consultant.	✗	✗	✗	✗	✗	✗	✗	✗	✓	✓
19	A structured process to be in place for the medical handover of patients twice a day. These arrangements to also be in place for the handover of patients at each change of responsible consultant/medical team. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions.	✗	✓	✓	✗	✓	✓	✓	✓	✗	✓
20	Consultant-led communication and information to be provided to patients.	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
21	Patient experience data is captured, recorded and routinely analysed and acted on. Is a permanent item on board agenda and findings are disseminated.	✗	✓	✗	✗	✗	✗	✓	✓	✗	✓
22	All acute medical and surgical units to have provision for ambulatory emergency care.	✗	✓	✗	✗	✓	✓	✗	✓	✓	✓
23	Prompt screening of all complex needs inpatients to take place by a multi-professional team which has access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy.	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
24	Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes.	✗	✗	✗	✗	✓	✓	✗	✗	✓	✓
25	Hospitals admitting emergency patients to have access to comprehensive 24 hour endoscopy services that has a formal consultant rota 24 hours a day, 7 days a week	✓	✓	✗	✗	✗	✗	✓	✓	✗	✗
26	a) All hospitals dealing with complex acute medicine to have onsite access to levels 2 and 3 critical care (i.e. intensive care units with full ventilatory support).	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	b) All acute medical units to have access to a monitored and nursed facility.	✓		✓		✓		✓		✓	
27	Training to be delivered in a supportive environment with appropriate, graded consultant supervision	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓

33. The clinical advisory group and delegates at the acute workshops held on 11 and 24 September 2012 recognised that the challenges in delivering the London-wide standards for hospital-based acute emergency and maternity care would be a significant challenge for providers in south east London as no Trust currently met all of them. To meet these standards, hospitals would need to increase their consultant workforce (figure 6), which would not only present a financial challenge but clinicians also raised concerns about staff maintaining the required skill set with insufficient levels of activity.

Figure 6: Shortfall in consultant workforce in south east London

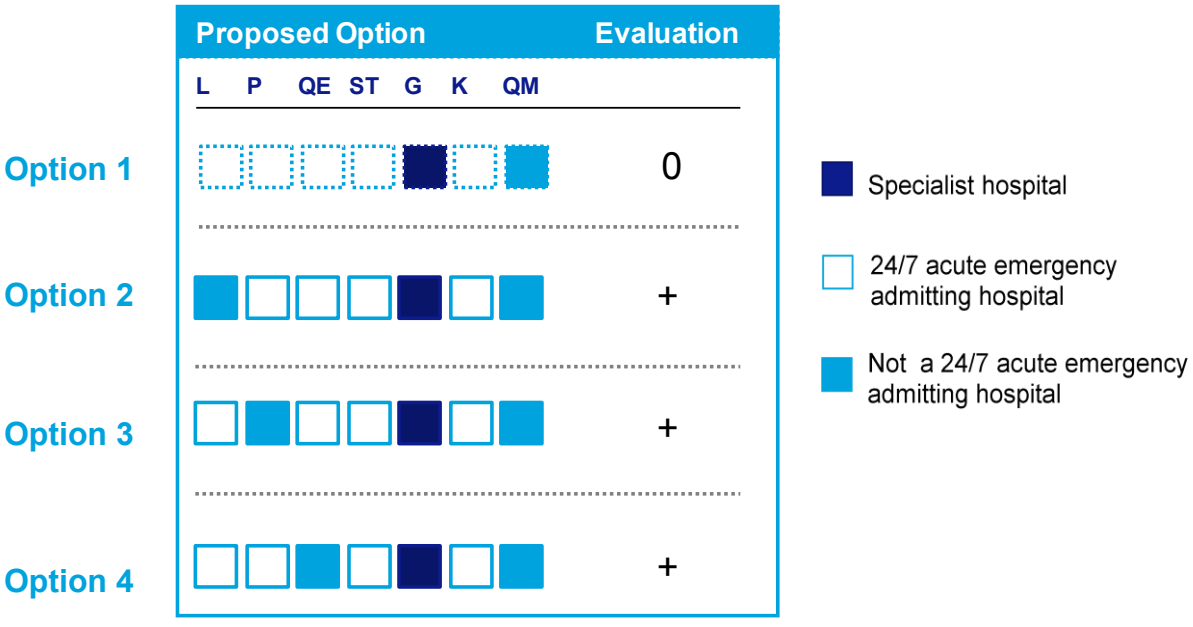
	Recommended consultant workforce	Shortfall in south east London (total)
Emergency general surgery	10 per site	8 consultants
Emergency medicine	12 per site	21 consultants
Paediatrics	10 per site	9 consultants
Obstetrics	21 per site	41 consultants

1B: Patient experience and estate quality

34. Indicators used to measure patient experience and estate quality were selected by the clinical advisory group as metrics regarded as the most meaningful and representative from the national NHS Patient Survey Programme, 2011/12 Survey of Inpatients, on behalf of the Care Quality Commission. For quality of estate, the metrics used were considered as indicators of overall patient satisfaction. Data were considered by the clinical advisory group to decide whether patient experience and estate quality scores would differentiate the options.

35. The clinical advisory group recommended that the options were to be rated equally – each Trust was constantly striving to improve the quality of its estate and enhance patient experience. Therefore each of the proposed options with four 24/7 acute emergency admitting hospitals would have a positive impact.

Figure 7: Evaluation of sub-criterion 1B – Patient experience and estate quality



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36. The clinical advisory group based this assessment on the principle that with recent investment across sites in south east London that were being evaluated, there was

no way to differentiate between the options on quality of estate. Additionally, patient experience was assumed to improve with four 24/7 acute emergency admitting hospitals as a consolidation of services would increase the scale of care, providing greater opportunity for improved training and professional standards to meet patients' needs.

2: Access to care

2A: Distance and time to access services

37. In order to evaluate the impact of each proposed option on distance and time to access services, the impact on the population weighted average travel times for options 2, 3 and 4 were considered by the clinical advisory group, in comparison to option 1. These were based on activity and travel time estimates for blue light travel, private car (am peak) and public transport (am peak).

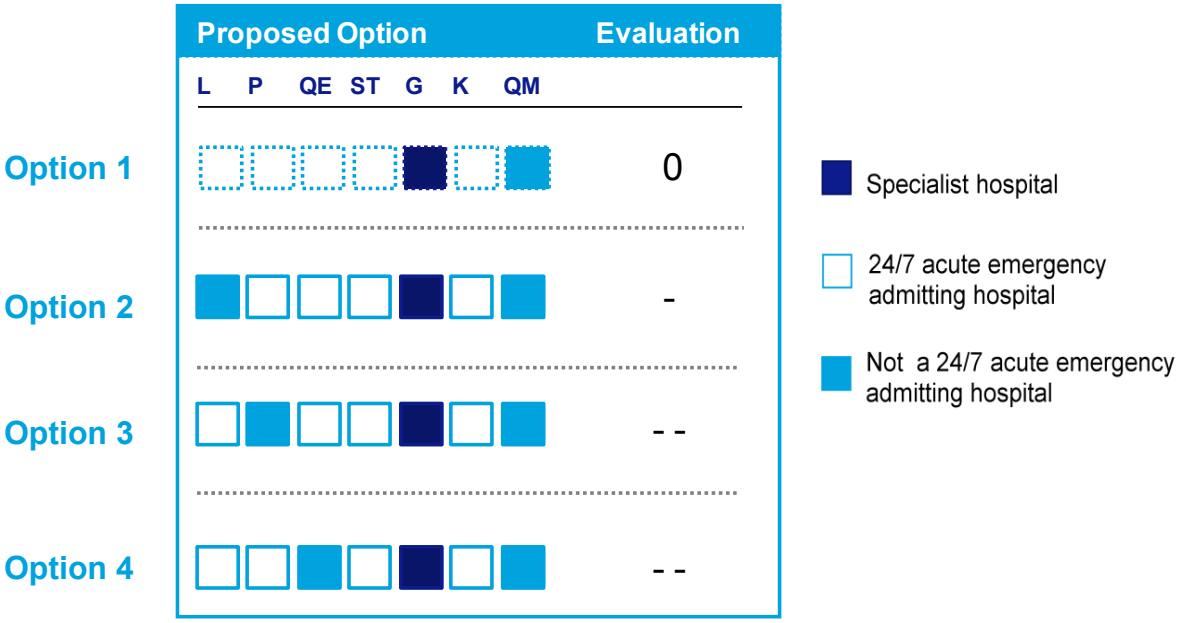
Figure 8: Change in weighted average travel time (minutes)

	Blue Light		Private Car (am peak)		Public Transport (am peak)	
	Average	95th Percentile	Average	95th Percentile	Average	95th Percentile
Option 2	1.4	1.3	2.2	2.0	2.7	1.1
Option 3	1.8	7.3	2.5	11.0	3.3	13.4
Option 4	1.8	4.0	2.6	6.0	3.4	11.4

Sources: Transport for London; HSTAT travel time model, TSA SEL travel time model

38. Options 2, 3 and 4 were scored negatively when compared to option 1, by the clinical advisory group. The clinical advisory group concluded that for all options with four 24/7 acute emergency admitting hospitals, travel times would be adversely affected compared to having five 24/7 acute emergency admitting hospitals. Furthermore, the negative impact would be greater for the options that proposed to change the configuration of services at Princess Royal University Hospital (option 3) and Queen Elizabeth Hospital (option 4).

Figure 9: Evaluation of sub-criterion 2A – Distance and time to access services



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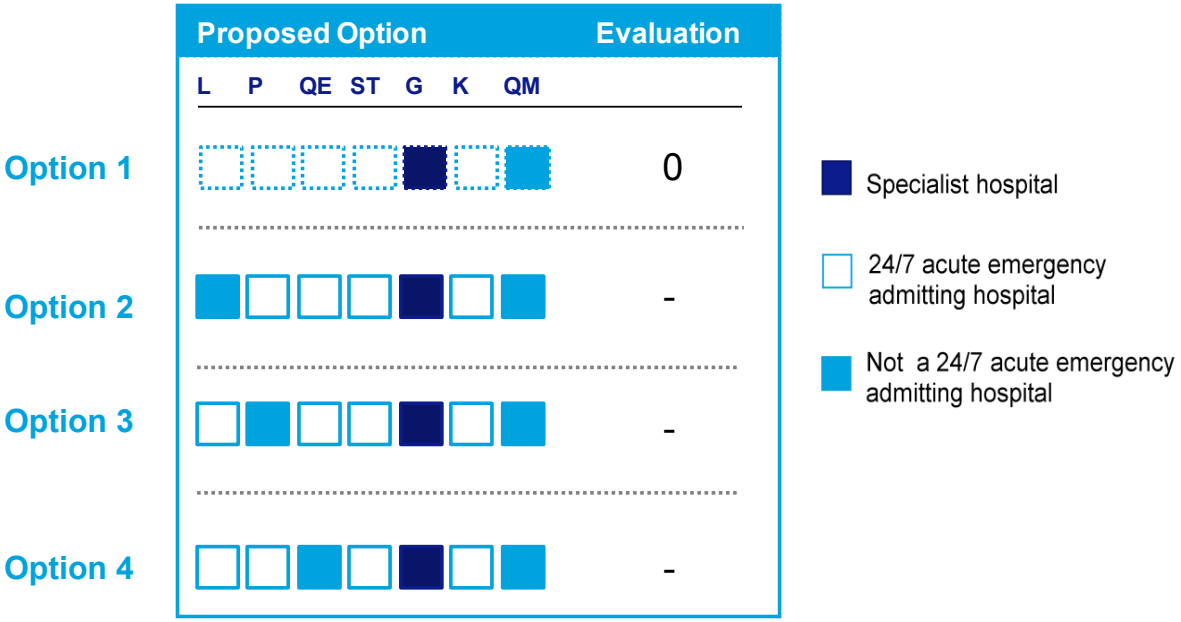
2B: Patient choice

39. In terms of the impact on patient choice, the indicator considered was the level of choice and ease of exercising that choice experienced by the patient at every stage of interaction with the hospital. All proposed options with four 24/7 acute emergency admitting hospitals impacted negatively compared to the option of developing five 24/7 acute emergency admitting hospitals.

Figure 10: Evaluation of sub-criterion 2B – Patient choice



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40. The clinical advisory group concluded therefore that each proposed option with the development of four 24/7 acute emergency admitting hospitals scored negatively against the option to develop five 24/7 acute emergency admitting hospitals, as each of them would result in a reduction of patient choice.

2C: Access to integrated services

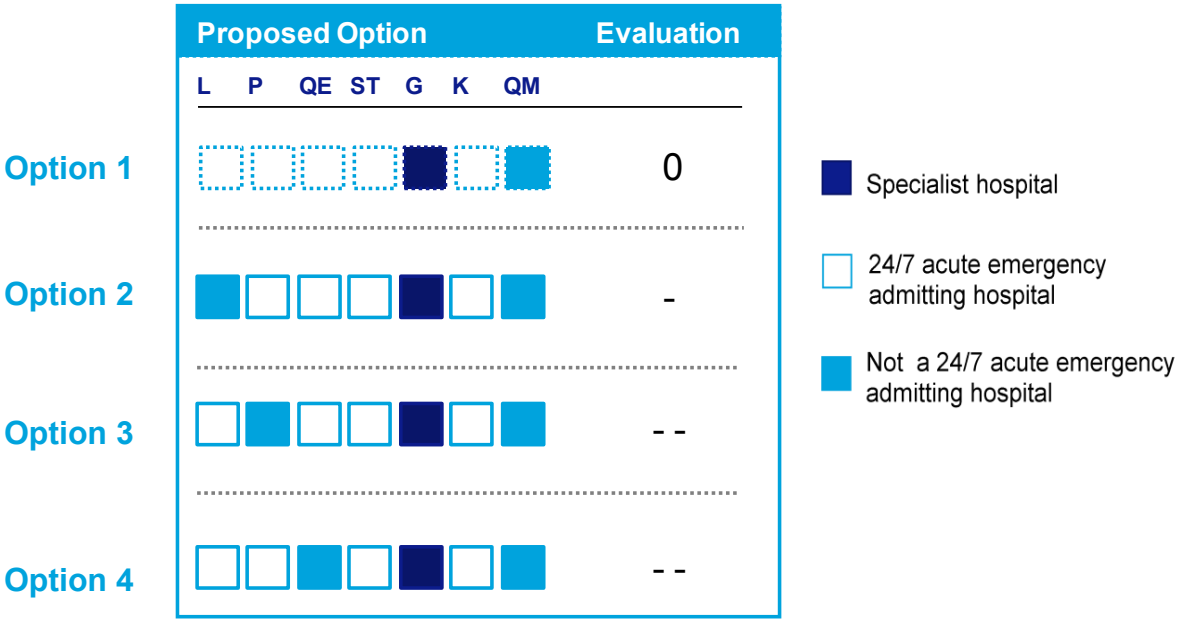
41. For access to integrated services, metrics to demonstrate the level and effectiveness of integrated care between a hospital site and community-based services were considered by the clinical advisory group.

42. The clinical advisory group highlighted that South London Healthcare NHS Trust was deemed to be the best performer when considering average length of stay for elderly patients, readmission rates and delayed transfers of care, all of which were considered to be good proxy measures for access to integrated services. The Trust had an average length of stay for elective patients of 4.0 days in 2011/12 and 9.9 days for non-elective patients – both of which were lower than the national average. 28-day readmission rates for the Trust in 2011/12 were 2.3% for elective patients and 11.4% for non-elective patients. With regard to delayed transfers of care, these occurred for 4.0% of patients living in the home boroughs of the Trust (Bromley, Bexley and Greenwich) and for 2.7% of patients living outside of these boroughs.

43. The clinical advisory group noted that University Hospital Lewisham's acute emergency average length of stay (10.5 days) and rates of delayed discharge (7% and 11% for home borough and non-home borough respectively) were some of the highest amongst the Trusts in south east London.

44. The options to develop four 24/7 acute emergency admitting hospitals scored negatively compared to the option to develop five 24/7 acute emergency admitting hospitals, with those options that propose not to have a 24/7 acute emergency admitting hospital at Princess Royal University Hospital (option 3) and Queen Elizabeth Hospital (option 4) deemed to cause the greatest deterioration in terms of access to integrated services.

Figure 11: Evaluation of sub-criterion 2C – Access to integrated services



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3: Value for money

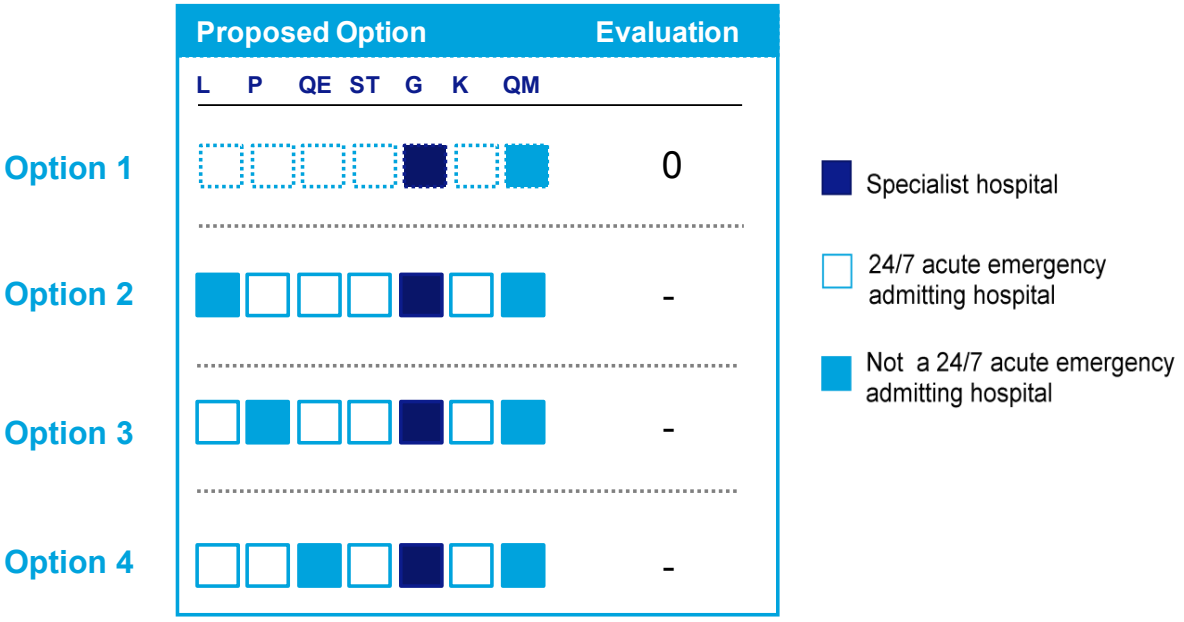
45. This assessment was undertaken by the finance, capital and estates group at its meetings on 27 September and 4 October.

3A: Capital cost to the system

46. The capital costs were identified as being £45m for option 2, £65m for option 3 and £102m for option 4. The key assumptions in assessing these costs (appendix M) were that:

- all mothballed beds are available for re-opening at no additional capital costs;
- the first 90 beds would cost £225k per bed;
- beyond 90 beds the cost per bed would rise to £600k a bed, reflecting the additional support structure required for such a large growth in capacity.

Figure 12: Assessment of sub-criterion 3A – Capital cost



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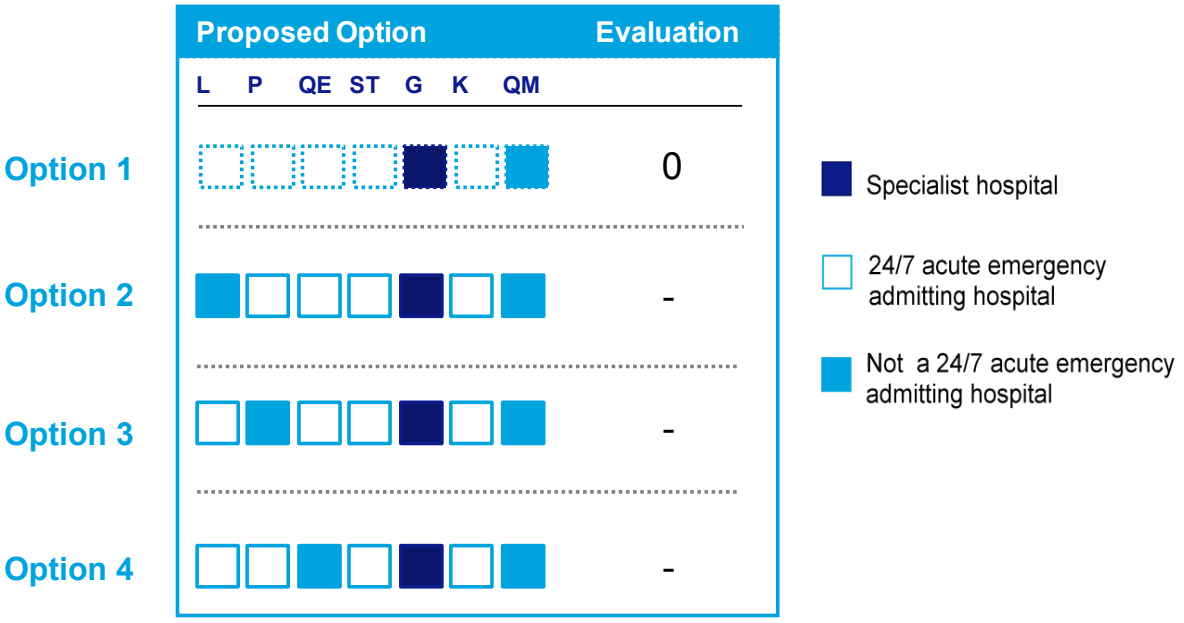
3B: Transition costs

47. At the time of the financial assessment of the options, the transition costs were identified as being £33m for option 2, £45m for option 3 and £41m for option 4, as double running costs of £250 per bed day for a year of implementation.

Figure 13: Assessment of sub-criterion 3B – Transition cost



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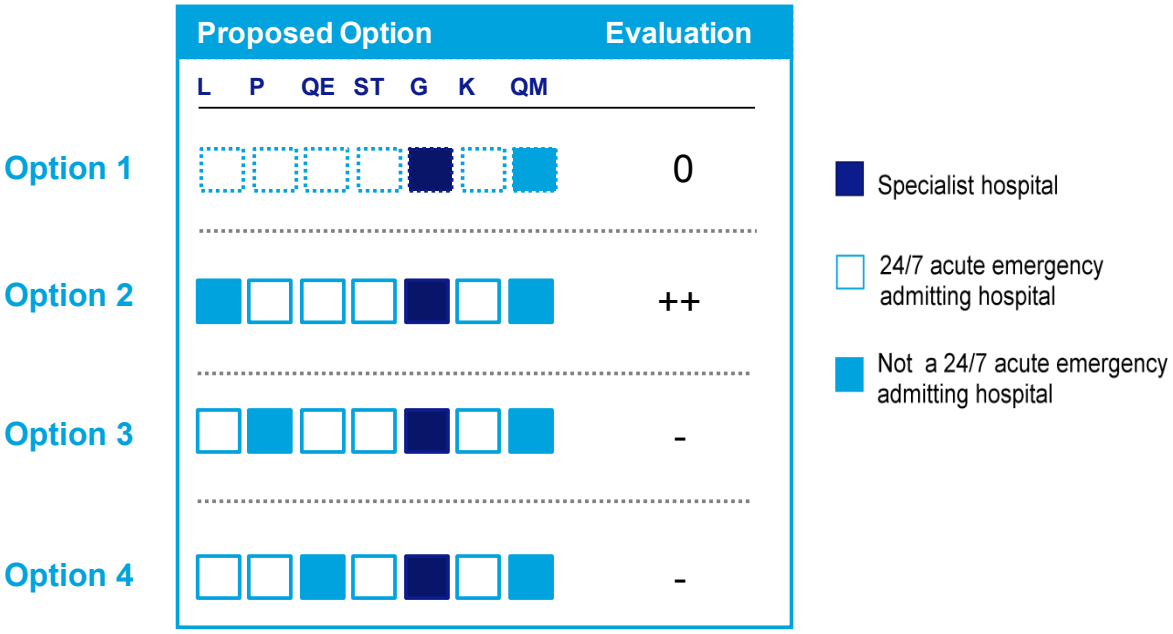
3C: Fixed cost and operational savings

48. At the time of the financial assessment of the options, the fixed cost savings were identified as being £29m (a year) for option 2. There was no impact for option 3 and an additional £4m cost for option 4. The key driver of this difference is the ability to dispose of considerable parts of the estate at University Hospital Lewisham estate under option 2.

Figure 14: Assessment of sub-criterion 3C – Fixed cost and operation savings



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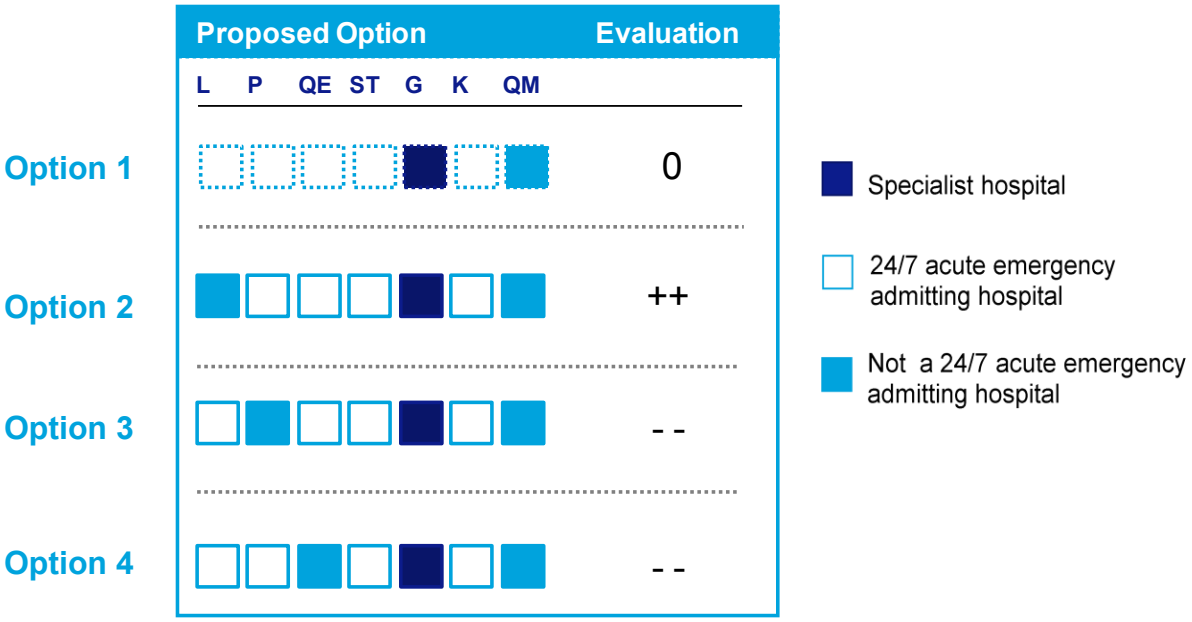
3D: Net present value (relative to the current forecast)

49. At the time of the financial assessment of the options, the net present value (when compared to the current forecast) was identified as being +£283m for option 2 and a net present value of -£107m for option 3 and -£278m for option 4. This assessment was conducted over a 20-year period, with a 3.5% discount rate with the assumption of no terminal value. Other time periods were also looked at, with no material difference to the overall assessment.

Figure 15: Assessment of sub-criterion 3D – Net present value (relative to the current forecast)



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3E: Site viability

50. At this stage of the options evaluation process, none of the proposed options resulted in the financial viability of any of the hospital sites. Financial viability of an individual site is only achieved through a combination of actions.

4: Deliverability

4A: Workforce

51. In order to evaluate each of the options in terms of the impact that each would have on the future workforce, the clinical advisory group considered a qualitative assessment based on overall turnover, sickness and staff satisfaction rates (figure 16). In doing so, each of the options was rated equally.

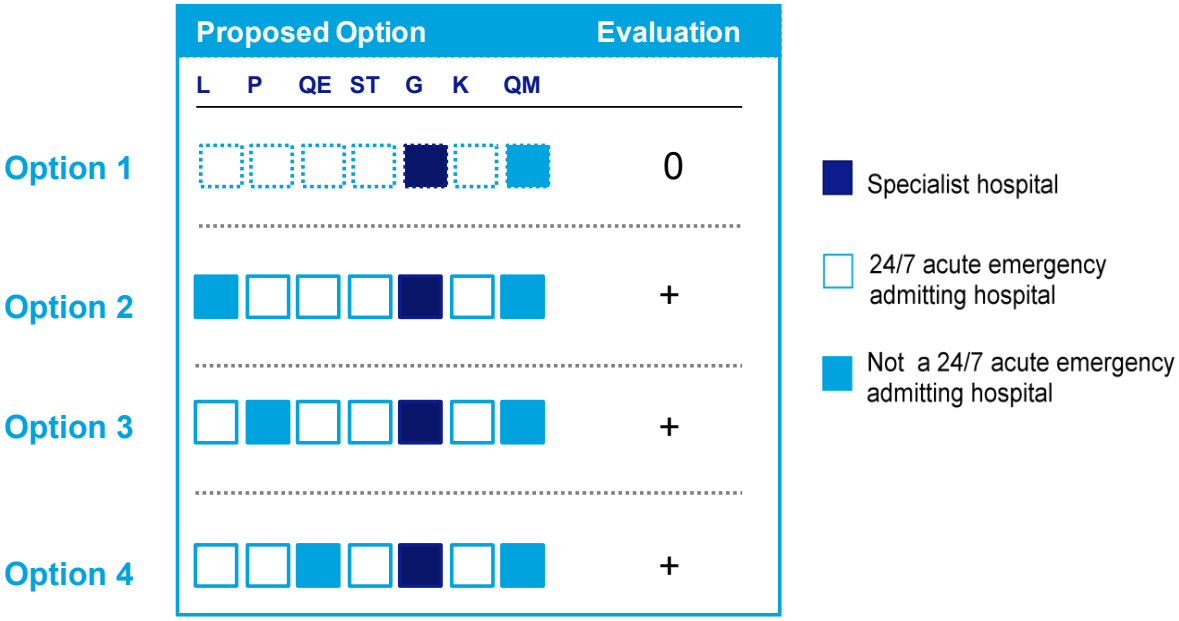
Figure 16: Turnover, sickness and staff satisfaction rates at south east London trusts

Sources: NHS Information Centre (workforce section) January to March 2012, Sickness Rates in the NHS; National NHS Staff Survey 2011, National NHS Staff Survey Co-ordination Centre, Department of Health

52. The clinical advisory group noted that Guy's and St Thomas' NHS Foundation Trust was the strongest performer on staff turnover and staff satisfaction, compared to South London Healthcare NHS Trust and Lewisham Healthcare NHS Trust. South London Healthcare NHS Trust had low performance when it came to staff satisfaction and along with all trusts in south east London had above average turnover rates. Additionally, Lewisham Healthcare NHS Trust had the highest turnover and sickness rates and staff satisfaction levels close to the national average.

53. The clinical advisory group advised that consolidating acute hospital services on to fewer sites would make it easier to recruit, motivate and retain a high quality, highly trained workforce. Additionally, such consolidation would help generate additional scale to support training and development of staff better and in a sustainable way. The group also highlighted that the financial stability of an organisation would make it easier to attract and retain staff. The difficulty in forecasting future trends in this area and, hence, differentiating between the options, resulted in the options to develop four 24/7 acute emergency admitting hospitals being scored equally and more positively than the option to develop five 24/7 acute emergency admitting hospitals.

Figure 17: Evaluation of sub-criterion 4A – Workforce



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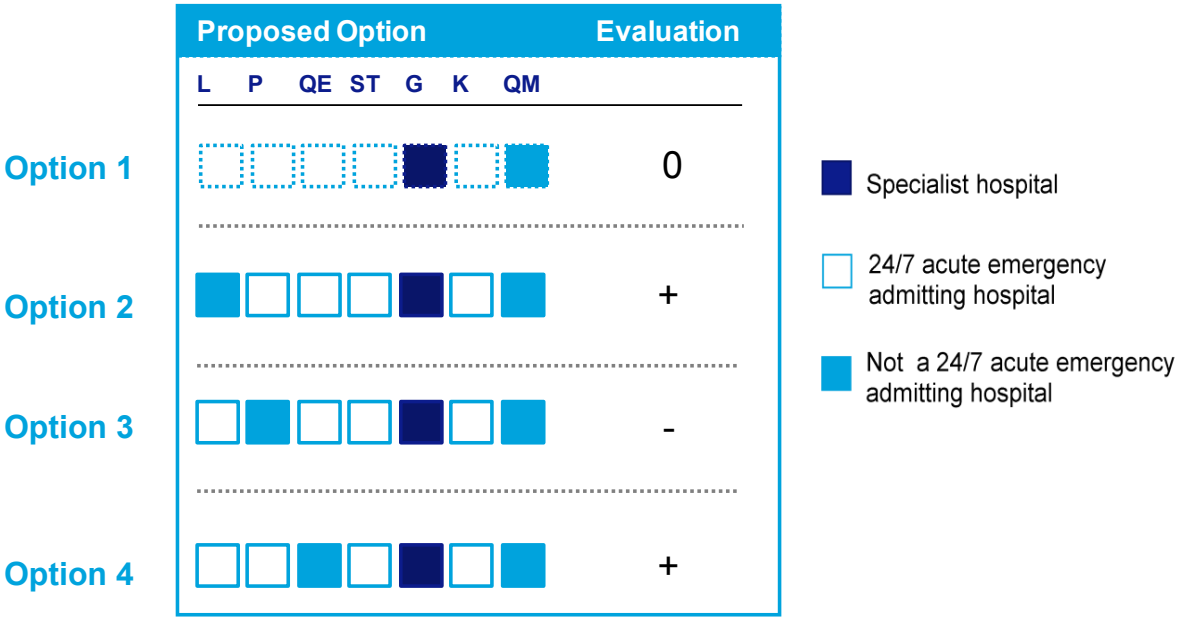
4B: Expected time to deliver

54. The expected timescale for implementing each of the proposed options was not fully evaluated by the clinical advisory group. The clinical advisory group was advised that the quantity of bed movements would form the basis of the assessment of the time required to implement the changes.

4C: Co-dependencies with other strategies

55. To consider the impact of the proposed options on their co-dependencies with other strategies, the clinical advisory group chose to look at the strategic interface between the London Stroke Strategy and the development of 24/7 acute emergency admitting hospital. The clinical advisory group highlighted that any change in the configuration of services at Princess Royal University Hospital would impact negatively. It noted the need to have an A&E department and supporting infrastructure on this site to support the hyper-acute stroke unit located at the Hospital, which due to its geographical location was the only option for hyper-acute stroke services in this part of south east London. This proposed option (option 3) was therefore scored lower. The other two proposed options (options 2 and 4) for developing four 24/7 acute emergency admitting hospitals were rated equally.

Figure 18: Evaluation of sub-criterion 4C – Co-dependencies with other strategies



Key: L - University Hospital Lewisham; P - Princess Royal University Hospital; QE - Queen Elizabeth Hospital; ST - St Thomas' Hospital; G - Guy's Hospital; K - King's College Hospital; QM - Queen Mary's Hospital Sidcup

56. The clinical advisory group based this assessment on their opinion that the proposed options not to develop either University Hospital Lewisham (option 2) or Queen Elizabeth Hospital (option 4) as a 24/7 acute emergency admitting hospital could not be differentiated between. These options therefore scored positively against the option to develop five 24/7 acute emergency admitting hospitals.

57. At this stage, due to the inter-dependency with the changes implemented as a result of the pan-London stroke strategy the clinical advisory group recommended that the proposed option to not develop Princess Royal University Hospital (option 3) as a 24/7 acute emergency admitting hospital should no longer be an option for consideration. The rationale for this was that the Princess Royal University Hospital is the location of a hyper-acute stroke unit, providing specialist stroke care to the population of south east London. This was agreed and developed following the pan-London consultation on stroke services in London in 2009. At the time decisions were taken, it was agreed that there was no other hospital site in this part of London that could meet the clinical criteria and be within a 30-minute 'blue light' ambulance journey, the travel time standard established by clinicians as the proposals for improving stroke services were developed.

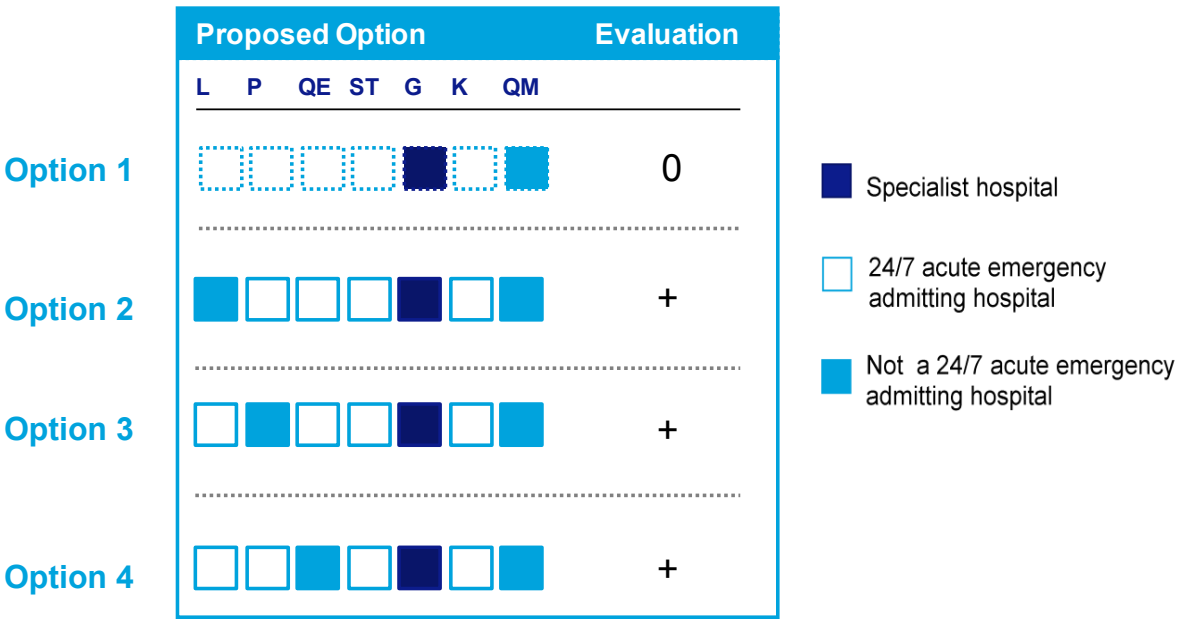
5: Research and education

58. In order to consider the impact that each of the proposed options would have on research and education, the assessment of the degree to which each proposed option would disrupt or damage current and future potential research and education - measured by a percentage of total spend on education impacted by changes - was considered by the clinical advisory group. Additionally, the assessment of the overall

satisfaction levels, as indicated by General Medical Council trainee surveys and staff surveys, was taken into consideration.

59. The evaluation of the proposed options highlighted that consolidation of services would concentrate expertise and opportunities for research and education. Together, this would provide an improved environment for education and therefore scored positively. Disruption to nursing education was cited as an important factor, but it was recognised that was difficult to assess. The clinical advisory group recommended combining the assessment of the impact of the options on research and education into one, so as not to give the criterion disproportionate weight in the overall assessment

Figure 19: Evaluation of sub-criterion 5 – Research and education



Key: L - University Hospital Lewisham; P - Princess Royal University Hospital; QE - Queen Elizabeth Hospital; ST - St Thomas' Hospital; G - Guy's Hospital; K - King's College Hospital; QM - Queen Mary's Hospital Sidcup

60. The clinical advisory group advised that each of the options to develop four 24/7 acute emergency admitting hospitals scored equally and positively compared to developing five 24/7 acute emergency admitting hospitals.

Weighting of the evaluation criteria

61. Weighting of the options evaluation criteria was considered by the clinical advisory group in line with input from clinicians and patient representative groups, with the overriding view being that quality of care was the most important criteria. It was therefore agreed that the best approach would be to double the weighting of scores on quality of care, in effect resulting in each of the two sub-criteria – clinical effectiveness and patient experience and estate quality – having equal weighting to the remaining criteria.

Developing 24/7 acute emergency admitting hospitals

62. Following the recommendations from the clinical advisory group that St Thomas' Hospital, King's College Hospital and Princess Royal University Hospital should be developed as 24/7 acute emergency admitting hospitals, there were three remaining options, Queen Elizabeth Hospital to be developed as a 24/7 acute emergency admitting hospital or University Hospital Lewisham to be developed as a 24/7 acute emergency admitting hospital, or the status quo.

63. The clinical advisory group concluded that the population of south east London would be best served by four hospitals providing emergency care for the most critically unwell.

64. The non-financial and financial evaluation of the option to develop University Hospital Lewisham as a 24/7 acute emergency admitting hospital (option 2) resulted in a score of plus 6 (i.e. the sum of the pluses and the minuses against this option). The non-financial and financial evaluation of the option to develop Queen Elizabeth Hospital as a 24/7 acute emergency admitting hospital (option 4) resulted in a score of minus 3.

65. Figure 20 shows the full scoring of the remaining options against the non-financial and financial criteria.

Figure 20: Evaluation scores

Quality scores were multiplied by 2 to double-weight this criteria

■ Specialist hospital ☐ 24/7 acute emergency admitting hospital ■ Not a 24/7 acute emergency admitting hospital

++ High evaluation
- - Low evaluation

L	P	QE	ST	G	K	QM	Quality of care (weighted x2): Clinical effectiveness	Quality of care (weighted x2): Estate quality and patient experience	Access: Distance and time to access services	Access: Patient choice	Access: Access to integrated services	Value for money: Capital cost to the system	Value for money: Transition on costs	Value for money: Fixed cost & operational savings	Value for money: Net Present Value	Value for money: Provider viability	Deliverability: Work-force	Deliverability: Expected time to deliver	Deliverability: Co-de-pendencies with other strategies	Research & Education: Conducive to research & education	Sum of pluses and minuses
☐	☐	☐	☐	■	☐	■	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
■	☐	☐	☐	■	☐	■	++	++	-	-	-	-	-	++	++	N/A	+		+	+	6
☐	■	☐	☐	■	☐	■	++	++	- -	-	- -	-	-	-	- -	N/A	+		-	+	-5
☐	☐	■	☐	■	☐	■	++	++	- -	-	- -	-	-	-	- -	N/A	+		+	+	-3

L: University Hospital Lewisham, P: Princess Royal University Hospital, QE: Queen Elizabeth Hospital, ST: St Thomas' Hospital, G: Guy's Hospital, K: King's College Hospital, QM: Queen Mary's Hospital

66. The outcome of the evaluation process was tested with the TSA advisory group and reviewed by the external clinical panel. The evaluation identified only one clinically and financially viable configuration developing 24/7 acute admitting emergency hospitals in south east London. The option to develop Queen Elizabeth Hospital as a 24/7 acute emergency admitting hospital (option 4) was considered in full, but discounted as it had a more detrimental impact on access and the financial viability of the health economy.

67. On this basis, a draft recommendation was put forward for the TSA's draft report that 24/7 acute emergency care should be provided at four sites – King's College Hospital, St Thomas' Hospital, Queen Elizabeth Hospital and Princess Royal University Hospital – and these hospitals should be developed as 24/7 acute emergency admitting hospitals to meet the agreed London-wide clinical quality standards. Alongside this, University Hospital Lewisham, Guy's Hospital and Queen Mary's Hospital should provide urgent care for those patients that do not need to be admitted to hospital. It was also recommended that emergency services for those patients suffering from a major trauma, stroke, heart attack and complex vascular problems should not change from the current arrangements, which means:

- major trauma services at King's College Hospital;
- hyper acute stroke services at King's College Hospital and Princess Royal University Hospital;
- heart attack services at St Thomas's Hospital and King's College Hospital; and
- emergency vascular services at St Thomas's Hospital.

Consultation responses

68. Responses to consultation from commissioners were broadly supportive of the TSA's recommendation that any future configuration of services in south east London would need to meet the London-wide clinical standards for emergency care. Bromley, Greenwich, Lambeth and Southwark CCGs all endorsed the need for consolidation of services to achieve this.

69. Feedback received from Lewisham CCG during the consultation recognised the need to improve the quality and safety of services by delivering the London clinical quality standards and, therefore, the need for the configuration of acute services to be agreed in line with the London clinical dependency framework (see annex 2). While the recommendation for University Hospital Lewisham to cease providing emergency services and potentially changing obstetric-led births was not supported by Lewisham CCG and other local stakeholders during consultation, they were unable to put forward a viable alternative.

70. An alternative option that Queen Elizabeth Hospital, rather than University Hospital Lewisham, should operate in this way was fully considered but discounted, as implementing that option would have a more detrimental impact both on access and on the financial viability of the health economy.

71. Many of the consultation responses did not support the recommendations, in particular the proposal that A&E services should no longer be provided at University Hospital Lewisham (noting that a large proportion of consultation respondents were Lewisham residents).

72. A significant proportion of respondents were concerned about access to A&E services from the Lewisham borough to the four proposed sites for south east

London. Travel times had been analysed in detail using Transport for London's Health Service Travel Analysis Tool and implementing the proposals for emergency services would increase the journey time to reach an A&E across south east London by an average of approximately one minute for those in a 'blue light' ambulance, two minutes for those using private transport and three minutes for those using public transport. This is shown in figure 21, which also includes the impact on travel time for those whose journeys are relatively long currently (the 95th percentile)[1].

Figure 21: Impact of implementing the proposals on travel times for the population of south east London

Mode of transport:	Weighted average (min)			95th percentile (min)		
	Current	Proposed	Change	Current	Proposed	Change
'Blue light' ambulance	15.4	16.8	1.4	24.0	25.3	1.3
Private transport	23.0	25.2	2.2	36.0	38.0	2.0
Public transport	32.9	35.7	2.7	52.5	53.6	1.1

73. As the proposed changes are for those who are critically unwell, travel times to emergency services for 'blue light' ambulances are very important. Clinicians advising the London-wide programme to improve stroke services concluded that the journey time to the relevant emergency centre should be no more than 30 minutes in a 'blue light' ambulance. Similarly, for a major trauma, clinicians concluded that the journey time should be no more than 45 minutes.

74. Using 30 minutes as the benchmark for accessing emergency services, figure 22 shows the proportion of patients in south east London within 30 minutes of one or more A&E department in a 'blue light' ambulance if the recommendation were to be implemented.

Figure 22: Access to A&E services for the population of south east London

Number of A&Es within 30 minutes in a 'blue light' ambulance (nearest 5%)	1 or more	2 or more	3 or more
Current	>95	>90	>75
If draft recommendation 5 were implemented	>95	>85	>65

75. Many of the concerns raised during consultation focused on access to A&E services for Lewisham residents to the proposed four acute emergency admitting hospitals. As shown in figure 22, travel time analysis undertaken confirms that travel times to A&E departments after implementation of the recommendation are within the acceptable limit. However, there are increases in travel times for some residents of

[1] Explanatory note: the 95th percentile is used to consider those who have the longest travel time; in doing this a point at the 95th percentile (where 1 is a short travel time and 100 is a long travel time) is used in order to prevent data outliers distorting the result.

Lewisham, with the weighted average travel time for ‗blue light' ambulance journeys increasing by seven minutes, as shown in figures 23 and 24.

Figure 23: Impact of recommendation on travel times for the population of Lewisham

Mode of transport:	Weighted average (min)			95th percentile (min)		
	Current	Proposed	Change	Current	Proposed	Change
'Blue light' ambulance	13.2	20.6	7.4	18.1	26.8	8.7
Private transport	19.7	30.7	11.0	27.0	40.0	13.0
Public transport	26.7	40.8	14.1	40.1	51.2	11.1

Figure 24: Access to A&E services for the population of Lewisham

Number of A&Es within 30 minutes in a 'blue light' ambulance (nearest 5%)	1 or more	2 or more	3 or more
Current	>95	>95	>95
If draft recommendation 5 were implemented	>95	>95	>70

76. Travel times to emergency services in south east London, including for the residents of Lewisham, would continue to be very good if the proposed changes were implemented. Put in the context of access to A&E services nationally, while access for many residents of the London borough of Lewisham is worse than at present under this recommendation, it is still much better than the access many residents across England currently have to A&E services.

77. Concerns were raised during consultation about the capacity of the remaining four hospitals to take on additional activity after the changes to emergency care are implemented. This has been considered, and capital investment of £37m, for expanding A&E departments and the number of emergency beds to cope with additional demand at these hospitals, has been factored into transition costs. It is also expected that some staff will also transfer, so that there will be sufficient capacity in the system to ensure no negative impact on the quality of services or waiting times in A&E departments. Other changes, including a reduction in average lengths of stay and improvements in the provision of community-based care, will also help to reduce the demand and therefore minimise the increased pressure on the other hospital sites. The need to make such changes was raised in meetings during the consultation and will form part of the three-year transitional change programme.

78. Significant concerns were raised during consultation about the lack of commentary on and specific proposals on paediatric services. In the development of the draft recommendations, the clinical advisory group and the external clinical panel did discuss paediatrics and a workshop was held on 24 September 2012 specifically to consider the clinical quality standards for paediatrics and potential implications of implementation. All stakeholders endorsed the principles of the clinical quality

standards and these formed the basis for the recommendation on hospital configuration.

79. Throughout discussions it was clear that sustaining the current number of paediatric inpatient units in south east London would not be viable, due to the volumes of patients and the shortfall in consultant workforce. During the clinical advisory group meeting of 10 October 2012 and the external clinical panel meeting of 6 December 2012, it was considered whether the units should be consolidated further than the recommended consolidation of acute admitting sites and options for two or three paediatric inpatient units were considered.

80. However, when considering the need to maintain good access and ensure the required clinical dependencies were in place it was concluded that, at this stage, paediatric inpatient units should be recommended at each acute admitting hospital. Although it was raised at these meetings that the local NHS may need to consider further consolidation of these services at some point in the future.

81. Responses to the consultation highlighted that paediatric services at University Hospital Lewisham are held in high regard for their quality and the strong integrated care pathways that have been developed with community services, such as those for patients with chronic obstructive pulmonary disorder. Clinical and non-clinical working groups highlighted that careful planning would be needed to ensure these pathways are maintained in the development of the services that are proposed to remain at University Hospital Lewisham for children that do not require admission and that robust protocols are developed for those that do require admission. It was also proposed that a paediatric ambulatory service is developed as part of the urgent care service at University Hospital Lewisham.

82. Clinicians also highlighted that particular attention would need to be paid in implementing the recommended changes to the building of strong relationships and clear referral pathways between social care services and the four acute emergency admitting hospitals, thus ensuring that safeguarding children – and vulnerable adults – is at the forefront of service planning.

83. Analysis included in the draft recommendation suggested that an estimated 77% of the people who currently attend University Hospital Lewisham‘s A&E and urgent care services would continue to be suitably treated at the University Hospital Lewisham site. A number of responses to consultation suggested that this activity estimation was too high. Therefore, further analysis was undertaken and, based on practice elsewhere in London; a revised figure of 50% has been used for the modelling that underpins the TSA‘s recommendation. This revised figure was considered and endorsed by the external clinical panel as a more achievable figure.

84. The multiplicity of offerings for urgent and emergency care is currently the subject of work being undertaken by the Medical Director of the NHS, the aim of which is to eradicate the confusion that many people experience in understanding which

emergency and urgent care services are provided at different places. Reflecting on what the public said during the TSA's consultation, emergency and urgent care services across all sites in south east London should be developed in line with the output from the Medical Director's work as it emerges.

85. The types of conditions urgent care services will be able to treat include:
    - Many illnesses and injuries not likely to need a stay in hospital;
    - Minor fractures (breaks);
    - Stitching wounds;
    - Draining abscesses that do not need general anaesthetic; and
    - Minor ear, nose, throat and eye infections.

86. These services will be equally applicable to paediatric patients and for both – adults and paediatrics – where patients need to be admitted to hospital; robust 'treat and transfer' protocols will apply. These currently exist and are found to be effective in ensuring patients are transferred to the correct location for their condition, for example heart attack patients who are transferred to one of eight heart attack centres in London for appropriate specialist treatment.

Health and Equalities Impact Assessment: urgent and emergency care

87. The Health and Equalities Impact Assessment (HEIA) has stated that reduced access to A&E services can disproportionately impact on economically and socially deprived groups. This impact will be mitigated by the improved quality of care at those hospitals that will provide emergency department services in the future. The HEIA states: "*The change in travel time, relating to emergency and urgent care currently at University Hospital Lewisham, is not statistically correlated with economic and social deprivation*", although there is an impact on those considered in the broader category of "health deprivation".

88. The entire socially and economically deprived population in south east London will continue to be within around 30-minutes 'blue light' ambulance journey of an A&E department. However, as a result of the changes to urgent and emergency care this section of the population will also be impacted by increased costs of both private and public transport journeys and this point is particularly relevant for patients who will have to travel from care. As outlined in the HEIA, in order to mitigate this impact, more information should be made available on cost support schemes already in place, including the Healthcare Travel Costs Scheme which entitles patients who receive income support and income based jobseekers allowance to full or partial reimbursement of travel expenses to and from care. Although it is noted that this may not help deprived relatives and carers, and other mechanisms may need to be considered. Discussions have begun with Transport for London that could also lead to changes in travel routes, which might reduce travel times and costs.

89. In terms of age, children (0-15 years) are associated with high, and growing, levels of A&E usage. The HEIA report states: *"…the majority of children currently attending A&E at University Hospital Lewisham could continue using the urgent care services. Through streamlining A&E attendances and ensuring that children with minor conditions are treated by urgent care services or by their own GP, there is a potential positive impact on health outcomes overall as critical A&E paediatric specialists are freed to deal with the most serious conditions in a small number of hospitals*".

90. The model of paediatric care to be delivered at University Hospital Lewisham will be based on the population's need and developed by drawing on the excellent service currently provided. Throughout the transitional period improved information will be supplied to parents to ensure they are aware of the range of services to be provided at the site.

91. Older people are also relatively frequent users of A&E services and are more than twice as likely as others to be admitted to hospital following an A&E attendance. Therefore, the proposed changes have significant implications for continuity of care for these patients. However, older people who would currently present with problems at University Hospital Lewisham could benefit from being admitted to a step-up facility there, or will need to be transferred and admitted to another hospital before being transferred back to a step-down facility at University Hospital Lewisham. These multiple interfaces will require clear protocols and robust systems in place to ensure adequate continuity of care is maintained.

92. When considering race, the HEIA identifies that stroke and hypertension are disproportionately prevalent amongst people from black, asian and minority ethnic (BAME) groups. However, these services are already centralised and, as such, there is no expected impact of the proposed changes on health outcomes for these patients. Sickle cell anaemia tends to be more prevalent amongst people from BAME groups and has a high level of prevalence in south east London. The condition presents in crisis in A&E and requires appropriate diagnosis and often rapid treatment. Therefore, it will be important to ensure that the skills and expertise of staff providing urgent care at University Hospital Lewisham are maintained and that the capacity to treat patients at the four remaining A&E departments is expanded as appropriate.

93. BAME groups tend to have lower levels of GP registration rates than the population as a whole and are more likely to attend urgent care settings, to access healthcare. The HEIA shows a correlation between BAME populations and those negatively impacted by travel time changes. It will be important to ensure that there is sufficient relevant information on the services provided if the recommendation is accepted and implemented, and that this information is accessible for BAME groups.

94. Mental health and coronary heart disease are particular health issues for people with learning disabilities. The proposed changes will have no negative impact for these patients. South east London as a whole has high rates of emergency admissions for patients with respiratory disease, another significant issue for people with learning disabilities. This service should be better managed in primary and community settings and implementation of the Community Based Care strategy will have a positive impact on the quality of care received by this group.

95. Similar to other groups with protected characteristics, there is a correlation between this group and negative impact on travel times. It will be important to ensure that measures taken to improve information available are developed with regard to those with disabilities. Small improvements to infrastructure can have significant positive health impacts, for example an induction hearing loop should be installed at Queen Elizabeth Hospital.

Recommendation

96. Having regard to the responses to the consultation, the HEIA, and that no viable alternative solution was proposed, the TSA‘s recommendation is that 24/7 acute emergency care should be provided at four sites in south east London – King‘s College Hospital, St Thomas‘ Hospital, Queen Elizabeth Hospital and the Princess Royal University Hospital – and these hospitals should be developed as 24/7 acute emergency admitting hospitals to meet the minimum London-wide clinical quality standards. This view was also endorsed by the external clinical panel in light of their consideration of the consultation responses.

97. Services at University Hospital Lewisham, Guy‘s Hospital and Queen Mary‘s Hospital should provide urgent care for those that do not need to be admitted to hospital. Emergency care for those patients suffering from a major trauma (provided at King‘s College Hospital), stroke (provided at King‘s College Hospital and the Princess Royal University Hospital), heart attack (provided at St Thomas‘ Hospital and King‘s College Hospital) and complex vascular problems (provided at St Thomas‘ Hospital) will not change from the current arrangements.

Maternity services

98. As the clinical advisory group was undertaking the full evaluation of the options for developing 24/7 acute emergency admitting hospitals in south east London, Lewisham Healthcare NHS Trust proposed the retention of obstetric and co-located midwifery-led maternity services on the University Hospital Lewisham site. Two options were therefore presented in the TSA's consultation, to ensure the provision of high quality of care for women needing to be in hospital during pregnancy and for women when giving birth. Both of these options include ante-natal and post-natal care provided, as now, at current hospital sites and in community settings.

99. Therefore, the two options were whether south east London has four or five hospital sites providing obstetric-led services:

    i) *The option of four hospital sites:* King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas' Hospital would all provide obstetric-led births, meaning these services are co-located with full emergency critical care. This co-location was the initial proposal developed by clinicians and endorsed by the external clinical panel. However, this option would mean the four sites would need to increase capacity which would require some investment.

    ii) *The option of five hospital sites:* King's College Hospital, Princess Royal *University* Hospital, Queen Elizabeth Hospital, St Thomas' Hospital and University Hospital Lewisham would all provide obstetric-led births. In this option, University Hospital Lewisham would not have full emergency critical care co-located with its maternity unit; instead it would have a surgical high dependency unit with obstetric anaesthetists present. This means the service would only take lower risk obstetric-led births. This option would provide better access to obstetric-led services in south east London. It would also provide more resilience to the needs of a growing population.

Forecasting births in south east London

100. As was outlined in the TSA's draft report, there is a range of views on the expected birth rate in south east London over the next 3 to 10 years. It was recommended that agreement should be reached on the best projection so that correct assumptions on capacity requirements could be used to inform the final recommendation.

101. During the development of the draft recommendation, the TSA had gathered from each provider Trust their forecast births for 2012/13. These were validated by the finance, capital and estates advisory group and shared with the clinical advisory group. The baseline data (shown as totals for each of the five hospitals with maternity services in south east London) is set out in figure 25.

Figure 25: Forecast births in south east London 2012/13

Hospital site	Births in 2012/13*
LEW	4,222
PRUH	4,603
QEH	4,386
STT	6,630
KCH	5,500
Total	25,341

* 2012/13 was based on mid-year figures and extrapolated to provide a full-year forecast

Key: LEW - University Hospital Lewisham; PRUH - Princess Royal University Hospital; QEH - Queen Elizabeth Hospital; STT - St Thomas' Hospital; KCH - King's College Hospital

102. The TSA's forecast birth rates for 2013/14 and 2014/15 were based on commissioners' plans for those years (which themselves were based primarily on Greater London Authority (GLA) forecasts). The birth rates forecast for subsequent years were then based on Office of National Statistics (ONS) data on population projections.

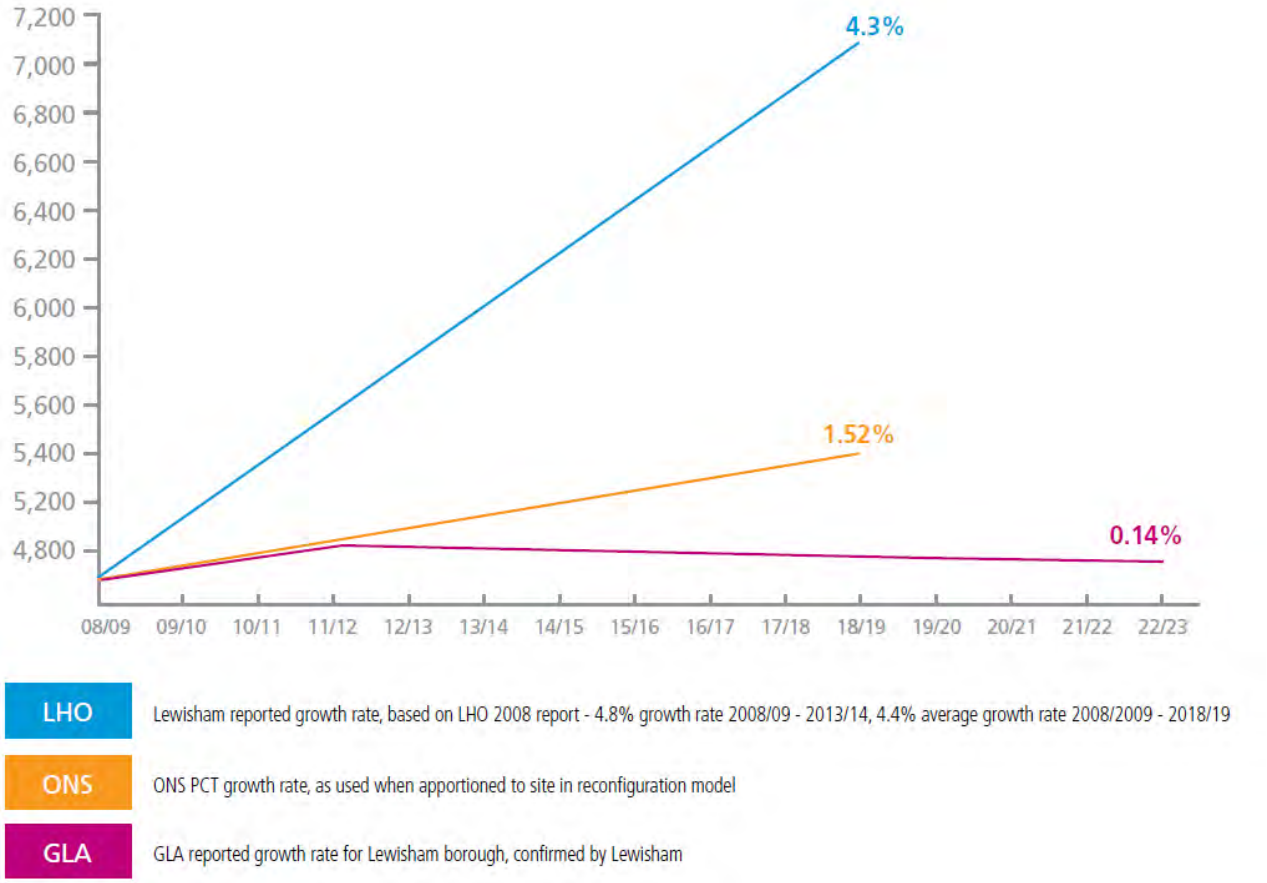
103. Lewisham Healthcare NHS Trust was concerned that the TSA's forecast for birth rate numbers in 2015/16 was an underestimation. This was based on the Trust's own forecast, based on its review of Hospital Episode Statistics (HES) data for the three years 2009/10 to 2011/12 and, for 2012/13 and beyond, based on London Health Observatory's (LHO's) borough-level projections, which had been published provided in 2008[2].

104. The TSA's team considered that because HES data, while a useful data repository, is updated intermittently by Trusts and not used as a basis for contracting, Trust-reported data was a more accurate basis for forecasting birth rates in 2012/13. These forecast birth rates were then compared to other data available, including the GLA's and the LHO's. The LHO forecasts were deemed inaccurate as, when compared with actual activity from 2008/09 (the base year) to 2011/12, LHO data shows significantly higher forecast birth rates than actually observed.

105. Having discounted the LHO population projections as unreliable data, the TSA's team considered GLA and ONS data further. Although Lewisham and Greenwich local authorities confirmed their use of GLA population projections for forecasting births in those two boroughs, it was agreed by CCGs and Trust planning and finance leads that the ONS data would be used for the TSA's forecast of birth rates, as these were the higher figures and would therefore ensure that the capacity required for maternity services at south east London's hospitals would not be underestimated. Figure 26 shows the comparative data for projected birth rates in the borough of Lewisham.

[2] London Health Observatory, *Estimating future births in the Capital: A discussion document*, 2008

Figure 26: Lewisham borough birth projections data – comparing growth rates applied to GLA borough baseline



106. In order to forecast births across south east London, Trust-reported data for 2012/13 birth rates were rolled forward and forecast to 2013/14 based on the demographic growth forecast in commissioners' plans, and beyond 2013/14 based on ONS population projections. All assumptions were discussed and endorsed by the six CCGs and the Trusts' planning and finance teams.

107. The borough-level birth rate forecasts were then allocated to the five hospitals with maternity services in south east London, based on the activity accruing to each site from each borough. The forecast birth numbers are shown in figure 27.

Figure 27: Forecast births in south east London 2012/13 to 2015/16 and annual growth

Hospital	2012/2013	2013/2014	2014/2015	2015/2016	Annual growth
LEW	4,222	4,237	4,275	4,335	0.88%
PRUH	4,603	4,629	4,657	4,685	0.59%
QEH	4,386	4,433	4,493	4,542	1.17%
STT	6,630	6,705	6,780	6,865	1.17%
KCH	5,500	5,560	5,621	5,691	1.14%
Total	**25,341**	**25,563**	**25,825**	**26,117**	**1.01%**

Key: LEW - University Hospital Lewisham; PRUH - Princess Royal University Hospital; QEH - Queen Elizabeth Hospital; STT - St Thomas' Hospital; KCH - King's College Hospital

108. The external clinical panel accepted the approach and process that had been used to forecast births in south east London as appropriate and robust.

Evaluation of the options

109. Clinical quality standards for maternity services have been developed (appendix P) and were endorsed by the London Clinical Senate in September 2012 and London-wide Clinical Commissioning Council in November 2012, along with clinical dependencies for hospital-based acute emergency and maternity services (annex 2).

110. During the development of the draft recommendations, the clinical advisory group and external clinical panel considered these clinical quality standards and further endorsed them and advised the TSA that any future models of maternity care in south east London should consistently meet these standards to secure long-term clinical sustainability.

111. Option 1 (four sites) would provide obstetric units with co-located midwifery-led units on each of the four sites: King‘s College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas‘ Hospital. Maternity services would therefore be co-located on the same site as 24/7 acute admitting emergency hospitals which would enable all of the clinical dependencies (annex 2) for obstetrics to be met. All maternity services would meet the London clinical quality standards (appendix P). Antenatal and postnatal care would be provided at King‘s College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital, St Thomas‘ Hospital and University Hospital Lewisham (and/ or in the community).

112. Option 2 (five sites) would provide obstetric units with co-located midwifery-led units on each of the four sites: King‘s College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas‘ Hospital. For University Hospital Lewisham, an obstetric unit and co-located midwifery led unit, not located on the same site as 24/7 acute admitting emergency hospital would be provided. Maternity services at University Hospital Lewisham would be provided as a single service within a new Lewisham-Greenwich organisation, operating across the University Hospital Lewisham and Queen Elizabeth Hospital. All maternity services would meet the London clinical quality standards (appendix P). Antenatal and postnatal care would be provided at King‘s College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital, St Thomas‘ Hospital and University Hospital Lewisham (and/ or in the community). Additionally, all maternity services would need to meet the clinical dependencies (annex 2) with critical care provided through the proposed elective centre. Forecasted births for each of the options are shown in figure 28.

Figure 28: Forecasted births 2015/16 in each of the options

Forecast births 2015/2016	LEW	QEH	PRUH	STT	KCH	TOTAL
Option 1 (four sites)	0	5,798	5,691	7,099	7,308	25,896
Option 2 (five sites)	4,335	4,542	4,685	6,865	5,691	26,118

Key: LEW - University Hospital Lewisham; PRUH - Princess Royal University Hospital; QEH - Queen Elizabeth Hospital; STT - St Thomas' Hospital; KCH - King's College Hospital

113. Under option 1, dispersal of the forecast births amongst King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas' Hospital was modelled based on travel times (data provided by Transport for London) and patient choice. Under option 1, a further 222 births in 2015/16 would be dispersed to providers outside of south east London.

114. In considering how a population might be affected by a change in services at a particular hospital site, provider Trusts supplied the TSA team with data about which Lower Super Output Area (LSOA)[3] the patients they currently treat come from. Any activity impacted was modelled from that LSOA and distributed to another hospital.

115. Based on the available data, the base scenario used in the modelling was to assume that any population affected by a change in hospital service provision would move to the hospital that could be reached in the shortest time.

116. When considering patient movements specifically for the Lewisham borough, Lewisham clinicians recommended that patient preference would mean that a higher proportion of patients would flow to central London hospitals than those hospitals suggested by objective travel times. This preference was therefore taken into account for non-blue light travel times and a weighted average taken for future patient flows for University Hospital Lewisham catchment population (this includes patients from boroughs other than Lewisham). These were developed based on conversations with the Chair of Lewisham CCG.

117. This methodology was applied to disperse University Hospital Lewisham births to the four sites (King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas' Hospital). Under option 1, only patients that currently had a preference for University Hospital Lewisham were included in this calculation. An assumption was made that any patients who currently used central London hospitals such as St Thomas' or King's College Hospital from the London borough of Lewisham would be unaffected by the above changes and would continue to go there (figure 29).

[3] Explanatory note: Super Output Areas (SOAs) are a geographic hierarchy designed to improve the reporting of small area statistics. Within England and Wales a Lower Layer (minimum population 1000) and a Middle Layer (minimum population 5000) were introduced in 2004. Unlike electoral wards, these SOA layers are of consistent size across the country and won't be subjected to regular boundary change

Figure 29: Forecast births 2015/16 under option 1

Forecast births 2015/2016	LEW	QEH	PRUH	STT	KCH	TOTAL
Option 1 (four sites)	0	5,798	5,691	7,099	7,308	25,896

Key: LEW - University Hospital Lewisham; PRUH - Princess Royal University Hospital; QEH - Queen Elizabeth Hospital; STT - St Thomas' Hospital; KCH - King's College Hospital

118. The benefits and risks of both options were discussed by the external clinical panel at a meeting on 15 October 2012, where some reservations around the clinical sustainability of option two were raised. At a further meeting of the external clinical panel on 22 October 2012, no conclusion was reached and the panel recommended that further work was undertaken to examine each option in more detail.

119. It was recommended that further work was required on the detail of the two proposals so that a more thorough clinical assessment could be made; and that broader engagement in exploring these options should be sought through the consultation process.

Benefits, risks and mitigating actions of the options

120. Further development of the benefits, risks and mitigating options was undertaken by the clinical advisory group and through meetings with providers in south east London.

121. A maternity services workshop was held on 5 December 2012. The event was attended by approximately 40 individuals, comprising a mix of obstetricians, midwives, paediatricians, anaesthetists and intensivists from each of the five maternity units in south east London. Commissioner representatives from CCGs were also in attendance. The purpose of the workshop was to ensure that all benefits, risks and mitigating actions had been captured ahead of final consideration of the options by the external clinical panel.

122. The workshop sought clinical input into the assessment of the two options for the recommendation for maternity services in south east London. The clinical models for each of the two options were outlined to delegates and a facilitated session then took place on the benefits, risks and mitigating actions of each of the options; these were broken down into the following categories:

- Clinical
- Patient experience
- Operational
- Workforce

A summary of the benefits, risks and mitigating actions is provided in figure 30.

Figure 30: Summary of the benefits, risks and mitigating actions of each option

Clinical			
	Benefits	**Risks**	**Mitigating actions**
Option 1 (4 sites)	• All units to meet the London clinical quality standards • All units will be co-located with the supporting services of a 24/7 acute emergency admitting hospital	• Insufficient capacity planning, particularly at units closest to Lewisham may cause women to be re-directed resulting in increased babies born before arrival • Reduced resilience – lesser number of sites to deal with impact of service suspensions • Longer transfer times to an obstetric unit for home births • Poorer compliance with antenatal pathway with increased number of women not attending appointments • Increased safeguarding risks due to loss of relationships with local services	• Robust capacity and resilience planning with associated investment • Travel time analysis to ensure adequate access is maintained • Satellite/ outreach antenatal clinics provided by St Thomas' Hospital, King's College Hospital, Princess Royal University Hospital and Queen Elizabeth Hospital at University Hospital Lewisham site and/ or in the community to maintain local access where possible • Implementation of robust pathways in place for women between antenatal services at University Hospital Lewisham and the obstetric-led units with clear protocols for safeguarding
Option 2 (5 sites)	• All units to meet the London clinical quality standards • Shorter travel times for some if mother/baby needs to be transferred during a home birth • Improved resilience – higher number of sites to deal with impact of service suspensions	• Non co-location of supporting services of a 24/7 acute emergency admitting hospital • Unpredictability of true emergencies • Transfer of emergencies/ critically ill women to intensive level 3 care • Clinical viability of a small critical care unit providing high dependency care and short level 3 care	• Triage protocol to stream very high risk women to deliver at an alternative obstetric-led unit • Enhanced recovery model providing short term level 3 care, with transfer to a 24/7 acute emergency admitting hospital for patients requiring longer term level 3 care in a general intensive care unit
Patient experience			
	Benefits	**Risks**	**Mitigating actions**
Option 1 (4 sites)	• Services to meet London women's experience standards for labour, birth and immediate postnatal care	• Shortage of capacity, particularly at units closest to Lewisham, requiring mothers to re-directed to other units further away • Increased transfer time (if required) for home births requiring transfer to an obstetric-led unit • Increased travel times for some, resulting in potential reduction in visiting possibilities • Reduction in patient choice	• Robust capacity and resilience planning with associated investment • Travel time analysis to ensure adequate access is maintained • Choice of birth setting would be maintained
Option 2 (5 sites)	• Services to meet London women's experience standards for labour, birth and immediate postnatal care • Maternity unit closer to home • Convenience for local parents of attending outpatient appointments, antenatal classes, midwifery care at local GPs and delivering at a closer unit • Maintenance of pathways for hard to reach groups	• Unpredictability of true emergencies • Transfer of emergencies/ critically ill women to intensive level 3 care	• Triage protocol to stream very high risk women to deliver at alternative obstetric-led unit • Enhanced recovery model providing short term level 3 care, with transfer to a 24/7 acute emergency admitting hospital for patients requiring longer term level 3 care in a general intensive care unit

Operational			
	Benefits	**Risks**	**Mitigating actions**
Option 1 (4 sites)	• Consolidation of workforce may increase compliance of clinical quality standards – consultant presence and 1:1 midwifery care • Opportunity for midwifery case-loading	• Shortage of capacity and risk of service suspensions and increased red alerts • Underestimate of birth numbers in the model • May lead to additional capping • Number of deliveries through dispersal may reach tipping point for double rotas at some sites • Potential impracticalities of satellite antenatal clinics • Loss of pathways between local units and hard to reach groups • Disconnected community midwifery service and poorer links with primary care	• Robust capacity and resilience planning with associated investment • Local authorities and CCGs have verified birth projections. The highest projection of births has been used. Additional sensitivity analysis of birth forecasts in the model can be undertaken • Double rotas estimated at 8-10,000 births • Satellite/ outreach antenatal clinics provided by St Thomas' Hospital, King's College Hospital, Princess Royal University Hospital and Queen Elizabeth Hospital at University Hospital Lewisham site and/ or in the community to maintain local access where possible • Implementation of robust pathways and protocols in place for women between antenatal services at University Hospital Lewisham and the obstetric-led units
Option 2 (5 sites)	• Capacity in place • Antenatal clinics held on same site as women give birth (except very high risk women)	• Unsustainable rotas for supporting services	• Full retention of anaesthetic rota • Rotation of all staff across University Hospital Lewisham and Queen Elizabeth Hospital to ensure exposure to full casemix
Workforce			
	Benefits	**Risks**	**Mitigating actions**
Option 1 (4 sites)	• Exposure to a full range of case-mix at each unit • Supports education and training posts	• Anecdotal evidence suggests larger units produce poorer staff and patient satisfaction • Increased risks in a high risk population from disconnection of maternity units from local services - community midwives, health visitors and GPs • Additional 20 consultants required to provide 168 hour a week labour ward cover	• Comparison of unit size and Care Quality Commission women's satisfaction survey shows no correlation • Implementation of robust pathways and protocols in place for at risk women at the 4 providers
Option 2 (5 sites)	• Maintains relationships between maternity units local community midwives, health visitors and GPs	• Limited exposure to very high risk women at University Hospital Lewisham as these would be triaged out to other providers through the antenatal period • University Hospital Lewisham model may not support education and training posts • Additional 41 consultants required to provide 168 hour a week labour ward cover	• Rotation of all staff across University Hospital Lewisham and Queen Elizabeth Hospital to ensure exposure to full casemix

Consideration of the options by the external clinical panel

123. Following the workshop, a presentation of the clinical models for each of the options along with the feedback from the workshop was considered by the external clinical panel on 6 December 2012. The panel was expanded with extended membership to include obstetric and midwifery representatives, as well as representatives from the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

124. During this meeting, the clinical models were presented to the panel and the benefits, risks and potential mitigations were discussed. The major concern raised related to the level of critical care provision at University Hospital Lewisham and the sustainability of this model.

125. The disadvantage of four hospital sites providing obstetric-led services is the negative impact on some women on access and the capacity at remaining units in the face of additional demand. The disadvantage of five hospitals providing obstetric-led services is the increased clinical risk associated with the unit at University Hospital Lewisham – while it would have critical care facilities for women requiring high-dependency care; it was not proposed to have full intensive care facilities. The external clinical panel recognised that the need to transfer women to a facility with full intensive care facilities would happen infrequently; however, this is a risk that the external clinical panel was not willing to endorse, even for a small number of women. For this sole reason, the panel agreed that this model was not clinically sustainable and therefore that an obstetric unit at University Hospital Lewisham was not a viable option.

126. The panel‘s decision, endorsed by the representatives from the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, was therefore to recommend to the TSA a configuration of four obstetric-led services.

127. At the time the TSA‘s draft report was published, a free-standing midwifery-led birthing unit was considered not to be financially viable as; generally, experience in London is that women do not choose to use them. However, during the consultation the focus sessions for maternity services users held at locations in Lewisham came out in support of maternity services being retained at the University Hospital Lewisham site, with participants particularly positive about the model of midwifery-led birthing units. This emerging view, as well as other consultation responses, prompted the TSA to suggest to the external clinical panel that it considered whether a free-standing midwifery-led unit could be made to work for University Hospital Lewisham.

128. The Royal College of Midwives representative and other members of the panel suggested that, in this case, it would likely to be an attractive choice for women due to the popularity of the current midwifery-led birthing unit at University Hospital Lewisham, which is rated highly in patient satisfaction surveys. Evidence of

successful free-standing midwifery-led birthing units elsewhere in the United Kingdom added further support to the external clinical panel's recommendation.

129. In summary therefore, it is recommended that four obstetric led units with co-located midwifery-led birthing units should be provided in south east London and a freestanding midwifery-led birthing unit be provided at University Hospital Lewisham. In making these recommendations, concerns raised regarding the capacity at the four recommended obstetric-led units have been addressed. Capital investment of £36m has been factored into transition costs to provide additional capacity; this includes the development of midwifery-led birthing units at Queen Elizabeth Hospital and King's College Hospital.

Financial analysis

130. The financial analysis was developed in parallel with the clinical options. There were three financial options considered:
    i) Obstetric and co-located midwifery-led services to be provided on four sites;
    ii) Obstetric and co-located midwifery-led services to be provided on five sites; and
    iii) Obstetric services to be provided on four sites with a free-standing midwifery-led unit at University Hospital Lewisham.

131. The financial analysis of each of the options was developed in parallel with the clinical consideration of the options. The full assumptions behind the development of these financial models are detailed in appendix M.

132. The comparative net present value (NPV) of each of the three options was calculated. The option with the lowest (least favourable) NPV was option 2 (. This was primarily because of the high recurrent cost of staffing five obstetric units that would achieve the London clinical quality standards for maternity services.

133. Substituting a free-standing midwifery-led unit at University Hospital Lewisham for an obstetric unit generated a NPV £18.4m higher than option 2. The increased benefit is primarily a result of avoiding the costs of staffing a fifth obstetric unit, although there are staffing costs for the free-standing midwifery-led unit at University Hospital Lewisham and some additional capital costs associated with increasing capacity at the four sites that would provide obstetric led services. The annual impact of the free-standing midwifery-led unit is to generate a cost pressure of c£1m for the University Hospital Lewisham site.

134. Option 1 generates a NPV £22.1m greater than option 2 and £3.7m more than the option of four sites with a free-standing midwifery-led unit on the University Hospital Lewisham site. The higher NPV is primarily driven by the avoidance of the costs associated with staffing a fifth obstetric unit and the free-standing midwifery-led unit is offset somewhat by additional capital costs associated with adding capacity at the four sites.

135. The financial impact of developing a free-standing midwifery-led unit at University Hospital Lewisham is relatively small when considered alongside the financial loss of option 2, other benefits and the strong clinical support for such a model from the external clinical panel. It is anticipated that local commissioners, in a direct response to the comments expressed by Lewisham residents as part of the consultation will respond by financially supporting the development, implementation and on-going financial shortfall which is projected at c£1m. This level of support has been assumed in the detailed financial modelling shown in appendix M.

Consultation responses

136. Overall, the responses from the consultation showed no clear support for either option for the recommendation for maternity services across south east London.

137. Significant support was received during consultation in favour of retaining the obstetric-led unit at University Hospital Lewisham from Lewisham GPs, consultants and Lewisham mothers. This message was reiterated through the focus group sessions held with service users in Lewisham.

138. However, the majority of free-text consultation responses emphasised the need for obstetric-led maternity services to be co-located on the same hospital site as a 24/7 acute emergency admitting hospital with concerns raised around providing obstetric-led services without an accident and emergency department on the same site. Therefore these consultation responses also endorsed the need for acute emergency and maternity services to meet the London Quality and Safety Programme clinical dependency framework (annex 2). This was further emphasised in the consultation response from King‘s Health Partners‘ clinicians, which outlined significant reservations about the option for a free-standing obstetric unit at University Hospital Lewisham if it did not have access to a co-located intensive care unit on site and the other support services of 24/7 acute emergency admitting hospital.

139. Additionally, the Royal College of Obstetricians and Gynaecologists stated in its response that 168 hours of consultant presence should be aspired to, to ensure that all women receive safe and effective care day and night regardless of unit size.

140. A response received from Greenwich and Lewisham National Childcare Trust suggested that the option of developing or retaining a free-standing midwifery-led unit on any site facing the closure of birthing services should be seriously considered, in order to allow as many women as possible to experience continuity of care when accessing antenatal, intrapartum and postnatal services. The response stated that such units can be successful when properly supported and invested in.

Health and Equalities Impact Assessment: maternity services

141. The HEIA raised that the final recommendation could improve maternity outcomes by concentrating obstetric-led maternity services onto fewer sites thereby enabling greater consultant presence. The report recognises that critical mass of deliveries could be achieved under the final recommendation, thus justifying 168-hours (24/7) consultant presence. While there is evidence to suggest concentrating obstetric units onto fewer sites is associated with positive health impacts, the report also states that this is by no means conclusive, and is an issue which is debated in the relevant literature[4].

142. The further mitigation suggested in the HEIA report regarding maternity health outcomes and patient experience are as per the final recommendation, that is, all obstetric units to have co-located midwifery led birthing units and all units to meet the full clinical quality standards developed for London. In particular, this will benefit women with high risk pregnancies.

143. For low risk births, there are also potential benefits in terms of health outcomes; midwife-led care is associated with improved experience for mothers and fewer interventions[5].

144. However, reduced maternity choice, access and continuity of care were raised as an issue, particularly in Lewisham. The reduction in choice, access and continuity was also identified as likely to impact the economically deprived, BAME groups and teenage mothers particularly in the area. As per emergency care, the entire socially and economically deprived population in south east London will continue to be within a reasonable journey time of a maternity unit, and will still have much better access to maternity units than many residents across England. Continuity of care must be carefully considered during implementation planning to ensure robust pathways and protocols exist across health and social care providers through the whole maternity pathway.

Recommendation

145. The TSA‘s recommendation for maternity services in south east London is that four hospital sites (King‘s College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas‘ Hospital) should provide obstetric-led birthing services, with co-located midwifery-led birthing services. A free-standing midwifery-led birthing unit should be developed on the University Hospital Lewisham site.

[4] Macfarlane 2008
[5] Birthplace in England Collaborative Group 2011

Elective care

146. During the development of the draft recommendations, work was undertaken to review the options for elective surgery. The clinical advisory group concluded that the TSA should look at options for having one or two elective centres for non-complex inpatient cases serving the population of south east London. The clinical advisory group recommended that all sites should continue to deliver day case procedures and complex procedures should be provided at the four proposed 24/7 acute emergency admitting hospitals (St Thomas' Hospital, King's College Hospital, Princess Royal University Hospital and Queen Elizabeth Hospital, as well as being undertaken at Guy's Hospital) to ensure that the necessary clinical back up services are available, and specialist elective procedures should remain at Guy's Hospital, King's College Hospital and St Thomas' Hospital.

147. Establishing non-complex elective centres is possible by separating emergency care from planned care and thereby delivering improved, more efficient services, with a reduced risk of patients having their operations cancelled. The TSA concluded that the final decision should be made on the basis of the financial analysis.

148. In developing the final recommendation, the TSA worked with clinicians, providers, commissioners and external experts to determine the right case mix and optimal clinical model and to work up a proposal for the governance arrangements for the proposed elective centre at the University Hospital Lewisham site. An assessment of the financial implications of the elective centre was then undertaken.

149. The approach to agreeing the activity that would be suitable for the proposed elective centre was bottom up using 2011/12 activity data from Hospital Episode Statistics (HES) from hospitals across south east London. Clinicians from each hospital in south east London - nominated by clinical advisory group members - identified, at a procedure level, the activity that would be suitable to be undertaken in the proposed elective centre within the agreed parameters (i.e. non-complex procedures only, and day cases to remain at all sites). The information was aggregated and validated by a clinician independent of south east London.

150. A number of assumptions, agreed by the clinical advisory group and further endorsed by the external clinical panel and by an external elective expert panel, were then applied to the procedure analysis as follows:

    - *Complex cases*: As part of the procedure analysis, complex surgery was excluded; but some patients would also be unsuitable who require non-complex procedures but have other complexities such as co-morbidities. It was therefore agreed that all ASA (American Society of Anaesthesiologists) 1, 2 and 3 categorised patients would be suitable for treatment at the elective centre, but any patients categorised as ASA 4 or above would not be suitable for the elective centre and would continue to be treated at the proposed 24/7 acute emergency admitting sites (St Thomas' Hospital, King's College Hospital, the Princess Royal

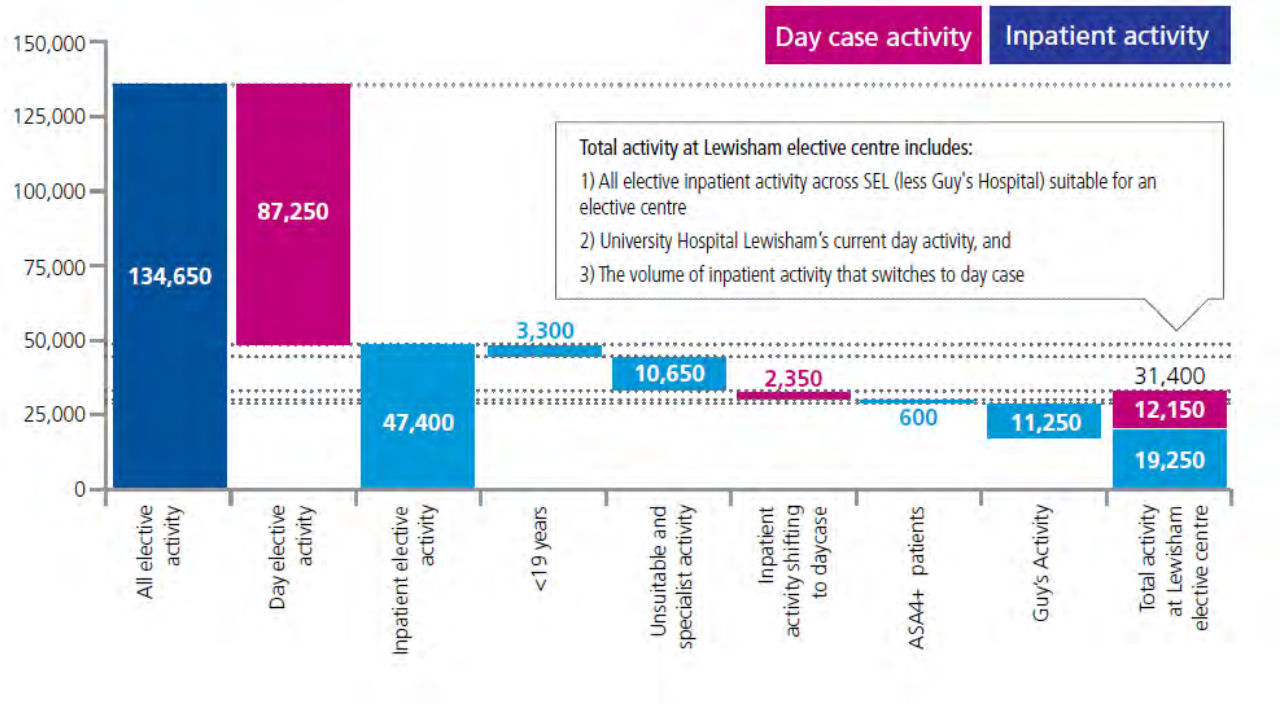
University Hospital and Queen Elizabeth Hospital). Based on a large European study undertaken in 2011, an assumption was applied that ASA4+ patients would account for 2% of all suitable elective activity[6].

- *Day case surgery*: To ensure the proposed elective centre is sustainable going forward, an assumption on the expected shift of current inpatient activity to day case activity was applied. This assumption was based on the difference between current inpatient procedures and British Association of Day Surgery recommendations. This assumption was agreed as an 8% shift of current inpatient surgery to day case surgery by 2015/16.
- *Paediatrics*: It was agreed that there would be no procedures undertaken on under 19 year olds at the proposed elective centre, due to the specific requirements for this group of patients.
- *Cancer patients:* It was agreed that cancer patients would not be excluded from treatment at the proposed elective centre. Cancer procedures currently undertaken at specialist cancer centres would remain there and it would only be procedures undertaken at local cancer units that would be suitable. This was included as part of the procedure analysis. The clinical advisory group and the external panels agreed with this approach, highlighting that it was important to ensure specific requirements for cancer patients would be available at the proposed elective centre.

The agreed activity for the elective centre is shown in figure 31.

[6] Pearse, R. M. et al (2012) Mortality after surgery in Europe: a 7 day cohort study The Lancet; 380: 1059-1065

Figure 31: Agreed activity for elective centre (procedures 2015/16)



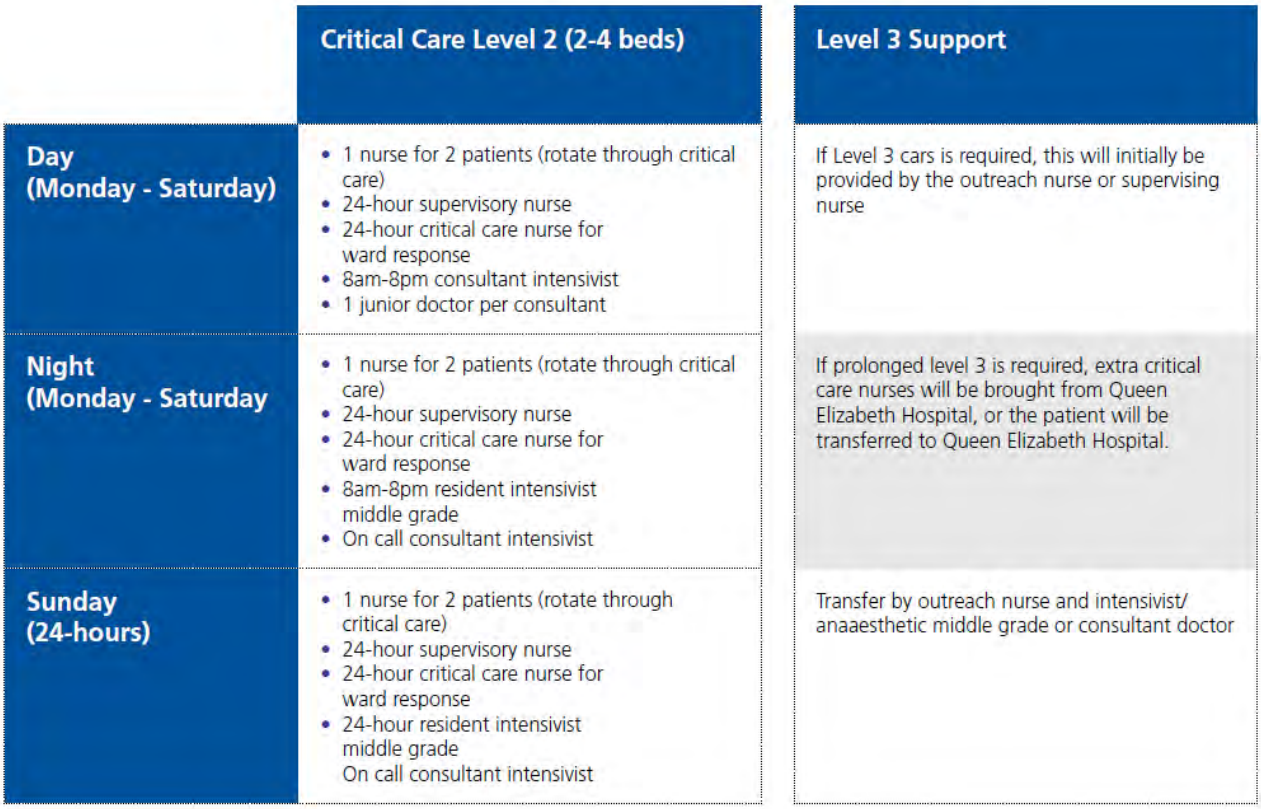
Clinical infrastructure

151. The proposed clinical infrastructure required at the elective centre was based on: recommendations from the Royal College of Surgeons of England; learning from elective centres of excellence elsewhere in the United Kingdom; discussions with clinicians from south east London; and was further informed and endorsed by the clinical advisory group, external clinical panel and external elective expert panel. The proposed support services are defined as:

- Anaesthetics
- Radiology and access to pathology
- Pharmacy
- Post-operative care to (at least) critical care level 2
- Access to intensive care level 3 facilities, if required
- Resident medical cover (for post-operative management of complex surgery and routine surgery on patients with complex co-morbidities)
- Access to general medical opinion
- Therapy support, including physiotherapy and occupational therapy
- Relevant surgical services
- Operating theatre services

152. Extensive discussion and clinical challenge took place on the proposals for the clinical and workforce model for critical care provision at the elective centre. The agreed model shown in figure 32 was developed by intensivists from within south east London and external to south east London and subsequently endorsed by the clinical advisory group and the external clinical panel and external elective expert panel.

Figure 32: Proposal for critical care at the elective centre



	Critical Care Level 2 (2-4 beds)	Level 3 Support
Day (Monday - Saturday)	• 1 nurse for 2 patients (rotate through critical care) • 24-hour supervisory nurse • 24-hour critical care nurse for ward response • 8am-8pm consultant intensivist • 1 junior doctor per consultant	If Level 3 cars is required, this will initially be provided by the outreach nurse or supervising nurse
Night (Monday - Saturday	• 1 nurse for 2 patients (rotate through critical care) • 24-hour supervisory nurse • 24-hour critical care nurse for ward response • 8am-8pm resident intensivist middle grade • On call consultant intensivist	If prolonged level 3 is required, extra critical care nurses will be brought from Queen Elizabeth Hospital, or the patient will be transferred to Queen Elizabeth Hospital.
Sunday (24-hours)	• 1 nurse for 2 patients (rotate through critical care) • 24-hour supervisory nurse • 24-hour critical care nurse for ward response • 24-hour resident intensivist middle grade On call consultant intensivist	Transfer by outreach nurse and intensivist/ anaaesthetic middle grade or consultant doctor

153. The critical care unit at the elective centre will be led by a consultant intensivist and will provide a 24/7 response to the inpatient wards for deteriorating patients not currently on the unit. Patients that would be suitable for the unit would be those requiring high dependency care and, in addition, there would be the facility to provide short-term intensive care for those patients requiring ventilation before transferring to a critical care unit on a 24/7 acute admitting hospital site. The model meets the London clinical quality standards for critical care and the proposed staffing model would ensure flexibility to meet demands based on the acuity of patients on the unit.

154. The external clinical panel and external elective panel confirmed that the critical care model proposed was well established at the South West London Elective Orthopaedic Centre, safe and adequate for the activity proposed at the elective centre. It was concluded that the model of provision would minimise transfers to a critical care unit on a 24/7 acute emergency admitting hospital site.

Patient flow

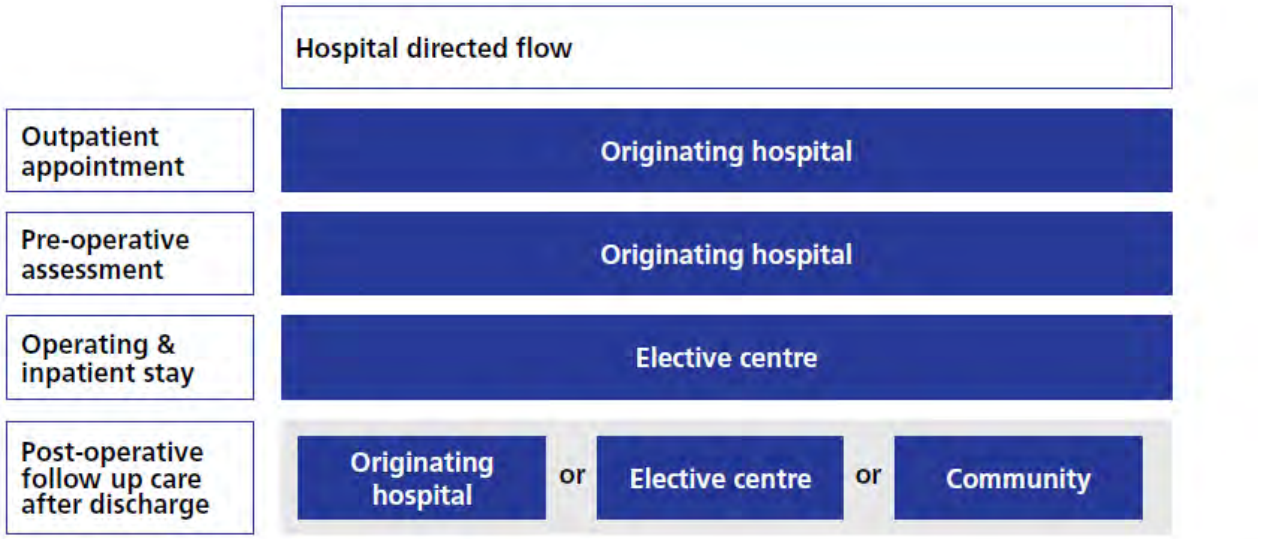
155. Individual meetings with each of the provider organisations in south east London took place to discuss the options for how patients would flow to the elective centre and the implications for the patient pathway. The options discussed for patient flow included direct referral from a GP to the elective centre; patient choice whereby the patient would choose to have their procedure carried out at the elective centre; patient flow directed by trusts; and individual surgeon choice. The preferred option was for trusts

to direct patients to be treated at the elective centre following the patients‘ outpatient appointments. This will ensure that outpatient appointments are retained locally and the flow of patients is then directed by the trust according to commissioning arrangements with the elective centre.

Patient pathway

156. Under the model of trust-directed flow, the full patient pathway and where activity is proposed to take place, is shown in figure 33.

Figure 33: Where patient activity will take place



157. Clinicians recommended that ‗one-stop‘ clinics for outpatient and pre-operative assessment be developed at all originating hospitals to minimise the number of patient attendances at hospital and maximise patient convenience. Pre-operative assessment would need to be protocol driven across south east London providers in line with anaesthetic protocols at the elective centre.

158. Through discussions with clinicians and providers about the patient pathway, the importance of ensuring that all patients are on an enhanced recovery programme at the pre-operative assessment stage was highlighted. The benefits of the enhanced recovery programme in improving patient outcomes and speeding up a patient‘s recovery after surgery would make it critical to the clinical effectiveness and efficiency of the elective centre.

159. Discussions on post-operative follow up care concluded that this could take place in a range of settings – the originating hospital; the elective centre; or in a community setting – and by a range healthcare professionals, as clinically appropriate. As the proposed elective centre is implemented, this should be defined at a procedure pathway level with clinical commissioners to ensure it is in line with their Community Based Care Strategy.

Workforce model

160. A number of options for the workforce model at the elective centre were discussed with providers, the external clinical panel and external elective expert panel. These included a model where the elective centre employed no staff; instead clinical staff would be employed by the originating trusts, with non-clinical staff seconded from host organisations. A full employment model, with all staff employed by the elective centre, was also discussed. In the end a concession model emerged as the preferred approach, whereby non-clinical and core nursing staff would be employed by the elective centre and medical (surgeons and anaesthetists) and specialist nursing staff would be employed by their originating trust. This preferred approach is similar to the workforce model that is deployed at other elective centres and has been found to work well.

161. Following discussions with providers, the proposed patient pathway and preferred approach for the workforce model were presented to and endorsed by the TSA advisory group, clinical advisory group and external clinical panel, as well as the external elective expert panel.

Governance arrangements

162. Four alternative models for the management and accountability arrangements of the elective centre were considered by providers. The first model outlined that the proposed Queen Elizabeth Hospital and University Hospital Lewisham merged trust would manage the elective centre, reporting to its own trust board with contractual relationships with other trusts. The second option was for the elective centre to be managed by the proposed Queen Elizabeth Hospital and University Hospital Lewisham merged trust, but it would be accountable to a partnership board on quality and access issues and originating trusts would retain accountability for meeting access targets. Third, an independent management model was considered, which proposed that the elective centre was independently managed, with independent quality control and lines of accountability to the proposed Queen Elizabeth Hospital and University Hospital Lewisham merged trust. Finally, a shared arrangement, with hosting rotated between trusts to provide independence, was considered.

163. The first option outlined above would have a straightforward management structure with clear accountabilities, but it lacked ownership and engagement from provider organisations across south east London. Other options were viewed as unnecessarily complex. The preferred option was therefore for a robust partnership board to be established, with each trust represented on it.

164. The partnership board would oversee the management of the elective centre and the centre would be accountable to the partnership board for quality and access. Advice from the external elective expert panel during the development of the recommendation was that the establishment of a partnership board with clear responsibilities and accountabilities of all partner provider organisations is critical to

the success of the elective centre. In discussions with providers, it was clear that within this arrangement each originating trust would prefer to retain the reporting arrangements and accountability of 18 week referral to treatment access targets for admitted patients.

165. A clear clinical governance framework would be established at the outset, overseen by the partnership board. It is recommended that a medical director and a nursing director for the elective centre are appointed to offer clear clinical leadership. Concerns were raised by the clinical advisory group regarding individual clinical accountability. As part of the development of the clinical governance framework during the implementation stage, these concerns will be addressed.

166. Following discussions with providers, the preferred option for governance arrangements was presented to and endorsed by the TSA advisory group, clinical advisory group and external clinical panel, as well as the external elective expert panel.

Financial analysis

167. The forecast activity was developed by clinicians. Clinicians on the clinical advisory group also developed the productivity assumptions as follows.

168. The assumption for operating productivity was for 12-hour operating days, 6 days a week, utilising nine theatres. This was, as per other assumptions, agreed by the clinical advisory group and endorsed by the external panels, although the external elective expert panel advised that it would seem sensible from a productivity point of view to move towards operating 7 days a week, thereby reducing theatre and bed requirements in the future.

169. Elective centre activity modelling indicates that an estimated 19,250 procedures would be undertaken each year, which would require 112 beds – three of which would need to be high dependency beds – and a total of nine operating theatres for inpatient surgery and three theatres for day cases.

170. The estates configuration proposed on the University Hospital Lewisham site for the development of the elective centre was challenged in response to the TSA‘s consultation. One option put forward would have seen the retention of “A” and “F” blocks at the hospital, in addition to the proposed estate configuration set out in the draft report. While this option could save capital redevelopment costs, the associated increase in fixed costs over those included in the TSA‘s proposals risks make the site financially unviable.

171. The issue of excess capacity and associated excess estates cost is one that is recognised throughout south east London. The need to reduce these costs and increase estate utilisation is key to the overall development of increased operational efficiency and, through this, the financial viability for all organisations. While it is an

attractive option to retain buildings, this is often at an inappropriate financial cost, resulting in a disproportionate drain on the financial resources of the organisation.

172. The fixed costs savings at the University Hospital Lewisham site has been estimated at £22.6m (gross before re-investment), or £12m excluding depreciation, public dividend capital (PDC) and interest. The TSA's proposals would see an allowance for a further £7m of similar annual fixed costs to reflect the investment in the site. The TSA's proposals see around 60% of the total estate (gross internal floor area) of the University Hospital Lewisham site disposed of and a net reduction in fixed costs of around 34%.

173. During consultation a number of specific elements of the fixed costs at the University Hospital Lewisham site were highlighted as potentially being difficult to achieve in the short to medium term, because of current contractual arrangements. The financial due diligence conducted into the financial viability of the overall recommendations has identified some areas of financial risk while also recognising the potential for clear mitigations in certain areas and the opportunities for further financial benefits in others.

174. The changes in the balance and nature of services delivered from the Lewisham site, the increasing integration with local community services and the other providers in south east London should provide further opportunities to mitigate fixed cost pressures. Due to the statutory time requirements of the Unsustainable Provider Regime and the desire to ensure that the most appropriate clinical solution was developed, it has not been possible to establish a fully detailed operational financial model for the elective centre. This is appropriate, since it will be for the proposed partnership board, responsible for the delivery of safe clinical services at the centre, to agree and develop detailed operational budgets. The financial case developed for the TSA demonstrates that such a centre is financially viable and contributes to ensuring the financial viability of all provider organisations. Figure 34 illustrates the financial impact of the elective centre contained in the detailed financial modelling, highlighting the financial impact of the changes since the draft report.

Figure 34: Elective centre financial impact

Elective Centre Financial Impact		
£m	**Pre-consultation**	**Post-consultation**
Inpatient Surgery		
Income	67.4	54.9
Variable costs	19.1	15.7
Semi-variable costs	34.1	27.9
Critical Care	2.8	2.8
Operating margin	**11.4**	**8.5**
Daycase Surgery		
Income	13.8	14.2
Variable costs	1.7	1.8
Semi-variable costs	6.6	6.9
Critical Care	0	0
Operating margin	**5.5**	**5.5**
Total Elective Centre		
Income	81.2	69.1
Variable costs	20.8	17.5
Semi-variable costs	40.7	34.8
Critical Care	2.8	2.8
Operating margin	**16.9**	**14.0**

175. The business case necessary to support the c£55.9m capital investment to develop the elective centre at University Hospital Lewisham will need to fully consider all of the estate options, to ensure overall value for money is obtained for this significant investment of taxpayers' money. The business case will also need to move from residual costing to a bottom up appraisal of the lean operating costs of services, should the recommendation be agreed by Secretary of State.

Consultation responses

176. Commissioner and provider support for the proposed elective centre of excellence at University Hospital Lewisham was tested during the development of the final recommendations. Commissioners were largely in favour of the development of the elective centre; this was mainly re-stated in their responses to the consultation. In its consultation response, Lewisham CCG noted that the success of the centre was dependent on other Trusts in south east London referring to the centre.

177. With strong commissioner support this risk is, in part, mitigated. It can be further mitigated by provider support, which was articulated by some during consultation in terms of the benefits the centre could bring by splitting emergency and elective services; however, the detail of the clinical and business model needed to be developed further in planning for implementation to provide further assurance to provider Trusts.

Health and Equalities Impact Assessment

178. The HEIA highlighted that patients could benefit from the centralisation of non-complex elective procedures, both in terms of health outcomes and patient experience. For example, benefits that could result from the separation of elective and emergency care include the reduction and elimination of hospital-acquired infections and a reduction of cancellations in procedures.

179. The HEIA also outlined that travel times and cost will increase for many patients previously attending University Hospital Lewisham for complex elective inpatient procedures, given the proposal is that those procedures would no longer be provided there. At the same time, the consolidation of non-complex inpatient elective services into the proposed centre at University Hospital Lewisham will lead to an increase in travel times for some patients to receive treatment. This could particularly impact people with disabilities, economically and socially deprived and older people. Furthermore, people supporting patients, such as carers and relatives, could also be impacted. However, public transport access to University Hospital Lewisham is rated as ‗very good' by the Transport for London Public Transport Accessibility Level (PTAL) score; conversely, public transport access to Princess Royal University Hospital and Queen Mary's Hospital is rated as ‗poor'.

180. Given that older people and people with disabilities may rely on their relatives and carers to transport them to hospital, there may be an adverse impact on these individuals. Pre- and post-surgery appointments will continue to take place close to patients' homes, so any increased journey time is only likely to be for the operation itself. Additionally, for non-complex elective inpatient admissions at University Hospital Lewisham, patients, their relatives and carers may benefit from the proposed development of a new car park. The new car park will potentially improve accessibility and could enhance patient experience by encouraging the involvement of the patient's family and friends.

181. In relation to the change in services, the HEIA states that it may be more difficult for some people from BAME groups to understand the changes in service provision and where they need to go to access a particular service. This is important given that patients may be travelling to different locations at different stages in the elective care pathway. It is therefore important that patients, their relatives and carers receive clear information along the care pathway.

Recommendation

182. With this in mind and considering feedback from the consultation period and the HEIA, options for the development of one or more dedicated elective centres for the population of south east London were considered by all of the advisory groups in order to assess both the clinical and financial benefits of the options. Based on these considerations the TSA's recommendation is for an elective centre for non-complex inpatient procedures to be developed at University Hospital Lewisham and for non-

complex inpatient procedures to continue to be provided at Guy‘s Hospital, together serving the whole population of south east London. Alongside this, complex procedures should be provided at King‘s College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas‘ Hospital; and specialist procedures should continue to be provided at Guy‘s Hospital, King‘s College Hospital and St Thomas‘ Hospital. Day case procedures would continue to be provided at all seven main hospitals.

Summary of recommendations

183. This appendix sets out the process for developing the draft recommendations for service change across south east London, is the work and analysis that was undertaken during consultation on the draft recommendations, and the consultation responses. An assessment of the impact of the recommendations on health and equalities has also been considered.

184. With regard to urgent and emergency care, the recommendation is to develop 24/7 acute emergency admitting hospitals at King‘s College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas‘ Hospital. Services at University Hospital Lewisham, Guy‘s Hospital and Queen Mary‘s Hospital Sidcup should provide urgent care for those that do not need to be admitted to hospital. Emergency care for those patients suffering from a major trauma (provided at King‘s College Hospital), stroke (provided at King‘s College Hospital and the Princess Royal University Hospital), heart attack (provided at St Thomas‘ Hospital and King‘s College Hospital) and vascular problems (provided at St Thomas‘ Hospital) will not change from the current arrangements.

185. For maternity services, the recommendation is for King‘s College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas‘ Hospital to provide obstetric-led birthing services, with co-located midwifery-led birthing services. A free-standing midwifery-led birthing unit should be developed on the University Hospital Lewisham site.

186. With regard to elective care, the TSA‘s recommendation is for an elective centre for non-complex inpatient procedures to be developed at University Hospital Lewisham and for non-complex inpatient procedures to continue to be provided at Guy‘s Hospital, together serving the whole population of south east London. Alongside this, complex procedures should be provided at King‘s College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas‘ Hospital; and specialist procedures should continue to be provided at Guy‘s Hospital, King‘s College Hospital and St Thomas‘ Hospital. Day case procedures would continue to be provided at all seven main hospitals.

Annex 1: Benefits of implementing the community based care aspirations, London clinical quality standards and elective centre across south east London

Community Based Care		
Issue	**Evidence**	**Impact**
Ageing and growing population	The overall population of south east London is forecast to grow by 6% in the next five years[i]	Investment in community based services planned to address issues[iv]
Significant health inequalities in part due to a lack of good preventative and primary care access	3.5 years difference in life expectancy between Greenwich and Bromley[ii]	37 heart attacks and strokes could be prevented each year through early detection of risk factors with improved use of NHS Health Checks[ix]
Increasing number of people living with long terms conditions which are not managed effectively	More than 1 in 4 people aged 75+ have one or more of the major long term conditions[iii]	700 lives could be saved each year through early detection and improved management of diabetes alone[x]
High rates of uncontrolled diabetes	Up to 27% of people with diabetes remain undiagnosed and 53% of those diagnosed do not have their condition controlled and therefore have a higher risk of exacerbation, amputation, stroke and other complications	The number of people with uncontrolled diabetes should be reduced by half[xi] Around 200 amputations a year could be avoided through improved diabetes management in the community[xii]
Variation in access to and quality of community based care	10% of admissions for older people could have been managed through better community based care[iv] 41% of patients do not feel they are supported enough by local services to manage their long term conditions[v]	10% reduction in emergency admissions for older people with long term conditions managed effectively in community care[iv] 85% of patients to feel supported to manage their long term conditions[xiii]
Insufficient access in primary care for urgent same-day or out-of-hours services	20% of patients do not believe that GP surgeries are open at convenient times[v]	6% reduction in A&E attendances[xiv]
High A&E attendance rates across hospitals Unnecessary admissions to hospital care	3 of the 6 boroughs are below the national average for out of hours access to primary care[vi] 44% of all emergency activity is coded as minor and could potentially have been dealt with in the community[vii]	Improvement in % of respondents to annual GP patient survey that are very or fairly satisfied with GP opening hours by 2015/16
End of life care is not always available in the patient's preferred place of death - too may people die in hospital which is not their preference	A local Coordinate My Care (CMC) pilot survey indicates that 82% of people would prefer to die at home. In 2010, just 20% of residents who died, died at home[viii]	A significant increase in the number of patients that will be supported to die in their preferred place of death by 2015/16[iv]

Emergency Care		
Issue	**Evidence**	**Impact**
Variation in mortality rates across hospitals particularly between weekdays and weekends	HSMR across trusts varies from 80.5 – 97[xviii]	Around 250 fewer observed deaths every year if all trusts reached HSMR level of lowest in sector[xviii]
Inconsistent service arrangements between hospitals and within hospitals, between weekdays and weekends.	10% higher mortality rate for weekend acute emergency admissions[xix]	Around 100 lives could be saved every year if mortality rates at weekends were consistent with weekday mortality rates[xix]
Variation in senior doctor presence across emergency – adult and paediatric – services	Consultant cover for acute emergency admissions at the weekend is half of what it is during the week[xx]	
Variation in the availability of experienced and skilled senior staff	Only 88% of consultant surgeons are laparascopically (key hole) trained[vii]	Potential decrease in mortality and morbidity if patients were treated laparoscopically by specialist surgeons[xxii]
Inability to meet London minimum clinical quality standards for emergency – adults and paediatrics – care	Significant shortfall of consultants to achieve minimum standards of acute emergency care across all hospitals[vii]: • Shortfall of approximately 21 WTE emergency medicine consultants to achieve standards at all sites • Shortfall of approximately 8 WTE emergency surgery consultants to achieve standards at all sites • Shortfall of approximately 9 WTE paediatric consultants to achieve standards at all sites	Decrease in unnecessary paediatric admissions to hospital if there was increased senior decision making available[xxiii]

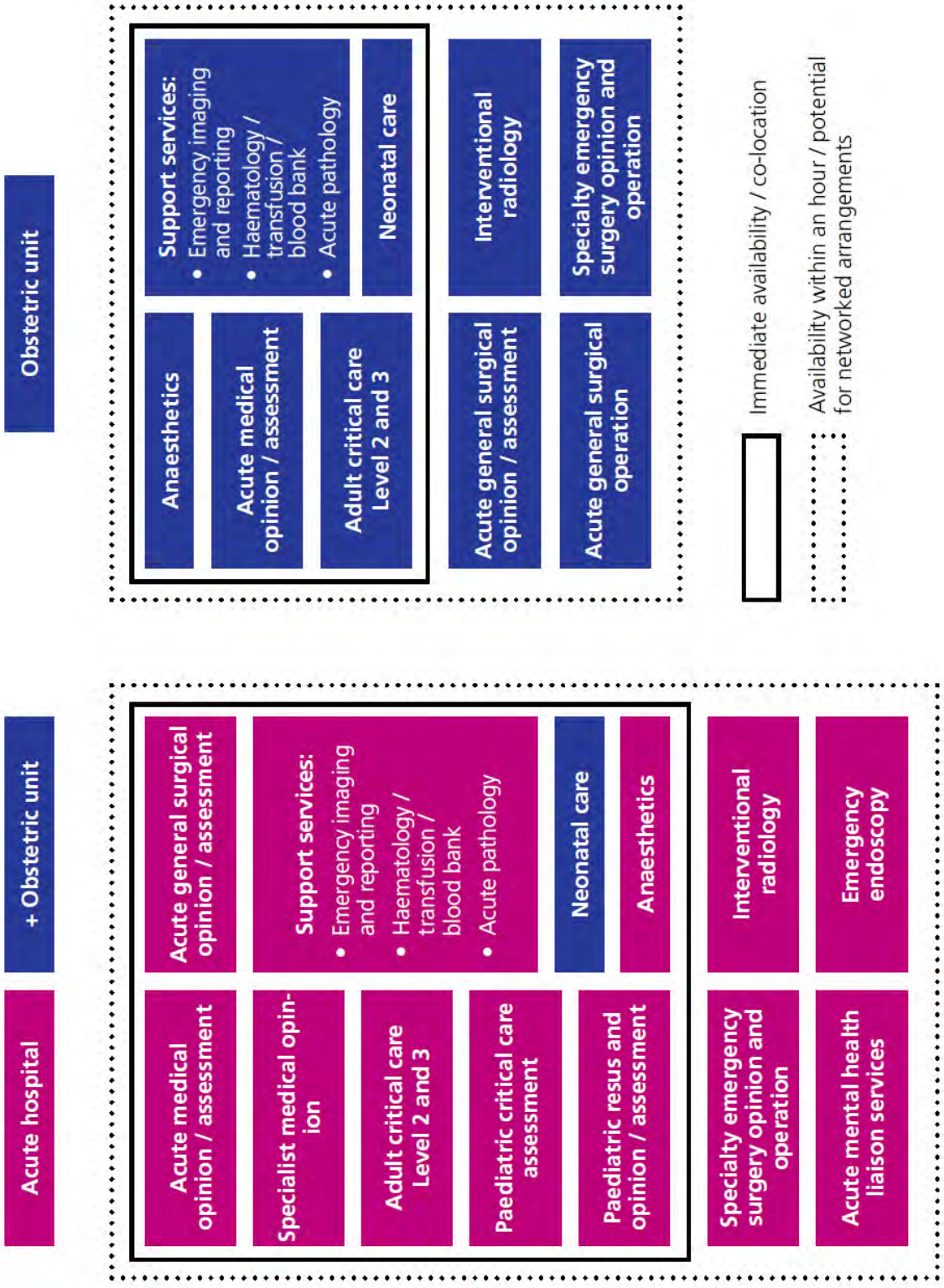
Maternity Care		
Issue	**Evidence**	**Impact**
Inability to meet Royal College of Obstetricians and Gynaecologists' standards for consultant labour ward presence across all hospitals A skilled and competent workforce is essential to deliver a safe and high quality maternity service for all women and their babies yet there is variation in the level of consultant labour ward cover	Currently labour ward cover by consultants in maternity units ranges from 60 hours per week to 94 hours per week[xvi]	168 hours (24/7) consultant labour ward presence reduces risk to mothers and babies and improves outcomes[xvii]

Elective Care		
Issue	**Evidence**	**Impact**
High cancellation rates and delays for elective procedures - due to non-clinical reasons - associated with the insufficient separation of planned and unplanned care	In 2011/12 1,250 elective procedures were cancelled at the last minute for non-clinical reasons[vii] Waiting times for elective procedures did not consistently meet NHS constitution in 2011/12 in all but one hospital	No last minute cancellations for non-clinical reasons due to separation of elective and emergency activity[xv] A reduction in waiting times, meeting pledge to patients in NHS constitution

Sources:

1. ONS Interim mid 2011based Sub-national population projections
2. London Health Inequalities Network
3. Estimated from HES 2010/11; QOF 2010/11; ONS 2011
4. SEL Cluster –Simple Operating Models"; TSA Commissioning forecast model, team estimates, CCG working groups
5. Greater London Authority, myhealthlondon indicator
6. GP Patient Survey July-September 2011
7. Trust data submissions
8. National End of Life Care Programme Intelligence Network
9. NHS Choices
10. NAO 2012 –Management of Adult diabetes service in the NHS"0
11. National Audit Office report, 2012; Clement, Kyle, Tierney, Tierney (2010), South central Foundation: The SCF Nuka Model of Care—Customer-Owners Driving Healthcare
12. Diabetologia 2012
13. South East London Commissioning Strategy Plan
14. CBC working group planning assumptions, TSA reconfiguration model
15. Based on Gateway Elective Centre in north east London
16. Local Supervising Authorities of London
17. Royal College of Obstetricians and Gynaecologists
18. Dr Foster
19. London Health Programmes (2011) Adult emergency services: case for change
20. Survey of London acute trusts (2011)
21. Dr Foster
22. Royal College of Surgeons of England
23. Royal College of Paediatrics and Child Health

Annex 2: Clinical dependencies



Office of the Trust Special Administrator

Appendix F

Proposed organisational arrangements following dissolution of South London Healthcare NHS Trust

Securing sustainable NHS services

Introduction

1. This appendix to the final report of the Trust Special Administrator (TSA) appointed to South London Healthcare NHS Trust relates to chapters 4, 5 and particularly 6 of the report. These chapters describe the full set of recommendations being made in relation to South London Healthcare NHS Trust and, as necessary to secure sustainable services, the consequences on the wider health economy. The focus of this appendix is on the conclusion that South London Healthcare NHS Trust should be dissolved and that new organisational solutions should be sought to drive up the capability to execute the complex and extremely challenging set of recommendations laid out in the final report. When we refer to organisational solutions or to the organisational future of South London Healthcare NHS Trust, we mean the organisations which may provide the services currently provided by South London Healthcare NHS Trust.

2. Following an extensive assessment of South London Healthcare NHS Trust (see chapter 4 of the report) it has been concluded that South London Healthcare NHS Trust cannot be made financially viable in the current service and organisational arrangements. This appendix sets out the work that has been undertaken by the TSA to determine recommendations relating to the organisational arrangements. It describes: the process undertaken, including market engagement, to assess options for the organisational future of the Trust and the outcome of that assessment; the recommendations included in the draft report issued on 29 October 2012; the key messages received during consultation; a summary of the work done during and after consultation; and the final recommendations.

3. Various options were considered by this process including: statutory merger and/or acquisition, joint venture, franchise, management of healthcare services, management of support services and/or delivery of clinical services and the creation of stand alone NHS trusts covering parts of South London Healthcare NHS Trust as it exists today. On the initiation of this work the retention of South London Healthcare NHS Trust was also an option to be reviewed. However, as the work of the TSA progressed this option was excluded as not being feasible because firstly, a broader change in service configuration is necessary to deliver long term clinical and financial viability and secondly, the TSA decided that the organisational capacity and capability necessary to deliver the recommended operational efficiencies (see

recommendation 1 in the final report) is not present in South London Healthcare NHS Trust.

4. The potential pace of change has been a critical factor in the assessment process. It is recommended that all of the TSA's proposals are implemented over the three financial years 2013/14, 2014/15 and 2015/16. Delivering improvements in a three-year period is critical to the overall success of the recommendations as it will enable organisations in south east London to respond to the further financial constraint expected in the public sector. Meeting this challenging timetable will require appropriate leadership capability and engaged staff. Eliminating organisational uncertainty as quickly as possible and ensuring clear lines of accountability is therefore essential to success. As a result, the pace of change and the speed of implementation have been a central theme of the work. The proposed date for dissolution of South London Healthcare NHS Trust and the establishment of new or enlarged organisations is recommended to be 1 June 2013. This will maintain this pace but also ensure that all the necessary work required ahead of dissolution can be completed to time.

Approach

5. The approach taken to assess the most appropriate organisational arrangements for South London Healthcare NHS Trust had five stages:
   - understand the overarching options and legal constraints;
   - determine evaluation criteria;
   - gauge market interest;
   - engage in dialogue with interested parties; and
   - assess options and draw conclusions.

6. The detail of the process followed for each of these stages is described below. Given the commercially sensitive and confidential information considered as part of this work, some information gathered as part of the market engagement process is confidential and therefore not included in this report.

Overarching options and legal constraints

7. Six overarching options were identified as potential alternatives to the retention of South London Healthcare NHS Trust. These were: statutory merger and/or acquisition; joint venture; franchise; management of healthcare

services; management of support services and delivery of clinical services; and creating new NHS trusts covering parts of South London Healthcare NHS Trust.

8. Certain options could involve either NHS or non-NHS organisations, or groups of organisations, as providers or managers of some, or all, of the services currently provided by South London Healthcare NHS Trust.

9. For each option, the mechanics of the transaction and the associated risks and issues were assessed. These issues varied depending on the functions or services that could potentially be transferred; the proposed treatment of land and assets; the ability to involve (and provide a level playing field between) NHS or non-NHS providers; and the proposals for single providers or groups of providers.

10. Although EU and UK procurement law does not apply to NHS statutory mergers and acquisitions, the TSA has considered the need for equal treatment, transparency and non-discrimination in the selection of an NHS partner. This included the need to make information available on an even and transparent basis.

11. Consideration was given to whether it was necessary to name particular providers in order to make recommendations in respect of South London Healthcare NHS Trust achievable. In particular, it was necessary to consider whether any option may affect other providers in the wider south east London health economy and the need for services to be delivered in a clinically and financially sustainable manner.

Determination of evaluation criteria

12. To ensure only workable, clinically and financially viable organisational arrangements were considered, hurdle criteria were developed with input from the patient and public advisory group, the clinical advisory group and the TSA advisory group. The criteria are outlined in figure 1. The first criteria was to require any provider to be financially sustainable. The second criteria was to require providers to be able to deliver acute clinical care or care to the local population. The third criteria, “Is there market interest?”, recognises that the majority of the overarching options open to the TSA are only workable if there is interest from another provider, either NHS or non-NHS, to operate one or more of the sites that make up South London Healthcare NHS Trust.

Figure 1: Hurdle criteria to assess responses to market engagement.

	Criteria	Description
Hurdle criteria	▪ Viability, clinical synergy and market interest	▪ Are providers financially sustainable? ▪ Can providers demonstrate an ability to deliver acute clinical care *or* clinical care to the local population? ▪ Is there market interest?

13. Working with all the advisory groups, an organisational solutions working group (as described in appendix C) developed a set of criteria for evaluating options that met the hurdle criteria, these are outlined in figure 2.

Figure 2. Evaluation criteria for organisational options.

Evaluation criteria	▪ Quality of acute care	▪ To what extent does the option meet the quality envisioned in the site strategy or offer enhanced quality?
	▪ Productivity	▪ To what extent does the option deliver or exceed the required productivity gains?
	▪ Integrated care	▪ To what extent does the option enable better integration between primary, community, acute and social care?
	▪ Deliverability	▪ Over what time frame will benefits be realised?
	▪ Choice and competition	▪ What impact will the option have on patient choice, access and competition?
	▪ Stakeholder alignment	▪ How aligned are stakeholders (potential partners, patients, public, staff) behind the option?

Market interest

14. The TSA undertook a market engagement exercise that ran from 23 August to 14 September 2012. This was to judge the feasibility of some of the overarching options and assess the level of interest from NHS and non-NHS providers in operating the services currently delivered by South London Healthcare NHS Trust. This was important because it would be impractical for the TSA to recommend actions that were not workable due to a lack of interest from the market. This process also provided an opportunity for additional proposals for achieving sustainability at South London Healthcare NHS Trust to come forward. This opportunity was particularly relevant to the emerging recommendations relating to operational efficiencies and service change. For the latter, it also presented the opportunity to explore whether a provider could take the financial risk associated with the operating losses at South London Healthcare NHS Trust (or part of it) and thus reduce or negate the need for recommendations relating to the wider health economy.

15. On 23 August 2012 a request was issued to all acute, mental health, ambulance and community NHS Trusts, NHS Foundation Trusts and non-NHS healthcare providers in England. Organisations were asked to respond if they were interested in being involved in part of one or more of the organisational options.

16. The documentation confirmed that the TSA was looking to understand interest from parties that met the following criteria:

    - Ability to deliver acute clinical care; or
    - Ability to deliver clinical care to the local population; and
    - Financial sustainability.

17. The documentation set out that the market engagement exercise was not to be regarded as a commitment or a representation to enter into a procurement exercise or any contractual arrangement (on the part of commissioners or the TSA). The purpose of the engagement was to test the appetite of the market in order to develop the organisational arrangements to be included in the draft report and to be consulted on. The market engagement exercise served the purpose of:

    - Assessing the level of interest for services and sites;
    - Establishing if there was no interest in certain services or sites;
    - Enabling the TSA to understand a view on the requirements of the market so that time or cost was not wasted tendering a contract for which there was no interest; and
    - Presenting an opportunity to identify alternative options.

18. Each interested party was asked to provide:

    - An overview of the party;
    - Information on clinical care provision over the last five years, including provision of acute care.
    - Audited financial statements for the last five years and evidence of ability to access capital.
    - A description of options of interest to the party.

19. The organisational solutions working group assessed the responses received against the hurdle criteria to identify with which parties the TSA should re-engage.

Dialogue with interested parties

20. Letters were sent to all respondents. Organisations identified to be re-engaged were requested to sign a non-disclosure agreement and were furnished with additional relevant information regarding South London Healthcare NHS Trust in advance of meeting with the TSA. Information included financial data on the Trust, emerging analysis undertaken by the TSA team including the operational efficiency assessment, a description of the service configuration recommendations under consideration, with the impact on the Trust and high level assumptions for future activity. Additional information was provided at request and, therefore, tailored according to the respondent's area of expressed interest.

21. This approach did not rule out other interested parties from competing for any services currently provided by South London Healthcare NHS Trust that commissioners or the Secretary of State may decide should be put out for competitive tender at a later time.

22. Meetings took place between September and October 2012. The broad purpose of all meetings held was to ensure that any recommended option would be capable of delivery by the relevant party and that any recommendation to be included in the draft report could be implemented successfully within the required timeline. At the meetings, emerging service configuration options for South London Healthcare NHS Trust and south east London were discussed (see chapters 4 and 5 of the final report and appendices N and E) to enable providers to understand the services that they may be required to provide if service changes were to be proposed and accepted.

Assessment of options

23. Consideration of the market engagement responses and the subsequent meetings with interested parties enabled the creation of a short list of options for organisational recommendations. These options were bespoke by site. The short listed options were then evaluated by the Organisational Solutions Working Group against the evaluation criteria (see figure 2).

24. This evaluation resulted in a preferred organisational solution and alternate providers for each of the three main sites that make up South London Healthcare NHS Trust. These conclusions were outlined in the draft report of the TSA, which was published on 29 October 2012, and consulted on for 30 working days. Alongside the consultation process further work was completed

on the preferred options to further test their potential for supporting the resolution of the issues at South London Healthcare NHS Trust as part of the overall set of recommendations.

Outcomes of the market engagement process

25. In response to the market engagement exercise, the TSA received 39 responses. Seven of these were from NHS providers and 32 from the independent or voluntary sector.

26. Among the responses received, there was a high level of interest in integrated models and community care. Approaches to proposed delivery varied, but no new models were identified that challenged the emerging service configuration options being developed by the clinical advisory group and the community based care working group.

27. Application of the hurdle criteria identified nine parties (four of which were NHS providers) with whom the TSA would re-engage. The other 30 responses were assessed as follows:

    - Response did not provide the requested information to enable an assessment against the hurdle criteria;
    - Response did not meet the hurdle criteria "ability to deliver acute clinical care";
    - Response was regarding provision of a single service at the Trust. These respondents may be suitable for consideration in the future should a procurement process be considered appropriate by commissioners or providers however they did not represent viable alternatives to South London Healthcare NHS Trust and its wide ranging service provision;
    - Response proposed integrated models of care, but did not present organisational options that would resolve the challenge the TSA has been tasked with addressing.

28. Three of the nine organisations to pass the hurdle criteria indicated they would consider providing all of South London Healthcare NHS Trust's current services within the funding available, thereby taking on the considerable financial challenges of South London Healthcare NHS Trust and avoiding the need for service change.

29. The TSA further engaged with these three organisations to understand if this was a viable option to recommend due to the importance that such an option

could have as set out in paragraph 14 in this appendix. Following the signing of non-disclosure agreements and the subsequent release of further information to the three parties all organisations confirmed that they considered the size of the financial challenge insurmountable with the current configuration of services. Consequently the option of appointing an alternative provider to deliver improvements at the sites that make up South London Healthcare NHS Trust without associated service reconfiguration was ruled out.

30. Further dialogue with all nine parties who were interested in discussing potential solutions for individual component sites of South London Healthcare NHS Trust, as part of an overall package of recommendations to include service change, was then undertaken. Following these discussions, the organisational solutions working group generated a short list of options for new organisational arrangements (for example, creation of a standalone NHS trusts, merger or procurement of clinical or franchising services) for each site which were then evaluated against the set of criteria. The short list was as follows:

Queen Elizabeth Hospital

- Queen Elizabeth Hospital as a standalone NHS trust with no external management support
- Queen Elizabeth Hospital either:
  - as a standalone NHS trust with management support provided under a franchise arrangement following a procurement exercise; or
  - with clinical services provided following a procurement exercise (with the site retained by a NHS body)
- Queen Elizabeth Hospital merged with or acquired by another NHS provider (by the statutory transfer of relevant assets and liabilities relating to that site), with Lewisham Healthcare NHS Trust being the only NHS provider to express an interest in this site.

Princess Royal University Hospital

- Princess Royal University Hospital as a standalone NHS Trust with no external management support
- Princess Royal University Hospital either:
  - as a standalone NHS trust with management support provided under a franchise arrangement following a procurement exercise; or
  - with clinical services provided following a procurement exercise (with the site retained by a NHS body).

- Princess Royal University Hospital merged with or acquired by another NHS provider (by the statutory transfer of relevant assets and liabilities relating to that site), with King's College Hospital NHS Foundation Trust being the only NHS provider to express an interest in this site.

Queen Mary's Hospital

- Transfer of Queen Mary's Hospital land and buildings to another NHS organisation and services (relating only to those currently being provided by South London Healthcare NHS Trust) being transferred to appropriate NHS providers for an interim period, with services tendered by local commissioners after this interim period.

Assessment of options

31. The evaluation of the short listed options for each of the three sites, and the preferred organisational option recommended by the organisational solutions working group and included in the draft report, are summarised below. Figures 3, 4 and 5 include the broad arguments discussed by the organisational solutions working group in relation to the evaluation criteria.

Queen Elizabeth Hospital

Figure 3: Assessment of short listed options for Queen Elizabeth Hospital

Option	Advantages	Disadvantages
Queen Elizabeth Hospital as a standalone NHS trust with no external management support and an NHS management team.	• Current provision of good quality of care where it exists would likely continue • No reduction in patient choice • Could be delivered quickly.	• Reliance on service reconfiguration to achieve financial viability, reducing likelihood of being viable as standalone trust • there are no additional integrated care synergies from being a standalone trust • assembling a NHS management team capable of delivering the required operational improvements in the available time frame would be difficult. • Less potential for improving clinical services due to continuation of existing systems and processes
Queen Elizabeth Hospital either: (1) as a standalone NHS trust with management support provided under a franchise arrangement following a procurement exercise; or (2) with clinical services provided following a	• Current provision of good quality of care where it exists would likely continue • No reduction in patient choice - additional competition compared to a merger • Under option (2) a new provider (selected following the competitive tension in a procurement exercise) could drive additional productivity improvement.	• The market engagement process provided no interest in the delivery of the complete bundle of acute services through a competitive procurement process • Only Lewisham Healthcare NHS Trust expressed an interest in providing or managing the services to be delivered from the Queen Elizabeth Hospital site, suggesting the franchise option is unlikely to be delivered within the timeframes required • There are no additional integrated care synergies from being a standalone trust.

procurement exercise (with the site retained by a NHS body).		
Queen Elizabeth Hospital coming together with Lewisham Healthcare NHS Trust.	• The new organisation would facilitate the implementation of the service change recommendation (5) • With the new service configurations both hospitals within the new organisation would be financially viable • Lewisham Healthcare NHS Trust has a record of delivering acute clinical services in financial balance in recent years • Lewisham Healthcare NHS Trust has issues with its sustainability being part of a bigger Trust would help enable the viability of both elements • Lewisham Healthcare NHS Trust currently provides community services, thus there are potential opportunities for improving the integration of services • The transaction could be completed quickly due to the involvement of another NHS trust.	• Merger of two NHS trusts does not always bring the required benefits (Lewisham Healthcare NHS Trust is a relatively small Trust and the addition of Queen Elizabeth Hospital would be a significant increase in the scale of the organisation, with associated risks to delivery of benefits) • Lewisham Healthcare NHS Trust does not have a track record of delivering operational efficiencies at the scale and pace necessary at Queen Elizabeth Hospital • Patient choice could be reduced by merging the Queen Elizabeth Hospital with an existing south east London provider – although this could be mitigated by including recommendations in relation to the protection of patient choice.

32. The TSA must ensure that recommendations in respect of South London Healthcare NHS Trust are viable, workable and clinically and financially sustainable. In this context, alongside the qualitative analysis of these options the TSA considered the financial viability of each option in more detail, taking into consideration the impact of the wider set of draft recommendations to ensure the draft recommendations were viable.

33. Financial analysis of the Queen Elizabeth Hospital site suggests that it is not viable in the long term as a stand-alone organisation without recommendation 5. Additionally, implementation of recommendation 5 would destabilise Lewisham Healthcare NHS Trust as it is currently organised and would render it unable to achieve foundation trust status in its current form. Through the

market engagement exercise, however, Lewisham Healthcare NHS Trust brought forward a single expression of interest to merge with Queen Elizabeth Hospital. This configuration, supported by the implementation of recommendations 1 to 5 will ensure the long-term viability of the merged organisation and will be conducive to a future foundation trust application.

34. Given the need to ensure that Lewisham Healthcare NHS Trust is part of a viable organisation, coupled with the limited market interest in Queen Elizabeth Hospital from acute providers (and the lack of other capable providers), the option to run a competitive process to select a NHS partner was considered to be impractical and disproportionate.

35. Following this assessment, the preferred option in relation to Queen Elizabeth Hospital of creating a new NHS Trust by coming together with Lewisham Healthcare NHS Trust was included as the recommendation in the draft report.

Princess Royal University Hospital

Figure 4: Assessment of short listed options for Princess Royal University Hospital

Option	Advantages	Disadvantages
The Princess Royal University Hospital as a standalone NHS trust with no external management support.	• Current provision of good quality of care where it exists would continue • No reduction in patient choice • Could be delivered quickly.	• Assembling a NHS management team capable of delivering the required operational improvements in the available time frame would be difficult. • There were no integrated care synergies realised through being a standalone site. • Less potential for improving clinical services due to continuation of existing systems and processes
The Princess Royal University Hospital either: (1) as a standalone NHS Trust with management support provided under a franchise arrangement	• Market testing suggested that there was sufficient –albeit limited – interest in the hospital (both NHS and via third party providers) in either procurement option • A competitive process should be able to identify the organisation best placed to deliver safe and effective services from that site efficiently. • A competitive process could	• The procurement exercise could be accelerated, however it would still take a minimum of 9 to 12 months although a longer period is more realistic • During the procurement the Trust would need to be run by an interim management team. The risk of operational and financial deterioration during that period was thought to be high. • There are no integrated care

following a procurement exercise; or (2) with clinical services provided following a procurement exercise (with the site retained by a NHS body)	minimise the need for financial support • The procurement would likely add additional competition and choice within the health economy.	synergies emerging from this option. • The degree of competition in any procurement might be limited and the chances of either failure (no plausible bidder emerging) or a very small number of bidders and consequently limited negotiating power on the part of the NHS and ability to capture benefits could be high.
The Princess Royal University Hospital being acquired by King's College Hospital NHS Foundation Trust.	• King's College Hospital NHS Foundation Trust has a strong record of delivery of acute services and a respected management team. Trust performance over the last three years has been excellent, with a financial risk rating of 3 and between 95 – 100 per cent governance compliance rating with Monitor. • King's College Hospital NHS Foundation Trust could further develop services (eg. the hyper acute stroke unit) at the site and enhance clinical synergies • King's College Hospital NHS Foundation Trust also has a very strong record in productivity, evidenced by asset utilisation. For example: acute medicine length of stay has fallen from 8 days to 4 days over the last 3 years, with admission avoidance rates of 20 per cent and the Trust has a theatre utilisation rate of 85 per cent. • Initial indications suggested that with an accelerated timetable, the transaction could clear NHS regulatory requirements by the end of February 2012, and be completed within a 4 to 5 month time period thereby addressing the key issue of progressing at pace. • Stakeholders working closely with South London Healthcare	• King's College Hospital NHS Foundation Trust has commenced work on a merger with the NHS organisations that make up King's Health Partners: Guy's and St Thomas' NHS Foundation Trust and South London and the Maudsley NHS Foundation Trust as well as with Kings College London. The complexity of managing multiple transactions raises the risk of failing to deliver on the required operational improvements. • King's College Hospital NHS Foundation Trust had not, prior to the draft report, made a full commitment to the acquisition in the near term. • The acquisition would be subject to Monitor's Compliance Framework and there was, prior to the draft report, no certainty that the risk rating would remain at least at 3 which is the minimum acceptable to King's College Hospital NHS Foundation Trust. • The proposed King's Health Partners merger and Princess Royal University Hospital acquisition may impinge on the ability of commissioners to offer choice to their patients.

	NHS Trust and Kings College Hospital NHS Foundation Trust appear supportive of the transaction.	

36. The financial modelling for these options suggested that, without service reconfiguration, the Princess Royal University Hospital could not achieve financial viability as a standalone entity. However, post-reconfiguration the site could achieve financial viability if it can fully capture the operational efficiency opportunities outlined in recommendation 1. The working group concluded that delivering the required improvements in the available time frame would be difficult for the Princess Royal University Hospital operating as a standalone NHS trust given the challenge around recruiting the leadership capacity and capability and changing the organisational culture that would be required.

37. Recognising this, responses to the market engagement were considered. A number of parties were interested in taking the hospital as a whole entity – including a number of private sector providers and a single NHS provider, King's Colleges Hospital NHS Foundation Trust.

38. Having assessed these options the organisational solutions working group recommended the there are two viable options for the Princess Royal University Hospital. The first, and preferred option, is an acquisition by King's College Hospital NHS Foundation Trust which can happen at pace. It would enable the delivery of service change, enhance the services offered at the site and strengthen the capacity of the site to deliver the necessary operational improvements. The alternative option is to run a procurement process that would allow any provider from the NHS or independent sector to bid to run the bundle of services on the site. This could offer benefits around operational improvements and competition, but potentially less opportunity around service change and integration and would take significantly longer to implement.

Queen Mary's Hospital

39. A single option was identified for Queen Mary's Hospital (see figure 5). This solution was identified based on previous work discussed and agreed by the Queen Mary's Hospital Campus Steering Group that has proposed Oxleas NHS Foundation Trust take over the site. Oxleas NHS Foundation Trust already provide a range of community and mental health services on Queen

Mary's Hospital, and the proposal for them to take over the site has received support from local stakeholders including Bexley CCG, the London Borough of Bromley, Oxleas NHS Foundation Trust and South London Healthcare NHS Trust. In addition to this, Oxleas NHS Foundation Trust were the only organisation, of those that put themselves forward through the market engagement process, that are in a position to provide the necessary investment to ensure the hospital is fit for purpose in line with the commissioner's vision for its future use (see chapter 4 of the final report and appendix N for details of the vision).

Figure 5: Assessment of options for Queen Mary's Hospital

Option	Advantages	Disadvantages
Transfer Queen Mary's Hospital land and buildings to Oxleas NHS Foundation Trust, with South London Healthcare NHS Trust services being transferred to appropriate NHS providers for an interim period, with a re-tender of services by local commissioners after a transitional period	• Keeping the ownership of the land at Queen Mary's Hospital within the NHS, and ensuring that the hospital will continue to be a centre for local health and social care provision in Bexley; • Investment (from Oxleas NHS Foundation Trust) in the hospital to ensure that all buildings and equipment are fit for purpose and can continue to provide services for the local population • Maintaining many of the current South London Healthcare NHS Trust services on the site, including day case elective surgery to support local patient choice • Interim provision by an NHS provider will support continuity of care and patient safety as the wider TSA recommendations are implemented, providing staff at South London Healthcare NHS Trust with some continuity during transition and allowing commissioners to develop their capacity and capability to complete a full procurement of services • The procurement of a longer-term provider after a period of transition will ensure that there is clarity on the services being commissioned from the hospital in the future and allow commissioners to identify the organisation best placed to deliver safe and effective services from that site safely and	• An increased level of complexity during transition as multiple transactions are completed for the transfer of land and services • Interim provision, followed by a subsequent procurement and potential change of provider, may cause further disruption staff which may impact on the operation of services • Risk of service fragmentation with multiple providers on site • Risk of challenge around the award of any interim contracts.

	efficiently. It would also mitigate the concerns of any adverse impact on choice and competition.	

40. Through the market engagement exercise a number of organisations expressed an interest in providing individual South London Healthcare NHS Trust services on the Queen Mary's Hospital site. Given the wide reaching impact of the TSA recommendations, it was agreed that separating out services for individual procurements would not be effective at this time and may put the continued provision of quality care at risk.

41. With this in mind, the work for the draft report focused on the services to be provided on the Queen Mary's Hospital site, in particular day case and endoscopy services. In relation to these day case and endoscopy services, of the organisations that passed the hurdle criteria (described in section 2) the only one that demonstrated an interest in providing the South London Healthcare NHS Trust services on the hospital site was Dartford and Gravesham NHS Trust. Dartford and Gravesham NHS Trust already provides care to many Bexley residents, including emergency and maternity services, and therefore has an existing relationship with Bexley CCG and can offer synergy benefits and continuity for many local patients. In addition, they will not be distracted by the other TSA recommendations during transition to the same extent as other south east London providers and are supportive of the need to complete a procurement of these services in the longer term.

42. The draft report therefore recommended that the core elements of the Queen Mary's Hospital site required to deliver the NHS services outlined by commissioners should be transferred to Oxleas NHS Foundation Trust, and that the day case services provided on the site should be provided by Dartford and Gravesham NHS Trust for an interim period, with commissioners completing a procurement exercise to determine the longer term provider of these services.

43. There are a number of services currently provided at Queen Mary's Hospital, which commissioners have outlined as part of their vision of the future, that Dartford and Gravesham do not currently provide or are highly specialised services. These include specialist outpatient and day case services for oral surgery, ophthalmology and chemotherapy. Following discussions with local clinical and operational experts King's College Hospital NHS Foundation Trust are being recommended as the provider for oral surgery and ophthalmology. King's College Hospital NHS Foundation Trust already provide the clinical staff to deliver South London Healthcare's oral surgery services and are the

other prime provider of ophthalmology services in south east London so can offer synergies to these services across south east London, especially if they are the provider running the Princess Royal University Hospital in Bromley. It is also recommended that the chemotherapy service currently provided by South London Healthcare NHS Trust should be provided by Guy's and St Thomas' Trust NHS Foundation Trust in the future, as they are looking to provide satellite radiotherapy service on the site which would allow integrated provision of cancer service on the site. It is also being recommended that Oxleas NHS Foundation Trust provide the Children's Development Centre and the Children's and Young Person's Assessment Unit as they already provide a range of community paediatric services so can improve the integration of the services on offer.

Developing the final organisational solutions recommendations

44. Since the publication of the draft report further work has been undertaken to test the benefits and risks of each of the preferred organisational solution options. Having recognised through the draft report that South London Healthcare NHS Trust should be dissolved work progressed on considering the best approach to delivering that and establishing new arrangements as quickly as possible.

45. In recognition of the volume of work required a working group was established for each of the transactions related to the future of each South London Healthcare NHS Trust hospital and one to consider the activities required to dissolve the Trust itself. A working group to focus on the human resources (HR) requirements for these proposals was also established and has agreed a framework for implementation going forward if the recommendations are accepted by the Secretary of State or he provides an alternative approach.

46. Further work has been done to consider the financial impact of each of the proposals in more detail, including the requirements for any interim transitional support whilst the other recommendations are implemented. Alongside this an independent due diligence exercise to support consideration of the proposal that a new organisation is created which brings together Queen Elizabeth Hospital with Lewisham Healthcare NHS Trust was commissioned. King's College Hospital NHS Foundation Trust has developed its Outline Business Case for the transaction and is in the process of completing its own independently commissioned due diligence exercise.

47. Further work has also been completed to expand the proposals relating to the future providers of services at Queen Mary's Hospital and potential service offerings for the future. Information on this work is provided in appendix N.

Consultation responses

48. Consideration has also been given to the feedback from the TSA consultation, summarised in figure 6 (further information on this can be found in the Mori Report in appendix I), and to the outcome of the Health and Equalities Impact Assessment (HEIA). The HEIA has not identified any specific impacts on patients and the public based on the organisational changes proposed in the draft report. However, there are potential impacts on staff, which have been considered in developing the final recommendations (the full HEIA can be found at appendix L).

49. Staff could be affected by potential reductions in staffing due to operational efficiencies, movements in activity (meaning services are now delivered at other sites) and from altered rotas needed to deliver more expert care 24/7. These changes could impact on staff training, travel and morale. 80% of South London Healthcare NHS Trust non-medical staff are women, and 35% are from ethnic minority groups which will require a review of HR policies and procedures to ensure these groups of staff currently working at South London Healthcare NHS Trust, do not suffer and are not disadvantaged.

50. Feedback from the consultation has been focused around the five key areas of organisational change proposed by the TSA:
    - The dissolution of South London Healthcare NHS Trust;
    - The merger between Queen Elizabeth Hospital and Lewisham Healthcare NHS Trust;
    - The acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust;
    - The transfer of Queen Mary Hospital to Oxleas NHS Foundation Trust
    - The write-off of the debt accumulated by South London Healthcare NHS Trust by the Department of Health.

Figure 6: Consultation feedback in relation to organisational solutions

Consultation feedback in relation to the dissolution of South London Healthcare NHS Trust
The majority of responses (65%) from individuals indicated opposition to the

dissolution of South London Healthcare NHS Trust. There was significant variation of opinion depending on the borough where the respondent resided (e.g. 41% of Bexley respondents were supportive compared with 9% in Lewisham) and the occupation of the respondent (32% of respondents who were NHS workers were supportive of the proposal compared with 11% of those who had never worked in healthcare).

Organisations and groups were generally more positive with 34% supporting the proposal to dissolve South London Healthcare NHS Trust but with 42% against. Feedback noted from organisations and groups included:

- **From commissioners:**
  - There was very limited response from commissioners on the proposed dissolution. Bexley CCG did note the TSA draft recommendations on organisational change and considered that they are consistent with their requirements; and
  - NHS South East London PCT Cluster confirmed the organisational changes recommendation should be implemented as quickly as possible to achieve efficiency and quality improvements.
- **From providers:**
  - King's Health Partners support this recommendation; and
  - Oxleas NHS Foundation Trust noted the impact of the dissolution of South London Healthcare NHS Trust may have on Oxleas in respect of the current provision of Greenwich Community Services.
- **From other health bodies:**
  - NHS London support the proposal.
- **From local authorities and other public representative groups:**
  - The London Borough of Bexley support the proposed breakup of South London Healthcare NHS Trust and the move to new organisational configurations;
  - The London Borough of Bromley notes that they see no future for South London Healthcare NHS Trust as a result of the reconfiguration proposed;
  - Lewisham Council believe that given the merger of three trusts to form South London Healthcare NHS Trust did not succeed in creating a sustainable NHS trust, the TSA's draft recommendations fail to outline why de-merging and subsequently re-merging in different configurations is likely to succeed;
  - Mid Surrey LINk were strongly in support of the dissolution, Bexley LINk had broad support, although raised concerns about ensuring that suitable management was put in place to avoid a repeat of the situation and Southwark LINk were unsure due to possible greater pressure on A&E and maternity services at King's College Hospital; and
  - Bromley LINk, Greenwich LINk, Lambeth LINk, Lewisham LINk and Kent LINk did not comment on this proposal.
- **From workforce and staff representative groups**
  - Unison support the proposal for the dissolution of South London

Healthcare NHS Trust as long as services continue to be managed and delivered by NHS organisations;
    - Unite and SLHT Staff-side disagreed with the proposal to dissolving South London Healthcare NHS Trust; and
    - The South London Local Education and Training Board noted that they will be involved at an early stage to support any reorganisation by ensuring the design and development of the workforce is underpinned by high quality education.

Key themes from this feedback:

- Belief that the Trust could be rescued with better management, without the need for major reorganisation and a belief that poor management at South London Healthcare NHS Trust had led to many of the problems;
- Concern about the level of disruption that dissolution would cause; and
- If the dissolution of South London Healthcare NHS Trust goes ahead, suitable management and processes should be put in place to prevent this from happening again.

In response to these key themes:

- The Regime for Unsustainable Providers was enacted at South London Healthcare NHS Trust after a series of other initiatives, including turnaround measures and system wide reconfiguration, have already been tried and failed to resolve the underlying issues. Throughout the TSA programme, consideration has been given to the best available expert guidance on the deliverability of proposed changes;
- As outlined in chapter 4 of the final report, after extensive analysis and detailed internal review, it has been concluded that it is not possible to make the sites that exist as South London Healthcare NHS Trust financially viable in the current service and organisational arrangements; and
- The HEIA does not list any specific impacts relating to the organisational changes. Mergers and the acquisition of NHS Trusts are complex but are not uncommon. Significant best practice guidance and expertise is available to ensure that quality of care is, at the very least, maintained throughout this process. An implementation/transition team with the capability to manage the changes will be put in place to ensure quality is maintained.

Consultation feedback in relation to the merger between Queen Elizabeth Hospital and Lewisham Healthcare NHS Trust

The majority (71%) of individual respondents were opposed to the proposed merger of Queen Elizabeth Hospital with Lewisham Healthcare NHS Trust. There were variations depending on the location of the respondent, with only 8% of those living close to University Hospital Lewisham being supportive of the proposals but 28% of those living close to Queen Elizabeth Hospital being supportive. Residents in Bexley and Bromley were more supportive than those living in Lewisham.

Around 10% of individual respondents and 27% of group or organisational responses were in support of the merger. Feedback noted from organisations and groups included:

- **From commissioners:**
  - Lewisham CCG (covering the borough of Lewisham where Lewisham Healthcare NHS Trust is located) noted the proposed organisational changes and consider that they are consistent with their requirements; and
  - Greenwich CCG (covering the borough of Greenwich where Queen Elizabeth Hospital is located) did not comment on this proposal.
- **From providers:**
  - Lewisham Healthcare NHS Trust has restated their desire to merge with Queen Elizabeth Hospital. It also expressed the desire to plan the details of the service changes itself.
- **From other health bodies:**
  - NHS London support the proposal;
  - The Royal College of Midwives and Royal College of Nursing were supportive of the proposal for the creation of a new organisation;
  - No other comments from Royal Colleges were received on this recommendation.
- **From local authorities and other public representative groups**
  - The Royal Borough of Greenwich (where Queen Elizabeth Hospital is located) welcomed the decision to commence early work on the arrangements for the proposed merged Trust. It noted that the required transformation will be particularly challenging if solutions are being imposed and not owned by managers and staff;
  - Bexley LINk broadly supported the merger, although were concerned that there was no proof that the new organisations (potentially private) will be able to deliver services. Mid Surrey LINk and Southwark LINk also gave support. Greenwich LINk were concerned that the merger was „penalising' Lewisham Healthcare NHS Trust; and
  - Bromley LINk, Lambeth LINk, Lewisham LINk and Kent LINk did not comment on this proposal.
- **From workforce and staff representative groups**
  - Unison support the proposal for Queen Elizabeth Hospital and Lewisham Healthcare NHS Trust to come together in principle.

Key themes from this feedback:

- Failure of previous mergers;
- Perceived risk to Lewisham Healthcare NHS Trust of taking on a „failing hospital' and concern around the potential impact on services provided at University Hospital Lewisham; and
- Some concern around detailed planning for implementation.

In response to these key themes:

- The TSA report itself is clear that proposed benefits from merging NHS

Trusts have historically not been fully realised. There are, therefore relatively, limited financial benefits assumed to be realised from the mergers. The mergers do however, support the delivery of some of the other recommendations, particularly recommendation 1 and recommendation 5, whilst ensuring there is sufficient leadership capacity and capability in the system to provide oversight and direction throughout transition;

- Lewisham Healthcare NHS Trust is a relatively small Trust. There are concerns around the ability of Trust's current leadership to manage the new, significantly larger, organisation. Recommendations 1 and 4, including the recommendation that new organisations are not faced with any repayment requirements relating to historic debts will ensure that the new Trust will be in a good starting position, but there are still risks, which must be mitigated through the HR elements of the transition process, ensuring that all senior leaders in the new organisation have the skills and experience to be successful in their new roles;
- If Lewisham CCG and Lewisham Healthcare NHS Trust were to pursue plans to determine their local configuration of services, the TSA believes that the processes and timescales involved are not suitable to address the issues that have led to the placing of South London Healthcare NHS Trust into the Unsustainable Provider Regime. During the time taken to follow a more „traditional' reconfiguration programme it is likely that the financial and clinical challenges would be exacerbated and that it is essential that TSA proposals include the service changes necessary to ensure financial as well as clinical sustainability;
- Additional work to assess the financial viability of the new organisation, including an independent due diligence exercise, has been undertaken, demonstrating financial viability as defined by the TSA. This work has confirmed that the new organisation will face a number of operational finance risks that are consistent with those being faced by many other NHS trusts; and
- The TSA recommends that NHS Trust Development Authority provides support and close oversight during the creation of the new organisation.

Consultation feedback in relation to the acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust

37% of individuals were in support of the acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust. 31% of individual respondents did not support either proposal. There was very little support for the option to run a procurement process with only 5% of individuals in favour of this.

The views of groups and organisations were similar to individuals, with 41% in favour of the acquisition by King's College Hospital NHS Foundation Trust. 27% did not support either option. Feedback noted from organisations and groups

included:

- **From commissioners:**
  - Southwark CCG (covering the borough of Southwark where King's College Hospital NHS Foundation Trust is located) wishes to understand in greater detail the impact of the proposed acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust upon the quality of care and outcomes and in particular the impact of this proposal upon the delivery of services at the Denmark Hill site with assurance that the potential acquisition would not negatively impact on King's College Hospital NHS Foundation Trust's ability to deliver high quality services from the Denmark Hill site or on their underlying financial viability; and
  - Bromley CCG (covering the borough of Bromley where the Princess Royal University Hospital is located) supports the preferred option of King's College Hospital NHS Foundation Trust acquiring the Princess Royal University Hospital, subject to clarity from the TSA about the impact of the Market Forces Factor on Payment By Results prices at the Princess Royal University Hospital, in the event that it is acquired by King's College Hospital NHS Foundation Trust.
- **From providers:**
  - King's Health Partners stated their support for King's College Hospital NHS Foundation Trust to acquire the Princess Royal University Hospital; and
  - King's College Hospital NHS Foundation Trust reiterated their desire and commitment to acquiring the Princess Royal University Hospital (letter dated 20 December 2012, received outside of the formal consultation process but alongside their work to progress the development of their Outline Business Case).
- **From other health bodies:**
  - NHS London support the option for King's College Hospital NHS Foundation Trust to acquire the Princess Royal University Hospital; and
  - The Royal College of Midwives and the Royal College of Nursing were in broad agreement with the acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust and disagree with a tendering process for independent sector provision. No further comment was received from other Royal Colleges.
- **From local authorities and other public representative groups**
  - The London Borough of Bromley noted the market testing process but also the sense of urgency and understood why the TSA would look to King's College Hospital NHS Foundation Trust to integrate provision with the Princess Royal University Hospital. The London Borough of Bromley noted that it wants a sustainable solution, not a quick fix and needs assurance of King's College Hospital NHS Foundation Trust leadership capacity and capability to secure the very rapid improvements needed;

- Both Lambeth and Southwark Overview and Scrutiny Committees strongly supported the proposal for the acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust and did not support the option of a procurement exercise to be undertaken;
- Bromley LINk (which represents Bromley residents where the Princess Royal University Hospital is located) strongly supported the option for King's College Hospital NHS Foundation Trust to acquire the Princess Royal University Hospital, however also noted they would want assurance of the capacity and ability of leadership to secure the improvements needed. Southwark LINk (which represents Southwark residents where King's College Hospital NHS Foundation Trust is located) also fully agreed with the proposed acquisition, with questions around staff travel time and travel arrangements for visiting Southwark residents who were admitted to the Princess Royal University Hospital. Bexley LINk had a majority in agreement, as per their views on the organisational changes proposed for Queen Elizabeth Hospital. Mid Surrey LINk also agreed with the proposal, saying that a procurement process would be too lengthy and costly; and
- Greenwich LINk, Lambeth LINk, Lewisham LINk and Kent LINk did not comment on this proposal.

- **From workforce and staff representative groups**
  - South London Healthcare NHS Trust Staffside are opposed to the acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust due to part of King's College Hospital NHS Foundation Trust being run by private enterprise

Key themes from this feedback:

- The majority of respondents were opposed to a procurement exercise for the Princess Royal University Hospital;
- Assurance is required to give confidence of the capacity and capability of leadership at King's College Hospital NHS Foundation Trust to deliver the service improvements needed; and
- Significant opposition to the possibility that some NHS services may be provided by private organisations and that in particular by following a procurement exercise this might be the outcome.

In response to these key themes:

- King's College Hospital NHS Foundation Trust are preparing an Outline Business Case and Finance Business Case (including detailed implementation plans) for the acquisition. They are also undertaking other work that they will need to do to meet the Monitor requirements and to discuss the transitional requirements with the Department of Health.

Consultation feedback in relation to the sale / transfer of land and buildings required for Bexley Health Campus (Queen Mary's Hospital) to Oxleas NHS

Foundation Trust

Almost half of individual responses (45%) were opposed to this proposal with 15% in support. Residents in Bexley were most supportive of the proposal

In contrast 38% of groups and organisations supported this proposal. Feedback noted from organisations and groups included:

- **From commissioners:**
  - Bexley CCG (which covers the borough of Bexley where Queen Mary's Hospital is located) support Oxleas NHS Foundation Trust taking on the site and are already working with Dartford and Gravesham NHS Trust and Oxleas NHS Foundation Trust to ensure Queen Mary's Hospital continues to offer affordable services and patient choice.
- **From providers:**
  - Oxleas NHS Foundation Trust reiterated they welcome the opportunity to take ownership of Queen Mary's Hospital to create a Bexley Health Campus that better meets the needs of local people.
- **From other health bodies:**
  - NHS London strongly supported the proposal for the land and buildings at Queen Mary's Hospital be transferred to Oxleas NHS Foundation Trust;
  - The Royal College of Midwives agrees with this recommendation, with clarification required as to which organisation would be the provider of antenatal and postnatal services from the site;
  - The Royal College of Nursing supports this recommendation; and
  - No other comments from Royal Colleges were received on this recommendation.
- **From local authorities and other public representative groups**
  - The London Borough of Bexley (where Queen Mary's Hospital is located) has welcomed the TSA's recommendation to transfer the core land to Oxleas NHS Foundation Trust, who will provide investment in the site and they have supported the arrangement for delivery of day case elective services by Dartford and Gravesham NHS Trust;
  - The MP for Orpington supports the recommendation that Queen Mary's Hospital be developed under the governance of Oxleas NHS Foundation Trust;
  - Bexley LINk (which represents Bexley residents where Queen Mary's Hospital is located) had a majority in support of the proposal with questions around the funding of the site and whether Oxleas would take on PFI debt. Mid Surrey LINk gave this proposal strong support; and
  - There was little feedback or no comment from Bromley LINk, Greenwich LINk, Lambeth LINk, Lewisham LINk, Southwark LINk and Kent LINk.
- **From workforce and staff representative groups**

- The trade union, GMB, believe the proposal to transfer the site to Oxleas NHS Foundation Trust would suggest that Queen Mary's Hospital will not become a centre for elective surgery (as envisaged under A Picture of Health) therefore creating significant problems for the residents of areas such as Bexley, Erith and Thamesmead and would see choice severely restricted. GMB also comments that staff working at Queen Mary's Hospital have concern after having gone through previous transfers that have been lengthy and unsettling.

Key themes from this feedback:

- Concern that the proposal would lead to the privatisation of healthcare services;
- Concern about what services would actually be provided on the site and that what was needed was „a hospital'; and
- The name „Queen Mary's Hospital' should be retained.

In response to some of the specific feedback:

- The TSA team have been working with CCGs to better understand what services they wish to commission for their local populations (this information can be found in appendix N. The term „Bexley Health Campus' has been used by local commissioners and the London Borough of Bexley to express their mutual desire for a thriving and innovative centre of excellence. Consultation feedback has been clear however that this name is confusing and open to misinterpretation, the TSA has therefore recommended that the site continues to be known as Queen Mary's Hospital.

Consultation feedback in relation to the Department of Health to write-off debt accumulated by South London Healthcare NHS Trust

There was strong support from both individual respondents and groups and organisations to the proposal for the Department of Health to write-off debt accumulated by South London Healthcare NHS Trust, with 77% and 81% in support, respectively. Feedback noted from organisations and groups included:

- **From commissioners:**
  - All CCGs in south east London support the proposal for the Department of Health to write-off debt accumulated by South London Healthcare NHS Trust.
- **From providers:**
  - King's College Hospital NHS Foundation Trust believe this recommendation is vital to ensure financially sustainable organisations and local health economy in future.
- **From other health bodies:**
  - NHS London strongly agreed with the recommendation to write-off historic debt. They stated that this should be a pre-condition to making the service changes to meet the agreed clinical quality

standards, no matter the organisational solutions finally agreed.
    - The Royal College of Nursing supports this recommendation; and
    - No other comments from Royal Colleges were received on this recommendation.
- **From local authorities and other public representative groups**
    - There was broad support from local authorities and other public representative groups (including LINKs) to support the write-off of debt.
- **From workforce and staff representative groups**
    - Unison welcomed the recommendation to write-off historic debt for South London Healthcare NHS Trust.

Key themes from this feedback:

- The impact of PFI on the debt accumulated by South London Healthcare NHS Trust;
- Some action should be taken to ensure that the same issues do not arise again;
- The need for more effective management in the future; and
- Whether organisational change and / or changes to services would be required if the debt was written-off.

In response to some of the specific feedback:

- It is clear that the financial issues of South London Healthcare NHS Trust should not be allowed to reoccur in the future, however the challenges faced by the Trust are complex and wide ranging. Effective management is part of, but not the entire solution, this is reflected in the suite of recommendations required to resolve the Trust's issues; and
- South London Healthcare NHS Trust's deficit is certainly significant, however, the write-off is a one-off occurrence, and it alone will do nothing to improve the underlying financial position of the Trust. Without significant change, as described in the report, the Trust will simply continue to be in deficit and accumulate debt. It is the other recommendations, particularly around operational efficiency and service change that will ensure that in the future the new organisations remain clinically and financially sustainable.

Co-operation and Competition Panel

51. A response was also received from the Co-operation and Competition Panel (CCP). Their response noted the following for each of the three recommendations:

- The recommendation that the Queen Elizabeth Hospital, currently operated by South London Healthcare NHS Trust, comes together with Lewisham Healthcare NHS Trust could give rise to adverse effects on patients and taxpayers in respect of elective and non-elective services under Principle 10 of the Principles and Rules of Co-operation and Competition. The CCP has further noted that this will not be the case if there are sufficient countervailing benefits to offset the likely reduction in patient choice and competition that they have identified. The CCP has also recommended if the TSA considers that there are insufficient countervailing benefits then safeguards be included in the recommendations, which include the requirement for commissioners to specify and monitor detailed service indicators to preserve or enhance the level of quality that would have existed in the absence of this merger. The TSA considers that sufficient countervailing benefits do arise but concurs that it is helpful to include safeguards, as outlined above, in the recommendations.

- The recommendation that the acquisition by King's College Hospital NHS Foundation Trust of the site and services currently provided by South London Healthcare NHS Trust at the Princess Royal University Hospital is likely to be consistent with the merger provisions of the Principles and Rules.

- The acquisition by Oxleas NHS Foundation Trust of land and certain unspecified community services that are currently provided at the Queen Mary's hospital by South London Healthcare NHS Trust is likely to be consistent with the merger provisions of the Principles and Rules;

- The recommendation for Dartford and Gravesham NHS Trust to take over, on an interim basis, the management and provision of the elective day case surgery and endoscopy services that are currently provided at the Queen Mary's Hospital site by South London Healthcare NHS Trust could raise concerns in relation to patient choice or competition under Principle 10 of the Principles and Rules of Co-operation and Competition. The CCP further noted that this would not be the case if there are sufficient countervailing benefits to offset the likely reduction in patient choice and competition that they have identified. They have also recommended that in order to remove or mitigate this risk a formal procurement process to appoint a provider of day case elective and endoscopy services at Queen Mary's Hospital should be carried out in the near future.

Education and training

52. Throughout the TSA process there has been engagement with staff as described in chapter 3 of the final report. This should continue throughout the transition period to ensure staff are fully apprised of any changes. The broader NHS is also currently undergoing a transition process. In order to ensure that learning and experience from this programme can be brought to bear on any future changes a transition working group has been established, chaired by the individual responsible for the wider London NHS transition programme.

53. There have also been concerns regarding training and education raised during the consultation. In order to better understand and mitigate against any negative impacts on staff training, and to enhance positive impacts, the TSA team has been in regular contact with NHS London's People and Organisation Development Directorate, the London Deanery and the South London Local Education and Training Board (LETB).

54. The LETB are supportive of the TSA recommendations and have offered further support to ensure the subsequent design and development of the workforce is underpinned with high quality education.

55. These actions, taken together with a well managed transition, should ensure that there is unlikely to be a significant negative impact on staff from any organisational changes.

Final recommendations

56. Taking into consideration the feedback from the consultation process and the work completed in the second phase of the TSA programme the final recommendations relating to the future of South London Healthcare NHS Trust are for:

- Queen Elizabeth Hospital to be merged (by acquisition) with Lewisham Healthcare NHS Trust;
- Princess Royal University Hospital to be acquired by King's College Hospital NHS Foundation Trust; and
- The core estate at Queen Mary's Hospital to be transferred to Oxleas NHS Foundation Trust, and for the services currently provided by South London Healthcare NHS Trust to transfer to a range of local providers for an interim period of 22 months ahead of a commissioner led procurement process.

57. The pace of implementing these new organisational arrangements will be critical to the overall delivery recommendations set out in the final report. Delivering the recommendations in a three-year period is essential to ensuring organisations in south east London are able to respond to further financial constraints in the public sector. Meeting the challenging timetable will require appropriate leadership capability and engaged staff. Eliminating organisational uncertainty as quickly as possible and ensuring clear lines of accountability is therefore critical to success. As a result, the potential speed of being able to implement a set of new organisational arrangements has been a core consideration. Based on the assessment of what is required to do this, it is proposed that if the recommendation is supported by the Secretary of State, transactions should be completed by 1 June 2013.

58. Effective commissioning of these organisations will be essential to ensuring the quality of services. Revised joint commissioning arrangements should be put in place by local CCGs to reflect these new organisational arrangements. In so doing commissioners should take full consideration of the recommendations laid out in the CCP report.

59. For these organisations to operate effectively they will need a level of financial support during the first three years. This support to Oxleas NHS Foundation Trust, the new organisation combining Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital, and King's College Hospital NHS Foundation Trust, will need to be agreed with the Department of Health and should be made conditional on the delivery of the planned operational improvements and the engagement of the new organisations as active partners in the delivery of the necessary service change.

NHS

Office of the Trust Special Administrator

Appendix G
Stakeholder Engagement

Securing sustainable NHS services

Staff, stakeholder, patient and public involvement and engagement during the enactment of the Unsustainable Provider Regime at South London Healthcare NHS Trust for the period 16 July – 13 December 2012

The following grid gives an overview of key meetings, (but does not include meetings or membership of governance groups which are detailed in chapter 3 and in appendix C), discussions and events held between the Trust Special Administrator and members of his team with a wide range of front-line staff, informed stakeholders such as health and care commissioners, providers, NHS and local authority leaders, MPs, health regulators, think tanks and other bodies, clinicians, patients and members of the public and their representatives across south east London and beyond, during the Unsustainable Provider Regime. It demonstrates the breadth and depth of activity during the development of the draft recommendations and during the formal consultation phase. These meetings, discussions and events, and the learning, debate and the exchange of information they facilitated helped inform the Trust Special Administrator and his team as they undertook the detailed work described in this report.

Further information about the engagement and involvement approach taken during the period of this regime is outlined in chapter 3 of the TSA's final report.

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
17-Jul-2012	Matthew Kershaw Hannah Farrar	South London Healthcare NHS Trust Senior Management Team (approx 50 clinicians and managers)
	Matthew Kershaw Hannah Farrar	Site visit, Queen Marys Hospital
18-Jul-2012	Matthew Kershaw Hannah Farrar	Royal Borough of Greenwhich, CEO
	Matthew Kershaw	Oxleas NHS Foundation Trust, CEO
	Matthew Kershaw	Clive Efford MP for Eltham
19-Jul-2012	Matthew Kershaw Hannah Farrar	London Borough of Bromley, Leader and CEO
	Matthew Kershaw Hannah Farrar	South London and Maudsley NHS Foundation Trust, CEO; Guy's and St Thomas' NHS Foundation Trust, CEO; and King's College NHS Foundation Trust, CEO; King's Health Partners
20-Jul-2012	Matthew Kershaw Hannah Farrar	Lewisham Healthcare NHS Trust, CEO
24-Jul-2012	Matthew Kershaw Hannah Farrar Steph Hood	Secretary of State for Health and south east London MPs at Richmond House: Jim Dowd MP, Heidi Alexander MP, Nick Raynsford MP, Clive Efford MP, Bob Stewart MP, James Brokenshire MP, David Evenett MP representative, Jo Johnson MP representative, Bob Neill MP representative, Teresa Pearce MP representative
	Matthew Kershaw Hannah Farrar	NHS Trust Development Authority, CEO
	Matthew Kershaw	South London Healthcare NHS Trust Medical Staffing Committee (consultants), Chair
25-Jul-2012	Matthew Kershaw Steph Hood	Bexley LINk, Chair and Officer
	Matthew Kershaw	South London Healthcare NHS Trust Medical Staffing Committee meeting, Princess Royal University Hospital
	Matthew Kershaw Hannah Farrar	London Borough of Bromley, CEO
	Matthew Kershaw Hannah Farrar	Dartford and Gravesham NHS Trust, CEO

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
26-Jul-2012	Matthew Kershaw Hannah Farrar	London Borough of Lewisham, CEO
	Matthew Kershaw	South London Healthcare NHS Trust, Clinical Directors
	Matthew Kershaw	Visit - staff/patients at A&E, Queen Elizabeth Hospital
31-Jul-2012	Matthew Kershaw Steph Hood	Visit - staff/patients ward visit at Queen Elizabeth Hospital
	Matthew Kershaw Steph Hood	Visit - staff/patients ward visit at Princess Royal University Hospital
01-Aug-2012	Matthew Kershaw Hannah Farrar	Bromley Healthcare, CEO
	Matthew Kershaw Steph Hood	South London Healthcare NHS Trust staffside representatives and trades union officials
	Matthew Kershaw Steph Hood	Bromley LINk, Chair and Co-ordinator
02-Aug-2012	Matthew Kershaw	South London Healthcare NHS Trust Medical Staffing Committee meeting, Queen Elizabeth Hospital
	Matthew Kershaw Steph Hood	Visit - staff/patients children's ward, Queen Marys Hospital
03-Aug-2012	Matthew Kershaw Steph Hood	Visit - staff/patients theatres and endoscopy, Queen Marys Hospital
	Matthew Kershaw Hannah Farrer Steph Hood	All staff open meeting at Queen Marys Hospital
06-Aug-2012	Matthew Kershaw Steph Hood	All staff open meeting at Princess Royal University Hospital
	Matthew Kershaw	London Borough of Lewisham, Mayor of Lewisham
07-Aug-2012	Matthew Kershaw	Joint Staff Consultative Partnership Committee at Queen Elizabeth Hospital
	Dr Jane Fryer	Lewisham GPs
	Matthew Kershaw	Visit - staff /patients at A&E and fracture clinic, Queen Elizabeth Hospital

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
08-Aug-2012	Matthew Kershaw	Care Quality Commission, Compliance Team
	Matthew Kershaw	Bexley Trust Patients' Council, Chair
	Matthew Kershaw	Lewisham Healthcare NHS Trust, CEO
09-Aug-2012	Matthew Kershaw Steph Hood	Visit - staff/patients Acute Medical Unit, Queen Elizabeth Hospital
	Matthew Kershaw Steph Hood	All staff open meeting at Queen Elizabeth Hospital
	TSA Team Dr Jane Fryer Hannah Farrar	TSA led community based care clinical workshop - approx 80 acute and primary care attendees, Coin Street Neighbourhood Centre
10-Aug-2012	Matthew Kershaw	South London Healthcare NHS Trust, Medical Education Lead
	Matthew Kershaw	Visit - staff/patients - theatres and anaesthetics, Princess Royal University Hospital
13-Aug-2012	Matthew Kershaw Steph Hood	Visit - staff/patients - maternity and paediatrics, Princess Royal University Hospital
14-Aug-2012	Matthew Kershaw Hannah Farrar	Royal Borough of Greenwich, Leader and CEO
	Matthew Kershaw	Visit - staff/patients - outpatients, diabetic, sleep path, chaplaincy, discharge lounge, Queen Elizabeth Hospital
15-Aug-2012	Matthew Kershaw	Visit - staff/patients ward visits, Queen Mary's Hospital
	Matthew Kershaw	Visit - staff/patients site visit, Erith Hospital
	Steph Hood Louise Hutchinson	Lewisham and Greenwich patient and public focus groups (evaluation criteria), Blackheath
	TSA Team	Community Based Care Working Group
	Steph Hood Louise Hutchinson	Lambeth and Southwark patient and public focus groups (evaluation criteria), London Bridge
16-Aug-2012	Matthew Kershaw	Consultant geriatricians, Queen Elizabeth Hospital
	Matthew Kershaw	James Brokenshire MP for Bexley and Sidcup
	Matthew Kershaw Hannah Farrar	Meridien
17-Aug-2012	Matthew Kershaw	Greenwich LINk, Chair and members
	Steph Hood	Bexley and Bromly patient and public focus groups (evaluation criteria), Bexley
	Matthew Kershaw	Visit - staff - pathology and theatres, Princess Royal University Hospital

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
20-Aug-2012	Matthew Kershaw	Senior Nursing Team, Princess Royal University Hospital
	Matthew Kershaw	Visit - staff - medical records department, Princess Royal University Hospital
	Matthew Kershaw	Visit - staff/patients, Beckenham Beacon
	Matthew Kershaw	Visit - staff/patients - A&E, Princess Royal University Hospital
21-Aug-2012	Matthew Kershaw	Visit - staff/patients - maternity, ultra sound, foetal unit, Queen Elizabeth Hospital
	Matthew Kershaw	Visit - staff/patients - outpatients, pathology, Queen Elizabeth Hospital
22-Aug-2012	Matthew Kershaw	London Borough of Bexley, Leader and CEO
24-Aug-2012	Matthew Kershaw	Visit - staff/patients - ICU and outpatients, Princess Royal University Hospital
	Matthew Kershaw	Clinicians meeting, Princess Royal University Hospital
29-Aug-2012	Steph Hood	League of Friends at Princess Royal University Hospital, Chair and Vice Chair
03-Sep-2012	John Bailey	South East London Clinical Commissioning Groups - testing assumptions
04-Sep-2012	Matthew Kershaw	Visit - staff/patients - the Trafalgar Clinic, Queen Elizabeth Hospital

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
05-Sep-2012	Matthew Kershaw Steph Hood	South London Healthcare NHS Trust senior leadership team (approx 50 clinicians and managers)
	Matthew Kershaw	Monitor
	Matthew Kershaw	Visit - staff - bed managers meeting at Queen Elizabeth Hospital
06-Sep-2012	Matthew Kershaw	South East London Health Council Meeting
	Matthew Kershaw Steph Hood	Visit - staff/patients - evening shift, including 'hospital at night', Queen Elizabeth Hospital
	TSA Team Dr Jane Fryer Hannah Farrar	TSA led community based care clinical workshop - approx 80 acute and primary care attendees, Coin Street Neighbourhood Centre
07-Sep-2012	Matthew Kershaw	Visit - staff/patients - radiology, Princess Royal University Hospital
10-Sep-2012	Matthew Kershaw	Lewisham Healthcare NHS Trust, Chair
	Matthew Kershaw	Visit - staff - clinical coders, Princess Royal University Hospital
	Matthew Kershaw	South East London PCT Cluster Non Executive Directors
	Steph Hood	London Borough of Bromley Health, Social Care and Housing Partnership Board
11-Sep-2012	Amy Darlington	South East London NHS Stakeholders Reference Group
	TSA Team Dr Jane Fryer Hannah Farrar	TSA led Acute Services Clinical Workshop - approx 80 attendees, Church House Conference Centre
12-Sep-2012	Matthew Kershaw	Visit - staff/patients - Diabetes and Endocrinology Centre, Queen Elizabeth Hospital
	TSA Team	Community Based Care Working Group
	Matthew Kershaw	Lewisham Healthcare NHS Trust, CEO
	Matthew Kershaw	Visit - staff/patients - evening shift, Princess Royal University Hospital

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
13-Sep-2012	Matthew Kershaw	Clinical Directors Day at Queen Elizabeth Hospital
	Matthew Kershaw	London Deanery
14-Sep-2012	Matthew Kershaw	Surgeons at Princess Royal University Hospital
	Matthew Kershaw	Sisters at Princess Royal University Hospital
17-Sep-2012	Matthew Kershaw	Endoscopy lead at Queen Elizabeth Hospital
	Matthew Kershaw Hannah Farrar	Royal Borough of Greenwich, Shadow Health and Wellbeing Board
18-Sep-2012	Matthew Kershaw	Guy's and St Thomas' NHS Foundation Trust, CEO
	Matthew Kershaw	Lewisham Healthcare NHS Trust, CEO
19-Sep-2012	Matthew Kershaw	Visit - staff/patients - day surgery unit, Queen Elizabeth Hospital
	Matthew Kershaw	South London Healthcare NHS Trust Senior Leadership Development Programme Members, Queen Elizabeth Hospital
20-Sep-2012	TSA Team	Community Based Care Working Group
	Matthew Kershaw	Clive Efford MP for Eltham
	Matthew Kershaw	Nick Raynsford MP Greenwich and Woolwich
	Matthew Kershaw	James Brokenshire MP for Bexley and Sidcup
	Matthew Kershaw	Teresa Pearce MP for Erith and Thamesmead
21-Sep-2012	Matthew Kershaw	Visit - staff/patients - West Kent Eye Centre, Princess Royal University Hospital
	Matthew Kershaw	Oxleas NHS Foundation Trust, CEO
	Matthew Kershaw	Care Quality Commission, CEO
	Matthew Kershaw	Visit - staff - bed managers meeting, Princess Royal University Hospital
24-Sep-2012	TSA team Dr Jane Fryer Hannah Farrar	TSA team led maternity and children's services clinical workshop
	Matthew Kershaw	Visit - staff/patients - diabetes services, Queen Elizabeth Hospital
	Matthew Kershaw Hannah Farrar	NHS South of England, CEO
	Matthew Kershaw	Royal Borough of Greenwich, CEO
	Matthew Kershaw	South London Healthcare NHS Trust Medical Staffing Committee consultants meeting, Queen Elizabeth Hospital
	Matthew Kershaw Steph Hood	All staff open meeting at Queen Elizabeth Hospital

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
25-Sep-2012	Matthew Kershaw Steph Hood	Bexley Health Overview and Scrutiny Committee
	Matthew Kershaw	Visit - staff - central booking office, Queen Elizabeth Hospital
	TSA Team Dr Jane Fryer Hannah Farrar	TSA team led community based care clinical workshop - approx 80 acute and primary care attendees
26-Sep-2012	Matthew Kershaw	Consultant Orthopaedic Surgeon at Queen Marys Hospital
	Matthew Kershaw	Visit - staff/patient, Orpington Hospital
	Louise Hutchinson	Southwark LINk host organisation
	Louise Hutchinson	Lambeth LINk host organisation
	Matthew Kershaw Hannah Farrar	Lewisham Clinical Commissioning Group
27-Sep-2012	Matthew Kershaw Hannah Farrar	Market engagement exercise, provider of services
	Louise Hutchinson	Lewisham LINk host organisation
	Louise Hutchinson	Greenwich LINk host organisation
28-Sep-2012	Matthew Kershaw Steph Hood	Visit - staff/patients - paediatrics and outpatients, Queen Marys Hospital
	Matthew Kershaw Steph Hood	All staff open meeting at Queen Marys Hospital
	Matthew Kershaw Steph Hood	South London Healthcare NHS Trust staff side and trades union representatives
02-Oct-2012	Matthew Kershaw Hannah Farrar	Market engagement exercise, provider of services
	Matthew Kershaw	Kate Hoey MP for Vauxhall
	Matthew Kershaw	Elderly Medicine Director at Queen Elizabeth Hospital
	TSA Team Dr Jane Fryer Hannah Farrar	TSA Team led joint community based care and acute services clinical workshop - approx 100 attendees
	Matthew Kershaw	General Surgeon at Queen Elizabeth Hospital
	Matthew Kershaw	Site Practitioners at Queen Elizabeth Hospital

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
03-Oct-2012	Matthew Kershaw	Visit - staff - site practitioners, Princess Royal University Hospital
	Matthew Kershaw	Jim Dowd MP for Lewisham
	Matthew Kershaw Hannah Farrar	NHS West Kent Clinical Commissioning Group, Accountable Officer
	Matthew Kershaw Hannah Farrar	NHS South West London PCT Cluster, Accountable Officer
	Matthew Kershaw Hannah Farrar	Market engagement exercise, provider of services
	Steph Hood TSA Team	Patient and Public Advisory Group (PPAG)
04-Oct-2012	Matthew Kershaw Dr Jane Fryer Steph Hood TSA Team	Pre-consultation public engagement workshop. Representative members of the public from all six south east London boroughs - approx 60 people
	Matthew Kershaw Hannah Farrar	Market engagement exercise, provider of services
	Matthew Kershaw Hannah Farrar	Lewisham Healthcare NHS Trust, CEO
05-Oct-2012	Matthew Kershaw Hannah Farrar	Market engagement exercise, provider of services
	Matthew Kershaw Hannah Farrar	Market engagement exercise, provider of services
	Matthew Kershaw Dr Jane Fryer Steph Hood TSA Team	Pre-consultation NHS staff engagement workshop. Mix of professional groups and roles from all South East London NHS organisations, approx 100 people
08-Oct-2012	Matthew Kershaw	Stroke Strategy Group at Princess Royal University Hospital
	Matthew Kershaw	Dartford, Swanley and Gravesham Clinical Commissioning Group, Chair
	Matthew Kershaw	Choice and Competition Panel
	Matthew Kershaw	Emergency medicine consultant at Princess Royal University Hospital
09-Oct-2012	Matthew Kershaw Hannah Farrar	Market engagement exercise, provider of services
	Matthew Kershaw Hannah Farrar	Market engagement exercise, provider of services
	Matthew Kershaw	Visit - staff/patients - Critical Care Outreach Team, Queen Elizabeth Hospital

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
10-Oct-2012	Matthew Kershaw Steph Hood	South London Healthcare NHS Trust staffside and trades union representatives
	Matthew Kershaw	Bob Stewart MP for Beckenham
	Matthew Kershaw	James Brokenshire MP for Bexley and Sidcup
	Matthew Kershaw	Heidi Alexander MP for Lewisham East
	Matthew Kershaw Hannah Farrar	Market engagement exercise, provider of services
	Matthew Kershaw Hannah Farrar	Market engagement exercise, provider of services
11-Oct-2012	Matthew Kershaw	All staff open meeting, Princess Royal University Hospital
12-Oct-2012	TSA Team	Community Based Care Working Group
15-Oct-2012	Matthew Kershaw Hannah Farrar	Lewisham Healthcare NHS Trust, CEO and Director of Clinical and Academic Strategy
	Matthew Kershaw	Visit - staff/patients - pain management and spinal intervention unit, Queen Marys Hospital
	Matthew Kershaw	Departmental meeting - orthodontics, Queen Marys Hospital
	Matthew Kershaw	South London Healthcare NHS Trust, paediatrician
	Matthew Kershaw	Visit - staff/patients - outpatients, Queen Marys Hospital
	Matthew Kershaw	Market Engagement Exercise, provider of service
	Matthew Kershaw Steph Hood	Joint meeting with Lambeth and Southwark Health Overview and Scrutiny Committee Chairs
16-Oct-2012	Matthew Kershaw Hannah Farrar	Lewisham Clinical Commissioning Group
	Matthew Kershaw	Independent Reconfiguration Panel, CEO
	Matthew Kershaw Hannah Farrar	Lewisham Health Overview and Scrutiny Committee, Chair
18-Oct-2012	Louise Hutchinson	Southwark Clinical Commissioning Group Engagement and Patient Experience Sub Group meeting
	Matthew Kershaw Hannah Farrar	South East London Clinical Commissioning Groups

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
19-Oct-2012	Matthew Kershaw	Visit - staff/patients, Queen Marys Hospital
	Matthew Kershaw	Visit - staff/patients, Queen Elizabeth Hospital
	Matthew Kershaw	Visit - staff/patients, Princess Royal University Hospital
22-Oct-2012	Matthew Kershaw	Jo Johnson MP for Orpington
	Matthew Kershaw	Oxleas NHS Foundation Trust, CEO
23-Oct-2012	Matthew Kershaw	Anaesthetists at Queen Elizabeth Hospital
24-Oct-2012	Matthew Kershaw	Visit - staff/patients - orthopaedics, Queen Marys Hospital
	Matthew Kershaw Hannah Farrar	East Surrey Clinical Commissioning Group
	Matthew Kershaw	David Evennett MP for Bexleyheath and Crayford
	Matthew Kershaw	Greenwich Stakeholder group
	Matthew Kershaw	Lewisham stakeholder group
	Matthew Kershaw	Kings Health Partnership stakeholder group
	Matthew Kershaw	Bromley stakeholder group
	Matthew Kershaw	Bexley stakeholder group
25-Oct-2012	Matthew Kershaw	Joan Ruddock MP for Lewisham Deptford
	Matthew Kershaw	Heidi Alexander MP for Lewisham East
	Matthew Kershaw	Jim Dowd MP for Lewisham
	Dr Jane Fryer	Royal College of General Practitioners, Chair
	Matthew Kershaw	South East London PCT Cluster Non Executive Directors
26-Oct-2012	Matthew Kershaw	Visit - staff/patients - early discharge team, Princess Royal University Hospital
	Matthew Kershaw	Anaesthetists at Princess Royal University Hospital
	Matthew Kershaw	Kings Fund, Director of Policy
	Matthew Kershaw	Teresa Pearce MP for Erith and Thamesmead
	Matthew Kershaw	Chuka Umunna MP for Streatham
	Matthew Kershaw	Nick Raynsford MP for Greenwich and Woolwich
	Matthew Kershaw	Clive Efford MP for Eltham
	Matthew Kershaw	NHS Confederation, CEO
	Matthew Kershaw	Ophthalmology departmental meeting, Princess Royal University Hospital
28-Oct-2012	Matthew Kershaw	Care Quality Commission, CEO
	Matthew Kershaw	London Borough of Lewisham, Mayor of Lewisham
	Matthew Kershaw	Royal Borough of Greenwich, Leader
	Matthew Kershaw	Kate Hoey MP for Vauxhall
	Matthew Kershaw	London Borough of Bexley, Health Overview and Scrutiny Committee Chair
	Matthew Kershaw	Simon Hughes MP for Bermondsey and Old Southwark
	Matthew Kershaw	London Borough of Bexley, Leader

Pre consultation engagement		
Date	**TSA representative**	**Meeting / Event**
28-Oct-2012	Matthew Kershaw	Jo Johnson MP for Orpington
continued…	Matthew Kershaw	South London Healthcare NHS Trust, staffside representative
	Dr Jane Fryer	Royal College of Obstetricians and Gynaecologists, President
	Dr Jane Fryer	Royal College of Midwives, CEO
	Dr Jane Fryer	Royal College of Physicians, President
	Matthew Kershaw	James Brokenshire MP for Old Bexley and Sidcup
	Matthew Kershaw	Bob Stewart MP for Beckenham
	Matthew Kershaw	Bob Neill MP for Bromley and Chislehurst
	Matthew Kershaw	London Borough of Bromley, Leader's Office
	Matthew Kershaw	London Borough of Lambeth, Leader
	Matthew Kershaw	London Borough of Southwark, Leader
	Hannah Farrar	NHS Commissioning Board, Regional Director (London)
	Hannah Farrar	London Mayor's Office, Greater London Authority Director (health portfolio)
	Hannah Farrar	NHS London (strategic health authority) Board
29-Oct-2012	Matthew Kershaw	Harriet Harman MP for Camberwell and Peckham
	Dr Jane Fryer	Royal College of Surgeons, President
	Matthew Kershaw	Tessa Jowell MP for Dulwich and West Norwood
	Matthew Kershaw Dr Jane Fryer	South east London, trade and national media - press conference and media interviews
	Matthew Kershaw Dr Jane Fryer Steph Hood	All staff open meeting at Queen Elizabeth Hospital
	Matthew Kershaw Dr Jane Fryer Steph Hood	All staff open meeting at Queen Mary's Hospital
	Matthew Kershaw Dr Jane Fryer Steph Hood	All staff open meeting at University Hospital Lewisham
	Matthew Kershaw Dr Jane Fryer Steph Hood	All staff open meeting at Princess Royal University Hospital
30-Oct-2012	Matthew Kershaw	Royal Borough of Greenwich, Health Overview and Scrutiny Committee Chair
	Matthew Kershaw	London Borough of Bromley, Health Overview and Scrutiny Committee Chair
	Matthew Kershaw	London Borough of Lambeth, Health Oveview and Scrutiny Committee Chair
	Matthew Kershaw	London Borough of Lewisham, Health Overview and Scrutiny Committee Chair
	Matthew Kershaw	London Borough of Southwark, Health Overview and Scrutiny Comittee Chair
	Matthew Kershaw	Visit - staff - theatre productivity, Queen Elizabeth Hospital
	Matthew Kershaw Steph Hood	South London Healthcare NHS Trust staffside and trades union representatives
31-Oct-2012	Matthew Kershaw Dr Jane Fryer	All staff open meeting at University Hospital Lewisham
01-Nov-2012	Matthew Kersaw	South East London Clinical Commissioning Groups, Accountable Officers

Engagement during Consultation		
Date	**TSA representative**	**Meeting / Event**
05-Nov-2012	Matthew Kershaw Steph Hood	London Borough of Bromley Health, Housing & Social Care Partnership Board
	Dr Jane Fryer	College of Emergency Medicine
06-Nov-2012	Matthew Kershaw Steph Hood	Medical Staffing Committee meeting, Queen Elizabeth Hospital
07-Nov-2012	Matthew Kershaw	Visit - staff/patients - outpatients department, Queen Mary's Hospital
	Matthew Kershaw	Visit - staff/patients - orthopaedics department, Queen Mary's Hospital
	Matthew Kershaw	Visit - staff - pharmacy, Queen Mary's Hospital
	Matthew Kershaw	Lewisham Healthcare NHS Trust, Chair
	Louise Hutchinson	Lewisham LINk, Development Manager
	Matthew Kershaw Hannah Farrar	Lewisham Healthcare NHS Trust, CEO
08-Nov-2012	Matthew Kershaw	Kings College Hospital NHS Foundation Trust, CEO
	Matthew Kershaw Dr Jane Fryer Steph Hood	NHS South East London Primary Care Trust Cluster Joint Boards workshop
	Louise Hutchinson	Bobby Dazzlers (over 60s community group), Lewisham
09-Nov-2012	Matthew Kershaw	London Borough of Bexley, Leader and CEO
	Matthew Kershaw Dr Jane Fryer	London Deanery, including TSA visit to Medical School
	Matthew Kershaw	Oxleas NHS Foundation Trust, CEO
	Matthew Kershaw	Open staff event at Orpington Hospital
12-Nov-2012	Matthew Kershaw	London Borough of Lambeth, Leader
	Matthew Kershaw	All staff open meeting at Beckenham Beacon
13-Nov-2012	Matthew Kershaw	All staff open meeting at Queen Elizabeth Hospital
	TSA Team	TSA hosted open public meeting in Greenwich at Greenwich West Community Centre (afternoon)
		Queen Mary's Hospital Working Group
	TSA Team	TSA hosted open public meeting in Bexley at The Boathouse (evening)
	SLHT Team	Staff round table consultation event at Beckenham Beacon
	SLHT Team	Knoll Residents Association at Reform Church, Bromley
	Louise Hutchinson	Lewisham Carers Group at the Lewisham Carers Centre
14-Nov-2012	TSA Team	TSA hosted open public meeting in Lambeth at Lambeth Town Hall (evening)
	Matthew Kershaw Hannah Farrar	NHS Trust Development Authority, CEO and directors
	Matthew Kershaw	King's College Hospital NHS Foundation Trust, CEO and directors
	Hannah Farrar	LETB, managing director
	Louise Hutchinson	Greenwich Mencap
	Louise Hutchinson	Metro Centre Lesbian, Gay, Bisexual & Transgender group, Greenwich and Lewisham

Engagement during Consultation		
Date	**TSA representative**	**Meeting / Event**
15-Nov-2012	Matthew Kershaw	South London Healthcare NHS Trust Senior Leadership Development Programme members
	Matthew Kershaw	Event for NHS Chaplains in south east London
	Amy Darlington	London Borough of Bromley Shadow Health and Wellbeing Board
	Matthew Kershaw Dr Jane Fryer Steph Hood	Royal Borough of Greenwich, Healthier Communities and Older People's Scrutiny Committee
	Steph Hood	Bexley Clinical Commissioning Group Patients' Council workshop
16-Nov-2012	Matthew Kershaw Dr Jane Fryer Dr Mike Marrinan Steph Hood	TSA hosted open public meeting in Lewisham at Goldsmiths College (morning)
19-Nov-2012	Matthew Kershaw	Guy's and St Thomas' NHS Foundation Trust, CEO
	Matthew Kershaw Dr Jane Fryer Steph Hood	London Borough of Greenwich hosted open public meeting at Woolwich Town Hall (evening)
	Matthew Kershaw	Clive Efford MP for Eltham
	Matthew Kershaw	Royal Borough of Greenwich, Leader
20-Nov-2012	Matthew Kershaw Steph Hood	Bromley Local Involvement Network hosted open public meeting at Bromley Central Library (evening)
	TSA Team Dr Jane Fryer Hannah Farrar	Community Based Care Clinical Workshop
	SLHT Team	Staff round table consultation event at Queen Elizabeth Hospital
	Matthew Kershaw	Jo Johnson MP for Orpington
21-Nov-2012	Dr Jane Fryer	Bexley Local Involvement Network hosted open public meeting in Bexley (evening)
	Matthew Kershaw Dr Jane Fryer Dr Mike Marrinan Steph Hood Dr Chris Palin	TSA hosted open public meeting in Greenwich at the Forum at Greenwich (morning)
	Louise Hutchinson	Meeting with Advocacy Greenwich disability group
	Matthew Kershaw Steph Hood	Kent Health & Wellbeing Board reps and West Kent commissioners at County Hall in Maidstone
	Matthew Kershaw	Nick Raynsford MP for Greenwich and Woolwich
	Matthew Kershaw	London Borough of Bromley, Leader
	Hannah Farrar	Oxleas NHS Foundation Trust, senior staff meeting

Engagement during Consultation		
Date	**TSA representative**	**Meeting / Event**
22-Nov-2012	Matthew Kershaw Dr Jane Fryer Dr Chris Palin Steph Hood	TSA hosted open public meeting in Bromley at Crofton Halls (evening)
	Louise Hutchinson	Greenwich Pensioners Forum
	SLHT Team	Staff round table consultation event at Princess Royal University Hospital
	Matthew Kershaw	Bromley Healthcare, CEO
23-Nov-2012	SLHT Team	Staff round table consultation event at Queen Marys Hospital
	Matthew Kershaw	Lewisham Healthcare NHS Trust, CEO
	Matthew Kershaw	South London Healthcare NHS Trust, Chairman
26-Nov-2012	Matthew Kershaw Dr Jane Fryer Dr Chris Palin Steph Hood	TSA hosted open public meeting in Bromley at Bromley Court Hotel (morning)
	Matthew Kershaw Dr Jane Fryer Dr Mike Marrinan Steph Hood	TSA hosted open public meeting in Lewisham at the St Andrew's Centre (afternoon)
	TSA Team	Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital Working Group
	TSA Team	King's College Hospital NHS Foundation Trust and Princess Royal University Hospital Working Group
	Matthew Kershaw Steph Hood	Royal Borough of Greenwich hosted open public meeting at St Mary's Community Centre, Eltham (evening)
	Dr Jane Fryer	Bexley Health Overview and Scrutiny Committee
27-Nov-2012	Matthew Kershaw Dr Jane Fryer Dr Chris Palin Hannah Farrar	TSA hosted open public meeting in Southwark at Cambridge House (evening)
	Matthew Kershaw	NHS Commissioning Board, directors
	SLHT Team	Staff round table consultation event at Queen Elizabeth Hospital
	Matthew Kershaw	Greenwich Local Involvement Network hosted open public meeting at Woolwich Town Hall (afternoon)
	Matthew Kershaw Dr Jane Fryer Hannah Farrar	Mayor of London Borough of Lewisham

Engagement during Consultation		
Date	**TSA representative**	**Meeting / Event**
28-Nov-2012	Matthew Kershaw Dr Howard Stoate Steph Hood	TSA hosted open public meeting in Bexley at Bexleyheath Marriott Hotel (afternoon)
	Matthew Kershaw	All staff open staff meeting at Princess Royal University Hospital
	Dr Jane Fryer	Greenwich Clinical Commissioning Group GP consultation meeting at Queen Elizabeth Hospital
	Matthew Kershaw	'We Love the NHS' Campaign Group hosted open public meeting at the Lionel Road Community Centre, Eltham with Teresa Pearce MP for Erith & Thamesmead, Clive Efford MP for Eltham, and Nick Raynsford MP for Greenwich & Woolwich (evening)
	Louise Hutchinson	TSA initiated, independently facilitated maternity service users focus group, Brockley, Lewisham (evening)
29-Nov-2012	Louise Hutchinson Steph Hood	TSA initiated, independently facilitated maternity service users focus group, Deptford, Lewisham (morning)
	Louise Hutchinson	Lewisham Young Citizens Panel, Catford
29-Nov-2012	SLHT Team	Staff round table consultation event at Erith Hospital
	Matthew Kershaw	Medical Staffing Committee meeting, Princess Royal University Hospital
	Matthew Kershaw	Lewisham Healthcare NHS Trust, CEO
	Matthew Kershaw	Visit - medical team for children and young people's services, Princess Royal University Hospital
	Matthew Kershaw	Bob Neill MP for Bromley and Chislehurst
03-Dec-2012	Matthew Kershaw Dr Jane Fryer Steph Hood	TSA hosted open public meeting in Bromley at Crofton Halls (afternoon)
	Matthew Kershaw Dr Jane Fryer Dr Chris Palin Steph Hood	TSA hosted open public meeting public in Greenwich at Charlton Football Club (evening)
	Matthew Kershaw Hannah Farrar	Kings College Hospital NHS Foundation Trust, CEO and directors
	Dominic Harris	London Specialist Commissioning Group Board
	SLHT Team	Staff round table consultation event at Princess Royal University Hospital
	Matthew Kershaw Dr Jane Fryer Shaun Danielli	TSA meeting with National Clinical Advisory Team representative
	Louise Hutchinson	Bexley Multi Faith Forum, Belvedere Sikh Temple

Engagement during Consultation		
Date	**TSA representative**	**Meeting / Event**
04-Dec-2012	Matthew Kershaw Dr Jane Fryer Dr Andy Mitchell Dr Mike Marrinan Hannah Farrar	TSA hosted open public meeting in Lewisham at the Calabash Centre (evening)
	Steph Hood	Royal Borough of Greenwich Shadow Health and Social Care Board
	Dr Jane Fryer	Lambeth Clinical Commissioning Group all practice event
	Matthew Kershaw Hannah Farrar	Lewisham Healthcare NHS Trust Board
	Matthew Kershaw Steph Hood	All staff open meeting at Lewisham Hospital
	Louise Hutchinson	Gypsy traveller event, Orpington
05-Dec-2012	Matthew Kershaw Dr Jane Fryer Steph Hood	Joint Lambeth and Southwark Health Overview and Scrutiny Committee
	TSA Team Dr Jane Fryer	Comminity Based Care Transforming Primary Care session
	SLHT Team	Staff round table consultation event at Orpington Hospital
	Abbas Mirza	Bexley Youth Parliament
	TSA Team Dr Jane Fryer Hannah Farrar	TSA clinical workshop with south east London NHS clinicians - maternity services
	Mark Palin	Lewisham Stroke Club
	Matthew Kershaw	London Borough of Bromley, Director of Care Services
	SLHT Team	South London Healthcare NHS Trust Patient Experience Strategy Group
06-Dec-2012	Hannah Farrar	London Partnership Board (London NHS employers and trade unions representatives)
	Abbas Mirza	Creative Sparkworks (community group for over 50s), Lambeth
	Matthew Kershaw Hannah Farrar Dr Jane Fryer	The Mayor of London
	Matthew Kershaw	All staff open meeting at Queen Elizabeth Hospital
	Matthew Kershaw Dr Jane Fryer Steph Hood	The Sydenham Society hosted open public meeting at Sydenham Girls School (evening)
	Matthew Kershaw Dr Jane Fryer	London Borough of Bexley Shadow Health & Wellbeing Board
07-Dec-2012	Matthew Kershaw Dr Jane Fryer Dr Chris Palin Steph Hood	TSA hosted open public meeting in Bexley at Bexley Civic Offices (morning)
	Matthew Kershaw	All staff open meeting at Queen Mary's Hospital
	Matthew Kershaw	Visit - staff/patients - child development centre, Queen Mary's Hospital
	Matthew Kershaw	Friends of Queen Marys Hospital
	Mark Palin	Lewisham Irish Centre
	Matthew Kershaw	Visit - staff/patients - maternity outpatients, Queen Mary's Hospital
	Abbas Mirza	Bexley Mencap

Engagement during Consultation		
Date	**TSA representative**	**Meeting / Event**
10-Dec-2012	Matthew Kershaw Steph Hood	London Borough of Lewisham, Health Overview and Scrutiny Committee Chair
	Abbas Mirza	Support group for vulnerable women, Woolwich
	SLHT Team	Staff round table consultation event at Princess Royal University Hospital
	Matthew Kershaw	Oxleas NHS Foundation Trust, CEO and Chairman
	Abbas Mirza	Lewisham Health and Social Care Forum
	Louise Hutchinson	Latin American Forum, Southwark
	Louise Hutchinson	Bromley Disability Voice Community Event
11-Dec-2012	Matthew Kershaw Steph Hood	South East London (Health and Care) Stakeholder Reference Group
	Dr Jane Fryer	Royal College of Surgeons
	Louise Hutchinson	Meeting with Asian residents at sheltered housing scheme, Plumstead, Greenwich
	Abbas Mirza	Visit to Lewisham Mosque to talk to Mosque elder and give out documents
	SLHT Team	Staff round table consultation event at Queen Marys Hospital
	Matthew Kershaw	Monitor
	Matthew Kershaw	Lewisham Healthcare NHS Trust, CEO
	Dr Jane Fryer	Royal College of Obstetricians and Gynaecologists
12-Dec-2012	Matthew Kershaw Dr Jane Fryer Dr Andy Mitchell Steph Hood	Lewisham Healthcare NHS Trust, clinicians meeting
	Matthew Kershaw Hannah Farrar	Independent Reconfiguration Panel, CEO
	Matthew Kershaw Dr Jane Fryer Steph Hood	Lewisham Clinical Commissioning Group hosted all GPs meeting, St John's Health Centre
	Dr Jane Fryer OTSA Team	External Clinical Panel
	Matthew Kershaw	London Borough of Lewisham, CEO
	Louise Hutchinson	Asian Women's Group at Belvedere Community Centre, Bexley
13-Dec-2012	Louise Hutchinson	Discussion with Afro-Caribbean service users at Calabash Day Centre, Lewisham
	Matthew Kershaw TSA Team	Community Care Working Group
	SLHT Team	Staff round table consultation event at Queen Elizabeth Hospital
	Matthew Kershaw	South East London Health Council

NHS

Office of the Trust Special Administrator

Appendix H

Securing sustainable NHS Services Consultation document

Securing sustainable NHS services

NHS

Office of the Trust Special Administrator

Securing sustainable NHS services

Consultation on the Trust Special Administrator's draft report for South London Healthcare NHS Trust and the NHS in south east London

These are our recommendations

Let us know what you think

Your comments are important

Consultation document 2 November – 13 December 2012

For more information about the consultation, or to request a summary of the information provided in this document in a different format or language*, please get in touch with us.

*Requests for information in a different language will be provided in a document format where possible, and if not possible, via an interpretation service.

欲知有关咨询资料或者想请求提供本文当中的不同语言或格式的资料概要 * 请联系我们。
* 不同语言的资料请求将会尽量设置于一个文当格式，若无法提供便可通过口译服务。

கலந்தாய்வு பயிற்சி குறித்த மேலும் தகவல்களுக்கு அல்லது இந்த ஆவணத்தில் தரப்பட்டுள்ள சுருக்கமான தகவல்களை வேறொரு வடிவத்தில் அல்லது மொழியில்* பெறுவதற்கு வேண்டுகோள் விடுக்க, தயவு செய்து எங்களை தொடர்பு கொள்ளவும்.
*வேறொரு மொழியில் தகவல்களை பெறுவதற்கான வேண்டுகோள்கள் இயன்ற வரை ஆவண வடிவில் தரப்படும் மற்றும் இயலாத பட்சத்தில் மொழிபெயர்ப்பு சேவை வாயிலாக தரப்படும்.

Để biết thêm thông tin về buổi thảo luận hoặc để yêu cầu bản tóm tắt thông tin được cung cấp trong tài liệu này bằng một định dạng hoặc ngôn ngữ khác*, vui lòng liên lạc với chúng tôi.
*Thông tin được yêu cầu bằng ngôn ngữ khác sẽ được cung cấp ở dạng văn bản nếu có thể. Và nếu không thể thì thông tin đó sẽ được cung cấp thông qua dịch vụ phiên dịch.

Prosimy o kontakt z nami w razie potrzeby dalszych informacji na temat konsultacji lub by poprosić o streszczenie informacji zawartych w tym dokumencie w innym formacie lub języku.*
*Prośby o informacje w innym języku będą w miarę możliwości załatwione w formie dokumentu pisemnego, a przy braku takiej możliwości w formie tłumaczenia ustnego.

Si aad u heshid macluumaad dheeraad ah oo ku saabsan la tashiga dadweynaha, ama si aad u codsatid macluumaadka dukumentigan lagu bixiyey oo kooban oo qaab kale ama luqad kale ku qoran*, fadlan nala soo xiriir.
*Codsiga macluumaad luqad kale ku qoran waxaa lagu bixin doonaa qaab dukumenti meeshii ay suuragal ka tahay, haddii aysan suuragal ahayna, waxaa lagu bixin doonaa adeeg afka laga turjumayo.

Pour plus d'informations sur la consultation, ou pour demander un résumé des informations fournies dans ce document dans un format différent ou dans une autre langue*, veuillez entrer en contact avec nous.
*Les renseignements demandés dans une autre langue seront fournis sous forme de document dans la mesure du possible, et si ce n'est pas le cas, par l'intermédiaire d'un service d'interprétation.

Puede ponerse en contacto con nosotros para obtener más información sobre la consulta o para solicitar un resumen de la información contenida en este documento en otro formato o idioma*.
*Si es posible, la información en otros idiomas se proporcionará redactada en un documento. Si eso no es posible, se proporcionará mediante un servicio de intérprete.

Para mais informações sobre a consulta, ou para solicitar um resumo das informações fornecidas neste documento num formato ou idioma diferente*, por favor, entre em contato connosco.
*Os pedidos de informação num idioma diferente serão atendidos em formato de documento sempre que possível. Se tal não for possível, serão atendidos através de um serviço de interpretação.

Visit our website
www.tsa.nhs.uk

Call us (freephone)
0800 953 0110

Write to us
Office of the Trust Special Administrator
c/o South London Healthcare NHS Trust, Frognal Avenue, Sidcup, Kent DA14 6LT

Contents

What is this document for?

This document sets out the Trust Special Administrator's recommendations for securing a sustainable and long-term future for health services currently provided by South London Healthcare NHS Trust and the wider NHS in south east London. The London boroughs defined by the NHS as south east London are Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

The Trust Special Administrator has worked with GPs, hospital doctors, nurses, providers of community care and other services such as mental health services, social services as well as patients and members of the public to develop his recommendations.

This document is a consultation document and we would like to hear your views on the changes that the Trust Special Administrator is recommending.

Question

Throughout this document you will see a number of questions in boxes, looking like this. These questions relate to the response form that comes with this document, which contains the actual consultation questions we would like you to answer.

Once you have read the consultation document please give us your answers to these questions on the response form provided. We have shown which sections of the consultation document cover the issues raised by each of the questions. Please refer back to these sections as you answer the questions.

Throughout the response form there are boxes for you to explain your answers if you feel the questions have not given you the chance to give your views fully. If you think there are options that the TSA has not considered and should have done please say so in the box at the end of the response form.

If you would like to know more about the extensive work undertaken by the Trust Special Administrator that sits behind this document, please read the Trust Special Administrator's draft report which is on our website at **www.tsa.nhs.uk**

You can answer the questions on the printed response form and post it to our Freepost address:

Freepost Plus RSHB-CGKA-RYHK
TSA Consultation
Ipsos MORI Research Services House
Elmgrove Road
Harrow HA1 2QG

Or, you can complete the response form online on our website.

www.tsa.nhs.uk

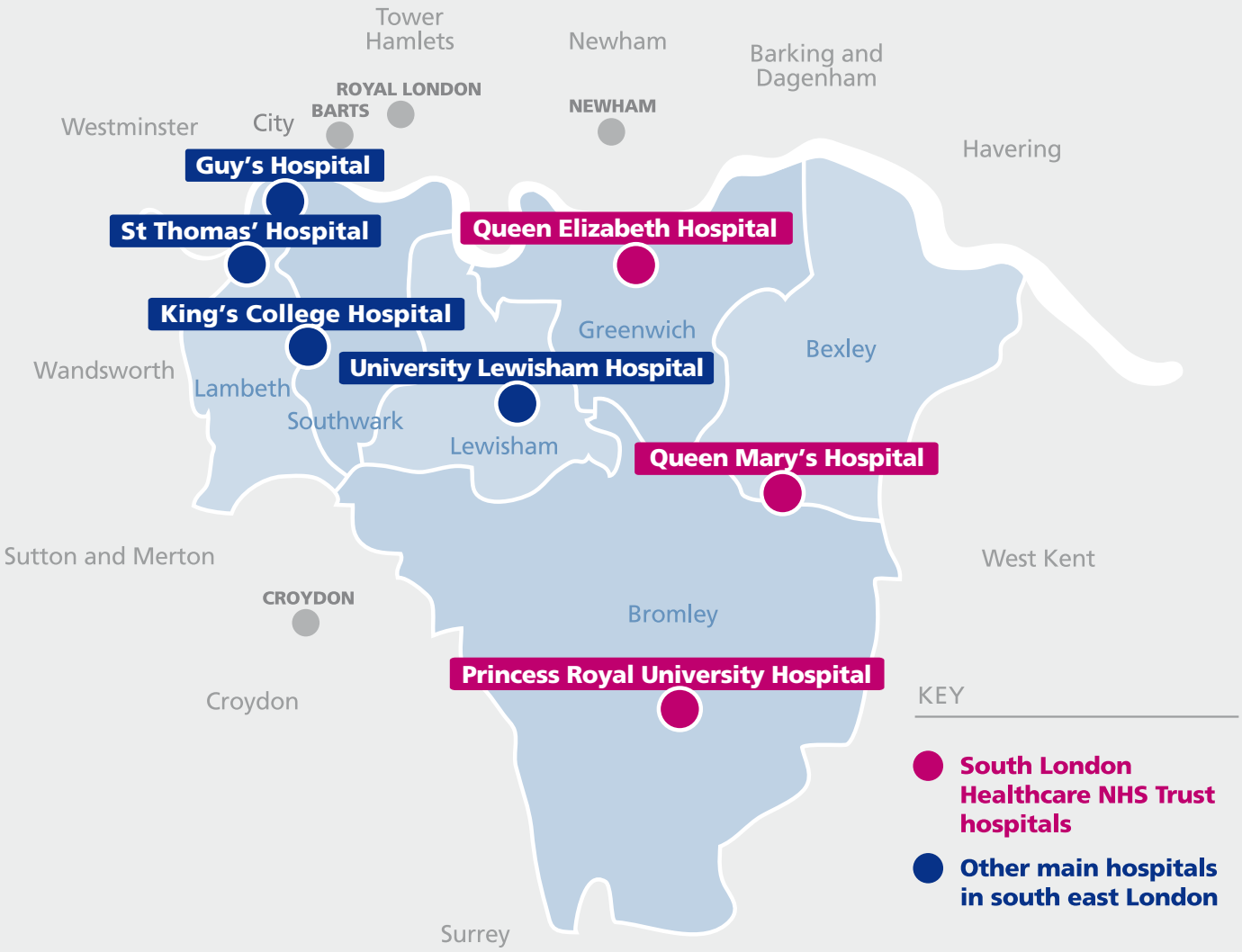
To make sure your views are considered we must receive your response form by no later than midnight on **13 December 2012**.

If you have any queries about how to complete the questionnaire, or about any of the questions themselves, please call **0808 129 5719** (free from landlines, mobile charges will apply).

If you have any complaints about the consultation please contact:

Amy Darlington
Associate Director of Communications,
Office of the Trust Special Administrator
c/o South London Healthcare NHS Trust
Frognal Avenue
Sidcup
Kent DA14 6LT

Main hospital sites in south east London



Foreword
Matthew Kershaw

Trust Special Administrator

You rely on the NHS being there when you need it most; to provide you and your family with high quality and safe care – looking after you when you are unwell and supporting you in staying healthy. You deserve nothing less.

Those of us working in the NHS have a responsibility to provide high quality and safe services to local patients, meeting your healthcare needs to the highest standard possible. However, we also have a responsibility to you the taxpayer; to provide these services within the money that is available; making sure that every pound of taxpayers' money given to us is spent wisely and provides the maximum benefit to patients. Any waste or inefficiencies means that money is being taken away from patient care which is not acceptable, especially in these financially challenging times.

In July 2012 I was appointed as Trust Special Administrator to South London Healthcare NHS Trust by the Secretary of State for Health. This was because the Trust was consistently failing to provide services to patients within budget and was spending around £1 million more than it had each and every week and had no long-term plan to fix this problem.

This money is being unfairly and inappropriately drawn from other areas of the NHS and therefore drastic action is needed to fix this very serious problem, the roots of which have existed for many years.

I have been tasked with developing recommendations to resolve this significant problem in a way that will make sure that high quality, safe and accessible services are available for the communities served by South London Healthcare NHS Trust as well as the wider NHS across south east London long into the future.

"...money is being unfairly and inappropriately drawn from other areas of the NHS and therefore drastic action is needed to quickly fix this very serious problem."

I have worked closely with GPs, hospital doctors, nurses, providers of community care and other services such as mental-health services and social services as well as patients and the public, to develop the recommendations outlined in this consultation document. Lots of people have given up their time to support me in this important work and for that I would like to extend my personal thanks.

I now want to hear what you think. Please take the time to read this consultation document and share your views using the response form enclosed. I will then review this feedback. I will use it, together with the additional work my team and I do, to inform my final recommendations. I will provide these to the Secretary of State in January 2013. He will then make a decision on my final recommendations in February 2013.

Matthew Kershaw

Foreword
Dr Jane Fryer

Chief Medical Advisor to the Trust Special Administrator

As a doctor and as a clinical leader in south east London, my passion is to make sure we deliver consistently high quality healthcare to people when they need it, whilst recognising we have to do this with a large but limited amount of money.

People nowadays have quite different healthcare needs to those of say 20 or 30 years ago. More people survive things like heart attacks, cancer and stroke, but may require ongoing care to help them in their longer-term recovery. And many more people are living with what we call 'long-term conditions' – things like asthma, diabetes and arthritis for example – conditions that can't be cured but can be managed with medicines and other therapies.

Alongside this, medicine and treatments for health conditions are also changing. This is because doctors, nurses and therapists are taking advantage of improved medicines and technology, as well as better knowledge and evidence of what works in treatment.

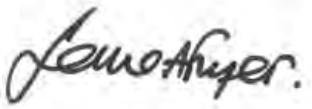
Because of these advances many more people's health and medical conditions are treated at home and in GP surgeries than ever before. Now only very sick people need to be treated in hospital and we therefore need to make sure that the coordination of care between different NHS organisations, and between hospitals and other community settings, is better to help patients receive the best care in the most suitable place.

At the moment South London Healthcare NHS Trust is overspending by around £1 million every week and this cannot continue.

"We want to use this opportunity to improve the quality and consistency of NHS services for all of the communities we serve across south east London, and ensure we do this in an affordable way."

I have led a group of senior doctors and nurses from across south east London in advising Matthew Kershaw in his role as Trust Special Administrator. As a group of leading clinicians from all NHS organisations across our six boroughs we have agreed that together we should seize the opportunity of his work and design healthcare differently. We want to use this opportunity to improve the quality and consistency of NHS services for all of the communities we serve across south east London, and ensure we do this in an affordable way.

Change is challenging for everyone whether you are a patient or a member of staff. However, I believe the recommendations for the NHS in south east London that Matthew has set out in his draft report and which are described in this consultation document, will secure high quality and affordable services for the long-term for the people of south east London.



Dr Jane Fryer

1 Why is change needed?

South London Healthcare NHS Trust is the most financially challenged trust in the whole of the NHS, overspending by around £1 million each and every week.

On 16 July 2012 a Trust Special Administrator was appointed to South London Healthcare NHS Trust by the Secretary of State for Health. His task is to resolve this significant problem in a way that would mean that high quality, safe and accessible services are available for the long-term for the communities served by South London Healthcare NHS Trust as well as the wider NHS across south east London.

This chapter describes in more detail the role of a Trust Special Administrator and why one was appointed to South London Healthcare NHS Trust.

The role of a Trust Special Administrator

The NHS is guided by the principles set out in *The NHS Constitution*[1]. These include an aspiration to attain the highest standards of excellence and professionalism in delivering high quality care to all and, in doing so, a commitment to provide best value for taxpayers' money. All NHS organisations have a duty to deliver these principles, however, for a variety of reasons, a small number of NHS trusts across the country fall short. This is unacceptable and action must be taken to ensure that safe and high quality services are delivered to patients within the funding available.

All NHS organisations have a duty to deliver these principles, however, for a variety of reasons, a small number of NHS trusts across the country fall short. This is unacceptable and action must be taken to ensure that safe and high quality services are delivered to patients within the funding available.

Under NHS legislation, the Secretary for State for Health has powers to appoint a Trust Special Administrator (TSA) to any NHS trust he deems is failing to meet its duty to provide high quality and safe services to patients within the funding that is available. These powers are used when other solutions have been tried and not worked.

The TSA has two roles:

1. Ensuring the Trust he is appointed to continues to deliver safe services to patients during the period of his work
2. Developing recommendations for securing safe, high quality and affordable health services for the long-term.

The drive behind the work of the TSA is an absolute focus on implementing rapid, fundamental and transformational change within a highly challenged Trust to ensure long-term sustainability and to protect access to high quality services for local patients.

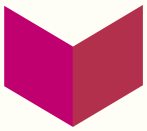
Therefore the timescales are short. The TSA's work has to be completed and the Secretary of State for Health decides what action to take within 150 working days of the TSA being appointed. This timescale includes a 30 working day public consultation period ahead of the TSA submitting his final recommendations to the Secretary of State.

The TSA is therefore required to work closely with GPs, hospital doctors, nurses, providers of community care and others such as mental-health services and social services as well as patients and members of the public to develop his recommendations within the set timescales.

[1] *The NHS Constitution*
www.dh.gov.uk/health/2012/03/nhs-constitution-updated/

Timeline

Trust Special Administrator (TSA) appointment takes effect on **16 July 2012**



Within 75 working days the TSA must produce and publish a draft report outlining his recommendations and a plan for how he will consult on them by **29 October 2012**

Consultation begins within five working days of publishing draft report by **2 November 2012**

Consultation ends after 30 working days on **13 December 2012**

Trust Special Administrator must submit his final report and recommendations to the Secretary of State within 15 working days of consultation ending by **7 January 2013**

Within 20 working days, the Secretary of State must make a decision on the Trust Special Administrator's recommendations by **1 February 2013**

Why has a Trust Special Administrator been appointed to South London Healthcare NHS Trust?

Despite recent improvements in the quality of services at South London Healthcare NHS Trust (SLHT), there is a long-standing history of being unable to deliver high quality services within budget meaning the Trust continues to overspend and end up in more and more debt.

A large number and wide range of solutions have been tried in an attempt to fix this deteriorating problem and make sure safe, high quality services can be provided to local patients within the funding that is available. These include, but are not limited to, a merger of three south east London NHS trusts in 2009 to form South London Healthcare NHS Trust, changes in senior management, significant cost reduction initiatives as well as changes to some services as a result of implementing *A Picture of Health*[2].

Whilst these solutions have delivered some improvements, none have delivered the scale of change required to enable SLHT to deliver high quality services for patients within budget for the long-term.

In the three years since its formation, SLHT generated a total debt of £153 million by the end of March 2012. It ended the last financial year (2011/12) with a £65 million deficit (how much it overspent by). This is equivalent to the cost of 12,000 hip replacement operations. It is predicted that by the end of this financial year (so by March 2013) SLHT will have overspent in the course of its lifetime as an organisation by £207 million.

SLHT is the most financially challenged Trust in the NHS and it does not have a credible plan in place to address this serious financial problem. This is not acceptable.

Unless action is taken now to put things right, over the next three years (ending March 2016) the Trust is expected to accumulate a further debt of more that £240 million. This cannot be allowed to happen. It is important that addressing this problem happens quickly, but in a planned way so services for patients are not put at risk by short-term or quick fix decisions. Finding a planned solution for the services provided by SLHT and the wider south east London system in the long-term is the task of the Trust Special Administrator.

[2] *A Picture of Health*
www.apictureofhealth.nhs.uk/consultation/index.html

2 How has the Trust Special Administrator gone about developing his recommendations?

When the Trust Special Administrator (TSA) first started work with the Trust, he and his team conducted a wide ranging review of South London Healthcare NHS Trust (SLHT). They looked at how it works as part of the wider south east London healthcare system, to understand where the problems are. This included identifying why the Trust has accumulated a debt that will reach £207 million by the end of March 2013.

The analysis showed that SLHT's financial problems have a number of different parts to it. Whilst the issues start with the Trust, the TSA's analysis has shown that there is a significant future financial challenge facing other parts of the NHS in south east London as well. The TSA's role is to address the financial problems sitting within SLHT and protect the quality of care. However, it is important that on the back of this wider south east London analysis that any recommendations he makes take the wider NHS in south east London into consideration. No hospital works in isolation from the other hospitals and health services around it. This will ensure that problems are not just pushed from one part of the NHS to another and patients can access safe and high quality sustainable services in the future across the whole of south east London. Indeed, commissioners (those who plan and buy care on behalf of their local populations) in the area agree that the solution to SLHT's problems must be south east London wide for this reason.

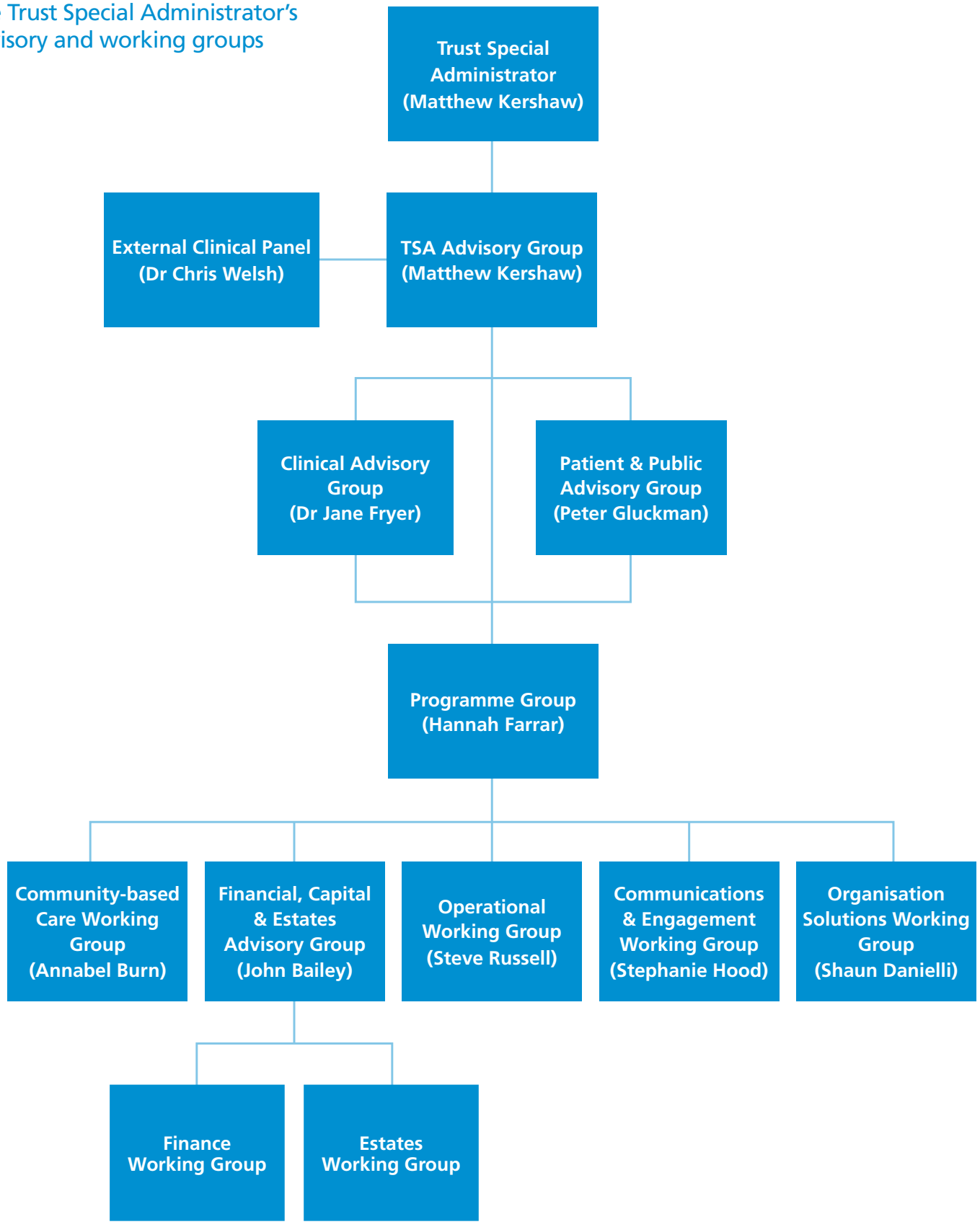
To make sure that all patients in south east London can access high quality and safe services in the future, and that all NHS organisations deliver affordable services and have a sustainable future, the TSA's recommendations cannot just be about changes to SLHT. The recommendations need to take a broader perspective and be developed with doctors, nurses, GPs, and other providers of community and social care across the whole of south east London.

A number of advisory and working groups involving doctors, nurses, community healthcare providers, ambulance staff and social care providers as well as health and other professional experts, such as accountants, were therefore set up. These groups have all helped the TSA develop the recommendations set out in this consultation document.

An additional group of nationally recognised expert doctors, drawn from across England, was set up as an External Clinical Panel to test and check the ideas of the south east London advisory groups, before the proposals were finalised.

The following chapters of this consultation document look at the different parts of the problem. They explain the Trust Special Administrator's recommendations and how these have been formed and then ask for your views on these.

The Trust Special Administrator's advisory and working groups



3 What is the problem the Trust Special Administrator must solve?

This consultation is called *Securing sustainable NHS services* but what does that mean?

If you look up the word sustainable in the dictionary the definition reads 'able to be maintained' and this is what we mean – services that can be maintained and be successful into the future.

However, these services must be safe and of a high quality and meet the needs of patients. They must also be affordable making sure they are designed within the available funding and that taxpayers' money is spent wisely.

In the NHS we refer to this as clinically and financially sustainable services.

What are clinically sustainable services?

You expect your NHS to provide high quality care for you and your family. After all, you deserve nothing less.

To make sure that NHS organisations are providing the best possible care, new clinical standards are regularly set by doctors and nurses working at a national level. These standards push the NHS to continuously improve for the benefit of patients. They take account of changes in technology, medicine, and scientific advances. And aspiring to meet these standards keeps the NHS at the top of its game. It ensures patients receive the highest possible standards of care. These standards are explained more in Chapter 8.

NHS organisations that are able to meet these standards, and are able to continuously adapt and respond quickly to advances in care, are said to provide clinically sustainable services.

What are financially sustainable services?

The Department of Health and the regulator for NHS foundation trusts, Monitor, expect NHS organisations to make a financial surplus – this means the amount it costs to provide services to patients needs to be slightly less than what trusts are paid to provide these services. This is so NHS organisations can sensibly manage their money and make sure they have some 'spare' money that they can use to spend on improving their services and / or in the event of an unexpected situation – just like when, as individuals, we might keep some money saved in case something unexpected happens that we need to pay for.

The measure of a financially sustainable organisation, as set out by the Department of Health and foundation trust regulator, Monitor, is the delivery of a 1% surplus in its budgeting. This means that the NHS organisation's costs are 1% lower than the amount it is paid to deliver the services it provides

The task of the Trust Special Administrator

The task of the Trust Special Administrator (TSA) is to secure sustainable NHS services for those people served by South London Healthcare NHS Trust and the wider NHS in south east London.

This means making recommendations that address the challenge of delivering both clinically and financially sustainable services. If he only addresses the financial problems, quality could suffer, and if he only addresses clinical sustainability services may be unaffordable.

The Trust Special Administrator therefore needs to balance both of these components in his recommendations, therefore securing clinically and financially sustainable NHS services for the future.

4 South London Healthcare NHS Trust's financial problems

Financial problems are not new for South London Healthcare NHS Trust.

South London Healthcare NHS Trust (SLHT) was formed in 2009 following the merger of three south east London NHS hospital trusts. However, the financial problems started long before this date as the three predecessor trusts had all been overspending since 2004.

This overspend has continued, despite the merger which was an attempt to overcome the problem. Last year the Trust overspent by £65 million and it is expected that SLHT will overspend by just over £54 million in this financial year (ending March 2013).

Every year SLHT overspends it needs to receive additional financial support from the Department of Health so it can continue to pay its staff and suppliers. By the end of March 2013 the total support received from the Department of Health will have reached £207 million.

Financial problems are expected to continue, and get worse, in the future

Looking forward over the next three years analysis shows the Trust will continue to have financial troubles if a resolution is not found.

It is expected that if the Trust does nothing differently to what it is doing now, over the next three years (ending March 2016) it is expected to accumulate a further debt of more that £240 million. The predicted figures show that in the financial year 2015/16 itself (April 2015 – March 2016) it will overspend by another £74.9 million if it carries on as now. This is a worse position than this year.

The financial problem will get worse if nothing is done to fix it. Quality will be put at risk because the Trust won't be able to afford to continue providing the quality of services it does now to local patients. It may be forced into taking some 'quick fix' financially driven decisions that impact on the quality of care it can provide in an unplanned way.

What is the size of the financial problem in the future?

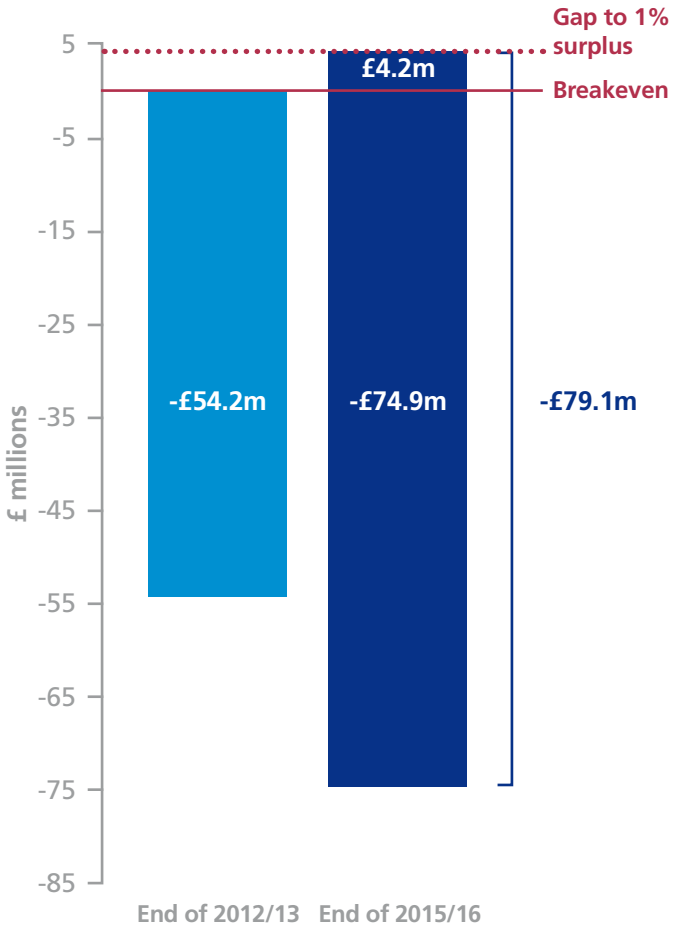
Like all NHS organisations, SLHT will be working to reduce as much of its costs over the next three years as it can. In its current form this could be £43.3 million by the end of 2015/16.

However, this is not enough to cover the expected overspend. And actually, the challenge of the Trust Special Administrator (TSA) is more than just getting SLHT to stop overspending – though this is a significant task – it is to make the services provided by SLHT sustainable for the long-term. As explained in Chapter 3, from a financial perspective this means that SLHT's income (what it gets paid to deliver services to patients) must be 1% more than the amount it costs to deliver those services – this is called a surplus.

This means that, even if SLHT makes savings of £43.3 million over the next three years, in 2015/16 the financial gap to stopping the overspend and achieving a 1% surplus will be £79.1 million pounds. This is shown in the chart below.

The task of the TSA is to develop a set of recommendations that address this gap of £79.1 million in 2015/16. This will make the Trust financially sustainable. His task is also to ensure this is done in a way that ensures services meet the required clinical standards so that they are clinically sustainable. Achieving both these will mean that sustainable NHS services will be secured for the future for the people served by SLHT and the NHS in south east London.

Forecast deficit for 2012/13 and 2015/16 for South London Healthcare NHS Trust



What is driving the financial problems at South London Healthcare NHS Trust?

The Trust has three main challenges which are driving its financial problems:

- It is not as efficient as it could be (see Chapter 5 for an explanation of what this means) and the clinical and managerial leadership has not made enough improvements
- It is not making the best use of the buildings it owns and rents, and has a number of very expensive Private Finance Initiative (PFI) buildings (see Chapter 6 for more detail about what the PFI challenges are) which has created a gap between what is owed and what is affordable
- No hospital anywhere in the country operates in isolation. Hospitals are part of a bigger NHS family, working closely with other healthcare services in a locality. Each NHS organisation's financial position is therefore affected by how it works as part of the wider healthcare system. This is true for South London Healthcare NHS Trust (SLHT), and for the wider NHS in south east London. This is explored later in this document in Chapter 8.

A financial challenge of this size cannot be dealt with easily. To ensure that high quality, safe and clinically sustainable services can be provided into the future within the funding available something radical is needed to fix the problem. The status quo simply is no longer an option as it is not in the best interest of patients.

5 Recommendations for South London Healthcare NHS Trust

There is a lot that could be done within South London Healthcare NHS Trust (SLHT) itself to improve the current position. These are described in recommendations one to three and outlined in this chapter.

Recommendation 1

Improve the efficiency of South London Healthcare NHS Trust.

When we talk about efficiency we mean the amount of resources the Trust uses, such as staff, buildings and supplies, and how they are used to treat a certain number of patients.

Hospital trust's that are more efficient will spend less on staff, buildings and equipment compared to the amount of income that they receive. The amount of income a hospital receives is related to the number of patients they treat.

One of the key challenges SLHT faces is the way it uses resources such as staff, buildings and equipment. In comparison with other NHS trusts, particularly the high performing ones across England, SLHT spends more on these things compared to the amount of income it receives.

If it was as efficient as other similar sized and structured NHS trusts, SLHT could provide the same services but save around £79 million over the next three years (ending March 2016).

This has been shown in two main pieces of analysis that were done to understand what improvements could be made in the way SLHT provides its current services.

1. a comparison of SLHT with 18 other NHS trusts – known as SLHT's 'peer' group or 'peer' trusts. These NHS trusts are similar to SLHT in terms of the number and types of patients they treat, the number of hospitals they have, and the amount of funding they receive.
2. an internal review looking in particular at SLHT's current finances, which included the latest data and interviews with staff.

This analysis has identified that improvements can be, and need to be, made in the following key areas.

Paying for hospital staff

SLHT spends more on doctors, nurses and other staff in relation to the amount of patients the Trust is paid to treat, compared to its peer NHS trusts.

It spends a relatively high amount on nursing staff, with more senior nurses than other similar NHS trusts in its peer group. Compared to other peer trusts, SLHT also has a high number of A&E nurses for the amount of patients it treats and does fewer operations per operating theatre nurse.

Again compared with its peers, SLHT has a higher number of staff in professions such as pharmacy, speech and language therapy, and pathology and is not using its non clinical staff as efficiently as possible.

The numbers of doctors and nurses need to be more closely matched to what SLHT delivers in terms of care. By better organising the way that doctors and nurses work and reducing the

duplication and overlap that currently exists, the same amount of patients could be treated with fewer doctors and nurses just as is the case with high performing peer NHS trusts across the country. And the number of full time equivalent Scientific, Technical and Therapeutic staff should be reduced in line with top performing peer NHS trusts. There is also real work to do to reduce the amount of money spent on using expensive agency staff in these areas.

Some may think that SLHT patients are receiving a better experience, or higher quality of care, because there is more staff. The peer trusts that SLHT was compared against have similar, or higher quality of care scores. This shows that SLHT could deliver its current services with fewer staff and could maintain or improve the quality of services provided.

Work already started on this should be accelerated and this will help reduce reliance on agency staff. Opportunities for more efficiencies in terms of the staff running SLHT's office systems such as Human Resources and IT (Information Technology) should be pursued, including outsourcing as a primary alternative.

What are the savings that could be achieved on staff pay? **£36m**

Operating theatres

Some of the most expensive care delivered by hospitals takes place in their operating theatres and, in the case of SLHT, these are not being run as efficiently as they could be in comparison with top performing peer NHS trusts.

In fact, SLHT is only achieving 67-76% operating theatre efficiency – this means that of the time that SLHT pays operating theatre doctors and nurses in theatre, only 67-76% of their time is spent treating patients. This is compared to 85% in peer NHS trusts. This is expensive for SLHT, and means patients are not getting as good a service as they could be.

SLHT's systems and processes need to change to improve the way it uses its operating theatres. This is particularly in planning numbers and types of patients undergoing operations, and ensuring its doctors and nurses work more efficiently. They should spend more of their time treating patients, so they can use theatre time more efficiently and operate on more patients in each theatre session, just as other peer NHS trusts do.

This would mean that either more patients could be treated or that the same number of patients could be treated as now, but with fewer operating theatre doctors and nurses.

Achieving 85% operating theatre efficiency and reducing the average time it takes to operate on a patient by 10% would reduce the number of theatre hours required by approximately 8,000 hours; saving time and improving care for patients.

The review has identified three specialties in which to begin this work. These are general surgery, gynaecology, and trauma and orthopaedics.

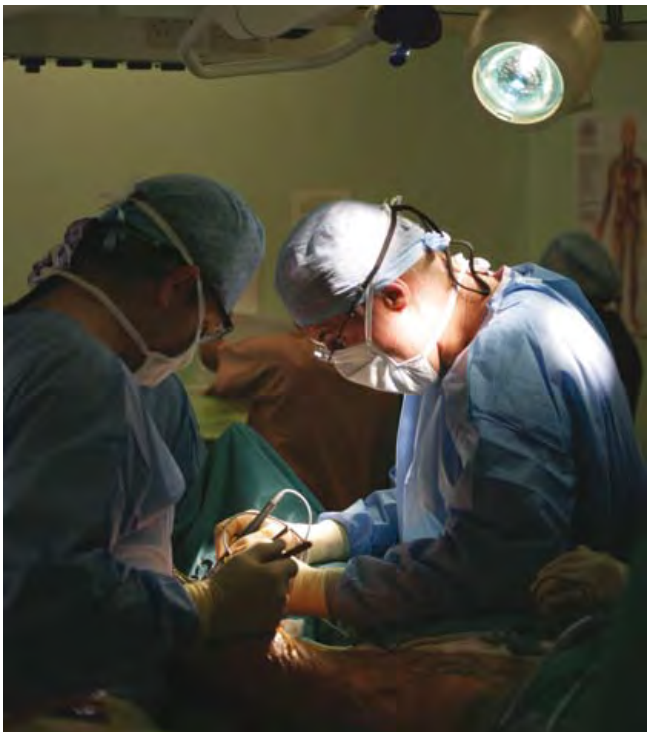
What are the savings that could be achieved in operating theatres? **£2m**

Outpatient services

SLHT could treat the same number of outpatients – patients who do not need to stay in hospital overnight – with fewer appointment slots if the number of patients seen per clinic matched the top performing peer NHS trusts.

A significant proportion of efficiencies can be achieved by better use of outpatient capacity at SLHT. For example this could be by reducing the number of changes and cancellations the hospital makes and the number of patients who do not attend their appointments – which is often because the communication with them from the hospital has not been clear.

What are the savings that could be achieved in outpatients? **£4m**



Length of stay in hospital

Although SLHT performs relatively well compared with peer NHS trusts when it comes to the length of time patients need to stay in the hospital – this being relatively low – it could be even better.

For example, SLHT could make a reduction of 90-100 beds if 'lengths of stay' were reduced still further in line with the best across the NHS. This doesn't affect the number of patients that can be treated, but means that the number of beds (and staff looking after patients in those beds) can be used more effectively. This would, also improve care for patients since they would be leaving hospital and getting home sooner. This is better for patients and the costs are less.

Changes need to be made to both the way patients are cared for by the hospital when they have to stay overnight, and the way they are cared for outside the hospital, such as in community facilities.

What are the savings that could be achieved in inpatients? **£6m**

Clinical equipment and supplies

Equipment and supplies bought by hospitals includes everything from bandages and dressings, syringes and protective gloves to surgical tools such as scalpels, drugs, and artificial prosthetics such as hip or knee replacements. SLHT currently spends £92.5 million on these kinds of items every year – which is 10% more than its peer NHS trusts.

Too many different suppliers are being used by SLHT, often to buy the same things. This makes the purchasing of simple items too complicated, and too expensive. SLHT should be buying more of its supplies in bulk, and from fewer suppliers, as well as managing its stock levels better.

What are the savings that could be achieved? **£9m**

Scientific, Technical and Therapeutic services

In SLHT, some of the Scientific, Technical and Therapeutic (ST&T) services are not working as efficiently as they could. In comparison with other similar NHS organisations across the country, SLHT is currently spending more on its pathology and pharmacy services.

By using better technology and increasing automation SLHT can make its pathology services more productive. For example, through the use of specialist machines more samples can be tested every hour, and need fewer staff to run them.

What are the savings that could be achieved in technical services? **£5m**

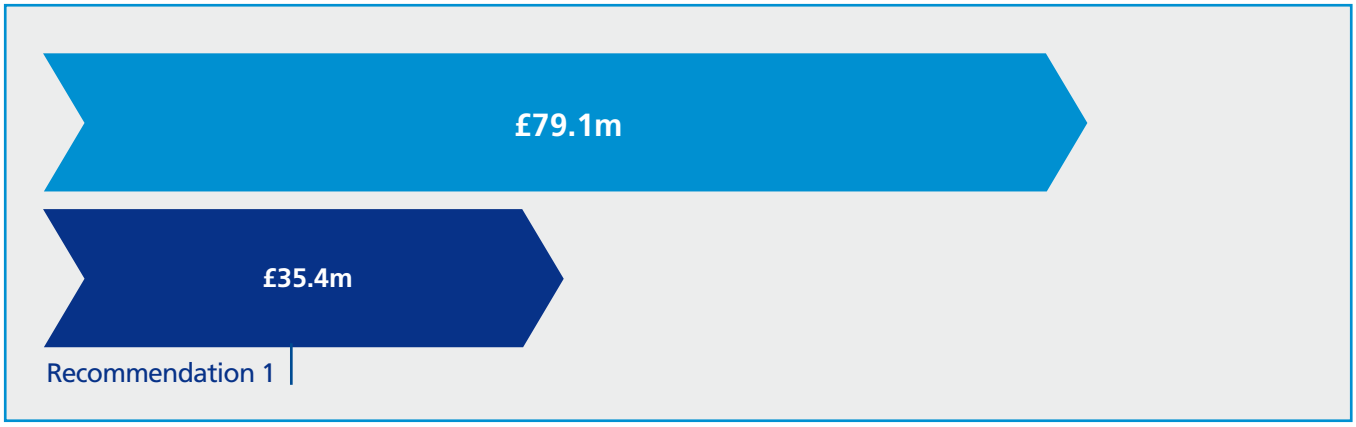
If SLHT were to implement all these improvements, it could potentially save £62 million over the next three years, and take its quality and efficiency to current levels seen in top performing peer NHS trusts.

However, top performing NHS trusts do not stand still and constantly work to improve how efficient they are, day by day, year on year, making best use of the resources available to them. In fact the best NHS trusts have demonstrated they can make everyday efficiencies equivalent to at least 2% of their overall costs per year.

If SLHT were to do this also, it would save a further £17 million over the next three years on top of the £62 million, taking the total potential savings from operational efficiencies to £79 million by the end of March 2016.

As explained in Chapter 4, SLHT could deliver £43.3 million savings over the next three years, however, the analysis undertaken by the Trust Special Administrator has shown that the opportunities to save money by changing how the Trust works are much larger than that - £79 million. Subtracting the £43.3 million figure from the maximum financial opportunity identified (£79 million) as this has already been accounted for, means the savings from Recommendation one total £35.4 million.

Financial impact of recommendations in 2015/16 for South London Healthcare NHS Trust



Question

To what extent do you agree or disagree that the efficiency of the hospitals that make up South London Healthcare NHS Trust needs to improve to match that of top performing NHS organisations?

Question

To what extent do you agree or disagree that the areas outlined in Chapter 5 of the consultation document for improving efficiency at the hospitals that make up South London Healthcare NHS Trust are appropriate?

Recommendation 2

Develop a Bexley Health Campus at Queen Mary's Hospital Sidcup.

The Bexley Health Campus

The future of Queen Mary's Hospital, Sidcup has been an area for discussion between the NHS and the London Borough of Bexley for the last two years – both organisations are keen to maximise Queen Mary's potential as a provider of a range of healthcare services to Bexley and neighbouring communities. Together Bexley Clinical Commissioning Group (the GP led NHS body responsible for planning and buying healthcare and services for local people) and the London Borough of Bexley have developed a vision for Queen Mary's Hospital to be transformed into a Bexley Health Campus that would provide a range of services to local communities.

Bexley Clinical Commissioning Group will need to go through a process to select an organisation to provide planned day case surgical services (ie services for those patients who have a planned operation but won't need to stay in hospital overnight). To ensure patients will continue to receive these surgical services ahead of a decision being taken, it is suggested that Dartford and Gravesham NHS Trust provide these services.

Making these changes would mean Oxleas NHS Foundation Trust would be the provider organisation delivering the largest number of services from the Queen Mary's Hospital Sidcup site, including the Urgent Care Centre, rehabilitation and mental health services. This creates an opportunity for SLHT to divest its assets here, which would help the organisation to resolve some of its financial challenges. In addition, developing Queen Mary's Hospital into a Bexley Health Campus will need a lot of investment in the buildings and equipment on the existing site. Given the financial challenges faced by South London Healthcare NHS Trust (SLHT), the Trust is not in a position to make this investment.

It is proposed that the following services would be provided from the Bexley Health Campus:

- Urgent care services that treat patients with urgent illnesses and injuries and conditions that can be seen and treated without the patient needing to stay in hospital overnight
- Rehabilitation services that allow people to recover from illnesses or treatment closer to home, often after receiving specialist treatment in a different hospital
- Community services to support those with long term conditions, such as diabetes
- A Children's Development Centre that will be at the centre of providing specialist services for children
- Outpatient services, including some diagnostic tests such as x-ray and ultrasound scans
- Radiotherapy services that allow patients to have cancer treatments closer to home rather than travel into central London
- Day case surgery for procedures that do not require a stay in hospital, such as general surgery, cataracts and endoscopy procedures
- Mental health services, including a dementia centre of excellence and possibly an inpatient mental health centre of excellence for patients in Bexley and Bromley.

These services are currently provided by a number of different NHS providers (primarily Oxleas NHS Foundation Trust and South London Healthcare NHS Trust) and will continue to be delivered to patients by a range of different of providers of NHS services. For example, Oxleas are likely to continue providing the Urgent Care Centre, rehabilitation and mental health services, and it is likely that staff from Guy's and St. Thomas' NHS Foundation Trust will run the radiotherapy service.

Current and future services to be provided at Queen Mary's Hospital, Sidcup site

Today	In the future
Non – admitting Urgent Care Centre*	Non – admitting Urgent Care Centre
Outpatients (inc. for children)	Outpatients (inc. for children)
Diagnostic tests and screening (e.g. X-rays)	Diagnostic tests and screening (e.g. X-rays)
Antenatal and post-natal care	Antenatal and post-natal care
Renal dialysis	Renal dialysis
Intermediate care/Rehabilitation beds*	Intermediate care/Rehabilitation beds
Mental Health Services for Bexley*	Centre of excellence for mental health services
Inpatient and Day case surgery	Day Case Surgery
Endoscopy	Endoscopy
Chemotherapy	Chemotherapy
	Radiotherapy
Children's Development Centre	Children's Development Centre

*services currently provided by Oxleas NHS Foundation Trust

It is therefore recommended that the space required to develop the Health Campus be transferred or sold to Oxleas NHS Foundation Trust. Oxleas not only provides a range of services from Queen Mary's Hospital site, it is also willing to invest in the site in it in order to bring it up to the standard required to deliver excellent care to local communities. As part of this investment they could develop an inpatient mental health centre of excellence for patients in Bexley and Bromley. Doing this would provide patients with a better experience and free up more money to invest in community services – as they did when they created a similar centre of excellence for dementia patients.

Developing a Health Campus is great for patients as they will have improved facilities and it helps address some of the financial problems at SLHT as the Trust would no longer have the cost of running the buildings which is £5.4 million.

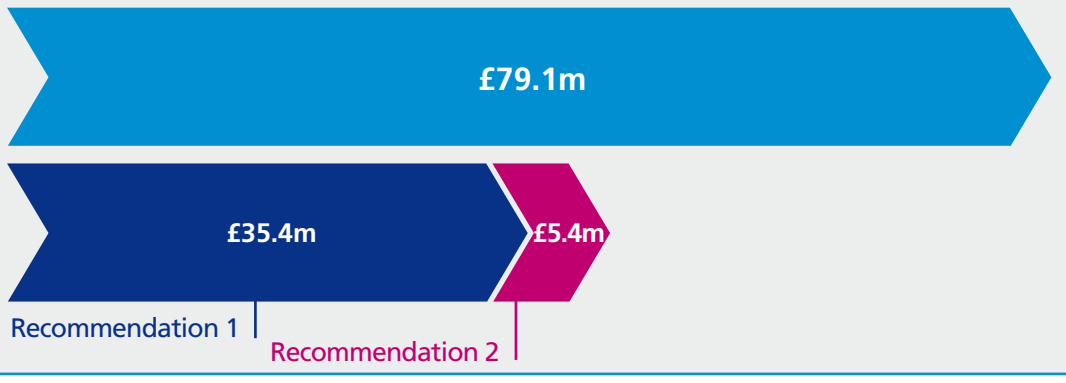
Question

How far do you support or oppose the proposal for Queen Mary's Hospital Sidcup to be turned into a Bexley Health Campus?

Question

How far do you support or oppose the proposal for the land and buildings required for Bexley Health Campus at Queen Mary's Sidcup site to be transferred or sold to Oxleas NHS Foundation Trust?

Financial impact of recommendations in 2015/16 for South London Healthcare NHS Trust



Recommendation 3

Making the best use of buildings owned and leased by South London Healthcare NHS Trust.

South London Healthcare NHS Trust (SLHT) has three main hospital sites, but also provides services from a number of other locations and buildings. Some of these buildings are not used as well as they could be. For example, space in some of the buildings SLHT rents is only used to treat patients for a few hours a day, and only five days a week– this is not a good use of taxpayers' money.

Addressing this issue would reduce how much SLHT spends on buildings meaning that more money could be spent on patient care.

Three opportunities have been identified within this recommendation:

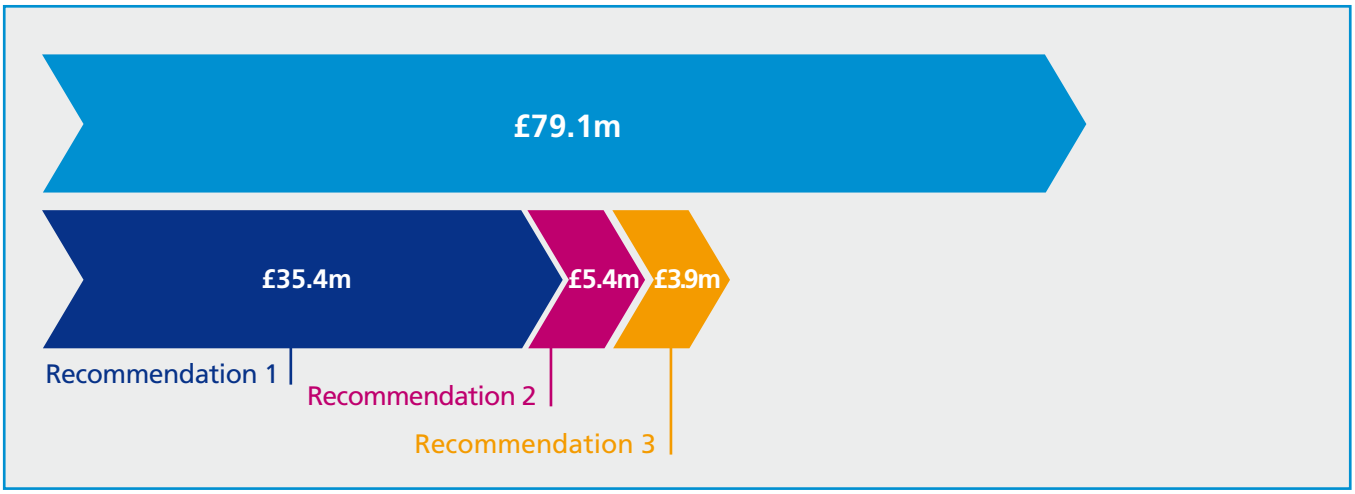
- Sale of excess land at Queen Mary's Hospital in Sidcup: with the development of a Bexley Health Campus some of the current hospital site will no longer be needed to deliver the services proposed for the future – this excess land should be sold to save money that can be reinvested into patient services. Selling this land would mean SLHT would reduce its costs each year by £0.7 million (see diagram on page 23).
- Sale of Orpington Hospital: SLHT had already identified that continuing to provide services from Orpington Hospital in its current form was not a good use of taxpayers' money. The Trust has therefore given notice that they are planning to sell Orpington Hospital and will continue to work with Bromley Clinical Commissioning Group and the London Borough of Bromley to ensure local people continue to receive the care they need. This is expected to save SLHT £1.5 million a year.

In order to make sure that healthcare services can still be provided for patients living in and around Orpington, Bromley Clinical Commissioning Group has very recently consulted on proposals for a modern health service for Orpington that puts services in the best place for patients. The consultation, which finished on 29 October 2012, is looking to determine what the right services are for the local population and is considering from where those services should be provided. Following the consultation, SLHT will continue to work with Bromley Clinical Commissioning Group and the London Borough of Bromley to ensure local communities continue to receive the care they need. This will include further discussions to agree the future of the site.

- Ending South London Healthcare NHS Trust's lease at Beckenham Beacon: the Trust currently rents almost half of the space at Beckenham Beacon to provide a range of outpatient and diagnostic services. This space is poorly used and is costing the Trust around £1.7 million a year. By providing these services from Princess Royal University Hospital in Bromley the Trust could save the money it spends on renting Beckenham Beacon every year. The Trust is proposing to end its lease for this site and is discussing options for this with Bromley Clinical Commissioning Group. This recommendation is not proposing services are not provided at Beckenham Beacon in the future, just that SLHT will not be the organisation delivering them. Bromley Clinical Commissioning Group will consider what primary and community care should be provided from the Beckenham Beacon site in the future to meet the needs of local communities.

Excess land at Queen Mary's Hospital, Sidcup site

Financial impact of recommendations in 2015/16 for South London Healthcare NHS Trust



Question

How far do you support or oppose the recommendation that South London Healthcare NHS Trust should sell or no longer rent poorly used or empty buildings?

6 Recommendation for national support

Recommendation 4

Department of Health provides additional annual funds to cover part of the costs of the PFIs.

What is a Private Finance Initiative (PFI)?

Private Finance Initiative is a concept that was introduced across the public sector, including the NHS, in the early 1990s. One of the concepts of PFI is that new buildings that previously would have been funded by public sector money are instead funded through private finance, which due to greater availability enables public sector organisations to invest more in improving buildings, equipment and services. In the NHS this is usually by building hospitals or other facilities - paying back the money borrowed over a period of up to 30 to 35 years.

PFI contracts can be likened to a mortgage on a house. PFI enables NHS trusts to buy or build new facilities which create huge benefits for patients when they do not have sufficient money to buy or build the facilities outright. PFI is quite commonplace within the NHS and many NHS organisations have entered into PFI contracts. The majority of these work well and provide modern and efficient (easy to heat, clean and maintain) facilities from which to provide services. In March 2012 there were 118 PFI contracts within the NHS across England, and 717 PFI contracts across the whole of the public sector.

As described in Chapter 4, one of the areas that is contributing to South London Healthcare NHS Trust's financial problems is the high cost it is paying for its Private Finance Initiative (PFI) contracts.

South London Healthcare NHS Trust (SLHT) has six PFI contracts in total across its three main hospital sites – two of these contracts are very large and were used to pay for the development of Princess Royal University Hospital in Bromley and Queen Elizabeth Hospital in Greenwich. The other four are smaller contracts are for the running of equipment and other services for the hospital buildings.

It currently costs SLHT £69 million each year to maintain its PFI contracts at Princess Royal University Hospital (£35 million) and Queen Elizabeth Hospital (£34 million).

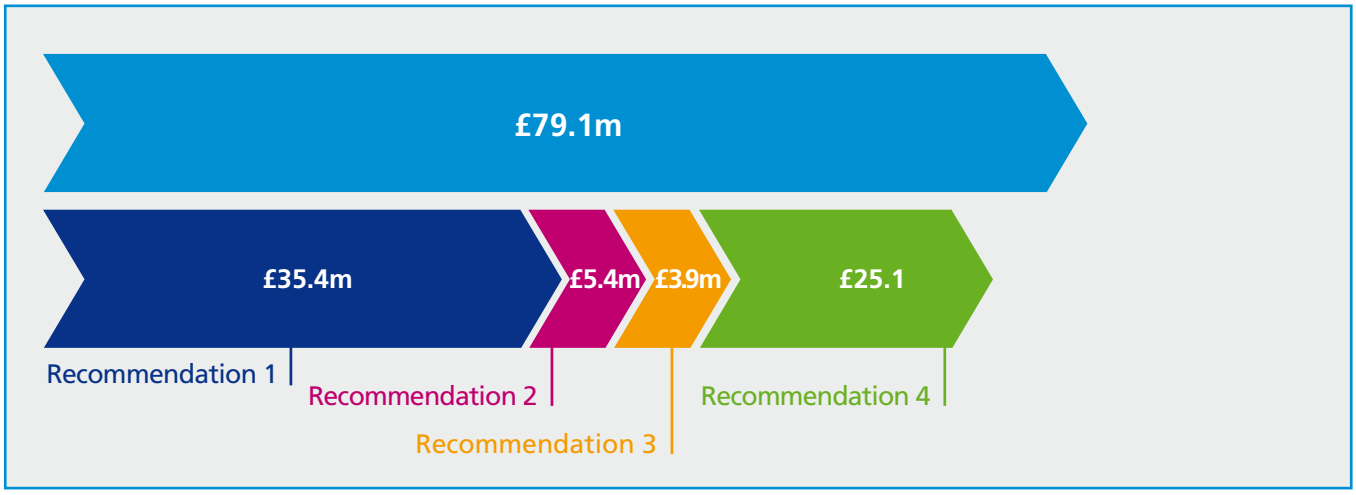
Just like people who enter into a mortgage, SLHT has budgeted for paying its PFI repayments each year. However, in looking at the PFI contracts in more detail it has become clear that SLHT cannot afford the full amount each year, and is paying a higher proportion of its income as annual payments for its PFI contracts than some other NHS organisations across the country.

The Trust spends 16% of its turnover on its PFI contracts which is much higher than the national average of just over 10%. These higher payments cannot be easily covered by the amount of income the Trust receives each year. Analysis has shown that the two PFI contracts cost substantially more than had they been financed through traditional public finance arrangements and for this SLHT should not be penalised.

Analysis has shown that even if SLHT was as productive as the most productive hospital trusts in England, and if it earned the most money it could from filling the beds and other clinic space within these buildings, it would still not receive enough income from its activity to pay the costs associated with the particular PFI arrangements in place.

SLHT is one of seven trusts across the country that the Department of Health believe needs help with paying for their PFI contracts due to the costs incurred. It is therefore recommended that the Department of Health provides additional funds each year to the local NHS to cover part of the costs of the PFI buildings at Queen Elizabeth Hospital and Princess Royal University Hospital until the relevant contracts end. In the financial year 2015/16, this would be a payment of £25.1 million.

Financial impact of recommendations in 2015/16 for South London Healthcare NHS Trust



Question

How far do you support or oppose the recommendation that the Department of Health provides additional annual funds to cover the additional costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth Hospital and Princess Royal University Hospital until the relevant contracts end?

7 How South London Healthcare NHS Trust works as part of the NHS locally

As outlined in Chapter 4 in 2015/16 the financial gap to stopping South London Healthcare NHS Trust's (SLHT) overspend and achieving a 1% surplus is £79.1 million pounds.

The improvements outlined in the first four recommendations will significantly reduce the costs of SLHT by £69.8 million in 2015/16, but they don't address the entirety of the problem as they do not bridge the financial gap (£79.1 million) which is required to secure sustainable services (see Chapter 3) in the long-term. The remaining financial gap is still very big, and the analysis shows it is due to how the wider health system in south east London is designed and delivered and SLHT's role in this.

No hospital anywhere in the country operates in isolation. Every hospital is part of a bigger NHS family, working closely with other healthcare services such as GPs, the ambulance service, community healthcare providers and indeed other hospitals. Each NHS organisation's financial position is therefore affected by how it works as part of the wider healthcare system.

SLHT is a core part of a wider NHS health system in south east London, which includes three other large NHS hospital and foundation trusts: Lewisham Healthcare NHS Trust, King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust (see map on page 5). Alongside these there are also a wide range of other health and social care providers.

The Trust Special Administrator (TSA) has therefore explored how SLHT works as part of the wider healthcare system in south east London. Only by doing this could he develop a set of recommendations that will ensure high quality, safe services can be provided within the funding available and last into the future across south east London.

Healthcare has changed in south east London

In looking at how South London Healthcare NHS Trust (SLHT) works as part of the wider NHS in south east London, and how this may continue in the future, it is important to understand the changing environment in which all NHS organisations are working within.

The way health services are delivered nowadays is changing: a phrase that is commonly used but what does this actually mean?

If we look at how and where healthcare is delivered to patients today compared with 20 years ago there are a number of big differences.

Due to advances in treatment as well as the growing skills of doctors, nurses and other healthcare professionals, many treatments that in the past would have had to be provided in a hospital can now be provided to patients in a community setting for example, at their local GP surgery, a local walk-in centre or even in their own home.

For example, 20 years ago patients with high blood pressure, diabetes or asthma would have been sent by their family doctor to see a specialist in a hospital in order to manage their condition. These days the treatment and monitoring of these conditions, with medicines and with lifestyle advice about diet and exercise, can easily be delivered by family doctors and specialist nurses in GP surgeries. Not only does this reduce patients going to hospitals as outpatients but it also reduces the amount of patients that are admitted to hospital with these conditions in an emergency situation – for example, good management of blood pressure significantly reduces the likelihood of patients having a stroke.

The length of time it takes to provide some treatments to patients in hospital has significantly reduced meaning patients spend less time in hospital than 20 years ago.

For example, due to advances in technology a number of operations can now be done via 'keyhole' surgery. Because the operations are 'key hole' the incisions are much smaller meaning it takes less time for the patient to heal and their recovery time is much quicker. This means for this type of operation patients only need to come into hospital for a single day – they don't even need to stay overnight – whereas 20 years ago they would have had to stay in hospital for at least a week. Removing a gall bladder or breast surgery would fall into this category.

The role of the ambulance service has changed significantly; ambulances now have a range of specialist equipment on board and ambulance staff are highly trained healthcare professionals who are able to provide life saving treatment and drugs to patients at the scene of an emergency.

For example, a person has a stroke in their home. The majority of strokes are caused by a clot on the brain and can be quickly treated by giving the patient a clot-busting drug known as a thrombolytic. The sooner this is given to the patient after the stroke the better as it increases their chance of survival as well as reduces the risk of long-term disability in the future, therefore improving their quality of life. Paramedics can now rapidly assess, treat as appropriate, stabilise and transfer patients to specialist centres across London, for example a Hyper Acute Stroke Unit where clot-busting drugs can be given quickly. Providing the right treatment immediately also means that the patient recovers more quickly, meaning less time spent in hospital. And nowadays many people who have suffered a stroke access rehabilitation services in the community. This also reduces the need for them to spend a long time in hospital away from their home.

The healthcare needs of the local population also need to be considered – these have changed and will continue to change. The NHS therefore needs to change too to be able to best meet the needs of local people. For example, more people are living with long-term conditions such as diabetes, asthma and high blood pressure.

More people are living for longer which is a good thing, but this does impact upon healthcare needs. When older people become unwell they are often taken into hospital, however, we know that this can lead to a more rapid deterioration in their health and independence. For example, older people living with dementia can be managing their condition fine at home but if they end up in hospital with an unrelated illness or condition they can get very confused and disorientated and this can lead to a deterioration in their health.

The number of births expected across south east London over the coming years is also changing. It is projected that birth numbers will increase by about 5% across south east London from 25,954 births in 2012/13 to a projected 27,351 births in 2017/18. Overall population growth during this time is expected to be about 6% (taking into account migration and other factors affecting the overall growth rate).

Ensuring patients can access the appropriate care for their needs in the community, and where possible in their homes, is vital in the future.

The fact that health services are being delivered differently now to how they were delivered in the past means that some services that could once only be delivered in a hospital setting are now being delivered more conveniently and as effectively outside of hospitals, and the time patients are spending in hospital when they do need to go there can be reduced.

This is more convenient for patients and also often a cheaper way of delivering services as they do not require all the costly infrastructure of a hospital setting. This is good for patients and good for the taxpayer.

When looking at how South London Healthcare NHS Trust works as part of the wider NHS, it is important to understand the potential impact of the changes in health need and healthcare delivery as described in this section.

Linking changing health need with the current and future financial position of the NHS in south east London

In looking at how healthcare is changing, and how it will continue to change over the coming years, we must also look at the funding available to the NHS across south east London and how this may change over time too. The two elements are inextricably linked.

The Trust Special Administrator (TSA) took a detailed look at the finances both for NHS commissioners (organisations that plan and buy NHS services on behalf of local communities) and NHS providers (organisations that provide NHS services to local communities).

All providers will face the same financial pressures in the future from an increase in inflation on costs, a reduction in the price that commissioners will pay for services (which is agreed nationally), and a drive towards reducing unnecessary admissions to hospital and delivering more care in the community, which reduces hospital income.

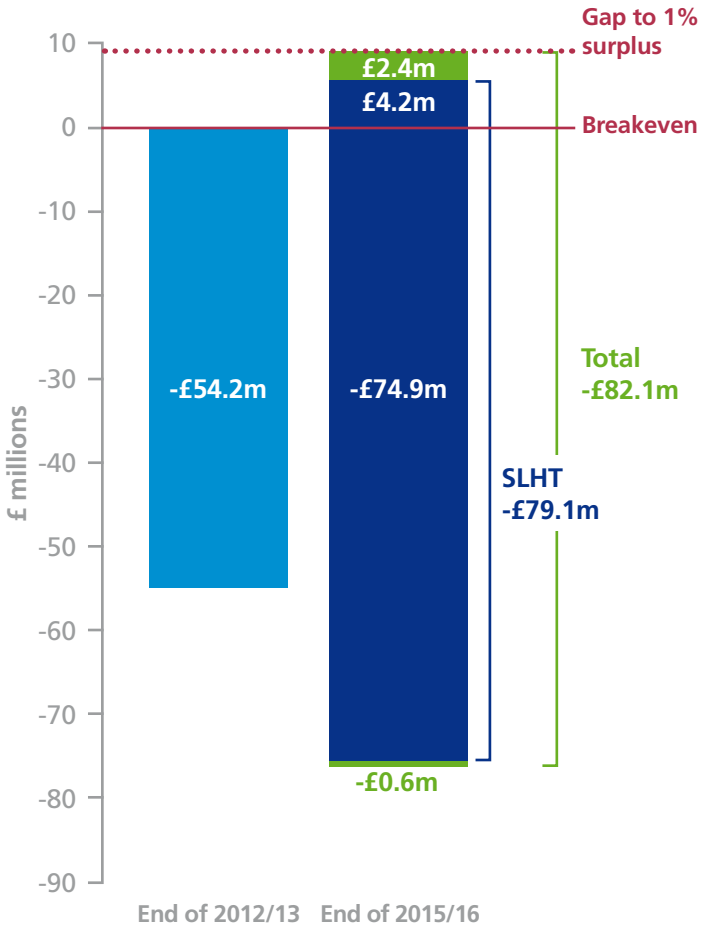
The financial position has been assessed to show income and costs today, and predicted income and costs over the next three years to 2015/16.

What the financial analysis of the wider NHS in south east London has revealed is that whilst South London Healthcare NHS Trust (SLHT) is facing significant financial challenges today making it unsustainable, those challenges will be faced by the wider NHS in south east London over the coming years.

This recent and updated analysis undertaken by the TSA based on new information from commissioners has highlighted that Lewisham Healthcare NHS Trust is expected to be making a loss from 2014/15 and by the end of March 2016 will have a £3 million gap to achieving a 1% surplus – the measure of a financially sustainable NHS organisation as outlined in Chapter 3. This figure is the total of a £0.6 million expected overspend and an additional £2.4 million gap to 1% surplus on top of that.

Taking together SLHT's financial gap to 1% surplus of £79.1 million and Lewisham Healthcare NHS Trust's gap of £3 million, creates a financial gap of £82.1 million for the NHS in south east London. The TSA's recommendations need to address this total financial gap to ensure sustainable services for the whole of south east London (this is shown in the chart to the right).

Forecast deficit for 2012/13 and 2015/16 for south east London health system



Why is the NHS in south east London facing financial problems in the future?

Just like in our own lives, the NHS has to live within its means – there is no bottomless pot of money available. The challenge for all NHS organisations across the country is to provide high quality, safe and accessible services to local communities within the money that is available. Due to a number of reasons this has become more challenging than ever for hospitals.

Hospitals are treating fewer patients than they did in the past, as a lot of care that has been historically delivered in hospitals can now be better and more conveniently delivered in the community and closer to home. And as hospitals are paid depending on the number of patients they treat, it means they are receiving less income each year.

The reduction in income goes further still as the prices set nationally that hospitals can charge for the different services they provide – known as the 'tariff' – is not expected to increase in line with inflation and rising costs over the coming years. This means that hospitals will not only get paid less as they are treating fewer patients, but won't be able to compensate for this by charging more for the work they do.

And as their income is reducing the inflation-related costs associated with employing staff, buying medicines and equipment and paying for buildings are increasing.

In addition, although the amount of money available to spend on healthcare will continue to increase, the way that NHS commissioners choose to spend on behalf of their local communities may change as more care is delivered to patients in the community, supporting people to stay healthy and avoid unnecessary trips to hospital.

This means that the amount of money being spent on hospitals will not significantly increase in future years, and in some cases will decrease.

However, the costs of delivering hospital care across the area are expected to rise. This is because hospitals are very large organisations with many buildings and staff – all of these cost a considerable amount of money to run and will cost more in the future as inflation impacts them as it will for all other parts of the economy.

This is why the NHS needs to rethink how and where services are delivered as hospitals will not be able to continue to provide high quality services in the future without overspending, just like South London Healthcare NHS Trust is today and Lewisham Healthcare NHS Trust will be in the future. This makes these organisations financially unsustainable.

If changes are not made to the way services are delivered, taking into account the changes in healthcare and the increased amount of care delivered in the community, then NHS trusts will have to make unplanned cuts to make the books balance as overspending is simply not an option.

The Trust Special Administrator (TSA) does not believe that allowing unplanned cuts to services is the best way to manage the NHS either now, or in the future. It would be highly irresponsible for the NHS to foresee these problems occurring, potentially putting quality of services and patient care at risk, and not act quickly to prevent it from happening.

This is why the TSA has been supported by a wide range of doctors, nurses, other healthcare professionals and managers to redesign the NHS in south east London, so high quality services can continue to be delivered into the future within the funding that is available.

8 Recommendations for NHS services in south east London

As outlined in previous chapters, the Trust Special Administrator's (TSA) work has identified that it is not only South London Healthcare NHS Trust (SLHT) that is financially challenged and needs to work with other NHS organisations to address its issues. In the future other NHS organisations in south east London will also be challenged financially thus threatening the quality of services in the future unless changes are made to where and how care is delivered.

This chapter sets out the process for how the TSA has worked with doctors, nurses, other healthcare professionals and managers to develop his fifth recommendation for the wider NHS in south east London to ensure high quality services can continue to be delivered into the future within the funding that is available.

Redesigning clinical services with doctors, nurses and other health experts

The Trust Special Administrator (TSA) brought together a group of senior doctors and nurses from all NHS organisations in south east London into a Clinical Advisory Group. He has asked the group to work with him to look at how services can be designed for the future so that they are clinically safe, effective and high quality, but also affordable for the long-term.

The group has met regularly from July 2012 to October 2012, and will continue to meet until the Trust Special Administrator presents his final report to the Secretary of State for Health in early 2013. The group has looked at what could be the best clinically designed system for delivering health services in south east London, within the available resources.

The Trust Special Administrator has also brought together a group of nationally recognised senior doctors to form a second group of clinical advisors. They are the Trust Special Administrator's External Clinical Panel. Their role is to provide additional assurance and challenge from an external perspective to the work and thinking of the south east London group.

Establishing some criteria to test and evaluate any proposed changes to health services

The Clinical Advisory Group recognised from early conversations and analysis of the current situation for the NHS in south east London, as outlined in Chapter 7, that there would need to be some changes to the way services are designed and delivered – to make them safe, high quality, affordable and therefore sustainable for the long-term.

Before getting into any detailed conversations about what any changes could look like, the group developed and agreed a set of 'evaluation criteria' against which suggested changes should be scored.

The 'evaluation criteria' set out what local clinicians and local people considered to be the five most important things to consider when judging any suggested changes to the way health services are designed. This list of five things was developed and discussed with the Clinical Advisory Group, but it was also discussed and tested with the Trust Special Administrator's Patient and Public Advisory Group, and separately by six independently run focus groups made up of a representative sample of residents from each of the six boroughs in South East London.

The 'evaluation criteria' set out what local clinicians and local people considered to be the five most important things to consider when judging any suggested changes to the way health services are designed.

The five overarching criteria are:

1 **Quality of care:** any proposed changes should be scored on the basis that they will improve quality of care and the patient experience.

2 **Access to care:** any proposed changes should be scored on the basis that access to care is not negatively affected, and if possible is improved. Access to care has been defined by looking at equality of access (whether care is available for all people in the community, not just some), distance from and travel time to particular services and whether patients have a choice of services available to them.

3 **Affordability and value for money:** any proposed changes should be scored against how affordable they are within the funding available for the NHS in south east London, and the degree to which any changes use the available resources (staff, buildings and equipment) most wisely.

4 **Deliverability:** how easy it would be to put any proposed change in place, including how long it would take to change from the current way of delivering services to a new way.

5 **Clinical research and education:** to assess any proposed changes against how supportive a differently designed system would be to levels of important clinical research and the training and education of doctors and nurses that currently goes on in south east London hospitals.

Recommendation 5

Transform the way services are provided across hospitals in south east London.

Any change proposed by the Trust Special Administrator (TSA) must ensure high quality and safe services are available to the communities across south east London, and that this is done in an affordable way.

The following section of this chapter looks at four areas of care and how standards and quality can be improved in all four across south east London, how that supports the need to create a financially sustainable solution and what changes need to be made to make this happen. This makes up the TSA's fifth recommendation.

The four areas are:

1. Care in the community and closer to home
2. Urgent and emergency care
3. Maternity services
4. Planned care

1. Care in the community and closer to home

Currently access to community care services, for example, GP services, community nurses and local clinics, is varied across south east London. The standards and quality of care also vary.

This is why the six clinical commissioning groups in south east London – the GP led organisations that are responsible for planning and buying healthcare services on behalf of the communities they serve – have produced a strategy or plan to improve community based care for south east London.

At the heart of this strategy is a set of aspirations for how care will be delivered in the future so that patients across south east London can receive the best possible care in the community, including their homes where possible. This will support people to live healthier and more independent lives and reduce unnecessary demand on hospitals. These aspirations have been grouped into three areas of care:

- **Primary and community care services** that will provide easy access to high quality care for all, to support people in staying healthy, are available to the whole population. Examples of what this will include are:
  - Being supported to manage your own health
  - Being supported to make decisions about your care
  - Having access to healthcare advice 24 hours a day, 7 days a week for urgent needs (for example through a new health telephone service 111).
- **Integrated care services** that support high risk groups, such as those with long-term conditions like diabetes, the frail elderly and those with long-term mental health problems, to remain active and supported in their own homes wherever possible. Examples of what this will include are:
  - Having a personal care plan, with a named care coordinator to help you in managing your care
  - Receiving expert advice and support promptly, so any problems you have are treated early and thereby preventing unnecessary trips to hospital for treatment of a worsening condition
  - If you do have to be treated in hospital, being supported to leave hospital as soon as you are fit enough to do so, knowing you will get the right ongoing support.
- **Planned care services** to support those with a specific healthcare need to receive consistently high quality care in the appropriate location. Examples of what this will include are:

- Having the right information to make an informed choice about the healthcare services you need
- Being confident you will receive the same high quality standard of care, wherever you receive your care in south east London
- Having pre- and post- surgery care closer to home, but receiving specialist care in specialist centres delivered by experts.

The provision of care closer to people's homes and improved care for people with long-term conditions will reduce the length of time patients need to stay in hospital if they do have to stay in hospital for treatment, as well as providing better care for patients. This approach will save the NHS money.

The TSA is therefore recommending that the community based care strategy for south east London is further developed and then implemented to deliver improved community services for patients. This will enable people to receive care in the most appropriate location, much of which will be closer to, or in, their home.

Question

How far do you support or oppose the recommendation to implement the community based care strategy as outlined in Chapter 8 of the consultation document?

The impact of improving community based care in south east London

Issue	Evidence	Impact
Ageing and growing population	The overall population of south east London is forecast to grow by 6% in the next five years[i]	£68m investment in community based services planned to address issues[iv]
Significant health inequalities in part due to a lack of good preventative and primary care access	3.5 years difference in life expectancy between Greenwich and Bromley[ii]	37 heart attacks and strokes could be prevented each year through early detection of risk factors with improved use of NHS Health Checks[ix]
Increasing number of people living with long terms conditions which are not managed effectively	More than 1 in 4 people aged 75+ have one or more of the major long term conditions[iii]	700 lives could be saved each year through early detection and improved management of diabetes alone[x]
High rates of uncontrolled diabetes	Up to 27% of people with diabetes remain undiagnosed and 53% of those diagnosed do not have their condition controlled and therefore have a higher risk of exacerbation, amputation, stroke and other complications	The number of people with uncontrolled diabetes should be reduced by half[xi] Around 200 amputations a year could be avoided through improved diabetes management in the community[xii]
Variation in access to and quality of community based care	10% of admissions for older people could have been managed through better community based care[iv] 41% of patients do not feel they are supported enough by local services to manage their long term conditions[v]	10% reduction in emergency admissions for older people with long term conditions managed effectively in community care[iv] 85% of patients to feel supported to manage their long term conditions[xiii]
Insufficient access in primary care for urgent same-day or out-of-hours services	20% of patients do not believe that GP surgeries are open at convenient times[v]	6% reduction in A&E attendances[xiv]
High A&E attendance rates across hospitals Unnecessary admissions to hospital care	3 of the 6 boroughs are below the national average for out of hours access to primary care[vi] 44% of all emergency activity is coded as minor and could potentially have been dealt with in the community[vii]	Improvement in % of respondents to annual GP patient survey that are very or fairly satisfied with GP opening hours by 2015/16
End of life care is not always available in the patient's preferred place of death - too may people die in hospital which is not their preference	A local Coordinate My Care (CMC) pilot survey indicates that 82% of people would prefer to die at home. In 2010, just 20% of residents who died, died at home[viii]	A significant increase in the number of patients that will be supported to die in their preferred place of death by 2015/16[iv]

2. Urgent and emergency care

A recent study[3] showed that patients in London admitted to hospital as an emergency at the weekend have a significantly increased (10%) risk of dying compared with those patients admitted on a weekday. Across London this accounts for 520 adult deaths a year, and in south east London this accounts for around 100 adult deaths a year. The reasons for this are complex but reduced service provision, including fewer senior consultant doctors working at weekends, is associated with this higher death rate.

As part of an ongoing piece of work across London, clinical expert panels made up of specialist doctors and nurses have developed a set of clinical quality standards for emergency care to address the existing variations in standards of healthcare and patient outcomes across London's NHS.

In south east London there is variation in the way services are provided between weekdays and weekends, with less senior consultant doctors available to treat patients who are admitted at the weekend. Changing where and how emergency care services are delivered to enable the NHS in south east London to meet the agreed clinical standards for emergency care could save around 100 lives a year. At the moment these standards are not met all the time in any of south east London's main hospitals.

The key themes of the emergency care standards include:

- Senior consultant doctors will be available at hospitals to care for patients 24 hours a day, 7 days a week
- Senior consultant doctors' workload will be managed so they care for the most seriously sick and injured emergency patients, without being distracted by anything else
- All patients admitted to hospital as an emergency will be seen by a consultant within 12 hours of the decision to admit that patient into hospital for care, or within 14 hours of the time of their arrival at the hospital
- Patients identified by doctors as 'high risk' will be seen by a senior consultant doctor within one hour, 24 hours a day, 7 days a week
- Patients admitted in to hospital will be assessed by all relevant clinical teams (for example, nursing, physiotherapy, occupational therapy, pharmacy, and acute pain management) within 24 hours of their admission
- All patients will be seen and reviewed by a hospital consultant doctor during twice daily ward rounds
- Key diagnostic imaging and reporting (for example x-ray and ultrasound scans) will be available 24 hours a day, 7 days a week
- Patients will be asked regularly to provide feedback on their experience of their care. This information will be reported to the hospital's senior leadership team, and acted upon where necessary.

Meeting the standards for emergency care will be a significant challenge for the NHS in south east London as no NHS trust currently meets all of them.

To meet these standards, hospitals will need to increase the number of doctors and nurses they have on their rotas. This is a challenge because the cost of additional doctors is significant and currently there are not enough doctors with the skills and experience needed to meet the standards.

Simply increasing the number of doctors at every hospital is not the answer, though this may seem the most obvious solution. This is because, for example, surgeons who perform a high volume of procedures tend to have better outcomes so, even if there were the staff available to provide this increased level of cover at every hospital, doctors may not be undertaking a sufficient number of procedures to maintain their skills and expertise.

An example of this is emergency surgery. Many patients needing an operation as an emergency have a relatively straightforward problem – for example an abscess that needs draining quickly to remove the pus and fluids. But some people have more serious conditions – such as a blocked gut – something which can rapidly lead to death if not treated.

[3] London Health Programmes, *Acute medicine and emergency general surgery case for change*, 2012

Surgeons need to be dealing with sufficient numbers of these more serious and complicated cases each year to maintain their surgical skills and experience – put more simply, so they don't become rusty.

If there are lots of emergency surgeons in one hospital with a small number of patients needing these operations, the surgeons rapidly lose their skills and capabilities. This is more of a problem now than in the past as surgeons have increasingly become more specialised and therefore only focus on a smaller area of surgery.

So, whereas in the past there were general surgeons who could operate on any part of the body, this is no longer the case. There are now surgeons who only do breast surgery, or only do urology (bladder and associated areas) surgery, vascular surgeons who only operate on blood vessels, and so on. This improves their skills in their specialist area but means they have less experience in general procedures.

So, the surgeons who could operate on a blocked gut, for example, are fewer in numbers and need to be based in a larger hospital which treats more patients so they can be available 24 hours a day (on a rota) to provide emergency life saving treatment to patients whilst at the same time maintaining their skills and experience.

So, in order to improve the standards of healthcare across south east London and ensure high quality and safe care is provided long into the future the Trust Special Administrator has been working with GPs, hospital doctors, nurses, community and social care providers as well as the ambulance service to look at how, where and when care is provided across the area. They have looked at how this might need to change in the future to meet the clinical standards set out in the previous sections of this document. They have also looked at how to do this in a way that ensures all NHS organisations in south east London are financially sustainable in the future.

In just the same way that hospitals don't work in isolation from other health services and other hospitals, the different departments and services within any one hospital don't work in isolation from each other either.

So, in order for an accident and emergency department to have the backup specialist services it might need to help treat its most critically ill patients it needs to be connected to 24 hours a day, 7 days a week diagnostic services, emergency surgery services and emergency medicine services within the hospital. These are the services that take over from the 'front door' of the hospital (the accident and emergency department) once the doctors there, or paramedics arriving to help someone in their home or a public place, have assessed a patient as so ill that they need to be admitted to hospital. To meet the clinical standards for emergency care outlined here, and increase the availability of consultant doctors for seriously ill patients, that include A&E consultants, surgeons, physicians and doctors specialising in intensive care, it is recommended those who are most critically ill will be best served by four major hospitals in the future instead of five.

It is recommended that these hospitals are:

- King's College Hospital
- St Thomas' Hospital
- Queen Elizabeth Hospital
- Princess Royal University Hospital

Care for those suffering from trauma, stroke or heart attacks and emergency vascular services will be provided in the same hospitals that they are now.

There will continue to be urgent care centres at:

- Queen Mary's Hospital in Sidcup
- Guy's Hospital

And there will be a 24 hours a day, seven days a week urgent care centre at University Hospital Lewisham providing round the clock treatment for conditions such as:

- Illnesses and injuries not likely to need a stay in hospital
- X-rays and other tests
- Minor fracture (breaks)
- Stitching wounds
- Draining abscesses that do not need general anaesthetic
- Minor ear, nose, throat and eye infections.

Clearly this recommendation will see change for Lewisham, however, less than some may initially think. Based on the work done by Lewisham Hospital itself, it is expected that nearly 80% of patients who currently visit University Hospital Lewisham's A&E would be treated at the urgent care centre in the future. This recommendation is not about 'closing' an A&E department but rather making changes to it. If you can get yourself to the hospital in a car or on public transport then University Hospital Lewisham's Urgent Care Centre would be able to give you the care you need.

If you do go to an Urgent Care Centre and the doctors there decide you need more specialist care you will be quickly transferred by ambulance to ensure you see the right doctors and nurses to meet your needs. The most critically ill patients – those who we are considering being treated in future in one of the four major hospital sites – would by and large not have to take a decision about where to go because the ambulance service would take them straight to the right hospital for their condition.

We understand that people may have concerns about how long it would take to get to hospital under these new arrangements, but as stated above the vast majority of patients will still be able to be treated at Lewisham's urgent care centre.

For the small minority who may be critically ill or injured, and therefore would be taken to a major hospital by ambulance, those patients will be taken straight to a specialist unit. This is similar to what happens now for stroke, heart attack and trauma patients, adopting the same principle to take the most critically ill patients straight to a specialist team to look after them.

Detailed and validated travel analysis has shown that the average increase in blue light ambulance journey time for the population of Lewisham to reach the specialist team would be just over seven minutes. Currently all people across south east London can reach one or more accident and emergency departments within 30 minutes in a blue light ambulance. This will not change under these recommendations.

Emergency and urgent care services across south east London today

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Full admitting accident and emergency department	Full admitting accident and emergency department	Non-admitting urgent care centre	Full admitting accident and emergency department	Full admitting accident and emergency department	Urgent care centre	Full admitting accident and emergency department
24/7 surgical emergency admissions	24/7 surgical emergency admissions		24/7 surgical emergency admissions	24/7 surgical emergency admissions		24/7 surgical emergency admissions
24/7 emergency medicine	24/7 emergency medicine		24/7 emergency medicine	24/7 emergency medicine		24/7 emergency medicine
Critical care unit	Critical care unit		Critical care unit	Critical care unit	Critical care unit	Critical care unit
Hyper-acute stroke unit				Evelina children's hospital		Hyper-acute stroke unit
						Major Trauma Centre

Emergency and urgent care services across south east London in the future

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Full admitting accident and emergency department	Full admitting accident and emergency department	Non-admitting urgent care centre	Non-admitting urgent care centre (adults and children)	Full admitting accident and emergency department	Urgent care centre	Full admitting accident and emergency department
24/7 surgical emergency admissions	24/7 surgical emergency admissions			24/7 surgical emergency admissions		24/7 surgical emergency admissions
24/7 emergency medicine	24/7 emergency medicine			24/7 emergency medicine		24/7 emergency medicine
Critical care unit	Critical care unit			Critical care unit	Critical care unit	Critical care unit
Hyper-acute stroke unit				Evelina children's hospital		Hyper-acute stroke unit
						Major Trauma Centre

Question

How far do you support or oppose the proposed plans for delivering urgent and emergency care in south east London? The following shows how urgent and emergency care would be delivered:

- Emergency care for the most critically unwell – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital
- Urgent care – Guy's Hospital, Queen Mary's Hospital Sidcup, University Hospital Lewisham

3. Maternity services

A 2012 study[4] highlighted that the maternal death rate (when a woman dies whilst giving birth or shortly afterwards) in London was twice the rate of the rest of the United Kingdom. Additionally, in terms of women's experience, London's maternity services are the least well performing nationally ie more women tell us in the NHS in London that they think the care they received could have been better, than in any other part of the country.

This is unacceptable and therefore maternity services must be improved in south east London.

Clinical expert panels made up of specialist doctors, nurses and midwives have developed a set of clinical quality standards for maternity services to address the existing variations in standards of healthcare and improve patient outcomes. These standards are not met in all hospitals all of the time in south east London at the moment.

The key themes of the clinical standards for maternity services include:

- A consultant obstetrician (senior doctor specialising in labour and birth) on the labour ward 24 hours a day, 7 days a week
- All women are provided with one-to-one care during established labour from a midwife
- New and expectant mothers will be provided with interpreting services if they need it and will be regularly asked to provide feedback on their experience of their care. This information will be regularly reported to the hospital senior leadership team and acted upon where necessary.

There are two options being considered for improving maternity services in south east London so they meet the clinical standards outlined here, these are:

1. Consultant obstetrician led deliveries across four major hospitals:
   - King's College Hospital
   - St Thomas' Hospital
   - Queen Elizabeth Hospital
   - Princess Royal University Hospital
2. Consultant obstetrician led deliveries across four major hospitals as well as a 'stand alone' consultant obstetrician led delivery unit at University Hospital Lewisham.

Ante-natal and post-natal care will continue to be delivered in a range of locations across south east London as it is today.

[4] Bewley, S. Helleur, A., 2012. *Rising Maternal Deaths in London, UK.* The Lancet, Vol. 379

Maternity services across south east London today

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Obstetric and co-located midwife-led birthing unit	Obstetric-led birth unit		Obstetric and co-located midwife-led birthing unit	Obstetrics and co-located midwife-led birthing unit		Obstetrics and midwife-led birthing unit
Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care		Ante-natal and post-natal outpatient care

Maternity services across south east London in the future

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Obstetric and co-located midwife-led birthing unit	Obstetric-led birth unit		Potential obstetric and co-located midwife-led birthing unit	Obstetrics and co-located midwife-led birthing unit		Obstetrics and midwife-led birthing unit
Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care		Ante-natal and post-natal outpatient care

Question

Which of the following options would you prefer, if any, for providing obstetric-led services:

- Obstetric-led services should only be provided at the four major hospitals that will offer care for those who are most critically ill (King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital)
- A stand-alone obstetric-led unit should also be provided at University Hospital Lewisham, in addition to the four above
- I do not support either of these options
- Not sure / don't know

4. Planned care

Planned care is when you know that you're having an operation or treatment and this is booked in advance.

There are three different types of planned care:

1. Day case surgery – when you go into hospital in the morning for an operation and go home the same day. This is between 70-80% of all planned care
2. Routine, non complex operations that require a stay in hospital, for example knee or hip replacements
3. More complex operations that it is known in advance will require intensive care support or backup.

Many people who have an operation planned find that they have their operation date changed or cancelled at the last minute, sometimes even when they are in hospital, because an emergency patient has arrived and more urgently needs the bed or the operating theatre.

We believe that the following proposals for planned care will improve patient experience, reduce cancellations and reduce waiting times to come into hospital, therefore improving care for patients.

It is recommended that day case surgery will continue to be delivered across all seven main hospitals (see map on page 5) in south east London as it is today so it is accessible to patients.

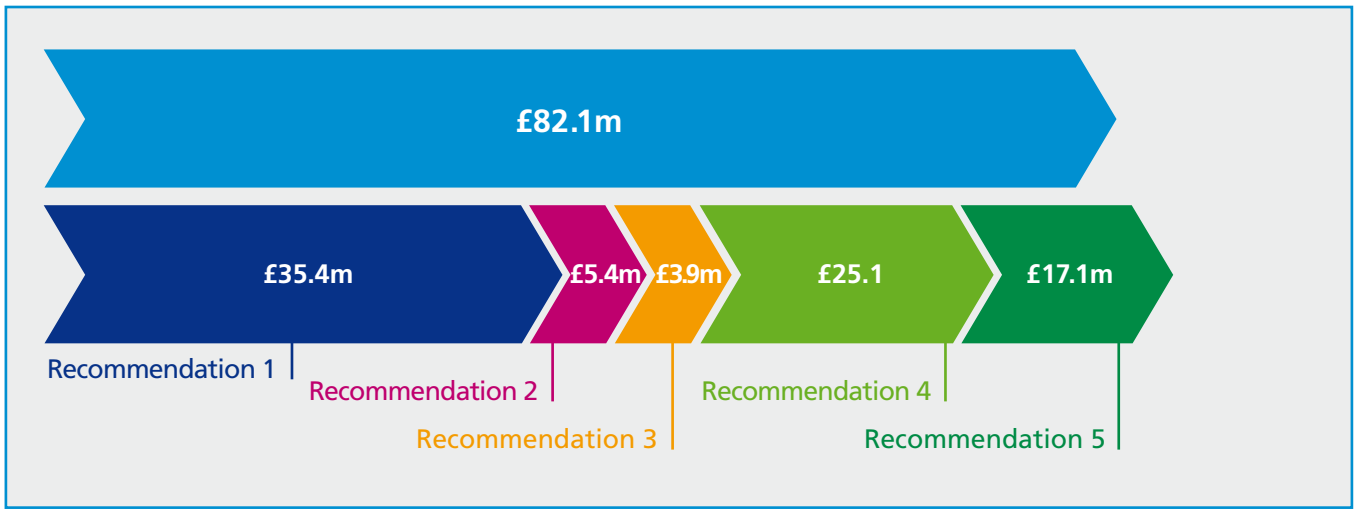
It is recommended that more complex operations will be delivered at the four major hospitals so patients have access to backup intensive care services should they be required:

- King's College Hospital
- St Thomas' Hospital
- Queen Elizabeth Hospital
- Princess Royal University Hospital

Specialist non complex elective services will be provided at Guy's Hospital, King's College Hospital and St Thomas' Hospital, as they are today.

And for routine, non complex operations that require a stay in hospital such as hip and knee replacements, some routine gynaecology, general surgery and other services, it is recommended that a new 'elective' (or planned care) centre is created at University Hospital Lewisham that will serve the whole of south east London. If this recommendation is accepted this is expected to be the largest elective centre for planned, routine operations in the country.

Financial impact of recommendations in 2015/16 for the NHS in south east London



Planned care across south east London today

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Non-complex inpatient elective care and day cases	Non-complex inpatient elective care and day cases	Non-complex inpatient elective care and day cases	Non-complex inpatient elective care and day cases	Non-complex inpatient elective care and day cases	Non-complex inpatient elective care and day cases	Non-complex inpatient elective care and day cases
Complex inpatient surgery	Complex inpatient surgery		Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery
				Specialist elective care	Specialist elective care	Specialist elective care
Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics

Planned care across south east London in the future

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Some non-complex inpatient elective care and day cases	Some non-complex inpatient elective care and day cases	Day case surgery	Non-complex inpatient elective care and day cases	Some non-complex inpatient elective care and day cases	Some non-complex inpatient elective care and day cases	Some non-complex inpatient elective care and day cases
Complex inpatient surgery	Complex inpatient surgery			Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery
				Specialist elective care	Specialist elective care	Specialist elective care
Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics

Question

How far do you support or oppose the proposed plans for providing planned care services in south east London? The following shows how planned care would be delivered:

- Day case surgery – Guy's Hospital, King's College Hospital, Queen Elizabeth Hospital, Queen Mary's Hospital Sidcup, Princess Royal University Hospital, St Thomas' Hospital, University Hospital Lewisham
- Complex operations – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital
- Specialist non-complex operations – Guy's Hospital, King's College Hospital, St Thomas' Hospital
- Routine non-complex operations that require a stay in hospital – University Hospital Lewisham

9 What do these proposals mean for you and your family?

Use of urgent care centres

Now

Margaret has been feeling unwell for a few days – with diarrhoea and vomiting and now her two children are also unwell. She has come home from work and is worried. She calls her GP but they are closed. She calls the out of hours service but can't get through. She bundles the children in the car, travels to A&E and then waits for three hours to be seen. They are then seen by a junior doctor who suggests light fluids and sends them home.

In the future

Margaret can now call the local 111 telephone health service who can offer advice as to what to do. If they are worried, or if Margaret is worried, she can now visit the local GP, based at her nearest urgent care centre if out of hours. They can offer advice and treatment, have access to her family's health records and can update those records.

Need for emergency surgery

Now

Tom has been having severe abdominal pain for several days. He collapses in his nursing home and an ambulance is called. The ambulance takes him to the closest A&E department where he is assessed by a junior doctor. The junior doctor is worried that he has an obstructed bowel and tries to contact a more senior doctor for an opinion and to consider whether emergency surgery is necessary. There is no senior doctor available so Tom has to wait while one is found from a neighbouring hospital. The surgeon eventually arrives and decides that Tom should be operated on as an emergency the next morning.

In the future

Tom's nursing home now has a direct number to call a GP who can come and assess Tom in the nursing home. The GP is concerned about Tom and so calls an ambulance. He shares background information with the ambulance team. Tom is now taken directly to a hospital which has senior surgeons available 24 hours a day, 7 days a week. He is rapidly assessed by a senior surgeon and proceeds to surgery immediately.

Community based care

Now

John has diabetes. His care is managed by his GP. John is not always very good about going to see his GP on a regular basis – sometimes he forgets to make appointments, sometimes he forgets to turn up for them. He struggles to stick to a diabetic diet and finds it hard to exercise as he is overweight. He is now starting to get problems with high blood pressure and is at risk of suffering damage to his kidneys.

In the future

John has diabetes. His care is now managed by the local diabetes service which includes a specialist diabetes nurse and a specialist GP. John visits the local health centre for his care. The nurse called John at home, having reviewed all patients in the local area who have a diagnosis of diabetes (something she does every month). She noticed from his health records that he has not been seen on a regular basis. She spent time with him reviewing his care and agreed with him a plan for regular appointments with her. She made him an appointment to see a dietician and to visit the local gym. She will coordinate his care and call him to make sure he attends future appointments.

Planned care

Now

Mary needs a hip replacement. She is in a lot of pain and struggles to walk. She is finding it hard to look after her grandchildren – something she does twice a week so her daughter can go to work. She has had two dates for the operation cancelled due to emergencies taking precedence. She finally gets a date, has the operation which goes well, but then develops an infection in the wound site which means she has to stay in hospital for two weeks rather than the 3-4 days which she had expected.

In the future

Mary can now go to the specialist elective centre to have her hip replacement operation. The centre does a very large number of cases and has no emergency work – so staff are very skilled and do not have to cancel operations due to emergencies taking priority. Mary has her operation done on the first date scheduled and is able to go home after two days. With regular physiotherapy she is rapidly getting back to walking and is able to look after her grandchildren again just four weeks after the operation.

Maternity

Now

Joanne is having her fourth baby. She has a straightforward labour but immediately after giving birth starts to bleed heavily. The bleeding doesn't stop and staff are concerned about how much blood she is losing. There is no senior doctor available and the junior doctors are concerned about what to do. By the time a senior doctor is tracked down, Joanne has lost a lot of blood. She is rushed to theatre and the doctors manage to save her life but she suffers complications and is on the intensive care unit at the hospital for five days. Joanne went on to suffer post natal depression as a result of her traumatic experience post birth.

In the future

All obstetric units in south east London now have consultant obstetricians available 24 hours a day, seven days a week – so when Joanne suffers her post partum haemorrhage, a consultant can rapidly assess her and make a timely decision to operate. Joanne's care is straightforward post operatively and she is reunited with her new baby after a day.

10 Recommendations for organisations delivering NHS services in south east London

The staff within South London Healthcare NHS Trust (SLHT) have worked hard over the past three years to deliver high quality care to patients and this is still the case today. There have been significant improvements in the quality of care in recent years.

However, since the merger of the three predecessor trusts in 2009 to form SLHT, the clinical and managerial leadership of SLHT has not been successful in seizing the opportunity of the merger to cut out duplication and do things once instead of three times. Nor has it been able to transform enough and embed a culture capable of delivering the operational efficiency and high quality care needed. Sustainable healthcare organisations need the capacity and capability to do both of these to make sure that they are providing the best care possible to patients and spending the finite amount of money they receive as wisely as they can, for the maximum benefit of patients.

One example of this is that the Trust still has a number of disconnected and/or duplicated systems in place across each of its sites. For example there are three different IT systems for booking patient appointments; a lack of integration in some of the clinical teams offering the same services at different sites; and, a lack of standardisation for buying some equipment and appliances. This means duplication and inefficiency has not been taken out where it could have been and money isn't being spent as wisely as it could.

Recommendation 6

Delivering service improvement through organisational change.

Recommendations one to five outline an even greater challenge than the one the Trust has faced in recent years. Making such big improvements in the way the hospitals are run (recommendation one), supporting the establishment of the Bexley Health Campus (recommendation two), selling off land that is not needed (recommendation three), ensuring support from the Department of Health around the Private Finance Initiative challenges (recommendation four) and making the changes that will redesign services to within the funding available whilst improving the quality of care in south east London (recommendation five) will all require very strong leadership and significant cultural change. Strong leadership that can work with staff throughout the organisations to make the changes required must be in place.

Therefore, recommendation six is that South London Healthcare NHS Trust stops being an organisation in its own right (is legally dissolved) and the Trust's services, staff and assets (for example buildings) become part of other organisations.

Question

How far do you support or oppose the recommendation for South London Healthcare NHS Trust to be dissolved, with current NHS services managed and delivered by other organisations?


Welch Allyn
ADULT
Welch Allyn
Blood Pressure Cuff

Considering options for the future

The Trust Special Administrator (TSA) has undertaken a 'market engagement' process to ask other organisations what they think could be done to ensure the sustainability of the services provided by South London Healthcare NHS Trust (SLHT).

This process asked other organisations, including those in the NHS and independent sector, what ideas they had about how they could run the Trust better. This included consideration about running the whole Trust as it currently is. It also included consideration about what they would do if the hospitals were split up.

Having looked in more detail at the Trust, none of the organisations the TSA spoke to thought it would be possible to keep the Trust going as it is currently run. They all agreed that without significant changes the services could not be made sustainable and also meet the quality standards clinicians have said should be provided in south east London.

Having ruled out the option of keeping the Trust as it is, the TSA talked to a wide range of people about options for the individual hospitals within it.

The options being considered within this recommendation are outlined below:

- Queen Mary's Hospital

  Recommendation two outlines a proposal for the future of Queen Mary's Hospital Sidcup as a Bexley Health Campus, providing a range of services for the local population. It is proposed that Oxleas NHS Foundation Trust should own and run the site with a number of other providers also providing NHS services from the Health Campus.

- Queen Elizabeth Hospital

  Lewisham Healthcare NHS Trust has said that it would like to run services at Queen Elizabeth Hospital in Woolwich. With this in mind this recommendation proposes that the two hospitals come together as one single organisation to deliver healthcare services for the populations in Lewisham and Greenwich from two sites.

  The leadership team at Lewisham Healthcare NHS Trust have already started thinking about how they would do this. Their proposals will need more work, but initial thinking is suggesting that the following services would be provided:

Queen Elizabeth Hospital, Woolwich	University Hospital Lewisham
24/7 emergency services	24/7 urgent care services
Complex planned surgery	Rehabilitation (including for patients recovering from strokes)
Day case surgery	Intermediate care – where patients still need intensive rehabilitation services but not 24/7 care from doctors
Maternity services (including obstetric-led and midwife-led services)	Day case surgery
Outpatient services	Outpatients
	Planned inpatient surgery for the whole of south east London
	Maternity*

* Depending on the decision around recommendation five, University Hospital Lewisham may also provide obstetric-led and midwife-led maternity services.

This new organisation would provide hospital services for Greenwich and Lewisham, and so would need to work closely with the local Clinical Commissioning Groups and other providers to help deliver better, joined up care for patients.

Setting up this new organisation and improving care for patients will be very challenging, but the strong leadership team at Lewisham Healthcare NHS Trust can draw on their experience to do this.

Question

How far do you support or oppose the plan for the Queen Elizabeth Hospital site and Lewisham Healthcare NHS Trust to come together to create a new organisation?

- Princess Royal University Hospital

  There are two options being considered for Princess Royal University Hospital.

  The first, and preferred option, is for King's College Hospital NHS Foundation Trust to run the hospital and the services it provides, and the second option is to run a procurement process to find the best organisation to run the hospital and its NHS services – which could be an NHS or an independent sector organisation or a combination of both.

Question

Which of the following options would you prefer, if any, for the running of the Princess Royal University Hospital?

- The Princess Royal University Hospital should be acquired and run by King's College Hospital NHS Foundation Trust
- A procurement process should be run allowing any provider from the NHS and/or independent sector to bid to run NHS services on the Princess Royal University Hospital site
- I do not support either of these options
- Not sure / don't know

Making sure the new organisations are successful

The Trust Special Administrator's role is to secure clinically and financially sustainable services in the future, and therefore his recommendations must ensure that the organisations proposed to implement these changes, as outline here, have the best possible chance of success. This is more likely if they are not saddled with the financial problem South London Healthcare NHS Trust has built up over the years. To make sure that there will be sustainable NHS services in the future this recommendation therefore includes a proposal that the Department of Health writes off the debt so that the future can focus on delivering improved patient care rather than managing the problems of the past.

Question

To what extent do you agree or disagree with the recommendation for the Department of Health to write off the debt accumulated by South London Healthcare NHS Trust?

11 What happens if we do nothing?

Why is there the need for such significant change? Surely the money can be found from somewhere or provided by the government?

Unfortunately, the situation facing South London Healthcare Trust, and indeed soon the wider NHS in south east London is very serious and therefore needs drastic solutions to protect services for local patients into the future.

The fact is, if nothing is done to address this worsening problem, things will become even worse for patients across south east London:

- People will continue to die unnecessarily. A recent study by London Health Programmes showed patients treated at weekends and evenings in London hospitals – when fewer consultants are available – stand a greater chance of dying than if they are admitted during the week when they can be seen by a consultant quickly. We need a system that allows all of our hospitals to benefit from having senior, expert consultants on-site at all times.
- Our dependency on hospital services would continue when this is not the best use of money, buildings or indeed doctors and nurses. We need to focus more on helping people to stay well in the community and avoid having to go to hospital at all. And for those patients that do need to go to hospital, we need to make sure they have 24/7 access to the specialist care they need.
- More hospital trusts would be under severe financial pressure, not just SLHT, meaning they could be entered into NHS administration. While the NHS can cope with some financial losses, this is obviously far from ideal and the deeper in debt that NHS trusts become the more difficult it is to keep services running, to retain doctors and nurses and to provide high-quality patient care. If hospitals get into this sort of financial trouble they will need to make ever more difficult and quick decisions and this would inevitably happen in a disorganised and unplanned way meaning a worse effect on patients and staff.
- All the time that an NHS organisation overspends means that money is being unfairly and inappropriately taken away from other parts of the NHS. The NHS as whole has a finite amount of money to spend on services each year. If one trust spends more than it should, this means another part of the NHS and its patients, has less money which is unacceptable.
- There would also be problems with the NHS workforce. As it is, some services have already had to be reduced because there are not enough clinicians to provide them safely. Recruiting and keeping clinical staff in London is always a challenge and if we do not offer the best places to work, and the best places to train, we will not attract the best staff. Equally, if there are not enough senior staff, trainee doctors can't be supervised and are withdrawn from the hospital. All this means patients will not get the best care, and services will be reduced.

While this may sound alarming, it is important that patients and local communities understand the severity of the situation and what would happen if we did nothing.

Though services are mostly providing good standards of care at the moment, they cannot do so into the future given the financial pressures all NHS organisations are facing. It will be patients, and the doctors, nurses and other health professionals who treat them and care for them, who will be the first to feel the consequences if nothing is done to address these immense financial problems.

12 Having your say

Ipsos MORI, an independent research and analysis organisation, has been commissioned to collect and analyse all responses to this consultation. The findings will help the Trust Special Administrator form his final recommendations to the Secretary of State for Health.

Please read this document all the way through then give us your answers to the questions either by completing the response form inserted in this document and sending it back to Ipsos MORI using the freepost envelope provided. You can also feedback your views online by visiting **www.tsa.nhs.uk** and completing the online response form.

In the response form (both the hard copy and online versions) we have shown which sections of the consultation document cover the issues raised by each of the questions. Please refer back to these sections as you answer the questions.

If you want to explain any of your answers, or you feel the questions have not given you the chance to express your views fully, or if you think there are options we have not considered that we should have done, please say so in the box at the end of the form.

You have until **midnight on 13 December 2012** to get your response form back to us. The freepost envelope provided is second class, so please ensure you post your response form in plenty of time to reach us. Responses received after midnight on 13 December 2012 will not be accepted or considered.

If you have any questions about the consultation call us on (freephone) **0800 953 0110**.

If you have any queries about how to complete the response form, please email Ipsos MORI at **tsaconsultation@ipsos-mori.com** or call them on **0808 129 5719** (free from landlines, mobile charges will apply).

13 Next steps

After the consultation on the Trust Special Administrator's recommendations closes at midnight on 13 December 2012, he has 15 working days to review the feedback and develop his final recommendations for the future of NHS services in south east London.

The recommendations will be outlined in his final report that he must submit to the Secretary of State for Health by Monday 7 January 2013.

The Secretary of State then has up to 20 working days to make a decision on the Trust Special Administrator's recommendations. A decision will be made on the future of South London Healthcare NHS Trust and health services in south east London by Friday 1 February 2013.

Glossary of terms

111	A new 24/7 telephone number that is being introduced to make it easier to access local NHS healthcare services.
24/7	Twenty four hours a day, seven days a week
A&E	Accident & Emergency is a service available 24 hours a day, seven days a week where people receive treatment for medical and surgical emergencies that are likely to need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery, and other serious illnesses.
Acute care	Acute care refers to short-term treatment, usually in a hospital, for patients with any kind of illness or injury.
Acute trust	NHS acute trusts manage hospitals. Some are regional or national centres for specialist care, others are attached to universities and help to train health professionals. Some acute trusts also provide community services.
Average Length of Stay	Average Length of Stay is an average of the length of time patients stay in a hospital when admitted.
Clinical Commissioning Groups (CCGs)	These are health commissioning organisations which will replace primary care trusts (PCTs) in April 2013. CCGs are led by GPs and represent a group of GP practices in a certain area. They are currently shadowing the PCTs and will be responsible for commissioning healthcare services in both community and hospital settings from April 2013 onwards.
Cost Improvement Plan	Plans to meet the cost savings target levied on NHS bodies by the government.
Commissioning	The planning, procurement and contract management of health and health care services for a local community or specific population.
Day case or day surgery	Patients who have a planned investigation, treatment or operation and are admitted and discharged on the same day.
Deficit	When expenditure is greater than income.
Elective centre	This is where patients go if they need an operation which is not urgent and so can be planned.
Elective surgery	Planned surgery that is not immediately necessary to save life, carried out in a hospital either as a day case or an inpatient.
Emergency admission	A patient who is admitted on the same day that admission is requested due to urgent need (also known as urgent admission and unplanned care).
Financial surplus	When income is greater than spending.
Foundation Trust	NHS foundation trusts are not-for-profit corporations. They are part of the NHS yet they have greater freedom to decide their own plans and the way services are run. Foundation trusts (FTs) have members and a council of governors. The aim is that eventually all NHS trusts will be FTs.
GP	General Practitioner
Independent sector	A range of non-public organisations involved in providing services, including private, voluntary and charitable organisations
Mortality rate	A measure of the number of deaths (in general or due to a specific cause) in a defined population, scaled to the size of that population, per unit of time.
Midwife-led unit	A unit which specialises in delivering babies by midwives.

Obstetrics	The medical specialty that deals with care for women during pregnancy, childbirth and the postnatal period.
Obstetric unit	A unit which specialises in delivering babies by obstetricians.
PFI	Private Finance Initiative: a government-led programme to enable the private sector to become involved in the provision of facilities which will then be run by the NHS.
South East London	The six London boroughs of Bromley, Bexley, Greenwich, Lambeth, Lewisham and Southwark.
SLHT	South London Healthcare NHS Trust
Specialist hospital	A hospital which provides specialist care for complex conditions.
Tariff	A set price for each type of procedure or admission type carried out in the NHS.
TSA	Trust Special Administrator: exercises the functions of the chairman and directors of the Trust and to develop recommendations for the Secretary of State that ensure all patients have access to high-quality, sustainable services
Urgent Care Centre	A centre that is open 24 hours a day, seven days a week. These centres will treat most illnesses and injuries that people have which are not likely to need treatment in a hospital. This includes chest infections, asthma attacks, simple fractures, abdominal pain and infections of the ear, nose and throat.

Notes

Office of the Trust Special Administrator

Visit our website
www.tsa.nhs.uk

Call us (freephone)
0800 953 0110

Email us
tsaconsultation@nhs.net

Follow us on Twitter
@OfficeTSA

Write to us
Office of the Trust Special Administrator
c/o South London Healthcare NHS Trust
Frognal Avenue, Sidcup, Kent DA14 6LT

Ipsos MORI
Social Research Institute

Appendix I

Ipsos MORI Independent Consultation Feedback Report

Securing sustainable NHS services

Ipsos MORI
Social Research Institute

‘Securing sustainable NHS services’ consultation on the Trust Special Administrator’s draft report for South London Healthcare NHS Trust and the NHS in south east London

Final report

Legal notice

Contents

Executive summary

The consultation process

This report contains an independent analysis of the responses received to the *Securing sustainable NHS services* public consultation on the six draft recommendations put forward by the Trust Special Administrator (TSA) for securing clinically and financially sustainable services for the people served by South London Healthcare NHS Trust (SLHT) and the wider NHS in south east London.

The TSA consulted public, patients, staff and stakeholders to give them the opportunity to put forward their views and comments in order to validate and improve the draft recommendations before he submits his final recommendations to the Secretary of State for Health in January 2013.

The consultation ran for 30 working days and received a total of 8,224 responses from stakeholders, patients, the public and health professionals. Respondents used a number of channels to feed back their views:

- A response form with questions about each of the recommendations, available online and in hard copy
- Written comments submitted in letters and e-mails
- Petitions
- There were also consultation events and supplementary qualitative research, both of which are reported on separately (available on the TSA website)

The numbers of each received are detailed below.

Table 1 – Responses to the public consultation

Method	Total
Hard copy response forms	884
Online response forms[1]	6,327
Written comments from individuals (letters & emails)[2]	842
Written comments from stakeholders (letters & emails)	156
Petitions	15
TOTAL	**8,224**

[1] Multiple responses were accepted from individual IP addresses to ensure, for example, that a family sharing a home computer were all able to submit individual responses. In some cases, a large number of responses were received from an individual IP address. There were ten IP addresses where over 10 responses were received from that one address. The highest number of responses from one IP address was 247, although the rest were significantly lower. Eight of the IP addresses were registered to NHS bodies.

[2] This figure includes 515 forms created by Save Lewisham Hospital Campaign, with pre-printed statements and respondents' own responses to three questions on the recommendations. Please see chapter 9 for further details.

More details about the consultation process and responses to the consultation can be found in chapter 1 of this report.

Ipsos MORI collated and analysed the responses to the consultation. It is important to remember that the results contained in this report are not representative of the population – they only refer to the people and organisations/groups that responded to the consultation.

Under statutory guidance, the Trust Special Administrator was required to consult a small number of stakeholders. However, recognising the need for wide engagement on the draft recommendations, further stakeholders were invited to respond to the consultation. Individuals, organisations and groups that the TSA invited to respond, along with organisations and groups who responded via letter or email rather than the response form, are referred to in the report as stakeholders and are included in a separate analysis in chapter 10 of this report. Organisations and groups not specifically invited to respond by the TSA who responded via response form are included with the main findings from the consultation and are referred to as organisations/groups.

Key findings

The key findings discussed below are based around responses submitted from individuals and organisations/groups Feedback from stakeholders is given consideration in a separate paragraph to conclude the key findings chapter.

Recommendation 1 – Improve the efficiency of South London Healthcare NHS Trust

The consultation asked whether people agreed or disagreed that the efficiency of the hospitals that make up South London Healthcare NHS Trust (SLHT) needs to improve to match that of top performing NHS organisations. It then went on to ask whether the areas that had been identified for making efficiencies by the Trust Special Administrator (TSA) were appropriate.

Individual respondents were divided in their support for the recommendation to improve the operational efficiency of the hospitals, with similar proportions agreeing and disagreeing (42% and 37% respectively). Half of individuals disagreed that the specific areas identified to improve efficiency were appropriate (56%), while one in five agreed (21%).

Those responding on behalf of an organisation or group were more positive, both about the need to make efficiencies and the specific areas suggested. More agreed than disagreed with each element of this recommendation.

A number of free-text comments (from across all respondents) suggested that the efficiency of the hospitals within SLHT could be improved. However, some concerns were raised, particularly around potential reductions to the number of staff, the impact on quality of care and patient outcomes, and a feeling that patient care should be the key driver rather than efficiency considerations. Other responses referenced the Private Finance Initiative (PFI) debt, saying that this was at the root of the problem rather than efficiencies.

Some respondents also raised concerns about the data used to support the recommendation, sometimes specifically saying SLHT should not be compared to other trusts, or that they did not have sufficient information to form an opinion.

Recommendation 2 – Develop a Bexley Health Campus at Queen Mary's Hospital, Sidcup

The consultation asked about two elements of this recommendation around Bexley Health Campus, firstly whether they supported or opposed the proposal that Queen Mary's Hospital, Sidcup (QMS) should become a Bexley Health Campus, and then whether or not the land and buildings required for this should be sold or transferred to Oxleas NHS Foundation Trust.

Individual respondents were broadly opposed to the development of a Bexley Health Campus, with 45% opposing both proposals and 15% supporting them. Bexley residents were more supportive.

Those responding on behalf of organisations or groups were more in favour of the proposals. One in three supported the proposal that QMS should become a Bexley Health campus (35%), while three in 10 opposed it (29%). They were also supportive of the proposal to sell or transfer the required land and buildings to Oxleas NHS Foundation Trust, with 38% support and 27% opposition.

Free-text comments (from across all respondents) appeared to indicate that opposition stemmed mainly from confusion as to the implications of the proposals and a fear that the proposals could lead to the privatisation of healthcare services. Some confusion extended to the meaning of the term 'Health Campus'.

Recommendation 3 – Making the best use of buildings owned and leased by South London Healthcare NHS Trust

Respondents were asked whether they supported or opposed the recommendation that South London Healthcare NHS Trust (SLHT) should sell or no longer rent poorly used or empty buildings.

Individual respondents were, on the whole, opposed to the recommendation that poorly used or empty buildings should be sold or no longer leased (70% opposed and 63% strongly opposed).

A more positive response was noted for those responding on behalf of an organisation or group; almost half supported the recommendation (48%).

Free-text comments (from across all respondents) showed opposition to the sale of any assets or buildings, and a concern was raised that once assets were sold they may not be recovered should a need arise in the future. Emphasis was often placed on the belief that services may need to expand in the future to accommodate a changing population. This led some responses to say the recommendation was short-sighted. Others felt that if there was space within the NHS, then it should be used to provide services.

Respondents sometimes referred to specific sites, for example, referencing the sale of land and buildings at University Hospital Lewisham (UHL) and opposing this sale. In addition, some responses related to this specific recommendation received via letter or

email registered concern about the provision of services for the local community at Beckenham Beacon.

Recommendation 4 – Department of Health provides additional annual funds to cover part of the costs of the Private Finance Initiatives

The consultation asked to what extent people supported or opposed the recommendation for the Department of Health (DH) to provide additional funds to the local NHS to cover the additional costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth Hospital (QEH) and Princess Royal University Hospital (PRUH) until the relevant contracts end.

There were mixed views regarding this recommendation, with 42% of individual respondents supporting it, and 35% opposing it.

Those responding on behalf of organisations or groups were more in favour of the proposal, with 61% supporting it.

Free-text comments (from across all respondents) suggested that opposition stemmed mainly from a resistance to paying the PFI debts back at all; or at least a desire for the contracts to be re-negotiated. Many respondents felt very strongly about the negative impact of PFI on the NHS.

Respondents supporting the recommendation felt that the local NHS should not have to suffer because of previous decisions by central government, and so agreed that the DH should provide funds for the relevant PFI debts.

Recommendation 5 – Transform the way services are provided across hospitals in south east London

Recommendation 5 concerns service provision across the wider NHS in south east London. This recommendation is split into four care areas, and respondents were asked whether they supported or opposed the proposals in each of these areas:

- Care in the community and closer to home
- Urgent and emergency care
- Maternity services
- Planned care

On the whole, individual respondents opposed the community care recommendation (47% vs. 23% in support), although 31% did not offer an opinion. A greater proportion of organisations and groups were in support of the community care recommendation compared to those in opposition (47% support vs. 23% oppose).

In the free-text comments (from across all respondents), some support was given to the proposed community care strategy, though this support tended to be conditional on the basis of increased funding and improvements to care in the community, while also not occurring at the expense of other services such as hospital services.

Regarding the proposed changes to urgent and emergency care, many individual respondents opposed the changes (90%), while amongst Lewisham residents (who make up a large proportion of the consultation responses received), the level of opposition rose to 96%. Overall, there was limited support for these proposed changes

(eight per cent). Amongst organisations and groups responding via the response form, the majority opposed the proposed changes to urgent and emergency care (24% support vs. 67% oppose), although support was higher than among individuals.

A large proportion of the free-text comments provided stated that University Hospital Lewisham (UHL) should keep its Accident and Emergency (A&E) department. The reasons underpinning this were good perceptions of the UHL service and not wanting to waste money from the refurbishment; the need for a large population to be served by an A&E; seeing it as unfair to penalise UHL when it is performing well; concerns about capacity at other A&Es; concerns about travelling to other A&Es, including travel times and their impact on safety.

For both individual respondents and organisations/groups, there was no clear support for either option for providing maternity services across south east London. Amongst individual respondents, nearly seven in 10 supported neither option (69%) and where they did choose between the two options, more preferred an additional stand-alone obstetric-led unit at UHL (24%). A similar proportion of organisations/groups also selected this option (26%), but one in four said they weren't sure which option they would prefer (23%). There was minimal support among individuals or organisations/groups for obstetric-led services at the four major hospitals only (three and seven per cent respectively).

The majority of free-text responses emphasised the need for maternity services to be co-located with emergency care, with concern about the risk of providing obstetric-led services without A&E at the same site. As for A&E, respondents mentioned the high quality maternity services they thought were already available at UHL and the recent investments; the growing population; concerns about capacity at other hospitals; concerns about distances and travel times including the impact on safety; and wanting maternity care to be provided locally.

Individual respondents tended to oppose the proposed changes to planned care (68%). Organisations/groups were more supportive, with three in 10 supporting the recommendation (31%), although half opposed it (50%). The most frequent theme emerging in the free-text responses was concerns about increased difficulties in accessing care as a result of the proposed changes.

Recommendation 6 – Delivering service improvement through organisational change

Recommendation 6 concerns organisational solutions for South London Healthcare NHS Trust (SLHT). Again, four separate questions were asked of respondents about the proposed plans in order to gauge support or opposition for them:

- Dissolution of SLHT
- Merging of Queen Elizabeth Hospital (QEH) and Lewisham Healthcare NHS Trust
- Preferred option for running the Princess Royal University Hospital (PRUH)
- The Department of Health (DH) to write off debt accumulated by SLHT to the end of 2012/13.

The majority of individual respondents opposed the plan to dissolve the current SLHT (65%), with some (in the free-text comments provided) believing that the Trust could be rescued with better management, without the need for extensive reorganisation.

Organisations and groups were more positive, with one in three supporting the move to dissolve the Trust (34%), although more still opposed the plan than supported it (42% oppose).

Individual respondents showed a similar level of opposition in relation to the plan for QEH and Lewisham Healthcare NHS Trust to merge (71%). While Lewisham residents were particularly likely to oppose this proposal, those living in Bexley and Bromley were more positive (although still opposed overall). Free-text comments revealed some concerns about the failure of previous mergers and the perceived risk to Lewisham Healthcare NHS Trust in joining with a failing hospital. Again, organisations and groups were slightly more supportive of the proposed recommendation although they still expressed strong opposition (27% supported and 47% opposed it).

Of the two options put forward by the Trust Special Administrator (TSA) for the future running of PRUH, nearly two in five individual respondents were in favour of the hospital being acquired and run by King's College Hospital NHS Foundation Trust (37%). Around three in 10 respondents supported neither of the two options suggested by the TSA (31%), while a further one in four said they were not sure or didn't know (27%). The key issue for many in the comments provided was a concern that running a procurement process would lead to private providers of NHS services, something that was strongly opposed. Support for the acquisition of PRUH by King's College Hospital NHS Foundation Trust was higher amongst those who said PRUH (58%) or King's College Hospital (62%) was their nearest hospital.

The views of organisations and groups were slightly more in line with those of individuals for this question; 41% were in favour of the plan for King's College Hospital NHS Foundation Trust running PRUH.

The majority of respondents agreed with the recommendation for the DH to write off debts accumulated by SLHT (77%). Free-text comments showed that respondents felt this was the only solution to ensure success in the future and to maintain services for residents of south east London. However, some queried the need for restructuring, if the debt was written off and effective management put in place. Four in five organisations/groups agreed with this recommendation (81%).

Other comments

Having provided feedback on each recommendation in turn, all individuals and organisations/groups were given the opportunity to give further comments on the consultation and the issues it covers.

University Hospital Lewisham (UHL) and its future was a central concern in the further comments provided. Access to care was also raised as a concern. Many comments emphasised that patient care should be prioritised before financial matters, and felt that the proposed recommendations did not place patients at the heart of the NHS.

Many took this opportunity to provide feedback more generally on the proposals and consultation process, sometimes critical of the recommendations and their underpinning evidence or the amount of information provided, sometimes feeling that they did not have enough information in the consultation document to form an opinion.

The views of differing sub-groups within south east London

There were a number of differences between sub-groups of individuals within south east London, which tended to apply across the recommendations. Generally, those who may be thought to have greater interaction with NHS services (because they are older, have a disability, or care for someone aged 16 or over) tended to be more supportive of the proposals. In addition, those who have worked in the NHS, whether at present or in the past, also tended to be more supportive. However, opposition still broadly outweighed support for the recommendations.

Stakeholder feedback

In total, 156 responses were received from stakeholders ranging from the Royal Colleges to staff groups to community and expert patient groups. Stakeholders tended to be more supportive of the TSA's draft recommendations than individual respondents, with many accepting that there is a need for change. However, support was often conditional and individual stakeholders raised a number of specific concerns around the draft recommendations, which are summarised in Chapter 10 of this report. For example, a common theme across stakeholder groups was a wish for greater detail to be provided and more modelling to be undertaken. Although generally more positive, some stakeholders were strongly opposed to some aspects of the draft recommendations.

Petitions and campaign responses

A total of 15 petitions were received to the consultation. Of these, 14 particularly focused on the recommendations around urgent and emergency care and maternity services, opposing the proposed changes to services at University Hospital Lewisham (UHL). Details of the petitions are outlined below.

Petition on behalf of		Number of signatories
1	Petition to "Keep politics out of the NHS"	50
2	Petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain, from Labour Party Bulletin	7
3	Petition against the plans to close Lewisham Accident and Emergency	13
4	Petition against proposal to close the Accident and Emergency department and remove maternity services at Lewisham Hospital	10
5	Petition opposing the withdrawal of a full 24 hour Accident and Emergency facility at Lewisham Hospital, also oppose the closure of the maternity and neonatal facility,	26

	from residents of Bentley Court Retirement flats	
6	Petition against proposed plans to close the Accident and Emergency and maternity services at Lewisham	13
7	“Save Lewisham Hospital!” petition, against the plans to close Lewisham Accident and Emergency and maternity services	159
8	Petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain, from members of Lewisham Seventh Day Adventist Church and local residents	84
9	Petition opposed to the closure of Lewisham Hospital Accident and Emergency, from Lewisham Speaking Up – an independent Charity set up for and by people with learning disabilities	150
10	Petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain, from Heidi Alexander MP	c.12,000[3]
11	Petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain, from local businesses, Doctor surgeries and local schools	231
12	iPetition against proposals to downgrade emergency medical and surgical services at Lewisham Hospital, from Health Workers in Southeast London	694
13	iPetition against proposals to downgrade emergency medical and surgical services at Lewisham Hospital, from Doctors In Lewisham	325
14	Petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain	23
15	Online petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain, sponsored by Heidi Alexander MP	23,991[4]

[3] Please note: Petition 10 consisted of a number of scanned hard copy pages of a petition sent via a USB stick. A note contained with the USB stick indicated 32,186 signatories – however there were a number of duplicate pages included in the file. Ipsos MORI estimated there to be c.12,000 responses to the petition contained on the USB stick.

As part of the response to the consultation process, 515 separate responses were received as part of a campaign organised by Save Lewisham Hospital. This campaign allowed respondents space to write in detail about their views of the proposed changes to urgent and emergency care and maternity care, also with space to record respondents' reported travel times to Queen Elizabeth Hospital (QEH) compared to the time they say it would take them to travel to UHL. These responses were coded alongside the other letters and emails received during the consultation.

[4] Please note: Petition 15 was an online petition which was still open after the consultation formally closed. As of midday on 14th December there were 23,991 signatories. Petition 10 and 15 may have been added together to provide the 32,186 signatories quoted on Petition 10 submission.

1. Overview of the consultation process and report

This chapter of the report outlines the background to the consultation and the way in which the consultation has been conducted. It also summarises the numbers and types of responses submitted during the consultation. Finally, the chapter provides information about how to interpret the responses and the structure of the remainder of the report.

1.1 Background

South London Healthcare NHS Trust (SLHT) was formed in 2009 through the merger of Princess Royal University Hospital (PRUH), Queen Elizabeth Hospital (QEH) and Queen Mary's Hospital, Sidcup (QMS). It is one of the largest NHS hospital trusts in the country, serving over one million people, employing over 6,000 staff and with an annual budget of over £400 million. However, SLHT is also the most financially challenged trust in the NHS, overspending by around £1 million every week. As a result, on 16 July 2012 a Trust Special Administrator (TSA) was appointed to SLHT by the Secretary of State for Health.

The TSA's task is to resolve the problems that SLHT faces in a way that would mean that high quality, safe and accessible services are available for the long-term for the communities served by the trust, as well as the wider NHS across south east London. The TSA developed six draft recommendations for how clinically and financially sustainable health services should be delivered.

The TSA has now consulted stakeholders and the public, to give them the opportunity to put forward their views and comments in order to validate and improve the draft recommendations. This report contains the main findings from the consultation. Following the consultation, the TSA will be submitting his final recommendations to the Secretary of State for Health in early 2013.

1.2 Structure of the consultation

Over 27,000 full consultation documents and 104,000 summary documents setting out the *Securing sustainable NHS services* recommendations were distributed during the consultation period. These documents were sent to nearly 2,000 locations across south east London including hospital sites, GP surgeries, libraries, town halls, local LINks offices and pharmacies as well as distributed at engagement events and posted to individuals on request. A dedicated website was created (www.tsa.nhs.uk), which received over 22,000 unique visits during the consultation period. Advertisements were placed in 13 local papers across south east London to raise awareness of the consultation and publicise the Trust Special Administrator (TSA) public meetings.

There were a number of channels through which participants could respond to the public consultation, all of which are listed below:

- **Online response form** – responses to specific questions on the proposals, on the Office of the TSA's website and hosted by Ipsos MORI. Closed questions

were asked to gauge levels of support for the proposals among those responding to the consultation. Demographic information was also collected to allow for sub-group analysis where possible. Free-text questions were included to give respondents the opportunity to express their opinions in their own words. The questions were developed by Ipsos MORI in consultation with the Office of the TSA.

- **Hard copy response form** – responses to specific questions on the proposals, mirroring the questions asked in the online response form. A large print version was also available on request. Hard copy response forms were inserted into every full consultation document.
- **Written comments** – letters and emails sent to the TSA directly, and/or the consultation email or postal addresses (those provided both by the Office of the TSA and Ipsos MORI). A number of petitions were also submitted by email and post.

People who wanted to complete the response form in another language, or who needed assistance due to a disability, were able to contact the Ipsos MORI freephone helpline and provide their responses over the telephone (using an interpreter if the respondent wanted to complete it in another language).

During the consultation period, the Office of the TSA attended or arranged over 90 events which included public meetings, meetings with stakeholders and events for staff. Engagement also took place with a range of community groups such as learning disability groups, refugee representatives, multi faith groups, patients' forums and senior citizens' groups. Two discussion groups were also held with people who had recently used maternity services in south east London and facilitated independently by CurvedThinking. The report on these groups is available separately on the TSA website.

The consultation ran from 2 November 2012 to 13 December 2012. All responses received within these dates were treated as valid consultation responses. In addition, to make allowance for any potential delays within the post, hard copy responses and letters received on 14 December 2012 were accepted. Responses received after this date were counted and stored securely but not logged.[5]

1.3 Responses to the public consultation

There were a total of 8,224 responses received within the consultation period, plus the consultation events. The number of responses via each means is shown in Table 1.

[5] A total of 58 responses were received between 15 and 20 December 2012.

Table 1 – Responses to the public consultation

Method	Total
Hard copy response forms	884
Online response forms[6]	6,327
Written comments from individuals (letters & emails)[7]	842
Written comments from stakeholders (letters & emails)	156
Petitions	15
TOTAL	**8,224**

Response forms

Respondents providing an individual response or a response on behalf of a group or organisation via the online or hard copy response form (7,211) included people with a professional and personal interest in health services in south east London. Many of these will have more detailed knowledge of health services in the area. For example, many of the individuals responding to the consultation worked in the NHS in the area, while others have used the services extensively, for themselves or because they have caring responsibilities. Throughout the report, key themes are broken down by audience where appropriate and possible. Table 2 shows the responses received by different types of respondent using the response form.

[6] Multiple responses were accepted from individual IP addresses to ensure, for example, that a family sharing a home computer were all able to submit individual responses. In some cases, a large number of responses were received from individual IP addresses. There were 10 IP addresses where over 10 responses were received from that one address. The highest number of responses from one address was 247, although the rest were significantly lower. Eight of the IP addresses were registered to NHS bodies.

[7] This figure includes 515 forms created by Save Lewisham Hospital Campaign, with pre-printed statements and respondents' own responses to three questions on the recommendations. Please see chapter 9 for further details.

Table 2 – Responses by specific audience groups

Response method	Audience	Total
Response forms	**Responses on behalf of individuals[8]**	**6,999**
	Currently or previously worked in the NHS	1,443
	Currently or previously worked in the independent health sector	97
	Carer for relative or friend with a health need	1,192
	Visited a hospital in south east London in the last six months	4,360
	Responses on behalf of an organisation or group[9]	**86**
	NHS trust (provider of services)	9
	Charity/voluntary sector group	17
	Local patient group	11
	Local Authority/London Borough	5
	Professional body (e.g. a Royal College)	5
	Trade union	2
	National patient group	1
	Academic organisation	4
	Other NHS body (e.g. a Strategic Health Authority)	1
	Clinical Commissioning Group or Primary Care Trust	1
	Regulatory body	1
	Political party/group	4
	Trade body	2
	Other	29
	Not stated (including 'don't know')	18
	Not stated as individual or organisation/group[10]	**126**

The total number of responses by population sub-group is shown in Table 3. Please note that demographic data are self-reported. In Appendix B, the profile of consultation responses by age, gender, borough and ethnicity is compared with the profile of south east London.

[8] Those completing a response form were able to allocate themselves to one or more of these categories. Please note these data are self-reported, and respondents sometimes did not provide a response to the question.

[9] Those completing a response form were able to allocate themselves to one or more of these categories. Please note these data are self-reported, and respondents sometimes did not provide a response to the question. The list provided here does therefore not tally fully with the list of organisations/groups responding to the consultation as listed in the appendix.

[10] Where respondents did not provide an answer at all to the question of whether they were an individual or an organisation/group, for analysis purposes they have been included in the data as individuals.

Table 3 – Responses by demographic sub-group responding

Audience[11]	Total
Age	
Under 18	28
18-24	228
25-34	1,148
35-44	1,773
45-54	1,466
55-64	1,186
65+	1,004
Ethnicity	
White	5,336
Mixed	183
Asian or Asian British	240
Black or Black British	419
Chinese	46
Other	135
Disability	
Yes	508
No	6,064

Respondents were also asked in which of the six south east London boroughs they live, if any. As the following table illustrates, the great majority of respondents who could be allocated to a local authority come from one of the six south east London boroughs (Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark). A number of respondents preferred not to confirm the borough in which they live.

Table 4 – Responses by London borough

Borough	Total
Bexley	341
Bromley	768
Greenwich	771
Lambeth	72
Lewisham	4,110
Southwark	193
None of these	310
Prefer not to say	437

[11] Those completing a response form were able to allocate themselves to one or more of these categories. Please note these data are self-reported, and sometimes were not provided.

Those providing responses on behalf of an organisation or group were asked to provide information on the type of organisation, its size and the way in which the views of its members were gathered. Respondents included community and special interest groups, representatives of educational, religious and charitable organisations, unions, groups of medical professionals and protest groups, in a range of different sizes. Methods of assembling members' views included events, ballots or simply asking them. A full list of these organisations is included at Appendix D.

Open written responses

Some respondents chose not to use the response form but sent in bespoke written comments via letter or email. A total of 842 were from individuals. Analysis of these responses is included at relevant points throughout this report.

A number of responses were also received from stakeholders such as local authorities, health providers and commissioners, LINks, and professional bodies. The qualitative analysis of stakeholder responses can be found at Chapter 10 of this report.

Campaigns/petitions

Petitions and campaign responses (with a varying volume of signatories) were on a whole opposed to the plans surrounding changes to healthcare in Lewisham, particularly with regard to the proposed changes to urgent and emergency care and maternity services at University Hospital Lewisham (UHL).

While the number of signatories to each petition or campaign is known, very little else is known about these individuals. The petitions and campaigns focused on the proposed changes affecting healthcare in Lewisham, rather than commenting on any other aspect of the proposals. It is not known how much those signing the petition would have known about the proposals or whether they would have read the consultation document. Chapter 9 contains details of these responses. It is worth noting that it is likely that these local campaigns also generated more responses via other methods of responding such as emails.

Other forms received

In addition to this, 81 people sent forms to the consultation address that were designed to gather feedback on the consultation events the Office of the Trust Special Administrator (TSA) was running. As such, these responses have not been considered as part of the consultation.

1.4 Interpreting the consultation responses

Understanding who has responded

While a consultation exercise is a very valuable way to gather opinions about a wide-ranging topic, there are a number of issues to bear in mind when interpreting the responses. While the consultation was open to everyone, the respondents were self-selecting, and certain types of people may have been more likely to contribute than

others. This means that the responses are not representative of the population as a whole.

Typically with consultations, there can be a tendency for responses to come from those more likely to consider themselves affected and more motivated to express their views. In previous consultations, we have found that responses also tend to be more biased towards those people who believe they will be negatively impacted upon by the implementation of proposals. As we have discussed above, responses are also likely to be influenced by local campaigns.

Understanding the different audiences

While attempts are made to draw out the variations between the different audiences, it is important to note that responses are not directly comparable. Across the different elements of the consultation, participants received differing levels of information about the proposals. Some responses are therefore based on more information than others, and may also reflect differing degrees of interest across participants. The response form signposted relevant chapters of the full consultation document for the respondent, but of course it is not known to what extent each respondent read the document, or the summary.

Similarly, while every attempt has been made to classify each participant into the correct category for reporting purposes, it is not always clear from the response the specific category to which they belong. The information is self-reported and is often incomplete.

Closed question responses

Where percentages do not sum to 100%, this may be due to computer rounding or multiple answers. Some respondents answering via postal response forms selected more than one answer on questions that only required one answer. These responses have been left in the data in the way in which respondents completed them, i.e. including all of their answers.

Throughout the report an asterisk (*) denotes any value of less than half of one per cent, but greater than zero.

Free-text responses

The consultation included a number of free-text questions which are exploratory in nature and allow respondents to feed back their views in their own words. Not all respondents chose to answer all questions, as they often had views on certain aspects of the consultation, and made their views on these clear, but left other questions blank. Therefore, there were many blank responses to certain questions. The figures in this report are based on all respondents answering each question (i.e. excluding those who did not answer) and this means that the base size (number of people the results for the question are based on) is different for each question.

A wide range of points were made in response to the questions which were asked. Responses from the free-text questions and written comments were coded to categorise and group together similar responses and identify the key themes. Ipsos MORI used qualitative analysis software (Ascribe) to build up a thematic framework (called a 'codeframe') from the first responses. The codeframe was then used to identify common

themes and key issues, and continued to be added to and refined throughout the consultation as more responses were received and new issues were raised.

As part of the free-text responses, respondents were invited to suggest improvements to the recommendations. Respondents generally used the free-text questions to give reasons for their answers to the closed questions and to expand on their views, rather than to suggest improvements.

A number of responses to free-text questions used the same or very similar wording. Where this could be identified as originating from a campaign, these were coded as campaign responses and coded into the relevant theme. Some of these figures are reported in this document, although they must be treated with caution.

While some figures may seem small given the scale of the overall consultation, all those reported on have been highlighted due to their importance relative to other themes, and despite small figures can reflect important themes.

A number of verbatim comments are included to illustrate and highlight key issues that were raised. These are included in the report in italics. It is important to remember that the views expressed in these verbatim comments do not always represent the views of the group as a whole, although in each case the verbatim is representative of, at least, a small number of participants.

1.5 Structure of this document

This report sets out Ipsos MORI's analysis of the responses received to the consultation. This first chapter gives details on the background to the consultation, how it was set up and run, and who responded, as well as some points on how to interpret the data.

The following chapters detail the analysis of responses. The consultation itself was based around the Trust Special Administrator's (TSA) six draft recommendations and the report is structured around these, with one chapter per recommendation. Chapter 8 then provides the analysis of a free-text question where respondents could provide any other comments. Chapter 9 details the petitions and campaign responses received, and Chapter 10 presents the analysis of the stakeholder responses.

For further technical details on the consultation, please see *Securing sustainable NHS services: Technical Annex.*

2. Recommendation 1

Improve the efficiency of South London Healthcare NHS Trust

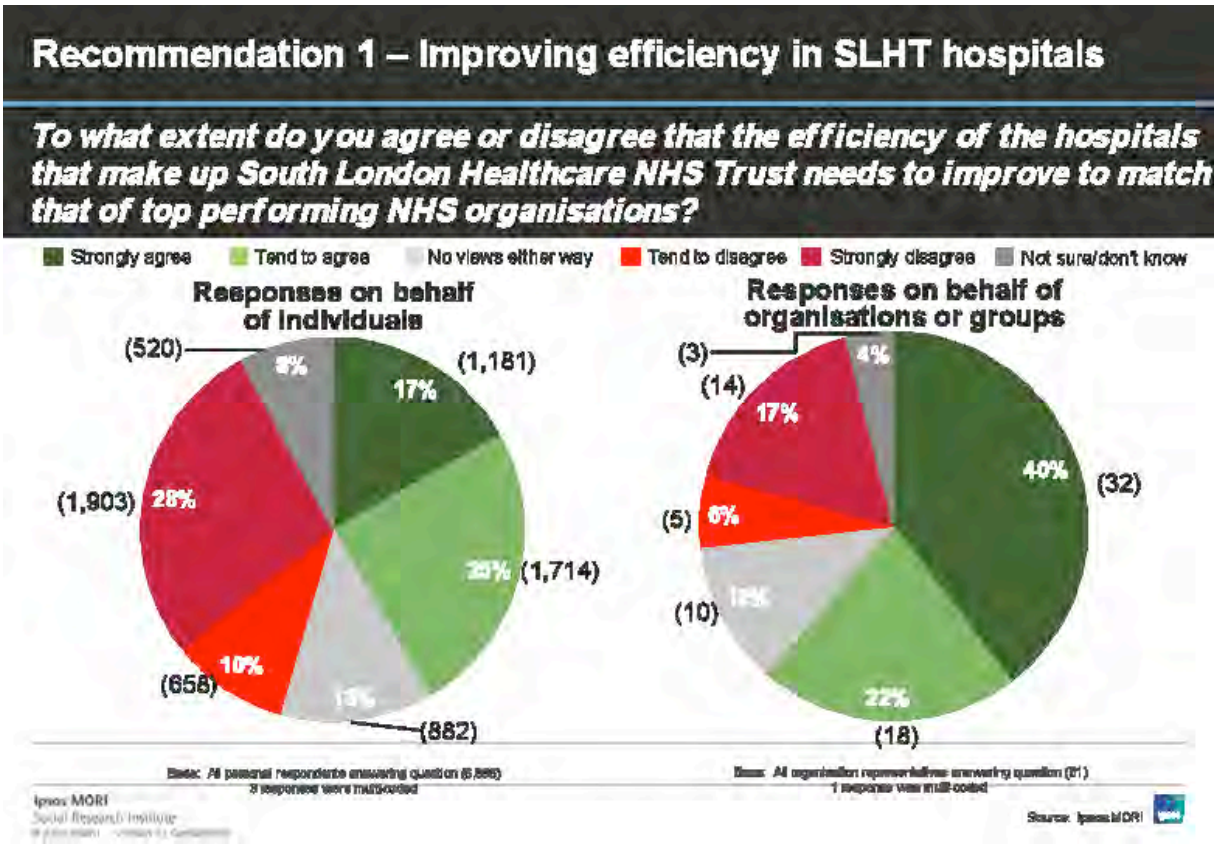
- Individual respondents were divided in their support for the recommendation to improve the operational efficiency of the hospitals within South London Healthcare NHS Trust (SLHT), with similar proportions agreeing and disagreeing (42% and 37% respectively). However, those with current or past experience working in the NHS were more supportive of the proposal, as were those who may be heavier users of the health service, such as older people and those with caring responsibilities for a family member aged 16 or over.
- Half of individuals disagreed that the specific areas identified to improve efficiency were appropriate (56%), while one in five agreed (21%). Those with professional experience within the NHS were more supportive, as were older people, although the majority of each group still did not think the areas were appropriate.
- A more positive response was observed for those responding on behalf of an organisation or group, both about the need to make efficiencies and the specific areas suggested. More agreed than disagreed with each element of this recommendation.
- A number of free-text comments (from across all respondents) suggested that the efficiency of the hospitals within SLHT could be improved. However, a number of concerns were raised, particularly around reductions to the number of staff, the impact on quality of care and patient outcomes, and a feeling that patient care should be the key driver rather than efficiency considerations. Other responses referenced the Private Finance Initiative (PFI) debt, saying that this was at the root of the problem rather than efficiencies.
- Some respondents also raised concerns about the data used to support the recommendation, sometimes specifically saying SLHT should not be compared to other trusts, or that they did not have sufficient information to form an opinion.

This chapter considers responses to Recommendation 1 in the draft report, which suggests a need for improvement in the efficiency of the three hospitals that form South London Healthcare NHS Trust (SLHT). Respondents were asked whether they agreed or disagreed that hospital efficiencies needed to be improved within SLHT and, furthermore, whether the areas outlined in the consultation document were appropriate to achieve this. They were also given the opportunity to provide further comments on the recommendation.

2.1 Improving operational efficiency in the hospitals within South London Healthcare NHS Trust

Opinions surrounding the proposed improvement in efficiencies were mixed among individuals answering this question. Two in five individual respondents agreed with the need to improve efficiency within the Trust to match that of top performing NHS organisations (42%). However, a similar proportion disagreed with the recommendation (37%), with almost three in 10 respondents *strongly* disagreeing (28%).

The views of those responding on behalf of an organisation or group, on the other hand, were more positive. Three in five organisations or groups who gave their views via the response form agreed that an improvement in efficiency of the hospitals within South London Healthcare NHS Trust (SLHT) is needed (62%).



Opinion differed by age; more individual respondents in older age groups agreed with the need to improve efficiencies (for example, 56% of those aged 65 and over agreed compared to 37% of 18-24 year olds). Those who care for a family member aged 16 or over with a health need were also more likely to agree (50% compared to 42% of those with no caring responsibilities).

Current or past experience of working within the NHS also appears important. Those respondents with NHS work experience were far more likely to agree with the recommendation than those without any experience of working within the health sector (58% compared to 38%).

Views also differed by borough; for example, the majority of Bexley residents agreed that the efficiency of the hospitals should be improved (74% compared to 37% in Lewisham and 38% in Southwark).

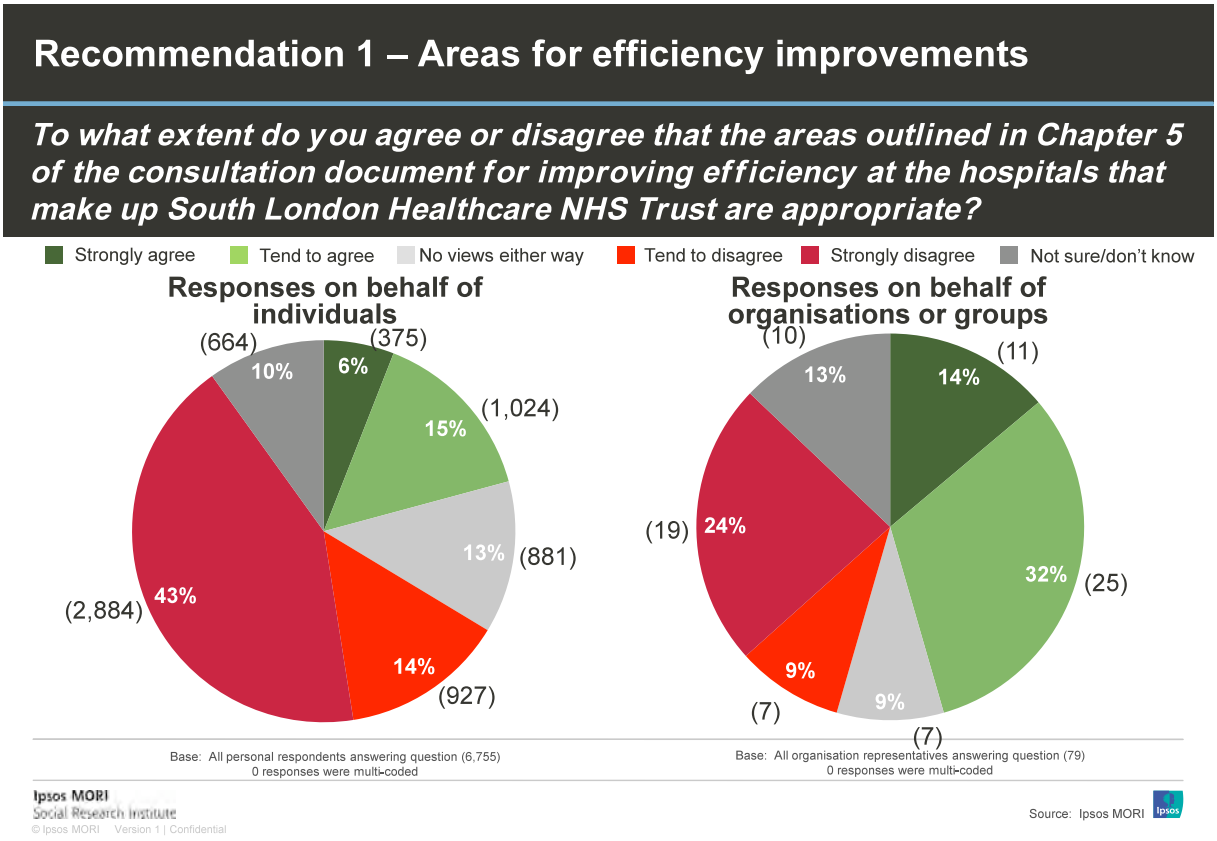
Q1	To what extent do you agree or disagree that the efficiency of the hospitals that make up South London Healthcare NHS Trust needs to improve to match that of top performing NHS organisations?

	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*333*	*750*	*756*	*71*	*3,926*	*190*	*306*	*420*
Strongly agree %	41	28	24	21	13	14	19	8
Tend to agree %	33	33	27	25	24	24	25	9
No views either way %	4	10	8	7	17	9	5	7
Tend to disagree %	8	9	10	6	11	8	8	5
Strongly disagree %	14	16	27	39	25	42	39	66
Not sure/Don't know %	1	3	4	1	11	3	6	5

2.2 Areas for improving efficiencies

One in five individuals responding agreed that the areas outlined in the consultation document to improve efficiencies were appropriate (21%). The majority disagreed (56%), with over two in five (43%) *strongly* disagreeing.

Responses on behalf of an organisation or group contrasted with those received from individual respondents; almost half of those answering agreed that the areas where efficiencies could be made were appropriate (46%).



Again, the views of individual respondents differed between those who have worked in the NHS at some point and those who have not. One in three of those who have

worked in the NHS agreed that the areas were appropriate (33%), compared to one in five of those who have not worked in the health sector at all (18%).

Opinions varied by age again; disagreement was higher in the younger age groups and decreased with age (for example, 63% of 18-24 year olds disagreed that the areas for improving efficiency were appropriate, compared to 51% of those aged 55 and over).

Again, views differed according to borough, with Bexley residents the most likely to agree (46%) compared to Lewisham residents, who were the least likely to agree (16%).

Q2 To what extent do you agree or disagree that the areas outlined in Chapter 5 of the consultation document for improving efficiency at the hospitals that make up South London Healthcare NHS Trust are appropriate?

	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*328*	*740*	*748*	*66*	*3,863*	*186*	*305*	*418*
Strongly agree %	14	10	6	6	4	8	8	5
Tend to agree %	32	27	20	21	12	14	15	4
No views either way %	5	10	12	3	16	9	9	5
Tend to disagree %	15	17	14	15	14	11	12	5
Strongly disagree %	30	31	42	48	41	54	50	76
Not sure/Don't know %	3	5	7	6	13	5	7	6

A total of 2,717 respondents provided further commentary on Recommendation 1. A range of themes emerged, including a suggestion among some respondents that South London Healthcare NHS Trust (SLHT) can and should improve efficiencies (241).

It appears that there are a number of efficiency savings that could be made within SLH Trust which could go some way to meeting the financial challenge the Trust is facing. I feel that the proposals relating to improving efficiency within the Trust appear sensible.[12]

However, this belief that efficiencies can be improved was often accompanied by concerns about how they would be achieved, while others did not accept that efficiencies should be made at all. One of the most common themes to emerge was the assertion that there should be no cuts in the number of staff (337), often specifically mentioning clinical staff such as doctors and nurses. This tended to be linked to a concern that reducing the numbers of clinical staff could compromise quality of care, with 183 responses saying quality of care will be poorer or there will be worse patient outcomes.

I do not support the reduction in the number of staff. You have not proved your argument that there is an inverse correlation between the number of staff and quality of care. A more efficient use of staff does not necessarily mean spending less

[12] Please note that verbatim comments are included in the report to illustrate the points respondents were making. Verbatim comments are included in italics. Please refer to chapter 1 for further details of how to interpret these.

money, better organisation of the current levels of staff could lead to increased quality of care.

Linked to this and also a common response, respondents felt that patient care and patient needs should be the key driver of changes rather than operational efficiency or financial considerations (227). This tended to be linked to a belief that the recommendation is too focused on operational or financial efficiency, rather than on quality of care and patient outcomes.

Strongly disagree that decisions about clinical services should be based on financial efficiency. Clinical services should only be about what is needed for the population.

Other responses referenced that SLHT should not be competing with, or should not be compared to, other NHS trusts (138). This often went along with a belief that there is not enough evidence to support the proposals or a concern about the data used to support the recommendation, or a feeling that the consultation document did not provide enough information to allow them to make a judgement (290). This was sometimes linked to a belief that the proposals had not been thought through, with respondents saying the arguments are not convincing or that the recommendations do not address the issue (157).

Efficiencies need to be made. However why compare with the top performers? Someone will always be average or even (dare I say it) half of all organisations will always be below average. Benchmarking against organisations with different healthcare demands is folly. What is needed is identification of what is needed to gain the needed improvements based on the local needs (high deprivation scores, low primary care use and high unscheduled care needs).

Some respondents took this opportunity to discuss the impact of Private Finance Initiative (PFI) debts (287). There was a feeling that the PFI debts were at the root of the financial problems faced by SLHT. Some respondents felt that PFI was a bad financial decision or the contracts were flawed (142) and some also asserted that these contracts should be re-negotiated or broken (86). This theme emerges strongly and is discussed again in relation to Recommendation 4.

While SLHT could improve its efficiencies, one of the major burdens is the cost of PFI at huge interest rates, which are burdensome for the next decades!

It should be noted that, as this was the first free-text question in the response form, many respondents used this question to feedback comments not directly related to Recommendation 1 (as is often the case in consultations). For example, 385 expressed their wish to retain Accident and Emergency (A&E) services at University Hospital Lewisham (UHL), and a total of 850 talked more generally about UHL. This was linked to other large numbers of mentions, for example concern about travel times for services (265) and a belief that the proposals would put people's lives at risk (163). These themes are discussed in more detail in relation to Recommendation 5.

Of the written responses received as letters and emails, only 98 commented on the recommendation around making efficiencies. However, similarly to the free-text responses, the most commonly mentioned area that is relevant to this

recommendation was the assertion that patients should be the key driver of any changes rather than efficiency or financial considerations (41).

3. Recommendation 2

Develop a Bexley Health Campus at Queen Mary's Hospital, Sidcup

- The recommendation that Queen Mary's Hospital, Sidcup (QMS) should become a Bexley Health Campus and that the land and buildings required for this should be sold or transferred to Oxleas NHS Foundation Trust was broadly opposed, with 45% of individual respondents opposing each proposal, and 15% supporting them. Those who have worked for the NHS and older respondents tended to be more supportive than others, as were Bexley residents.
- Those responding on behalf of organisations or groups were more in favour of the proposals. One in three supported the proposal that QMS should become a Bexley Health Campus (35%), while three in 10 opposed it (29%). They were also supportive of the proposal to sell or transfer the required land and buildings to Oxleas NHS Foundation Trust, with 38% support and 27% opposition.
- Free-text comments (from across all respondents) appeared to indicate that opposition stemmed mainly from confusion as to the implications of the proposals and a fear that the proposals could lead to the privatisation of healthcare services. Some confusion extended to the meaning of the term 'Health Campus'.

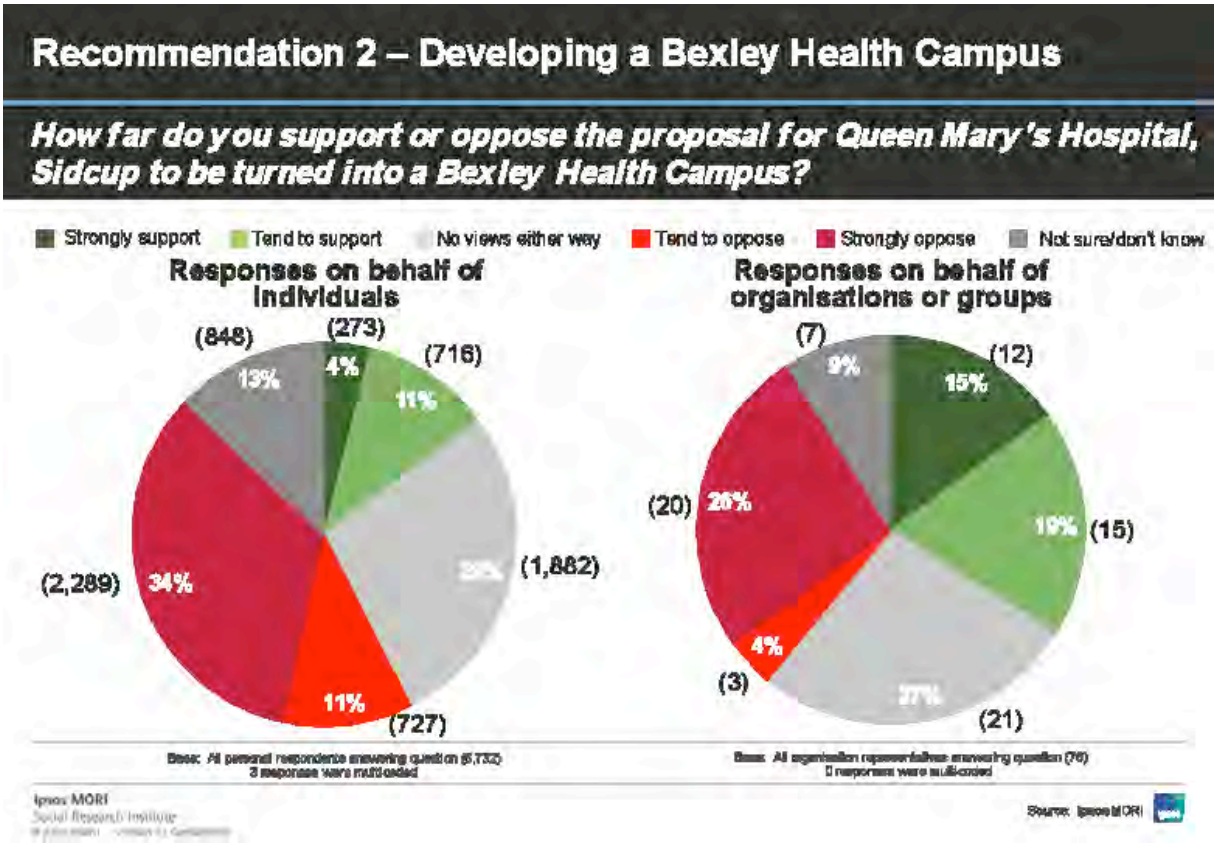
This chapter considers respondents' views on the recommendation to develop a Bexley Health Campus at Queen Mary's Hospital, Sidcup (QMS). Respondents were asked to consider the proposal in general, and specifically whether they supported or opposed the transfer or sale of the land and buildings necessary for the new Health Campus to Oxleas NHS Foundation Trust. They were also given the opportunity to provide further comments on the recommendation.

3.1 Bexley Health Campus

Fewer than half of individual respondents answering this question opposed the proposal to turn QMS into a Bexley Health Campus (45%). Few supported the proposal (15%), while two in five had no views either way or did not know (41%).

Where there was opposition, it tended to be particularly strong, with 34% strongly opposing the proposal. Supporters of the proposal tended to be more moderate; four per cent strongly supported the proposal.

Amongst those responding on behalf of an organisation or group, support for the proposal was higher. Around one in three supported the development of the Bexley Health Campus (35%), while three in 10 opposed it (29%).



Opinions varied between age groups, with older respondents tending to be more supportive of the proposal for a Bexley Health Campus. Support ranged from five per cent amongst 18 to 24 year olds to 23% of those aged 65 or over.

Past experience of health sector employment is again a differentiator. Around one in four current or past NHS workers supported the development of the Campus (27%) compared to one in 10 with no healthcare sector work experience (11%).

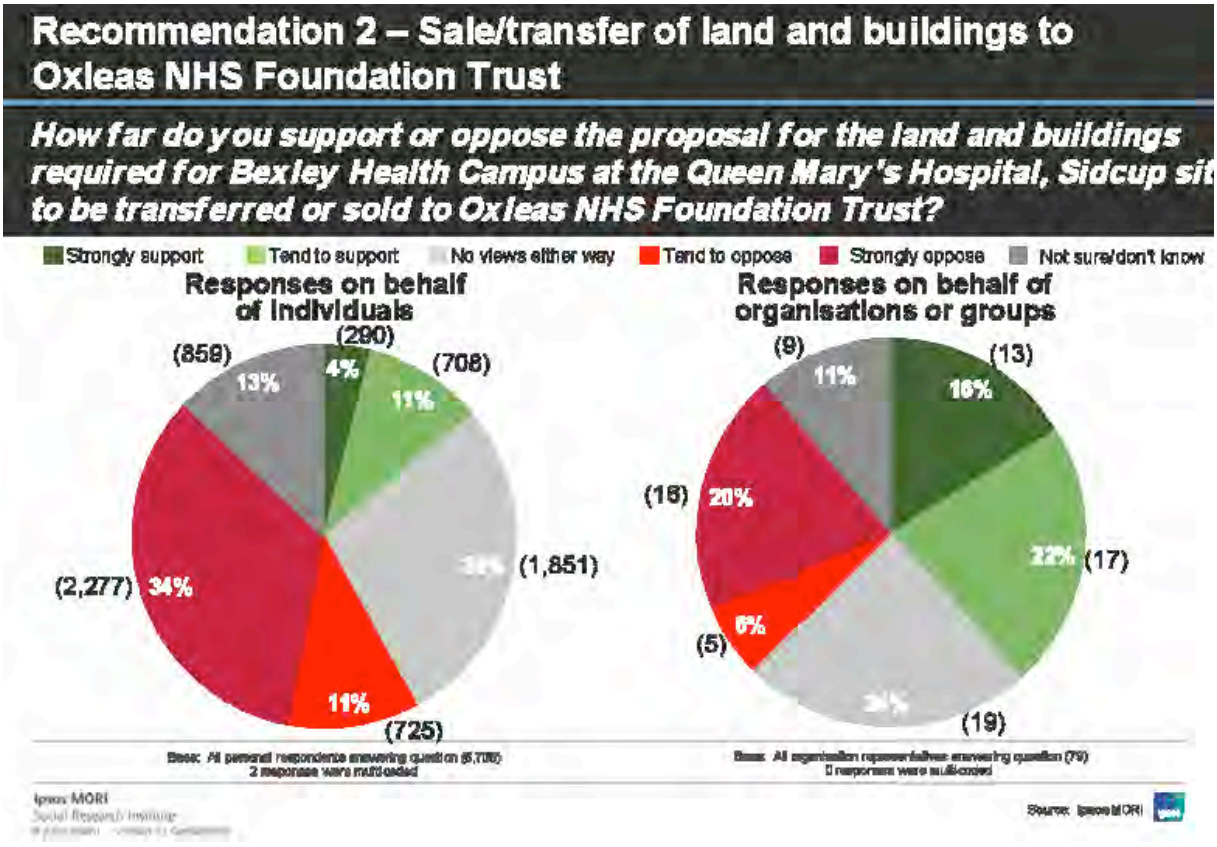
Finally, the results show that those who are most likely to use the service due to its proximity (those in Bexley, and closest to QMS) were more supportive of the proposal. For example, 45% of residents living in Bexley supported the proposal, and this contrasted sharply with eight per cent of residents living in Lewisham. The low support from Lewisham residents is particularly important, as a significant proportion of responses have been received from the borough (56% of all individual responses received to this particular question), thus impacting the overall results. However, although generally more supportive than many other respondents, half of individual respondents who say that QMS is their closest hospital still opposed the proposal (51%).

Q4	How far do you support or oppose the proposal for Queen Mary's Hospital, Sidcup to be turned into a Bexley Health Campus?							
	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*331*	*741*	*752*	*69*	*3,842*	*190*	*299*	*407*
Strongly support %	15	9	6	6	2	5	7	3
Tend to support %	29	24	14	12	6	9	14	3
No views either way %	6	27	21	20	35	19	17	12
Tend to oppose %	10	11	13	14	11	10	8	8
Strongly oppose %	36	23	38	42	30	46	44	64
Not sure/Don't know %	3	6	9	6	16	10	9	10

3.2 Sale/transfer of land and buildings

Recommendation 2 also states that the land and buildings required for Bexley Health Campus should be transferred or sold to Oxleas NHS Foundation Trust. Almost half of individual respondents opposed this proposal (45%), while 15% supported it.

As can be seen, the pattern of responses here is very similar to that for the proposal to develop the Campus. Again, where there was opposition it tended to be strong (34% of individuals *strongly* oppose the proposal). Organisational/group responses contrasted with individual responses, with almost two in five saying that the land and buildings should be transferred or sold to Oxleas NHS Foundation Trust (38%).



Again, differences in opinion were observed between the residents of different boroughs, with those in Bexley most supportive.

Q5	How far do you support or oppose the proposal for the land and buildings required for Bexley Health Campus at the Queen Mary's Hospital, Sidcup site to be transferred or sold to Oxleas NHS Foundation Trust?							
	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*331*	*739*	*746*	*68*	*3,830*	*190*	*299*	*404*
Strongly support %	15	9	5	9	2	3	7	4
Tend to support %	24	21	18	10	7	12	11	3
No views either way %	13	28	20	22	33	19	18	13
Tend to oppose %	11	10	12	9	11	11	12	5
Strongly oppose %	33	26	37	43	30	46	44	66
Not sure/Don't know %	4	7	9	7	17	8	9	8

The demographic differences noted for the previous proposal for a Bexley Health Campus were again evident here. For example, older people and those with previous experience of NHS employment were more likely to support the proposal. There were no notable differences in the pattern of responses observed for the proposal to Bexley Health Campus.

Of those answering the questions about Recommendation 2, 1,683 respondents provided further comments, which were wide-ranging in their nature. The minority of them referred specifically to Recommendation 2, and the largest proportion either had no comment or stated that they did not know enough to comment.

A common theme emerging from the free-text responses expressed confusion regarding the plans for Bexley Health Campus (69), often with a fear that the proposals could lead to privatisation of healthcare services. Where there was opposition, it tended to oppose privatisation (99) rather than the sale or transfer of land and buildings to Oxleas NHS Foundation Trust.

Plans for a Bexley "Health Campus" are not clear and will lead to fragmentation and privatisation of services. If land is to be sold, it should first be offered to another Trust.

Some were confused about what the term 'Health Campus' means.

The description "Health campus" is confusing and wrong. What is needed is a hospital and all the usual services that come with a hospital.

What on earth is a "health campus"? Inventing new terminology is not helpful. We are talking about hospital services. Everybody knows what that means.

Many people providing a comment here took the opportunity to express their opinion about other recommendations (particularly in reference to University Hospital Lewisham and access to care).

Just 18 responses received by letter or email referred to the issues under Recommendation 2, referring to mental health services or children's services on the site. The nature of these comments were diverse and no consistent themes could be identified.

4. Recommendation 3

Making the best use of buildings owned and leased by South London Healthcare NHS Trust

- Individual respondents were, on the whole, opposed to the recommendation that poorly used or empty buildings should be sold or no longer leased (70% opposed, with 63% strongly opposed). Those who may use NHS services more (older respondents, those who have a disability and those who care for someone aged 16 and over) tended to be more supportive of the recommendation, albeit still with a majority opposing it.
- A more positive response was noted for those responding on behalf of an organisation or group; almost half supported the recommendation (48%).
- Free-text comments (from across all respondents) showed opposition to the sale of any assets or buildings, and concern was raised that once assets were sold they may not be recovered should a need arise in the future. Emphasis was often placed on the belief that services may need to expand in the future to accommodate a changing population. This led some respondents to say the recommendation was short-sighted. Others felt that if there was space within the NHS, then it should be used to provide services.
- Respondents sometimes referred to specific sites, for example, referencing the sale of land and buildings at University Hospital Lewisham (UHL) and opposing this sale. In addition, some responses related to this specific recommendation received via letter or email registered concern about the provision of services for the local community at Beckenham Beacon.

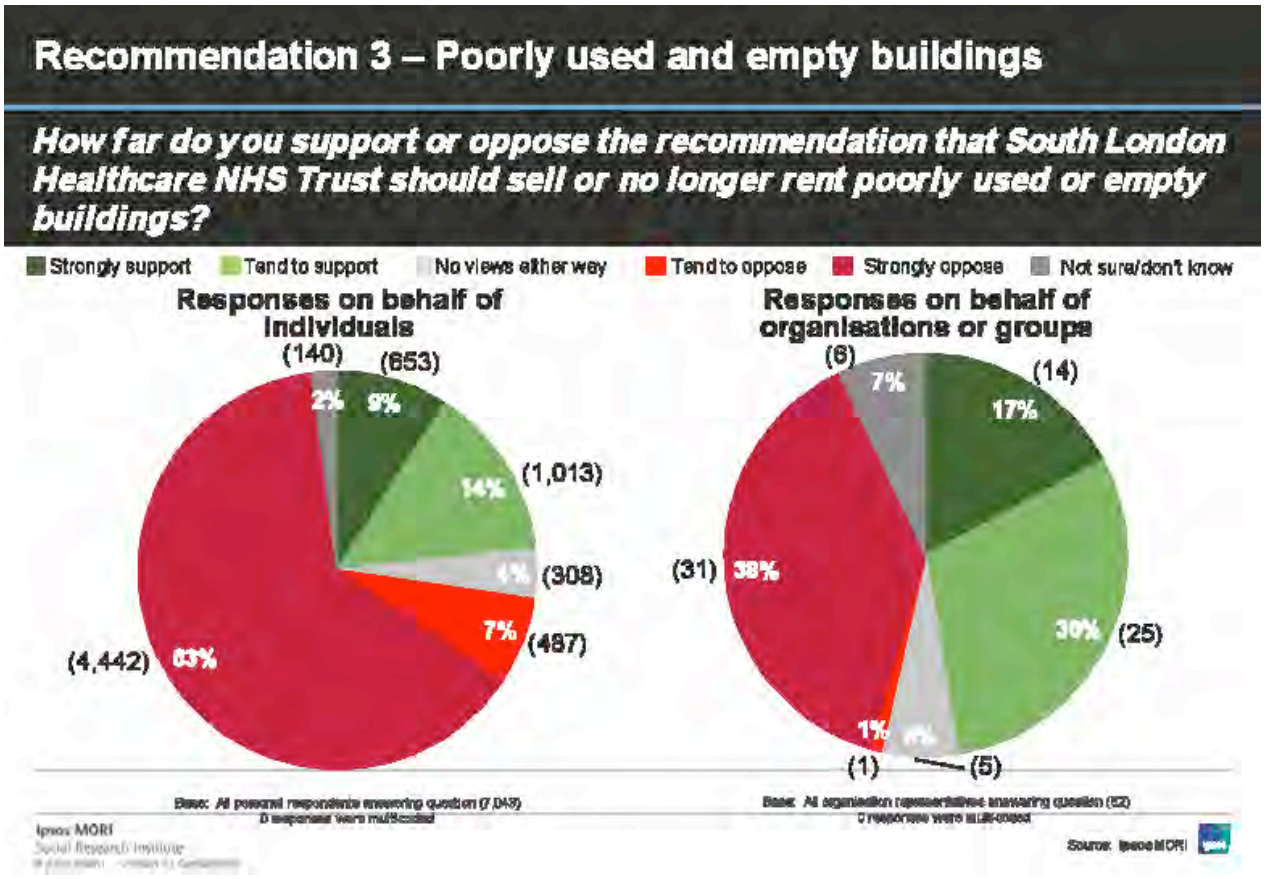
This chapter considers respondents' views on the recommendation that poorly used or empty buildings should be sold or no longer leased by South London Healthcare NHS Trust (SLHT). The consultation document outlined three opportunities within Recommendation 3:

- Sale of excess land at Queen Mary's Hospital, Sidcup (QMS)
- Sale of Orpington Hospital
- Ending SLHT's lease at Beckenham Beacon

Respondents were asked whether they supported or opposed the recommendation, and were given the opportunity to provide further comments.

Overall, seven in 10 individual respondents who answered the question opposed the recommendation (70%), and 63% *strongly* opposed.

Responses on behalf of organisations or groups were more positive, with almost half of those responding (48%) supporting the recommendation.



Sub-group differences were evident, broadly repeating the pattern seen throughout the consultation. Respondents from younger age groups were least supportive of the plans for poorly used or empty buildings (11% of 18-24 year olds supported the recommendation); however; as age increased so did the level of support (34% of those aged 65 or over). Individuals with a disability and those who care for a family member aged 16 and over with a health need were also more supportive (29% of each).

The level of support varied significantly according to employment within the health sector, with two in five respondents with experience of working in the NHS supporting the plans to sell or no longer rent poorly used or empty buildings (40%), compared to one in five of those with no previous health work experience (19%).

The greatest level of support was seen amongst Bexley residents (51%), whilst those living in Lewisham and Southwark were the least supportive (18% and 20% respectively).

Q7 How far do you support or oppose the recommendation that South London Healthcare NHS Trust should sell or no longer rent poorly used or empty buildings?

	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*336*	*760*	*758*	*71*	*4,068*	*193*	*310*	*434*
Strongly support %	21	15	14	15	6	9	15	5
Tend to support %	30	24	19	13	12	10	13	5
No views either way %	4	4	4	1	5	4	2	3
Tend to oppose %	11	11	7	1	7	4	5	2
Strongly oppose %	32	43	54	68	68	71	63	84
Not sure/Don't know %	2	2	2	1	2	2	2	1

Of the respondents who gave their view on the recommendation, a total of 2,240 provided further written comments.

The most common response was an overall opposition to the sale of any buildings or assets; 793 people gave a negative comment about this, with 305 of these simply expressing their opposition. There was particular concern that once sold, the assets could not be recovered if needed again (188). Linked to this, some responses cited the plans to be short-sighted or a short-term fix to the current problem which did not consider the longer term implications (176). Respondents felt that if assets were sold there would not be buildings or land available for any future expansion of NHS services in the area (253); this was often linked to the needs of a growing population.

Sale of land and buildings means that once it's gone, it's gone. This does not allow for any short or longer term flexibility in providing care.

I would suggest that the Trust's buildings, though underused at present due to cuts, are needed and will be needed. It makes more sense to retain them and use them, rather than put the NHS in SE London into the position of again having to expensively lease buildings from the private sector yet again in the future.

Many comments also suggested that a more efficient way should be found to better use the existing land and buildings (172), for example through the reorganisation of services across trusts. A common theme was the assertion that if there is additional space within the NHS, it should be used to provide services rather than be sold or leases ended (221).

The approach implied in question 7 needs comment as it seems to miss out a necessary first stage, which is to review how the buildings might be better used to provide the health care services required by the local population. Again, this reflects a key concern about the consultation document which is that it is driven by financial needs rather than the health care needs of the local population.

There was concern regarding the effect of the recommendation on University Hospital Lewisham (UHL), with a number of comments stating that land or buildings at UHL

should not be sold (125). Some respondents again used this free-text question to outline their views on other recommendations, often referring to proposals surrounding UHL.

A number of comments surrounded the overall consultation process, with responses stating that the consultation document did not provide enough information surrounding the proposals (163) and in particular, information on the exact buildings that could be affected by the proposals or what was currently provided from those sites.

This proposal is not specific about all buildings that could be sold. Further detail is required as to whether buildings will be sold and then leased back.

Fewer than one in 10 respondents providing written comments by letter or email rather than using the response form chose to comment on the use of land or buildings within SLHT (65). Many respondents commented on the effects within specific hospital sites.

In particular, opposition was expressed concerning an end to the lease at Beckenham Beacon (25). A number of respondents noted that the site offers good services to the local community.

Similar to what was observed in the response forms, there was also opposition to any potential sale of assets at UHL (19).

5. Recommendation 4

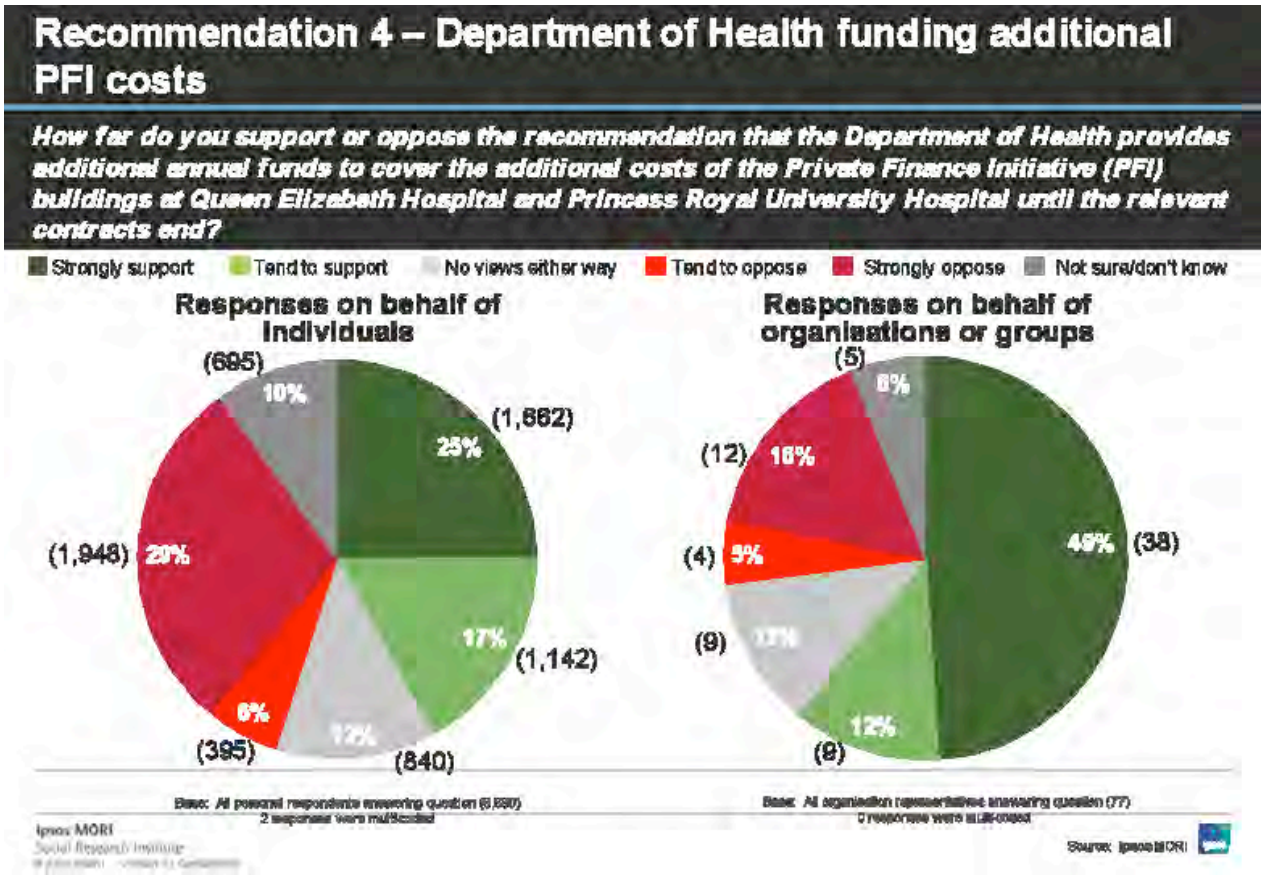
Department of Health provides additional annual funds to cover part of the costs of the Private Finance Initiatives

- There were mixed views regarding the recommendation that the Department of Health (DH) should provide additional funds to cover part of the costs of the Private Finance Initiatives (PFIs), with 42% of individual respondents supporting it, and 35% opposing it.
- Those responding on behalf of organisations or groups were more in favour of the proposal, with 61% supporting it.
- Free-text comments (from across all respondents) suggested that opposition stemmed mainly from a resistance to paying the PFI debts back at all; or at least a desire for the contracts to be re-negotiated. Many respondents felt very strongly about the negative impact of PFI on the NHS.
- Respondents supporting the recommendation felt that the local NHS should not have to suffer because of previous decisions by central government, and so agreed that the DH should provide funds for the relevant PFI debts.

This chapter considers respondents' views on the recommendation that the Department of Health (DH) should provide additional funds to cover part of the costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth Hospital (QEH) and Princess Royal University Hospital (PRUH), until the relevant contracts end.

Responses to this proposal were somewhat divided, with 42% of individuals who answered supporting and 35% opposing it. This was a particularly polarising proposal – the majority held their views 'strongly' either way.

There was greater support for the recommendation from organisations or groups; three in five thought that the DH should provide funds to cover the relevant PFI costs (61%), while one in five did not (21%).



Again, older respondents were more in favour of the recommendation. For example, 59% of those aged 65 or over felt that the DH should fund the additional PFI costs (compared to 23% of 18-24 year olds). Similarly, those with a disability were also more supportive (48%, compared to 42% of those with no disability). Carers were also more in favour of the plans; half of those caring for a family member with a health need aged 16 or over thought the DH should provide these funds (51%, compared to 41% of those with no caring responsibilities).

As seen earlier, health sector employment was also important. Nearly three in five of those who have worked in the NHS thought that the DH should provide funds to cover the PFI costs (56%), compared to two in five of those without any health sector work experience (38%).

Those who live closest to the three South London Healthcare NHS Trust (SLHT) hospitals were more likely to think that the DH should provide funds to meet the additional costs of PFI at these hospitals (73% for PRUH, 71% for Queen Mary's Hospital, Sidcup (QMS), and 60% for QEH, compared to 42% overall). Accordingly, those living in Bexley, Bromley and Greenwich were the most supportive (71%, 67% and 54% respectively).

Q9	How far do you support or oppose the recommendation that the Department of Health provides additional annual funds to cover the additional costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth Hospital and Princess Royal University Hospital until the relevant contracts end?							
	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*324*	*731*	*734*	*71*	*3,826*	*189*	*300*	*412*
Strongly support %	51	45	36	24	19	17	26	10
Tend to support %	20	22	17	14	18	12	13	9
No views either way %	8	7	8	11	16	7	7	7
Tend to oppose %	4	6	5	8	7	3	5	5
Strongly oppose %	17	17	27	39	26	52	43	62
Not sure/Don't know %	1	4	7	3	14	8	6	8

Of those answering the question about this recommendation, 2,132 respondents provided further comments. Many expressed strongly held negative views about PFI in general. They suggested that the initiative was ill-conceived, and should never have been introduced (846). These respondents were particularly critical of poor financial decisions, with some suggesting that the implications of PFI had not been fully understood at the time.

The PFI funding were a disastrous way to fund parts of the NHS in the first place. It was a scandalous waste of public money.

Respondents particularly objected to the impact they felt it had on the hospitals (340). Some believed that the private sector had taken advantage of the situation for its own gain and felt very strongly that public money should not be used to pay these debts (307). They objected to tax-payers' money being used to generate profits for private companies at the expense of public services.

It is totally unacceptable for huge amounts of taxpayers' money to line the pockets of the shareholders of private companies, furnishing PFI contracts that have already been shown to be bad value for money by the National Audit Office.

The results to the closed questions showed that respondents were divided in their support for the plan for the DH to provide funds for the additional PFI payments. Opposition to the proposal appears to stem mainly from a belief that the debts should not be paid at all, rather than a belief that SLHT should pay off the debts itself. A large proportion called for the contracts to be broken or re-negotiated (799), some referencing the burden it has placed on the NHS and individual trusts.

The PFI contracts should be re-negotiated, they are very poor value for money for the taxpayer and the users of the NHS. The PFI debt should be written off in its entirety, local trusts should not be burdened with paying for any of these debts out of their own budget. Ideally the Department of Health should not have to pay for this either, but better for this to be dealt with by the government centrally, rather than penalising individual trusts.

There was some support for the DH providing funds to pay the additional debts (475). Most commonly this was because they felt that responsibility for PFI rested with the DH and so it was only right that central government foots the bill. There was also a feeling of

resignation that the debts simply needed to be dealt with so that the hospitals could move forward to provide care to local residents.

DoH got the hospitals into this mess – they are responsible and should sort it out!

However, many of these respondents still held the view that the contracts should be re-negotiated, often putting forward both views simultaneously. In fact, 357 supporters of the proposal for the DH to provide additional funds to cover PFI costs also said that the PFI contracts should be re-negotiated or broken.

Extra funds should be provided but the PFI contracts should also be re-negotiated to better benefit the hospitals and public.

A total of 70 respondents providing written comments by letter or email chose to comment on PFI costs. As with the free-text questions, respondents expressed their negative views of PFI in general (24) and suggested that the DH should be re-negotiating the debts (20). There was also support for the DH providing funds towards paying the costs (14), although again, some thought this should be in conjunction with re-negotiation.

6. Recommendation 5

Transform the way services are provided across hospitals in south east London

- Recommendation 5 addresses four different care areas: care in the community and closer to home, urgent and emergency care, maternity services, and planned care.
- On the whole, individual respondents opposed the community care recommendation (47% vs. 23% in support), although 31% did not offer an opinion. A greater proportion of organisations and groups were in support of the community care recommendation compared to those in opposition (47% support vs. 23% oppose).
- In the free-text comments (from across all respondents), some support was given to the proposed community care strategy, though this support tended to be conditional on the basis of increased funding and improvements to care in the community, while also not occurring at the expense of other services such as hospital services.
- Regarding the proposed changes to urgent and emergency care, many individual respondents opposed the changes (90%), while amongst Lewisham residents (who make up a large proportion of the consultation responses received), the level of opposition rose to 96%. Overall, there was limited support for these proposed changes (eight per cent). Amongst organisations and groups, the majority opposed the proposed changes to urgent and emergency care (24% support vs. 67% oppose), although support was higher than among individuals.
- A large proportion of the free-text comments provided stated that University Hospital Lewisham (UHL) should keep its Accident and Emergency (A&E) department. The reasons underpinning this were good perceptions of the UHL service and not wanting to waste money from the refurbishment; the need for a large population to be served by an A&E; seeing it as unfair to penalise UHL when it is performing well; concerns about capacity at other A&Es; concerns about travelling to other A&Es, including travel times and their impact on safety.
- For both individual respondents and organisations/groups, there was no clear support for either option for providing maternity services across south east London. Amongst individual respondents, nearly seven in 10 supported neither option (69%) and where they did choose between the two options, more preferred an additional stand-alone obstetric-led unit at UHL (24%). A similar proportion of organisations/groups also selected this option (26%), but one in four said they were not sure which option they would prefer (23%). There was minimal support among individuals or organisations/groups for obstetric-led services at the four major hospitals only (three and seven per cent respectively).
- The majority of free-text responses emphasised the need for maternity services to be co-located with emergency care, with concern about the risk of providing obstetric-led services without A&E at the same site. As for A&E, respondents mentioned the high quality services they thought were already available at UHL and the recent investments; the growing population; concerns about capacity at other hospitals; concerns about distances and travel times and the impact on patient safety; and wanting maternity care to be provided locally.

- Individual respondents tended to oppose the proposed changes to planned care (68%). Organisations/groups were more supportive, with three in 10 supporting the recommendation (31%), although half opposed it (50%).
- The most frequent theme emerging in the free-text responses was concerns about

increased difficulties in accessing planned care as a result of the proposed changes.

Recommendation 5 concerns service provision across the wider NHS in south east London. This chapter is split into four care areas, reflecting the structure of the recommendation itself:

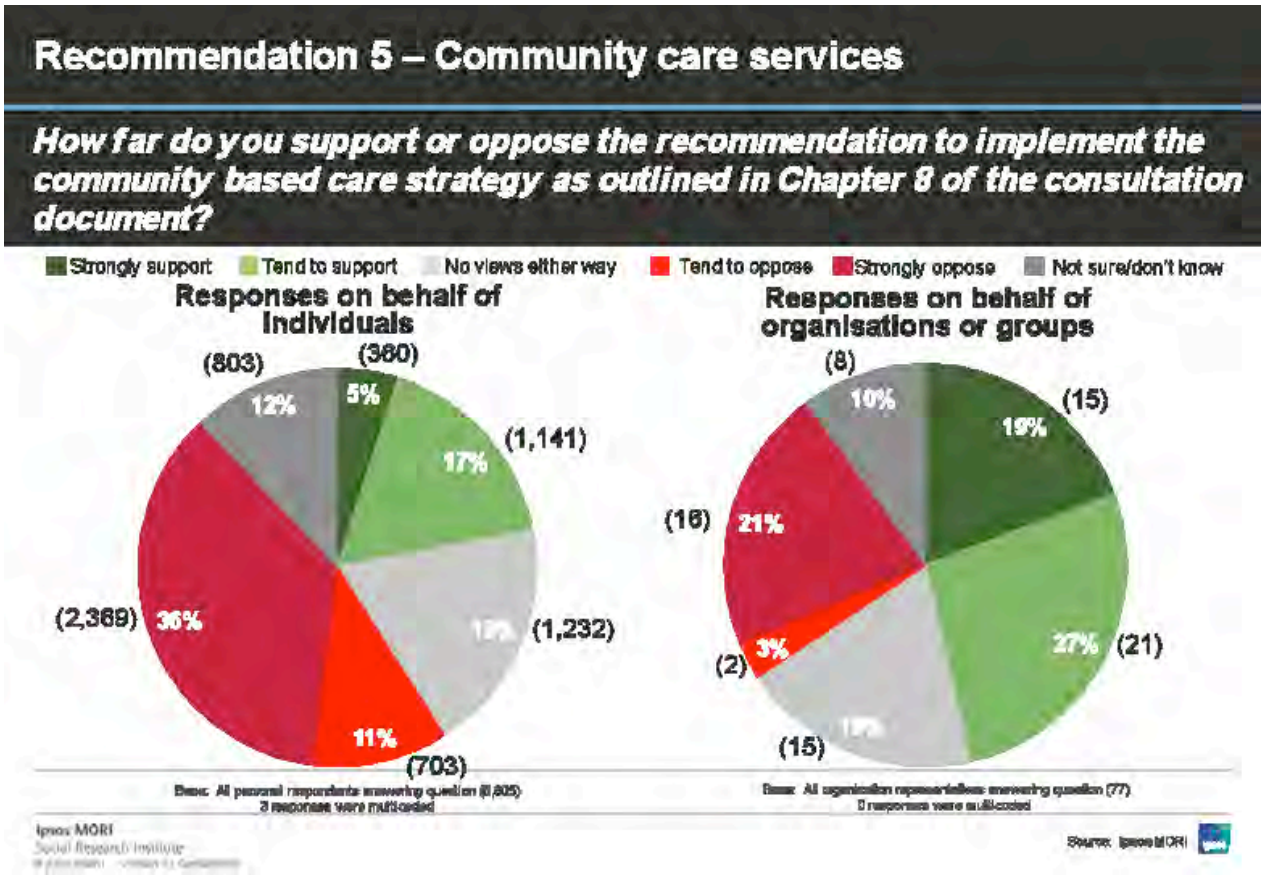
- Care in the community and closer to home
- Urgent and emergency care
- Maternity services
- Planned care

6.1 Care in the community and closer to home

The recommendation put forward by the Trust Special Administrator (TSA) is for the community based care strategy developed by south east London clinical commissioning groups to be progressed and implemented so that people receive care in locations closer to, or in, their home where appropriate. Respondents were first asked the extent to which they supported or opposed the community care recommendation before being given the opportunity to provide further comments on it.

The proposed recommendation drew some opposition from individual respondents. Almost half of individuals who gave their views were opposed to the suggested changes (47%), with 36% *strongly* opposed. Some ambiguity existed, with three in 10 saying they had no views either way or did not know (31%). Fewer than one in four supported the community care recommendation (23%).

The views of organisations and groups were distinctly different to that of individual respondents. Around half of organisations/groups who gave their view were in support of implementing the community based care strategy (47%), while around one in four opposed it (23%).



Support for the recommendation amongst individual respondents differed according to age. The oldest age group, those aged 65 and over, were most supportive of the strategy, with views balanced between support and opposition (38% supported it and 37% opposed it, compared to 23% and 47% overall).

Support for the community based care strategy was greater amongst individuals with a disability (29% compared to 23% of those without). Additionally, the level of support varied between those who provide care to a family member with a health need aged 16 or over (29% in support) and those who are not presently carers (22%). This tended to be because those who do not have a disability or are not carers were less likely to express an opinion; levels of opposition were similar.

Again in line with previous findings, those who have worked within the NHS were more supportive of the implementation of the community based care strategy. While around one in three current or past NHS workers supported the recommendation (36%), this fell to one in five of those with no experience of working in the health sector (19%).

As seen throughout, differences in opinion were observed according to borough. Support for the community based care strategy was greatest amongst Bexley (50%) and Bromley (43%) residents, compared to residents of Lewisham (17%) and Southwark (18%).

Q11 How far do you support or oppose the recommendation to implement the community based care strategy as outlined in Chapter 8 of the consultation document?								
	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*326*	*726*	*724*	*69*	*3,769*	*189*	*300*	*407*
Strongly support %	13	12	8	7	3	5	9	3
Tend to support %	37	31	22	20	14	13	16	4
No views either way %	14	17	16	19	22	13	13	9
Tend to oppose %	10	10	11	7	12	10	8	6
Strongly oppose %	23	23	34	45	34	51	46	71
Not sure/Don't know %	3	7	9	1	16	9	8	7

A total of 1,856 free-text responses were provided on the community care recommendation. Those who were in support of the recommendation were marginally less likely to provide a free-text response compared to those in opposition.

Some individuals (429), most of whom supported the recommendation, took the opportunity to say they felt that care closer to home was a good idea. Much of this support for community care was conditional, with some agreeing in principle but not wanting improved community care to be at the expense of other services (200). Individuals who said this often referred to the need for hospital services to be in place in conjunction with a strengthened community care offering.

These principles are reasonable, however, this improved provision should not be made at the expense of providing adequate easily accessible emergency and in-patient provision.

Quality of care was a consistent theme (523), with many stressing the need for increased funding if the community care strategy was to be successful (234). Some cynicism was apparent with individuals claiming that community care packages have failed previously (92) and many tied this back to a possible failure of the proposed strategy unless appropriately financed. A number of concerns centred around quality of care within community care at present. Respondents felt that quality was currently poor, or referenced that significant improvements would be required over a period of time in order to be able to rely on community care services (300).

I believe that hospital is not necessarily best for all patients and care at home/in the community can be more appropriate. HOWEVER the level of resource and funding and the logistics of such community services MUST be adequate and well planned.

Although the recommendations at first seem like a good idea, there is in fact no evidence to support the assumption that this kind of care can be delivered effectively within the community. The resources and infrastructure need to be in place and tested before existing services are cut.

Comments were made by both those in support and in opposition to the recommendation around the perceived risk of increased distance/cost/time to access care (145). Often these individuals tied their concerns about accessing care to the proposed changes to urgent and emergency care, commenting that University Hospital Lewisham (UHL) should retain its Accident and Emergency (A&E) department (114). In a similar vein, some took this opportunity to reiterate that no hospitals should have services removed/downgraded (211).

Care includes A and E care, and the proposal to close Lewisham A and E appears to me to be incompatible with certain aspects of the recommendations.

A number of respondents commented negatively on the consultation document, feeling that the information provided was not sufficient/relevant/accurate enough for them to provide informed feedback (275). They wanted more information on the strategy and how it would be implemented.

A small number of responses received via letter and email specifically referenced community care (23). The themes arising were very similar to those made in the free-text responses, but additionally made reference to the need for good working relationships and well-integrated care (5) and improvements to be made to GP and primary care services (10).

6.2 Urgent and emergency care

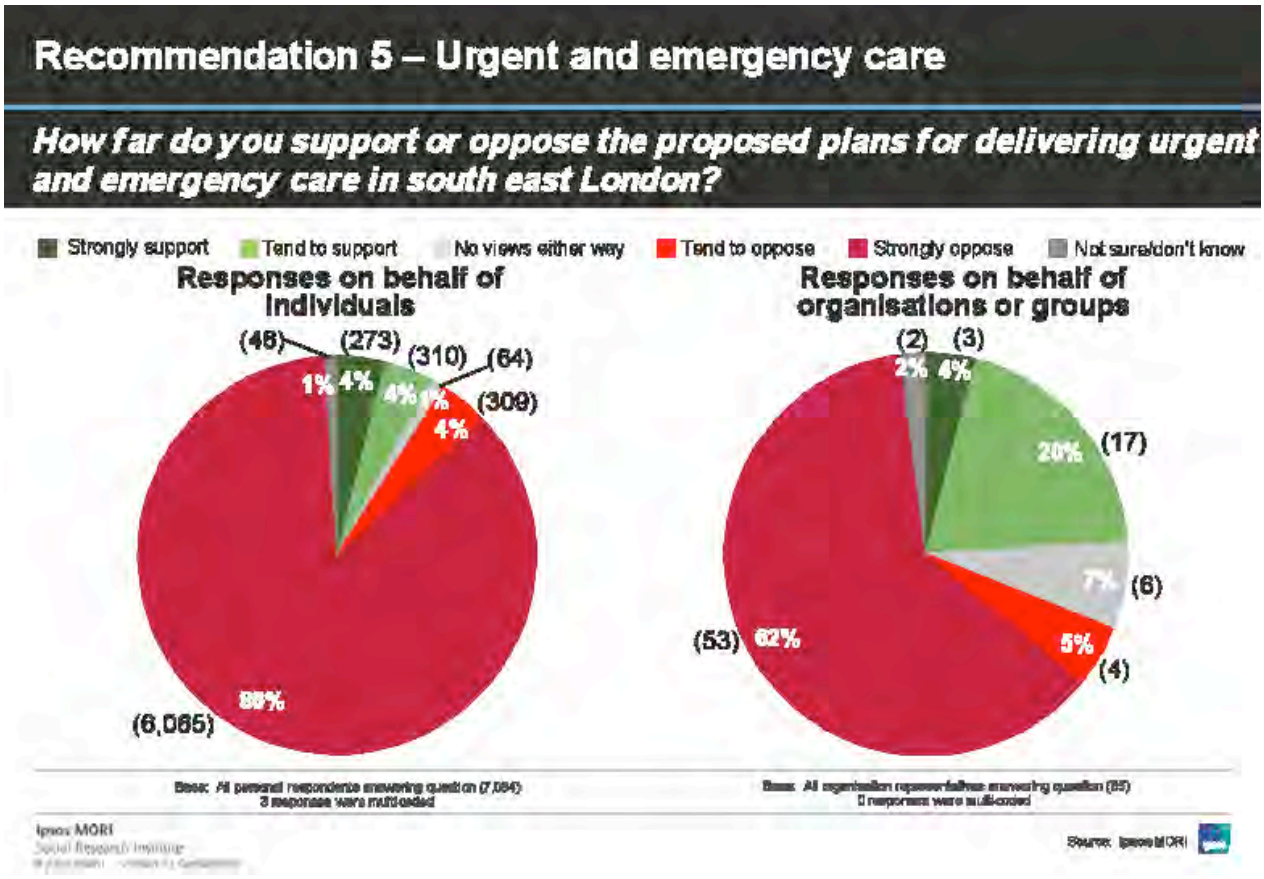
Recommendation 5 sets out where and how emergency care should be provided in south east London. The recommendation proposes care would be delivered as follows:

- Emergency care for the most critically unwell – King's College Hospital, Queen Elizabeth Hospital (QEH), Princess Royal University Hospital, St Thomas' Hospital

- Urgent care – Guy's Hospital, Queen Mary's Hospital, Sidcup, University Hospital Lewisham (UHL)

Of all the recommendations put forward by the Trust Special Administrator (TSA), the proposed plans for delivering urgent and emergency care in south east London received the greatest opposition. Nine in 10 individuals who responded to this question opposed the recommended changes to urgent and emergency care (90%), whilst 86% *strongly opposed*. There was limited support for the recommendation (eight per cent).

Again, the organisation/group perspective was different to the individual, though the majority still opposed the plans (24% supported them and 67% opposed them).



The level of opposition varied considerably according to resident borough. The greatest level of opposition was seen amongst those living in Lewisham and Southwark, where almost all residents opposed the plans for delivering urgent and emergency care (96% and 94% respectively). Opposition levels were lower elsewhere with, for example, two in three Bexley residents opposed to the changes (68%). It should be noted that individuals living in Lewisham were more likely to respond to the consultation than residents from other boroughs (57% of the individual respondents at this question are Lewisham residents).

Q13 How far do you support or oppose the proposed plans for delivering urgent and emergency care in south east London? The following shows how urgent and emergency care would be delivered:

Emergency care for the most critically unwell – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital

Urgent care – Guy's Hospital, Queen Mary's Hospital, Sidcup, University Hospital Lewisham

	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*334*	*756*	*763*	*72*	*4,092*	*193*	*307*	*434*
Strongly support %	10	11	5	8	2	3	7	2
Tend to support %	18	15	8	6	1	3	5	1
No views either way %	2	3	2	4	*	0	2	0
Tend to oppose %	16	9	6	3	3	1	4	2
Strongly oppose %	52	61	79	79	94	93	82	95
Not sure/Don't know %	2	2	1	0	*	1	1	0

Age again had some bearing on how people responded to the proposed changes, with lower opposition found amongst older age groups. Around three in four of those aged 65 or over opposed the recommendation (77%, compared to 90% overall), although more still opposed than supported it.

Of all the recommendations put forward by the TSA, the proposed changes to urgent and emergency care received the greatest number of free-text comments (5,184).

The most common response given was that UHL should retain its Accident and Emergency (A&E) department (2,869). Some individuals gave positive feedback about the performance of UHL and their own experiences there (903), whilst others referred to the recent refurbishment work carried out at UHL, often suggesting that closing the department would be a waste of money (577). Some took this opportunity to assert that they felt it was unfair that UHL and Lewisham residents would be affected by the failings of South London Healthcare NHS Trust (SLHT) when UHL itself was not in financial difficulties and was not responsible for the wider challenges SLHT faces (475). Throughout these comments there was some concern that the proposed recommendations were going to 'pull-down' a successful hospital, as once its A&E had been downgraded, they felt that other services would also follow (202).

Lewisham Hospital is a first class facility which is efficiently run and should not be sacrificed in order to support an inefficient failing facility.

Lewisham must remain open for emergency care... absolutely NO, this proposal is extremely frightening for local people.

Strong concerns were raised about the ability of other A&E departments to cope with increased case loads, with references to perceived current and possible future capacity issues at other A&E departments. Respondents sometimes talked more generally, and at other times in relation to specific hospitals that respondents felt would be overburdened by the recommendations, but in total 1,356 mentioned a concern about services being overstretched. QEH was commonly cited as a hospital already suffering capacity issues that would be overstretched as a result of the shift from A&E to urgent care at UHL. Responses towards QEH tended to be negative with comments about it being poorly located (570) or concerns about capacity, either at present or in the future (361).

Lewisham must have its own A&E department. To close it is dangerous and will result in the loss of life. The other surrounding hospitals simply won't cope.

A large number of responses included more general concerns about the availability of A&E (891). Many qualified their concerns about A&E provision by referring to the large and growing population (1,142). Reference was also made to the specific needs of the local population, with many mentioning its older, diverse and vulnerable residents living within a deprived area (449); many of whom would struggle to travel to A&E departments further afield. These comments about the local population were, in the main, made in reference to Lewisham.

The fear that the proposed recommendation would result in increased travel costs/distance and journey time was a dominant theme (2,193) with some reference to traffic congestion (481) and poor public transport links. All of these concerns contributed to the sentiment that lives were being put at risk by the proposed changes (1,358), with the time taken to access a service being crucial in an emergency.

I strongly feel closing Lewisham's A&E will put lives at risk as the other nearest hospitals are too far away. At the very least they will be very difficult to get to especially for the most vulnerable in society, i.e., the disabled and elderly and those travelling with children. With increasing traffic, ambulances will also have difficulty getting patients to the A&E departments in time, and this could make all the difference in patients' survival and quality of recovery.

As part of this, a number of people questioned the data used to support the recommendation (312). For example, a number of people queried the validity of the additional journey time stated in the consultation document to travel from UHL to QEH.

Of the 842 additional letters and emails received, UHL and the proposed changes which would affect it, were mentioned in 776 responses. Again, respondents explicitly stated that UHL needed to retain its A&E department (732). Similar reasoning was provided as that in the free-text responses. A number of letter and email responses praised UHL from individual experiences there and/or its reputation (167). Equally, reference was made to the recent investment made to refurbish UHL's A&E, feeling that it would be a waste of money (91) and many commented on the fear that other departments would be overstretched and struggling to cope with increased service demands (134).

6.3 Maternity services

Within Recommendation 5, the Trust Special Administrator (TSA) addresses how maternity services should be provided across south east London in the future. This section of the consultation gave respondents two possible options for the provision of obstetric-led services:

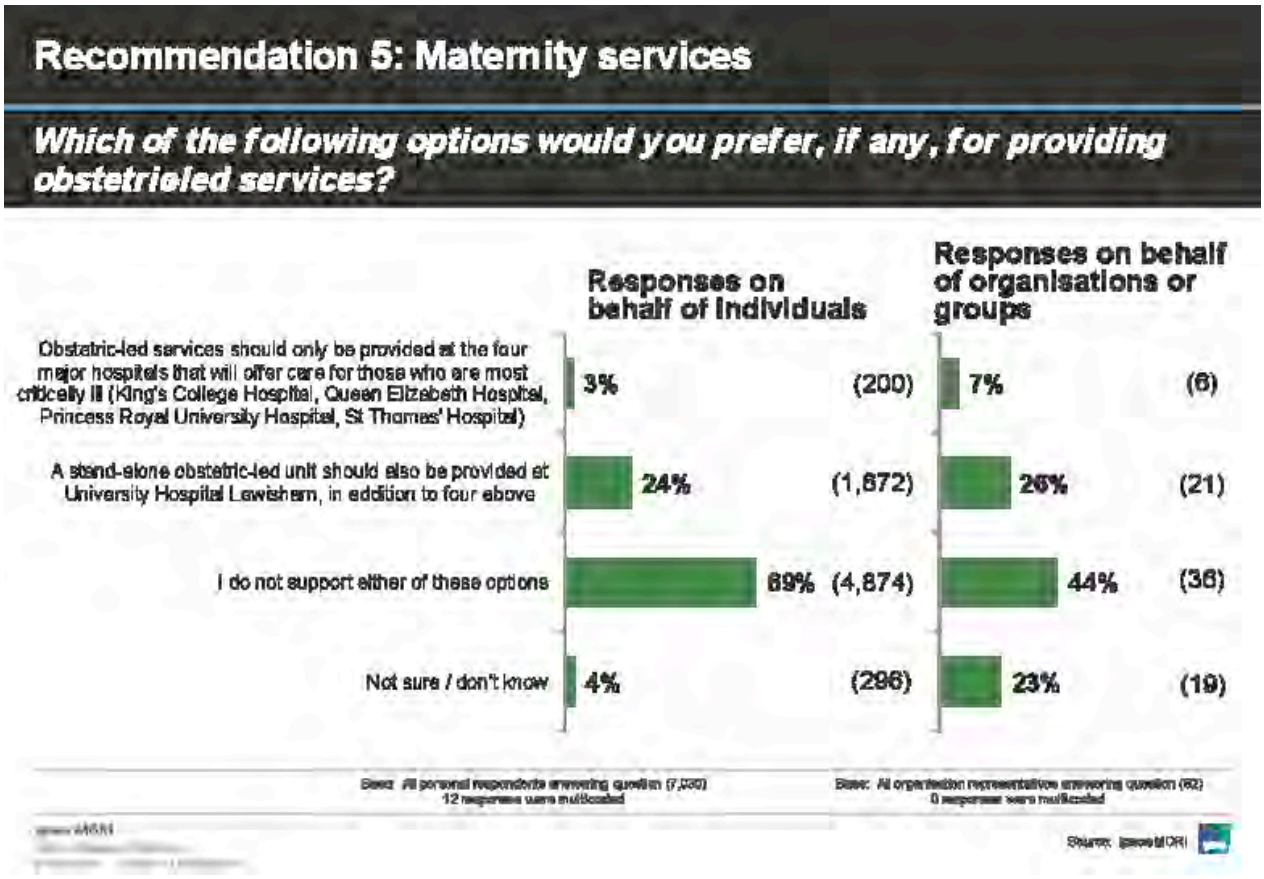
- Obstetric-led services should only be provided at the four major hospitals that will offer care for those who are most critically ill (King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital)

- A stand-alone obstetric-led unit should also be provided at University Hospital Lewisham (UHL), in addition to the four above

Respondents were asked to state their preferred option. As with all the recommendations, respondents were given the opportunity to provide free-text commentary.

Amongst individuals who responded to this question, seven in 10 did not support either of the two maternity options presented (69%). Of those who gave their support to one of the two options, a greater proportion said they were in favour of option 2, which would see an additional stand-alone obstetric-led unit provided at UHL (24%). A small proportion (three per cent) were in favour of option 1, which would see obstetric-led services only provided at the four major hospitals.

Of the organisations and groups responding to this question via the response form, two in five did not support either option (44%), while one in four stated a preference for option 2 (26%). More said they were not sure or did not know which was their preferred option (23%).



Lewisham and Southwark residents were the least likely to prefer either of the two options, with three in four not supporting either option (75% and 76% respectively, compared to 69% overall).

Q15 Which of the following options would you prefer, if any, for providing obstetric-led services?

	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*327*	*751*	*761*	*71*	*4,077*	*193*	*308*	*433*
Obstetric-led services should only be provided at the four major hospitals that will offer car for those who are most critically ill %	7	11	3	7	1	4	6	2
A stand-alone obstetric-led unit should also be provided at UHL, in addition to the four above %	35	35	30	20	22	19	19	10
I do not support either of these options %	46	45	60	66	75	76	69	86
Not sure/Don't know %	13	10	7	7	2	2	6	1

Some groups of respondents were more likely than others to support one of the options, and they tended to opt for an additional stand-alone obstetric-led unit at UHL. For example, almost three in five respondents aged 65 or over did not support either option

(57%, compared with 69% overall), while three in 10 supported option 2 (31%, compared with 24% overall). A similar pattern is observed among those who have a disability and current or past NHS workers.

Over half of those who responded to this question went on to give commentary on the maternity services recommendation (4,847). By far the most common response was that maternity and obstetric care needs to be co-located with emergency care (3,321), with respondents concerned about safety if emergency care was not readily available at the same site. Of those making this point, many used similar or identical wording suggesting possible campaign responses. A large proportion of the free-text comments linked the need for co-located services to their support for UHL retaining its Accident and Emergency (A&E) department (2,678).

Many took this opportunity to comment that UHL should maintain/expand its current maternity services (1,447). Of the individuals who wrote this, around four in five said they supported neither option presented. Many of these individuals described the good quality maternity care provided at UHL (501), with some specifically referencing the investment that had recently taken place (208). Others raised concerns about the availability of maternity services, suggesting that maternity care should be provided locally (372) and that maternity services are at risk of being overstretched (279) (for some they felt this was the case even before considering the proposed recommendations).

My feeling is that there should be an obstetrics-led unit at Lewisham Hospital AND that it should be properly backed up with a fully functioning emergency dept.

Maternity services provision with the back-up of full emergency medicine provision is a critical need at Lewisham Hospital. I do not support the removal or reduction of these services.

Some reference was made to the large, and growing, local population that would require maternity services in the future (549), asserting that the proposed changes needed to take into account future service demands. Some individuals expressed concerns about travelling further to reach maternity services (453). All of these concerns around maternity services led some to comment that the proposed options would result in increased risks to life (589).

Again the most common theme apparent in the responses received via letter and email in reference to maternity care was that maternity and emergency services needed to be co-located (532). Additionally, many references were made to the need for UHL to retain/expand its maternity services (598) and sometimes this was linked to a perceived waste of recent investment in refurbishments (21), while 48 provide positive reviews of maternity services at UHL.

6.4 Planned care

The final area of Recommendation 5 covers the way in which planned care should be delivered across south east London. It details which hospitals will offer day care surgery, complex operations, specialist non-complex operations and routine non-complex operations:

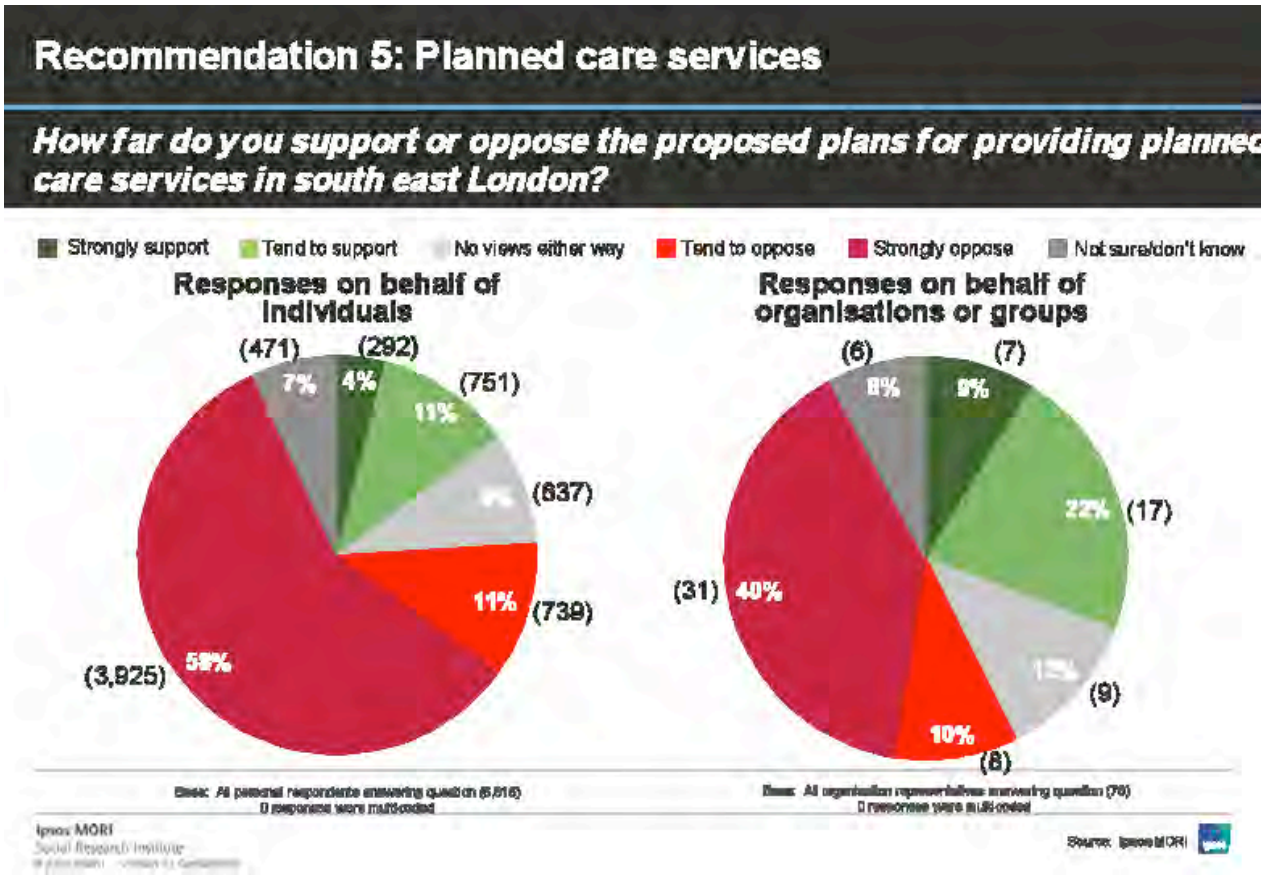
- Day case surgery – Guy's Hospital, Kings College Hospital, Queen Elizabeth Hospital, Queen Mary's Hospital, Sidcup, Princess Royal University Hospital, St Thomas' Hospital, University Hospital Lewisham

- Complex operations – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital

- Specialist non-complex operations – Guy's Hospital, King's College Hospital, St Thomas' Hospital

- Routine non-complex operations that require a stay in hospital – University Hospital Lewisham (UHL)

This element of Recommendation 5 was opposed by the majority of individual respondents (68%), while 15% supported it. Again, the organisational or group view was different to that of individual respondents, with three in 10 organisations/groups responding in support of the proposed structure for planned care (31%) and half opposing it (50%).



A number of differences in opinion were evident amongst various sub-groups. Continuing the pattern seen previously, older age groups were more positive towards the proposed changes. Three in 10 of those aged 65 and over were in support (30%, compared to 15% overall), although opposition outweighed support for every age group.

Similarly, individuals with a disability were more likely to support the proposed changes (24%) compared to those without a disability (15%). Support for the proposed changes was also higher amongst individuals where they or a family member had received

planned care from the NHS within the previous year (20% vs. the overall average of 15%).

Southwark, Lewisham and Lambeth residents were less likely to support the proposed changes to planned care than those living in the other six south east London boroughs (eight per cent, 10% and 17% respectively support them).

Q17 How far do you support or oppose the proposed plans for providing planned care services in south east London? The following shows how planned care woud be delivered:

Day case surgery – Guy's Hospital, King's College Hospital, Queen Elizabeth Hospital, Queen Mary's Hospital, Sidcup, Princess Royal University Hospital, St Thomas' Hospital, University Hospital Lewisham

Complex operations – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital

Specialist non-complex operations – Guy's Hospital, King's College Hospital, St Thomas' Hospital

Routine non-complex operations that require a stay in hospital – University Hospital Lewisham

	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*332*	*746*	*748*	*69*	*3,911*	*189*	*305*	*421*
Strongly support %	10	12	7	7	2	2	7	2
Tend to support %	30	24	16	10	7	6	11	2
No views either way %	6	12	11	10	10	6	6	3
Tend to oppose %	19	12	12	9	11	11	9	6
Strongly oppose %	35	35	47	64	62	70	62	82
Not sure/Don't know %	1	5	7	0	8	5	6	5

When given the opportunity to do so, 1,989 respondents provided a comment about the proposed changes to planned care. Of those responding, 643 made a comment in reference to accessing care. The majority of these comments focused on concerns about increasing distance/time/travel/costs to accessing care (328), (some of which referenced specialisation as making it harder to access services). Many of these comments were linked to a preference for hospital services to be provided locally (159) and suggested patients would benefit from friends and family being close by (88).

I don't really understand this proposal. Again it forces lower/no income and the elderly to travel greater distances when this is simply not feasible, for patients nor their families.

Respondents took this opportunity to comment that UHL should not have any services cut (348) and that it should retain its Accident and Emergency (A&E) department (248). Some added a concern that non-complex operations can turn complex (73), therefore requiring the full suite of hospital services at each site, and this was linked to a fear that the proposed changes would result in increased risks to life (107).

Very few responses received via letter or email made a direct comment about planned care (three).

7. Recommendation 6

Delivering service improvement through organisational change

- The majority of individual respondents opposed the plan to dissolve the current South London Healthcare NHS Trust (SLHT) (65%), with some (in the free-text comments provided) believing that the Trust could be rescued with better management, without the need for extensive reorganisation. Organisations and groups were more positive, with one in three supporting the move to dissolve the Trust (34%), although more still opposed the plan than supported it (42% oppose).
- Individual respondents showed a similar level of opposition in relation to the plan for Queen Elizabeth Hospital (QEH) and Lewisham Healthcare NHS Trust to merge (71%). Free-text comments revealed some concerns about the failure of previous mergers and the perceived risk to Lewisham Healthcare NHS Trust in joining with a failing hospital. Again, organisations and groups were slightly more positive (27% supported and 47% opposed it).
- Of the two options put forward by the Trust Special Administrator (TSA) for the future running of Princess Royal University Hospital (PRUH), nearly two in five individual respondents were in favour of the hospital being acquired and run by King's College Hospital NHS Foundation Trust (37%). Around three in 10 respondents supported neither of the two options suggested by the TSA (31%), while a further one in four said they were not sure or didn't know (27%). The key issue for many in the comments provided was a concern that running a procurement process would lead to private providers of NHS services, something that was strongly opposed. The views of organisations and groups were slightly more in line with those of individuals here; 41% were in favour of the plan for King's College Hospital NHS Foundation Trust running PRUH.
- The majority of respondents agreed with the recommendation for the Department of Health (DH) to write off debts accumulated by SLHT (77%), with little variation observed across sub groups. Free-text comments showed that respondents felt this was the only solution to ensure success in the future and to maintain services for residents of south east London. However, some queried the need for restructuring if the debt was written off and effective management put in place. Four in five organisations/groups agreed with this recommendation (81%).

Recommendation 6 concerns organisational solutions for South London Healthcare NHS Trust (SLHT).

This section has been split into sections to explore responses to the four separate questions asked of respondents to the proposed plans outlined in the Recommendation 6. These are:

- Dissolution of SLHT
- Merging of Queen Elizabeth Hospital and Lewisham Healthcare NHS Trust

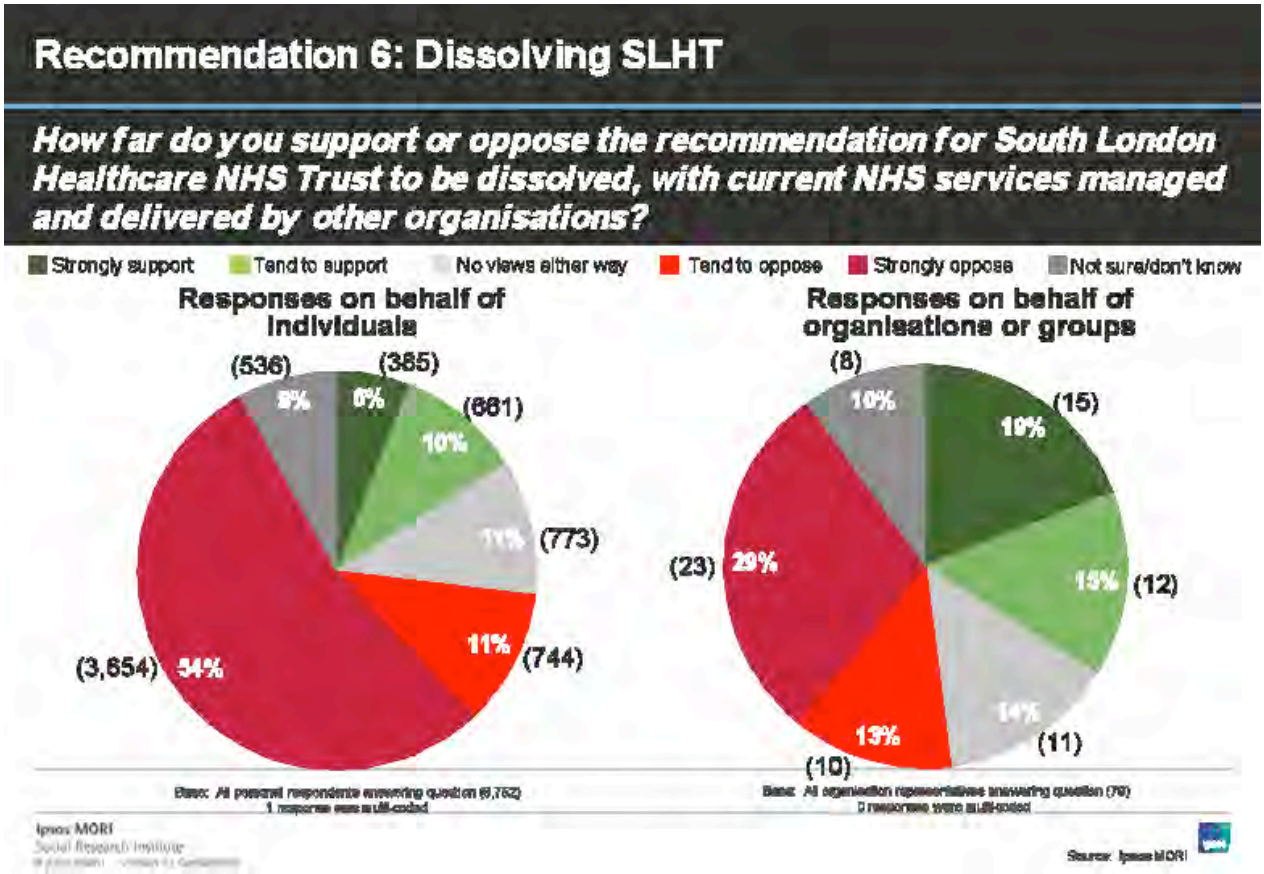
- Preferred option for running Princess Royal University Hospital
- The Department of Health to write off debt accumulated by SLHT

7.1 Dissolution of South London Healthcare NHS Trust

The recommendation put forward by the Trust Special Administrator (TSA) is that South London Healthcare NHS Trust (SLHT) be legally dissolved and the Trust's services become part of other organisations. Respondents were asked the extent to which they supported or opposed the recommendation for SLHT to be dissolved. All respondents were given the opportunity to provide free-text commentary at the end of the questions surrounding Recommendation 6.

The majority of individuals responding to this question were opposed to the plans to dissolve SLHT. Almost two in three opposed the recommendation (65%), with 54% strongly opposed. The recommendation was supported by 15% of respondents.

The view of organisations and groups was a little more positive, with one in three of those who responded supporting the move to dissolve the existing Trust (34%), but more opposing the plan (42%).



Support for the recommendation varied depending on the borough the individual respondent lived in; for example, respondents from Bexley were far more likely to agree that SLHT should be dissolved than those who live in Lewisham (41% in Bexley compared to nine per cent in Lewisham).

Q19 How far do you support or oppose the recommendation for South London Healthcare NHS Trust to be dissolved, with current NHS services managed and delivered by other organisations?								
	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*332*	*737*	*745*	*68*	*3,868*	*189*	*301*	*421*
Strongly support %	18	13	7	19	3	4	9	3
Tend to support %	23	20	15	4	6	10	10	4
No views either way %	8	11	11	7	13	10	8	4
Tend to oppose %	11	13	12	9	12	8	7	5
Strongly oppose %	34	37	48	59	56	65	60	80
Not sure/Don't know %	5	5	7	1	10	3	5	5

Respondents from older age groups were most supportive of the plans (for example, 24% of those aged 65 and over supported it compared to six per cent of 18-24 year olds). Those with caring responsibilities also showed greater support for the recommendation; one in five of those who care for a relative aged 16 or over with health needs supported it (20%), compared to 15% of those with no caring responsibilities.

Experience of working within the health sector was also important. NHS workers (past or current) were more in favour of the proposals to dissolve SLHT than those that had never worked in the health sector (32% compared to 11%).

The dissolution of SLHT received the fewest comments in the free-text question for Recommendation 6 (154), so there is limited further explanation of respondents' opposition to these specific plans.

Half of the comments here simply restated the respondent's opposition to the dissolution of the Trust (77). These tended to focus on the disruption that the dissolution would cause and a belief that changes could be enacted within the current SLHT structure. They questioned the need for the restructuring and suggested that better management was all that was needed.

The last thing the NHS trusts in our area need is more "reorganisation". That just creates yet more months and years of chaos, it disrupts the delivery of services, it hugely demoralises the staff that we desperately need to retain.

I believe that SLHT should solve its own problems and where required, services should be run by other NHS organisations. But there is no need to dissolve SLHT as such.

I see no justification in splitting the trust just because it has been badly run and managed. If other organisations and trusts can manage the hospitals better then why can't the current trust with different management?

A smaller number took the opportunity to express their support for the dissolution (39), and 18 their conditional support, suggesting that there was a need to move the situation forward successfully.

The South London Healthcare Trust has failed so it makes sense to look at other options.

It is very evident from the report that much of the mess at SLHT is a result of poor management. The sooner the trust is dissolved and better management put into place,

the sooner better health services will be delivered to this area of London, and at a sustainable cost all round.

Very few responses via letter and email comment on the dissolution of SLHT (4), and these tended to be against the proposal (3).

7.2 Merging Queen Elizabeth Hospital and Lewisham Healthcare NHS Trust

Within Recommendation 6, the Trust Special Administrator (TSA) considered the need to merge hospitals and trusts together. The proposals are outlined below:

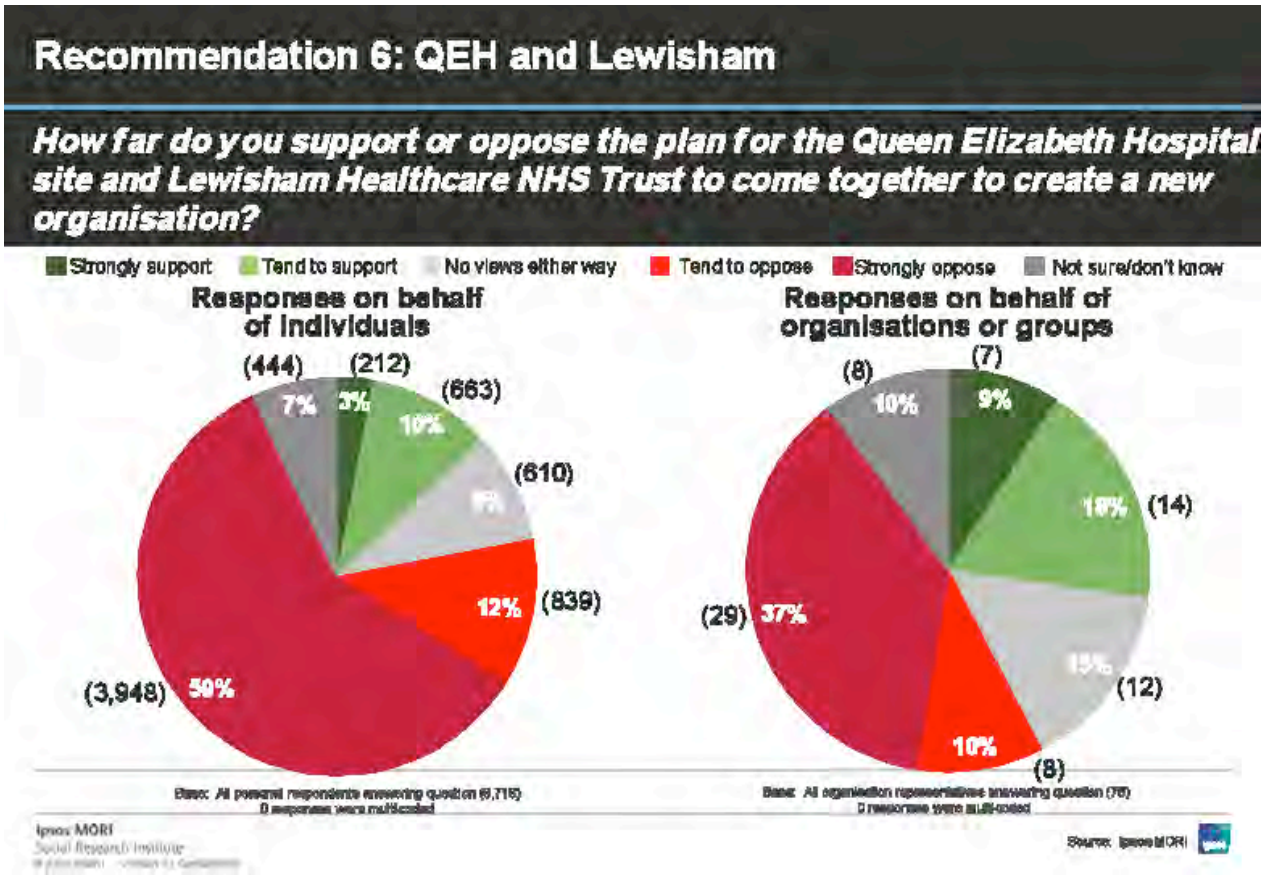
- Lewisham Healthcare NHS Trust to run services at Queen Elizabeth Hospital (QEH), Woolwich

- This will result in the two hospitals coming together as one organisation to deliver services to the population of Lewisham and Greenwich from two sites

Respondents were asked how far they supported or opposed the plan for the QEH site and Lewisham Healthcare NHS Trust to come together to form a new organisation. All respondents were given the opportunity to provide free-text commentary at the end of the questions surrounding Recommendation 6.

Amongst the individual respondents who answered this question, the majority opposed the plans (71%), with 59% strongly opposed to them. A little over one in 10 supported the recommendation (13%).

Those responding on behalf of organisations or groups were slightly more positive about the proposed merger, with around one in four supporting it (27%), although again more opposed it (47%).



Some sub-group differences were observed for individual respondents.

Among respondents living closest to the two NHS organisations affected, those living closest to University Hospital Lewisham (UHL) were least supportive (eight per cent), while those living closest to QEH were more supportive (27%).

Again, support for the proposed plans varied depending on the individual's borough; around three in 10 residents of Bexley and Bromley supported the plan (29% and 32% respectively), with the lowest level of support observed from residents of Lewisham (seven per cent).

Q20 How far do you support or oppose the plan for the Queen Elizabeth Hospital site and Lewisham Healthcare NHS Trust to come together to create a new organisation?

	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*331*	*728*	*742*	*68*	*3,860*	*184*	*298*	*417*
Strongly support %	8	9	6	7	1	1	6	2
Tend to support %	21	23	17	10	6	11	10	4
No views either way %	12	15	6	9	9	5	9	3
Tend to oppose %	17	13	15	19	13	11	12	5
Strongly oppose %	37	34	49	50	64	66	57	82
Not sure/Don't know %	5	5	6	4	8	5	6	4

As seen for other recommendations, older respondents were more supportive of the proposed merger, with one in five of those aged 65 and over in support (20%, compared to 13% overall).

Employment within the health sector was again a factor. Around one in four respondents with current or past experience of working in the NHS supported the plans (27%), compared to fewer than one in 10 of those with no previous experience of working in the health sector (nine per cent).

A total of 286 respondents provided further comments on the potential merger of QEH and Lewisham Healthcare NHS Trust, with 151 expressing their opposition to the plans. Within these comments, a number of fears were conveyed. Some mentioned the failure of previous restructures and queried whether the proposed merger would avoid the same fate. Others felt that Lewisham Healthcare NHS Trust would not benefit from the proposed arrangement; a key concern for many of the respondents was the risk to the Trust of aligning itself with a failing organisation (56).

Please do not tarnish Lewisham with the QE, unless you are certain that the QE will not drag Lewisham down!

There was some support for the possible merger, although this support was mainly conditional on several factors (104). For example, some respondents proposed a need for Lewisham Healthcare NHS Trust to be given responsibility for management of the new organisation.

Lewisham should be the senior partner in any merger due to their financial management being proved as efficient and their accountability being strong.

Respondents also wanted the new organisation to have full autonomy to decide its own structure and service provision. Some explicitly demanded that Lewisham should not lose its existing services.

Whilst I agree having Lewisham Hospital and Queen Elizabeth Hospital run by one organisation makes some sense, this should not come at the cost of Lewisham losing its emergency care service.

Most commonly though, respondents mentioned the need for debts to be written off, so that the new organisation would not be hampered by the financial problems. It should be noted that respondents often focused on writing off the Private Finance Initiative (PFI) debt.

[I] am happy for Lewisham and Queen Elizabeth Hospitals to come together as a new organisation but only if the PFI debt is written off and Lewisham does not suffer with future debts accrued by the PFI agreement. I do not want Lewisham to prop up or bail out the failing finances. The PFI debt should be written off completely so that a new organisation can start off on a clean slate debt free.

Very few responses via letter and email commented on the merger of QEH and Lewisham Healthcare NHS Trust (11). Comments were split between opposition and conditional support, reflecting the themes noted above.

7.3 Preferred option for running Princess Royal University Hospital

One area outlined within Recommendation 6 was a proposed change in the running of Princess Royal University Hospital (PRUH). This section of the consultation gave respondents two possible options for the future running of PRUH:

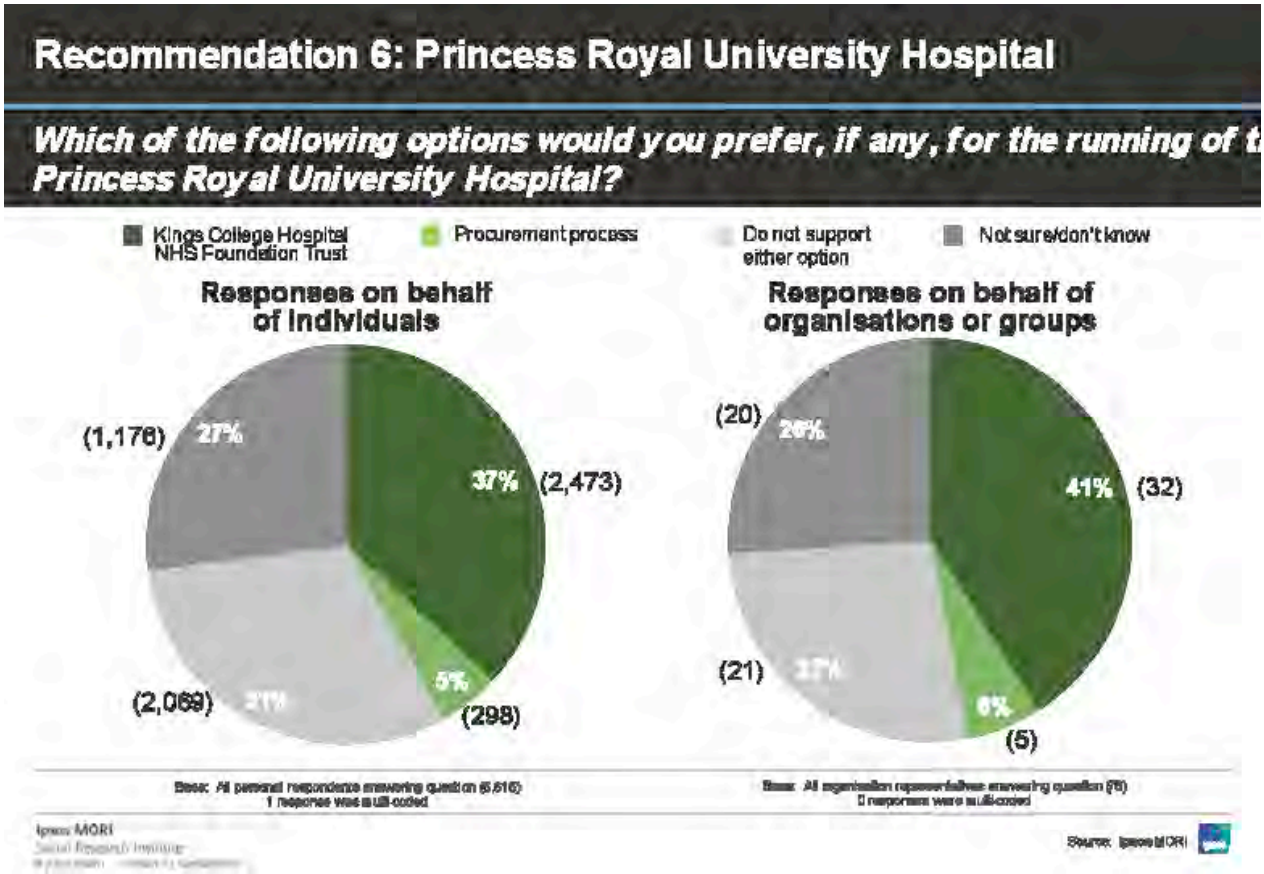
- Option 1 - King's College Hospital NHS Foundation Trust to run the hospital and the services it provides

- Option 2 - Run a procurement process to find the best organisation to run the hospital and its NHS services – this could be an NHS or independent sector organisation or a combination of both

Respondents were asked to state their preferred option, and were given the opportunity to provide free-text commentary at the end of the questions surrounding Recommendation 6.

Amongst individuals who responded to this question, almost two in five supported the plan for PRUH to be acquired by King's College Hospital NHS Foundation Trust (37%). Around three in 10 individual respondents did not support either option put forward (31%). Support for a procurement process to identify an organisation to run PRUH was very low, with only one in twenty respondents favouring this option (five per cent).

The views of organisations and groups were more similar to those of individuals here. Two in five were in favour of the plan for PRUH to be acquired by King's College Hospital NHS Foundation Trust (41%), while one in four did not support either option (27%).



Little variance was seen between sub-groups of individuals who responded to this question, although Lewisham residents were the most likely to support neither option (36%). Support for an acquisition of PRUH by King's College Hospital NHS Foundation Trust among the two NHS organisations affected was higher, with around three in five respondents who said PRUH (58%) or King's College Hospital (62%) was their nearest hospital preferring this option.

Q21 Which of the following options would you prefer, if any, for the running of the Princess Royal University Hospital?								
	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*331*	*738*	*735*	*68*	*3,783*	*185*	*292*	*401*
The Princess Royal University Hospital should be acquired and run by King's College Hospital NHS Foundation Trust %	44	52	42	50	27	57	51	65
A procurement process should be run allowing any provider from the NHS and/or independent sector to bid to run services on the Princess Royal University Hospital site %	7	7	5	6	4	5	8	2
I do not support either of these options %	31	27	27	26	36	24	23	16
Not sure/don't know %	18	14	26	18	33	14	17	17

Those respondents who went on to provide further comments on the future of PRUH tended to focus on the second option of running a procurement process. Many linked this to the possibility of a private provider running the service. These respondents tended to state their opposition to privatisation generally in the NHS (279) and specifically in relation to PRUH (63), with some simply saying that services should not be put out to tender (42). A small number expressed concern that privatisation would compromise patient care (32), but most seemed to object to private providers on principle within the NHS. They were particularly opposed to the idea of private companies generating profits from public money.

Services should be provided by the NHS and not by the private sector.

I strongly oppose any attempt to privatise the NHS.

These comments were not necessarily in support of King's College Hospital NHS Foundation Trust taking on PRUH but were simply opposed to the procurement process, which they felt would lead to privatisation and the inevitability of profits being placed ahead of patient welfare.

There was some support for King's College Hospital NHS Foundation Trust running the hospital and its services (54 support and 26 conditional support); it was thought that it was a competent organisation that would be able to ensure high standards of performance and provide good service to patients.

King's have proven track record with care services and I would welcome them taking over at PRUH.

I think King's to run Princess Royal would be very beneficial. I would like to make it clear that I don't think there should be a procurement process for Princess Royal, in case it

ends up in the hands of a private company. King's is a pioneering hospital and could really add value and improve services.

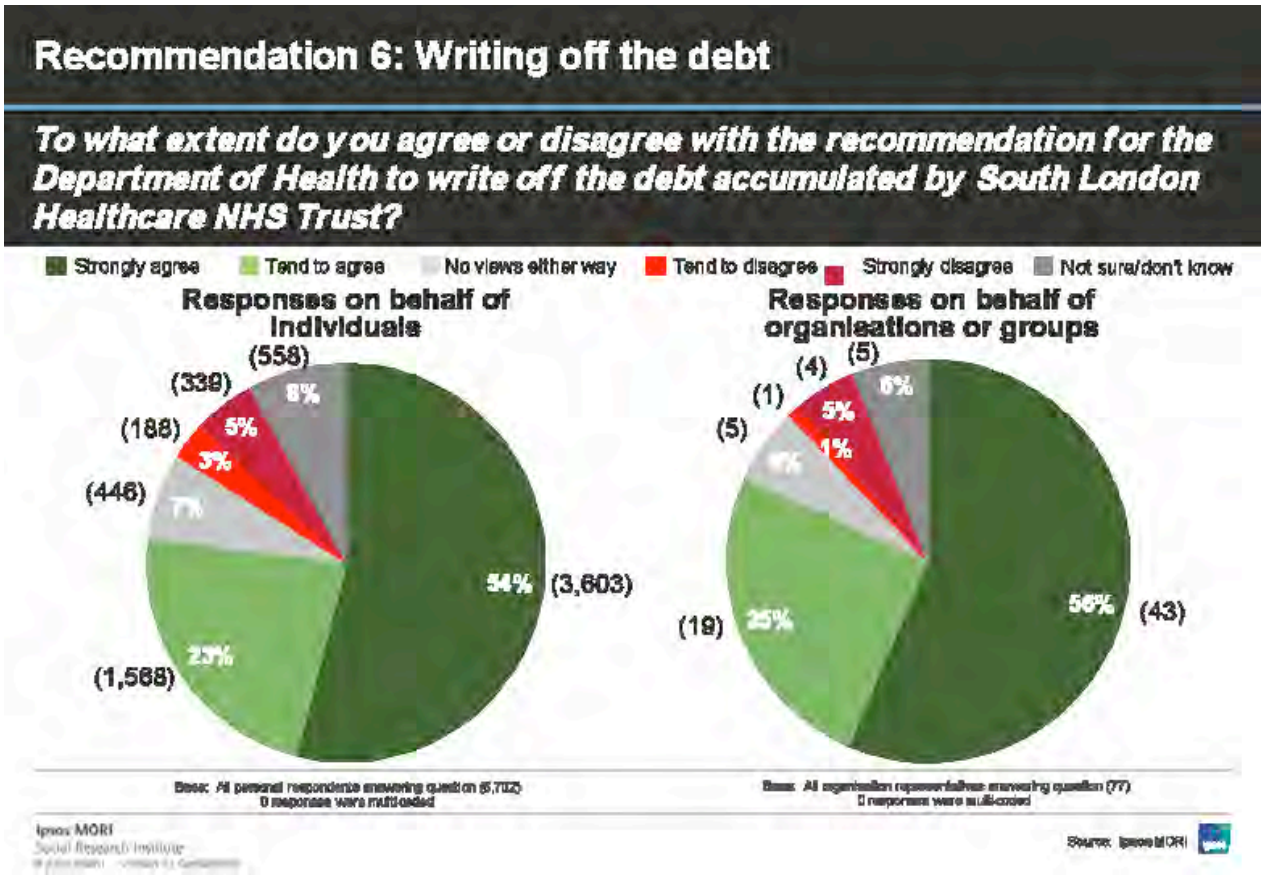
A smaller number of respondents specifically opposed this option in their free-text comments (26). As with the earlier recommendation regarding Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital, comments tended to query the wisdom of aligning a successful organisation with a failing one and/or called for the debt to be written off.

A small number of respondents commented on the options for the running of PRUH via letter or email. In most cases they stated their opposition to private companies running NHS services, as seen above (17).

7.4 Department of Health to write off debt accumulated by South London Healthcare NHS Trust

The final area covered as part of Recommendation 6 surrounded the Department of Health (DH) writing off the debt accumulated by South London Healthcare NHS Trust (SLHT) by the end of 2012/13. Respondents were asked the extent to which they agreed or disagreed with the recommendation for the accumulated debt to be written off, and were given the opportunity to provide free-text commentary at the end of the questions surrounding Recommendation 6.

Amongst individual respondents, the majority agreed with the plans to write off the debt accumulated by SLHT (77%), with around half strongly agreeing (54%). Similarly, four in five organisations/groups agreed (81%). There was very little opposition to this suggestion among individuals or organisations/groups (eight per cent and six per cent respectively).



Lewisham residents were slightly less likely than others to agree that the DH should write off the debt (71%, compared to 77% overall).

Q22 To what extent do you agree or disagree with the recommendation for the Department of Health to write off the debt accumulated by South London Healthcare NHS Trust?

	Bexley	Bromley	Green-wich	Lam-beth	Lewis-ham	South-wark	None of these	Prefer not to say
Those answering	*332*	*743*	*740*	*68*	*3,834*	*189*	*297*	*418*
Strongly agree %	68	59	62	66	46	63	66	69
Tend to agree %	22	25	21	21	25	21	22	16
No views either way %	4	6	5	1	8	3	4	3
Tend to disagree %	2	3	3	3	3	4	1	3
Strongly disagree %	4	4	4	6	6	3	4	4
Not sure/Don't know %	1	2	4	3	12	6	3	6

A total of 394 comments were provided in relation to this aspect of Recommendation 6. The vast majority of respondents commenting supported the DH writing off the debts of SLHT (286), and as discussed earlier in this chapter this was often linked to new organisations being able to take on the hospitals, free of the burden. As before, Private Finance Initiative (PFI) debt was often the focus of many of these comments.

The PFI burden of debt needs to be recognised and written off if clinical care is not to be compromised.

While many respondents talked of the need to write off the debt, they often laid down some conditions. For example, they thought that action should be taken so that the same issues do not arise again. They stressed the need for more effective management

in the future. Others queried the need for restructuring or removing services, if the debt was written off and sound management put in place.

Sorting out a debt is not achieved by changing the structure/organisation. Far better sort it out as a discrete entity. Otherwise the risk is that the mess is spread to the rest of the provision, causing a meltdown. If the Department will write of the debt then that is great; they can do it without the restructuring.

I feel the debt needs to be written off, in order for any future plans to be successful. However, if this debt is written off, I feel there is no need to alter the current Lewisham hospital facilities - merely use these as a guide and learning tool for how other trusts can be successfully run.

Just three individuals commented on this aspect of Recommendation 6 by letter or email, all supporting it.

8. Further comments

Having provided feedback on each recommendation in turn, all individuals and organisations/groups were given the opportunity to offer further comments on the consultation and the issues it covers. The question wording prompted respondents to explain their previous answers, detail their views fully, provide alternative options, and/or make suggested improvements, to the recommendations. A total of 2,241 responses were provided.

8.1 Comments on the recommendations

University Hospital Lewisham (UHL) and its future was a central concern in the further comments provided (809). Many took this opportunity to reiterate that UHL should retain its Accident and Emergency (A&E) department (331) and that no service cuts should be made at UHL (249); these responses were often emotive in nature. The comments tended to be closely bound with a sense of injustice that UHL was not part of a failing trust and therefore should not be penalised (286). Though not explicit in their mention of Lewisham, a number of comments were made which emphasised how local residents would suffer for financial difficulties (86).

Lewisham Hospital has continued to improve year on year, and should be held with pride for its ways, it should be looked on as a hospital that others should aspire to, not punish it and the residents of Lewisham for the failings of others!

Many of the further comments concerning UHL emphasised individuals' own positive experiences of the hospital and its good reputation (231). Slightly fewer took this opportunity to reassert that UHL should maintain or expand its maternity services (187).

Do not destroy a hospital that is at the centre of a community, which delivers good care and is well respected. Do not put lives at risk under the banner of "efficiency". Surely the most efficient proposal is to have good quality sound care close to home.

Access to care was raised as a concern throughout the six recommendations, and it was referenced another 589 times within the further comments section. Within this subject area, responses focused on the increased distance/time/costs/traffic concerns to accessing care under the proposed recommendations (224) and the apprehension about a lack of available A&E services (66). Respondents sometimes felt the Trust Special Administrator (TSA) did not understand what the proposals really meant for local residents who better understood the geography and transport links within the affected areas.

Tying in to concerns about service provision, a minority mentioned the changing population needs in the local area (216). Most of these comments referenced the large (and growing) local population that meant any reduction to services was not justifiable (132).

A number of mentions were made about operational efficiency (513). These comments focused on the culpability lying with South London Healthcare NHS Trust (SLHT) (101) and the need to drive decision-making by patient outcomes rather than financial considerations (189). These comments emphasised that patient care should be

prioritised before financial matters, and that the proposed recommendations did not place patients at the heart of the NHS. Some took this opportunity to mention the quality of care (300). There was a suggestion that the proposed recommendations would put lives at risk (154) and/or the quality of care would worsen as a result of them (78), or the safety of patients may be compromised (57).

Lewisham A&E is right on my doorstep. I cannot imagine it [not] being there... All the tax payers money that has been used to help it develop - to close it now – is a nonsense. Please, it's not just about numerics, it's about the basic human right to have emergency health care provision. If you cut off Lewisham A&E, you cut off a vital artery in the community.

Private Finance Initiative (PFI) was mentioned in a small number of responses (250). These comments tended to centre on the PFI arrangements being fundamentally flawed (84) which led many to conclude the arrangements should never have arisen in the first place. Often these comments were paired with a desire to break (or re-negotiate) the existing PFI contracts (79), with many again expressing anger that wider parts of south east London should bear the consequences of others' decisions.

8.2 Comments on the consultation

Many took this opportunity to provide feedback more generally on the draft report and consultation (805). Some thought the arguments for each recommendation were unconvincing and badly thought through (285). This concern was elevated for some by what they perceived as a lack of, or weak, evidence to support the recommendations (170). The consultation document itself was critiqued by some as giving insufficient evidence from which to provide informed feedback (180); but equally, the consultation document received some negative commentary on its length and the complexity of ideas and language used (156).

I believe the consultation document in large part failed to provide any evidence whatsoever for its recommendations, and failed to explain the full consequences of decisions.

The consultation process itself was an apparent theme within these further comments (733). Within this overarching subject area, the comments provided were diverse. Some expressed suspicion that the questions asked on the response form were leading (167), others felt the recommendations had already been decided upon, which rendered the consultation process 'a sham' and a formality (178), while others said that the process was flawed (166). Some stated that the consultation period was too short (235) and did not understand why this was the case, while others thought the consultation was poorly publicised or difficult to access (132).

I am not the only local resident who suspects that this consultative period is a waste of time and that you have already made up your minds to close Lewisham A&E and maternity. However, put yourselves in our shoes for a moment and consider how YOU would feel if you or a loved one suffered or, worse, died because of the increased journey time to get to another A&E. You need to save money, but do it in ways that will not harm people.

8.3 Comments from letters and emails

Access to care was also an apparent theme in the responses received via letter and email (412). As seen previously, many responses to the consultation emphasised a concern that the proposed recommendations would result in increased travel times and costs (282); for some these concerns were elevated by the threat of possible congestion on the roads (67). Many references were again made about the elevated demands which could be placed on other Accident and Emergency (A&E) departments and other services (41), when often it was felt these services are already stretched beyond capacity. A large number of these responses therefore stated that the proposed recommendations were endangering the lives of local residents (210).

Many of the letter and email responses referenced the growing/sizeable population served by the hospitals under review (106) and the particular nuances of those populations (age, vulnerability, diversity) (91) which make them more difficult to care for and more likely to struggle with increased travel distances/time.

A number of hospital specific comments were made (796); the majority of which focused on University Hospital Lewisham (UHL) (776) though a large number also concerned Queen Elizabeth Hospital (QEH) (206). Often these two hospitals were pitched in contrast with UHL comparing favourably to QEH which was thought to be poorly located (146) and already overstretched (37 for A&E and 36 more generally). Fewer comments were made about other hospitals affected by the consultation. The comments that were made tended to critique these hospitals again for being difficult to access or comment on concerns about their services being overstretched now and in the future.

The positive commentary on UHL often went hand-in-hand with demands that UHL retain its A&E (732), maternity services (598), and paediatric services (534) and a feeling that UHL should not be penalised as it is not in financial difficulties (95). It was sometimes felt that the recommendations would give out a message that organisations could have poor financial management without penalty.

As already mentioned, some responses received via letter or email also critiqued the consultation process itself for being poorly publicised or inaccessible (526), whilst other criticisms focused on the consultation document containing a lack of detail or feeling the evidence and statistics used were questionable in places (63), for example the modelling of journey times and the proportion of people who could still be treated at an urgent care centre in UHL. Some mentioned the Health Equalities Impact Assessment, which they would have liked to have seen as part of the consultation to help form their views.

9. Petitions and campaign responses

9.1 Petitions

A total of 15 petitions were received; with each containing a number of different signatures. Although a handful of petitions contained the same wording on the front page of the received petitions, if they were submitted separately to each other they were treated as separate petitions.

The responses given on the response form and those given in petitions are treated differently in the consultation. The percentages contained in the report refer to the proportion of respondents responding to a particular question that was posed to them with specific wording. Those signing a petition in support of a recommendation or hospital are responding to a differently worded question or statement. Therefore the two have to be treated separately. All feedback to the consultation will be considered by the TSA, including the petitions.

The following table lists each of the petitions received, indicating what each was expressing and listing the number of signatories. Ipsos MORI counted the number of signatories to the petitions (unless stated otherwise). If there was a discrepancy between the number of signatories counted and provided with the petition, we have used the figure from counting the petitions.

Petition on behalf of		Number of signatories
1	Petition to “Keep politics out of the NHS”	50
2	Petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain, from Labour Party Bulletin	7
3	Petition against the plans to close Lewisham Accident and Emergency	13
4	Petition against proposal to close the Accident and Emergency department and remove maternity services at Lewisham Hospital	10
5	Petition opposing the withdrawal of a full 24 hour Accident and Emergency facility at Lewisham Hospital, also oppose the closure of the maternity and neonatal facility, from residents of Bentley Court Retirement flats	26
6	Petition against proposed plans to close the Accident and Emergency and maternity services at Lewisham	13
7	“Save Lewisham Hospital!” petition, against the plans to close Lewisham Accident and Emergency and maternity	159

	services	
8	Petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain, from members of Lewisham Seventh Day Adventist Church and local residents	84
9	Petition opposed to the closure of Lewisham Hospital Accident and Emergency, from Lewisham Speaking Up – an independent Charity set up for and by people with learning disabilities	150
10	Petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain, from Heidi Alexander MP	c.12,000[13]
11	Petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain, from local businesses, Doctor surgeries and local schools	231
12	iPetition against proposals to downgrade emergency medical and surgical services at Lewisham Hospital, from Health Workers in Southeast London	694
13	iPetition against proposals to downgrade emergency medical and surgical services at Lewisham Hospital, from Doctors In Lewisham	325
14	Petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain	23
15	Online petition stating that a full admitting Accident and Emergency service and a full maternity service at Lewisham Hospital must remain, sponsored by Heidi Alexander MP	23,991[14]

As can be seen, these petitions have focused on the recommendations around urgent and emergency care and maternity services, opposing the proposed changes to services at University Hospital Lewisham (UHL). In addition to forming responses in their own right, it is likely that petitions have influenced responses via other methods, by

[13] Please note: Petition 10 consisted of a number of scanned hard copy pages of a petition sent via a USB stick. A note contained with the USB stick indicated 32,186 signatories – however there were a number of duplicate pages included in the file. Ipsos MORI estimated there to be c.12,000 responses to the petition contained on the USB stick.

[14] Please note: Petition 15 was an online petition which was still open after the consultation formally closed. As of midday on 14th December there were 23,991 signatories. Petition 10 and 15 may have been added together to provide the 32,186 signatories quoted on Petition 10 submission.

raising awareness and encouraging people to respond to the consultation. However, this is difficult to quantify exactly.

A number of petitions also allowed signatories to post their own comments or respond to specific questions about the proposals. For most[15] of these petitions, all of these comments have been read by Ipsos MORI and general themes have been identified.

Petition 6 – Comments provided by signatories to Petition 6

Although Petition 6 did not provide a specific place for any free-text responses, one of the forms did have some comments included. The comments expressed unhappiness about the proposal affecting Lewisham, and opposed the changes to UHL.

Petition 9 – Lewisham Speaking Up petition

Petition 9 allowed signatories to provide comments to support their signature. Signatories could provide a comment to the question "Why don't you want A&E closure". The majority of signatories did provide a comment to this question.

Comments generally stated that the Accident and Emergency (A&E) at UHL was needed by the local community and that it is the closest hospital for local residents, with many citing it as being their local hospital. Other signatories stated that the distance to travel to other sites in an emergency would be too far. Many signatories also provided personal experiences of using the A&E facilities both in the past and as an ongoing requirement for medical care.

Petition 12 – iPetition from Healthcare Workers of SE London

Petition 12 allowed signatories to post comments. Approximately half of signatories chose to just sign their name to the petition, whilst others also added further comments. A number of the signatories who chose to include a comment stated their job title or role, the petition included GPs, specialist nurses, and consultants amongst a variety of other NHS workers. Some signatories who provided a comment stated that they were a resident of Lewisham in addition to a healthcare worker.

Comments generally disagreed with the proposals affecting UHL A&E and maternity services, with some describing the proposals as 'ludicrous' and 'disastrous'. Concerns were raised regarding the effect the proposals would have on other hospitals and healthcare services within the area, and if these facilities would be able to cope with additional pressure – particularly Queen Elizabeth Hospital (QEH) and King's College Hospital.

A number of comments referred to the affect the proposals would have on the signatories' patients; with particular concern regarding the ease with which their patient's would be able to access services.

Many signatories stated that the A&E service at UHL is needed by the local community and that the changes would affect local people.

Petition 13 – iPetition from Doctors in Lewisham

[15] The exception is Petition 15, as the comments were not submitted to Ipsos MORI.

Petition 13 allowed signatories to provide comments in addition to signing the petition. More than one in three signatories chose to added further comments. Some signatories who provided a comment stated that they were a resident of Lewisham in addition to a doctor.

Many of the comments surrounded the impact the changes to the A&E at UHL would have on patient care in the local community, stating that Lewisham residents need a local A&E. Similar to Petition 12, a number of the signatories referred to the impact that would be felt by their own patients.

9.2 Campaign responses

As part of the response to the consultation process, 515 separate responses were received as part of a campaign. The campaign opposed the proposals for University Hospital Lewisham's (UHL) Accident and Emergency (A&E), did not support either option for maternity services and stated the time it would take for them to travel to Queen Elizabeth Hospital (QEH) compared to the time it would take them to travel to UHL. These responses were individually read and coded as additional letters, with the other letters and emails received. They have therefore been included in the analysis of these letters and emails provided throughout the report.

This campaign allowed signatories to provide specific comments to the questions within the consultation response form to the questions about urgent and emergency care and maternity services, in addition to detailing travel time to QEH compared to UHL.

The text included within the campaign response is as below:

Please accept this as my contribution to the consultation on the draft proposals on the NHS in south east London and in particular for Lewisham Hospital. I have been unable to find a copy of the official consultation response forms.

In answer to Question 13, I strongly oppose these proposals as they will lead to the closure of Lewisham Accident and Emergency Department, and its medical, surgical, paediatric and intensive care beds.

*Comment: (*space provided to add comment*)*

In answer to Question 15 on maternity services, I do not support either of these options. Both options are unacceptable as they would leave Lewisham without a maternity unit with full medical, surgical and intensive care back up for emergencies.

*Comment: (*space provided to add comment*)*

Travel time to Queen Elizabeth Hospital, Woolwich

It would take me ……. (time) to get to Queen Elizabeth Hospital by bus/car (delete as applicable) compared with ……. (time) to get to Lewisham Hospital.

*Comment: (*space provided to add comment*)*

10. Stakeholder responses

As noted earlier, the Trust Special Administrator (TSA) was required to consult a small number of stakeholders under statutory guidance. However, recognising the need for wide engagement on the draft recommendations, further stakeholders were invited to respond to the consultation. Their responses are considered in this chapter. A full list of stakeholders is included within the appendices, indicating which stakeholders are in each group below.

Some stakeholders chose to address each of the recommendations in turn, while others focused on one or two in particular. Some did not address the recommendations specifically. A brief summary of the responses received within each stakeholder group is provided here. These summaries cannot reflect all the points made by the stakeholders, some of whom submitted lengthy and detailed documents. Instead they draw out common themes and general support or otherwise for the draft recommendations. The stakeholders' submissions have been provided to the TSA for consideration and are available on the TSA website for a fuller understanding of the points raised. Specific improvements offered by stakeholders have also been pulled out and provided to the TSA.

10.1 National bodies

The national bodies submitting a response to the consultation provided a different perspective to many of the other stakeholders, often commenting at a high level on the issues faced, rather than addressing individual recommendations.

The NHS Commissioning Board recognised that change is necessary and welcomed the opportunity to address long-standing problems in south east London in a sustainable way. It agreed that this will require significant changes to the way in which services are delivered. However, it wanted assurance that any solutions would result in better outcomes and would be clinically and financially sustainable in the longer-term. It also stressed the need for clinicians, patients and the public to be fully involved in any decisions.

The Independent Reconfiguration Panel referred to its 2009 report on services in south east London. It acknowledged that some of the issues outlined at that time remain and were addressed in the TSA's draft report.

Monitor agreed that the methodology and criteria employed by the TSA were sensible. It welcomed the opportunity to work with the TSA and relevant NHS trusts and foundation trusts to take any recommendations forward.

The Care Quality Commission's response outlined its regulatory position with regard to South London Healthcare NHS Trust (SLHT) and the six NHS trusts and foundation trusts involved. It noted that the proposals offer the population a way forward, with an opportunity for the NHS and local authorities to work more closely together. It provided a review of each of the NHS trusts and foundation trusts, and stated some thematic concerns regarding the capacity of maternity services in the area, orthopaedic services at SLHT and capacity issues at Dartford and Gravesham NHS Trust.

The Co-operation and Competition Panel provided advice on the draft recommendations. They noted the challenges faced in south east London, and supported the efforts to identify an appropriate solution. They believed that developing different solutions for each of the three hospital sites would likely see the introduction of greater choice and competition than merging the three sites with one provider. They did advise the need for sufficient countervailing benefits to offset the likely reduction in patient choice and competition of the proposed merger between Queen Elizabeth Hospital (QEH) and Lewisham Healthcare NHS Trust and the recommendation for Dartford and Gravesham NHS Trust to run some services on an interim basis at Queen Mary's Hospital, Sidcup (QMS).

10.2 Royal Colleges

There was general recognition amongst the Royal Colleges that responded of the difficulties faced by the NHS in south east London, the specific financial challenges for South London Healthcare NHS Trust (SLHT), and the need to tackle these. The Royal College of Physicians, the Royal College of Midwives and College of Emergency Medicine all agreed that possible solutions will need to address the wider healthcare system across the area, with some rationalisation or reconfiguration of services.

For example, the Royal College of Midwives (RCM) said *"The RCM recognises the magnitude of the financial challenges affecting the operation of the South London Healthcare NHS Trust (SLHT). We were not opposed to the referral of the Trust to the Trust Special Administrator (TSA) and we acknowledge the need to address the underlying financial challenges in a way that maintains, or improves, the standards and quality of care. We also accept, because of the inter-dependencies between the Trust and the wider healthcare system in south east London, that the proposed solutions will inevitably impact on neighbouring NHS providers."*

The Royal Colleges were generally supportive of the clinical need for change underpinning the recommendations, with the Royal College of Physicians for example saying *"The RCP is unable to comment on specific proposals for locations for services, but is able to support the general clinical principles for change that underpin the proposals."* However, the Royal Colleges also expressed specific concerns about some of the proposals.

The Royal Colleges responding to the consultation made some general points about the proposals, which read across several of the recommendations. These points tended to focus on the need for appropriate workforce planning, capacity and established networks.

The Royal College of Obstetrics and Gynaecology (RCOG) particularly referred to workforce planning issues in relation to safe maternity care. While they said that the figures used in the TSA's draft report are achievable with centralisation, they pointed out that many of the larger units were struggling to meet this aspiration due to cost pressures and inadequate human resources. They stressed the importance of consultant presence and leadership to enhance clinical leadership and decision-making. They also outlined further considerations for workforce planning including trainee doctor staffing, anaesthetic care and support, neonatal care and surgical support.

The Royal College of Midwives expanded on this further. They felt that the 168 hour consultant obstetrician presence may be a useful long-term aspiration, but did not

believe it is affordable or achievable in the short-term. They would rather see a 98 hour presence at the three of the five sites that cannot achieve this at present.

The College of Emergency Medicine also commented on workforce planning for Accident and Emergency (A&E) departments and urgent care centres, stating that consolidating two departments with less than adequate staffing will not necessarily resolve staffing issues.

The Royal Colleges that responded were also looking for further reassurance about the implications of the recommendations, particularly in relation to capacity issues. For example, the College of Emergency Medicine suggested the need for more detailed assessment of the impact of the proposals in relation to urgent and emergency care on surrounding A&E departments, while several commented on the impact of the proposals on journey times and the demand for ambulances.

The Royal College of Nursing raised local capacity concerns in relation to the proposed changes to both A&E and maternity services at Lewisham Healthcare NHS Trust, highlighting that maternity services are currently overstretched. They also referred to travel times and transport links, while noting that clinicians have said there will be risks to patients from the proposals. They commented that if a change is to be made in Lewisham then it would be best achieved following the integration of Lewisham Healthcare NHS Trust and the Queen Elizabeth Hospital (QEH).

The Royal College of Midwives specifically raised concerns about capacity in maternity services if the four site option is implemented, questioning the ability of the remaining sites to absorb the total workload from Lewisham Hospital. They queried some of the assumptions underlying projected demand at the four remaining sites, in particular saying that more patients would use King's College Hospital and St Thomas' Hospital than projected. This would lead to more than 8,000 births at King's College Hospital and approaching, or more than, 8,000 births at St Thomas' Hospital, at which point RCOG's recommendation for operating a double rota for consultant obstetricians would need to be implemented. They felt that this, along with capacity issues, undermines the rationale for centralising obstetric services on four sites.

Several of the Royal Colleges responding, including RCOG, also referred to the growing population and the resulting demands on services in the future. Leading on from this point, the Royal College of Nursing noted the diversity within south east London, suggesting that a significant area of weakness of the TSA's draft report was the fact that a full Health Equalities Impact Assessment (HEIA) had not yet been completed. The Royal College of Midwives also commented that women living in disadvantaged and diverse communities such as exist in many wards in Lewisham are significantly less likely to access maternity services early or maintain contact with them throughout their pregnancy. It suggested that the four site option will reduce accessibility to maternity services and so may impact on health inequalities.

Several of the Royal Colleges that responded commented on the need for strong networks to be established, and for strong multi-disciplinary working across teams. This was made as a general point and also specifically in relation to the recommendations and the implementation of the proposals. For example, the College of Emergency Medicine supported the principles of improving access to emergency care and the emphasis on prevention and community care. However, they stated that networks

needed to be in place across primary and secondary health and social care, before any changes to current service provision can be implemented.

Two of the Royal Colleges specifically commented on this in relation to maternity care. RCOG discussed the need for multidisciplinary working and full medical back up in case of complications, while the Royal College of Midwives asked for further information in order to provide clarity as to which support services will continue to be provided elsewhere.

The majority of the Royal Colleges responding addressed specific aspects of the proposals or key considerations for their implementation, largely in relation to Recommendation 5. These are outlined briefly above. Where the Royal Colleges commented on Recommendations 1-4, they were generally supportive of them. For example, both the Royal College of Midwives and Royal College of Nursing accepted that efficiency could be improved within the hospitals that make up SLHT, although both warned that in their view a reduction in the workforce could impact upon clinical outcomes. The Royal College of Midwives presented the additional point that efficiency savings can be made through a reduction in unnecessary intervention in pregnancy and birth.

Both the Royal College of Midwives and the Royal College of Nursing expressed some concern over the lease on Beckenham Beacon, suggesting it is unclear what will happen here.

The Royal College of Midwives and the Royal College of Nursing agreed in principle with the recommendation for SLHT to be dissolved and the merger of QEH and Lewisham Healthcare NHS Trust. Both organisations stressed that the particular characteristics of residents of Lewisham and Greenwich should be taken into account in any reconfiguration, and would require close partnership working from a range of providers in the area in order to improve local health outcomes.

10.3 Strategic Health Authorities

Two Strategic Health Authorities (SHAs) responded to the consultation – NHS London and NHS South of England. Both agreed with all the recommendations on which they expressed a view, or nominated a preferred option where there is a choice.

Two themes which emerged from their submissions were the importance of leadership and communications. They suggested that the success of the transformation would be dependent on the right leadership capability and capacity being in place, across the board. This would drive through savings, secure community-based care and achieve an impetus for change. They thought that good communications were needed to reassure the public about some aspects of change, such as which emergency and urgent care services will be available to them, how services can be accessed and why the most local services are not necessarily the most effective ones.

NHS London added a third overarching consideration: that all six independent recommendations will have to be in place for the overall plan to succeed.

Both SHAs supported the proposals under the first three recommendations, with some specific comments on ensuring each achieves success. For example, NHS London said that the TSA should consider how to maximise the value to the taxpayer in deciding the

mechanism for effecting the change in ownership of the Queen Mary Hospital, Sidcup (QMS) site.

Both also supported exiting from vacant or poorly-utilised premises, as it was recognised that the cost of the estate has a significant impact on NHS finances.

NHS London strongly supported the recommendation that the Department of Health (DH) provides additional annual funds to cover the additional costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth Hospital (QEH) and Princess Royal University Hospital (PRUH) until the relevant contracts end (NHS South of England expressed no view).

The proposals for a transformation in the way services are delivered were, for the most part, supported by NHS London, with NHS South of England expressing no view.

NHS London commented that it has long supported a community-based approach to care; only by an increase in out-of-hospital care, improving the quality of services and patient experience, can the burden on hospital-based care be reduced.

In supporting the proposed plans for urgent care and emergency services, NHS London expects robust protocols to be in place at the urgent care centre (UCC) at Lewisham, as it would for other UCCs not co-located with Accident and Emergency (A&E), to ensure the safe transfer to any patients who self-present needing, or becoming in need of, emergency services.

NHS London would only support the four-site option for obstetric-led services, with the removal of these services from the University Hospital Lewisham (UHL). It echoed the Trust Special Administrator's (TSA) external clinical panel's reservations regarding the establishment of a stand-alone obstetric-led unit at Lewisham. It would be a challenge to construct a rota for medical staff such that skills are maintained, and rotating staff (such as between the QEH and UHL sites) may not be an attractive option for sufficiently high-quality staff. Its support for this approach is subject to sufficient capacity being in place to deliver high-quality services.

On planned care services NHS London noted that there is evidence to suggest that the separation of planned and unplanned care can lead to better outcomes for patients and an improved patient experience. It contends that the proposal for UHL to serve the whole of south east London for non-complex in-patient procedures will only be successful with the support of all Clinical Commissioning Groups (CCGs) in south east London, where local commissioning plans should reflect a commitment to it.

NHS South of England did not express a view on the remaining recommendations, but NHS London supported each of them, adding that it is imperative that any changes will enable services to meet the clinical standards and interdependencies that have been developed and agreed by clinicians through the London Quality and Safety Programme in 2011/12 and 2012/13: *"NHS London would not support any service change that does not enable these standards to be met*".

10.4 Commissioners

Overall, all commissioners (Clinical Commissioning Groups (CCGs) and Primary Care Trust clusters) commenting argued that the status quo was not sustainable in south east London. A number of commissioners were generally positive about the draft

recommendations. For example, NHS Southwark CCG said *"Overall, NHS Southwark CCG recognises that no change is not an option in respect of SLHT and the wider health economy, and broadly supports the recommendations put forward by the TSA as a basket of solutions which, when taken together, will reasonably address the underlying clinical and financial issues in south east London."*

However, commissioners identified a series of potential risks from the Trust Special Administrator's (TSA) recommendations and there was a common thread that the ideas presented need further development and testing.

In particular, Lewisham CCG questioned the data underpinning the proposals and stated its belief that the service configuration proposals outlined in Recommendation 5 will not deliver the intended outcomes. It argued that the proposed changes will affect its patients disproportionately, particularly the more vulnerable.

Other themes to emerge from these responses were the need for strong leadership, good communications with the public about the changes and a need for transport issues to be fully explored and resolved.

In principle, all the commissioners commenting agreed with the need for efficiency savings and welcomed the implementation of targets. However, they also tended to regard the targets for efficiency savings as challenging and ambitious.

All commissioners responding were broadly supportive of the proposal for Queen Mary's Hospital, Sidcup (QMS) to be turned into a Bexley Health Campus, generally on the basis that this will be more cost effective than current arrangements. NHS South East London noted that the loss of in-patient elective care places would be balanced by improved quality and standards of care. A number of CCGs made specific comments about the provision of other services at the Bexley Heath Campus. For example, Greenwich suggested that Dartford and Gravesham NHS Trust may not be the best provider of elective surgery: Bromley CCG discussed plans for mental health beds to be located on the site. Bexley CCG offered a series of recommendations for developing QMS into a Bexley Health Campus providing a range of services to the local population.

Bromley CCG was supportive of plans to sell Orpington Hospital, stating that this is consistent with the outcome of the recent consultation process which proposed a Health and Wellbeing Centre in Orpington instead. Regarding the Beckenham Beacon site, Bromley CCG recognised that there are opportunities to use this space more effectively to expand and develop the range of services available to local residents. Outlining opportunities to provide a range of services, including a planned care centre, integrated services for the elderly and expanded primary care provision, the CCG stated it has a strong commitment to the future provision and development of services for the local population on the Beckenham Beacon site.

Those commissioners responding were supportive of the community-based care strategy, highlighting the need for additional capacity and capability in primary care in order to be able to deliver more innovative services, as well as services that are responsive to the increasing and ageing population.

Support for the urgent and emergency care proposals was mixed and to a large extent focused on the proposed changes to University Hospital Lewisham (UHL) and the resulting impact on other hospitals. Lewisham CCG expressed strong opposition to the draft recommendation. The CCG felt that the proposals would impact disproportionately

on the Lewisham population and suggested the recommendations do "*not support the ongoing provision of quality health services and the health and wellbeing of the population of Lewisham*". It noted the strong local opposition to the proposals, and outlined a number of concerns. These include more expensive, complicated and longer journeys for Lewisham residents, doubts about the claims in the draft report that 77% of Lewisham Accident and Emergency (A&E) patients would be seen in the UCC and a negative impact on integration of care. The CCG also discussed the impact of the proposals on the quality of paediatric care, clinical training and Lewisham's ability to attract and retain staff.

Southwark, Greenwich and Bromley CCGs also had concerns about the impact on other A&E departments, particularly King's College Hospital (KCH). NHS South East London endorsed the proposals on the understanding that the four admitting A&Es will have the capacity to deliver the standards set out in the London clinical quality standards for emergency care.

The commissioners responding were broadly welcoming of work on changes in maternity services. Most indicated that the priority is safety and quality of care, and suggested that careful communication about the selected configuration will be important. They were also keen to seek assurance on the workforce and physical capacity in place to enable choice in terms of childbirth, and argued for the need for robust modelling of patient flows. NHS South West London was concerned as to whether the model would be compliant with clinical guidelines as set out in the London acute emergency and maternity clinical quality standards.

Again, opposition was strongest from Lewisham CCG. The CCG rejected the 'dispersal model', referring to the analysis of Public Health Lewisham, which suggests that it would have a significantly damaging effect on the health and well-being of children and mothers. The CCG also rejected the stand-alone model, but preferred the modified approach drawn up by managers and clinicians. Lewisham CCG cited a number of reasons, including loss of continuity of care for children and mothers and a loss of co-ordination around safeguarding children in Lewisham. They also envisage a loss of continuity with local midwifery services, an increase in financial costs to parents and relatives and an increase in investment at other sites/greater revenue costs in providing larger maternity units.

In general, commissioners agreed that there were benefits in separating urgent and elective care. However, they were also keen for more detail on how these plans will work in practice, for example, asking questions about how patient choice will be offered in terms of the location of care and how travel considerations and improvements will be made.

There was broad support for the recommendation for organisational solutions for SLHT, and many of the comments focused on the impact on their local populations' ability to access care. However Lewisham CCG suggested that the proposed reconfiguration risks losing the confidence of staff and patients as well as a shift in both of these towards the larger foundation trusts and further financial problems for the *"less popular newly merged Trust"*. They proposed a model of local determination for service configuration in a combined Lewisham and Queen Elizabeth Hospital (QEH) partnership.

The commissioners responding had much to say about effective delivery and implementation of the proposals, particularly the challenges that must be met. Most agreed the changes are achievable but require significant extra resources in terms of

leadership, co-ordination, change management capability and resourcing, and that this should be implemented across south east London.

10.5 Providers

Seven providers (including King's Health Partners which covers Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, King's College London and South London and Maudsley NHS Foundation Trust), both NHS trusts and foundation trusts, responded to the consultation, and presented a divided view of the recommendations. King's Health Partners and Oxleas NHS Foundation Trust explicitly endorsed the need for change. Lewisham Healthcare NHS Trust acknowledged the financial challenges facing the NHS, the need to respond effectively to these challenges, and the requirement for all providers to meet increasingly demanding clinical regulatory standards. However, the Trust did not believe that there is a convincing case for the radical change of services in Lewisham. It stated a belief that the recommendations will result in worse health care for local people, and commented negatively on the absence of the HEIA prior to the publication of the recommendations.

Two providers (the former Chair and Non-Executive Directors (NEDs) of South London Healthcare NHS Trust and King's Health Partners) were concerned with the data which underpins the recommendation that operational efficiency needs to improve so that costs are in line with strong performing NHS organisations. South London Healthcare NHS Trust's former Chair and NEDs queried why, with suitable strong leadership, more of the £79mill savings could not be secured within South London Healthcare NHS Trust (SLHT). King's Health Partners had reservations about some of the assumptions relating to the efficiency improvements which underpin the Trust Special Administrator's (TSA) modelling and is concerned that, if efficiencies are not delivered, these costs should not be applied to community or mental health services through savings on block contracts.

Providers which expressed a view were broadly supportive of the proposal that Queen Mary's Hospital, Sidcup (QMS) site should be developed into a Bexley Health Campus. King's Health Partners were concerned about the prospect of Dartford and Gravesham NHS Trust becoming the interim provider of day case surgery and endoscopy services at the site whilst a procurement process is being carried out, not least to avoid disrupting established cancer treatment pathways for patients. Dartford and Gravesham NHS Trust, however, welcomed the opportunity to provide day care elective surgery and endoscopy services on the site.

Oxleas NHS Foundation Trust welcomed the opportunity to take on the QMS site. It supported the vision for the site being developed by Bexley CCG and Bexley Council, as do the former Chair and NEDs of South London Healthcare NHS Trust which sees Oxleas NHS Foundation Trust as being able to rationalise its estate and further strengthen its financial position. Other service providers will need to be satisfied that the cost of providing services is economic given the pressure they will be under to make the maximum use of the assets on their main sites.

Respondents mostly endorsed the principle of vacant and poorly utilised premises being exited. However, Lewisham Healthcare NHS Trust's concern about the TSA's proposed estates plan for the Lewisham site has led it to commission a specific review of the TSA estates assumptions which concludes that insufficient capacity is included in the TSA proposals.

While no provider explicitly argued against the Department of Health (DH) providing additional funds to the local NHS to cover the excess costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth (QEH) and Princess Royal University Hospital (PRUH), King's Health Partners pointed out that the level of support must be sufficient to ensure a sustainable financial future, with funds tracked to the PFI inflationary uplift expectations. London Ambulance Service NHS Trust commented that it would need to understand the impact on the local economy and its ability to deliver services if a greater proportion of the finite health resource is given to support the PFIs.

Implementation of the community-based strategy for south east London was generally welcomed by providers. However, Lewisham Healthcare NHS Trust, though supporting the aspirations of the strategy, was concerned about the lack of supporting evidence or detailed plans underpinning its implementation. It queried whether the TSA's assumptions to reduce demand for secondary care will be delivered in the timescale, if at all.

There was little consensus on the future of emergency care. There were queries about the understanding of the clinical flow. Lewisham Healthcare NHS Trust also did not support the shift of emergency care services away from Lewisham which it believes will disproportionately impact access to emergency and critical care services for local people, including those in deprived areas, dependent on public transport, putting at risk the safety of patients, particularly the frail elderly, those with long-term conditions and sick children. London Ambulance Service NHS Trust commented that, in terms of clinical safety, the majority of patients who currently require a time-critical response are unaffected by this recommendation. However, there are potentially indirect consequences for time-critical patients through delays at the front door or in sending in clinicians and it suggests a thorough testing of the recommendations with providers and with acute and ambulance commissioning organisations.

On elective provision, Lewisham Healthcare NHS Trust strongly supported the development of a centre of surgical excellence on the University Hospital Lewisham site which it believes would lead to better patient outcomes and experience. However, it contends that there is a lack of clarity and detail in the TSA's report regarding the service and business model for the centre. King's Health Partners commented that the proposal for an elective centre at Lewisham would need to be based on a collective decision across south east London. Given that there is an elective centre at Guy's Hospital, it is critical that the model for such a centre is clinically and financially sustainable.

No stakeholder opposed the proposal that SLHT be dissolved, including the former Chair and NEDs of the Trust itself.

Generally, providers responding favoured a merger of QEH and Lewisham Healthcare NHS Trust. Nevertheless, the former Chair and NEDs of SLHT considered that this is *"the most challenging piece of the jigsaw"*. They, along with Lewisham Healthcare NHS Trust, said that it had not been given access to the necessary information to enable it to form a view as to the future financial viability of the new organisation. The agreement of an appropriate level of transitional funding will be critical to ensure the financial stability of the new organisation. Lewisham Healthcare NHS Trust acknowledged the financial challenges facing the NHS and the development of increasingly demanding clinical regulatory standards. It recognised that providers will need to make difficult decisions. It supported the proposed merger with QEH which it thought would mean they were better able to improve services and meet future regulatory and financial challenges. As noted,

it too asked for more information on the financial viability of the new organisations. It also rejected a prescriptive approach to service change. It recommended that the leadership team, working closely with patients, public and local stakeholders, should retain the ability to decide how to ensure the long-term clinical and financial sustainability of the new organisation. It referred to research which shows that proposals for service change only realise the benefits when they are developed and owned by those responsible for their implementation.

Providers generally favoured the acquisition of PRUH by King's College Hospital NHS Foundation Trust, rather than an open procurement process. However, King's Health Partners' support is subject to the detailed operational and financial Outline Business Case which is being prepared by King's College Hospital NHS Foundation Trust and which will take account of the potential impact on the two organisations.

King's Health Partners endorsed the proposal that the DH writes off the debt associated with the accumulation of deficits at SLHT, commenting that it is "*vital to ensure financially sustainable organisations and local health economy in future*". As King's College Hospital NHS Foundation Trust develops its detailed operational and financial Outline Business Case for the acquisition of PRUH, it will gain a greater understanding of the levels of financial support required to deliver the outcome desired by all parties.

10.6 Local authorities

A number of local authorities noted the need for changes to health services in south east London. However, while the London Borough of Bexley expressed its hope that the TSA's proposals will be endorsed, a number of other local authorities, notably the London Borough of Lewisham, raised criticisms and concerns about the proposals. The London Borough of Lewisham questioned both the legality of, and rationale behind, them. It stated its belief that the Trust Special Administrator (TSA) does not have the power to make recommendations which would affect Lewisham Healthcare NHS Trust under the statutory regime. It said that the options analysis undertaken was unbalanced and the method for evaluating and weighting the criteria selected was flawed. It suggested that the TSA has failed to take into account the needs of the local population and to recognise the cost-effectiveness of local partnership arrangements.

Local authorities commenting on the first recommendation agreed with the TSA on the principle of making the most effective use of resources. Indeed, the London Borough of Bexley noted that this is what did *not* happen when three local hospitals were merged to form South London Healthcare NHS Trust (SLHT) three years ago. Local authorities expressed a number of general concerns about how the report seeks to achieve this improved efficiency. Greenwich and Southwark Councils have concerns about the recommendation that the Trust needs to match that of top-performing NHS organisations. They questioned whether this is achievable within existing timescales, or appropriate considering the current health and care context.

The London Borough of Bexley supported the plans to establish a Health Campus. It proposed that the name 'Queen Mary's Hospital' be retained in order to provide a sense of continuity for local people. However, Greenwich Council expressed concerns about the proposed health campus, based largely on a lack of leadership of the site and the potential travel issues.

Local authorities did not take issue with the principle of the early resolution of land problems, both to secure efficiency and, just as important, bolster public confidence and

pride, some adding that health and community should have priority in future plans for the sites.

The recommendation that the Department of Health (DH) provides funds to cover the additional costs of the PFI buildings was generally supported by local authorities which have expressed a view. There was, however, some concern about how residual debts would be handled. Local authorities would be concerned if local services are to be further reduced in order to continue paying for SLHT's historic debt.

There was general agreement with the principle of a community-based care strategy in south east London and the need for this to be appropriately resourced. The London Borough of Lewisham questioned how an expansion of community care is to be provided, contending that *"the TSA's modelling does not appear to include any additional resources for primary care, let alone for the increased demand on social care"*. A number of other local authorities queried how the strategy will be implemented and resourced. Greenwich Council asked for more information on the resourcing implications and how transitional arrangements will be managed. It suggested that this will need to include an understanding as to how Clinical Commissioning Groups (CCGs) will be required to take the decisions necessary to deliver the strategy across the area.

Local authorities generally opposed any changes to UHL's A&E department. Concern was expressed with the modelling which suggests 70-80% of people who currently use Accident and Emergency (A&E) will continue to receive treatment at the Lewisham urgent care centre (UCC). This, if inaccurate, could lead to significantly increased waiting times. There was also a general view that communications will be important to help people understand each service, where to obtain care, and when. The London Borough of Lewisham noted the scale of behaviour change that would be required from patients using such services and suggested that the TSA's draft report does not sufficiently recognise the negative impact of the recommendations on patients, carers and relatives. It outlined specific impacts on older people, and children and families. Greenwich Council similarly outlined a number of arguments against the closure of the A&E unit. It also sought clarity as to the degree to which the finances of the new Greenwich and Lewisham Hospital Trust depended on the closure of the A&E and how the new Trust could implement the recommendations, given its concerns.

Of the two options offered for obstetric-led services, local authorities generally preferred the latter, fearing that the former would not meet the demand, with a particular impact on vulnerable and disadvantaged communities. Greenwich Council was amongst those questioning whether the reduction in the number of maternity units could meet present demand, let alone future projections. It noted that the Health Equalities Impact Assessment (HEIA) should provide further information on this point. The London Borough of Lewisham favoured the alternative proposals for maternity services proposed by Lewisham Healthcare NHS Trust (a five-site option but with UHL's services integrated with maternity services at Queen Elizabeth Hospital (QEH), rather than as a stand-alone unit). It expressed strong concern that quality and safety would suffer under both proposed options. It also pointed to evidence that better outcomes are associated with smaller and medium-sized units. The Council suggested that the alternative proposal offered would means that the majority of women would have the choice of giving birth locally.

The London Borough of Bromley and Kent County Council welcomed the proposals for planned care, so far as their own residents were concerned. Other local authorities had

some concerns, however, some focusing on the travel implications for patients, particularly the elderly and vulnerable. The London Borough of Lewisham strongly questioned the feasibility of the proposals and the assumption that a reduction of the UHL site is possible.

Greenwich Council welcomed the decision to commence early work on the arrangements for the new Greenwich and Lewisham Trust. It sought reassurance that the new Trust is financially viable, can achieve Foundation status by 2014, and that the governance arrangements can ensure compliance of the entire sector. Southwark Council was concerned that this proposal could impact on the clinical and leadership capacity of these trusts at a time of change, which has the potential to impact on patient care and financial sustainability, and that any change to the organisation of healthcare should be locally determined.

Local authorities were generally opposed to a procurement process to find the best organisation to run Princess Royal University Hospital (PRUH). The proposal for the DH to write off SLHT debt was generally agreed with by local authorities.

As with other stakeholder groups, local authorities made a number of comments about assumed travel times, the impact on blue light/ambulance journeys, and the capacity of the London Ambulance Service. The London Borough of Bexley recommended that more modelling is undertaken.

A number of local authorities made comments about the delivery of the proposals, and there were requests for a more detailed implementation plan in the final report. Queries were also raised about the timings and funding of the transitional phase. The London Borough of Bromley argued that there needed to be a senior level body to co-ordinate delivery of the changes. The London Borough of Lewisham pointed to the significant risks of implementation, calling for any risk assessments taken by the TSA to be made available.

10.7 Overview and scrutiny committees

The overview and scrutiny committees responding stressed their interest in ensuring that local residents continue to be able to access high quality services. Bexley Health Overview and Scrutiny Committee welcomed "*the TSA process towards long-term sustainability to the health economy"*. It expressed support for plans to establish a new health campus at Bexley, referring to work in recent years by the London Borough of Bexley and Bexley Clinical Commissioning Group (CCG) to develop the proposal. It requested some reassurances in the final report about other services which were not specifically addressed in the draft report.

Lambeth and Southwark committees welcomed the recommendations to shift more care from hospital buildings into the community. Both, however, were concerned that this should be properly resourced and monitored, so that secondary care is not overwhelmed if there are problems.

Southwark Scrutiny Sub-Committee was concerned by the proposal for a south east London Elective Care Centre and was unconvinced it is necessary to deliver a better service for Southwark's residents. It was particularly concerned at the prospect of residents having to travel to Lewisham for routine surgery as public transport is already expensive for many residents. It also argued that losing the well-established elective surgery units at Guy's and King's College Hospitals (KCH) is a retrograde step. It

recommended that the TSA works closely with KCH and Guy's and St Thomas' NHS Foundation Trust to develop this proposal and establish if it is viable, including whether patient records will be able to be shared on a common IT system. It argued that the private sector should not be involved in the management of any new Elective Care Centre, due to potential conflicts of interest.

All three committees responding were concerned about the knock-on effect of closing or reducing Lewisham's maternity service because existing provision is stretched and the population is projected to increase; any extra burden on KCH and St Thomas' Hospital from reduction in the maternity services at Lewisham should be matched with proper resources and physical space. Southwark Scrutiny Sub-Committee also noted the need for detailed proposals on paediatric and neo-natal services.

Lambeth and Southwark Sub-Committees preferred the proposal for (KCH) to acquire Princess Royal University Hospital (PRUH), Bromley, rather than to run a procurement process. There is considerable confidence in KCH, while take-over by a private sector organisation would, it was argued, compromise the ability of the local NHS to develop improved services and stabilise the changes.

Southwark Scrutiny Sub-Committee expressed its concern that the implementation plan has not been consulted upon, and recommended that this plan is robustly tested and reviewed regularly. It also suggested that opportunities to improve public and mental health services are sought.

10.8 Politicians

Twenty-two submissions were received from political groups or individual politicians. Only one respondent, a local councillor, explicitly argued against the premise that the current situation is unsustainable and that significant change of some sort is necessary. However, recurrent themes are: queries about data and projections underpinning the recommendations; doubts about the feasibility of some targets; the speed with which the report has been produced and of the consultation and decision-making processes; concerns about travel and transport and the perceived optimism of travel times; a sense of injustice that a 'good' Lewisham hospital is being penalised because of the faults of others'; and references back to previous, short-lived proposals for change (notably 'A Picture of Health', 2009).

Most welcomed improved efficiency, but with some concerns. They tended to view the targeted savings as highly ambitious, particularly in the present environment, and that a failure, even by a small margin, to achieve full anticipated efficiency gains within the timetable, could undermine the viability of some of the proposed new structures.

The proposal for Queen Mary's Hospital, Sidcup (QMS) to be turned into a Bexley Health Campus was broadly supported by four MPs. Two however, were concerned about the possible increase in private sector provision which might result there, arguing that services should remain in the NHS. Three submissions raise the question of whether the term 'Campus' was appropriate or understood. There was broad, agreement that the facility should be owned by Oxleas NHS Foundation Trust, although (once again) some politicians were concerned that this could lead to future privatisation, and queried the logic behind Dartford and Gravesham NHS Trust taking on interim responsibility for elective day surgery on the site.

There was considerable unease about the disposal of sites. The general view was that, if land and buildings are definitely not needed for current or future service delivery, then it is appropriate to consider disposal to realise capital and to reduce on-going running costs. Some highlighted the risk that it could prevent expansion of services in the future.

Politicians were generally fully supportive of the Department of Health (DH) providing additional funds to cover the excess costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth (QEH) and Princess Royal University Hospital (PRUH).

Politicians generally welcomed an increased emphasis on community-based care, but most who expressed a view also had concerns about how it will be implemented. Six respondents described the proposals as *"aspirational"* and those commenting on community-based care often felt that the detail of how it would be implemented and funded still needed to be developed to demonstrate that these aspirations could be achieved.

There was very little support from any politician for the plans for the Lewisham site, specifically in relation to Accident and Emergency (A&E) and maternity services, and selling much of the site. Concerns were expressed about the sufficiency of the modelling in the report. There were doubts about the ability of the UCC to cope with the volume of cases required to avoid imposing impossible pressures on the remaining A&Es.

Many respondents applied similar considerations to maternity services, bearing in mind Lewisham's rising birth rate and increased demand for maternity services, concerns about the ability of the four proposed sites to cope with additional patients, and (again) the impact of longer journey times.

Only six submissions commented on the plans for elective care. Politicians mentioned consequential needs for more travel, increased vulnerability to privatisation, and queries over the assumption that all hospitals except Guy's Hospital will use University Hospital Lewisham (UHL) for their non-complex elective work.

Few of this stakeholder group commented on the proposed dissolution of South London Healthcare NHS Trust (SLHT). Most respondents regarded the proposed merger of the QEH site with Lewisham Healthcare NHS Trust as logical, but had some queries about the long-term viability of the Trust. Of the options for the PRUH, respondents who expressed a view all favoured the option of acquisition by King's College Hospital NHS Trust. Politicians favoured writing off SLHT's accumulated debt so that the new organisations are not saddled from day one with unreasonable financial burdens. Measures to ensure that the situation does not recur are put forward, including a transition period and robust administrative and financial procedures.

A number of politicians referred to the short time since the last reorganisation, which created SLHT, and a concern that these latest proposals may be similarly short-lived, particularly in view of the concurrent dissolution of NHS London and introduction of new local clinical commissioning arrangements. Some politicians acknowledged that their experience of the recent past has influenced their confidence in a further set of new organisational proposals.

10.9 Local Involvement Networks (LINks)

LINks responding to the consultation tended to provide a co-ordinated view of their members' responses to each recommendation. Lambeth LINk commented more

generally on the proposals, agreeing that major changes needed to take place, before turning to each recommendation in turn. They stressed, as others did throughout their responses, that patients should be at the heart of any proposed changes. While they stated an understanding that the Health Equalities Impact Assessment (HEIA) could only be carried out once the draft recommendations were in the public domain, they felt that engagement with seldom heard groups most affected by the proposals had not been satisfactory.

Some LINks acknowledged that efficiencies need to be made and that the operational efficiency of South London Healthcare NHS Trust (SLHT) needs to improve, but at the same time raised concerns about the impact of the proposals on the continuity and quality of services. As such, they seek reassurances and explanations from the Trust Special Administrator (TSA) as to the impact of the changes and what will be provided where services change.

The LINks generally supported the concept of providing care in the community and closer to home. They asked for reassurances about how this would be funded and how it will work in practice.

LINk organisations who provided comment opposed the TSA's proposals for delivering urgent and emergency care. Concerns were raised about the lack of capacity at Queen Elizabeth Hospital (QEH), Princess Royal University Hospital (PRUH) and King's College Hospital (KCH) and the lack of definition and detail regarding urgent care centres (UCCs). In particular, they argued that members of the public will not understand the difference between an UCC and Accident and Emergency (A&E), and so may present at the wrong place.

Most of the LINks who responded to the consultation did not support either of the options for maternity services. As with the urgent care proposals, this is largely due to concerns around capacity and the knock-on effect this may have on patient safety. LINks responding also worried about the impact on patient choice and continuity of care. More information on how the proposals would work was requested.

Some LINks highlighted the potential benefits of the planned care proposals; largely that this would be efficient, would free up space at other hospitals and would mean fewer procedures would be cancelled due to emergency procedures taking priority. As such, one or two tended to support the proposals. However, most again expressed concerns about patient safety. The main concern was that there may not be the resources available at UHL to deal with emergency situations should a simple procedure go wrong.

Most LINks agreed with the Trust Special Administrator's (TSA) proposals that the Department of Health (DH) should write off SLHT's debt. However, while they believe it is the right course of action, one or two LINks highlighted that this will mean fewer funds are available for elsewhere in the NHS, but that they feel there is no viable alternative.

Several LINks raised concerns about the impact of the proposals on patient and family transport, including problems with parking, public transport and cost. Most notably, LINks emphasised the impact this may have on vulnerable groups such as older people, people on low incomes and those with mental health problems who may find it especially difficult to travel to their appointments. As such, LINks felt they need more detail about the transport implications of the proposals.

Further detail was also sought on how transitional costs will be funded, how the results of the HEIA will be taken into account, and the impact of proposals on mental health services.

10.10 Union and staff representatives

Responses to the consultation were received from a number of unions and staff side representatives. Amongst this stakeholder group there were calls for an extended and more in-depth consultation with concerns expressed that the time period allowed to form the recommendations was insufficient. Additionally there was concern that any changes made as a result of the recommendations were likely to be enacted faster than would be advisable if the short-term benefits were to be sustainable in the long-term.

Throughout all of the recommendations, questions were raised about the accuracy of data used in the consultation document, particularly in relation to the proposed journey times.

Within this stakeholder group, SLHT Staffside were the only group to explicitly acknowledge the need for change. Whilst GMB acknowledged the financial difficulties of South London Healthcare NHS (SLHT), they felt these difficulties were not as severe as suggested by the Trust Special Administrator (TSA) and could be solved in the main through addressing the Private Finance Initiative (PFI) contracts.

There was broad support for improved efficiencies within SLHT though this recommendation presented a number of questions. Concerns were raised about reductions in staffing levels as many were unconvinced that a decline in staff numbers would pay dividends in financial savings. Additionally it was not understood how a reduction in staff numbers could not adversely compromise quality of care. Requests were made for the TSA to give greater consideration to the particular demographics of the population served by SLHT.

Recommendations 2 and 3 elicited fewer and shorter responses from unions and staff representatives compared to other areas covered by the consultation. Recommendation 2 prompted calls for QMS to retain its name. It was thought a change to ‘Bexley Health Campus’ could discourage service users from attending and thus would erode QMS’s service offering. Unison took this opportunity to stress the adverse effects on patient care that can stem from the involvement of private companies in the NHS. No clear consensus emerged about the involvement of Oxleas NHS Foundation Trust with ambiguities evident in which parts of the site would be transferred or sold, and opposition from GMB on behalf of staff currently working at Queen Mary’s Hospital, Sidcup (QMS).

Although the organisations commenting on Recommendation 3 supported it in principle, many were concerned that SLHT would have a need for the buildings in time and this would accordingly compromise operational abilities.

Unison and GMB strongly approved of the TSA’s recommendation for the Department of Health (DH) to cover the excess costs of the PFI arrangements, acknowledging the detrimental effect these financial arrangements have had on SLHT.

Of the three unions and staff representatives commenting on the proposed strategy for community based care, all were in support of it. In order for this proposal to achieve

success, Unison stressed the need for improvements to the integrated care pathways, greater financial investment in the strategy, robust modelling and protection of the present workforce which was likely to be further stretched by increased travel times to visit patients. Equally, SLHT Staffside emphasised the need for community care to be fully functioning before proposals could possibly be enacted.

The proposed changes to urgent and emergency care were met with some concern by this stakeholder group. It was felt that the proposed changes would result in worsened health outcomes due to increased travel times and A&E capacity issues. Unison, GMB and SLHT Staffside all queried data used in the consultation document.

Of those commenting on the proposed changes to maternity services, Unison/Unison's Community and Voluntary Organisations branch and GMB supported neither option, whilst SLHT Staffside placed a preference for an additional stand-alone unit at University Hospital Lewisham (UHL) (though they expressed strong concerns about patient safety in this scenario). Again the high levels of deprivation within many of the affected boroughs were thought to be important.

In reference to the proposed changes for planned care, Unison were opposed to the effect these would have on UHL specifically. GMB felt planned care should be protected from change as the proposals would result in unacceptable increases to travel times. They did however recognise the benefits of specialisation but felt these benefits could be derived within the current infrastructure. SLHT Staffside felt that elective surgery needed to be maintained at all hospitals to generate income. Additionally they felt the proposed changes would deter patients from using certain hospitals due to increased travel distances and this would leave these hospitals vulnerable to further service closures.

The dissolution of SLHT was only supported by Unison whilst GMB and SLHT Staffside felt the reorganisation would not address the core reasons for SLHT's financial difficulties thus rendering it a distracting exercise. The joint venture of Queen Elizabeth Hospital (QEH) and Lewisham Healthcare NHS Trust was only commented on by Unison and Lewisham NUT. The former was in favour of the move providing the hospitals were entrusted with autonomy in planning future service provision, whilst the latter referenced QEH's inability to cope with any additional workload. The options for running Princess Royal University Hospital (PRUH) elicited various responses that demonstrated an opposition to NHS involvement with private organisations; for SLHT Staffside this also meant involvement with King's College Hospital NHS Foundation Trust. Amongst those commenting, there was strong support for the DH to write off SLHT's accumulated debt.

10.11 Staff

In general, while some staff groups noted the need for change, the specific proposals received little support, with particular opposition from those based in Lewisham. For example, a group of GPs in Lewisham who responded remarked on the proposals affecting University Hospital Lewisham (UHL) despite the fact that it is a solvent, successful organisation, delivering high quality care.

A few staff groups commented on the practicalities of improving efficiency and stressed that efficiency gains must be made without compromising quality. Other staff groups commented on this recommendation in relation to the impact on their own area of interest. There was little comment from staff on Recommendations 2-4, although

roundtable staff discussions are Queen Elizabeth Hospital (QEH) suggested the selling of land should only be viewed as a short-term fix.

Staff groups were mixed in their support of changes to the way in which services are provided. Most commenting on community care caveated their support on the basis that there is little evidence that, in its current form, it could deal with the proposed changes, and also pointed to a lack of detail in the TSA report on how it will work in practice, pointing to questions around financing, management structures, patient education and the overall timescales for implementation.

Those based in Lewisham Healthcare NHS Trust were strongly opposed to the proposed changes to urgent and emergency care and questioned the closure of, what they view as, a high performing unit. For example, Lewisham Healthcare NHS Trust consultant general surgeons noted that UHL already achieves the majority of clinical quality standards and so questioned why the changes to its Accident and Emergency (A&E) have been proposed. The consultant ITU team similarly argued that the Lewisham Intensive Care Unit (ICU) is one of the better performing units in the country and the recommendations will disproportionately hit critically ill patients from the most deprived areas of south east London

Some staff responses paid specific attention to the loss of the children's A&E department and the impact of the proposals on children more generally. For example, clinicians from the Children and Young People's Service at Lewisham Healthcare NHS Trust expressed concern that the recommendations make no reference to how the proposed changes will affect the provision of children's services. They expressed particular surprise that the Health Equalities Impact Assessment (HEIA) has not been available for public consultation.

Several responses from Lewisham Healthcare NHS Trust staff talked of, consequences of the plans for urgent and emergency care including fragmentation of services and impacts on patient outcomes in terms of safety and quality of care. Among other things, they suggested the proposals will lead to greater travel costs, increased lengths of stay and will have a detrimental impact on achieving community care goals as effective communication will be much harder to establish across more centres.

Further, they argued the urgent care centre (UCC) model is un-tested, and in contrast to the 77% of patients that it is anticipated will continue to use the UCC in Lewisham, they suggested this figure will be closer to 30%. This is a result of a variety of factors including the fact that the proposed referral pattern is not workable; the non-admitting nature of the UCC will impact on numbers of patients using the hospital for planned care and leads them to question whether other hospitals will be able to deal with the resulting increases in patient flows. These concerns about capacity were also raised by those outside Lewisham. The loss of specialist skills and impact on teaching and training were also mentioned.

Staff groups supported retaining an obstetric service on the Lewisham site, but had concerns about the practicalities of operating a low risk unit that is isolated from other acute services on the basis that it is neither safe nor sustainable. Again, they also questioned whether other sites will be able to cope, and believe that local women will choose to use King's College Hospital (KCH) and St Thomas's instead of QEH. Those responding referred to the more complex patient pathways and the resulting potential for breakdown in communication placing mothers and children, many of whom are particularly vulnerable, at increased risk, and suggested that this safeguarding

responsibility has been inadequately considered. Lewisham Healthcare NHS Trust Gynaecology and Obstetrics Consultants expressed serious reservations about the two proposed options for maternity care, describing them as unsustainable and unsafe. They questioned the concept of *"lower risk obstetric-led births"* and the sustainability of the site with the number of low risk births that would take place. They also expressed concerns about a lack of support from acute services and ITU to a stand-alone obstetric unit, They have put forward an option which maintains a consultant-led obstetric service at UHL with appropriate back-up from other clinical specialities, with redistribution of high risk patients.

Similarly, Lewisham Healthcare NHS Trust Consultant General Surgeons were concerned about the viability of an elective centre at Lewisham, particularly one surrounded by other local hospitals alongside critical care services, and as noted above, one with a lack of referrals from a local emergency department.

Few commented on the organisational changes proposed within Recommendation 6, and views were mixed. For example, West Kent Eye Centre was supportive and Lewisham Healthcare NHS Trust Ear, Nose and Throat consultants said the merger appears sensible but stressed that it must be clinically-led. A number of responses, particularly those from Lewisham Healthcare NHS Trust staff, argued for local determination, i.e. more local control over the changes, taking a patient-centred approach to healthcare. For example, Lewisham Healthcare NHS Trust Emergency Department Consultants strongly urged that the proposed merged trusts, local GPs and local residents are left to decide on service configuration. Similarly, the Trust's Consultant and Specialist Doctors outlined their belief that the distribution of acute and elective services across the two sites of the future merged trust should be left to *"its new management, insofar as they can be resourced by and agreed with the CCGs of Lewisham and Greenwich, as they are best placed to represent the interests of their local populations."*

Those mentioning it in their submission were in favour of PRUH being run by KCH, but there were some concerns over how this will happen in practice.

A few staff groups commented on the impact of the proposals on travel. They argued that the proposed journey times are unrealistic as they were calculated without traffic. Staff in Lewisham also pointed to the disproportionate impact on local residents, particularly those on low incomes, the elderly and those reliant on public transport. KCH Older People's Committee focused on the impact on medical staff of congestion and lack of parking facilities.

The Director of Medical Education at South London Healthcare NHS Trust (SLHT) provided a practical comment on the implementation of the plans, in relation to the timing of any organisational change. He suggested that it would make sense to synchronise these changes with the major rotations for trainee doctors, i.e. the first Wednesday in August, and also the first Wednesday in December and April each year, which are times when change is already expected.

10.12 Education and training bodies

Submissions were received from four education and training bodies. Generally, it would seem these organisations agree with the need for change, but Lewisham GP Vocational Training Scheme argued that the changes should not only be financially driven, but must be matched by considered management processes. From an educational perspective,

there appears to be a view that training is often one of the first areas to experience efficiency savings or "*cuts*", indeed it was noted that it is not referred to in the Trust Special Administrator's (TSA) report. However, these education and training bodies argued it can actually facilitate efficiency gains by helping to embed culture change, and are keen to work with the TSA to ensure this occurs.

The South London Local Education and Training Board and the London Deanery both supported the plans to establish a new healthcare campus at Bexley, with the former suggesting it would be an ideal co-ordinating site for one of its planned Community Education Hubs. In any reorganisation, both these bodies requested the TSA considers space for education is provided.

Lewisham GPs Vocational Training Scheme echoed the concerns of Lewisham groups elsewhere, that the loss of Accident and Emergency (A&E) in the borough will reduce the ability of remaining services to operate safely and effectively. For example, they queried what will happen in the event of post-operative complications. They also identified risks in terms of safeguarding children and women, particularly in relation to proposed changes in maternity care. They suggested that the best solution would be the integration of care from CCGs and local hospitals.

Lewisham GPs Vocational Training Scheme was joined by GP Educators in south east London in their concern that the loss of acute medicine in Lewisham will also impact significantly on training opportunities for doctors in the area, which could impact on recruitment to local jobs.

As with other stakeholder groups, there was some comment on movement between sites within the new configuration. For example, GP Educators in south east London identified a risk in terms of moving clinicians and patients resulting in a loss of information and disjointed care. They also suggested that thought must be given to the impact on the ambulance service and how those with basic but urgent and acute problems will be managed.

10.13 Independent sector

One submission was received from a stakeholder within the independent sector, Serco. They stated that they believe the extent of the problems facing healthcare in south east London have been communicated clearly, and solutions presented are reasonable to achieve the required change. They noted that the savings modelled regarding operational efficiency are achievable, and that the concept of a shared Elective Care Centre of Excellence could benefit the wider health economy. Although they support the proposed changes to South London Healthcare NHS Trust (SLHT), they felt there is *"great opportunity to combine efficiency with important improvements to patient experience and care quality".*

10.14 Other community and expert patient groups

A range of community and expert patient groups responded to the consultation from across south east London. Most concentrated on Recommendation 5 and specifically the plans for University Hospital Lewisham (UHL). A number of common themes emerged across many of the responses.

Firstly, they talked about the size of the population in south east London, its potential growth in the coming years and its relative deprivation. For example, Lewisham People Before Profit stated that the proposals do not take into account plans for new homes in the area, attracting young families with needs for a range of services. Commenting specifically on the proposals for maternity care, the Stillbirth and Neonatal Death Society (South East London) expressed concern that a full Health Equalities Impact Assessment (HEIA) was not completed before the draft recommendations were published.

Stakeholders' main comments were around local residents' access to care, particularly emergency care. The proposed changes to UHL's Accident and Emergency (A&E) were of concern to these respondents, who referred to capacity issues at other hospitals. Some recognised the value of the proposed urgent care centre (UCC), but there were questions about the accuracy of patient flow modelling. For example, the Charlton Central Residents' Association suggested that many people will still go to A&E regardless. Goldsmiths, University of London noted there were no plans to increase capacity at other sites.

Several of the responses raised the issue of travel times and the need for better transport links if patients are to be able to access care easily. Disability Voice Bromley highlighted this particular issue for disabled people, who may be reliant on public transport or specialist door-to-door transport as visitors, or on patient transport as patients. They felt it imperative that the full impact of the proposed changes on travel times and ease of travel from different parts of the borough was investigated and adverse outcomes ameliorated.

A number of responses were received from local branches of the National Childbirth Trust who made several points about the recommendations for maternity care. They felt that obstetric services should be retained at UHL, with midwife-led centres available at all local hospitals, so that women's choices would not be reduced. They questioned the evidence that larger units provide safer, more effective care and said that consideration should be given to retaining a stand-alone midwife-led unit on any site facing the closure of birthing services.

Several of the responses commented on the Private Finance Initiative (PFI) debt, and commented on the perceived unfairness of the consequences for UHL. Save Lewisham Hospital stated that UHL was outside the Trust Special Administrator's (TSA) remit, and felt that the recommendations would lead to worsening care for local residents. It felt that the TSA should have carried out a full HEIA before publishing the draft report to help shape the recommendations for consultation. King's College Hospital's Older People's Committee suggested that the proposals *"represent an experiment with no basis in evidence"*, and argued that generally the TSA's review fails the four tests laid down by the Secretary of State for Health and will lead to a reduction in the quality of clinical care.

10.15 Other health bodies

Other health bodies responding included local GP practices, hospices and local networks. Their responses tended to focus on the proposals for transforming care in south east London. Several noted the deprivation within the area and were concerned that the recommendations would have a negative impact on local residents and widen health inequalities. They commented on the lack of an Health Equalities Impact Assessment (HEIA) prior to the publication of the draft recommendations. Amersham Vale Practice in particular called this a *"shocking failure"*.

There was some recognition of the problems faced by South London Healthcare NHS Trust (SLHT) and the need for action, both to ensure financial sustainability and clinical safety. However, several of the health bodies responding, particularly GP practices, expressed concerns about the proposed changes to University Hospital Lewisham, in relation to urgent and emergency care, paediatrics and maternity.

Some questioned the modelling of patient flows for emergency care, suggesting that patients would be more likely to attend King's College Hospital (KCH). They did not believe there would be capacity across other local hospitals to cope with increased demand from Lewisham.

Several commented on the lack of attention paid to paediatrics in the draft report, saying that it omitted to mention the services provided at University Hospital Lewisham (UHL) for the children and families of Lewisham, and the impact of the proposals on these services.

In the opinion of most of those commenting, a stand-alone obstetric unit would not be a safe or viable option. They also tended to reject the other option of the current obstetric-led deliveries being transferred to other providers; it was not felt to be viable as they were already struggling with capacity.

While there was strong agreement with the need for high quality community care, health bodies responding asked for more information on how this would be funded and provided. GP practices also referred to the draft report's statement that primary care could manage a significant amount of work that is currently provided in hospitals. They emphasised that there would need to be investment for this to be successful. This point was also made by London-wide Local Medical Committees, who said that careful time and contract management would be needed.

Similarly, a few GP practices pointed to the fact that social care is a crucial element of community care, not only to prevent admission or readmission into hospital, but also to maintain the health of people living with long-term conditions.

The South London Cardiovascular and Stroke Network noted some specific points about the proposals. For example, it asked for consideration to be given to the medical support a stroke unit needs and how this could be met in services proposed for the Lewisham hospital site. They also wanted greater clarity in the implementation plan as to how a combined trust would manage its emergency and elective services, and which cardiac services would remain on the Lewisham site.

10.16 Other stakeholders

A number of stakeholder responses did not fall into the previously defined categories, and have been grouped within a separate category. Where appropriate some responses have been discussed together.

The Lewisham Healthcare NHS Trust Safeguarding Children and Young People and Vulnerable Adults Committee expressed deep concern that safeguarding of vulnerable people within the borough would be adversely affected due to the draft recommendations. They had concerns regarding both options for maternity care in the area, and highlighted a loss of integrated health and social care teams that support many highly vulnerable women. Lewisham Safeguarding Children Board provided a

similar response to the consultation, and emphasised that proposed changes relating to A&E and maternity services in Lewisham are likely to have a detrimental effect on the welfare of children.

Lewisham Adult and Older Adult Mental Health Commissioning was concerned by the proposal to close Lewisham Accident and Emergency (A&E), and the affect this will have on mental health services and patients in the borough. They stated that the Trust Special Administrator (TSA) draft report does not outline the effect on mental health services or service users of the planned proposals. They argued that although an urgent care centre (UCC) may provide a level of access for psychiatric patients, it is unfeasible that a full psychiatric liaison service will be retained without a fully functional A&E department. They suggested that if the proposals do go ahead, a full impact assessment on mental health needs to be undertaken and actions planned to minimise the effect on this population.

The Lewisham Director of Public Health submission focused on concerns relating to emergency care, maternity services and community based care. The paper intentionally identified only the most important potential negative impacts of each recommendation, which it noted will affect the health and wellbeing of Lewisham residents. Where possible, the paper identified a number of factors which may mitigate the potential negative effects of the recommendation; for example consultant-led paediatric specialist support for the UCC or joint care planning to reduce the loss of continuity of care for children and mothers.

11. Appendices

Appendix A: Glossary

A&E: Accident and Emergency

CCG: Clinical Commissioning Group

DH: Department of Health

HEIA: Health Equalities Impact Assessment

KCH: King's College Hospital

ICU: Intensive Care Unit

LINks: Local Involvement Networks

NHS: National Health Service

NED: Non-Executive Director

NUT: National Union of Teachers'

PFI: Private Finance Initiative

PRUH: Princess Royal University Hospital

QEH: Queen Elizabeth Hospital

QMS: Queen Mary's Hospital, Sidcup

RCOG: Royal College of Obstetrics and Gynaecology

SHA: Strategic Health Authority

SLHT: South London Healthcare NHS Trust

TSA: Trust Special Administrator

UCC: urgent care centre

UHL: University Hospital Lewisham

Appendix B: Demographic information

Demographic information, where this information has been recorded via the response form, is given below, although it is important to bear in mind that this is just a subset of the consultation participants and cannot be taken to be representative of the consultation participants in general. (It should be noted that all percentages referred to below are rounded to the nearest whole number, and that when two or more such figures are added, it can create rounding error; the rounded figures given in a column, therefore, may not sum to exactly 100%.)

Comparative figures for the population of south east London (where available) are also provided.[16]

Table A1

Consultation responses by gender

Gender	Number of responses	% of responses giving gender[17]	% of population in south east London
Male	2586	37	49
Female	4200	60	51
Prefer not to say	250	4	N/A
Stating gender	7034		
Not answered	91		
Total	***7125***[18]		

Source: Ipsos MORI

[16] Source: Census 2011

[17] Please note percentages are not directly comparable with the percentages given for south east London because a category is also included in the table for 'prefer not to say'.

[18] Those completing a hard copy response form were able to allocate themselves to one or more of these categories, so responses to this question do not sum to the total.

Table A2

Consultation responses by age

Age	Number of responses	% of responses giving age[19]	% of population in south east London
Under 18	28	*	22
18-24	228	3	13
25-44	2921	42	35
45-64	2652	38	22
65+	1004	14	11
Prefer not to say	201	3	N/A
Stating age	7034		
Not answered	91		
Total	***7125***		

Source: Ipsos MORI

[19] Please note percentages are not directly comparable with the percentages given for south east London because a category is also included in the table for 'prefer not to say'.

Table A3

Consultation responses by borough

Borough	Number of responses	% of responses giving borough[20]	% of population in south east London
Bexley	341	5	14
Bromley	768	11	19
Greenwich	771	11	15
Lambeth	72	1	18
Lewisham	4,110	59	17
Southwark	193	3	17
None of these	310	4	N/A
Prefer not to say	437	6	N/A
Stating borough	6999		
Not answered	126		
Total	***7125***[21]		

Source: Ipsos MORI

[20] Please note percentages are not directly comparable with the percentages given for south east London because a category is also included in the table for 'prefer not to say'.
[21] Those completing a hard copy response form were able to allocate themselves to one or more of these categories, so responses to this question do not sum to the total.

Table A4

Consultation responses by ethnicity

Ethnicity	Number of responses	% of responses stating ethnicity[22]	% of population in south east London
White	5336	76	66
Mixed	183	3	5
Asian or Asian British	240	3	6
Black or Black British	419	6	19
Chinese	46	1	2
Other	135	2	2
Prefer not to say	655	9	N/A
Stating ethnicity	7010		
Not answered	115		
Total	***7125***[23]		

Source: Ipsos MORI

[22] Please note percentages are not directly comparable with the percentages given for south east London because a category is also included in the table for 'prefer not to say'.
[23] Those completing a hard copy response form were able to allocate themselves to one or more of these categories, so responses to this question do not sum to the total.

Appendix C: Petitions and campaigns

The text of each petition/campaign that was received is detailed here

Petition 1:

Keep politics out of NHS. Doctors and nurses and medical staff are very capable to run NHS services (*hand written comment – slightly illegible*)

Petition 2:

Save Lewisham Hospital - A&E and Maternity Services under threat

Earlier this year, South London Healthcare NHS Trust went “bust”. The Lib-Dem/Tory Government appointed a Special Administrator who proposed closing Lewisham’s Accident and Emergency Unit, slashing Lewisham’s maternity services and merging Lewisham health services with those in Greenwich.

Lewisham Labour’s Mayor, MPs and Councillors strongly object to these outrageous proposals as they spell the end of Lewisham Hospital as we know it.

We will be doing everything we can to save Lewisham’s A&E and Maternity Services from the worst of the libdem/tory government’s cuts in Lewisham and arguing that people across South London should have the full benefit of good quality NHS services.

KEEP LEWISHAM’S FULL A&E AND MATERNITY SERVICES OPEN

We, the undersigned, note with great concern the proposals in respect of A&E and maternity services at Lewisham Hospital contained in the draft report of the Special Administrator of the South London Healthcare Trust published on 29 October 2012.

We believe a full admitting A&E services and a full maternity service at Lewisham Hospital must remain and ask the Administrator to amend his final recommendations to the Secretary of State to reflect this.

We further call upon the Secretary of State for Health to reject any recommendations put to him which would result in reductions in the services provided to residents of Lewisham by Lewisham Hospital.

Petition 3:

I am writing to state that I am against the proposed plans to close Lewisham A&E. The plans will not result in improved services, actual financial gains or support for a long-term strategy in line with the future of the NHS.

The demise of A&E services at Lewisham hospital will indirectly cause a massive financial burden to other services (e.g. ambulance services).

I beg you to take a moral stand and halt this consultation process as its proposals do not serve any of the stakeholders involved.

Petition 4:

I am writing to object to the current proposal to close the accident and emergency department and remove maternity services at Lewisham hospital. This proposal would results in only one fully functioning accident and emergency unit to serve the three

quarters of a million people who live in Bexley, Greenwich and Lewisham. This is not acceptable. The plans regarding a stand-alone UCC have been completely discredited by the clinical staff at Lewisham hospital who have stated that “On review of our case mix, by our estimation at most only 30% of the total attendances to the present-day combined ED and UCC could be safely managed in a stand-alone UCC”.

According to David Cameron, *Hansard*, 31 October 2012; Vol. 552, c. 230: there will be no changes to NHS Configurations unless they have:

1. The support of local GPs
2. Unless they have strong public and patient engagement
3. Unless they are backed by sound clinical evidence
4. Unless they provide support for patient choice

The current situation at Lewisham, does not meet even one of these criteria.

1. Local GPs have written as a group to the consultation to express their concerns that the proposed plan will risk the health and wellbeing of the community those GPs serve.
2. There has been an appalling lack of proper consultation with the public. The public in turn have voiced their complete disagreement with the plan as can clearly be seen by the overwhelming numbers that marched through Lewisham last Saturday.
3. As I mentioned above, the clinical evidence has been discredited by the clinicians who serve at Lewisham hospital.
4. The results of the proposal leaves one A&E unit serving the people in Bexley, Greenwich and Lewisham. Surely you cannot consider this aligned with the aims and intentions of Patient Choice?

I insist that you respect the remit given by the prime minister and halt the current consultation process.

Petition 5:

We, the residents of Bentley Court Retirement flats, Whitburn Road, Lewisham SE13 7US, strongly oppose the proposed withdrawal of the full 24 hour A and E facility at Lewisham Hospital. This brand new, state of the art department was upgraded very recently at great expense and it is desperately needed in this area with its high incidence of “red alert” cases needing emergency inpatient treatment. Closure of Lewisham A and E would force these cases, many of them affecting the elderly and other vulnerable groups, to be taken to Woolwich or King’s College Hospital through some of the worst traffic black-spots in London. This could quite conceivably lead to loss of life. We also oppose the closure of the acclaimed Maternity and neonatal facility which is recognised as being one of the best in the country and has also been in operation for a very short time.

We urge you to re-think your proposed strategy and put patients before penny-pinching.

Petition 6:

Last Saturday, I marched along with thousands of others to demonstrate against the proposed plans to close the A&E and maternity services at Lewisham. If these proposals

are acted upon, the people of this borough and beyond will be left with poorer, less accessible and more inconvenient services. What are the benefits of these proposals? The benefits are supposed to be that the current financial difficulties that are being faced by South London Healthcare NHS Trust will be resolved. However, the proposal forgets to take account of the incredibly complex financial burdens that are placed on a society that neglects to provide quality care to all of its citizens regardless of their individual financial circumstances. If the plan is to save money and have a casual regard for the real vision behind the NHS, then that plan will sow the seeds for the disintegration of the NHS. The long-term costs will be far greater than the burden that exists currently.

I fully appreciate that there is no funding to continue to support the South London Healthcare NHS Trust. Therefore, we need a proper and legal clinical review of services across south-east London not the current consultation which has ignored the input of key stakeholders such as the clinical staff who work at Lewisham A&E.

I urge you to halt the current consultation and proceed with a course of action that will resolve the financial difficulties at the South London Healthcare NHS Trust without causing irreparable damage to the services in this part of London.

Petition 7:

Save Lewisham Hospital!

A “special administrator” was appointed by the government to propose solutions to the financial crisis in neighbouring Queen Elizabeth Hospital, Woolwich (QEH) and Princess Royal University Hospital, Bromley (PRU) – a crisis caused by crippling PFI debts.

His “solution” is to close Lewisham A+E, including its children’s A+E, so it will no longer admit sick patients. That means Lewisham will also lose its emergency medical, surgical and paediatric services and intensive care unit. This is despite the fact that Lewisham Hospital is not in debt and is a very busy, popular and clinically well performing hospital!

He hopes this will divert patients, and therefore money, towards QEH. He wants to sell two thirds of the Lewisham site to pay the debts in the neighbouring hospitals. Closing Lewisham A+E will be a disaster, not only for the people of Lewisham, but also for Greenwich and Bexley.

If Lewisham A+E closes that will mean 3 boroughs with a population of 750,000 sharing one A+E, at Queen Elizabeth, Woolwich.

It will mean long journeys for sick people from Lewisham. It will overwhelm QEH, where £100 million of cuts are being made, and it could cost lives.

Lewisham could lose its maternity services with its popular new Birth Centre and the 4000 woman who give birth there each year would have to go to already overstretched units in other hospitals. The maternity doctors in Lewisham have said the alternative proposal of a “stand-alone” maternity, without emergency backup such as blood transfusion, is unsafe.

These plans are not supported by Lewisham Hospital doctors, nurses or local GPs.

See the Save Lewisham Hospital campaign website for guidance on completing the online form

This form is long and not always clear what the questions mean, so if you don't want to answer any questions you should just leave them.

The most important questions are:

Question 13 about the plans to close Lewisham A+E. We suggest you ANSWER 'Strongly Oppose' to Question 13.

ANSWER question 14 to say why Lewisham Hospital needs it A+E and emergency care to stay open.

Question 15 is about the plans for maternity services. We suggest you ANSWER "I do not support either of these options" to Question 15.

ANSWER Question 16 to say why we need to keep our maternity unit with full emergency back-up for safe maternity care in Lewisham Hospital.

You can speed through the other questions with 'strongly disagree' or 'next'

We, the undersigned, note with great concern the proposals in respect of A&E and maternity services at Lewisham Hospital contained in the draft report of the Special Administrator of the South London Healthcare Trust published on 29 October 2012.

We believe a full admitting A&E service and a full maternity service at Lewisham Hospital must remain and ask the Administrator to amend his final recommendations to the Secretary of State to reflect this.

We further call upon the Secretary of State for Health to reject any recommendations put to him which would result in reductions in the services provided to residents of Lewisham by Lewisham Hospital.

Petition 8:

A petition against the closure of Lewisham Hospital Accident and Emergency Department signed on behalf of members of Lewisham Seventh Day Adventist Church and local residents.

We the undersigned note with great concern the proposals in respect of A&E and Maternity services at Lewisham Hospital contained in the draft report of the Special Administrator of the South London Healthcare Trust published on 29 October 2012.

We believe a full admitting A&E service and a full maternity service at Lewisham Hospital must remain and ask the Administrator to amend his final recommendations to the Secretary of State to reflect this.

We further call upon the Secretary of State for Health to reject any recommendations put to him which would result in reductions in the services provided to residents of Lewisham by Lewisham Hospital.

Lewisham Seventh Day Adventist church members believe these changes would have a deleterious and in some cases fatal impact on residents of the borough and vehemently oppose the closure of A&E and changes to maternity services.

Petition 9:

We are from Lewisham Speaking Up an independent Charity set up for and by people with learning disabilities and we say: Stop the closure of Lewisham Hospital A&E. Please sign our petition.

Petition 10:

We, the undersigned, note with great concern the proposals in respect of A&E and maternity services at Lewisham Hospital contained in the draft report of the Special Administrator of the South London Healthcare Trust published on 29 October 2012.

We believe a full admitting A&E service and a full maternity service at Lewisham Hospital must remain and ask the Administrator to amend his final recommendations to the Secretary of State to reflect this.

We further call upon the Secretary of State for Health to reject any recommendations put to him which would result in reductions in the services provided to residents of Lewisham by Lewisham Hospital.

Petition 11:

Save Lewisham Accident & Emergency Dept

We, the undersigned, note with great concern the proposals in respect of A&E and maternity services at Lewisham Hospital contained in the draft report of the Special Administrator of the South London Healthcare Trust published on 29 October 2012.

We believe a full admitting A&E service and a full maternity service at Lewisham Hospital must remain and ask the Administrator to amend his final recommendations to the Secretary of State to reflect this.

We further call upon the Secretary of State for Health to reject any recommendations put to him which would result in reductions in the services provided to residents of Lewisham by Lewisham Hospital.

Petition 12:

We, health workers in Southeast London, have grave concerns about the proposal to downgrade emergency medical and surgical services at Lewisham Hospital made by the Trust Special Administrator (TSA) for South London Healthcare NHS Trust. Lewisham Hospital is not part of that trust. It is a solvent, successful organization that delivers high-quality care to its patients. Yet the TSA has taken the extraordinary view that Lewisham's Accident and Emergency Department should close to admissions, leading to closure of acute services including full maternity services, and that most of the hospital site be sold.

Emergency services are vital for the population of Lewisham, which contains some of the most deprived wards in England. Lewisham Hospital's new £12 million A&E department opened as recently as April 2012 in response to the need for expanded services. The TSA's report asserts that the need for emergency care would be reduced by 30% simply by providing more care in the community. However, there is simply no clinical evidence to back this up. In any case Lewisham Hospital has already been innovative in working with social services to provide more care at home and avoid admissions in patients with chronic illness. Our intensive care unit has excellent

standardised mortality rates. Our new birthing centre has high maternal satisfaction and provides high-quality care to a community with a high proportion of ‘high risk’ births, which would be jeopardised if maternity services are lost or downgraded. Lewisham Hospital features in the top 40 hospitals in the CHKS rankings. If its acute services are lost, they could not be provided by others without risking patients' safety and quality of care.

The TSA’s review fails the “four tests” that you and the Secretary of State for Health have recently laid down in Parliament. It does not have the backing of GPs. It does not have public support, as the demonstrations, public meetings and the petition have shown. It is not based on sound clinical evidence (detailed responses from groups of clinicians, including GPs, are at http://www.savelewishamhospital.com/). Even the report itself acknowledges that it will not improve patient choice.

Your government's response to this report has an importance beyond Lewisham. The report is an attempted regional reconfiguration, tacked onto the statutory regime for an unsustainable provider, which is being used here for the first time ever. The report was drawn up to statutory timescales that are much too short for a considered reconfiguration, with the result that the clinical consultation is desultory and the clinical evidence is of poor quality. If this report is accepted as it stands, it will create a dangerous precedent for the rest of England. Furthermore, the TSA has produced a report which perversely recommends that a solvent and successful organisation be punished to save a separate, unsustainable provider. We doubt that this is a signal that you will want to send to the NHS and the public.

We urge you and the Secretary of State for Health to reject the recommendation that Lewisham Hospital lose its A&E and acute services.

Petition 13:

We, doctors in Lewisham, have grave concerns about the proposal to downgrade emergency medical and surgical services at Lewisham Hospital made by the Trust Special Administrator (TSA) for South London Healthcare NHS Trust. Lewisham Hospital is not part of that trust. It is a solvent, successful organisation that delivers high-quality care to its patients. Yet the TSA has taken the extraordinary view that Lewisham’s Accident and Emergency Department should close to admissions, leading to closure of acute services including full maternity services, and that most of the hospital site be sold.

Emergency services are vital for the population of Lewisham, which contains some of the most deprived wards in England. Lewisham Hospital’s new £12 million A&E department opened as recently as April 2012 in response to the need for expanded services. The TSA’s report asserts that the need for emergency care would be reduced by 30% simply by providing more care in the community. However, there is simply no clinical evidence to back this up. In any case Lewisham Hospital has already been innovative in working with social services to provide more care at home and avoid admissions in patients with chronic illness. Our intensive care unit has excellent standardised mortality rates. Our new birthing centre has high maternal satisfaction and provides high-quality care to a community with a high proportion of ‘high risk’ births, which would be jeopardised if maternity services are lost or downgraded. Lewisham Hospital features in the top 40 hospitals in the CHKS rankings. It its acute services are lost, they could not be provided by others without risking patients' safety and quality of care.

The TSA's review fails the "four tests" that you and the Secretary of State for Health have recently laid down in Parliament. It does not have the backing of GPs. It does not have public support, as the demonstrations, public meetings and the petition have shown. It is not based on sound clinical evidence (detailed responses from groups of clinicians, including GPs, are at http://www.savelewishamhospital.com/). Even the report itself acknowledges that it will not improve patient choice.

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We urge you and the Secretary of State for Health to reject the recommendation that Lewisham Hospital lose its A&E and acute services.

Petition 14:

Save Lewisham Accident & Emergency Dept

We, the undersigned, note with great concern the proposals in respect of A&E and maternity services at Lewisham Hospital contained in the draft report of the Special Administrator of the South London Healthcare Trust published on 29 October 2012.

We believe a full admitting A&E service and a full maternity service at Lewisham Hospital must remain and ask the Administrator to amend his final recommendations to the Secretary of State to reflect this.

We further call upon the Secretary of State for Health to reject any recommendations put to him which would result in reductions in the services provided to residents of Lewisham by Lewisham Hospital.

Petition 15:

We, the undersigned, note with great concern the proposals in respect of A&E and maternity services at Lewisham Hospital contained in the draft report of the Special Administrator of the South London Healthcare Trust published on 29 October 2012.

We believe a full admitting A&E service and a full maternity service at Lewisham Hospital must remain and ask the Administrator to amend his final recommendations to the Secretary of State to reflect this.

We further call upon the Secretary of State for Health to reject any recommendations put to him which would result in reductions in the services provided to residents of Lewisham by Lewisham Hospital.

Campaign response:

Dear Mr Kershaw, Trust Special Administrator

Please accept this as my contribution to the consultation on the draft proposals on the NHS in south east London and in particular for Lewisham Hospital. I have been unable to find a copy of the official consultation response forms.

In answer to Question 13, I strongly oppose these proposals as they will lead to the closure of Lewisham Accident and Emergency Department, and its medical, surgical, paediatric and intensive care beds.

Comment: (*space provided to add comment*)

In answer to Question 15 on maternity services, I do not support either of these options. Both options are unacceptable as they would leave Lewisham without a maternity unit with full medical, surgical and intensive care back up for emergencies.

Comment: (*space provided to add comment*)

Travel time to Queen Elizabeth Hospital, Woolwich

It would take me ……. (time) to get to Queen Elizabeth Hospital by bus/car (delete as applicable) compared with ……. (time) to get to Lewisham Hospital.

Comment: (*space provided to add comment*)

Appendix D: Responses from organisations and groups

Stakeholder analysis

The Trust Special Administrator (TSA) was required to consult a small number of stakeholders under statutory guidance. However, recognising the need for wide engagement on the recommendations, an expanded list of stakeholders were invited to respond to the consultation. Where these stakeholders have responded by letter and email, their comments have been analysed qualitatively as part of the stakeholder analysis in Chapter 10[24]. Where they have responded by response form, their responses to the closed questions have been included in the closed question analysis throughout the report and their free-text comments have been included in the analysis in Chapter 10.

National bodies
Care Quality Commission
Cooperation and Competition Panel
Independent Reconfiguration Panel
Monitor
NHS Commissioning Board

Royal Colleges
College of Emergency Medicine, London Board
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians

Strategic Health Authorities
NHS London
NHS South of England

Commissioners
Bexley Clinical Commissioning Group
Bromley Clinical Commissioning Group
Dartford, Gravesham and Swanley Clinical Commissioning Group
Greenwich Clinical Commissioning Group
Lambeth Clinical Commissioning Group
Lewisham Clinical Commissioning Group
London Specialised Commissioning Group
NHS South East London
NHS South West London

[24] Please note that the National Clinical Advisory Team also submitted a response, but it was received too late to be included in the analysis.

Southwark Clinical Commissioning Group
West Kent Clinical Commissioning Group

Provider Trusts
Bromley Healthcare
Dartford and Gravesham NHS Trust
King's Health Partners[25]
Lewisham Healthcare NHS Trust
London Ambulance Service NHS Trust
Oxleas NHS Foundation Trust
South London Healthcare NHS Trust Former Chair and Non-Executive Directors

Local authorities
Bexley Council
Bromley Council
Greenwich Council
Kent County Council
Lambeth Council
Lewisham Council
London Assembly Health and Environment Committee
Southwark Council

Overview and Scrutiny Committees
Bexley Health Overview and Scrutiny Committee
Lambeth Council's Health and Adult Services Scrutiny Sub-Committee
Southwark Council's Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

Politicians
Bellingham's Councillors
Bexley, Bromley and Greenwich Constituency Labour Parties
Bob Neill MP
Boris Johnson, Mayor of London
Clive Efford MP
Councillor Amanda De Ryk
Councillor Chris Best
David Evenett MP
Greenwich Conservative Council
Harriet Harman MP and Tessa Jowell MP
Heidi Alexander MP
James Brokenshire MP
Jim Dowd MP
Jo Johnson MP
Joan Ruddock MP
Len Duvall AM
Lewisham Green Party
Lewisham Liberal Democrat Council Group
Lewisham Liberal Democrats
Lewisham West and Penge Constituency Labour Party

[25] King's Health Partners includes Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, King's College London and South London and Maudsley NHS Foundation Trust

London Assembly Labour
Nick Raynsford MP
Penge and Cator Councillors
Teresa Pearce MP

Local Involvement Networks (LINks)
Bexley LINk
Bromley LINk
Greenwich LINk
Kent LINk
Lambeth LINk
Lewisham LINk
Mid Surrey LINk
Southwark LINk

Union and staff representatives
GMB
Lewisham NUT
South London Healthcare NHS Trust Staffside
Unison
Unison Communities and Voluntary Organisations Branch (London Region)
Unite

Staff*
Group of Lewisham GPs
GSTS Pathology
Lewisham Healthcare NHS Trust Emergency Department Consultants
Lewisham Healthcare NHS Trust Senior Medical Staff
Lewisham Intensive Therapy Unit - High Dependency Unit Nursing Staff
Lewisham Public Health
Princess Royal University Hospital Library and Knowledge Service
Princess Royal University Hospital Specialist Palliative Care Team
Queen Elizabeth Hospital Midwifery Clinical Practice Facilitators
Queen Elizabeth Hospital Outpatient Department Reception Staff
Queen Elizabeth Hospital Roundtable
Queen Mary's Hospital, Sidcup Dementia Strategy Group
Queen Mary's Hospital, Sidcup Roundtable
South East London Screening Board
South London Healthcare NHS Trust Director of Medical Education
South London Healthcare NHS Trust Ophthalmology Consultants
South London Healthcare NHS Trust Supervisors of Midwives Team
University Hospital Lewisham Acute, Elderly and Specialty Medicine, Radiology and Pathology Consultants and Physicians
University Hospital Lewisham Anaesthesia and Pain Management Consultants
University Hospital Lewisham Consultant General Surgeons
University Hospital Lewisham Consultant Obstetricians and Gynaecologists
University Hospital Lewisham Ear, Nose and Throat Consultants
University Hospital Lewisham Intensive Care Consultants
University Hospital Lewisham Paediatric Consultants

West Kent Eye Centre

***** Groups of staff from Lewisham are indicated in **bold** and were analysed as a subset within the overall staff group of stakeholders. Please note that staff responding as individuals, for example as individual consultants or chaplains, are included with the data from response forms if they submitted a response form, or with the additional letters or emails if they submitted a letter or email.

Education and training bodies
GP Educators in south east London
Lewisham GP Vocational Training Scheme
London Deanery
South London Local Education and Training Board

Independent sector
Serco

Other community and expert patient groups
Beckenham and Borders National Childbirth Trust
Bellingham Interagency
Bexley Patient Council
Bishop of Woolwich and Colleagues
Bromley and Chislehurst National Childbirth Trust
Bromley Learning Disability Partnership Board
Catford and Bromley Synagogue
Charlton Central Residents' Association
Disability Voice Bromley
Forest Hill Society
Goldsmiths, University of London
Greenwich Parents with a Learning Disability Self Advocacy Group
Hambleden Clinic Patient Participation Group
King's College Hospital Older People's Committee
Ladies of the Monday Home Group
Lewisham Maternity Services and Liaison Committee Lay Members
Lewisham People Before Profit
Lewisham Speaking Up Advocacy Group
London Health Emergency
Multiple Sclerosis Society, South East London and Kent Region
National Childbirth Trust Greenwich and Lewisham
Orpington and District National Childbirth Trust
Parkinsons UK Lewisham Branch
Prendergast Hilly Fields College
Save Lewisham Hospital Campaign
St Dunstan's Bellingham Parochial Church Council
Stillbirth and Neonatal Death Society
Sydenham Society

Other health bodies
Amersham Vale Practice
Bellingham Green Surgery
Bellingham Health Forum

Greenwich and Bexley Community Hospice
Lee Road Surgery
Lewisham Centre for Children and Young People
Londonwide Local Medical Committees
Morden Hill Surgery
Neighbourhood 3 GPs
Queens Road Partnership
South Lewisham Group Practice
South London Cardiovascular and Stroke Network
St Christopher's Hospice
Sydenham Green Practice
Woolstone Medical Centre

Other
Lewisham Adult and Older Adult Mental Health Commissioning
Lewisham Director of Public Health
Lewisham Healthcare NHS Trust Safeguarding Children and Young People and Vulnerable Adults Committee
Lewisham Safeguarding Children Board

Responses using the response form

A number of respondents using the response form stated that they were representing an organisation or group. Where this was the case and they gave the name of that organisation or group, this is listed below (where this was legible). It is not known whether these respondents were **formally** responding on behalf of that organisation or group, or how they assembled the views of other members. While this information was asked, it was not always supplied and where information was provided, it was self-reported.

More than one response was submitted on behalf of some of these organisations or groups.

Many other respondents who stated that they were responding on behalf of an organisation or group did not provide any information or did not specify exactly which organisation or group they were representing. For example, some said they were representing a hospital or particular department with no further information. For this reason, the number of organisations listed below does not match the 86 organisations included throughout this report.

Addey and Stanhope School
Advocacy in Greenwich
All Saints' Church of England Primary School
Area Dean of Orpington (Church of England)
Bexley Patient Council
Bexley Specialist & Community Children’s Services
Bexley Voluntary Service Council
Bexley, Bromley & Greenwich Local Pharmaceutical Committee
Bromley Mencap (incorporating Bromley Scope)
Bromley Sparks and Advocate 4 Health
Burney Street Patient Participation Group

Burney Street Practice
Chair of West Beckenham Residents Association
Chartered Society of Physiotherapy
Coalition of Latin American Organisations (CLAUK)
Community Centre, Mitchell Close
Copers Cope Area Residents' Association
Councillor Amanda de Ryk on behalf of residents of Blackheath Ward, Lewisham
Deptford Action Group for the Elderly
Elderly Watch
Greenwich & Bexley Community Hospice
Greenwich Asian Parents Association
Greenwich Conservative Council Group
Healthcare Audit Consultants Ltd
Heidi Alexander MP
Hither Green Community Association
Indian Workers Association (GB), Greenwich & Bexley Branch
Indo Caribbean Organisation
Knoll Residents Association
Lewisham branch of Parkinson's UK
Lewisham Healthcare NHS Trust[26]
Lewisham ITU/HDU Nursing Staff
Lewisham Pensioners Forum
Lewisham Special School Headteachers and the Brent Knoll Watergate Co-operative Trust
Library & Knowledge Services at SLHT
Local tax payers in Lewisham
Macmillan Cancer Support
Mid Surrey LINk
Multiple Sclerosis Society Bexley & Dartford Branch
Oxleas NHS Foundation Trust[27]
Park Langley Residents Association
Pensioners Forum, Lewisham
QE Imaging Department, Queen Elizabeth Hospital
Queen Elizabeth Hospital patients
SLHT Medical Microbiology staff
Soroptimist International Beckenham and District
South London Academic Health Science Network, King's Health Partners
Southwark Council
Speech and Language Therapy, Specialist Children's Services, QEW/QMS
Speech and Language Therapy, Specialist Children's Services, Queen Mary's

[26] Please note that a separate formal response was received from this organisation. It is not known who provided the response on the response form.

[27] Please note that a separate formal response was received from this organisation. It is not known who provided the response on the response form.

Hospital
Speech and Language Therapy Service to Children in Bexley, Specialist SLT Team – Hearing Impairment
St Margaret's Lee C of E School
Steering Group of the Health & Wellbeing Forum, GAVS
The Ladywell Society
Vanburgh Group 2000 Patient Participation Group
We Love the NHS
Woolstone Medical Centre
www.savelewishamhospital.com