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 1 of 3
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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 1 of 3

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Foreword

By Matthew Kershaw
Trust Special Administrator

I was very proud to be appointed, in July 2012, by the previous Secretary of State for Health, Andrew Lansley, to be the first Trust Special Administrator. At the same time, I recognised that it would be foolish to under-estimate the task ahead, which is to work up recommendations to address the long-standing challenges faced by South London Healthcare NHS Trust in a way that secures the clinical and financial sustainability of services for the population of south east London, and to do so to the very tight timescale required by the Regime for Unsustainable NHS Providers.

It has been a privilege to be working alongside so many professional and committed people in South London Healthcare NHS Trust and elsewhere in the NHS in south east London. In addition to developing recommendations on long-term solutions, since July I have also been accountable for the day-to-day running of the Trust. I have been heartened by the way in which staff have continued, throughout this difficult period, to show significant commitment and dedication in providing the best possible care to patients.

This is not the first time that the health system in London has come under scrutiny or been reviewed. Recently it was brought to my attention that as far back as 1890, a review by a Select Committee of the House of Lords looked at the distribution of hospitals. A series of reviews in the intervening hundred years or so have had variable success in terms of improvements. More recently, there have been turnaround, strategic change and organisational restructuring programmes in south east London, notably *A Picture of Health* and the merger of three hospital Trusts to create South London Healthcare NHS Trust in April 2009. These previous changes did not go far enough, in terms of both the decisions made and the implementation of the changes that were agreed – they have failed to deliver clinically sustainable and financially viable hospitals.

I have been pleased to engage with so many patients, patients' organisations, the public and their representatives who have developed and shared ideas, especially over the last few weeks when I have been consulting on the recommendations in my draft report. This consultation – not just with patients, but with doctors, nurses, other health professionals and staff – has generated a public debate that has involved thousands of local people.

One thing is most evident from engaging people in this way: the NHS (and its future) is dear to people's hearts. Everyone relies on the NHS being there when they need it most. However, what is less evident is that people do also recognise and understand that the NHS needs to change, if it is to thrive going forward – that standing still will not generate improvements in the quality of health outcomes, nor will it deliver value for money for the taxpayer in a public finance environment where this is more important than ever.

I am confident that the recommendations in my report, if implemented, will succeed in delivering the scale of change that is needed in a way that previous attempts have failed. In developing them I have received significant input from a range of doctors and other professionals working in commissioning and provider organisations across south east London and beyond. At the same time, I acknowledge that contrary views have emerged, unsurprising given the size of the challenge – and therefore the scale of change proposed – and the natural inclination of some people to want to maintain the status quo. Many with those contrary views will argue that the recommendations should have been confined to changes at South London Healthcare NHS Trust and its hospitals. However, it has been clear from the beginning of this work – and indeed before this, given the Secretary of State's guidance when I was appointed – that, given the size of the challenge, I would have to look at solutions beyond the Trust itself and across the NHS in south east London. The many reviews of south east London and of South London Healthcare NHS Trust have consistently concluded that internal efficiency improvements, even if fully realised, would be insufficient to bridge the financial sustainability gap.

There are bound to be some who will remain deeply uncomfortable with what I am recommending to the Secretary of State. Change is often unsettling for people. Proposed changes to much loved institutions, such as local hospitals, unite people who are concerned about what those changes would mean for them. This is why I understand what I have seen and heard in Lewisham in particular. There is a powerful strength of feeling among local people, who are anxious about the implications of the proposals for the future of University Hospital Lewisham despite, for example, the fact that around one half of the number of patients currently attending the A&E department would continue to receive high quality urgent care there if the proposed changes are implemented. The challenge for all of us in leadership positions in the NHS is the need to communicate the benefits of changes effectively – such as those to cardiovascular, trauma and stroke services, where changes already made in south east London have saved lives – otherwise those responsible for delivering change will not be trusted.

Prompted by an increasing body of evidence that highlights the potential for improving clinical services, the recommendations for service change in the report have been generated by a clinical advisory group, made up of doctors, nurses and other health professionals from south east London. These recommendations have also been endorsed by a clinical panel from outside south east London – experts who have been able to view the proposals as they have emerged through a different lens – and the principles underpinning the recommendations, for example the agreed London-wide clinical standards, have been supported by a number of Royal Colleges and professional bodies in their responses to consultation, such as the Royal College of Physicians and Royal College of Obstetricians and Gynaecologists. If the recommendations are implemented, it will be vital for engagement to continue with the professional bodies, especially given the reservations aired by some of them – such as the Royal College of Midwives – about the system's capacity to deliver the changes.

In developing the final recommendations we have reflected on all the contributions made during the consultation. Whilst they are not fundamentally different from those set out in my draft report, they have, however, been refined and improved in response to what stakeholders told us during the consultation. And, where the draft report signalled particular areas that needed more work on them during the consultation period, the final recommendations also reflect the additional analysis, assessment and engagement with experts that has been undertaken and a clear recommendation provided to the Secretary of State.

In conclusion and as we have said consistently, no change is not an option. That is why I was appointed under the Regime for Unsustainable NHS Providers. Only by meeting the challenge of implementing significant change over the next three years will we have an NHS that can continue to deliver services to meet the needs of people across south east London.

I should like to thank everyone who has supported me over the last six months. It has been very much a joint effort. Without the significant input of others, I would not have been able to produce this report. In particular, I am grateful to Hannah Farrar who has overseen the development of the draft and final reports and the core team that has supported us – John Bailey, Shaun Danielli, Amy Darlington, Patrice Donnelly, Dominic Harris, Stephanie Hood, Katie Horrell, Emily Hough, Steve Russell and Philip Tydeman. We are both grateful to the leadership shown by Dr Jane Fryer and Dr Chris Welsh – chairs of the clinical advisory group and external clinical panel respectively – and to Peter Gluckman, chair of the patient and public advisory group and the health equalities impact assessment steering group. These last two groups have played a major role in ensuring that the work has been properly informed by the users of services. I am grateful too for the support of the various advisory and working groups – chaired by some of the core team plus Sheree Axon, Sarah Blow, Annabel Burn, Tim Higginson and Jacob West. Finally, I am grateful for the support of all those from across the system, including provider organisations and clinical commissioning groups, who have given so much of their time to attend working and advisory group meetings and workshops.

Matthew Kershaw
Trust Special Administrator

Foreword

By Dr. Jane Fryer, Clinical Advisor to the Trust Special Administrator and Chair of the Clinical Advisory Group

It has been a great privilege to have been deeply involved in the work of the Trust Special Administrator over the past six months. Having been a practising GP in south east London for the last 24 years, I am well aware of the challenges facing the NHS – affecting not just South London Healthcare NHS Trust but the whole local health system.

The challenges are clear – a rising population, one that is steadily growing older, increasing demands on and expectations of the NHS, and innovations in medical practice. And all this comes at a time of severe financial constraint, with no prospect of the NHS receiving any significant increase in funding in real terms for the next few years. We therefore have an NHS under increasing pressure to deliver – a situation that for South London Healthcare NHS Trust and the NHS in south east London demands a different way of organising and delivering healthcare in order to secure the best services for the population.

The story of services at the Trust isn't all doom and gloom. Since the Trust was set up in 2009, we have seen improvements in a number of important clinical areas. There have been improvements in mortality rates, maternity services and infection control, as well as some signs of progress with waiting times. However, as was acknowledged when this work programme started, the improvements don't go far enough, nor can we be confident that they can be sustained in the long term, particularly if the financial situation is not resolved.

As a family doctor, I am wholly familiar with what concerns individual patients. I hear about them all the time in surgery. They want – and deserve – the best possible health care and they want that care where and when they need it – the right care, in the right place at the right time. But I know too that it isn't possible to meet patients' aspirations all the time. And I also know there is always great fear and resistance to proposals to change local services. For me, this was reinforced during the consultation period, when I met many people and heard their concerns.

As clinical advisor to the Trust Special Administrator and as chair of his clinical advisory group, it has been my job to ensure that the recommendations, in particular those relating to service change, are founded on the best possible evidence. Clinicians across London have come together in the last two years to articulate a case for change and to agree standards for adult and paediatric emergency services and maternity care, drawing on best practice and the best national and international evidence available. Colleagues and I are clear that, by applying these standards to services in south east London, we have the chance to secure high quality sustainable services. Making these changes, alongside the important improvements we need in primary care and community services, will deliver a transformation in the NHS locally – a service saving lives and improving health outcomes.

Clinicians need to continue to be at the heart of these changes. We need to be the people who drive through the changes. This means a transformation in the workforce, as the key enabler for the service transformation – changes delivered through a focus on training and professional development; changes through doctors, nurses and other professionals working in different ways. And all this will only happen with the right clinical leadership in place.

Clearly, not all clinicians agree with the specific plans in the recommendations, particularly in Lewisham where this will impact most directly on some of their patients. But overall, I believe that by implementing the recommendations we can, at last, secure a transformation in the way the NHS delivers services in south east London, so that it improves the quality of care for all the population in a sustainable way. Then, we will have an NHS locally capable of meeting the challenges of the coming decade without being blighted by the financial challenges of the last.

I should like to thank all of my colleagues who have taken part in the discussions and for the passionate and helpful debate about many issues. I should also like to thank all those who have supported me and the group in our deliberations, specifically Matthew, Hannah and the core team.

Dr. Jane Fryer
Clinical Advisor to the Trust Special Administrator
and Chair of the Clinical Advisory Group

Foreword

By Dr. Chris Welsh
Chair of the External Clinical Panel

I was delighted to be invited to chair the Trust Special Administrator's external clinical panel for his work on South London Healthcare NHS Trust. The challenges facing the National Health Service across England are well known – securing high-quality services for the long term when we are under ever-increasing financial pressures and trying to meet ever-increasing expectations from the public. As recognised by Andrew Lansley last summer, this complex set of interdependent issues is illustrated in a highly visible form in the NHS in south east London.

As the Trust Special Administrator, Matthew Kershaw has had to make sure that his proposals for the Trust are focused on the best interests of patients, backed up by the best clinical evidence and opinion and fit within the wider health system. In leading the external assurance of his work programme, and specifically its implications for the workability, quality and disposition of services across the system, I have made sure that a team of clinical experts with no direct interest in the outcome of the work have posed the difficult questions designed to make the proposals robust. Similarly, I have also made sure that throughout the development of proposals, we have challenged the responses to those difficult questions.

As a group of clinicians we have rightly been agnostic about decisions around the bricks and mortar, focusing instead on services, models of care and quality standards. It is viewed through this lens that genuine improvements can be delivered for patients. This is why we have been able to endorse the standards for emergency and maternity services agreed by clinicians in London.

I am confident that commissioning and planning services in the future against these standards will act as the best foundation for the service improvement that is needed. What is clear is that preserving the status quo is the wrong recipe, even though rationalising hospital services may be unpalatable for some people. I understand why people care deeply about their local hospitals – this is where many people experience some of the best and the worst days of their lives. For many people, their local hospital is the most visible representation of all that is good about the NHS – they have come to rely on their local hospital being there for them, irrespective of the nature of their injury, illness, ailment or condition. But that doesn't mean things should not change. Medicine is an ever-evolving science, with new evidence and innovations in practice constantly driving the case for change.

The challenge for the NHS in south east London is to make sure that any changes that the Secretary of State agrees to are implemented by doctors, nurses and other health professions working together – underpinned by the best clinical and managerial leadership – and working with those charged with overseeing the changes to make sure that the clinical quality benefits of those changes are realised as quickly as possible. This will also need a transformation in the workforce in south east London, supported by modernising the education and training for all health professionals across the area. In short, the vision that we found so compelling is one of a workforce that will lead sustainable improvement in the health and wellbeing of the population of south east London.

Finally, I'd like to thank all members of the external clinical panel, for the wisdom and challenge that they all brought to these important discussions. I should also like to thank Shaun Danielli for supporting the work of the panel.

Dr. Chris Welsh
Chair of the External Clinical Panel

1. Introduction

1. On 13 July 2012 the Secretary of State for Health laid before Parliament the *South London Healthcare NHS Trust (Appointment of Trust Special Administrator) Order 2012*[1] alongside an Explanatory Memorandum which included *The Case for Applying the Regime for Unsustainable NHS Providers*[2]. These documents can be found at appendix A. This confirmed the Secretary of State's decision to enact the Regime for Unsustainable NHS Providers (UPR) for the first time at South London Healthcare NHS Trust with effect from 16 July 2012. The Trust Board was suspended from this date and a Trust Special Administrator (TSA) was appointed, to be accountable officer for the Trust, and to develop recommendations for the Secretary of State, on how to deliver clinical and financial sustainability, in the form of a final report by 7 January 2013. This is the final report.

2. The Explanatory Memorandum to the Order and the Case describe a long-standing challenge in south east London, with the recurrent deficits in South London Healthcare NHS Trust (SLHT) existing prior to the organisation's establishment in 2009, its creation being one of several attempts to resolve them. The Case states that *"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 by the wider health economy in south east London. This has included a major commissioner-led review of service reconfiguration, the merger of three previous Trusts into one and numerous organisational reviews and management changes. None have succeeded in bringing about the required level of change"*[2].

3. As required by this mandate, the TSA and the team that have supported him has brought forward recommendations in relation to South London Healthcare NHS Trust that propose *"the transformational level of change needed to ensure clinically and financially viable services are secured for the people of south east London"*[2]. This report outlines the final recommendations of the TSA, which rise to this challenge.

4. This final report has been delivered to the exacting timetable set out in the Order, which has four key parts to it:

   - *Preparation of Draft Report* – rapid assessment of the issues facing the organisation, engagement with a range of relevant stakeholders, including staff and commissioners, and development of a draft report including initial recommendations for achieving sustainability. There were 75 working days in which to do this – 16 July to 29 October 2012.
   - *Consultation* – consultation over 30 working days to validate and improve the draft recommendations. This took place between 2 November and 13 December 2012.
   - *Final Report* – taking on board consultation responses and the health equalities impact assessment, the final report to the Secretary of State should be prepared within 15 working days by 7 January 2013.
   - *Secretary of State Decision* – The Secretary of State has 20 working days to determine what action to take. The Secretary of State must then publish and lay in Parliament a notice containing the final decision and the reasons behind it. The Secretary of State's decision is final with no right of appeal; this final decision must be made by 1 February 2013.

5. This document is the final report of the TSA and represents the end of the third part of the timetable. It builds on the draft report, taking responses from the public consultation and the health equalities impact assessment to support the finalisation of proposals for change. The report includes background and context and describes the process and approach that have been used to arrive at the final recommendations for the Secretary of State to consider.

6. Chapter 4 provides an assessment of the position at South London Healthcare NHS Trust, including financial projections for the next three years, and makes recommendations relating to it. However, it concludes – as the Case did – that change is required beyond the organisational boundaries of the Trust in order to resolve the challenges facing it and deliver sustainable services. Despite the best efforts, it has not been possible to identify a means of securing organisational and site viability in the current service and organisational configuration of South London Healthcare NHS Trust. All sites will continue to operate with a recurrent deficit without a broader set of recommendations relating to the configuration of services in south east London.

7. Chapter 5 examines the wider south east London health economy and makes recommendations relating to the configuration of services, which look to maximise improvements in health outcomes whilst ensuring the viability of hospital sites. Chapter 6 explains the proposed organisational arrangements to replace South London Healthcare NHS Trust in a way that will support delivery and viability, which should be put in place as a consequence of the recommendations in the previous two chapters. Only in taking these recommendations together can the challenge set down in the Order and the Case be met. The final set of recommendations, in chapter 7, relates to the critical tasks of transition and implementation.

2. Context

1. South London Healthcare NHS Trust came into existence on 1 April 2009, the product of a merger of three hospital Trusts – Queen Mary's Sidcup NHS Trust, Queen Elizabeth Hospital NHS Trust and Bromley Hospitals NHS Trust. It operates largely out of three main sites: Princess Royal University Hospital in Farnborough, near Orpington; Queen Elizabeth Hospital in Woolwich; and Queen Mary's Hospital in Sidcup.

2. The three Trusts brought together in the merger had long-standing financial issues, recording annual deficits every year since 2004/05[3]. Immediately before the merger on 31 March 2009 they had a total combined debt, arising from accumulated annual deficits, of £149m. Many attempts have been made to address these issues; more information on these can be found at the end of this chapter. The combination of implementing the changes agreed under the commissioner-led service reconfiguration programme *A Picture of Health* and the merger of the three organisations to create South London Healthcare NHS Trust was expected to support the resolution of these problems. However, since its establishment, the Trust has continued to operate at a loss. Despite some areas of improvement, it has failed to integrate as effectively as an organisation as it should have and has made insufficient progress on the delivery of sustainable cost reduction, particularly in the area of clinical productivity where the Trust performs poorly compared with peers (more detail on this can be found in chapter 4). By the end of the current financial year – four years since it was set up – the Trust is forecast to have debt relating to the accumulation of annual deficits of £207m. This means that since 2004/05 the hospitals that make up South London Healthcare NHS Trust will have overspent by £356m by the end of this financial year.

3. The Trust serves a population of approximately 1 million people, predominantly from the London Boroughs of Bexley, Bromley and Greenwich – which together account for over 91% of its income – but also from other parts of south and south east London, such as Croydon and Lewisham, and from north west Kent. The Trust is a significant provider of hospital services within the south east London health economy. Over 1.7 million people live in the six boroughs that make it up: Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

4. South London Healthcare NHS Trust employs around 6,300 people and has an annual income of approximately £440m, making it the 28th largest Trust, by income, in the country[4].

5. The disposition of key services at the Trust's three main sites is outlined in figure 1. The Trust also currently operates from other smaller sites, including Orpington Hospital and Beckenham Beacon, where the Trust mainly delivers outpatient care and associated support services.

Figure 1: Key services by main three sites[5]

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital
Full admitting accident and emergency department	Full admitting accident and emergency department	Non-admitting urgent care centre▲
24/7 surgical inpatients	24/7 surgical inpatients	
24/7 medical inpatients	24/7 medical inpatients	
Inpatient paediatric service	Inpatient paediatric service	Paediatric ambulatory care service
Hyper-acute stroke unit		
Critical care unit	Critical care unit	
Obstetric-led unit and co-located midwife-led unit	Obstetric-led unit	
Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care
Complex inpatient surgery	Complex inpatient surgery	
Routine inpatient elective and day case surgery	Routine inpatient elective and day case surgery	Routine inpatient elective and day case surgery
Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics
		Intermediate/rehabilitation beds▲

▲Provided by Oxleas NHS Foundation Trust

6. The six primary care trusts (PCTs) that currently commission NHS services for the population of south east London are planning to spend £3bn in 2012/13, of which £1.5bn will be spent on acute hospital-based services*.

7. NHS services for the population in this part of London are commissioned by NHS South East London – a single PCT cluster that consists of the six PCTs that are coterminous with their boroughs. NHS South East London works with six clinical commissioning groups (CCGs), which are similarly coterminous with the boroughs, and the NHS Commissioning Board. The CCGs and the NHS Commissioning Board will be responsible for commissioning services for the south east London population from April 2013.

8. These commissioners plan and purchase NHS services from a number of healthcare organisations. NHS services are provided by:

- 261 general practices, employing over 1,100 General Practitioners and 650 practice nurses, 242 dental practices and 360 community pharmacies. Out-of-hours care is provided by the GP co-operatives Grabadoc Healthcare Society, South East London Doctors Co-operative (SELDOC) and EMDOC Bromley Doctors On Call;
- four community service providers across the six boroughs. Community services for Southwark and Lambeth are provided by Guy's and St Thomas' NHS Foundation Trust; those for Greenwich and Bexley by Oxleas NHS Foundation Trust; Lewisham's by Lewisham Healthcare NHS Trust; and Bromley's predominantly by Bromley Healthcare, a Community Interest Company;
- two acute NHS Trusts – South London Healthcare NHS Trust and Lewisham Healthcare NHS Trust;
- two mental health NHS Foundation Trusts – South London and the Maudsley NHS Foundation Trust and Oxleas NHS Foundation Trust; and

* TSA analysis

- two NHS Foundation Trusts which also undertake significant teaching and research – Guy's and St Thomas' NHS Foundation Trust, operating from two main sites at St Thomas' Hospital (including the Evelina Children's Hospital) and Guy's Hospital; and King's College Hospital NHS Foundation Trust, operating from a main site in Denmark Hill and a smaller site at Dulwich Hospital.

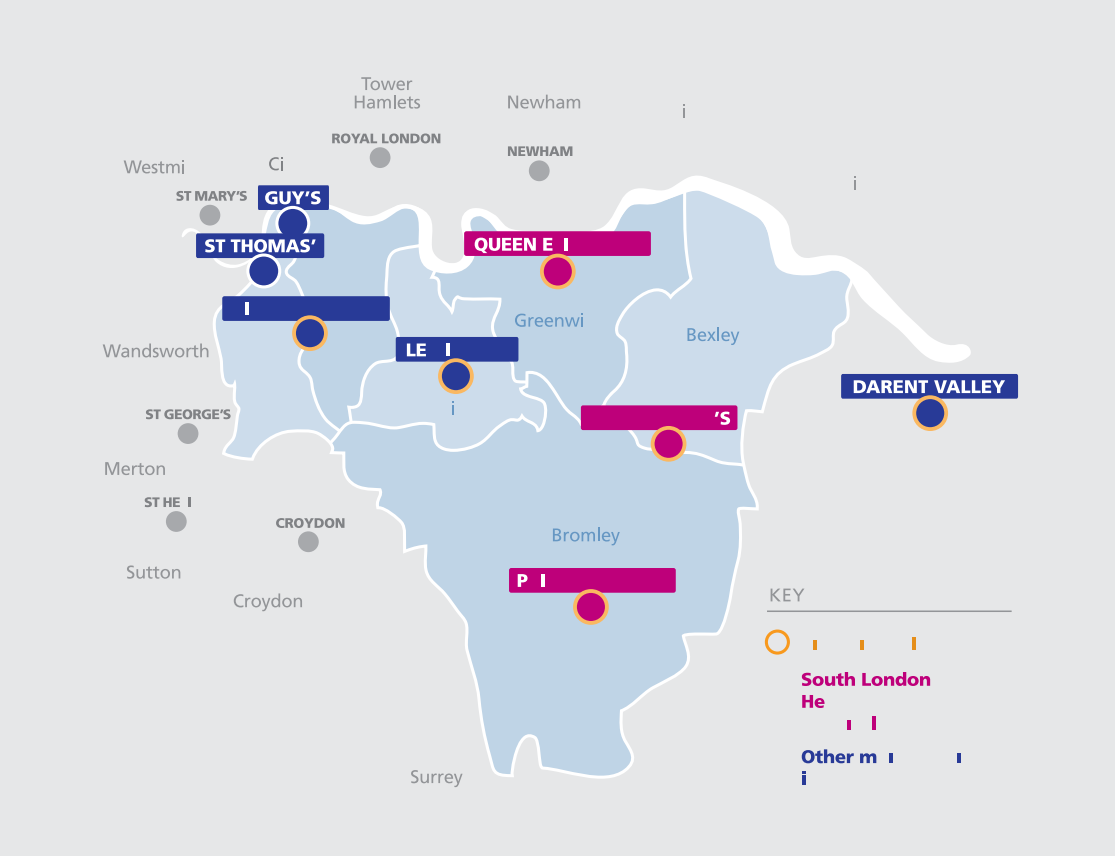
9. The NHS also funds a number of charitable and voluntary sector organisations such as the five hospice organisations: Greenwich Hospice, Bexley Community Hospice, Harris Hospice Care, St Christopher's Hospice and Trinity Hospice.

10. The providers of NHS services work in partnership with the voluntary sector and social services, which are provided for their residents by local authorities, to ensure that the needs of patients and service users are met in an integrated fashion.

11. South east London also has one of the country's five Academic Health Science Centres, King's Health Partners. The AHSC is a strategic partnership between Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, South London and the Maudsley NHS Foundation Trust and King's College London.

12. Figure 2 shows the acute hospital sites across south east London and those in neighbouring areas. All sites are accessible by public transport. There are significant patient flows from Bexley to Darent Valley Hospital (part of Dartford and Gravesham NHS Trust) in Dartford in north Kent, from Lambeth to St George's Hospital in Tooting and from Bromley to Croydon University Hospital. In addition there are significant flows 'out of the area' for specialist services, principally delivered at University College Hospital, in Euston.

Figure 2: Map of acute hospitals in south east London



A History of Strategic Reviews

13. Concerns regarding the sustainability of services in south east London have been long-standing. *The Case for Applying the Regime for Unsustainable Providers* published by the Secretary of State at the time of enacting the UPR at South London Healthcare NHS Trust, describes repeated strategic reviews and interventions made in an attempt to resolve challenges in the south east London health economy.

14. The first review specifically related to the financial problem in the hospitals that make up South London Healthcare NHS Trust was undertaken by South East London Strategic Health Authority following the emergence of deficits in NHS Trusts in south east London in 2004/05. The review, known as the *Service Redesign and Sustainability Project,* concluded that efficiency improvements and service changes, including a radical reshaping of hospital services, would be required to secure sustainability, particularly at the four Trusts in deficit: Queen Mary's Sidcup NHS Trust, Queen Elizabeth Hospital NHS Trust, Bromley Hospitals NHS Trust and University Hospital Lewisham NHS Trust.

15. This project led to *A Picture of Health* which started in December 2005. The aim was to secure improved, affordable and sustainable health services across the six boroughs in south east London. In the summer of 2007, in light of what appears to have been the inability of the NHS organisations to identify a way forward and the continued pressures experienced by the Trusts – highlighted by the Department of Health as part of its Financially Challenged Trusts programme – it became clear that *A Picture of Health* needed to re-focus efforts on addressing the urgent clinical and financial challenges in the four outer boroughs – Bexley, Bromley, Greenwich and Lewisham. Building on extensive engagement with patients and the public, the PCTs led the development of proposals for reconfiguring services and, ahead of public consultation, the preferred option for change that emerged would have seen the hospital landscape rationalised to create a 'borough' hospital at Queen Mary's Hospital, a 'medically admitting' hospital at University Hospital Lewisham and two 'admitting' hospitals at Princess Royal and Queen Elizabeth Hospitals*.

16. A review of the proposals for change under *A Picture of Health* was undertaken by the National Clinical Advisory Team in the autumn of 2007[6], ahead of public consultation. The National Clinical Advisory Team concluded that, while moving immediately to two 'admitting' hospitals might not be feasible, nonetheless that should be the longer-term goal for the NHS in this part of London. It also highlighted the risks of not rationalising inpatient obstetric and paediatric services onto two sites, which was considered necessary in order to allow 98-hour resident consultant obstetrician cover (in line with the *Safer Childbirth*[7] minimum standards) and dedicated paediatricians for the neonatal intensive care unit. Five years on, inpatient maternity services in this part of London still fail to deliver against this minimum standard.

17. In July 2008, following consultation, the PCTs decided that Princess Royal, Queen Elizabeth and Lewisham Hospitals were to become specialist emergency centres with 24-hour A&E, maternity units and children's inpatient services; and Queen Mary's Hospital was to focus on planned surgery and become a base for community healthcare services, with a 24-hour urgent care centre. This became the preferred option for implementation when, in response to consultation, the AHSC in south east London outlined its willingness to support the delivery of maternity and paediatric services at University Hospital Lewisham, should they be retained. Arguably, one of the reasons for the continued challenges in south east London is that the final decision under *A Picture of Health* did not go far enough to

* Explanatory note: The 'borough' hospital would not have provided a full A&E service, with the service re-modelled as a primary care-led urgent care centre. The 'medically admitting' hospital would have had an A&E department that can admit patients who may need some emergency monitoring, but would not provide inpatient maternity or inpatient paediatric services.

transform services. Services were rationalised, which meant movement between sites, but without a pursuant reduction in capacity at any sites. Therefore, no significant savings were realised.

18. When endorsing the PCTs' decisions on *A Picture of Health* in March 2009, in its report to the Secretary of State[8] the Independent Reconfiguration Panel signalled its misgivings about the financial viability of the proposals, fearing that all the financial benefits would not be realised. It recommended that this be kept under review as the changes were implemented.

19. The merger of the three Trusts on 1 April 2009 was proposed as a means of facilitating the service changes under *A Picture of Health*, as well as achieving cost and operational synergies across the three organisations, each of which were facing their own significant, individual challenges. While the merger, alongside these service changes, has delivered some improvements to the quality of care that patients receive, the financial benefits anticipated have not been realised[9] and sustained. Since its establishment, South London Healthcare NHS Trust has amassed debt relating to the accumulating deficit totalling £154m; by the end of this financial year that debt will have risen to £207m. Taking the periods before and after merger together, the hospitals that make up the Trust will have overspent by £356m by the end of this financial year, 31 March 2013. Lewisham Healthcare NHS Trust – the Trust was renamed following its acquisition of community health services in August 2010 – is now in recurrent underlying balance due to the efforts of the Trust but has also accumulated deficit in the last eight years totalling £6.3m. To date, this has not been repaid.

20. While the financial situation very much defines the requirement for change, the financial challenges that have now spanned the best part of a decade have a broader impact. They lead to pressure merely to cut services, as opposed to transforming them; they reduce the attractiveness of an organisation as an employer, which only compounds the financial challenges due to the need to rely on temporary staff; they have a detrimental effect on a Trust's relationship with other NHS organisations and other partners, particularly local authorities. All of these are symptomatic of the failure to address fully the challenges faced by South London Healthcare NHS Trust and the wider south east London health economy.

21. Enacting the UPR is not a guarantee for resolution. It requires the recommendations, laid out in this report, and the decisions on them to reflect fully the scale of the challenge. Equally critical is the capacity and capability of the organisations charged with implementing those decisions, to be able to do so in full and at pace. These points are addressed throughout this report, but specifically in chapter 7.

3. Approach

1. The overall timeline the TSA has been working to is set out in statute and summarised in chapter 1. As this was the first time the UPR had been enacted, and given the complexity of the challenge in this locality (see the Order at appendix A), the Secretary of State extended the period allowed for writing the draft report by 30 working days, to 75 working days in total.

2. At the start of this period, a strong programme management approach was adopted to support the identification and development of long-term solutions for South London Healthcare NHS Trust in the context of the significant challenges facing the local NHS. Governance structures were established to ensure that recommendations were developed in line with the five principles of the UPR[10]:

   - *Principle 1* – Patients' interests must always come first. The most important consideration is the continued provision of safe, high-quality and effective services so that patients have the necessary access to the services on which they rely.
   - *Principle 2* – State-owned providers are part of a wider NHS system. NHS Trusts, for example, are not free-floating, commercial organisations and the assets of state-owned providers will be protected.
   - *Principle 3* – The Secretary of State is ultimately always accountable to Parliament for what happens to local NHS services. In exceptional circumstances, such as dealing with a failed NHS Trust, accountability to Parliament should be emphasised.
   - *Principle 4* – The Regime should take into account the need to engage staff in the process. Retaining the necessary staff and maintaining staff morale within the organisation will be crucial.
   - *Principle 5* – The Regime must be credible and workable. Critically, the Regime must also be time-bound and ensure rapid decision making in the exceptional circumstances in which it is used.

3. The Secretary of State also issued directions to the TSA, identifying specific organisations to work with in developing the draft report. These directions can be found at appendix B.

4. When consulting on whether to enact the UPR at the Trust, the Secretary of State received written responses from South London Healthcare NHS Trust, NHS London and the collective view of the Trust's main commissioners: South East London PCT Cluster and Bexley, Bromley and Greenwich CCGs. In general, the responses[2] welcomed the proposed enactment of the UPR and all explicitly suggested that, in addition to exploiting significant improvement opportunities within the Trust itself, the TSA would have to look for solutions outside of the Trust, looking across the NHS in south east London. These responses were taken into consideration in the establishment of the work programme.

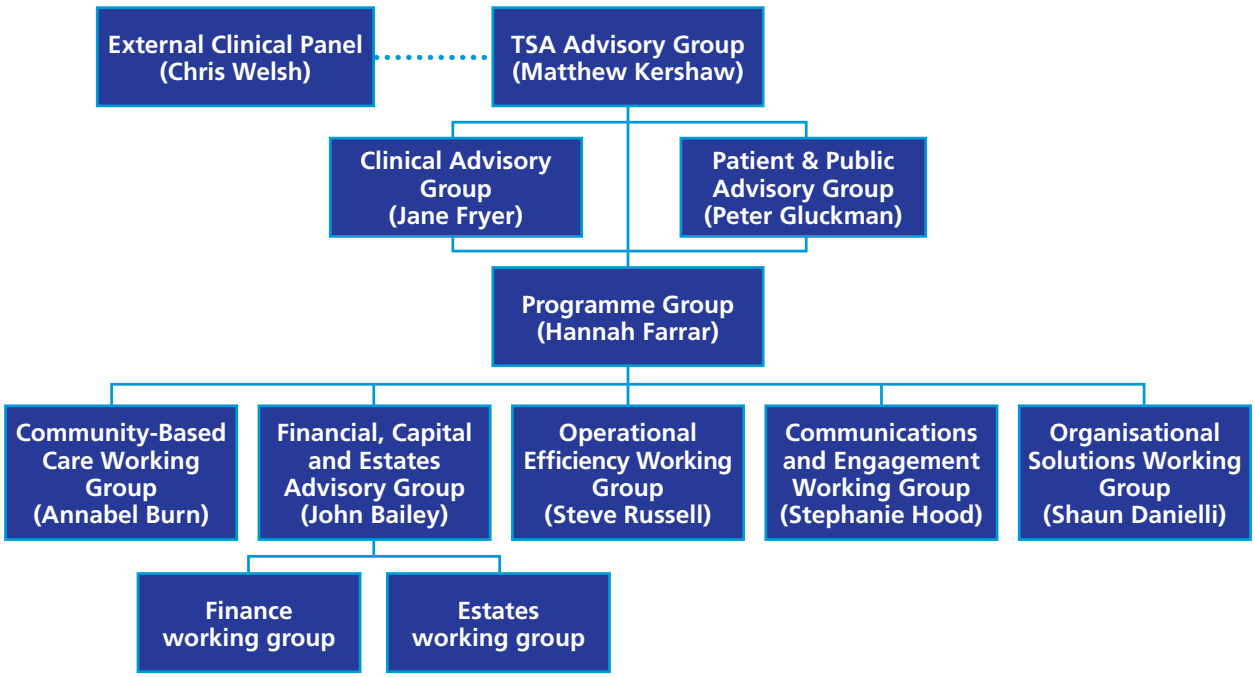
5. Advisory and working groups were established immediately. They have been integral to developing, improving and validating the recommendations as they emerged, both for the draft report and this final report. Each group has had a clear understanding of its role and remit, bringing specialist expertise to bear on relevant areas of the programme.

6. A clinical advisory group – composed of clinicians from all NHS organisations in south east London – and a patient and public advisory group – formed of representatives of Local Involvement Networks and patient councils – have contributed directly to the TSA programme. Placing south east London's clinical leaders and leaders of patient representative groups at the centre of the programme ensured that the work has had a very strong clinical focus and an emphasis on the needs of local communities.

7. An external clinical panel has provided additional scrutiny to the development of the recommendations. The panel was assembled to act as a 'critical friend' – an independent group that fully understands the context of the work and can provide constructive criticism and ask challenging questions. In carrying out its function, the panel has provided valuable insights, based on independent clinical expertise. It has played a key role in challenging the development of the recommendations, for example in relation to emergency and maternity services.

8. The programme governance arrangements in place for the development of the draft report are outlined in figure 3.

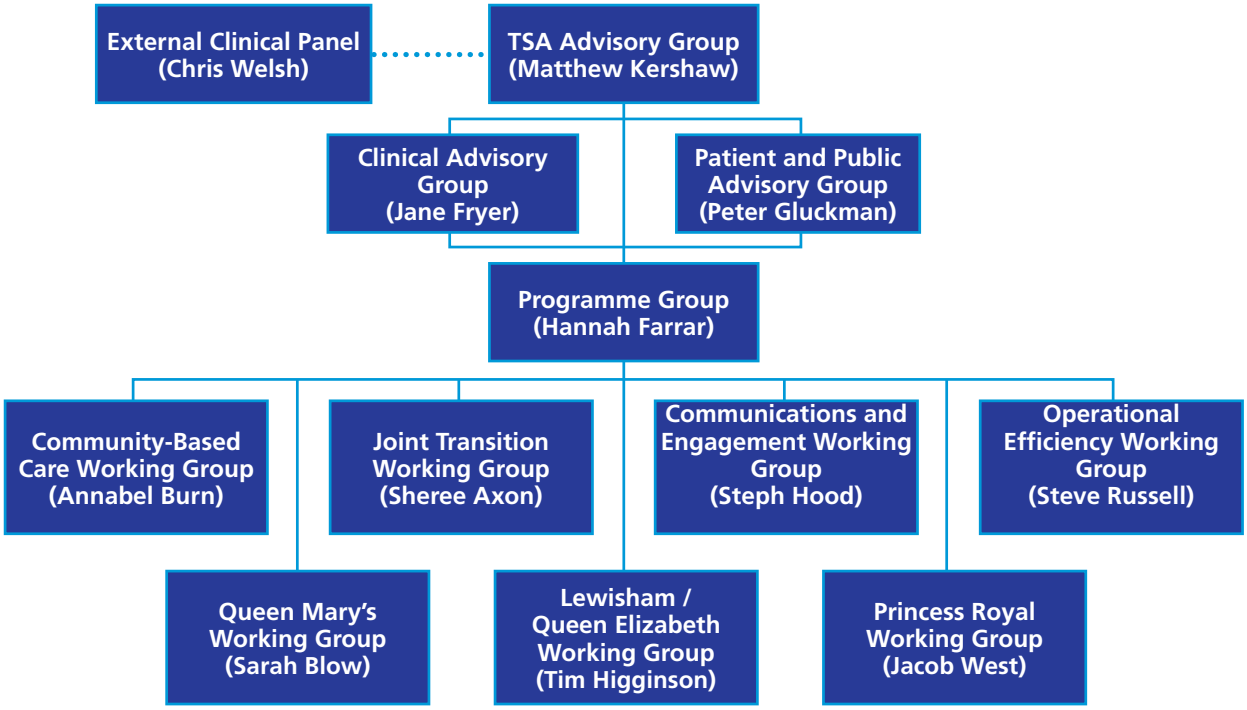
Figure 3: Draft report programme governance arrangements



9. The number and remit of the working groups changed after the TSA's draft report was published in October. This reflected the start of a new phase in the TSA's work, focusing on developing some of the recommendations in further detail – for example, those supporting the organisation solutions – and testing and validating other recommendations during the consultation period.

10. The programme governance arrangements in place for the development of the final report are outlined in figure 4.

Figure 4: Final report programme governance arrangements



11. The nature of the UPR has meant that, whilst the advisory and working groups have played a central role in developing, testing and validating the draft and final recommendations, they have not functioned as more traditional programme boards. The TSA himself retains ultimate decision making responsibility for the recommendations and for delivering the report to the Secretary of State. In exercising this accountability, the TSA has sought to draw on the work of all of the advisory and working groups in formulating final recommendations capable of meeting the requirement for clinically and financially sustainable services. The external clinical panel has been integral to supporting the TSA in finalising recommendations, particularly where there have been differing opinions and competing interests.

12. Appendix C sets out the programme governance arrangements including further detail on each of the advisory and working groups, demonstrating the extensive involvement and engagement that has taken place during the development of the draft and final recommendations. Membership of the groups is also detailed at appendix C.

Work undertaken in preparing the report

13. In view of the fixed timescales for the UPR process, several lines of enquiry associated with understanding and resolving the issues facing the Trust were investigated in parallel. Three key areas of work were established to assess:

- the drivers of the deficit at South London Healthcare NHS Trust and its future financial prospects;
- the Trust's operational performance and opportunities for making efficiency improvements; and
- the impact on the Trust of the costs associated with Private Finance Initiative (PFI) contracts.

14. Acknowledging the feedback from the Secretary of State's consultation ahead of enacting the UPR, and the issues outlined in *The Case for Applying the Regime for Unsustainable NHS Providers*, work on understanding the wider health economy was initiated in parallel with the internal review of the Trust outlined above. It would not have been feasible to undertake this work in sequence, given the statutory timetable to which the TSA must adhere. There was also considerable evidence indicating that an internal review alone would be insufficient to resolve the sustainability issues at the Trust. This wider piece of work assessed:

- the clinical and financial position of the south east London health economy, including the six local commissioners and the other NHS acute providers, specifically Lewisham Healthcare NHS Trust, Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust; and
- options to deliver improved clinical care in the future within the financial resources available.

15. Finally, a strand of work was initiated to assess the most appropriate organisational arrangement for South London Healthcare NHS Trust, with retaining the Trust in its existing form being one of a set of options looked at. By the conclusion of the three key areas of work listed in paragraph 13, it was clear that South London Healthcare NHS Trust could not be made viable in its current organisational form. This led to a conclusion that the Trust must be dissolved, but it also confirmed the need for the work already under way on the wider review of hospital capacity in south east London in order to bring forward recommendations that secured high quality services for the future and delivered financial viability. The organisational appraisal process was therefore focused on bringing forward a proposal capable of supporting the delivery of the emerging set of operational and service recommendations.

Assessing the financial position of South London Healthcare NHS Trust

16. The assessment of the Trust's underlying position and Long Term Financial Model, including analysing the drivers of the recurrent deficit, was a key starting point of the work. This included examining recording and invoicing procedures to assess potential under- or over-recovery of income and an analysis of profitability by site. A forecast for future years was developed, with activity projections informed by in-depth dialogue with commissioners leading to validation and, where necessary, agreed modifications to their intentions for service demand. Income and expenditure were forecasted, with assumptions aligned to national guidance. The potential for cost improvements was assessed and overall conclusions were drawn to determine the financial projections for the Trust.

17. This work, including its outcomes, is discussed in more detail in paragraphs 13 to 32 in chapter 4.

Operational efficiency

18. A detailed analysis of the potential cost saving opportunities within the Trust was completed, to assess how efficient the organisation could become in its current organisational form and how efficient it could be with enhanced leadership capability to drive it forward. This assessment of potential focused on opportunities across the set of cost categories defined in the NHS costing manual[11]. The TSA team also looked at opportunities to maximise the utilisation of estate across the Trust.

19. A detailed description of the approach can be found at appendix D. This work was overseen by the operational efficiency working group and, in summary, the approach consisted of an external benchmarking in which South London Healthcare NHS Trust was compared with 18 similar NHS organisations and a detailed internal review of the current cost base of the Trust. The work sought to be as ambitious as possible, ensuring that every opportunity to maximise efficiency was explored fully. Senior staff in the Trust were assisted by external advisors with national and international expertise, to identify the savings opportunities and to challenge their thinking in a way that generated innovative solutions.

20. Between the publication of the draft report and the completion of the final report the identified opportunities were translated into detailed cost improvement programme schemes (CIPs) for the period 2013/14 to 2015/16. This further refined and validated the assessment of cost saving opportunities. As part of this, the CIPs were challenged by the external clinical panel, as well as the Medical Director and Nursing Director at South London Healthcare NHS Trust, to ensure that the plans had at least a neutral impact on the quality and safety of services.

Impact of PFI costs

21. As well as considering opportunities to improve the internal efficiencies of the Trust, the TSA's team undertook a detailed assessment of the impact of the main PFI contracts held by the Trust. This work built on Department of Health analysis[12], which concluded that seven hospital sites in England were carrying an unaffordable level of cost from PFI contracts. As well as quantifying the excess cost impact of the PFI, opportunities to minimise this impact – both for the Trust and for the broader public finances – were identified.

Understanding the south east London health economy

22. An analysis of the current and projected use of NHS services and resources in south east London was undertaken. Working with local commissioners and providers, the TSA's team established an understanding of the services commissioned across south east London. Commissioning expectations for the next three to five years were reviewed and their impact on providers assessed. Based on these expectations a position was agreed with Lewisham Healthcare NHS Trust on its current and future finances. The TSA team also developed an understanding of the financial positions at Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust.

Developing service options

23. The TSA team worked with commissioners, clinicians and other stakeholders to understand how the quality of service provision by the NHS in south east London could be improved and secured within the available financial resources. This included the CCGs developing a strategy for community-based care, which outlines their aspirations for primary care and community services, integrated care and planned care services. In developing this strategy, the CCGs have engaged local authorities as a critical partner and also the NHS Commissioning Board as the future commissioner of primary care.

24. Developing primary care and community services is core to the CCGs' intentions and the delivery of their activity projections, and it forms a secure platform for the TSA's review of hospital-based services. But, with the TSA's remit being to bring forward recommendations for securing clinically and financially sustainable services, it was the nature and disposition of acute services that needed to be fully explored.

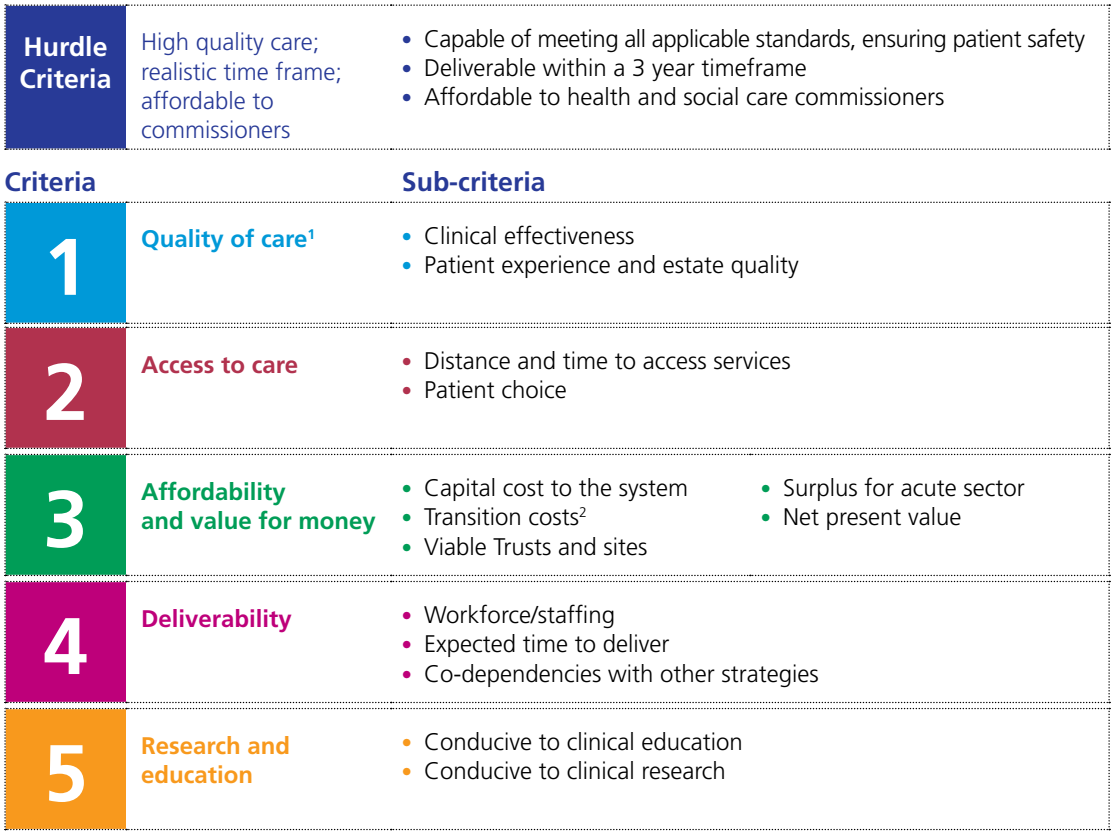
25. Some respondents to the consultation have argued that the TSA team's assessment of services did not go far enough, for example by excluding mental health services (although this is included in the community-based care aspirations). On the other hand, others suggested that any work that challenged the configuration of services beyond the boundaries of South London Healthcare NHS Trust was a step too far. However, as the Trust is an acute provider unviable in its current form, it was necessary to focus on its services and, where necessary, those of other acute providers in south east London. This was set out in the Case and reflected in the involvement of all south east London's acute trusts and commissioners in this work from the outset.

26. The CCGs also confirmed their intent to commission hospital-based services in a way that would meet the London-wide clinical quality standards for acute emergency and maternity services. This intent is reiterated in their responses to the consultation. The principles underpinning this approach were endorsed by the clinical advisory group and supported by the external clinical panel. It is in line with decisions being made across the capital, following the development of the standards by London-wide clinical expert panels and their agreement by the London Clinical Senate.

27. Working with the clinical advisory group and the external clinical panel, the TSA team considered how these quality standards could be met alongside the financial challenges that need to be addressed. Options for the future provision of hospital-based services across south east London were developed. These were tested with the clinical advisory group, as well as with some of the organisations that responded to the market engagement process (described below).

28. The approach adopted for evaluating the options, including the evaluation criteria, was challenged by 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 criteria against which options were evaluated are summarised in figure 5 and provided in detail at appendix E. The evaluation of options was completed by the clinical advisory group and the finance, capital and estates advisory group. The outcome of this 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 for emergency and obstetric-led maternity services in south east London.

Figure 5: Service configuration evaluation criteria



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

29. The market engagement process and, specifically, proposals put forward by Lewisham Healthcare NHS Trust led to an additional option for the configuration of obstetric-led maternity services. This meant two options were included in the draft report and presented for consultation. Running parallel to the consultation, further work was undertaken on detailing the two options' benefits, risks and potential mitigations. The outputs from this work were reviewed by the Lewisham and Queen Elizabeth Hospital working group and by the clinical advisory group. A bespoke workshop was held, to secure the input from relevant clinicians across south east London to the evaluation of the two options, and two workshops were held with local mothers and parents to secure their views on the options. The external clinical panel then played a critical role challenging the options and providing the TSA with advice on the final recommendation.

30. In the meantime, a variant option emerged for maintaining midwifery-led birthing services at University Hospital Lewisham. Responding to what some people were saying during the consultation, the external clinical panel recommended that a standalone midwife-led unit at University Hospital Lewisham would be a clinically viable model, which should be considered in order to enhance choice of and access to midwifery-led care and help to alleviate pressure on capacity at the other four sites sites if that recommendation was made and accepted.

31. Finally, options for the potential configuration of elective services were also considered. The clinical advisory group and external clinical panel examined and agreed the benefits of consolidating services and the financial implications of the options were assessed, leading to a preferred option. This option included the creation of an elective centre at University Hospital Lewisham. The proposed activity (including defining appropriate procedures) and operating model for this centre have been looked at in detail by the clinical advisory group, the external clinical panel and the TSA advisory group.

Developing organisational options

32. In considering the future of the Trust, a market engagement process was undertaken to seek input from other organisations on the best organisational solution to deliver clinically and financially sustainable services. This process included seeking input from any interested party.

33. A broad range of interested parties – including Foundation Trusts and those from the voluntary and independent sectors – responded as part of this process. However, conversations were pursued only with those organisations looking to discuss solutions that could help to resolve the challenge the TSA has been tasked with addressing. For those interested only in providing an individual or small, discrete range of services, it was reiterated that the TSA was not undertaking a specific procurement at this stage, but focusing on discussions with those interested in providing a broader solution to the Trust's and the local health system's challenges. This approach does not rule out other interested parties from competing for any services currently provided by the Trust that the Secretary of State, or commissioners, determine should be put out for competitive tender in the future.

34. A small number of organisations initially indicated that they would consider providing the Trust's current services within the funding available, thereby taking on the considerable financial challenges faced by the Trust and avoiding the need for service change. These organisations were furnished with additional relevant information and, following further analysis, all of them confirmed that the size of the financial gap prevented them from providing the current services in this way, which has served to underline the case for service reconfiguration across the health system in order to resolve the Trust's issues.

35. This led to further dialogue with those parties who were interested in discussing potential solutions for individual components of the Trust. These discussions generated a list of options for organisational solutions that were then evaluated against a set of criteria, which had been tested with the TSA advisory groups (summarised in figure 6).

Figure 6: Evaluation criteria for organisational solution options

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

36. The outcome of this evaluation was three preferred options, one for each site:

- Queen Mary's Hospital to be transferred to Oxleas NHS Foundation Trust, with a range of providers delivering services from the site;
- Princess Royal University Hospital to be acquired by King's College Hospital NHS Foundation Trust; and
- the creation of a new organisation bringing together Lewisham Healthcare NHS Trust with Queen Elizabeth Hospital.

Further details on this appraisal process can be found at appendix F.

37. Following publication of the draft report, working groups were established to challenge the feasibility of the preferred options. These groups, which are outlined at appendix C, have supported the work to finalise the recommendations and the development of an outline business case by King's College Hospital NHS Foundation Trust for the acquisition of Princess Royal University Hospital, as well as transition timings and costs. Due Diligence on the proposed merger between Lewisham Healthcare NHS Trust and the Queen Elizabeth Hospital site, currently part of South London Healthcare NHS Trust, has also been conducted by Deloitte.

Stakeholder engagement

38. The development of the final recommendations in this report has been underpinned by ongoing engagement with a wide range of stakeholders in south east London. This engagement has sought to deepen people's understanding of the challenges faced by South London Healthcare NHS Trust and how they impact on the wider NHS in the area – and, therefore, the need to look again at how health services in south east London are delivered. It has also been used to understand how best to make changes that secure safe, high quality health services for the local population in a way that is financially sustainable going forward.

39. The case for change and the process for assessing the emerging ideas for long-term solutions were both tested with clinicians, commissioners, Trust staff, other healthcare providers, representative groups of patients, the public and others who have an interest on health services. The TSA and his team led a broad programme of pre-consultation stakeholder engagement events across south east London (see appendix G). The comments and suggestions informed the development of the recommendations that were set out in the draft report.

40. All engagement activities have been underpinned by the launch in September of a Stakeholder Bulletin, published by the TSA and circulated widely to ensure developments in the work programme were communicated. The bulletin provided an update on the work and tells readers where they could find further information. Information about the UPR and signposts to further information have also been publicised through South London Healthcare NHS Trust's website and those of other local NHS organisations and local authorities.

Engagement through a series of workshops to look at the clinical issues

41. A series of workshops were held in August and September 2012, with around 60-80 clinicians, commissioners, managers and representatives from local authorities and the voluntary sector attending each one. The workshops focussed on considering the care that will be required in south east London over the coming years, including the need to provide quality services and transform the way care is provided and integrated across primary, community and hospital services.

42. The workshops provided an opportunity for stakeholders to review the financial challenges facing South London Healthcare NHS Trust and the wider health economy and the objective to meet London-wide quality standards. They were also a forum for clinicians and stakeholders to discuss options for how best to meet the quality standards for emergency and maternity services and for considering the benefits of an elective centre. The discussions at these workshops contributed to the development of the Community-based Care Strategy, which has been an important part of developing the recommendations.

43. These conversations highlighted the need to continue building on the existing joint working across south east London and the benefit that can be gained from regularly bringing together commissioners and providers to discuss opportunities for improvement and integration. In line with this, the key themes arising from these workshops were:

- a recognition that the status quo was neither a desirable nor a sustainable option for delivering clinical excellence within a constrained economic context;
- a consensus to implement agreed, evidence-based clinical standards; and
- a desire for innovative approaches to integrated care.

Engagement with staff

44. Executing a dual role – to develop a set of recommendations for the Secretary of State; and to act as the board of, and Accountable Officer for South London Healthcare NHS Trust, ensuring the day-to-day delivery of services for patients during the UPR period – the TSA has engaged with staff at every level across the Trust. This has involved working at all hospital sites every week and conducting a rolling programme of visits to wards and departments. It has also involved leading the executive team, meetings with clinical teams, a series of regular open staff meetings, attendance at the medical staff committee, one-to-one meetings with clinicians, senior leaders and others and meetings with staff-side representatives. This engagement has helped to maintain the delivery of safe and effective services and helped the TSA to understand the strengths of and challenges facing the organisation and, therefore, has been invaluable in informing the development of the recommendations in this report.

45. As part of the ambassadorial role of members of the TSA advisory group, leaders from other organisations were asked to engage with their staff to update them on the work being undertaken and support their engagement in it as required. Chief executives and directors of all organisations in south east London have been actively involved with the work programme, enabling them to engage effectively with their staff. Information and key messages were also discussed at and conveyed through the communications and engagement working group, to ensure that existing networks and communications channels were utilised during the UPR period.

Engagement with patients and the public

46. Patients and the public have been involved throughout the process, both through a patient and public advisory group and in individual meetings with representatives from Local Involvement Networks, as well as through representative focus groups and by attending engagement events.

47. Feedback gathered from these groups and events has shaped the development of the programme, for example influencing the evaluation criteria used to assess potential options. The groups also developed ideas that helped to ensure that the scope and nature of the consultation was sufficient to facilitate meaningful dialogue with 'seldom heard' or 'hard to reach' groups while fully embracing the requirements of the Equality Act 2010.

48. The media (print, broadcast and digital) have been a significant means of supporting engagement throughout the UPR period. They have highlighted the presence and rationale for the UPR at the Trust, heightened awareness of the work and, in turn, prompted correspondence and reaction from a variety of stakeholders, thereby informing the development of the recommendations.

Formal consultation

49. On 2 November 2012, a formal public consultation with stakeholders on the recommendations set out in the draft report commenced, the purpose of which was to help refine and improve the recommendations and provide an opportunity for alternative options to be proposed. In line with the statutory requirement, the consultation ran for 30 working days and closed at midnight on 13 December.

50. More than 27,000 full consultation documents (see appendix H) and 104,000 summary documents were distributed during the consultation period – these were sent to 2,000 locations across south east London including hospital sites, GP surgeries, libraries and town halls. A dedicated website was established to support the consultation, which has received over 25,000 unique visits since going 'live' on 29 October. During the consultation period, the TSA team attended or arranged more than 100 events or meetings, which included 14 public meetings organised by the TSA team, meetings with a range of community groups and other stakeholder organisations and events for staff (see appendix G).

51. The consultation generated over 8,200 responses, an encouraging figure given the statutory time constraints of 30 working days within which the formal consultation was undertaken under the Unsustainable Provider Regime. The key issues and themes that emerged through the consultation were:

- The importance of the quality and safety of clinical services in the future, including emergency and maternity services;
- Specific views about national policy on the Private Finance Initiative, with particularly personal views from individuals about whether taxpayer's money should be spent on this together with views about the impact the Private Finance Initiative has on the finances of the NHS both nationally and locally;
- Specific views about national policy and preferences, particularly from the public responses received, that NHS services should be provided by traditional NHS providers rather than independent sector providers;
- Agreement about the need for NHS monies to be spent wisely, but concerns that efficiency plans may have an adverse impact on the quality of services and the need to mitigate against this;
- Concerns that planning and modelling for the future, and the subsequent design and configuration of services, takes sufficient account of population growth predictions, likely changes in demographic and health profiles of the population, and the potential need for additional capacity for services in the future in south east London;
- Access to services – including travel times and waiting times; and a strong view that the design and configuration of health services should enhance health and improve the gaps in health inequalities amongst patients and communities;
- The deliverability of the proposed recommendations – including adequate investment, commitment and leadership for transition planning and implementation and the need to address capacity issues where changes to one part of the health system would impact on demand and activity volumes elsewhere; and
- A desire, and expressed need for confidence, that new services (eg improved community-based care) would be put in place before significant changes to other services would be made.

52. Ipsos MORI was commissioned to independently analyse all of the consultation responses received, their report can be found at Appendix I. These themes have been considered in developing the final recommendations. The TSA response to issues and feedback arising from consultation activity can be found at Appendix J.

'Four Tests'

53. In 2010, the Government introduced 'four tests' to be applied to NHS service changes. In producing this report, the TSA has applied these tests in developing the recommendations. A full report can be found at appendix K, but a summary is outlined below.

The changes have support from GP commissioners

54. This began with commissioners supporting the application of the UPR at the Trust in response to the Secretary of State's initial consultation. CCGs' – as the GP commissioners – involvement in the development of the recommendations has included:

- the GP Chairs of the six south east London CCGs being part of the TSA advisory group and clinical advisory group;
- GP Chairs and other members of the CCGs working as part of the team to develop the Community-based Care Strategy and ensuring these were aligned with commissioning intentions; and
- the six clinically-led workshops that were held to help develop draft recommendations, maximising the quality and productivity opportunities, and to gain buy-in for the proposed changes.

55. Support from GP commissioners for the recommendations has been sought through the consultation. In response, Lewisham CCG raised a number of concerns, mainly about the perceived detrimental impact on local residents of the proposed service changes at University Hospital Lewisham. Lewisham CCG's concerns appear to reflect the views of the wider GP community, in that they do not support the emergency care and maternity changes in Lewisham. The other CCGs in south east London are more supportive of the proposals, arguing that they are the right solution for securing high quality services for their populations. They also note the challenges inherent in implementing the changes.

56. Recognising that the TSA, in order to address the issues facing South London Healthcare NHS Trust, has had to make recommendations for service change that impact the health economy across the whole of south east London, it is on this basis (ie. the broad support of the CCGs in south east London) that the application of this test should be gauged.

Strengthened public and patient engagement

57. Patients and the public have been engaged prior to formal consultation both through the TSA's Patient and Public Advisory Group (PPAG), established in early August, and also in individual meetings with representatives from Local Involvement Networks (LINks) and a number of other patient organisations in the area.

58. Feedback gathered from these groups has shaped the development of the programme, for example influencing the evaluation criteria used to assess potential options. These groups have also advised on how to ensure that the consultation plan extends the reach of its activity to embrace the nine protected characteristic groups from the equalities legislation as well as other 'seldom heard' or 'hard to reach' groups.

59. In addition to this, focus group work, with a representative sample of members of the public from all six boroughs in south east London, has been undertaken in order to gather a broad range of views and perspectives and to find out what is important to people when considering local health services. The focus group work was used to critique and test the evaluation criteria.

60. Engagement with patients and the public has been strengthened by using members of the PPAG and Communications and Engagement Working Group, amongst other fora, to cascade information to local groups and networks.

61. During the consultation the TSA hosted 14 public consultation meetings, across all six boroughs, which were publicised via local press and through a range of NHS and public networks. The TSA also attended several additional public meetings organised by local authorities, LINks and community groups. Consultation materials were sent to more than 2,000 sites across south east London, such as GP practices, libraries, pharmacies and community centres.

62. All local authorities in south east London and LINks (with the exception of Southwark) submitted their considered response to the consultation, describing their extensive activities undertaken in engaging their residents. Accepting the limitations of the time constraints applied to the TSA, all have requested to continue to be engaged as the process develops, particularly in the implementation of any resulting changes.

63. A more detailed record of the significant stakeholder engagement activity that has been undertaken since the start of the regime on 16 July through to the publication of this final report of recommendations can be found at appendix G. Considering the timescales in which the TSA has to operate, it is reasonable to assess that this test, on balance, is met.

The recommendations are underpinned by a clear clinical evidence base

64. The work of the TSA has been guided throughout by clinical experts to ensure that solutions reached will improve health outcomes and reduce inequalities for all patients across south east London. Both the recommendations relating directly to the operations of South London Healthcare NHS Trust and those pertaining to the wider south east London health economy are supported by robust clinical evidence and support from a range of national experts. However, the level of support locally is variable, with Lewisham clinicians unsupportive of the detailed proposals.

65. A clinical advisory group – composed of clinicians from each hospital trust and CCG in south east London has fed directly into the TSA advisory group. Placing south east London's clinical leaders at the centre of the programme ensured that work was clinically led and locally appropriate.

66. In addition, an external clinical panel was established to provide additional scrutiny to the draft recommendations. The external clinical panel was assembled to act as a 'critical friend': an independent group that fully understands the context of the work and can provide constructive criticism and ask provocative questions.

67. Clinicians have developed evidence-based minimum clinical commissioning standards for hospital-based acute emergency and maternity services to address these variations in service arrangements and patient outcomes. These were fully endorsed by the London Delivery Group in August 2011 and the London Clinical Senate in September 2011.

68. The TSA clinical advisory group and external clinical panel have further endorsed the clinical quality standards and advised that any future models of acute care in south east London should consistently meet these standards. CCGs in south east London have made this a key aspiration

for their future commissioning intentions. In addition to these groups, London's Clinical Commissioning Council (consisting of representatives of all of London's CCGs) has endorsed the use of these standards.

69. The Royal Colleges responded to the TSA's public consultation and, in summary their views on the recommendations from clinical evidence considered over a number of years have been resoundingly clear: early and consistent input by consultants improves patient outcomes. Compliance with these standards will ensure that the assessment and subsequent treatment and care of patients attending or admitted to these services will be consultant-delivered, seven days a week and consistent across all providers of these services.

70. The clinical benefits of the consolidation of services have already been realised across a range of acute services in London. Consolidation of stroke, trauma and cardiovascular services has led to improvements in care and facilitated the delivery of consistent services across all days of the week and the impacts on outcomes are clear. It is on the basis of all of this evidence that on balance it is concluded that this test is met.

The changes give patients a choice of good quality providers

71. The recommendations proposed in the draft report aim to resolve the long-standing financial challenges of South London Healthcare NHS Trust and deliver a clinically and financially sustainable NHS for the people of south east London. To do this, some services are being centralised, which will impact on the number of locations offering the service. Accessibility and the quality and safety of a service have been taken into account when considering patient choice. Quality of service is ranked highest by patients and clinicians and, for patients, is closely followed by choice of service; therefore the proposals' impact on patient choice is complex and difficult to quantify.

72. The balance between choice and safe, high quality care has been tested by clinicians and informed by feedback from public and patients. Work with stakeholders, through a series of workshops and engagement events, and the integral input of CCGs, the patient and public advisory group and the TSA advisory group, will contribute to the development of services that achieve this balance.

73. The advice offered by the Co-Operation and Competition Panel should also be noted, which sets out that, "*the effect of the recommendations on patient choice and competition in elective, non-elective and community-based services in south east London. In general, developing different solutions for each of the three hospital sites would likely see the introduction of greater choice and competition in the south east London area compared to merging the three hospitals with one single provider.*"

74. With any service change that seeks to drive up clinical quality by concentrating clinical skills on too fewer sites, at face value the choice patients will have if the recommended changes are implemented will reduce. However, the final recommendations for service change in this report, if implemented, will maximise the opportunity for patients to choose between high quality services (delivering the right care in the right place), within the available resources. In this light, it seems reasonable to consider that this test is, on balance, met.

Health and equalities impact assessment

75. All public sector bodies have to give due regard to the "public sector equality duty" that arises from the Equality Act 2010 as part of their-decision making. A combined health and equalities impact assessment (HEIA) has been undertaken to understand the potential impact of the initial recommendations in the draft report as well as assessing the third maternity option, which

emerged through consultation. The purpose of the independent HEIA is to contribute to the information available to support the development of this report and enable the TSA in meeting the formal requirements of the Equality Act 2010.

76. The HEIA is intended to answer three questions:

- What are the positive and negative impacts of the proposed changes on communities within south east London, particularly in respect of health inequalities, equalities and access; taking specific regard, but not exclusively, to the groups defined in legislation?
- What is the scale of each impact; its likelihood and duration, ie whether the impact is long term or temporary; and the impact on those with protected characteristics?
- How can any adverse impacts be mitigated and positive impacts enhanced?

77. In summary, the HEIA captured views from relevant stakeholders and identified several impacts, which could affect differentially the protected groups covered by the Act. Mostly these flow from the relative abundance in the catchment population of University Hospital Lewisham of those at socio-economic disadvantage, black and minority ethnic (BAME) groups, teenage mothers and young children. Several potential mitigations for adverse impacts are suggested, which will reduce but may not fully negate them. The HEIA report also has suggestions for how some of the beneficial impacts of the TSA's proposals might be enhanced.

78. The key positive impacts and enhancements set out by the independent consultants appointed to complete the HEIA include:

- *Emergency and urgent care health outcomes:* reducing variation in performance could save lives and improve outcomes. Economically deprived and older populations could benefit most.
- *Improved Maternity Outcomes:* concentrating obstetric-led maternity could enable 24/7 consultant presence, which could save lives and improve outcomes. Women with high-risk pregnancies could benefit most.
- *Non-complex elective procedure centralisation:* can lead to improved outcomes, better patient experience and reduction in hospital acquired infections. Older people and the BAME population could benefit most.
- *Enhancement to ensure realisation of benefits:* Mechanisms to support the delivery of these benefits, including regular monitoring and binding commitments, should be established, ensuring appropriate capacity is maintained throughout implementation.
- *Enhancement of Community Based Care and integration:* strong Community-based Care services enhance and mitigate several impacts, and can lead to greater integration. There is significant opportunity to improve on current services; resource to support this development should be identified. Older people, people with disabilities and BAME communities could benefit most.

79. Negative impacts and mitigations include:

- *Emergency and urgent care travel time:* Increased travel times for some residents. This could be mitigated through working with the London Ambulance Service and other relevant stakeholders for ambulance transport, and a review of and improvements in public transport, particularly bus routes, to and from hospital sites in south east London.
- *Impact of capacity on patient experience:* if efficiency savings are not appropriately delivered there could be an impact on patient experience due to, for example, increased waiting times. This could be mitigated through robust capacity modelling and clear transition monitoring and implementation planning.

- *Impact on integrated care:* integration could be impacted by increased movement of patients across organisational barriers, this potentially increases safeguarding risks. This could be mitigated by enhanced community based care services, and appropriate policy and models of care being established between organisations in south east London
- *Non-complex elective travel time impact:* an elective hub at University Hospital Lewisham could potentially increase travel time for patients, relatives and carers. However, Transport for London rate the site 'very good' for public transport access, and this could be further enhanced through the review of transport outlined above.
- *Barriers to A&E impact:* there is poor understanding amongst patients of the different services provided by an urgent care centre compared to an A&E department. This could be mitigated through improved information flows, particularly from GPs and primary and community health service staff.
- *Impact on paediatric A&E:* University Hospital Lewisham's paediatric A&E department is highly regarded and delivers good outcomes. To mitigate the impact of changes to this service, the level of paediatrician support in the urgent care centre should be considered.
- *Reduced maternity choice:* the option to centralise obstetric-led deliveries could reduce choice for mothers. There is evidence that co-located midwifery-led units improve patient experience and outcomes, these should be considered at Queen Elizabeth and King's College Hospitals.

80. In drawing up the final recommendations, the TSA is required to give due consideration to the impact on protected groups. The HEIA does not prioritise its impacts and mitigations, however in developing recommendations for the longer term, particular attention during implementation should be paid to:

- the improvements to local public transport that would help ease more complex journeys to new sites. This would be of special relevance to older people, the disabled and those at socio-economic disadvantage;
- the need for a wide ranging and proactive communication plan for any changes, including special targeting at the more vulnerable among the protected groups;
- the necessity for support for community services networked pathways from which the protected groups have most to gain; and
- the monitoring of the equality impact during implementation.

81. The HEIA has enabled the final recommendations to be based on an understanding of the impact of those recommendations on the population of south east London. The potential impacts have been given due consideration in the development of the final recommendations, with mitigating actions and enhancements identified where possible. The full report for the HEIA is provided at appendix L.

4. Assessment of and recommendations relating to South London Healthcare NHS Trust

Introduction

1. The previous chapter explained the approach taken to understand the challenges facing South London Healthcare NHS Trust and the extensive engagement undertaken to ensure all analysis is embedded in a real understanding of the NHS in south east London. This chapter explains, in detail, the outcomes of the TSA's assessment of the Trust. It describes recent clinical and financial performance at South London Healthcare NHS Trust and sets out the financial challenges that the Trust is projected to face over the next three years. Finally, it sets out recommendations relating to the Trust itself and the operations of the sites that make it up.

Clinical performance

2. South London Healthcare NHS Trust and its component hospitals have had, for many years, a number of performance issues in respect of the delivery of clinical services. The Trust has made some improvements since 2009, particularly significant over the last 12 months, achieving the standards within the NHS Performance Framework in relation to service performance and quality domains for the first two quarters of 2012/13. However, the sustainability of these improvements is not yet clear.

3. In 2010/11 the Care Quality Commission (CQC) found the Trust to be non-compliant with essential standards of quality and safety in eight areas. In 2011/12, further CQC visits were made to all three of the Trust's sites, which resulted in confirmation that all essential standards were being met at Queen Elizabeth Hospital and Princess Royal University Hospital, with all but one met at Queen Mary's Hospital Sidcup. A review of maternity services in 2012 found the Trust compliant with all maternity standards at Queen Elizabeth Hospital and Princess Royal University Hospital. Since then additional reviews of standards at all three main sites have been undertaken, including an annual review of standards across the whole of the Trust. The outcome of the annual reviews in October 2012 was compliance against all standards, except those relating to medical records at Orpington Hospital and the management of medicines at Princess Royal University Hospital and Queen Elizabeth Hospital, where minor concerns were raised. Action plans are in place to achieve full compliance by the end of March 2013, this improvement reflects positively on the efforts made by staff across the Trust.

4. For Referral to Treatment Time (RTT) (admitted and non-admitted performance) the Trust failed to meet both the 90% and 95% standard for admitted and non-admitted waits throughout most of 2011/12. However, the Trust has reduced its backlogs to a sustainable level and since May 2012 it has met the RTT standards for admitted, non-admitted and incomplete pathways[13]. It is on track to achieve the standards at speciality level by November 2012.

5. The Trust has a historical track record of poor A&E performance and has been consistently ranked in the bottom 10% of NHS Trusts for A&E wait times nationally. The Trust failed to meet the A&E 'all type' operational standard for 2011/12 – with performance of 93.5% against the 95% standard.

6. However, since February 2012 there has been a significant improvement in the Trust's A&E performance as a result of action taken by the Trust leadership to strengthen ambulatory care, elderly care support to the emergency care pathway and weekend medical cover, as well as ongoing support from the national emergency care intensive support team. In Q1 and Q2 of 2012 the Trust achieved the A&E 'all type' operational standard. There remain significant sustainability issues as evidenced by more variable performance since October due to pressure at both Princess Royal University Hospital and Queen Elizabeth Hospital, although for the first two months of Q3 the Trust, as a whole, continues to meet the standard.

7. The prevention and treatment of venous thromboembolism is a key safety priority and is a measure of the level of care in a hospital. The Trust was significantly below the national benchmark, but has been achieving the standard of 90% and above consistently since June 2012.

8. Infection prevention and control performance continue to be strong at the Trust, with MRSA targets achieved for the last three years (with no cases in 2012/13 to date) and an improved profile for Clostridium difficile (C diff) during this time. The Trust is currently ahead of trajectory to deliver further improvements against the national target for C diff in 2012/13.

9. The efforts of the current staff and leadership team in delivering improvements across key performance standards and the quality and safety of care should be acknowledged and commended. However, there is 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 changes in systems, processes and culture internally and action across the broader local health system to secure services that are financially and clinically sustainable in the long term.

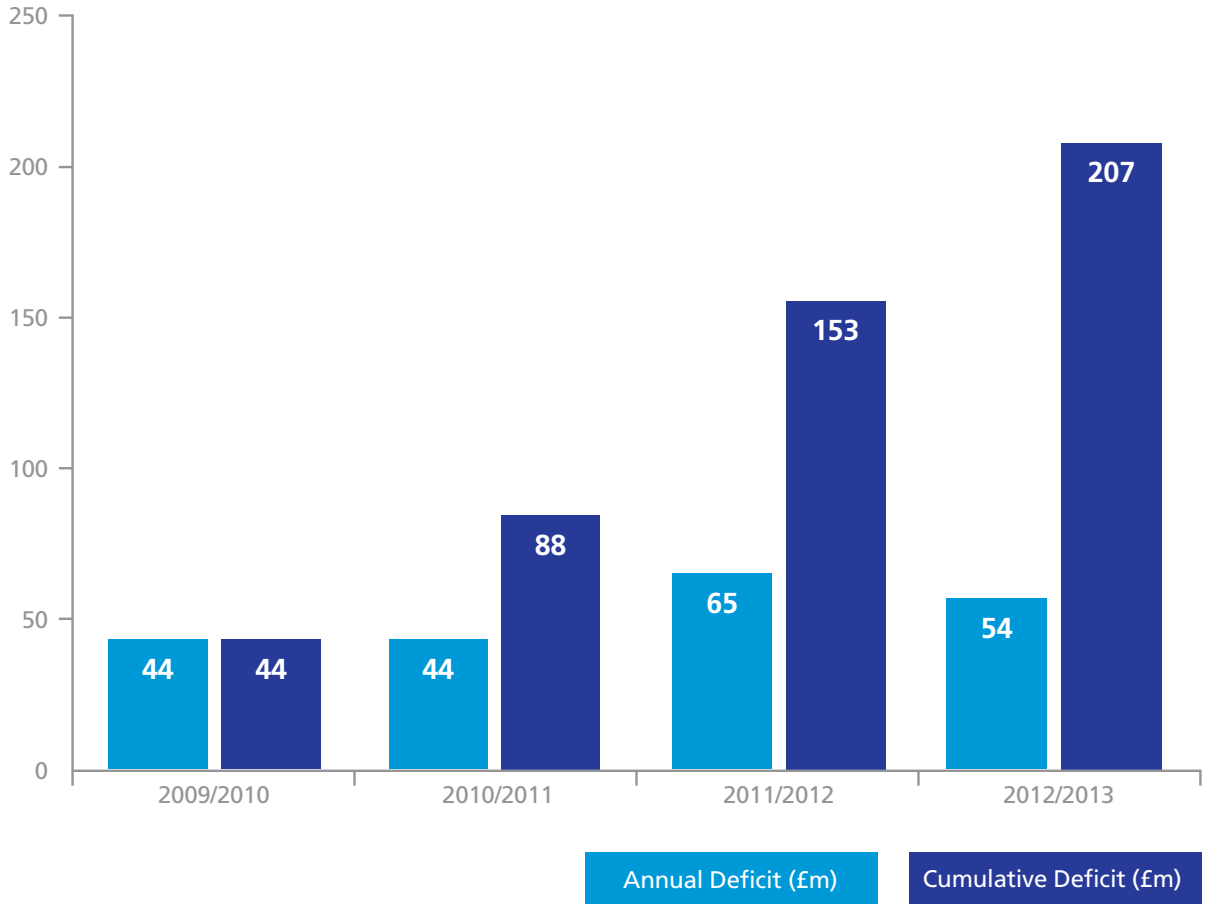
Financial performance

10. South London Healthcare NHS Trust is in a very poor financial position. It has experienced a range of financial challenges, particularly in the chronically poor control of costs and in its repeated failure to deliver against agreed plans. These issues are well rehearsed and were a feature of *The Case for Applying the Unsustainable Provider Regime* (see appendix A).

11. Since its establishment in 2009, the Trust has accumulated deficits totalling £153m. By the end of this financial year, this will have risen to £207m (see figure 7). In the financial year 2011/12, only 30 out of the 266 NHS Trusts and NHS Foundation Trusts in England reported a deficit*. Of these, South London Healthcare NHS Trust had the largest at £65m (14.8% of the Trust's income) making it the most financially challenged Trust in the NHS. This was an increase of nearly 50% from £44m in each of the financial years 2009/10 and 2010/11.

* 9 of 104 NHS Trusts and 21 of 163 NHS Foundation Trusts reported a deficit.

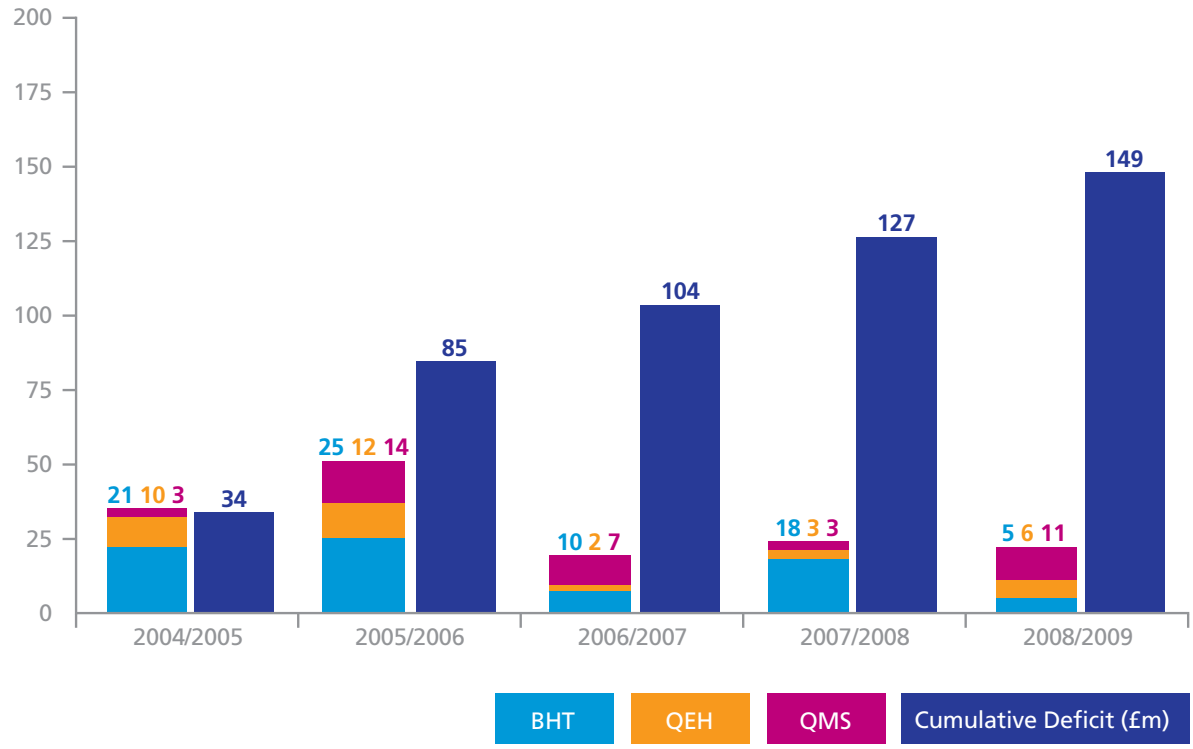
Figure 7: Normalised deficit of South London Healthcare NHS Trust 2009/10 to 2011/12 and forecast for 2012/13[14,*]



12. The financial issues of the Trust did not start with its establishment in 2009. Each of the three predecessor organisations – Queen Mary's Sidcup NHS Trust (QMS); Queen Elizabeth Hospital NHS Trust (QEH) and Bromley Hospitals NHS Trust (BHT) – had overspent every year since 2004/05 (see figure 8). In 2009/10, the first year as a merged Trust, South London Healthcare NHS Trust reported a normalised deficit of £44m. The main cause of this was the failure to deliver cost improvement programme schemes (CIPs), the implementation of which were hindered by organisational disruption caused by merger, an increasingly challenging commissioner environment and an inability to contain expenses within previous levels, which had, to some extent, been achieved by non-recurrent and unsustainable measures. By the time of their dissolution on 31 March 2009, they had £149m of debt associated with the accumulation of deficits. Taking these two periods together (ie. 2004/05 to 2012/13), the total forecast cumulative deficit is £356m.

* NHS Control Total basis excluding impairments and IFRS impact.

Figure 8: Normalised deficit of Queen Mary's Sidcup NHS Trust, Queen Elizabeth Hospital NHS Trust and Bromley Hospitals NHS Trust 2004/05 to 2008/09[15]



Summary of financial performance for 2009/10 to 2012/13

13. In making recommendations to resolve the current and future challenges faced by South London Healthcare NHS Trust, it is important to understand fully the underlying financial challenges facing the Trust. This includes its financial performance since 2009/10, how it has responded to the challenges it has faced since its establishment and its current financial position.

14. Figure 9 outlines the financial performance of the Trust since its formation and the forecast position for 2012/13. It shows a deterioration over the period, with any cost improvements generally proving unsustainable. The key points are:

- Total revenue has declined by £32.1m (6.9%) over the four years, which the Trust has inadequately adjusted for. The most significant decline took place between 2009/10 and 2010/11.
- Operating costs have reduced by £27.1m (5.6%) over the four years. This has not been a consistent reduction, as operating costs increased between 2010/11 and 2011/12 by £20.6m (4.5%), despite income remaining constant. The 2012/13 financial plan sees this being reduced by £20.3m so that costs return to a similar level to 2010/11. The fluctuation of these costs demonstrates a lack of financial control during this period.
- Finance costs, which principally relate to the two whole hospital PFIs located at Princess Royal University Hospital and Queen Elizabeth Hospital, have increased by £6.24m (29.5%) over the last four years as the interest associated with the PFI has increased because of IFRS accounting standards and changes to the principal due.
- The 'control total' operating deficit is forecast to be £54.2m in 2012/13. Whilst this is an improvement on the 2011/12 position, it still means the Trust is losing over £1m a week.

Figure 9: Normalised financial performance 2009/10 to 2011/12 and forecast for 2012/13[14]

Currency: £m	2009/10	2010/11	2011/12	2012/13	% Change
Revenue from patient care activities	421.7	407.8	408.8	396.2	(6.0)
Other operating revenue	40.9	30.0	30.1	34.3	(16.1)
Total revenue	**462.6**	**437.8**	**438.9**	**430.5**	(6.9)
Employee costs	(306.9)	(293.8)	(301.7)	(282.2)	(8.0)
Non pay costs	(173.8)	(159.5)	(172.2)	(171.4)	(1.4)
Total operating costs	**(480.7)**	**(453.3)**	**(473.9)**	**(453.6)**	(5.6)
Finance costs	(21.0)	(23.3)	(26.3)	(27.2)	29.5
Public Dividend Capital dividends payable	(9.1)	(8.4)	(8.4)	(8.5)	(6.6)
IFRS Adjustment	4.5	3.4	4.7	4.6	2.2
Surplus / (Deficit) on NHS Control Total Basis	**(43.7)**	**(43.8)**	**(65.0)**	**(54.2)**	19.2
Impairment	(42.3)	0.0	(16.9)	0.0	
Retained Surplus / (Deficit) for the financial year	(86.0)	(43.8)	(81.9)	(54.2)	

Income

15. The significant majority of the Trust's income (91%) comes from Bexley, Bromley and Greenwich PCTs. The Trust has seen its income reduce by £32.1m (6.9%) over the last four years (see figure 10) as a result of:

- national tariff deflation, which requires an annual efficiency improvement to be made by all NHS Trusts;
- commissioners' plans that have led to a reduction in patient care activity-related income, as more activity is delivered through community-based care; and,
- overall income fell most significantly between 2009/10 and 2010/11, as a consequence of commissioners applying more rigorous but appropriate, contract management techniques.

Figure 10: Breakdown of income 2009/10 to 2011/12 and forecast for 2012/13

Currency: £m	2009/10	2010/11	2011/12	2012/13	% Change
Primary care trusts	419.9	404.2	405.6	393.1	(6.4)
Non NHS: other patient care	1.8	3.6	3.2	3.1	72.2
Total income from patient care activities	**421.7**	**407.8**	**408.8**	**396.2**	**(6.0)**
Other operating revenue	17.7	12.2	8.3	5.1	(71.2)
Education, training and research	16.5	15.7	15.2	15.2	(7.9)
Non-patient care services to other bodies	1.7	2.1	5.7	13.2	676.5
Income generation	5.0	0.0	0.9	0.8	(84.0)
Other operating income	**40.9**	**30.0**	**30.1**	**34.3**	**(16.1)**
Total operating income	**462.6**	**437.8**	**438.9**	**430.5**	**(6.9)**

Operating costs

16. Within a slightly reducing overall cost base, the proportion related to employee cost has remained in the region of 62-65% (see figure 11).

17. Temporary staff expenditure is a significant and continuing problem for the Trust. For example, in 2011/12 agency staff costs were budgeted to be less than £3.4m, whilst the actual cost was £13.3m. South London Healthcare NHS Trust's target for agency usage is 1.0% of total workforce and yet, in 2011/12, it was 4.4%. Compared with its peers, the Trust has consistently underperformed in controlling its levels of usage of temporary staff and such staff mix comes at a premium. In 2012/13, the Trust's plan was to spend £23.9m on temporary staff, but at the half year point the Trust's year end forecast had risen to £33.8m, indicating that the Trust is still struggling to control temporary staff costs.

Figure 11: South London Healthcare NHS Trust Employee costs 2009/10 to 2011/12 and forecast for 2012/13

Currency: £m	2009/10	2010/11	2011/12	2012/13
Total, excluding bank staff, locums and agency staff	268.2	259.5	262.2	258.3
Bank staff	17.8	18.5	22.2	13.3
Locum staff	2.7	3.1	4.0	4.0
Agency staff	18.2	12.7	13.3	6.6
Total bank, locum and agency staff	**38.7**	**34.3**	**39.5**	**23.9**
Total	**306.9**	**293.8**	**301.7**	**282.2**
% of expenses	63.8%	64.8%	63.7%	62.2%
% of bank, locum and agency staff	12.6%	11.7%	13.1%	8.7%

18. The Trust's inability to contain these 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 some permanent positions being removed, only to be replaced with more costly temporary staff. This has been a recurrent issue and one which the Trust has been unable to address. The lack of a clear plan for financial and operational viability and the worsening financial outlook has compounded this issue, making the Trust a less attractive organisation for potential recruits.

19. Non-pay costs, excluding impairments, are forecast to decrease by 1.4% over the four years to 2012/13 (see figure 12). This contrasts with the much more signifcant reduction in patient-related activity and income shown in figure 10.

20. The gains made through a concerted turnaround programme in 2010/11 proved to be unsustainable, and non-pay costs returned in 2011/12 to levels above those seen in 2009/10. The £12.7m (8.0%) increase was driven largely 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. The operational efficiency assessment has identified a lack of capacity and capability in the Trust's procurement function, with the same products being purchased from different suppliers and at different costs.

Figure 12: Non-pay costs 2009/10 to 2011/12 and forecast for 2012/13[15]

Currency: £m	2009/10	2010/11	2011/12	2012/13	% Change
Supplies and services – clinical	68.9	70.9	83.3	83.3	20.9
Premises	38.2	31.4	35.8	37.0	(3.1)
Clinical negligence	10.6	11.2	13.3	13.5	27.4
Supplies and services – general	13.3	12.7	12.8	13.0	(2.3)
Establishment	5.2	5.2	5.1	5.1	(1.9)
Depreciation	16.0	13.2	13.5	13.9	(13.1)
Other	21.6	11.6	8.4	5.6	(74.1)
Total non-pay operating expense	**173.8**	**159.5**	**172.2**	**171.4**	(1.4)

Cost improvement programme schemes (CIPs)

21. In the three years up to and including the financial year 2011/12, the Trust generated CIP savings of £91.5m. The cumulative level of savings is forecast to rise to £117.4m by the end of the current financial year. This is a significant level of cost reduction (c. 25%) but it is not in line with what the Trust was planning to do. South London Healthcare NHS Trust has a history of underperformance against budget (see figure 13). In 2011/12, only 68% of cost savings were achieved. The key reason for this underperformance has been the Trust's limited ability to deliver successfully against plans that it has developed, against an organisational environment that has lacked sufficient clinical and wider staff commitment to radical change. The historic trend at the Trust has also been for savings realised in one year not to be fully maintained in subsequent years. It is also clear that the savings plans outlined in the initial case for merger were not sufficient to realise longer term financial viability, as the commissioning environment changed.

22. Given that clinical productivity is one of the prevailing issues at the Trust, a much greater level of clinical leadership would have been required to deliver on plans. The TSA team also found the governance arrangements for holding the divisions to account for the delivery of CIPs to be lacking, with unachievable and therefore unrealistic targets being set.

23. The Trust has also failed to reflect long-term changes in demand. In such circumstances, plans are often short-term reactions to pressures and demonstrate a lack of planning, engagement and / or awareness of the impact of changes in activity levels on the cost base.

24. The Trust has had to respond to a number of complex and difficult challenges from its commissioners relating to the coding and invoicing of its activity, with the Trust struggling to be able to present reliable activity data. During 2012/13, the benefits of improved systems have significantly reduced the level and nature of activity queries, and to date 2012/13 is the first year the Trust and commissioners have not had to resort to formal arbitration to resolve these queries. However the cumulative destabilising effect of the lack of robust, agreed data has been a significant impairment to understanding the underlying financial position.

Figure 13: Summary of CIP savings 2009/10 to 2011/12 and forecast for 2012/13*,16

Currency: £m	2009/10	2010/11	2011/12	2012/13
CIP - Plan	30.4	51.5	30.6	25.9
CIP - Actual	24.1	46.7	20.7	25.9
% CIP actual vs plan	79.3%	90.7%	67.6%	100.0%
Actual CIP as % total costs	4.6%	10.4%	4.2%	6.0%

25. The key headlines underpinning the Trust's poor performance on the delivery of CIPs each year have been:

- 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.
- The 2010/11 savings 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, the Trust underperformed by £9.9m against its CIP. The Trust's primary explanation for this was the changing nature of activity and the desire to ensure services remained safe. As noted above, the overall operating cost evolution in this year (+4.5%) would also suggest that many of the gains from the 2010/11 programme were reversed, in part for similar reasons of safety concerns.
- In 2012/13, the Trust is £1.1m behind its CIP at the half-year point, but actions are in train to ensure the full delivery of the CIP by the year end through the identification and delivery of additional schemes since the appointment of the TSA. While this will ensure the Trust will achieve its financial plan for 2012/13, it would still be in the context of a deficit for the year of more than £50m.

26. One of the common trends reflected through the Trust's CIP efforts is the absence of a clear and embedded turnaround strategy across the Trust. This is demonstrated by the high number of low value CIPs rather than the Trust addressing key strategic challenges, such as overall medical productivity. At the time of establishing the Trust, its clinical and managerial leadership did not harness the opportunity to embed a culture capable of maximising operational efficiency. This, in addition to the legacy cultures that exist in the individual sites, has not helped the organisation make the scale or pace of change required. As a consequence opportunities to address some of the underlying issues have been missed. One of the key tasks of those taking on the leadership of the Trust's operations will be to exploit these opportunities to the full and then ensure they are sustained.

27. To illustrate this, figure 14 demonstrates the significant variation in 2010/11 and 2011/12 between the Trust's initial plans, which are generally submitted in the January prior to commencement of the financial year (in April), the final plans and the actual outturn. In both 2010/11 and 2011/12, the Trust's financial plans were not settled until well into the financial year, the significant shifts in all areas highlights the lack of detailed understanding within the Trust regarding its own income and cost base, and the real drivers of its financial position.

* TSA analysis

Figure 14: Plan versus actual delivery for 2010/11 and 2011/12*

2010/11	Plan	"Final Plan"	Actual
Income	452.2	438.9	438.9
Operating Cost	442.5	450.3	453.3
CIP	36.8	51.5	46.7
2011/12			
Income	435.2	410.4	438.9
Cost	434.6	446.4	473.9
CIP	19.6	30.6	20.7

Cash flow

28. The operating cash position has deteriorated since 2009/10, with a significant cash outflow in all years, including a forecast funding requirement of £58.8m in 2012/13. This has been driven by the significant deficit generated by the Trust during the year. The Trust would be insolvent without the significant additional public dividend capital that it has received (£226.2m in the four years up to and including 2012/13).

Deficit analysis

29. Extensive analysis, assessment and modelling have been undertaken to understand better the reasons for the Trust being consistently in deficit. As part of this, the TSA team has considered the financial status of each of the three main sites on which the Trust operates. Adjustments have been made to the forecast outturn for 2012/13 to recognise a net £0.7m non-recurrent benefit available in 2012/13, and to reflect International Financial Reporting Standards (IFRS), resulting in a recurrent normalised deficit of £59.5m. The analysis of the future financial position is based on the Trust's normalised position. All three sites make a deficit on an annual basis. The 2012/13 forecast deficit for the Trust consists of: Princess Royal University Hospital £20.3m (11% of income), Queen Elizabeth Hospital £28.3m (16.3% of income) and Queen Mary's Hospital Sidcup £10.9m (15.2% of income).

30. In the course of this analysis, four key drivers for the annual deficits have emerged:

- *Assets* – The Trust owns a significant amount of land and buildings. Many of these buildings could be much more efficiently used; indeed, some of the buildings on the Queen Mary's Hospital Sidcup site are entirely empty. All of these buildings carry a cost with them. For example, the Queen Mary's Hospital Sidcup site's significant excess capacity is attracting an ongoing cost per year of £4.4m. In addition, some of the Trust's *assets* are significantly more expensive than the average cost of NHS estate. This is particularly true for the whole hospital PFI contracts at Princess Royal University Hospital and Queen Elizabeth Hospital. The PFI arrangements are discussed further later in this chapter. The payment arrangements in the NHS mean the Trust is not being adequately recompensed for the costs of the PFI-funded buildings.
- *Operational efficiency* – When compared with their peers, the Trust is significantly less efficient in a range of areas, particularly staffing, equipment and materials costs.

* Although the actual income remained broadly consistent between 2010/11 and 2011/12, in both years the final income positions were negotiated between commissioners and the Trust, taking overall affordability into account

- *Leadership* – The Trust has undergone a series of reviews and turnaround programmes over the last two years, resulting in short-term leadership. In addition, a lack of clinical and managerial leadership capacity and an insufficiently developed organisational culture have meant lasting improvements have not been delivered.
- *Merger synergies* – Many of the potential benefits of the merger that created the Trust have not been realised since it was created. While there has been integration of some corporate and a small number of clinical services, the development of a single organisational culture, coherent strategy and decision making framework has not taken place. Decision making remains variable and distinct across the three sites and the hospitals function largely independently of one another with little standardisation of clinical strategy or operational support (such as medical records and IT). Notwithstanding the progress made in some services such as stroke care and maternity, clinicians have not developed into cohesive Trust-wide teams, which could have taken advantage of scale, and relationships between the legacy teams, both clinical and non-clinical are unsophisticated and have not matured as would have been expected. The lack of integration of clinical and operational performance reporting combined with the lack of development of a 'single trust' clinical culture combined with gaps in leadership have hampered efforts to transform productivity at scale.

31. The work has also examined whether the Trust receives income at a level that is appropriate for the work it carries out. In the past, the Trust's activity and income generation systems, as noted above, have not allowed the Trust to develop an understanding of its activity base. Additionally the Trust has had issues with the preparation and quality of its financial information, such as the late submission of its Annual Accounts for 2010/11. Although a programme for improving financial reporting began in 2011 and has made progress, some considerable issues remain. Continued failings can be put down to poor financial governance, record keeping and difficulties with information systems. The weaknesses have also led to repeated claims from its commissioners that it is 'overcharging' for activity, countered by the Trust that commissioners are 'underpaying' for their services.

32. These contradictory positions have resulted in significant management time being invested in attempting to address the issue. It has also led to significantly different assumptions about future activity levels being represented in commissioners' and the Trust's long term plans. The Trust's internal systems have been unable to resolve these problems with any accuracy. That said, having explored this issue in some detail, the TSA's team has concluded that whilst there remain a number of problems with the way the Trust collects and records information about its activities, the financial impact of this on both the Trust and its commissioners is minimal.

Financial projections – 2013/14 to 2015/16

33. Having understood the drivers of the current deficit, the Trust's financial projection for the three years 2013/14 to 2015/16 (see figure 15) has been produced. This projection has taken full account of commissioning intentions and an assessment of the Trust's CIP opportunity for that period. The three-year CIP opportunity for the Trust (£43.3m) is based on a risk assessed proportion of the total potential productivity opportunity (£74.9m). This assessment of opportunity has been made at the level of cost category (eg. medical, nursing, scientific, therapeutic and technical staff (ST&T), non-clinical pay, supplies and other variable costs) with an assessment of the ability to deliver being based on the Trust's track record and capacity for delivery in these areas. With these two things in mind it has been assumed that the Trust can deliver £43.3m of CIPs over three years. Despite this, the Trust will continue to be in deficit every year, in part driven by the efficiency requirement in the national tariff (see appendix D for further detail on the operational efficiency assessment).

Figure 15: Normalised financial plan for 2012/13 and financial projections for 2013/14 to 2015/16*

2012/13	Income	Cost	Deficit	Gap to 1% (positive = below 1%)
Princess Royal University Hospital	184.1	204.4	-20.3	22.1
Queen Elizabeth Hospital	174.1	202.4	-28.3	30.0
Queen Mary's Hospital	72.1	83.0	-10.9	11.6
Total	**430.3**	**489.8**	**-59.5**	**63.8**

2013/14 Full year effect	Income	Cost	Deficit	Gap to 1% (positive = below 1%)
Princess Royal University Hospital	184.1	207.0	-22.9	24.8
Queen Elizabeth Hospital	173.1	205.7	-32.6	34.3
Queen Mary's Hospital	61.6	72.3	-10.7	11.3
Total	**418.8**	**485.1**	**-66.2**	**70.4**

2014/15 Full year effect	Income	Cost	Deficit	Gap to 1% (positive = below 1%)
Princess Royal University Hospital	183.7	210.4	-26.7	28.6
Queen Elizabeth Hospital	176.2	211.1	-34.9	36.6
Queen Mary's Hospital	62.7	74.4	-11.7	12.3
Total	**422.6**	**495.9**	**-73.3**	**77.5**

2015/16 Full year effect	Income	Cost	Deficit	Gap to 1% (positive = below 1%)
Princess Royal University Hospital	184.0	212.4	-28.4	30.3
Queen Elizabeth Hospital	179.7	215.2	-35.5	37.3
Queen Mary's Hospital	64.2	75.3	-11.1	11.7
Total	**427.9**	**502.9**	**-75.0**	**79.3**

Implications and recommendations for action

34. The TSA's analysis and forecast sets the basis of the financial challenge to be resolved within South London Healthcare NHS Trust. A good benchmark of a viable organisation is its ability to deliver a 1% net surplus each year. As demonstrated by the financial projection shown in figure 15, South London Healthcare NHS Trust has a considerable financial gap to bridge to meet that benchmark. The projections also highlight the deteriorating financial position of the Trust due to its forecast inability to meet national efficiency requirements and the difficulty of aligning its cost base with expected levels of income and activity.

35. It is the responsibility of the TSA to produce a set of recommendations that address this shortfall. The rest of this chapter details proposals for addressing the challenges within South London Healthcare NHS Trust. The recommendations cover the substantial changes that are required to stabilise the Trust's financial position in a way that aims to deliver long-term sustainability.

* TSA analysis

Recommendation 1: Operational efficiency

36. The first phase of the TSA's work programme included developing a detailed understanding of the operational performance of South London Healthcare NHS Trust. The work was designed to understand what needs to be done to improve operational efficiency at the Trust by addressing the following questions:

- How big is the operational efficiency opportunity at the Trust?
- What are the main improvement opportunities and what could they be worth?
- What will it take to deliver these improvements over the next three years?
- How does this translate into implementation plans?

37. A six-week piece of work reviewed the Trust's current operational efficiency and identified the size of the potential opportunity that exists to improve the efficiency and effectiveness of the services currently delivered by the Trust. The work was supported by an external consultancy team which worked with senior leaders within South London Healthcare NHS Trust to identify and confirm the opportunities, challenge the Trust's thinking and bring innovative solutions, based on proven best practice.

38. The approach consisted of two methodologies – an external benchmarking, in which the Trust was compared with 18 similar NHS organisations, and a detailed internally-focused review of the current cost base of the Trust. Both of these identified a similar efficiency gap. The benchmarking methodology showed that an opportunity of £57m existed to match the top three performers in the Trust's peer group, whilst the detailed internal review of the cost base indicated that the opportunity was £62m.

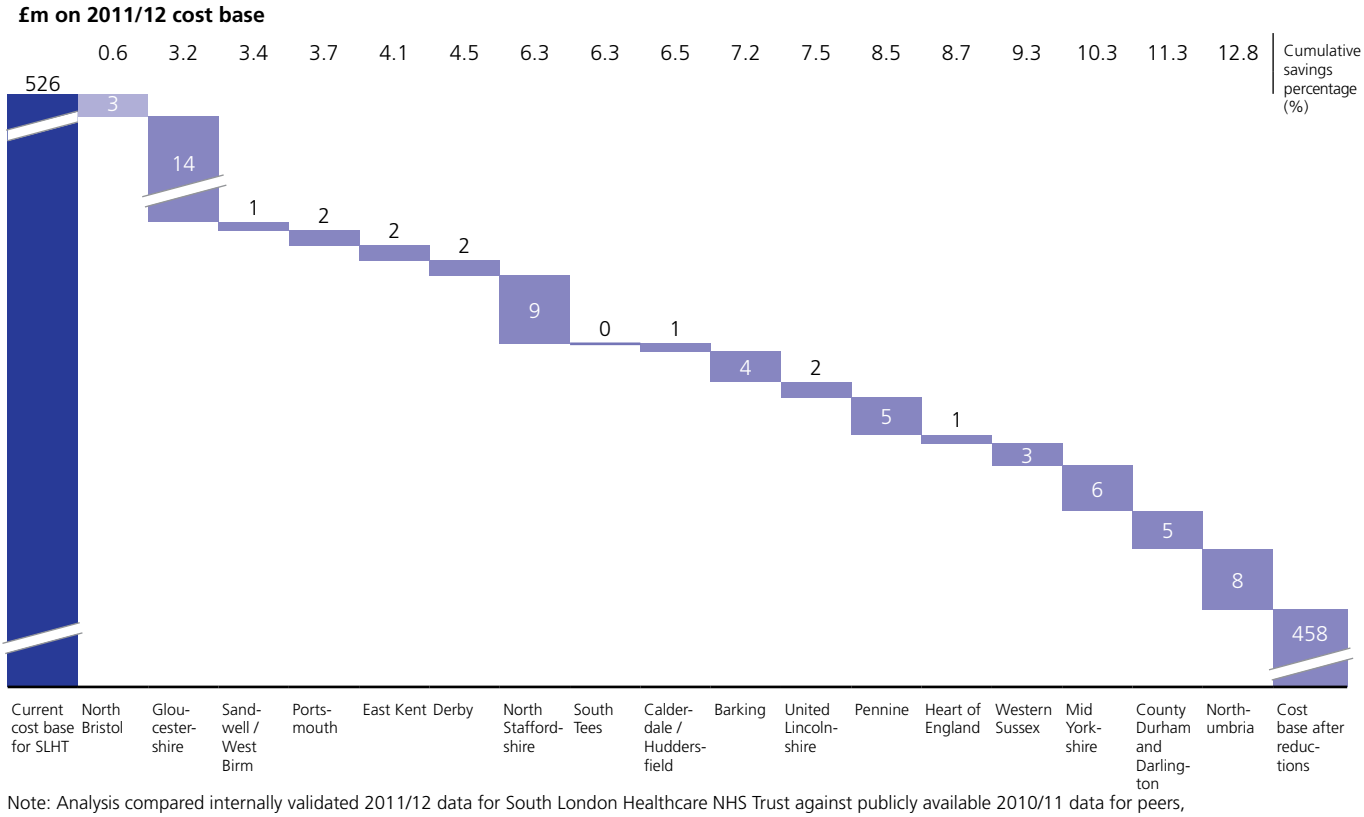
39. Figure 16 shows how the cost base of the Trust would reduce if it matched the productivity levels of 17 of its 18 peer Trusts. Eight of the 17 Trusts that perform better than South London Healthcare NHS Trust are foundation trusts and the other nine are NHS trusts.

40. The financial position and quality assessment of the peer group of trusts is shown as part of appendix D. Importantly, the top peer trusts against which South London Healthcare NHS Trust was benchmarked – County Durham and Darlington NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust – have higher quality scores* than the Trust and strong financial risk ratings (both are rated 4 by Monitor**). This indicates that reducing cost, whilst achieving improved quality is possible.

* This is a composite quality index made up of around 20 indicators which are collected nationally

** Monitor publishes financial risk ratings (FRRs) for each Foundation Trust, which are updated every quarter. FRRs are the single critical measure of Monitor's assessment of the risk to the financial health of a Foundation Trust. FRRs range from 1 - which represents the highest risk - to 5 - which represents the lowest risk

Figure 16: Reductions in cost base from matching overall performance of South London Healthcare NHS Trust to that of peer hospitals*



Note: Analysis compared internally validated 2011/12 data for South London Healthcare NHS Trust against publicly available 2010/11 data for peers, except in case of clinical supplies, where 2010/11 data used for South London Healthcare NHS Trust (publicly available, but validated as well)

41. These organisations, and all other Trusts, will continue to deliver greater efficiencies. To keep in line with national assumptions these Trusts will be looking to make 4% efficiency improvement every year. As it is not plausible to deliver £62m of operational improvements in a single year, a three-year programme of improvement has been considered for South London Healthcare NHS Trust. Linked to this is an assumption that further savings from continuous improvement will be required over and above the £62m to ensure the Trust keeps aligned with national requirements and with higher performing peers. The original assessment of opportunity was increased by 2% a year to account for this, using an assumption drawn from recent Department of Health and NHS London studies. This takes the overall efficiency opportunity to £79m over three years which equates to 5.4% a year**,16.

42. The £62m of savings opportunity identified through the benchmarking and detailed internal review of the Trust's operations showed costs can be reduced in a number of 'cost categories':

- *Medical pay (£20m)*: The Trust has the lowest income per consultant in its peer group, a very high ratio of junior doctors to consultant staff and high use of locum and agency staff.
- *Nursing pay (£14m):* Compared to its peers, 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). The Trust also has a higher proportion of senior staff than its peers.

* South London Healthcare NHS Trust was less efficient than 17 of the 18 Trusts in its peer group. The Trust that is less efficient than South London Healthcare NHS Trust, which is North West London Hospitals NHS Trust, is not shown on the chart

** NHS London's Sustainable and Financially Effective Report identified, based on analysis of achievements by leading national and international organisations, that a healthcare provider cannot be expected to sustain a rate of efficiency improvement of more than 20& or 5.4% per annum over four years or without structural change

- *Scientific, Technical and Therapeutic (ST&T) staff pay (£4m):* Compared with its peers, the Trust has a higher number of full time equivalent staff relative to the income of the Trust in multiple professional groups. These include pharmacy, speech and language therapy and various sub-specialities of pathology. In addition, the Trust has high bank spend for scientific, technical and therapeutic staff relative to its peers.
- *Average length of stay (£6m):* Overall average length of stay for the Trust is lower (and therefore better) than the peer median for elective spells and only slightly higher (and therefore worse) than peer median for non-elective spells. However, there is still a gap to the top three peers. To estimate the actual opportunity in this area, the average lengths of stay for individual groups of patients in each specialty were benchmarked to peers. This more detailed analysis reveals a potential savings of 90-100 beds (on top of recent changes) if the Trust were to achieve top quartile performance.
- *Non-clinical pay (£4m):* The £50m non-clinical pay spent on 'back office' staff (eg. human resources, IT and procurement) and 'middle office' staff (eg. medical secretaries, ward clerks and receptionists) has been 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 were assessed, using outsourcing as the primary alternative.
- *Supplies (£9m*): The review of non-pay spend at category level (eg. prosthetics, dressings, disposable items and other consumables) concluded that there was the potential for a saving of £9m across the Trust, through a combination of supplier consolidation, better negotiation, managing demand and reducing stock levels.
- *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.

43. It was also recognised that there are 'settings of care' that cut across a number of the individual 'cost category' opportunities in the previous paragraph:

- *Theatre utilisation*: the current amount of time that is used for operating is on average 67%, compared to a national average of 85%. On average, in a theatre session staffed for four hours, only 2 hours 40 minutes are used for operating on patients. This means the Trust has to staff and run more lists than should be needed.

- *Outpatient utilisation*: there are currently very high numbers of unused outpatient slots because of patients failing to attend their appointments, meaning that the Trust has to staff and run more clinics than should be needed. Reviews of potential reasons behind this indicate that the Trust's shortcomings, including inflexible booking arrangements, poor communication with patients and multiple changes to appointment times are significant contributory factors.

44. Between the publication of the draft report and the completion of the final report, a second phase of work was undertaken in which the identified opportunities were translated into detailed CIPs for the three year period 2013/14 to 2015/16. The schemes were all developed over an intensive five-week process in which the external advisors from phase one continued to work with the leadership teams of the four clinical care groups and corporate services. Dedicated finance, workforce and information management resources were provided to work alongside each group to develop and validate all initiatives. The teams developed 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).

45. A significant number of responses to consultation highlighted concerns about the potential negative impact of the proposed efficiency improvements on the safety and quality of clinical services.

46. Throughout the work, the importance of safeguarding service delivery, quality and safety has been recognised and is paramount. A combination of internal clinicians from the key professional groups and external clinicians, including the external clinical panel, have been involved in the development of many of the schemes. An initial review of the schemes has been undertaken by the Chief Nurse and Medical Director for South London Healthcare NHS Trust and by 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 are considered.

47. Together, the outcome of ther reviews have made four major recommendations:

- 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 that are related to existing local and pan-London service networks;
- a strong implementation programme and ongoing 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.

48. The Trust is currently working to implement these recommendations, which will include a process of review and assurance. Significantly, the clinical review panel highlighted the need for both strong clinical and managerial leadership to deliver this ambitious programme.

49. The detailed CIP work and the clinical oversight it has been given should provide reassurance that quality and safety of services should not ne negatively impacted by this recommendation. The quality of care of more efficient hospitals being as good as or better than South London Healthcare NHS Trust's, as referenced in paragraph 40, is also an important point. Clinical leadership and engagement in implementing schemes will be critical to ensure successful delivery.

50. The CIPs have been developed on the basis of changes to the current clinical and corporate services provided by the Trust. Potential opportunities arising from changes to service configuration and organisational arrangements have been addressed separately within the TSA's overall work programme and are addressed in chapters 5 and 6 respectively.

51. A total of £74.9m of savings have been developed through the phase two work (see figure 17), which closes the identified productivity gap of £62m over the three-year period, as well as delivering the majority of the additional efficiency gains required to keep pace with national expectations. 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.

Figure 17: Recommended CIPs by site for 2013/14 to 2015/16*

Site	Queen Elizabeth Hospital	Princess Royal University Hospital	Queen Mary's Hospital	Total
2013/14	£11.2m (5.5%)	£10.9m (5.3%)	£4.2m (5.1%)	£26.3m (5.4%)
2014/15	£10.9m (5.7%)	£9.7m (5.0%)	£4.2m (5.5%)	£24.9m (5.4%)
2015/16	£10.2m (5.6%)	£10.3m (5.6%)	£3.2m (4.3%)	£23.7m (5.4%)
Total	**£32.3m (15.9%)**	**£30.9m (15.1%)**	**£11.7m (14.1%)**	**£74.9m (5.4%)**
CAGR	-5.6%	-5.3%	-5.0%	-5.4%

52. The change over the three the three-year period by cost category is shown in figure 18.

Figure 18: Proposed change in the cost base by cost category[25]

Cost category	Current cost base	Improvement over the 3-year period
Medical	£90m	£14.8m (16.4%)
Nursing	£98m	£16.9m (17.2%)
ST&T	£37m	£4.5m (12.2%)
Average length of stay		Included in medical, nursing and ST&T
Non clinical pay	£50m	£10.1m (20.2%)
Supplies	£72m	£14.9m (20.7%)
Other variable	£18m	£13.7m (91.3%)
Total	**£526m****	**£74.9m**

53. The following levers are considered to be critical to the successful delivery of the CIPs, and in particular ensuring that there is rapid progress on productivity at the clinical service line:

- significantly strengthened leadership of the board and clinical divisions;
- a substantial upgrading of clinical and operational management capability throughout the organisation;
- a culture based on much stronger clinical, and specifically, medical engagement, with a step change in partnership working between clinicians and managers;
- improved systems and processes to support clinicians in performing to their maximum potential;
- strengthened job planning;
- timely and accurate information that provides insight into performance and productivity relative to peers; and
- significantly strengthened procurement capability.

54. The Trust's performance since its establishment, which was outlined earlier in this chapter, demonstrates its inability to deliver sustainable cost improvement despite several Trust-commissioned external reviews to support the identification of CIP opportunities and set up the implementation mechanisms required. The TSA analysis has concluded that the depth of the clinical and managerial capability currently available within the Trust is simply not sufficient to deliver this level of operational efficiency transformation, and that it cannot be "acquired" at the required pace by the Trust continuing to operate in its current form. Embedding a new culture and underpinning ways of working throughout the organisation by organic means would also take too long to impact on medium term CIP delivery.

* In year % savings are shown as a percentage of the total estimated cost base at the start of the year.

** £164m costs not included in the initial analysis in benchmarking include other clinical pay, premises establishment and non-operating costs (PDC interest depreciation)

For this reason the financial forecast for South London Healthcare NHS Trust, as currently configured, assumes only £43.3m of efficiency improvement.

55. The TSA has concluded that, over the next three years, the sites that make up South London Healthcare NHS Trust need to make significant greater efficiencies. As opposed to the £43.3m of CIPs included in the financial projections for the Trust the full £74.9m (15.4%) of efficiency opportunities identified through the TSA analysis, as outlined above, should be delivered.

56. As set out above, this requires more than the detailed articulation of CIPs which has now been developed. It will require a transformation both in clinical and managerial leadership and in fundamental organisational culture. These form the basis of the TSA's first recommendation. However, they call into question the Trust's organisational form, which is discussed further at the end of chapter.

Recommendation 2: Queen Mary's Hospital Sidcup

57. Services at Queen Mary's Hospital have changed considerably since November 2010 when temporary closures of maternity and A&E services took place due to safety concerns. The six south east London PCTs had agreed in 2008 to change services on the site following decisions taken under the *A Picture of Health* programme described in chapter 2. Approval to permanently change services on the site was only granted by the Secretary of State in December 2010 following an independent review process. This decision marked the end of two processes which contested the decision of the PCTs. As a consequence there has been a considerable period of uncertainty which seems to have blighted the development of the site. At the beginning of the TSA process there was no clear plan for the site that ensured its ongoing viability. It currently has a significant recurrent deficit as outlined in figure 15.

58. This recommendation is built on the joint work of Bexley CCG and London Borough of Bexley to develop a shared vision and strategy for a 'Health Campus', to be provided on the site of Queen Mary's Hospital Sidcup. In a letter sent to the TSA on 18 October the CCG and local authority set out their preference for Queen Mary's Hospital to be the 'hub' of their proposed hub-and-spoke model for community-based care. The recommendation also takes account of the feedback from the consultation. Responses from the local NHS bodies, local authorities and politicians were generally supportive of the development of Queen Mary's Hospital and its transfer to Oxleas NHS Foundation Trust. Although responses from the public were generally less positive, the public responses from Bexley residents were more favourable than those from elsewhere in south east London.

59. The independent report on the consultation has suggested part of the reason for the responses received may be related to confusion around the term 'Health Campus' and concern that the proposals could lead to the privatisation of healthcare services; following discussion with local stakeholders, it is therefore recommended that the site continue to be known as Queen Mary's Hospital.

60. Bexley CCG has outlined their commissioning intentions that reflect the vision shared with the local council for their proposed 'Health Campus' as including:

- a hub for urgent care services for Bexley and neighbouring areas, in conjunction with local A&E services at other sites;
- a site for 'step up / step down' services for Bexley residents, as part of community-based health and social care services for older people;
- a centre for specialist and rehabilitation elements of community-based services for local residents suffering from long term conditions;

- the centre of a hub-and-spoke model for specialist developmental services for children, maximising the potential of the recently commissioned Children's Development Centre at Queen Mary's Hospital;
- a satellite centre for specialist services, such as radiotherapy and chemotherapy treatment for common, non-complex cancers closer to patients' homes, in line with national strategies; and
- elective surgery.

61. In addition to this it is being recommended (as part of the proposals outlined in recommendation 5, see chapter 5) that an area of Queen Mary's Hospital be developed to provide mental health inpatient services for the population of Bromley and Bexley (Bexley services are already provided from the site). This will provide an opportunity to create an innovative and effective service, located at the border of Bexley and Bromley that could meet high standards of care for mental health patients.

62. These commissioning intentions have been outlined in increasing levels of detail by Bexley CCG through the course of the TSA programme. Figure 19 provides a more detailed overview of what commissioners have currently indicated they intend to commission from the site in the future.

Figure 19: Recommended services to be provided at Queen Mary's Hospital

Services to be provided on Queen Mary s Hospital in the future, as outlined in CCG commissioning intentions:
24 hour **unscheduled care**, including an Urgent Care Centre and GP Out of Hours services
Older People's services, including 'step up, step down' intermediate care beds
Children's services, including the Children's Development Centre and Paediatric Ambulatory Unit
Specialist services, including: Chemotherapy Renal proposed radiotherapy unit[3]
Community midwifery services, linked to the hospitals where Bexley patients give birth
Outpatients, including high volume specialties such as: General Medical specialities (such as gastroenterology, cardiology and rheumatology) General surgery Gynaecology Paediatrics Trauma and orthopaedics and some specialty outpatients such as: Ophthalmology Oral surgery, orthodontics and restorative dentistry Dermatology
Elective day surgery for high volume specialties such as: General surgery Gynaecology Trauma and orthopaedics Endoscopy And for some specialty areas: Ophthalmology Oral surgery, orthodontics, restorative dentistry and Maxillo-Facial Dermatology
Diagnostics to support outpatients and day surgery and direct access services, including: CT Ultrasound X-ray Endoscopy
Therapies to support outpatients and diagnostics as well as direct access services, these include physiotherapy and occupational therapy
Bexley and Bromley inpatient mental health services

63. Under these proposals inpatient elective surgery will not be provided from Queen Mary's Hospital. In the future Bexley patients will have a choice of where they receive their surgery. In line with the proposals outlined in recommendation 5 (chapter 5), this may be from the proposed centre at Lewisham Healthcare NHS Trust or from Dartford and Gravesham NHS Trust. To ensure continuity of care during transition, and in recognition of the need to meet national standards (such as 18 weeks) there will be a transition to move to future arrangements to ensure that capacity is available in the right location before any changes are made. Detailed plans for this will be developed and communicated to patients going forward.

64. Bexley CCG believes that, taking into account the Community-Based Care Strategy (see appendix O) and their current QIPP plans, this will be an affordable model for commissioners locally. This includes an assumption that local commissioners and providers will work together to transform the local older people's services to reduce acute admissions by one third and to redesign outpatient services to reduce volumes by around 6% per annum for three years. The success of the hospital in the long term will also be dependent on the CCG effectively delivering the Community-Based Care Strategy locally, with shifts in activity from acute to community settings being supported by a reduction in the activity taking place in acute hospitals through agreed changes to contracts and the implementation of agreed efficiency programmes.

65. The development of Queen Mary's Hospital to deliver Bexley CCG's commissioning intentions should be supported, as it will provide improved services for the local population. However, to do this there will need to be significant investment in the hospital to improve the estate and equipment. Given South London Healthcare NHS Trust's financial position it was agreed in early 2012 that it is not in a position to provide the investment required to do this. As an existing provider of community and mental health services on the site and an NHS organisation with a strong and stable financial position, Oxleas NHS Foundation Trust was identified as the preferred partner to take over the ownership and running of the site, investing in it to make it the healthcare 'hub' commissioners have envisioned. This was confirmed by the market engagement process (outlined in chapter 6 and appendix F).

66. In July 2012, just before the TSA process began, this proposed estate transfer was endorsed by Oxleas NHS Foundation Trust, South London Healthcare NHS Trust and NHS London in a Board-to-Board discussion. The proposal already had the support of Bexley CCG and London Borough of Bexley. Through the TSA process options for implementing this effectively have therefore been progressed. This has taken into consideration the potential use of the land, the areas of the current hospital site that have already been declared surplus that could be sold off for other purposes and the need to ensure value for taxpayers in the transfer of NHS assets.

67. Following this work, it is recommended that the core part of the Queen Mary's Hospital estate, which will be needed to provide the services outlined in the commissioner's intentions, should be transferred to Oxleas NHS Foundation Trust. The rest of the site that is no longer required should be disposed of (see recommendation 3).

68. As the new owners of the hospital site, Oxleas NHS Foundation Trust will invest in its development to ensure that the buildings and equipment are fit for purpose – both for their services and for the acute services that will continue to be provided on the site. This will include providing investment to cover the backlog maintenance requirements to bring the buildings and equipment up to standard and the development of the site to maximise its use. In doing this Oxleas will need to work with the other providers on the site, such as Guy's and St Thomas' NHS Foundation Trust, as the provider of the proposed satellite radiotherapy unit, and local social care providers. Oxleas will also look to maximise the use of the site by consolidating some of their own services there, further improving its long term viability as a local hospital. For the first two years the Department of Health will need to provide transitional support to Oxleas NHS Foundation Trust to cover the site deficit while this recommendation is implemented.

69. More work is required to complete the due diligence of the proposed transfer, and as an NHS Foundation Trust, Oxleas will need to test their proposals with Monitor. However, it is expected that this could be done in time to facilitate a transfer of the land and estate by 31 May 2013. Appendix N provides more detail on the proposals around the future of Queen Mary's Hospital.

70. Therefore, in summary, the TSA's recommendation is to support the development of Queen Mary's Hospital as a 'hub' for the provision of health and social care in Bexley, facilitated by the transfer of the required portion of the land and estate to Oxleas NHS Foundation Trust.

71. The TSA projects that implementing this recommendation will deliver annual savings to South London Healthcare NHS Trust of £4.5m by the end of financial year 2015/16.

Figure 20: Annual impact of recommendation 2

	2013/14	2014/15	2015/16	Cumulative total
Recommendation 2	£ 0m	£2.7m	£1.8m	£4.5m

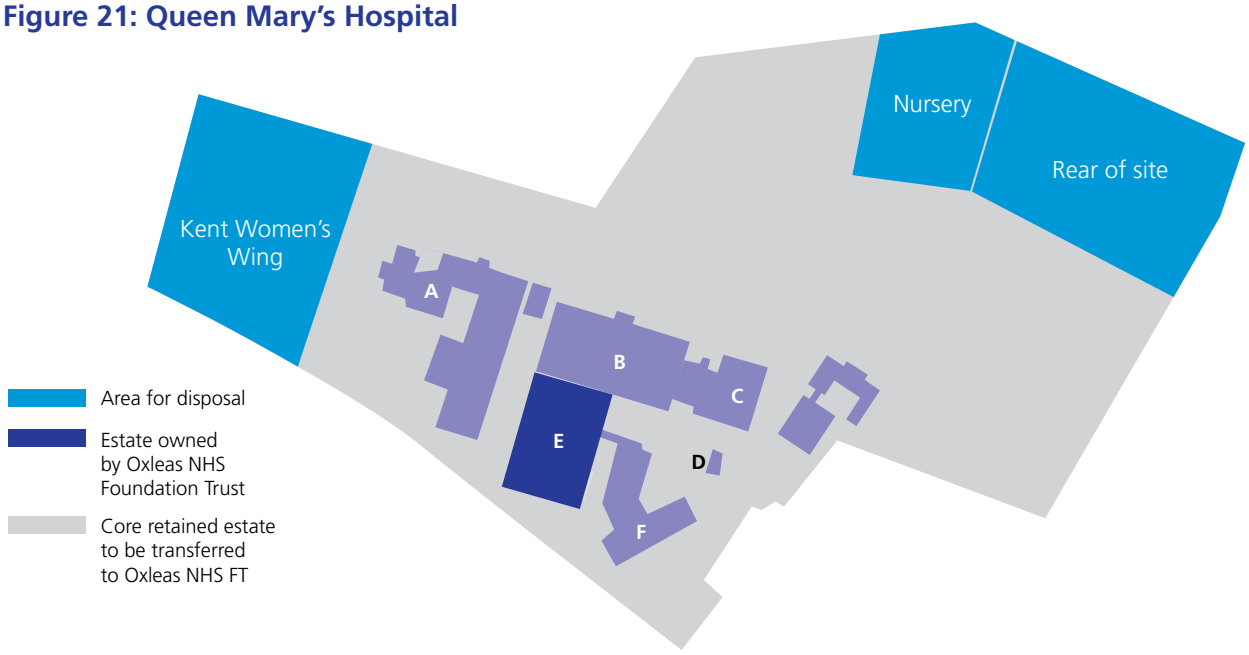
Recommendation 3: Estate utilisation

72. As outlined in the analysis of the South London Healthcare NHS Trust deficit, the Trust owns a significant amount of land and buildings that are not currently being well utilised, all of which carry a cost. Disposing of land that has been identified as no longer required for the delivery of services is a further way that the Trust can reduce its cost pressures and improve its financial position going forward.

Queen Mary's Hospital

73. Recommendation 2 describes the services that commissioners want to be provided from Queen Mary's Hospital in the future. These services do not require the full footprint of the site currently owned by South London Healthcare NHS Trust, and the surplus land should therefore be sold to reduce the site's operational costs and generate capital receipts. A number of responses to the TSA consultation have highlighted a desire from local stakeholders to see any funds raised from the sale of land on the hospital site to be invested directly back into the local community. As with the sale of all land owned by NHS Trusts, any capital receipts will need to be returned to the Department of Health. However, transitional support and capital funding will need to be provided to Oxleas NHS Foundation Trust to the implement recommendation 2, helping them to invest in the local services.

Figure 21: Queen Mary's Hospital



74. Three areas of the Queen Mary's Hospital site have already been identified for disposal. There are a number of challenges around the sale of this land as the hospital has been built on 'green belt' land that has a high number of planning restrictions around its use and the size of buildings that can be on it. However, South London Healthcare NHS Trust has already progressed a number of opportunities:

- *Kent Women's Wing:* A Memorandum of Sale with regard to the disposal of Kent Women's Wing has already been signed and a corresponding planning application for a residential care home and sheltered housing is due to be submitted to Bexley Council in 2013 to a timescale that would (subject to approvals) enable a sale to be completed by end of May 2013;
- *Nursery:* A Memorandum of Sale with regard to the Nursery has been signed and the sale is expected to be completed by March 2013; and
- *Rear of site:* An opportunity for the disposal of the remainder of the rear of the site is being pursued.

75. It is recommended that these sales be progressed at pace. This would not only generate capital receipts of around £5m, but also recurrent savings of around £0.7m from not having to run those elements of the site.

Orpington Hospital

76. The future of services currently provided on Orpington Hospital has been considered through a consultation completed by Bromley CCG between 16 July and 19 October 2012, separate to but during the first phase of the TSA process. The consultation was part of the Orpington Health Services Project that was established following notification from South London Healthcare NHS Trust that it was no longer sustainable for the Trust to continue providing services from Orpington Hospital. The project was set up to secure the services needed to meet local health needs while resolving the future of Orpington Hospital.

77. Following the completion of the consultation and analysis of the responses, the Bromley CCG recommended to the PCT Board that services currently commissioned from Orpington Hospital site should be relocated and re-commissioned. The PCT Cluster Joint Board endorsed this decision at a meeting on 29 November and supported CCG's decision to:

- create a Community Health and Wellbeing Centre in the Orpington area;
- develop a broader range of suitable alternative out-of-hospital care;
- reduce the number of block bought intermediate care beds from 62 to 42 when re-tendered and offered in a community setting in Bromley;
- transfer outpatient hospital attendances to Princess Royal University Hospital where the ongoing clinical pathway determines this; and
- delay making the final decisions for some services currently delivered in Orpington Hospital until the Secretary of State has made decisions on the final TSA report.

78. The detail of the services that will be provided in the Community Health and Wellbeing Centre is on page 12 of the Orpington consultation document[17].

79. Following the completion of the Orpington consultation, the TSA has continued to work closely with the CCG in developing the proposals for the future of services that are currently provided at Orpington Hospital, the need to maintain this dialogue was reiterated in responses to the TSA consultation. This has focused on the services the CCG has delayed making a decision on, subject to the TSA process. Consideration for the future of these services has now taken into account the recommendation set out in chapter 6 that King's College Hospital NHS Foundation Trust should acquire Princess Royal University Hospital. Based on this, the following is being recommended:

- *Specialist dermatology:* the Orpington service should be provided at Queen Mary's Hospital Sidcup. This is in line with the Orpington consultation and would enable consolidation of services with King's College Hospital NHS Foundation Trust as the proposed provider on the Princess Royal University Hospital. A separate service would also be provided at Queen Elizabeth Hospital, which would be integrated with the Lewisham service;
- *Oral surgery:* should be provided at Queen Mary's Hospital Sidcup. This is in line with the Orpington consultation and allows the consolidation of the current services provided by South London Healthcare NHS Trust on to a single site. This service will be provided by King's College Hospital NHS Foundation Trust, given that it already provides the consultants involved in the service;
- *Rheumatology:* should be provided at Princess Royal University Hospital;
- *Hydrotherapy:* as the proposed future provider of acute services in Bromley, King's College Hospital NHS Foundation Trust has confirmed that it does not wish to provide an 'in-house' hydrotherapy service and would look to buy-in sessions for patients as required. Based on this, Bromley CCG will need to look for specific alternatives for any direct access patients*; and
- *Neurophysiology:* should be provided at Princess Royal University Hospital.

80. The CCG is now developing its business case for the development of the Community Health and Wellbeing Centre which, subject to site acquisition and potential building works, will be in place by the middle of 2014. The CCG is also taking forward plans to complete the procurement of an alternative model of intermediate care from November 2013. In line with this, it is recommended that South London Healthcare NHS Trust services currently provided at Orpington Hospital are transferred to the appropriate location, recognising that some services will take longer to re-locate in order to ensure the appropriate capacity and equipment are in place.

* Based on feedback from the consultation process, the TSA has considered the feasibility of 'carving off' the hydrotherapy pool in to a single storey building to allow it to be sold separately. An initial assessment would suggest that there would be a very high cost associated with this, as the fabric of the pool area has not been designed to be free-standing, and investment would be required to reconnect it to ancillary services it currently uses, if it were moved to a separate building.

81. Effective planning and communications around these service transfers will be essential to ensure that the local population is aware of how patients can continue to access the services they require. Alongside this, those planning the service transfers will need to take into consideration the travel needs of the population, including the car parking requirements at sites where services are to be re-located, such as at Princess Royal University Hospital. This was raised as a specific concern during the Orpington consultation; it has been part of the discussions between the TSA and the CCG and should continue to be a focus for future planning.

82. The CCG's financial case within the Orpington consultation did not support the continued use of the Hospital to house the proposed future model of care and recommended an alternative solution be found. It is therefore recommended that Orpington Hospital be declared surplus and disposed of. This process should be progressed in partnership with the CCG as it considers the future location of the Community Health and Wellbeing Centre, the local council in its capacity as the local planning authority, and the Mayor of London, who can support the effective use of the land for the local community.

83. Subject to the development of appropriate business cases and relevant planning approvals, the sale of the site should be completed by mid-2014, which will provide a recurrent financial benefit of around £2.3m to South London Healthcare NHS Trust.

Beckenham Beacon

84. Feedback from stakeholders in Bromley has recognised the need to maximise the use of local estate, but also to ensure that there is a continued provision of local services that meets the needs of the local population. Specifically in its response to the consultation, Bromley CCG recognised the need to develop a portfolio of local community-based services, built around primary care, that provide a focus on health and wellbeing and support the use of hospital space for services that require the infrastructure of an acute hospital.

85. The CCG also recognised that the current range of outpatient services provided by South London Healthcare NHS Trust at Beckenham Beacon is not optimal, but also that there are services currently provided in a hospital setting that could be provided in the community, such as some sexual health services. In line with the Community-Based Care Strategy (see appendix O) and given the CCG's commitment to Beckenham Beacon, the CCG intends to develop a planned care centre at the site that could include:

- an extended range of outpatient services, diagnostic facilities and simple procedures, to increase the volume of patients flowing through the existing space and support an extension of clinical hours;
- integrated services for older people at the site, including rapid access clinics, a day hospital for the elderly and therapy support;
- an extension of primary care on the site; and
- improvements to the current minor injuries and ailments services.

86. Bromley CCG will be working up more detail around these proposals. In addition to this, there will be a requirement for South London Healthcare NHS Trust to continue providing many of the services on the site while it improves the operational efficiency of services at Princess Royal University Hospital and while commissioners decide what they want to be provided from Beckenham Beacon in the future. In view of this, it is recommended that there should be a transitional period, during which the Trust continues to pay for some of the space within Beckenham Beacon, limited to the current rental charge. However, this support should be restricted to a three-year transitional period.

87. Based on this approach, the TSA is recommending that the under-lease for Beckenham Beacon be transferred to Community Health Partnerships as the independent company, wholly owned by the Department of Health, which is responsible for the delivery of Local Improvement Finance Trust (LIFT) initiatives, such as Beckenham Beacon. Community Health Partnerships will then need to agree sub-leases to accommodate the acute and community services with Bromley CCG and the appropriate providers. The TSA projects that implementing this recommendation provides an increasing benefit over time as the Trust's services are transferred to other sites. This is valued at £0.5m for 2014/15 and £1.7m in year 2015/16 and thereafter.

88. Taken together, implementation of recommendation 3 will contribute £4.7m towards the financial challenges facing South London Healthcare NHS Trust as outlined in figure 22.

Figure 22: Annual impact of recommendation 3

	2013/14	2014/15	2015/16	Cumulative total
Recommendation 3	£0.7m	£2.8m	£1.2m	**£4.7m**

Recommendation 4: National support in relation to excess PFI costs

89. South London Healthcare NHS Trust has six PFI contracts outlined in figure 23. The largest of these contracts are for whole hospitals (Princess Royal University Hospital and Queen Elizabeth Hospital), with an approximate annual cost of £69m (£35m for the former and £34m for the latter). The Trust spends 16% of its income on all its PFI contracts, compared with the national average of 10.3%[2].

Figure 23: South London Healthcare NHS Trust PFI contracts

PFI	Approximate Annual Cost – £m
Princess Royal University Hospital	30.0
Princess Royal University Hospital – Equipment	5.4
Queen Elizabeth Hospital	29.1
Queen Elizabeth Hospital – Equipment	4.6
Queen Mary's Hospital	0.8
Princess Royal University Hospital – Power	0.1

90. The Department of Health has previously recognised that the PFI contracts for the Princess Royal University Hospital and Queen Elizabeth Hospital cost the Trust substantially more per year than had they be financed through traditional public financing arrangements[18]. These costs are not adequately recompensed by the income the Trust receives from local commissioners for the services it delivers from these buildings.

91. An analysis has been undertaken to review the costs of the PFI contracts and their impact on the Trust's financial position. The details of this review have been submitted to the Secretary of State as part of the delivery of a final report. This information will remain confidential due to commercial sensitivities.

92. The Department of Health has several options as regards the PFI contracts, each of which provides different levels of value to the public sector. These options are covered in the confidential paper to the Secretary of State.

93. The final recommendation is that the Department of Health provides direct support to the future operators of these two sites to cover the excess costs of the PFI contracts on an annual basis until the relevant contracts are modified or end. Figure 24 sets out the relevant schedule of payments.

Figure 24: Proposed support schedule to cover (£m)

Site	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
PRU	10.5	10.7	11.8	11.8	11.8	11.8	11.8
QEH	12.2	12.2	13.6	13.6	13.6	13.6	13.6
Site	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**
PRU	11.8	11.8	11.8	11.8	11.8	11.8	11.8
QEH	13.6	13.6	13.6	13.6	13.6	13.6	13.6
Site	**2027/28**	**2028/29**	**2029/30**	**2030/31**	**2031/32**	**2032/33**	**2033/34**
PRU	11.8	11.8	11.8	11.8	11.8	11.8	11.8
QEH	13.6	13.6	13.6	13.6	13.6	13.6	
Site	**2034/35**	**2035/36**	**2036/37**	**2037/38**	**2038/39**		
PRU	11.8	11.8	11.8	11.8	11.8		
QEH							

94. During public consultation overall support has been voiced for this recommendation, with more of the public supportive than opposed, and the Royal Colleges, local authorities and patient representative groups from across south east London all expressing their support.

Conclusion

95. Implementing these recommendations, in particular recommendation 1, would present a transformation for the Trust. There is no doubt that they present a significant challenge to implement. Even after doing so, including the national support for the excess costs of the PFI contracts at Queen Elizabeth Hospital and Princess Royal University Hospital, the Trust will have a recurrent underlying deficit. The position for the next three years is in figure 25 (overleaf).

96. The transfer of Queen Mary's Hospital to Oxleas NHS Foundation Trust resolves the issues the Trust faces at that site. However, the operating losses will continue at the Princess Royal University Hospital and Queen Elizabeth Hospital sites and the trajectory for future years will be negative. In this environment, where delivering challenging efficiency improvements is not sufficient to prevent the continuation of operating deficits, there will inevitably be little incentive for those charged with leading the organisation. Nor is this scenario conducive to improving clinical practice and embracing, for example, the agreed London-wide clinical standards.

97. The TSA has therefore concluded, through the very extensive assessment that has been undertaken, that these sites cannot be made financially viable in the current service and organisational arrangements. Nor is there the capacity and capability to deliver the full operational efficiencies that have been identified. To continue in this form would require the Trust to be sustained indefinitely by cash support from the Department of Health with no prospect of repayment. Deficits would continue to accumulate. While figure 25 summarises the theoretical extent of the resulting deficits, the true quantification is the difficult in view of the lack of incentive to deliver extremely challenging levels of CIPs.

98. The outcome of the market engagement process, outlined in chapter 3 (see also appendix F), was that no party was willing to take the Trust in its entirety or in part with this level of financial challenge.

99. In view of this, the TSA recommends that it is necessary to reorganise services and find new organisational arrangements to drive up the capability to execute a complex and extremely challenging set of recommendations for improvement. Therefore, chapters 5 and 6 examine the wider health economy and make recommendations relating to the configuration of services across south east London and organisational solutions – changes that are consequent to the challenges faced by South London Healthcare NHS Trust and are needed to secure clinically and financially sustainable services for the whole population.

Figure 25: Impact of recommendations 1-4 on the financial projections for South London Healthcare NHS Trust

Before TSA Recommendations				
2012/13	Income	Cost	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	184.1	204.4	-20.3	22.1
QEH	174.1	202.4	-28.3	30.0
QMS	72.1	83.0	-10.9	11.6
Total	**430.3**	**489.8**	**-59.5**	**63.8**

2013/14 Full year effect				
2013/14	Income	Cost	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	184.1	207.0	-22.9	24.8
QEH	173.1	205.7	-32.6	34.3
QMS	61.6	72.3	-10.7	11.3
Total	**418.8**	**485.1**	**-66.2**	**70.4**

2014/15 Full year effect				
2014/15	Income	Cost	Deficit	Gap to 1%
PRU	183.7	210.4	-26.7	28.6
QEH	176.2	211.1	-34.9	36.6
QMS	62.7	74.4	-11.7	12.3
Total	**422.6**	**495.9**	**-73.3**	**77.5**

2015/16 Full year effect				
2015/16	Income	Cost	Deficit	Gap to 1%
PRU	184.0	212.4	-28.4	30.3
QEH	179.7	215.2	-35.5	37.3
QMS	64.2	75.3	-11.1	11.7
Total	**427.9**	**502.9**	**-75.0**	**79.3**

Changes in I&E

	Rec 1	Rec 2	Rec 3	Rec 4			
2013/14	Further productivity	QMS site change	Estates	PFI support	Total changes	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	4.9			10.5	15.4	-7.6	9.4
QEH	5.2	0.6		12.2	18.0	-14.6	16.3
QMS	2.1	-0.6	0.7		2.2	-8.5	9.1
Total	**12.2**	**0.0**	**0.7**	**22.7**	**35.6**	**-30.7**	**34.8**
2014/15							
PRU	8.5		2.8	10.7	22.0	-4.7	6.6
QEH	9.9	0.6		12.2	22.7	-12.2	13.9
QMS	4.2	2.1	0.7		7.0	-4.7	5.3
Total	**22.6**	**2.7**	**3.5**	**22.9**	**51.7**	**-21.6**	**25.8**
2015/16 Full year effect							
PRU	12.6		4.0	11.8	28.4	0.0	1.9
QEH	13.8	0.6		13.6	28.0	-7.5	9.3
QMS	5.2	3.9	0.7		9.8	-1.3	1.9
Total	**31.6**	**4.5**	**4.7**	**25.4**	**67.5**	**-8.8**	**13.1**

Note: The full year effect of the income adjustments are not considered until the post implementation forecast. Further detail is provided in appendix M.

5. Commissioning context and recommendations relating to the south east London health economy

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 fully responds to the need to deliver the quality improvements in healthcare, recommended following a recent review of emergency and maternity care in London. The TSA was therefore required to look more broadly at the financial and clinical state of the whole health economy in south east London.

2. This is consistent with responses to the Secretary of State's consultation on the use of the UPR, all of which suggested that solutions to South London Healthcare NHS Trust's challenges would necessitate a broader review of the NHS in south east London (see appendix A).

3. Securing a clinically and financially sustainable health system for South London Healthcare NHS Trust and south east London has been at the heart of the local NHS's strategic change agenda for many years. There have been repeated attempts, involving different types and scales of intervention, to solve the deep-rooted problems. The most recent attempts are outlined in chapter 2.

4. The TSA has developed recommendations for resolving the sustainability challenges within South London Healthcare NHS Trust and the consequences on the wider south east London health system with full regard to the commissioning intentions of the six CCGs in south east London.

5. As set out in chapter 3, the six CCGs and South East London PCT Cluster have played a critical role throughout this process. In addition to supporting the advisory and working groups and providing advice, they have undertaken work to define their strategy for developing community-based care over the next five years and for using the money available to commission health services for the population of south east London.

6. A five-year time horizon was set to ensure that the work adequately acknowledged the strategic intent of CCGs in terms of improving health and developing health services. In doing this they have engaged with a wide set of partners, their CCG members and local authorities. They will need to continue with this work as they develop their commissioning strategy plans and will need to ensure that their strategy reflects the shared intent of their local health and wellbeing board partners.

7. In 2012/13, the commissioners in south east London have a total resource allocation of £3.0bn to spend on the local population[19]. The allocation for CCGs for south east London in 2013/14, covering a more limited scope of services, has now been confirmed as £2.1bn. However, given the timing of the TSA work, a set of total resource assumptions for the population of south east London over the next five years was agreed, recognising that the funding will be split across the local CCGs, local authorities and the NHS Commissioning Board from April 2013. These projections are outlined in figure 26.

Figure 26: Five-year projected NHS allocations across south east London (£m, nominal)

Currency: £ m	2013/14	2014/15	2015/16	2016/17	2017/18
Bexley	357.1	366.8	376.8	387.1	397.6
Bromley	508.7	516.2	524.0	531.8	539.8
Greenwich	468.7	478.6	488.9	499.4	510.2
Lambeth	636.0	644.7	654.4	664.2	674.2
Lewisham	531.6	540.2	549.4	558.7	568.1
Southwark	542.4	556.8	571.0	585.2	600.4
Total	**3,044.5**	**3,103.3**	**3,164.5**	**3,226.4**	**3,290.3**

8. As figure 26 indicates, there will be growth in the resources available to the NHS in south east London, but it will be limited. This should also be viewed against the background of a population that will see growth of around 6% over the next five years, from around 1.6 million to around 1.8 million*, with the most significant increases expected in the boroughs of Southwark and Greenwich. In all cases, the TSA analysis has used the larger figures available on population growth between the Office of National Statistics and the Greater London Authority, so that the basis for the recommendations does not underestimate the additional challenges of a growing population.

9. Alongside this, the demographics of the population are changing. Over the next five years, the number of those aged 65 and over will increase from around 180,000 in 2012 to around 195,000 by 2018.

10. Not only will people be living longer, the number of people living with one or more long term condition will also increase, with one in four older people in south east London living with a long term condition by 2017/18. The challenges that result from an ageing population and a growth in the number of people living with long term conditions, coupled with constrained NHS funding, puts significant pressure on the NHS, as it strives to deliver safe, high quality healthcare within the budget available.

11. These changing requirements mean that commissioners need to reshape local services in line with local health priorities, the broader NHS agenda for Quality, Innovation, Productivity and Prevention (QIPP) and the necessary quality improvements described earlier. They must take into account the need to improve quality, changes to local population health needs and also the advancement of medicine and the impact of improved specialist interventions and medical technology (eg. where a heart attack patient would once have required open heart surgery, safer procedures have been developed to unblock coronary arteries; clot-busting drugs have improved survival rates for stroke patients; and more surgery is carried out using key-hole techniques as day cases rather than inpatient surgery). Such improvements not only have an impact on the survival and recovery of patients, but also on the cost of treatment, both of which commissioners need to take into consideration in their planning.

12. Making the best use of resources for the benefit of the population means having a clear vision for the provision of care. *Better for You: Commissioning Strategy Plan 2012/13 – 2014/15*, the three-year plan developed by South East London PCT Cluster and the six CCGs in 2011/12, outlined a vision that "*more people in south east London will stay healthy, and every patient will experience joined-up healthcare which meets their needs in the most effective way*". Under this vision, the six CCGs have agreed a set of five strategic goals that they will deliver locally:

* Interim 2011-based sub-national population projections for England

- In every contact with the NHS and local public service partners, people are encouraged and enabled to positively manage their own health, in partnership with health professionals and their carers;
- Patients experience the NHS as a joined-up personalised service, rather than a disconnected set of services they are required to navigate;
- Patients are treated with dignity and the respect due to them at all times;
- Clinical decision-making and healthcare delivery is in line with evidence-based best practice and takes account of value for money; and
- The logistics of healthcare delivery, within and across different care settings, are designed to meet patient needs, whether long-term or acute, in the most effective way.

13. Delivering such a strategy will significantly improve health inequalities and health outcomes. However, it does mean a change in the pattern of healthcare spending.

14. As part of the TSA process, an understanding of the context of the financial position of acute providers in south east London has been reached. In addition to the detailed understanding of the financial challenges of South London Healthcare NHS Trust described in chapter 4, work was undertaken to assess the financial pressures facing the foundation trusts in the sector. As the only other NHS Trust, detailed work with Lewisham Healthcare NHS Trust was also undertaken and a financial projection produced using commissioners' current forecasts. The work undertaken by the TSA has isolated some issues of financial sustainability for the Trust. There have been significant recent improvements in Lewisham Healthcare NHS Trust's financial position but the Trust has had a history of financial challenge:

Figure 27: Lewisham Healthcare NHS Trust normalised financial performance

Currency: £m	2008/09	2009/10	2010/11	2011/12
Revenue from patient care activities	150.9	161.5	200.6	205.6
Other operating revenue	23.4	26.6	21.7	23.6
Total revenue	**174.3**	**188.1**	**222.3**	**229.2**
Employee costs	(112.3)	(119.4)	(149.5)	(153.5)
Non pay costs	(46.8)	(48.2)	(57.0)	(57.8)
Total operating costs	**(159.1)**	**(167.6)**	**(206.5)**	**(211.3)**
Finance costs	(11.9)	(11.3)	(12.4)	(14.8)
Public Dividend Capital dividends payable	(4.9)	(4.0)	(3.8)	(4.5)
IFRS Adjustment	1.9	1.5	1.4	1.4
Surplus / (Deficit) on NHS Control Total Basis	**0.3**	**6.7**	**1.0**	**0.0**
Impairment	(4.2)	(6.4)	0.0	0.0
Retained Surplus / (Deficit) for the financial year	(3.9)	0.3	1.0	0.0

- In 2004/05 and 2005/06 the Trust had deficits. At the start of 2007/08, the Trust was one of 17 NHS trusts identified by the Department of Health as "financially challenged" (as were the three Trusts in outer south east London that merged to form South London Healthcare NHS Trust in 2009).

- The Trust's financial performance since 2008/09 is shown in figure 27. Although the Trust has not made a deficit on a NHS control total basis it is clear that the financial position has been challenging and in three of the four years under review the Trust has failed to make one percent surplus.
- From 2008/09 to 2010/11 the Trust saw an increase in its income of around £50m. Approximately £35m of this is attributable to the transfer of community services for the borough of Lewisham previously delivered by Lewisham PCT. The residual £15m amounts to a10% increase, compared to an equivalent decrease of 8.3% in South London Healthcare NHS Trust and its predecessor trusts.
- With a projected turnover of around £240m, the Trust has to sustain the overheads and the broader infrastructure of a trust's operations on a small income base, especially when compared with its neighbours – King's College Hospital NHS Foundation Trust, Guy's and St Thomas' Hospital NHS Foundation Trust and South London Healthcare NHS Trust.
- In order to support its foundation trust application, which was submitted before this TSA analysis, the Trust had to assume a £5m cash injection to support its liquidity position. The foundation trust application was also predicated on a more favourable commissioner settlement than has been included by the TSA following more recent discussions with the commissioners.

15. The financial projection produced through the TSA analysis (see figure 28) shows that the Trust is predicted to return to a deficit in 2014/15, and by 2015/16 the gap to a 1% surplus will have reached £3.0m. Whilst this is not to the same extent as the financial challenge in South London Healthcare NHS Trust it does demonstrate a challenge for Lewisham Healthcare NHS Trust that needs to be addressed to deliver long term sustainability to the NHS in south east London.

Figure 28: Forecast recurrent financial position for Lewisham Healthcare NHS Trust (£m)*

Currency: £m	2012-13			
	Income	Total Cost	Surplus	Gap to 1%
Lewisham Healthcare NHS Trust	236.4	236.2	0.2	2.2
Currency: £m	**2013-14**			
	Income	**Total Cost**	**Surplus**	**Gap to 1%**
Lewisham Healthcare NHS Trust	236.9	235.9	1	1.4
Currency: £m	**2014-15**			
	Income	**Total Cost**	**Deficit**	**Gap to 1%**
Lewisham Healthcare NHS Trust	237.2	237.4	-0.2	2.6
Currency: £m	**2015-16**			
	Income	**Total Cost**	**Deficit**	**Gap to 1%**
Lewisham Healthcare NHS Trust	239.5	240.1	-0.6	3.0

* TSA analysis

16. Added to the £79.3m shortfall (against a 1% surplus benchmark) at South London Healthcare NHS Trust, the total financial challenge for NHS Trusts across south east London will amount to £82.4m by 2015/16.

17. In considering proposals for change, these recommendations need to address that substantial financial gap while securing safe, high quality and affordable services for the population of south east London. It is clear, and always has been, that the solutions cannot be found within South London Healthcare NHS Trust in isolation.

Community-based care

18. Although there has been continuous improvement in the quality of care provided across south east London, current provision still requires significant improvement. South east London has some of the highest mortality rates in England[20]. Other examples of challenges faced are high levels of teenage pregnancy, childhood obesity and cancer incidence.

19. In addition to having a range of poor health outcomes in aggregate, there continue to be health inequalities both across the boroughs and within them. For example, a man born in Greenwich can expect to live for three and half years less than a man born in Bromley[21]; but even within boroughs stark variation exists, the impact of deprivation means that there is a seven-year life expectancy difference for men across Greenwich and almost a nine-year difference across Bromley.

20. Addressing these challenges and reducing these inequalities cannot be done by hospitals alone. In fact, the greatest improvements will come through providing effective primary care services. More than 90% of all health contacts in England occur in primary care[22], and not only is effective primary care associated with better and more equitable health outcomes, it can be provided at a lower cost[23]. A recent report by the King's Fund has shown that there is an association between patient experience and practice performance on measures of clinical quality, and that practices that generally perform poorly in both areas are more likely to be located in London and in more deprived areas[24].

21. Primary care in south east London is not delivering at the level it should be, in terms of both access and patient experience. The 2011/12 patient survey has shown that the NHS in south east London consistently performs below the national average on key satisfaction measures, including the ability to get an appointment to see or speak to someone. This has been further demonstrated through the feedback received during the public consultation, which has recognised the need to improve the access to and quality of primary care across south east London.

22. Improving the quality of primary care has been proven to deliver improvements in access, patient satisfaction, outcomes and use of services. One example of this is the clinically-led primary care improvement programme in Tower Hamlets, established to improve access and quality in primary care. Through investing in primary care services, to address local behaviours and provide tools to support effective care management, Tower Hamlets saw a rise in 48-hour access scores from 78% to 89%, a reduction in missed appointments and an overall 21% increase in patient satisfaction. Alongside this, they saw a reduction in the use of walk-in services (9% in one year) and in minor and non-urgent A&E attendances (27% in the first six months).

23. This shows how improvements in primary care not only deliver improved patient experience but also make sure that patients access the right care in the right place. It also helps manage the use of NHS resource.

24. To address these issues and meet south east London commissioners' vision, and as a key building block in developing the recommendations, the CCGs themselves have produced a Community-based Care Strategy 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 the population of south east London receives the best possible care in the community, including in their homes, where feasible. This will support 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. These aspirations (summarised in figure 29 and detailed in appendix O) have been grouped into three areas of care:

- *primary and community care* – services available to the whole population, which will provide easy access to high quality care to support people in staying healthy;
- *integrated care* – services that support high risk groups, such as those with long term conditions, the frail elderly and those with long term mental health problems, to remain active and supported in their own homes wherever possible; and
- *planned care* – services to support those with a specific healthcare need to receive consistently high quality care in the appropriate location.

Figure 29: Aspirations for community-based care in south east London

People living in south east London will…	
Easy access to high quality, responsive primary and community care	• Have access to public health programmes that support **prevention and early detection** of diseases by proactively finding people at risk of losing their good health. • Be supported to **manage their own health** and any illnesses that they have and given confidence to take decisions about their own care, including navigating access to specialist services where needed • Have access to **telephone advice and triage** for all community health and care services **24 hours a day, seven days a week** either through their General Practice or through a telephone single point of access • **Have access to primary care service/advice 24hrs, 7 days a week for urgent needs** through a combination of appointments and walk in services, telephone appointments, 111/ NHS Choices or same day urgent care etc. • Receive **high-quality care** that meets agreed quality standards and outcomes, provided through teams working in networks across primary care, community and specialist services that may be based in the hospital • Know that their local commissioners (CCGs) **proactively plan** how to meet the health needs for the population they have responsibility for and have confidence they are **supporting hard to reach groups of patients**

Integrated care for people with long term conditions	• Receive targeted and more personalised care appropriate to their needs, as a result of SEL-wide real-time **population risk stratification allowing clinicians to proactively identify and support more patients before a crisis**. • Play an active part together with their health professionals and carers in developing a **care plan** that sets out what they and those involved in delivering their care will do to support them staying as healthy as possible, or what should happen in the event of problems • Have a named **'care coordinator'** who will work with them to coordinate their care across health and social care. This role will be clearly defined and clinical accountability for care will be remain with their GP • Know that their GP is working within a **multi-disciplinary group of health professionals** to co-ordinate and deliver care, incorporating input from primary, community, social care, mental health and specialists • Be well supported when they are at risk of being admitted to hospital, **receiving the expert advice, tests or access** to equipment they need promptly to ensure they will only go to hospital if absolutely necessary • Be confident that as soon as they are referred to hospital their Community Based Care Team will be working with staff in the hospital and the community to **coordinate an individual discharge plan**, including intermediate care, reablement and rehabilitation, to support efficient **discharge from the hospital within 24 hours** of being declared medically fit, knowing they will receive the right **continuing care** in the community
Timely, convenient and effective planned care	• Have access to relevant and complete **information**, in the right formats to **inform personal choice** and decisions • Experience **consistent quality of care and access to services** anywhere is SEL, based on agreed standards, protocols, access times and approaches to referrals and diagnostics such as radiology, phlebotomy, ECG and spirometry • Receive treatment for planned **specialist diagnostics and care in specialist hospitals**, but be able to access other planned routine outpatient appointment, diagnostics, pre- and post-operative appointments in **settings closer to home** or via telephone / web consultations to reduce unnecessary travel
…all aspirations apply to both community and mental health	

25. Since the start of the TSA's work in July, CCGs have worked with clinicians and managers from across the health service – including GPs, nurses and acute clinicians – local authorities and the voluntary sector to develop an overview of how patients will receive care in line with these aspirations and how this will be delivered. This overview is provided in appendix O, along with examples of success that commissioners have already had in improving care for patients.

26. Improving the quality of community-based care has underpinned the work led by commissioners as they look to change the way services are delivered to help ensure clinically and financially sustainable services for the long term. The provision of care closer to people's homes and improved proactive care for people with long term conditions will reduce admissions and reduce the length of stay for patients who do need to be admitted to hospital. As well as providing significantly better care for patients, this approach would reduce the pressure on commissioners' limited resources. However, this does not reduce the funds going to acute trusts; instead they are held broadly flat. This projected income and activity, outlined in figures 30 and 31, has been factored into the work undertaken through this programme and therefore addresses concerns raised in consultation about the impact that assumed changes in community-based care have on acute activity levels.

Figure 30: Projected income going to south east London acute providers over the next 3 years[25,*]

Currency: £m	2012/13	2013/14	2014/15	2015/16
Princess Royal University Hospital	184.6	184.1	183.7	184.0
Queen Elizabeth Hospital	174.1	173.1	176.2	179.7
Queen Mary's Hospital	72.1	61.6	62.7	64.2
South London Healthcare NHS Trust Total	430.8	418.8	422.6	427.9
Lewisham Healthcare NHS Trust	236.4	236.9	237.2	239.5
King's College Hospital NHS Foundation Trust	654.9	652.6	660.9	669.7
Guy's & St Thomas' NHS Foundation Trust	1143.3	1141.6	1152.3	1167.8
Total South East London	**2465.4**	**2449.9**	**2473.0**	**2504.9**

Figure 31: Projected activity going to south east London acute providers over the next 3 years[24]

Spells / attendances ('000s)	2012/13	2013/14	2014/15	2015/16
Princess Royal University Hospital	454	476	461	465
Queen Elizabeth Hospital	418	417	430	443
Queen Mary's Hospital	215	212	219	226
South London Healthcare NHS Trust Total	1087	1105	1110	1134
Lewisham Healthcare NHS Trust	469	476	483	492
King's College Hospital NHS Foundation Trust	935	941	963	988
Guy's & St Thomas' NHS Foundation Trust	1161	1162	1190	1221
Total South East London	**3652**	**3684**	**3746**	**3835**

27. The CCGs' strategy is very much in keeping with the prevailing evidence about best models of care and national policy advocated by leading patient charities. Delivering the strategy should be done at pace as it will significantly improve health outcomes and reduce inequalities and will also provide a key platform for the improvements to hospital-based care for South London Healthcare NHS Trust and across south east London.

28. The responses to the TSA's consultation set out concerns from some people about the feasibility of delivering a programme of change of such scale and at pace. At the same time, respondents endorsed the strategy's principles and the HEIA has set out clearly a range of significant benefits to large sections of the population in south east London if the changes are delivered. Therefore, it is the TSA's view that implementation of the Community-based Care Strategy will deliver significant clinical benefits, including saving around 700 lives a year just through early detection and better management of diabetes. Details of some of the opportunities to improve the quality of care, outcomes, patient experience and performance on health inequalities are detailed in figure 32. CCGs will continue to work on developing the detail of the initiatives and programmes they will use to deliver these aspirations, as they develop their five-year commissioning strategy plans to 2017/18. They have developed a robust programme management approach to oversee implementation. This is outlined in appendix O.

* Trusts record activity in various ways. The pattern for each Trust demonstrates the consistency in activity levels. The TSA analysis has adjusted Trusts' returns, where appropriate, to reflect the different methodologies.

Figure 32: Benefits of implementing the community-based care aspirations across south east London (Sources can be found in appendix E)

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]

Hospital-based care

29. In view of growing concerns and an increasing body of evidence that significant variations in quality and outcomes existed in hospital-based care, over 90 clinicians agreed to form multidisciplinary clinical expert panels and develop clinical quality standards on behalf of commissioners across the capital. These standards were developed throughout 2011 and 2012 before the regime for unsustainable providers was enacted; the standards have been endorsed by the London Clinical Senate and the London-wide Clinical Commissioning Council.

30. Full details of the standards are outlined in appendix P. Overall the aim of the standards is to ensure that acute emergency and maternity services are consultant delivered and consistent seven days a week.

31. The clinical advisory group and the external clinical panel have further endorsed the standards and CCGs have committed to ensuring all future hospital based care in south east London is commissioned in line with these. This was echoed in commissioners' responses to the consultation, stating that any future configuration of services in south east London would need to meet the London clinical standards for emergency and maternity care and supported the need for consolidation of services to achieve this. During the consultation, Lewisham CCG recognised the need to improve the quality and safety of services by delivering the clinical quality standards and, therefore, the need for the configuration of acute services to be agreed in line with the clinical dependency framework agreed across London (appendix E). However, in its response, the CCG also expressed its concern about the impact of any reconfiguration of services on the future of University Hospital Lewisham, reflecting many of the public's concerns about the perceived difficulty of accessing services in the future.

32. Strong support for implementing the standards was also received from the Royal Colleges during consultation; particularly the Royal College of Physicians who also highlighted in its response that the recommendations were consistent with its perspective and it "...supported the emerging solutions particularly around integrated care and the management of urgent and emergency care".

Adult emergency services

33. Clinical evidence over a number of years has demonstrated that early and consistent input by consultants improves care and outcomes for patients admitted to hospital as an emergency[26,27,28].

34. Consultants are the most skilled and experienced doctors. They are therefore able to make rapid and appropriate decisions to ensure patients receive the correct diagnosis and that they are quickly on the right pathway of care. This leads to better patient outcomes including mortality[29,30,31]. However, in London there is significant variation in consultant presence and in outcomes for patients. This variation exists between hospitals and also depends on the time of day or day of the week that patients are admitted to a hospital as an emergency.

35. In London it has been demonstrated that patients admitted as an emergency at the weekend have a significantly increased (10%) risk of dying compared with those admitted on a weekday[32]. Across London, this accounts for 520 adult deaths a year; in south east London, it accounts for around

100 lives. The reasons for differences in mortality rates are complex but reduced service provision, including fewer consultants working at weekends, is associated with this higher mortality rate.

36. In 2011 clinical expert panels across London developed and agreed a set of clinical quality standards for acute medicine and emergency general surgery to address these variations in service arrangements and patient outcomes. In 2012 the development of standards was expanded to cover the full emergency pathway including emergency departments, critical care and the fractured neck of femur pathway. The standards represent the minimum quality of care that patients admitted as an emergency should expect to receive, wherever and whenever they are admitted to a hospital in London.

37. This work has built on the successful changes to other emergency services across London to improve the care and treatment of patients with major trauma, stroke, heart attack or complex vascular problems, which have delivered significantly improved outcomes for the population[33]. For example, London's heart attack centres already operate a consultant-delivered service seven days a week and no observed difference is now found in mortality rates for admissions during the week and admissions at the weekend, demonstrating that where systems are in place to respond seven days a week, there is a direct effect on mortality rates. Another example is the lives that have been saved since the changes to stroke services in London – it is estimated that 200 lives have been saved across London and will continue to be saved each year following the centralisation of acute stroke services in eight hyper-acute stroke units, with associated networks of care.

38. Addressing the quality deficit in other acute services, such as acute medicine and emergency surgery, through the development of 24/7 acute admitting hospitals that meet the defined minimum clinical quality standards, will complete this journey.

39. The clinical quality standards address the issues found. Compliance with these standards will ensure that the assessment and subsequent care of patients will be consultant-delivered, seven days a week and consistent across all providers of these services. The key themes across all of the standards for adult emergency services include:

- Increased consultant presence across all seven days of the week;
- Consultants on call to be freed from all other clinical duties to focus on emergency admissions;
- 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;
- Consultant involvement, for patients considered 'high risk', to be within one hour – 24 hours a day, 7 days a week;
- A clear multi-disciplinary assessment, including input from nursing, physiotherapy, occupational therapy, pharmacy, and acute pain management (where appropriate) to be in place within 24 hours of admission;
- All patients to be seen and reviewed by a consultant during twice-daily ward rounds;
- 24-hour timely access to key diagnostic imaging and reporting; and
- Clear patient communication and information and patient experience data to be routinely collected, reported at board level, and acted upon.

40. Delivering the standards will, however, be a significant challenge for providers in south east London, as no Trust currently meets all of them. Hospitals in south east London were audited by London Health Programmes – and separate to the TSA process – from July to September 2012 for compliance with the

already commissioned acute medicine and emergency general surgery services clinical quality standards. Although progress had been made by all hospitals, no hospital met all of the standards as shown in figure 33.

Figure 33: Quality and safety 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.	✗	✓	✓	✗	✓	✗	✓	✓	✗	✓
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.		✗		✓		✗		✗		✓

No	Standard	KCH		SLHT PRUH		SLHT QEH		GSTT-ST		UHL	
		Medicine	Surgery	Medicine	Surgery	Medicine	Surgery	Medicine	Surgery	Medicine	Surgery
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	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓

41. To meet all of the clinical quality standards, hospitals will need to increase the number of senior staff they have on their rotas, a challenge both because of the cost of additional staff and a lack of available staff with the required skills set. Figure 34 shows the current shortfall in the number of consultants to meet the standards.

Figure 34: 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

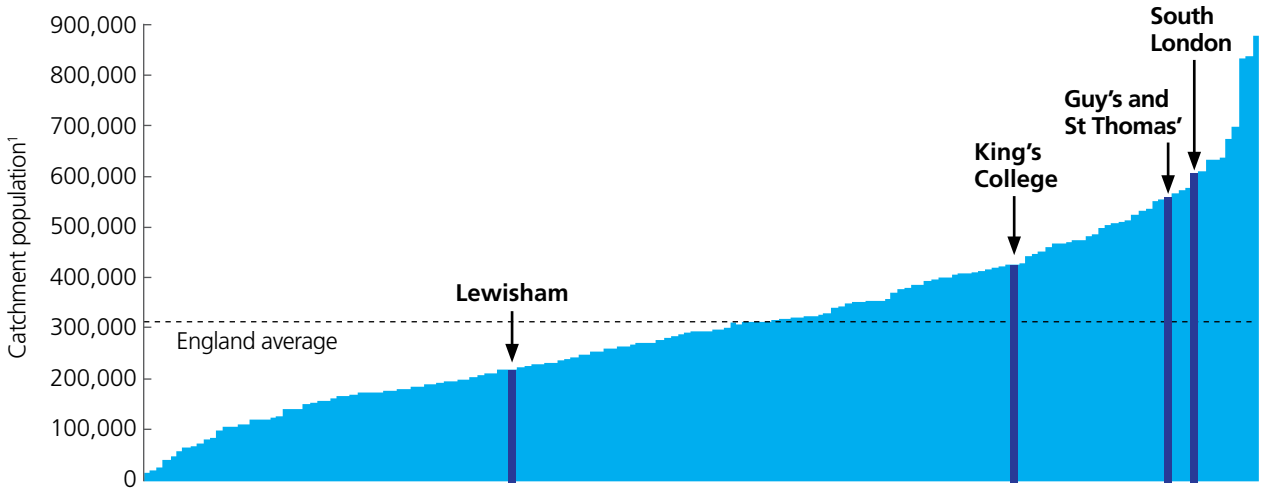
42. However, simply increasing the number of doctors at every hospital is not the answer. In addition to meeting the standards services also need to be delivered where there are sufficient activity volumes to ensure that clinical teams can keep their expertise and skills up to date by treating a sufficient number of patients in their specialty. Evidence shows that a relationship exists between the volume of procedures and the outcome of treatment[34,35].

* Trust Data Submissions

43. The Royal College of Surgeons recommends that the preferred catchment population size for an acute hospital providing the full range of medical and surgical care would be 450,000 to 500,000[36]. However, noting that the majority of acute hospitals had catchments of approximately 300,000, the College recommends a strategically-planned reorganisation so that, where feasible, smaller hospitals are able to merge to achieve a catchment of at least 300,000.

44. South east London has a population of 1.6m, growing to 1.8m, with five sites offering acute services to an average catchment population of 320,00 growing to 360,000. Each Trust's current population catchment is detailed on the chart in figure 35 (note that the data is at Trust level, rather than site level).

Figure 35: Catchment population by hospital trust in England 2009



[1] 2009 catchment populations for all admissions by Trust

Source: East of England Public Health Observatory, 2011, McKinsey & Company

45. As part of the overall work to address the issues facing South London Healthcare NHS Trust, and coupled with the drive to meet the clinical standards whilst ensuring activity levels are sufficient to maintain skills, 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. The other three main hospitals in south east London would continue providing a range of services for those that do not need to be admitted to hospital on an emergency basis. The types of conditions these 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.

46. These services will be equally applicable to adult and paediatric patients and where patients need to be admitted to hospital, robust treat and transfer protocols will apply. Such protocols currently exist and have been 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 for appropriate treatment.

47. 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.

48. Options for the potential configuration of hospitals in south east London providing clinically sustainable emergency services were developed. So that only those options that were clinically and financially viable were considered fully, hurdle criteria were agreed and applied to the long list of options.

49. Application of the hurdle criteria in this way immediately removed from consideration a large number of possible configuration options – for example, options that would mean the creation of new hospital sites were ruled out on the grounds that they were neither affordable nor deliverable in a realistic time frame; options that would mean the reversal of recent reconfigurations of services, which had improved outcomes, were also ruled out. In the application of these criteria, three 'fixed points' were established by the clinical advisory group: Guy's Hospital, King's College Hospital and Queen Mary's Hospital. The detail of these 'fixed points' is in appendix E.

50. Key clinical and non-clinical stakeholders were then engaged to develop a full set of more detailed criteria to evaluate the remaining options. The clinical evaluation of these options was completed by the clinical advisory group and endorsed by the external clinical panel.

51. A value for money assessment for each option was then undertaken by the finance, capital and estate advisory group. Full details of the process and the outcome of this evaluation are in appendix E.

52. A significant number of responses to the consultation opposed the draft recommendation that University Hospital Lewisham should no longer provide emergency care, arguing that this would have a detrimental impact on the population that currently depend on those services and that current services are high quality and delivered out of a recently refurbished department. However, on the basis of the full clinical and financial evaluation of options and after taking into account the consultation responses, , including the fact that no viable alternative option was suggested, the TSA's final recommendation is that King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas's Hospital should provide emergency care for the most critically unwell. University Hospital Lewisham, Guy's Hospital and Queen Mary's Hospital Sidcup should provide a range of services for patients who do not need to be admitted to hospital.

53. The analysis demonstrates that recommending that University Hospital Lewisham should not have an emergency department is the only viable option. 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.

54. Urgent care services are well established at Guy's Hospital and Queen Mary's Hospital Sidcup. The TSA recommends University Hospital Lewisham provide these services also, with a view to treating at least 50% of the people currently attending the A&E and urgent care services at the site. This would mean that urgent care services will continue to be available locally and it will also help to minimise the impact on the four remaining A&E departments in south east London.

55. Analysis included in the TSA's draft report suggested around 77% of University Hospital Lewisham's current A&E activity would remain at the hospital under this scenario. However, a number of responses to the consultation suggested that this estimate 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.

56. The recommendation also means that the locations of services for those suffering from a major trauma, stroke, heart attack and complex vascular problems should not change, 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' Hospital and King's College Hospital; and
- emergency vascular services at St Thomas's Hospital.

57. 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 the 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, indeed there should be some improvements, or waiting times in A&E departments. Other changes, including a reduction in average lengths of stay, development of step-down and step-up care at University Hospital Lewisham, 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 should form part of the three-year transitional change programme.

Paediatric emergency services

58. Evidence also shows that, when compared to the rest of the country, London has a higher in-hospital mortality rate for paediatric emergency admissions and this has been rising over the last five years*.

59. Child death reviews across the country have highlighted that there are often avoidable factors in these deaths[37]. These avoidable factors include failings in the recognition and management of serious illness in children such as errors by doctors in training and unsupervised staff; inadequate patient observation; failure to recognise complications and failure to follow national guidelines. This upward mortality trend highlights the urgent need to ensure emergency services for children are safe and of a consistently high quality to achieve the best possible outcomes for children in London.

* Dr Foster analysis

60. Variable consultant presence, particularly between weekdays and weekends, is found to varying degrees in all sites across south east London. Paediatric clinical expert panels for London have therefore developed clinical quality standards for consultant delivered care, seven days a week to ensure care and outcomes for children are optimised. The key themes from these standards are similar to those for adult emergency services shown in paragraph 38.

61. Significant concerns were raised during consultation about the lack of commentary on and specific proposals for 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 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.

62. 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 as outlined in paragraphs 40 and 41 and figure 34. The clinical advisory group and the external clinical panel considered whether the units should be consolidated further than the recommended consolidation of acute admitting sites and options for two or three inpatient units were considered.

63. 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. The local NHS may need to consider further consolidation of these services at some point in the future.

64. Responses to the consultation have 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. Careful planning is needed to ensure these pathways are maintained in the development of the services that will 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 is proposed that a paediatric ambulatory service is developed as part of the urgent care service at University Hospital Lewisham.

65. Particular attention will 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.

Health and Equalities Impact Assessment – emergency care

66. The HEIA is clear that reduced access to emergency care can disproportionately impact on economically and socially deprived groups. This impact will be outweighed by the positive benefits derived from the improvement in the quality of care at those hospitals that will continue to provide emergency care under this recommendation.

67. However as the HEIA states: "The change in travel time, relating to emergency and urgent care currently at Lewisham Hospital, is not statistically correlated with economic and social deprivation", although there is an impact on those considered in the broader category of "health deprivation". The entire socially and economically deprived population in south east London will continue to be within around a 30-minute 'blue light' ambulance journey of an A&E department and will still have much better access to A&E services than the majority of the population in England."

68. 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 relatives and carers who may have to make multiple journeys. In order to mitigate these impacts, more information should be made available on cost support schemes and any Transport for London journey changes that would reduce costs.

69. When considering age, the assessment showed that children (defined as aged up to 16) are associated with high – and growing – levels of A&E usage. The HEIA report states: "…the majority of children currently attending A&E at Lewisham hospital could continue using the urgent care services. Through streamlining A&E attendances and ensuring that children with minor conditions are treated at the urgent care centre or by their own GP in primary care, 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 smaller number of hospitals".

70. Throughout the transitional period, improved information will need to be supplied to parents to ensure they are aware of the range of services for children that will be provided at University Lewisham Hospital in the future.

71. 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 the 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.

72. When considering race, the HEIA identifies that stroke and hypertension are disproportionately prevalent amongst people from black and minority ethnic (BAME) groups. However, these services are already centralised in south east London and, as such, there is no expected impact of the proposed changes on health outcomes for these patients. Sickle cell anaemia also tends to be more prevalent amongst people from BAME groups and has a high level of prevalence in south east London. The condition often presents in crisis in A&E and requires appropriate diagnosis and 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 remaining four A&E departments in south east London is expanded as appropriate.

73. When considering disability, the HEIA shows that mental health problems and coronary heart disease are disproportionately prevalent for people with learning disabilities, but 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. As many of these conditions could be better managed in primary and community settings, implementation of the Community-based Care Strategy will therefore have a positive impact on the quality of care provided to this group.

Maternity services

74. A 2011 study highlighted that the maternal death rate in London was twice the rate of the rest of the United Kingdom[38]. Avoidable factors were identified in many cases. These avoidable factors included delays in recognising a woman's high risk status, junior staff not being properly supervised and delays in referrals to an appropriate specialist leading to delays in or inappropriate treatment. These factors all highlight inadequate supervision and leadership. Additionally, in terms of women's experience, London's maternity services are the least well performing nationally[39].

75. These same issues are found in south east London. All sites have below national average performance on women's experience and no site meets the recommended consultant labour ward presence[40].

76. Work has also been undertaken to develop a set of standards for the provision of maternity services across the capital and, specifically, the quality of care required to support women in labour.

77. To address these issues, a clinical expert panel for London has already agreed a set of clinical quality standards that outlines the minimum quality of care for women who deliver a baby in any unit in London (see appendix P). The key themes from these standards include:

- obstetrician-led maternity services to be staffed to provide 168 hours (ie. 24 hours a day, 7 days a week) of obstetric consultant presence on the labour ward;
- midwifery staffing ratios to achieve a minimum of one midwife to 30 births, across all birth settings;
- all women to be provided with one-to-one care from a midwife during established labour; and
- women's experiences of care to be routinely collected, analysed, reported at board level and acted upon, and all women spoken with in a way they can understand through the use of interpreting services where appropriate.

78. To meet these standards, two options were considered for maternity services, as detailed in the draft recommendations. The two options related to the provision of services to women who need to be admitted to hospital during their pregnancy and those who need, or wish, to have an obstetric-led delivery. In both options, ante-natal and post-natal care would be provided, as now, at all hospital sites and in community settings and the option of a home birth would remain open to women.

79. The two options differed in whether south east London should have four or five hospital sites providing obstetric-led services:

- *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 their capacity which would require some investment.

- *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 (HDU) 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.

80. Reaching consensus on an option has not been possible. The pros and cons of the two options – including the importance of the agreed clinical standards and how each of the two options would meet those standards – were debated in full during the consultation. It is clear from the responses to the consultation that people have strongly-held views about the future of maternity services, even if many did not favour one option over the other. On the whole however, Lewisham stakeholders came out in favour of the five-site model; while other stakeholders, especially the professional bodies, continued to emphasise the importance of meeting agreed clinical standards.

81. During consultation, the clinical advisory group assessed the benefits and risks (and potential mitigating actions) associated with each of the options. Further clinical engagement was sought via a workshop of obstetricians, midwives, paediatricians, anaesthetists and intensivists from each of the five current maternity units in south east London. Feedback was also received from the Royal College of Midwives, the Royal College of Obstetrics and Gynaecologists, through service user focus groups, from consultation responses and through meetings with providers and clinicians in south east London. All of this further informed the assessment of both options.

82. The external clinical panel – 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 – considered the benefits and, in particular, the risks and proposed mitigating actions for each option.

83. The disadvantage of four hospital sites providing obstetric-led services is the negative impact on some women of 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 reason, the panel agreed that this model was not clinically sustainable and therefore that an obstetric-led unit at University Hospital Lewisham was not a viable option.

84. 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.

85. In reaching its decision, the external clinical panel further endorsed the proposal to develop midwifery–led birthing units alongside all remaining obstetric units and also recommended developing a free-standing midwifery-led birthing unit at University Hospital Lewisham.

86. 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 shows 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 University Hospital Lewisham, with participants particularly positive about the model of midwifery-led birth unit. This emerging view, as well as other consultation responses, prompted the TSA to suggest to the external clinical panel that it should consider whether the model could be made to work for the University Hospital Lewisham site.

87. The Royal College of Midwives representative and other members of the panel suggested that, in this case, it would likely 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.

88. The financial modelling of the proposed free-standing midwifery-led birthing unit at University Hospital Lewisham shows the unit will make a loss of c.£1m , although this compares favourably with the losses the financial modelling shows for a free-standing obstetric-led unit there. However, the recommendation has been put forward in response to consultation feedback which did not support either option in the draft report but strongly supported maintaining a maternity service presence at University Hospital Lewisham. It is recommended that the projected shortfall of c.£1m should be covered by the CCGs who would be commissioning this service locally. This level of support has been assumed in the detailed financial modelling shown in appendix M.

89. 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 but networked 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.

90. Similar to the transition plan for emergency services, a plan for the transition of some staff will be needed, ensuring there is an appropriate increase of medical, midwifery and support staff at each unit, so that there will be sufficient capacity in the system to ensure no negative impact on the quality of services.

91. The HEIA signalled that implementing this recommendation could improve maternity outcomes by concentrating obstetric-led maternity services on to fewer sites and enabling greater consultant presence. The report recognises that a critical mass of deliveries could be achieved under the proposal, thus justifying 168-hours (24/7) consultant presence.

92. The HEIA also endorses the recommendation that all obstetric units should be co-located with midwifery-led birthing units and that all units need to meet in full the clinical quality standards developed for London. In particular, this will benefit women with high risk pregnancies.

93. 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[41].

94. However, the HEIA echoed many of the responses to the consultation, namely that a significant number of people are concerned that implementing the proposals will reduce choice for women, have a negative impact on access to services and threaten continuity of care, particularly for women in Lewisham. The proposals were also identified as likely to impact negatively on economically deprived groups, BAME groups and teenage mothers. 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 an obstetric-led maternity unit and will still have much better access than much of the population elsewhere in England. Continuity of care will need to be carefully considered during implementation planning to ensure robust pathways and protocols exist across health and social care providers through the whole maternity pathway. This should help to mitigate the concerns that have been expressed in a set of changes that will bring improvements to services overall.

Alternative approach for proposing changes to emergency and maternity services

95. Some comments were received during consultation suggesting that the disposition of emergency and maternity services across the proposed new Lewisham and Queen Elizabeth organisation – see chapter 6 – should be determined locally at a point in the future by the new provider organisation, commissioners and other stakeholders. This is not the best approach.

96. First, in line with the current legal and policy framework for developing and consulting on proposals for service reconfiguration, this is typically a commissioner-led process in co-operation with healthcare providers and other local partners and could take up to two years to reach a decision. In some circumstances, it could take even longer. For example, *A Picture of Health* took in excess of four years to reach the point where the then Secretary of State endorsed the decision to implement changes. Implementation of changes then typically takes around three years before the clinical and financial benefits begin to be realised. Needless to say, during this time, the clinical and financial challenges would become even more pressing.

97. Second, the TSA's financial modelling has shown that a recommendation for organisational change alone would see a merged organisation of Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital delivering a deficit as detailed in chapter 6 with no way of resolving it. It would be fundamentally wrong for the TSA to recommend the setting up of a deficit organisation and, as such, it is critical that the TSA's proposals include the service changes necessary to ensure financial as well as clinical sustainability.

98. Feedback received from Lewisham CCG during consultation did recognise the need to improve the quality and safety of services by delivering the clinical quality standards and therefore the need for acute configuration in line with the London dependency framework (appendix E). 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. All other local commissioners were broadly supportive.

99. Taking clinical and financial considerations together, the recommendation is therefore for changes to be made to emergency and maternity services, as per the paragraphs above, to ensure the required quality improvements in those services are made across south east London and to avoid replacing one deficit NHS Trust, unable to resolve its financial issues, with another deficit NHS Trust.

Elective care

100. Elective services delivered by hospitals include a range of planned procedures with varying levels of complexity. These can be categorised as follows:

- *Specialist elective care* – highly specialised procedures that are required by a relatively small number of patients and are therefore provided from a small number of centres in England in order to ensure specialists maintain their expertise. Examples of specialist elective procedures include cardiothoracic, liver and neurosurgery.
- *Complex elective care* – procedures that may, or are likely to, need intensive care and should therefore only be provided in hospitals where these services are also available. Surgery for some cancers, such as bowel cancer, is classified as a complex elective procedure.

- *Non-complex elective care* – routine surgical procedures that require a stay in hospital, but do not require intensive or critical care back up services. Examples of non-complex elective procedures include hip or knee replacements or a cholecystectomy (surgical removal of the gall bladder).
- *Day case care* – routine procedures that do not require a stay in hospital, meaning patients can receive their procedure and recuperate in a single day, with further follow-on care provided through community-based services. Examples of day case procedures include cataracts, excision of breast lumps and a range of scope tests, for example endoscopy and colonoscopy.

101. Options for the future provision of elective care across south east London were considered by the clinical advisory group and external clinical panel. Both recognised that specialist procedures should be provided from a specialist hospital and complex elective procedures should be provided in locations where they can be supported by full intensive care, if required. However, non-complex inpatient and day case procedures could be provided from any of the seven main hospitals, or other locations, across south east London.

102. The clinical advisory group and external clinical panel supported the view that there can be clinical benefits from separating elective and emergency care. This is due to a reduction in the risk of hospital acquired infections and a reduction in cancellations, which are often experienced when emergency care takes priority over planned care when both are provided alongside each other[42]. This separation could be provided on any hospital site, subject to available capacity to develop the site to provide a dedicated elective centre.

103. With this in mind, 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 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, Guy's 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.

104. During consultation, discussions with the clinical advisory group, provider organisations and commissioners in south east London, and external experts, informed the development of the final recommendation to determine, based on best practice, the most appropriate activity casemix for the elective centre at University Hospital Lewisham, the optimal clinical model and the proposed governance arrangements for the centre. Full details of this are in appendix E.

105. The recommendation for the elective centre at University Hospital Lewisham is for it to be established as a centre of excellence, utilising the latest techniques and technology to provide high quality care, minimising infection and supporting patients to return to normal in the quickest and safest way.

106. The centre would be the largest multi-speciality centre in the country, serving around 20,000 patients a year. All of these patients would continue to receive their pre- and post-operative care at locations closer to their homes in line with the CCGs' Community-based Care Strategy. Patients would therefore only be required to travel for their operation, but would reap the benefits of bringing together knowledge and experience from across south east London to create a new

centre of excellence. Testimonials from patients who have used the treatment centre at the South West London Elective Orthopaedic Centre (SWLEOC) have highlighted that it provides a good patient experience, as they are able to meet with their consultant locally but receive an efficient and high quality service for their operation[43].

107. The recommended elective centre at University Hospital Lewisham would operate through a partnership model across all south east London trusts. A partnership board with members from all partner provider organisations would oversee the management of the elective centre and the centre would be accountable to the partnership board for quality and access.

108. The partner provider organisations would provide a team of consultant surgeons and anaesthetists who would deliver care in collaboration with the elective centre's multidisciplinary teams.

109. A number of potential funding flows were also considered for the elective centre. The finance, capital and estates advisory group recommended that the preferred option would be for the elective centre to receive the income for the operations undertaken there and therefore be responsible for the full operating costs of the centre. A risk sharing agreement would be in place and each of the trusts in south east London would share profits (or losses) in proportion to the respective share of patients originating from the trust. This model has the advantage of aligning the incentives of all participating trusts and is in place at other centres and found to work well.

110. Commissioner and provider support for the elective centre of excellence was tested during the development of the final recommendations. Commissioners were largely in favour of the development of the centre; this was again restated in their responses to the consultation. Concerns were raised in Lewisham CCG's response that the success of the centre was dependent on other trusts in south east London referring to the centre. With strong commissioner support, this risk is in part mitigated. This risk can be further mitigated by provider support, which was expressed by some during consultation in terms of the benefits the centre could bring by separating emergency and elective services. However, the detail of the clinical and business model would need to be developed further during implementation to provide assurance to provider trusts.

111. The HEIA, in relation to the elective centre, highlighted that patients treated there could benefit from the centralisation of non-complex elective procedures, both in terms of health outcomes and patient experience. These benefits result from the separation of elective and emergency care and include the reduction and elimination of hospital-acquired infections and a reduction of cancellations in procedures.

112. In terms of the impact on travel times, the movement of non-complex inpatient elective services in to the proposed centre at University Hospital Lewisham will lead to greater travel times for some patients to receive treatment. This could particularly impact on people with disabilities, on the economically and socially deprived population and on older people. Also, carers and relatives could also be impacted. However, it is noted that public transport access to University Hospital Lewisham is rated as very good by the Transport for London Public Transport Accessibility Level score.

113. The HEIA also outlines that journey travel times and costs will increase for many patients. While pre- and post-surgery appointments will take place closer to patients' homes, the increased journey times and costs are 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.

114. In relation to the recommended 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. It will therefore be important that patients, their relatives and carers receive clear information along the care pathway.

115. The external clinical panel endorsed the recommendation with the above proposed clinical model and governance arrangements for the elective centre on the basis of the improved outcomes and patient experience it would bring.

Impact of changes

Impact on Lewisham site

116. A vision for the University Hospital Lewisham under this recommendation has been brought forward by Lewisham Healthcare NHS Trust. This vision is for the proposed new organisation, combining University Hospital Lewisham and Queen Elizabeth Hospital, bringing together two groups of staff as one trust providing high quality, cost effective acute and community and emergency care services.

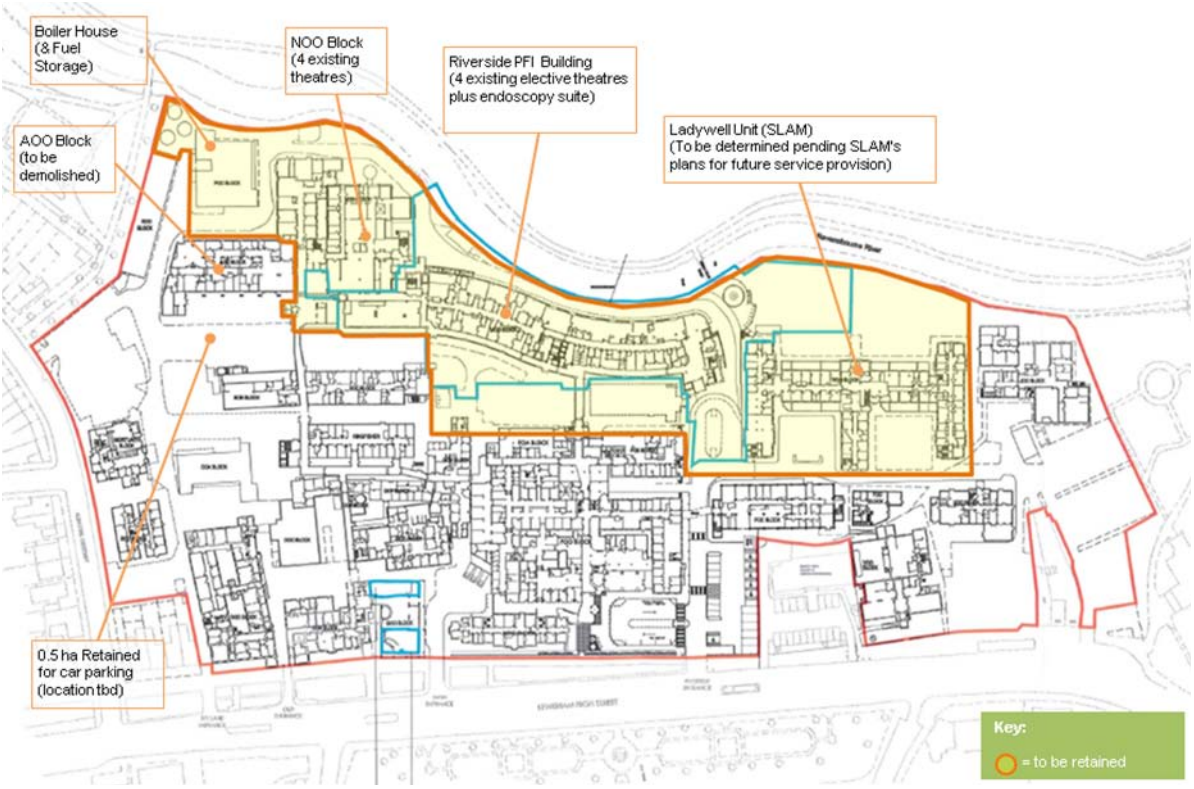
117. Under the recommendation, many services will be retained at University Hospital Lewisham and others developed to provide local access to a wide range of services that meet patients' needs and to maintain the well developed integrated care pathways in Lewisham. The services that will be retained or developed on the site are:

- Urgent care services for adults and children
- Elective centre of excellence for non-complex inpatients
- Day case surgery
- Step up and step down intermediate rehabilitation care inpatient facilities
- Outpatients and diagnostics
- Ante-natal and post-natal outpatient care
- Midwifery-led birthing unit

118. The services at University Hospital Lewisham will be networked with the emergency services at Queen Elizabeth Hospital, with robust 'treat and transfer' protocols for patients that present at the urgent care centre at University Hospital Lewisham and need to be admitted to hospital as an emergency. The ambulance service will still convey patients to the site in appropriate non-'blue light' circumstances. Service models for step up and step down facilities at University Hospital Lewisham will also be developed.

119. Maintaining these services will optimise the use of the high quality estate that exists at the University Hospital Lewisham site, with investment where necessary to develop, for example, the elective centre of excellence, where projected capital costs of £55.9m have been factored into transition costs. There will also need to be some rationalisation of the site to ensure it is financially viable. The proposed site usage is shown in figure 36.

Figure 36: Proposed estate usage at Lewisham



120. To avoid the issues and financial challenges that the Queen Mary's Hospital site in Sidcup has faced, it is recommended that further economic modelling is undertaken to ensure the potential financial benefits for the elective centre of excellence, and potentially other services, are fully realised ; moving from residual costing to a bottom-up appraisal of the lean operating costs of services. This should take place at the implementation stage, should the recommendation be agreed by Secretary of State.

Impact on all south east London sites

121. If the recommendations are accepted and implemented, the location of some services currently provided across the whole of south east London will change. These changes are outlined in figures 37 and 38. Figure 37 summarises the current location of services and figure 38 the proposed future location.

Figure 37: Services currently provided across the hospitals within south east London

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Full admitting emergency department	Full admitting emergency department	Non-admitting urgent care services	Full admitting emergency department	Full admitting emergency department	Non-admitting urgent care services	Full admitting emergency department
24/7 surgical inpatients	24/7 surgical inpatients		24/7 surgical inpatients	24/7 surgical inpatients		24/7 surgical inpatients
24/7 medical inpatients	24/7 medical inpatients		24/7 medical inpatients	24/7 medical inpatients		24/7 medical inpatients
Inpatient paediatric service	Inpatient paediatric service	Paediatric ambulatory care service	Inpatient paediatric service	Inpatient paediatric service		Inpatient paediatric service
				Evelina children's hospital		
Hyper-acute stroke unit						Hyper-acute stroke unit
						Major Trauma Centre
				Heart attack centre		Heart attack centre
				Emergency vascular centre		
Critical care unit	Critical care unit		Critical care unit	Critical care unit	Critical care unit	Critical care unit
Obstetric-led unit and co-located midwife-led unit	Obstetric-led unit		Obstetric-led unit and co-located midwife-led unit	Obstetric-led unit and co-located midwife-led unit		Obstetric-led 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	Ante-natal and post-natal outpatient care
Complex inpatient surgery	Complex inpatient surgery		Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery
Routine inpatient elective and day case surgery	Routine inpatient elective and day case surgery	Routine inpatient elective and day case surgery	Routine inpatient elective and day case surgery	Routine inpatient elective and day case surgery	Routine inpatient elective and day case surgery	Routine inpatient elective and day case surgery
Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics
		Intermediate/ rehabilitation beds*				
				Specialist services	Specialist services	Specialist services

Figure 38: Proposed services to be provided at south east London hospitals from 2015/16

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Full admitting emergency department	Full admitting emergency department	Non-admitting urgent care services	Non-admitting urgent care services	Full admitting emergency department	Non-admitting urgent care services	Full admitting emergency department
24/7 surgical inpatients	24/7 surgical inpatients			24/7 surgical inpatients		24/7 surgical inpatients
24/7 medical inpatients	24/7 medical inpatients			24/7 medical inpatients		24/7 medical inpatients
Inpatient paediatric service	Inpatient paediatric service	Paediatric ambulatory care service	Paediatric ambulatory care service	Inpatient paediatric service		Inpatient paediatric service
				Evelina children's hospital		
Hyper-acute stroke unit						Hyper-acute stroke unit
						Major Trauma Centre
				Heart attack centre		Heart attack centre
				Emergency vascular centre		
Critical care unit	Critical care unit		Surgical high dependency care unit	Critical care unit	Critical care unit	Critical care unit
Obstetric-led unit and co-located midwife-led unit	Obstetric-led unit and co-located midwife-led unit		Midwife-led unit	Obstetric-led unit and co-located midwife-led unit		Obstetric-led unit and co-located midwife-led 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	Ante-natal and post-natal outpatient care
Complex inpatient surgery	Complex inpatient surgery			Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery
Day case surgery	Day case surgery	Day case surgery	Routine inpatient elective and day case surgery	Day case surgery	Routine inpatient elective and day case surgery	Day case surgery
Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics
		Intermediate/ rehabilitation beds	Intermediate/ rehabilitation beds			
				Specialist services	Specialist services	Specialist services

Impact on access

122. Currently, around 315 patients arrive to be seen by University Hospital Lewisham's emergency and urgent care services each day*. Of these around three arrive in a 'blue light' ambulance** and would need to be taken to an alternative location in the future, 79 arrive in an ambulance without a blue light, and the remaining arrive via private or public transport. Over 150 of the 315 patients would still be able to attend the Hospital if the proposals were to be implemented.

123. Journey times have been analysed in detail using Transport for London's Health Service Travel Analysis Tool, and the proposals for emergency care outlined in this recommendation 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 39, which also includes the impact on travel time for those whose journeys are relatively long currently (the 95th percentile***).

Figure 39: 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

124. 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[44]. Similarly, for a major trauma, clinicians concluded that the journey time should be no more than 45 minutes.

125. Using 30 minutes as the benchmark for accessing emergency services, figure 40 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 40: 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

* Data provided by Lewisham Healthcare NHS Trust

** Explanatory note: London Ambulance Service define a 'blue light' ambulance journey as one that is required when a patient is identified as having life-threatening or abnormal vital signs

*** 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.

126. 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 41, 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 Lewisham, with the weighted average travel time for 'blue light' ambulance journeys increasing by seven minutes, as shown in figures 41 and 42.

Figure 41: 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 42: 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

127. A large number of responses to the consultation expressed concerns that the changes, if implemented, would mean increased travel times to access A&E services. However, travel times to emergency services in south east London, including for the residents of Lewisham, would continue to be very good after the changes have been implemented. Put in the context of access to A&E services nationally, while access for many residents 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.

Clinical and financial benefits

128. The clinical benefits for implementing the changes in this recommendation are clear. Improving acute clinical standards for emergency services could save 100 lives a year merely by matching mortality rates for weekend admissions to mortality rates for weekday admissions. Alongside this, implementation of the Community-based Care Strategy could save around 700 lives a year through early detection and management of diabetes. Many more opportunities to improve the quality of care, outcomes and the patient experience and to address health inequalities could also be realised, as detailed in figure 43 overleaf.

129. Appendix E details the financial considerations made to assess the impact of the recommendations for service change. Further detailed financial calculations are contained within appendix M.

Figure 43: Benefits of implementing the clinical quality standards and elective centre across south east London (Sources can be found in Appendix E)

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

130. Alongside the assessment of clinical benefits, the financial benefits of implementing this recommendation have been considered, including its value for money and how it will contribute to delivering sustainable services. This analysis has considered a range of factors, including:

- *Activity movement* – the impact of people attending different hospitals based on the changes to services and the related impact on the number of beds and operating theatres required at each site in south east London.
- *Consolidation savings* – additional efficiency savings that can be made by bringing services together.
- *Implementation of service standards* – the reduction in costs associated with implementing the clinical quality standards across only four hospitals delivering emergency services.
- *Running costs* – the cost of running the hospitals will be impacted, depending on whether they will be delivering more or fewer services.
- *Land disposals* – some of the land, specifically at University Hospital Lewisham, will become surplus to NHS requirements and can therefore be sold.
- *Capital costs* – the investment in buildings and equipment required to ensure all hospitals can deliver the required services.
- *Transition cost* – the non-recurrent costs of implementing the recommendations and service changes without compromising the quality of care during the implementation phase.

131. Taken together, once fully implemented these service change proposals deliver a £11.2m a year recurrent benefit for the Trust. As required by the Secretary of State the TSA has considered the financial impact on the other providers in south east London.

132. Despite the elective centre generating a £14.4m operating margin the Lewisham Healthcare NHS Trust will see a small gain in its financial position by £1.0m. This will serve to keep the financial pressure on this organisation with a £2m gap to financial viability previously highlighted.

133. The TSA calculations detailed in appendix M see a financial benefit in the other Trusts of £0.1m to Guy's and St Thomas' NHS Foundation Trust and £7.2m to King's College Hospital NHS Foundation Trust.

134. The recurrent financial benefits of implementing these recommendations in full are shown in figure 44.

Figure 44: Summary of recommendation 5: service reconfiguration

2015/16 Full year effect	
Princess Royal University Hospital	1.7
Queen Elizabeth Hospital	9.5
Queen Mary's Hospital	0.0
Total	**11.2**
Lewisham	1.0

135. Taken alongside recommendations 1-4 the impact of the TSA recommendations 5 is outlined in figure 45.

136. The Princess Royal University Hospital site makes a £1.7m recurrent surplus (over the 1% financial viability threshold by £0.2m). The Queen Elizabeth Hospital site makes a recurrent surplus of £2m, £0.2m above the 1% financial viability threshold, however this does not allow for the mitigation of any financial risks should they develop.

137. The financial position of the Lewisham Trust is forecast to improve by £1.0m a year resulting in a recurrent £0.4m surplus and a resultant £2.0m distance from the 1% financial viability threshold.

138. Chapter 6 considers the appropriate organisational structures for delivering the service changes and assesses the potential for further non-operational financial savings.

Figure 45: Impact of recommendations 1-5 on the financial projections for South London Healthcare NHS Trust and Lewisham Healthcare NHS Trust

Before TSA Recommendations

2013/14	Income	Cost	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	184.1	204.4	-20.3	22.1
QEH	174.1	202.4	-28.3	30.0
QMS	72.1	83.0	-10.9	11.6
Total	**430.3**	**489.8**	**-59.5**	**63.8**
Lewisham	236.4	236.2	0.2	2.2

2013/14 Full year effect

2013/14	Income	Cost	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	184.1	207.0	-22.9	24.8
QEH	173.1	205.7	-32.6	34.3
QMS	61.6	72.3	-10.7	11.3
Total	**418.8**	**485.1**	**-66.2**	**70.4**
Lewisham	236.9	235.9	1.0	1.4

2014/15 Full year effect

2014/15	Income	Cost	Deficit	Gap to 1%
PRU	183.7	210.4	-26.7	28.6
QEH	176.2	211.1	-34.9	36.6
QMS	62.7	74.4	-11.7	12.3
Total	**422.6**	**495.9**	**-73.3**	**77.5**
Lewisham	237.2	237.4	-0.2	2.6

2015/16 Full year effect

2015/16	Income	Cost	Deficit	Gap to 1%
PRU	184.0	212.4	-28.4	30.3
QEH	179.7	215.2	-35.5	37.3
QMS	64.2	75.3	-11.1	11.7
Total	**427.9**	**502.9**	**-75.0**	**79.3**
Lewisham	239.5	240.1	-0.6	3.0

Changes in I&E

2013/14	Rec 1 Further productivity	Rec 2 QMS site change	Rec 3 Estates	Rec 4 PFI support	Rec 5 Service Reconfiguration	Total changes	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	4.9			10.5	0.0	15.4	-7.5	9.4
QEH	5.2	0.6		12.2	0.0	18.0	-14.6	16.3
QMS	2.1	-0.6	0.7		0.0	2.2	-8.5	9.1
Total	**12.2**	**0.0**	**0.7**	**22.7**	**0.0**	**35.6**	**-30.6**	**34.8**
Lewisham							1.0	1.4

2014/15								
PRU	8.5		2.8	10.7	-1.3	20.7	-6.0	7.9
QEH	9.9	0.6		12.2	0.0	22.7	-12.2	13.9
QMS	4.2	2.1	0.7		0.0	7.0	-4.7	5.3
Total	**22.6**	**2.7**	**3.5**	**22.9**	**-1.3**	**50.4**	**-22.9**	**27.1**
Lewisham							-0.2	2.6

2015/16 Full year effect								
PRU	12.6		4.0	11.8	1.7	30.1	1.7	0.2
QEH	13.8	0.6		13.6	9.5	37.5	2.0	-0.2
QMS	5.2	3.9	0.7		0.0	9.8	-1.3	1.9
Total	**31.6**	**4.5**	**4.7**	**25.4**	**11.2**	**77.4**	**2.4**	**1.9**
Lewisham					1.0	1.0	0.4	2.0

Note: The full year effect of the income adjustments are not considered until the post implementation forecast. Further detail is provided in appendix M.

Summary

139. The recommendations outlined in this chapter have been developed to resolve the sustainability challenges within South London Healthcare NHS Trust and how that fits with and impacts on the wider south east London healthcare system, with full regard to the commissioning intentions of the six CCGs.

140. The evaluation of all options, as detailed in appendix E, demonstrates that these recommendations are the only viable solution to the financial and clinical sustainability challenges that face South London Healthcare NHS Trust and the rest of south east London.

141. These recommendations can be summarised as follows:

- The Community-based Care Strategy developed by the CCGs in south east London should be fully implemented, at pace.
- King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas's Hospital should provide emergency care for the most critically unwell and that these services be developed to meet the required clinical quality standards. University Hospital Lewisham, Guy's Hospital and Queen Mary's Hospital should provide urgent care services for patients that do not need to be admitted to hospital.
- Paediatric emergency services and inpatient units should be co-located with all acute admitting units and paediatric urgent care services should be provided at University Hospital Lewisham, Guy's Hospital and Queen Mary's Hospital.
- Four obstetric-led units should be provided at King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas' Hospital, each with a co-located midwifery-led birthing unit; and a freestanding midwifery-led birthing unit should be provided at University Hospital Lewisham.
- An elective centre of excellence for non-complex inpatient procedures should be developed at University Hospital Lewisham for patients across south east London, managed by a partnership board of representatives of all provider organisations.

142. The financial benefits of implementing these recommendations in full are shown in figure 45.

143. Successful delivery of these recommendations within the proposed three-year timetable will require a co-ordinated effort across all stakeholders within south east London. Large scale change of this nature can only be delivered through dedicated clinical and managerial leaders working together under the direction of strong programme management. This will ensure delivery is at the required pace, as set out in chapter 7, to ensure the full benefit of these recommendations is felt across the system.

6. Recommendations relating to organisational solutions

1. It should be recognised that the staff within South London Healthcare NHS Trust have worked and continue to work hard to deliver high quality care to patients. Indeed, there have been significant improvements in the quality of care in recent years. However, since 2009 the clinical and managerial leadership of the Trust has not been sufficiently successful in integrating operations across the three main sites. Nor has it been able to transform and embed a culture capable of delivering a combination of operational efficiency and high quality care. Sustainable healthcare organisations need the capacity and capability to do both of these, if they are to fulfil their duty to patients and to the taxpayer.

2. Chapter 4 demonstrated that although implementing recommendations 1 to 4 will enable a transformation in the financial position of the Trust; it does not bridge the financial gap. Operating losses will indefinitely remain at the Princess Royal University Hospital and Queen Elizabeth Hospital. South London Healthcare NHS Trust has also proved incapable of delivering sustainable improvements to operational efficiency at the level required by recommendation 1.

3. Both points support the conclusion that it is necessary to dissolve South London Healthcare NHS Trust, review the organisation of services across south east London and seek new providers and organisational arrangements to drive up the capability and capacity to execute a complex and extremely challenging set of recommendations for improvement.

4. In view of the fixed timescales within which the TSA has had to work, and acknowledging feedback from the Secretary of State's consultation prior to enacting the UPR process and the detail in *The Case for Applying the Regime for Unsustainable Providers* published by the Secretary of State at the time of enacting the Regime (see appendix A), work on understanding the wider health economy was initiated in parallel with the internal review of the Trust. Chapter 5 presented the analysis of the broader south east London health economy and described both the required clinical standards for acute emergency and maternity services and the service change proposals for south east London, designed to facilitate improved health outcomes and the viability of hospital services.

5. In this chapter, proposals for new organisational arrangements for South London Healthcare NHS Trust are set out. The process of market engagement and evaluation used to draw conclusions is described in appendix F. The market engagement process was carried out to identify whether there was market interest, in order to develop draft recommendations for consultation in the knowledge that these recommendations were workable and based on informed discussion with interested parties. The market engagement exercise sought views from any parties – including from the voluntary and independent sectors – interested in taking over South London Healthcare NHS Trust in its entirety or in part. The outcome of this was that no party was willing to take on the Trust in its entirety and that no party would take the financial risk associated with operating a site without a plan incorporating significant service change which would enable site viability.

6. The process described in chapter 3 and detailed in appendix F helped to identify options for organisational change which, in turn, have informed the development of recommendations in response to the proposed dissolution of the Trust. The pace of implementing new organisational solutions will be essential to delivering the changes proposed in recommendations 1 to 5. Delivering improvements in a three-year period is critical 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 component of this work. The proposed date for dissolution of South London Healthcare NHS Trust and the establishment of new organisational arrangements is recommended to be 1 June 2013. This balances the pace of change required with the importance of ensuring that changes affecting staff are clear and can be completed with sufficient involvement of staff themselves.

Queen Mary's Hospital

7. Recommendation 2 sets out the proposals for the future of Queen Mary's Hospital. The site should be owned and run by Oxleas NHS Foundation Trust. The transfer of the site to Oxleas NHS Foundation Trust will include provisions in relation to future use of the land and access for other providers. Under the Trust's leadership, the hospital will have a sustainable future, providing the services that commissioners have identified as being required for the local population and creating a centre of excellence for inpatient mental health services across Bexley and Bromley. It is also being recommended that Oxleas NHS Foundation Trust are the interim provider of the Children's Development Centre and the Children's and Young Person's Assessment Unit currently delivered by South London Healthcare NHS Trust. As Oxleas NHS Foundation Trust already delivers a range of community paediatric services this recommendation will support the better integration of children's services.

8. The majority of services currently provided from the site will continue to be provided there, with some new services being added (see recommendation 2 and appendix N) – specifically the proposed satellite radiotherapy unit to be provided by Guy's and St Thomas' NHS Foundation Trust. As per recommendation 5, outpatients, day case elective surgery and therapies currently delivered at Queen Mary's Hospital by South London Healthcare NHS Trust, will continue to be provided there. However, as the Trust will no longer exist, Bexley CCG should initiate a procurement exercise to secure the right provider(s) of care for the future. In the interim, in order to ensure that the quality and safety of services is maintained in the transitional period following the dissolution of South London Healthcare NHS Trust, for a period of 22 months, the recommendation is for Dartford and Gravesham NHS Trust to be the provider of the majority of these services. This formal procurement process is also proposed by the Co-operation and Competition Panel, following their review of the TSA's draft recommendations, as a means of mitigating any risk to patient choice or competition.

9. A number of consultation responses have queried this recommendation suggesting in particular that the new organisation which brings together Lewisham Healthcare NHS Trust with Queen Elizabeth Hospital would be a better choice than Dartford and Gravesham NHS Trust. It is important to recognise that this is an interim recommendation, with the final decision on who should provide these services being one for local commissioners following a competitive procurement process. Dartford and Gravesham NHS Trust provides a significant amount of emergency care for the residents of Bexley following the closure of the emergency department at Queen Mary's Hospital. Being the provider of elective and outpatients services at Queen Mary's Hospital will enable more integrated pathways of care, particularly supporting older people in partnership with the community services provided by Oxleas NHS Foundation Trust. It should also be noted that Dartford and Gravesham NHS Trust expressed interest in providing these services and Lewisham Healthcare NHS Trust did not.

10. Under the proposal the inpatient elective procedures that currently take place at Queen Mary's Hospital will cease. Patients who are currently receiving elective inpatient care at Queen Mary's Hospital who have their initial assessment at either Queen Elizabeth Hospital or Princess Royal University Hospital will have their surgery at the elective centre as outlined in recommendation 5. Patients who start their treatment at Queen Mary's Hospital may also choose to use the elective centre if they need an inpatient procedure, however, alternatively they could have their treatment at Darent Valley Hospital which is part of Dartford and Gravesham NHS Trust. To ensure continuity of care during transition, and in recognition of the need to meet national standards (such as 18 weeks) there will be a transitional period of up to one year to move to future arrangements to ensure that capacity is available in the right location before any changes are made. Detailed plans for this would need to be developed and communicated to patients if this recommendation is accepted.

11. 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 already provides the majority of clinical staff to deliver South London Healthcare's oral surgery services and are the prime provider of ophthalmology services in south east London. 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 alongside the proposed satellite radiotherapy service on the site which would allow the integrated provision of cancer services.

Queen Elizabeth Hospital

12. Through the market engagement process, Lewisham Healthcare NHS Trust expressed a strong interest in coming together with Queen Elizabeth Hospital in order to establish a new NHS Trust that provides services to the populations of Greenwich and Lewisham. At the same time, the TSA financial projections outlined in chapter 5 have shown that Lewisham Healthcare NHS Trust will struggle to be financially sustainable as a stand-alone organisation. It is important that the TSA's recommendations in relation to South London Healthcare NHS Trust are workable and deliverable, in this context, and considering the additional impact expected from the implementation of the service changes outlined in recommendation 5, it is clear that Lewisham Healthcare NHS Trust's long term viability would be assured by being part of a larger organisation.

13. Taking into account the proposed dissolution of South London Healthcare NHS Trust, the financial projections, the need for sustainable services and Lewisham Healthcare NHS Trust's interest in contributing to the solution, the recommendation is to support the Trust in setting up a new organisation that provides services to the populations of Greenwich and Lewisham. This new organisation will need to be capable of implementing the final decisions of the Secretary of State.

14. The recommendation envisages a combined organisation that provides a range of clinically and financially sustainable acute and community services in Lewisham and acute services for the population of Greenwich which will work in partnership with primary care, the local authority and Oxleas NHS Foundation Trust to ensure integrated services are provided across the primary and acute care interface. This new Trust would also host the proposed elective centre at University Hospital Lewisham.

15. In line with the criteria for evaluating options for organisational solutions, this will deliver the standards of care set out by commissioners. Lewisham Healthcare NHS Trust also has experience of delivering integrated care at scale, which should be used in the new organisation to support further improvements in integration for patients across its new wider geography. Capacity and capability to deliver the operational improvements set out in recommendation 1 will also be critical. The new Trust will need to ensure this capability is in place from the outset. The NHS Trust Development Authority has a critical role in assuring this.

16. Further detailed work has been undertaken between the draft report and this final report. This demonstrates that the new organisation has the potential to be clinically and financially sustainable and ought to be capable of achieving foundation trust status. It also has broad, in principle, support of local commissioners.

17. However, concerns have been expressed through the consultation process regarding the potential for University Hospital Lewisham to be destabilised as part of the creation of the new organisation. In addition, experience from the creation of South London Healthcare NHS Trust shows that in the first year as a merged Trust they reported a normalised deficit of £44m, double that of the corresponding figure of the three predecessor Trusts (£22m). Therefore, it is recommended that the NHS Trust Development Authority provides support and close oversight during the creation of the new organisation.

18. A number of consultation responses, including from Lewisham Healthcare NHS Trust and from Lewisham CCG, have supported the establishment of this new organisation. However, their stated preference is for the new Trust to determine its own plan for services. While they recognise the need for change, to replace one deficit Trust with another one, without an agreed strategy for improving clinical services, does not address the underlying structural issue and merely postpones the difficult decisions for another day. This new Trust would be reliant on cash support, with no plan to bring this to an end. There would be a consequential impact at Princess Royal University Hospital where operating losses would also continue as outlined at the end of chapter 4. In any case, in line with the Government's policy, commissioners – and not the Trust – would need to bring forward proposals for service change. All other local commissioners are broadly supportive of the recommendation 5.

19. The Co-operation and Competition Panel has noted that the recommendation that the Queen Elizabeth Hospital, currently operated by South London Healthcare NHS Trust, should come together with Lewisham Healthcare NHS Trust could potentially 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. However, the panel note that this will not be the case, if there are sufficient countervailing benefits to offset the likely reduction in patient choice and competition that it has identified.

20. The Co-operation and Competition Panel has also recommended, and the TSA concurs, that in order to remove or mitigate this risk, 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.

Princess Royal University Hospital

21. Modelling on the potential of Princess Royal University Hospital as a future standalone organisation, after the implementation of service changes proposed in recommendation 5, suggests that it could be a viable organisation, but only if it can fully implement recommendations 1 to 4. Chapter 4 highlighted that the current leadership within South London Healthcare NHS Trust, including those responsible for managing services at the Princess Royal University Hospital, is not capable of delivering the additional operational efficiency outlined in recommendation 1. From the alternative options that were considered through the market engagement process, two options were presented in the draft report as potential future solutions for both owning the site and managing the services there.

22. The first (and preferred) option in the Draft Report was for King's College Hospital NHS Foundation Trust to acquire the Princess Royal University Hospital site and its services. Under this option, King's College NHS Foundation Trust would take on the ownership and management of the hospital and be responsible for delivering the productivity improvements identified, as well as the proposed service changes outlined in recommendations 2, 3 and 5. King's College NHS Foundation Trust is a well-established NHS Foundation Trust with a track record of delivering high quality acute care, and it has a strong management team with a vision of becoming the best medical research campus in Europe. Its financial performance is sound, including a Monitor financial risk rating of 3.

23. Options for implementing this acquisition, from as early as April 2013, were considered, subject to the proposed acquisition meeting NHS regulatory requirements and a timetable for Monitor to consider the proposed business case. Further work has been undertaken on this, and it is now recommended that this is implemented from 1 June 2013. Implementing to this fast timescale will enable King's College NHS Foundation Trust to provide clear leadership and support to the staff and services at the Princess Royal University Hospital, which will assist in the effective delivery of both final decisions for service change and necessary productivity improvements and allow the necessary preparatory work to be completed in advance. King's College NHS Foundation Trusts will also be able to draw on the wider expertise within King's Health Partners in order to bring wider clinical and research benefits to staff and patients.

24. Discussions with King's College Hospital NHS Foundation Trust have indicated that they would be fully committed to the partnership model for the elective centre at University Hospital Lewisham proposed in recommendation 5 and will look to maximise the use of this service in delivering quality services for the local population. They are also interested in working with the proposed new Greenwich and Lewisham organisation to consider how to use rehabilitation services at University Hospital Lewisham effectively, where King's College NHS Foundation Trust currently provide inpatient rehabilitation services.

25. The second option in the draft report was for a competitive procurement for the services provided at the Princess Royal University Hospital site to be undertaken in line with EU procurement rules. Within this option there would be two sub-options: first, procurement of a franchised contract for the management support of the NHS services provided from the site, similar to the approach taken for Hinchingbrooke Hospital in Cambridgeshire; and second, a procurement for the provision of clinical services.

26. Under the option of the franchised model, NHS staff would be retained within the NHS, with a contracted provider managing the hospitals. In the model for provision of clinical services, the provider is responsible for managing and delivering all clinical services. Within this model staff may transfer to the contracted provider.

27. Undertaking a competitive procurement of this nature should identify the organisation best placed to deliver safe and effective services within the funding available – this could be an NHS organisation, or a national or international independent sector provider.

28. It is possible that the procurement timetable for this second option could be accelerated so that it is completed within six to eight months from the decision to commence, although that is subject to discussions with appropriate regulators and the Department of Health. There are additional risks to this option, over and above those for the first option, related specifically to the potential transition of workforce and pension requirements for current NHS staff. Also, under this option a new NHS Trust for managing the Princess Royal site would need to be established and run by an interim management team during the procurement process.

29. During the consultation there was support for the option of King's College Hospital NHS Foundation Trust acquiring the Princess Royal University Hospital, as opposed to a procurement process being undertaken.

30. Further detailed work has been undertaken between the draft report and this final report. This demonstrates that this combined organisation will be clinically and financially sustainable going forward. In light of these factors the TSA is therefore recommending that Kings College NHS Foundation Trust acquires Princess Royal University Hospital.

31. The Co-operation and Competition Panel has noted that the recommendation that King's College Hospital NHS Foundation Trust should acquire 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.

Health Equalities Impact Assessment

32. The HEIA has not identified specific impacts for patients and the public, based on the changes proposed in draft recommendation 6. However, there are potential impacts on staff which have been considered in developing the final recommendations. Staff could be affected by potential reductions in workforce due to operational efficiencies and 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 in turn could impact on staff health, training, travel and morale. For example, 80% of South London Healthcare NHS Trust's staff are women, and 35% are from ethnic minority groups. Appropriate HR policies and procedures should be reviewed, established if required, and followed to ensure these groups do not suffer or are disadvantaged.

33. Throughout the TSA process there has been extensive engagement with staff as described in chapter 3. This will need to continue throughout the transition period to ensure that 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 Transition Director responsible for the wider London NHS transition programme.

34. During the consultation, concerns were also raised regarding training and education. 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).

35. 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. While this will be challenging, not least for University Hospital Lewisham, the recommendations, if accepted, provide an opportunity to redesign, modernise and improve training. Following discussions with the London Deanery and the LETB, it is clear that review and redevelopment of training for acute and community services could be undertaken in a joint, coordinated fashion and presents an opportunity to deliver significant improvements. This opportunity has generated substantial interest and will therefore be taken forward if the recommendations are accepted by the Secretary of State.

36. These actions, taken together with a well managed transition, as described in chapter 7 should ensure that there is unlikely to be a significant negative impact on staff from any organisational changes.

Historic debt

37. The success of these organisations will be essential for the local population. They will have a significant agenda to implement in order to secure safe, high quality and affordable services. They should be allowed to dedicate themselves to that effort and not be burdened with the issues of the past. To facilitate this, this final report recommends the new organisations are not faced with any repayment requirements relating to historic debts.

Transition Support

38. For these organisations to operate effectively they will need a level of financial support during the first three years. This is to recognise that recommendations 1 to 5 will take three years to implement, during which time Queen Mary's Hospital, Queen Elizabeth Hospital and Princess Royal University Hospital will continue to have deficits.

39. The TSA work has identified £7.7m of merger synergies, which are broken down in figure 46. Based on experience in other NHS organisational changes an assessment of the potential efficiencies that could be achieved through rationalising corporate services (also known as back-office functions such as HR, Finance, and Estates) has been undertaken. While these functions are important to support the delivery of front-line clinical services, they can be provided at a lower cost in larger organisations. Early work has indicated that the organisational changes will enable a reduction of £7.7m in the cost of these services. There are other significant benefits of the organisational changes and it is likely that further benefits from clinical synergies will be identified over time by the new organisations.

Figure 46: Merger synergies to be realised by 2015/16

	Savings
Princess Royal University Hospital	3.2
Queen Elizabeth Hospital	3.2
Queen Mary's Hospital	1.3

40. Figure 47 presents the combined effect of recommendations 1 to 6. It demonstrates that site viability is possible and that the new organisation combining Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital should be in surplus by 2016/17.

41. The Department of Health will need to agree transition support payments for Oxleas NHS Foundation Trust, the new organisation combining Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital, and Kings College NHS Foundation Trust. These payments 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. For King's College NHS Foundation Trust support to a level that would maintain its Monitor Financial Risk Rating of 3 will be needed to the extent that this Risk Rating is affected by the transaction.

Figure 47: Impact of recommendations 1-6 on the financial projections for South London Healthcare NHS Trust and Lewisham Healthcare NHS Trust

Before TSA Recommendations				
2012/13	Income	Cost	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	184.1	204.4	-20.3	22.1
QEH	174.1	202.4	-28.3	30.0
QMS	72.1	83.0	-10.9	11.6
Total	**430.3**	**489.8**	**-59.5**	**63.8**
Lewisham	236.4	236.2	0.2	2.2

2013/14 Full year effect				
2013/14	Income	Cost	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	184.1	207.0	-22.9	24.8
QEH	173.1	205.7	-32.6	34.3
QMS	61.6	72.3	-10.7	11.3
Total	**418.8**	**485.1**	**-66.2**	**70.4**
Lewisham	236.9	235.9	1.0	1.4

2014/15 Full year effect				
2014/15	Income	Cost	Deficit	Gap to 1%
PRU	183.7	210.4	-26.7	28.6
QEH	176.2	211.1	-34.9	36.6
QMS	62.7	74.4	-11.7	12.3
Total	**422.6**	**495.9**	**-73.3**	**77.5**
Lewisham	237.2	237.4	-0.2	2.6

2015/16 Full year effect				
2015/16	Income	Cost	Deficit	Gap to 1%
PRU	184.0	212.4	-28.4	30.3
QEH	179.7	215.2	-35.5	37.3
QMS	64.2	75.3	-11.1	11.7
Total	**427.9**	**502.9**	**-75.0**	**79.3**
Lewisham	239.5	240.1	-0.6	3.0

2016/17 Post reconfiguration forecast				
2016/17	Income	Cost	Surplus	Gap to 1%
PRU	227.6	220.1	7.5	-5.2
QEH/LEW	379.8	375.1	4.7	-0.9
Total	**607.4**	**595.2**	**12.2**	**-6.1**

Changes in I&E

	Rec 1	Rec 2	Rec 3	Rec 4	Rec 5	Rec 6			
2013/14	Further productivity	QMS site change	Estates	PFI support	Service Reconfiguration	Merger synergies	Total changes	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	4.9			10.5	0.0	0.6	16.0	-6.9	8.8
QEH	5.2	0.6		12.2	0.0	0.6	18.6	-14.0	15.7
QMS	2.1	-0.6	0.7		0.0	0.6	2.8	-7.9	8.5
Total	**12.2**	**0.0**	**0.7**	**22.7**	**0.0**	**1.8**	**37.4**	**-28.8**	**33.0**
Lewisham								1.0	1.4
2014/15									
PRU	8.5		2.8	10.7	-1.3	1.7	22.4	-4.3	6.2
QEH	9.9	0.6		12.2	0.0	1.8	24.5	-10.4	12.1
QMS	4.2	2.1	0.7		0.0	0.9	7.9	-3.8	4.4
Total	**22.6**	**2.7**	**3.5**	**22.9**	**-1.3**	**4.4**	**54.8**	**-18.5**	**22.7**
Lewisham								-0.2	2.6
2015/16 Full year effect									
PRU	12.6		4.0	11.8	1.7	3.2	33.3	4.9	-3.0
QEH	13.8	0.6		13.6	9.5	3.2	40.7	5.2	-3.4
QMS	5.2	3.9	0.7		0.0	1.3	11.1	0.0	
Total	**31.6**	**4.5**	**4.7**	**25.4**	**11.2**	**7.7**	**87.4**	**12.4**	**-5.9**
Lewisham					1.0		1.0	0.4	2.0

Note: The full year effect of the income adjustments are not considered until the post implementation forecast. Further detail is provided in appendix M.

7. Recommendations relating to transition and implementation

1. Chapters 4, 5 and 6 outlined a significant and complex set of recommendations which, taken together, meets the scale of the challenge facing South London Healthcare NHS Trust and the broader health economy in south east London. The pace of change is consequential to the overall success of these recommendations.

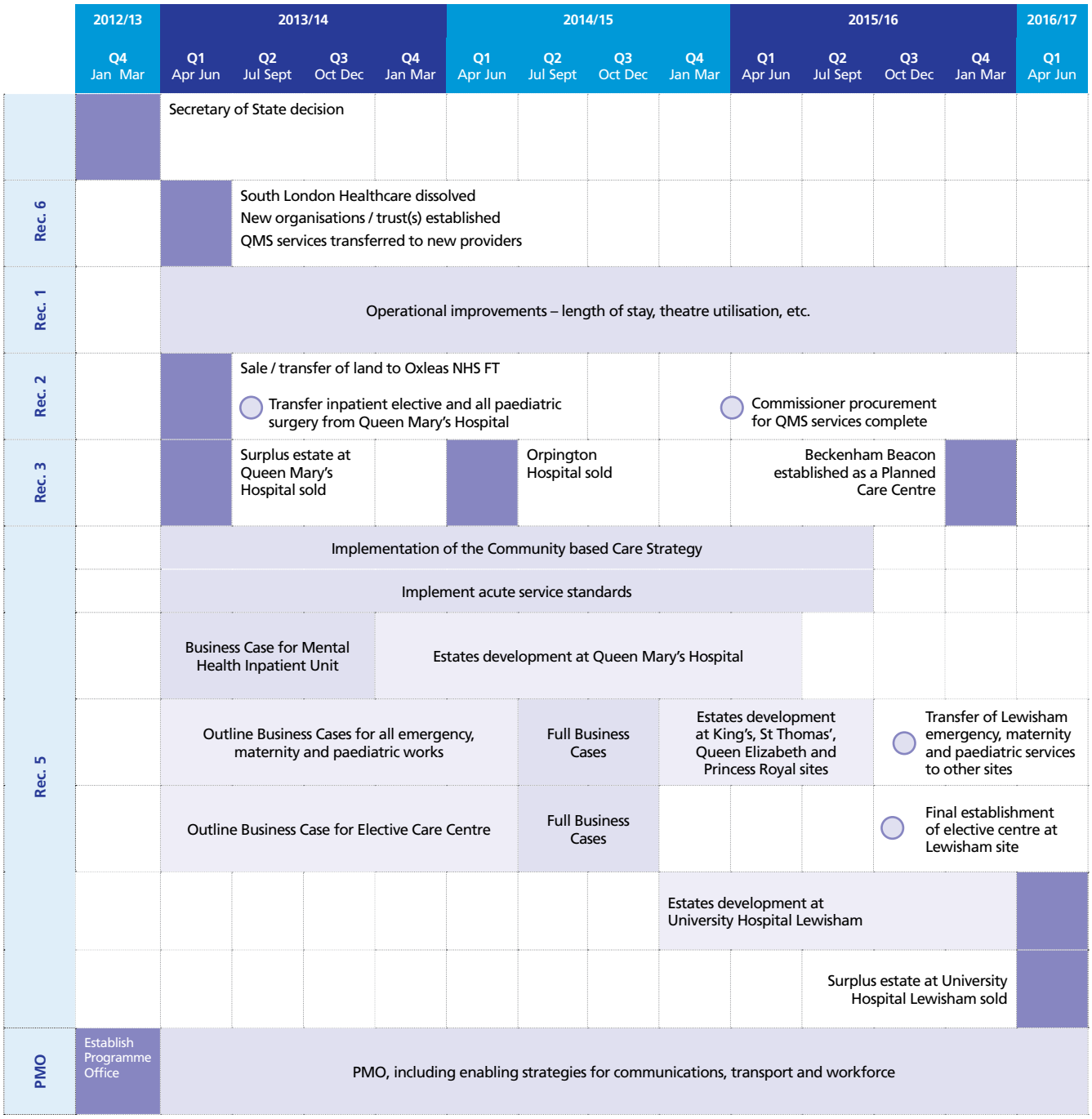
2. The ongoing financial constraint in the NHS – and broader public sector – means that all NHS providers need to make efficiency improvements year on year. If the proposed successor organisations to South London Healthcare NHS Trust are not able to deliver the changes recommended in this report quickly enough, they will be unable to keep up with this requirement, which is likely to result in the continuation of deficits. This is why the careful planning of a three-year programme of transition and implementation is necessary.

3. Successful delivery of large scale change of this nature can only be achieved through dedicated clinical and managerial leadership and strong programme management. The importance of this has been referenced in many of responses to the TSA's consultation. However, many also cautioned that the scale of what is being recommended, including the proposed pace of change, should not be underestimated, especially as much of the NHS will continue to be in transition to new organisational arrangements from April 2013.

4. Successful implementation requires a number of organisations to be aligned and work in partnership to an agreed timetable. The organisations with a key role facilitating the implementation of change include the six CCGs and six local authorities in south east London, all NHS service providers in south east London, the NHS Commissioning Board, Dartford and Gravesham NHS Trust, the NHS Trust Development Authority, the South London Local Education and Training Board, the Department of Health, Monitor and HM Treasury.

5. The remainder of this chapter sets out the high-level transition and implementation timeline, the costs of transition and the key risks to delivery that have been identified, together with proposed high-level mitigating actions. It concludes by recommending that the transition and implementation programme will need to be underpinned by effective programme management, with appropriate oversight and assurance by the Chief Executive of the NHS Commissioning Board and the Chief Executive of the NHS Trust Development Authority, to give the Secretary of State the confidence that the changes are being delivered to the agreed timetable and, when fully implemented, are realising the clinical and financial benefits that were expected, making good use of taxpayers' money.

Figure 48: Timeline



Transition costs

6. Implementing the TSA's recommendations effectively will incur a series of one-off costs, for which national support will be needed. However, it is the TSA's view that these unavoidable costs will be money well spent, given the positive benefits of change significantly outweigh the costs of maintaining the status quo. Specifically, there is a cost associated with the implementation of four of the recommendations (1, 2, 5 and 6) and with supporting the proposed new organisations, so that they can manage their financial controls through the transition period, up to the point that they have secured the improvements they need to deliver a surplus. The current assessment of costs are described below:

Recommendation 1

7. As a result of implementing the operational efficiencies outlined in recommendation 1, there will be a number of non-recurring staffing costs. These are predominantly associated with the reduction in workforce capacity – and consequent risk of redundancy – across the Trust's sites that will result from improved utilisation of theatres and reductions in the average length of stay. Some of these costs (up to £3.6m) would also be incurred through the 'do nothing' scenario where £43.3m of CIPs are to be delivered. However, there is an additional cost of up to £3.0m associated with the delivery of the full £74.9m. These costs should be thought of as an allowance, with every attempt being made to support staff to find suitable alternative employment.

Recommendation 2

8. The transformation of the core part of Queen Mary's Hospital into a 'hub' for local services has a non-recurrent cost of up to £6.7m associated with it. A significant proportion of this is to cover doubling running of staff and there may be a number of redundancies. There will also be a requirement to support staff that are transitioning through any training and development requirements that they have. There are also capital costs associated with this recommendation. These are shown in figure 49.

Recommendation 5

9. Implementing the service changes in recommendation 5 will require investment in a number of forms. To deliver the Community-based Care Strategy at the pace required to support the service changes, commissioners will need to increase their planned programme management support. They have also recognised a need to pump prime investments to increase the pace of improvement and to support double running of services until primary and community care services are developed sufficiently to enable the shift of activity, as appropriate, from hospital to community settings. The funding required for this will be sought from a range of sources including the NHS Commissioning Board's budget, drawn from the 2% top slice of CCGs' allocations set aside to drive service transformation.

10. Alongside the improvements to primary care and community services, investment in the hospital estate across south east London will be needed to ensure the physical capacity is in the right place to enable the changes across the system. To support the changes to emergency, maternity and paediatric services, there will need to be capital developments at King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital, Queen Mary's Hospital and St Thomas' Hospital. There will also need to be investment at University Hospital Lewisham to support the development of the elective centre. The total forecast capital investment requirements total £161.6m, see figure 49. However, this figure will be offset against capital receipts of £30.8m associated with the sale of surplus estate at Queen Mary's Hospital, University Hospital Lewisham and Orpington Hospital. Therefore, the net capital investment required to enable the proposed reconfiguration of services is forecast to be £130.8m. Providers will need to develop business cases which will refine the requirements, and therefore refine the figures, and demonstrate the value for money of these developments.

Figure 49: Forecast capital costs for recommendations 2 and 5

	Pru	QEH/LEW	QMS	Kings	GSTT	Total
	£m	£m	£m	£m	£m	£m
Elective Centre	0	55.9	0	0	0	55.9
King's Emergency and Maternity	0	0	0	34.5	0	34.5
A&E and Maternity	0	6.8	0	0	0	6.8
Green Parks Replace	0	0	21.1	0	0	21.1
PRUH	24.2	0	0	0	0	24.2
QMS Sundry	0	0	5.0	0	0	5.0
QEH / LEW IT	0	7.2	0	0	0	7.2
GSTT	0	0	0	0	6.9	6.9
Total Capital Costs	**24.2**	**69.9**	**26.1**	**34.5**	**6.9**	**161.6**

11. Changes to services of this nature will also impact on staffing requirements. There will need to be a proportion of doubling running of staff while services are provided at multiple locations as services are transferred and the ultimate service configuration may result in a number of further redundancies. Staff that are at the heart of the transition of services will need to be supported in any training and development requirements that they have. There is also a need to support the development of the elective centre so that this partnership is a success. Taken together, these requirements will result in non-recurrent costs which have been forecasted at this stage to be c.£40.8m.

Recommendation 6

12. Finally, there will be one-off costs associated with the proposed dissolution of South London Healthcare NHS Trust and the organisational changes. The agreed HR framework that has been put in place will reduce the number of redundancies, supporting staff in securing future employment and maintaining key skills in the local system. However, there will still be a cost associated with the changes, including a risk of a number of redundancies.

13. There will also be costs associated with the organisational development of each new corporate arrangement, to ensure that the benefit of merger synergies is exploited to the full. All of these costs are outlined against the transactions that will be taking place in figure 50. The total required is forecast to be £45.5m.

14. In addition to the series of costs incurred within the new organisational arrangements, there is also a sunk cost associated with the roll-out of a new IT system at Princess Royal University Hospital, which had been due to 'go live' in November 2012 as part of the Trust's deployment of Cerner. However, the upgrade did not go ahead while the TSA was developing options for the future arrangements for the site, including the proposal for King's College Hospital NHS Foundation Trust to acquire it. King's College Hospital is not a Cerner site and, if the proposed acquisition is agreed, King's College Hospital NHS Foundation Trust said it would implement its existing Patient Administration System on the Princess Royal University Hospital site. Therefore, the consequence of this would be the irrecoverable cost of around £6m already incurred by the NHS in relation to the Cerner upgrade, as part of the national contract with BT.

15. Figure 50 outlines the forecast non-recurrent transition costs associated with implementing the recommendations.

Figure 50: Estimated non-recurrent transition costs to implement recommendations 1, 2, 5 and 6

	2013-14				2014-15			
	PRU	QEH/ LEW	QMS	Total	PRU	QEH/ LEW	QMS	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Recommendation 1	0.5	0.3	0.2	1.0	0.5	0.3	0.2	1.0
Recommendation 2	0.0	0.0	6.7	6.7	0.0	0.0	0.0	0.0
Recommendation 5	0.0	0.0	0.0	0.0	0.0	2.5	0.0	2.5
Recommendation 6	17.5	8.0	0.6	26.1	8.8	5.5	0.6	14.9
Total	**18.0**	**8.3**	**7.5**	**33.8**	**9.3**	**8.3**	**0.8**	**18.4**

	2015-16				Total			
	PRU	QEH/ LEW	QMS	Total	PRU	QEH/ LEW	QMS	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Recommendation 1	0.5	0.3	0.2	1.0	1.5	0.9	0.6	3.0
Recommendation 2	0.0	0.0	0.0	0.0	0.0	0.0	6.7	6.7
Recommendation 5	1.7	36.6	0.0	38.3	1.7	39.1	0.0	40.8
Recommendation 6	2.0	2.5	0.0	4.5	28.3	16.0	1.2	45.5
Total	**4.2**	**39.4**	**0.2**	**43.8**	**31.5**	**56.0**	**8.5**	**96.0**

16. As outlined in chapter 6, transitional funding will be required for Oxleas NHS Foundation Trust, Kings College Hospital NHS Foundation Trust and the new organisation combining Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital, to cover the in-year finances while the recommendations are being implemented. This should be aligned with emerging policy on financial distress and funding of NHS bodies.

17. It is estimated that the level of support required will be in the region of £55.3m in the three-year transition period. The figures included here are estimates based on detailed discussions to date and allow an overall value for money test to be completed. However, if the recommendations are accepted, further work between the Department of Health and the Trusts to agree these figures will be a crucial element ahead of implementation.

18. Overall there will be revenue costs of £151.3m (excluding PFI support) over the next three years, compared with the 'do nothing' scenario costs of £153m. However, by the end of year three, this will represent the better value option, with this value increasing every year thereafter. Over 20 years this represents a Net Present Cost of £636.4m, if the recommendations are implemented, compared with a Net Present Cost of £1,086m for the 'do nothing' scenario. This would represent a saving for the tax payer of £449.7m.

Risks and risk mitigation

19. Implementing change of the scale recommended in this report clearly does not come without risks as evidenced in similar, but smaller, programmes of change in the NHS involving major service change or organisational transactions. The appropriate management of risk will need to be a core component of the transition and implementation programme.

20. To support implementation, if the recommendations are agreed, the TSA has produced a preliminary high-level risk register, drawing on responses to the consultation, which is set out in appendix Q.

Accountability and oversight of implementation

21. The magnitude of the challenges and risks associated with the change programme, together with the wide-reaching set of proposed mitigating actions and the scale of investment required to support delivery, underline the importance of a robust programme management approach to providing oversight and assurance in relation to the implementation of the recommendations. The TSA therefore recommends that an overarching programme structure should be established to oversee and monitor implementation and to ensure that benefits are properly realised. The TSA also recommends that funds should only be made available to the system against an agreed plan and subject to milestones and standards, agreed as part of that plan, being met. The programme management structures will be key to the implementation of this control mechanism.

22. It is proposed that a programme board be established to oversee the whole of the implementation programme, under the leadership of an independent chair. The independent chair should be jointly appointed by the Chief Executive of the NHS Commissioning Board and the Chief Executive of the NHS Trust Development Authority, who together should be responsible for the overall delivery. He or she should have national and local credibility in order to hold the local leadership to account and provide transparency on the success of implementation. The chair should be required to provide quarterly reports to set out progress on delivering against the whole programme. In addition to the chair, the success of this work requires all affected organisations, individually and collectively, to focus on making the changes. This joint working has been demonstrated in the UPR period and shows that providers, commissioners and other key stakeholders can work together in south east London. A compact or agreement between each of the constituent organisations will therefore be key to successful implementation.

23. The programme board will fulfil a central role in this and initially should have similar membership to the TSA's advisory group. Its role will be to:

- ensure the effectiveness of the overall programme and monitor the implementation of the decisions made by the Secretary of State;
- manage programme level risks and mitigations;
- monitor progress of all local projects set up to implement the changes, offering appropriate challenge;
- ensure that the quality and safety of services during implementation of key changes is monitored;
- ensure expected benefits are delivered;

- enable the patient and public advisory group to engage with senior decision-makers.
- encourage and facilitate joint working across the range of local NHS organisations and the wider public sector involved in implementation;
- work with other organisations, such as the Department of Health, NHS Commissioning Board, NHS Trust Development Authority and Monitor, local authorities and the Mayor of London to ensure that relevant processes are aligned to support the delivery of the programme;
- support local leaders to overcome any barriers to progress; and
- agree progress against the agreed milestones and standards so that transitional funding can be released.

24. A senior programme director should be appointed to lead the oversight of the implementation programme and provide leadership on a day-to-day basis, holding the various projects and workstreams to account for delivery against agreed milestones. The programme director would be the overall programme's senior responsible officer. It is estimated that the work of the programme director and the programme office in overseeing the implementation of the changes will cost around £750,000 a year, which will need to be covered as part of the overall package of transitional funding.

25. A clinical cabinet should be established to provide the clinical oversight and assurance of the implementation plans and to ensure that the quality and safety of services is maintained throughout the transition period. This clinical cabinet could have a similar membership to the TSA's clinical advisory group, though may benefit from including clinicians independent of any NHS organisation in south east London.

26. A patient and public advisory group should be established to provide oversight of the implementation plans and to ensure that the views of patients, service users, the public and their representatives are not lost by those responsible for delivering the plans. The TSA's patient and public advisory group could provide the basis for this forum.

27. Establishing all these arrangements, in particular appointing the independent chair of the programme board, will take a number of weeks after the Secretary of State has made a decision on the recommendations. It is therefore proposed that the TSA acts as interim chair of the programme board through to the point of dissolution of South London Healthcare NHS Trust.

28. Further details on a proposed approach to implementation are in appendix Q.

8. Conclusion

1. This final report to the Secretary of State from the Trust Special Administrator appointed to South London Healthcare NHS Trust brings to a conclusion 120 working days of detailed analysis, review and investigation by the TSA and his team. A considerable amount of engagement has been undertaken, and the results of a consultation lasting the mandated 30 working days have been analysed.

2. This work has concluded – as the *Case for Applying the Regime for Unsustainable Providers* did – that fundamental change is necessary not just at South London Healthcare NHS Trust, but across the broader south east London health economy, if sustainable services are to be secured (that is, services that provide a high quality of care, good levels of access and are affordable within the resources available to the NHS in south east London).

3. Seven overarching recommendations have been set out in this report. Recommendations 1 to 4 relate to the services and sites that currently make up South London Healthcare NHS Trust. However, they are insufficient to address the operating losses at Princess Royal University Hospital and Queen Elizabeth Hospital. Following the extensive assessment that has been undertaken, the TSA has concluded that these sites cannot be made financially viable in the current service and organisational arrangements. To continue in this form would require the Trust to be sustained indefinitely by cash support from the Department of Health. In view of this, recommendation 5 proposes a necessary reorganisation of services across south east London, and recommendation 6 proposes new organisational arrangements to drive up the capability to execute a complex and challenging set of recommendations for improvement. Finally, recommendation 7 defines the transition support and implementation oversight necessary to support delivery.

4. The seven recommendations do not stand alone. They are interlocking, and only when taken together is there a sufficient response to the scale of the challenges that have resulted in the continuous deficits in South London Healthcare NHS Trust and its predecessor organisations. Financial issues do not stand in isolation from the delivery of patient care. This continued financial distress hampers efforts to transform services, reduces the attractiveness of South London Healthcare NHS Trust as an employer and has a detrimental effect on organisational relationships, which in turn impacts on the ability of those in the NHS to work together and with local authorities to integrate services for patients effectively. A true vicious spiral, which will only break if the unique opportunity offered by the *Regime for Unsustainable Providers* to take radical action is taken.

5. The set of seven overarching recommendations, set out in detail in chapters 4, 5, 6 and 7 is the only viable option identified that has the potential to address the scale of the challenge. The proposals, especially those focused directly on service changes, are not universally popular with the general public that responded to the consultation. This should not be a surprise. The TSA and his team engaged broadly during the consultation – as evidenced in the number of responses – explaining the nature and scale of the problems under review and why change is necessary. Despite this, issues about location and access to services in the future are at the forefront of the public's concerns. However, the changes are necessary, if the Government wishes to cease the substantial cash support it currently has to give to the Trust to maintain its operations. The NHS has to operate with a finite amount of money, and the recommendations outlined in this report have the potential to provide much better value for money for the taxpayer.

6. The changes are also necessary, if the aim is to provide the quality of service which the communities of south east London have the right to expect. They will improve outcomes and save lives. The Health and Equalities Impact Assessment (HEIA) describes the potential positive benefits of the proposed changes for the health outcomes of people in south east London. It points to the improvements to health outcomes which will result from the changes to emergency, maternity and elective services, particularly for the more deprived and older populations; it also highlights the positive impact of delivering integrated care through the Community-based Care Strategy – particularly for older people, disabled people and people from black and minority ethnic groups.

7. The HEIA also describes the potential risks, and actions that could be taken to mitigate them: notably collaboration with Transport for London to minimise the impact of increased travel times for some people to and from hospital sites in south east London will be crucial and improvements to the quality of information for patients to help them make the right choices for their care and treatment.

8. NHS organisations deeply engaged in the operations and architecture of the health service are broadly supportive of the proposals. This includes local commissioners and the NHS Commissioning Board – the local PCT Cluster and the six CCGs in south east London – although Lewisham CCG has made clear its concerns about what it sees as a disproportionate impact on Lewisham residents and, therefore, is not supportive of the proposals despite recognition of the need for service change. There is also support from provider organisations in south east London, though with differing views on the detail of some of the recommendations, and from NHS London, which endorsed the proposals but stressed the importance of having the right leadership and capacity in place, if implementing the changes was to succeed in delivering the required transformation.

9. In itself, resolving to make these changes will not guarantee success. Adopting a robust programme approach to implementation will be required from the outset. Securing leadership of the highest calibre, supported by a sufficient level of resources dedicated to driving implementation across the various elements of the programme, will be critical to overseeing this challenging and ambitious change programme. Only by doing this will the system deliver, over the next three years, the required changes covered by the TSA's recommendations, so that the population of south east London at last has an NHS fit for the 21st century – an NHS providing clinically sustainable and financially viable health services, saving lives and maximising its potential to improve the health of local people.

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9. Glossary

111	A new 24/7 contact number that's 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: a service which provides care for emergency conditions – illness and injury of all severities – of all types and for patients of all ages, twenty-four hours a day, seven days a week
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
ALOS	Average Length of Stay, is an average of the length of time patients stay in a hospital when admitted
BHT	Bromley Hospitals NHS Trust
Care pathway	The care and treatment a patient receives for a particular illness or condition from start to finish, irrespective of which part of the health service or social care services deliver that treatment or care. Good care pathways follow consistent principles and protocols based on clear scientific evidence of what works
CCGs	Clinical Commissioning Groups: 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
CHD	Coronary Heart Disease: the narrowing or blockage of the coronary arteries
CIP	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
CQC	Care Quality Commission: an organisation funded by the Government to check all hospitals, care homes and care serices in England to make sure they are meeting government standards, and to share their findings with the public
Day case or day surgery	Patients who have a planned investigation, treatment or operation and are admitted and discharged on the same day
Deficit	The net financial position of an organisation where expenditure is greater than income
ECG	Electrocardiogram: A test of the electrical activity of the heart
Elective centre	A hospital which provides elective (planned) care
Elective surgery	Planned surgery (i.e. 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	The net financial position of an organisation where income is greater than expenditure
Foundation Trust	Foundation Trust: NHS hospital that is run as an independent, public benefit corporation, controlled and run locally. Foundation Trusts have increased freedoms regarding their options for capital funding to invest in delivery of new services. They are regulated by Monitor – The Independent Regulator of NHS Foundation Trusts

GP	General Practitioner
GSTT	Guy's and St Thomas' NHS Foundation Trust
Guy's	Guy's Hospital, part of Guy's and St Thomas' NHS Foundation Trust
HEIA	Health and Equalities Impact Assessment: a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population
HRG	Healthcare Resource Groups – the unit of the basis of payment by results, which is used to determine how much to pay hospitals for each admission
IFRS	International Reporting Finance Standards: a common global language for business affairs so that accounts are understandable and comparable across international boundaries
Independent sector	A range of non-public organisations involved in service provision, including both private, voluntary and charitable organisations
KCH	King's College Hospital NHS Foundation Trust
LINk	Local Involvement Network: a patient and public representative group, funded by local councils, although independent of the Government
LTFM	Long Term Financial Model: used as the basis for a Foundation Trust application to Monitor. The model provides a five year view of income, expenditure and financial risk for a Trust
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, without the intervention of a consultant obstetrician
NHS Commissioning Board	The body which will oversee the day-to-day operation of the NHS from April 2013 as set out in the Health and Social Care Act 2012
Normalised	Normalised figures are those where the impact of non-recurrent items has been removed, so we can see the ongoing trend
NPV	Net Present Value: the current value of the future cash flows of an investment.
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.
PCT	Primary Care Trust: NHS bodies that commission primary, community and secondary care from providers. Scheduled to be abolished in March 2013, many of their functions will transfer to CCGs or the NHS Commissioning Board
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
PRUH	Princess Royal University Hospital
QEH	Queen Elizabeth Hospital
QMS	Queen Mary's Sidcup
QIPP	Quality, Innovation, Productivity and Prevention: an NHS-wide initiative to deliver more and better services and care with fewer resources in the future

SaFE	Sustainable and Financially Effective: an analysis undertaken by NHS London in 2011 of the financial and clinical viability of Hospital trusts in London
SEL	South East London: the six London boroughs of Bromley, Bexley, Greenwich, Lambeth, Lewisham and Southwark
SHA	Strategic Health Authority: an NHS organisation established to lead the strategic development of the local health service and manage Primary Care Trusts and NHS Trusts on the basis of local accountability agreements.
SLaM	South London and Maudsley NHS Foundation Trust
SLHT	South London Healthcare NHS Trust
Specialist hospital	A hospital which provides specialist care for complex conditions
St Thomas'	St Thomas' Hospital, part of Guy's and St Thomas' NHS Foundation Trust
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
UCC	Urgent Care Centre: provides care and treatment for minor illnesses and injuries that require urgent attention but that are not critical or life-threatening
UHL	University Hospital Lewisham, part of Lewisham Healthcare NHS Trust.
UPR	Regime for Unsustainable Providers: The Regime is an exceptional way in which the Government can take decisive action to deal with NHS Trusts that are either unsustainable in their current configuration or at serious risk of failing to deliver sustainable services, and of failing to comply with the plans to move towards achieving Foundation Trust status.
VfM	Value for Money: a term often used to demonstrate the quality of a healthcare service balanced against the cost of delivering that service

9. List of appendices

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

B Directions to the Trust Special Administrator

C Programme Governance in the development of recommendations

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F Proposed organisational arrangements following dissolution of South London Healthcare NHS Trust

G Stakeholder Engagement

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M Finance, capital and estate evaluation

N The future of Queen Mary's Hospital

O The strategy for community-based care in south east London

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