

Appendix K

Applying the four tests for reconfiguration



**Securing
sustainable
NHS services**

1. The Department of Health published *Statutory Guidance for Trust Special Administrators appointed to NHS Trusts* on 5 July 2012¹. Section 39 sets out, “In assisting the Secretary of State to make a final decision on the future of the organisation, the Trust Special Administrator should have regard to the Secretary of State’s four key tests for service change in developing his or her recommendations.”
2. These tests were set out in the *Revision to the Operating Framework for the NHS in England 2010/11*², which requires reconfiguration proposals to demonstrate:
 - support from GP commissioners;
 - strengthened public and patient engagement;
 - clarity on the clinical evidence base; and
 - consistency with current and prospective patient choice.
3. Recognising that meeting these tests will build confidence within the services, with patients and communities, this appendix sets out how regard has been paid to each of these tests, along with how they are assessed, on balance, to have been met.

Support from GP commissioners

4. At the time the four tests were announced, GP consortia were mobilising as the Health and Social Care Bill progressed through Parliament. With the passing of the Health and Social Care Act 2012 and subject to being authorised, these consortia have been developed and will be established as statutory Clinical Commissioning Groups (CCGs), taking on the responsibility of commissioning the significant majority of healthcare services from 1 April 2013. All general practices must be a member of a CCG. On this basis, meeting this test would require the recommendations within the report to be supported, on balance, by the relevant CCGs.
5. The membership structure of CCGs means that this report does not consider whether the proposed service changes has the support of all general practices or, indeed, all general practitioners. It notes that the recommendations have an impact upon the whole south east London health economy and that it is on this basis that CCG support should be gauged.
6. The application of the Regime for Unsustainable Providers (UPR) at South London Healthcare NHS Trust was supported by all of the Trust’s principal commissioners: Bexley CCG, Bromley CCG, Greenwich CCG and NHS South East London PCT Cluster. Their response to the Secretary of State’s consultation on whether to enact the UPR was reported to Parliament:

¹ Department of Health, 2012 <https://www.wp.dh.gov.uk/publications/files/2012/07/statutory-guidance-trust-special-administrators.pdf>

² Department of Health, 2010 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116860.pdf

“The main commissioners wrote to say that they shared the Secretary of State’s concerns about the financial sustainability of many of the services provided by the Trust. They acknowledged evidence of rapid improvement in the accessibility and quality of care, but noted that the Trust is not financially viable beyond the short term. The commissioners advised that any strategy aimed at resolving the financial issues at the Trust needs to look at the whole health system for potential solutions. Looking at issues in the Trust alone will not resolve the factors causing the financial challenge. The commissioners offered their full support should the Secretary of State decide to trigger the unsustainable provider regime in relation to the Trust.”³

7. Building on this initial support, the TSA has worked closely with both the clinical leaders and the membership of these three CCGs and across the rest of south east London in Southwark, Lambeth and Lewisham. Neighbouring CCGs in Kent were also engaged to ensure that the final report aligns with the future commissioning intentions for the region. The clinical chairs of each of the six CCGs in south east London have been active members of the TSA’s advisory group and clinical advisory group.
8. The CCGs’ chairs and GP membership have been instrumental in developing the Community-Based Care strategy for south east London. The community-based care working group built on the existing south east London commissioning strategy plans through a series of workshops involving commissioners, clinicians and stakeholders across primary, community, acute and social care services, to develop and agree aspirations for the future delivery of care.
9. The CCGs’ chairs and GP membership have been active participants in other workshops and working groups to help shape the recommendations of the TSA. The membership and remit of these groups can be found in appendix C of the main report.
10. Through this extensive involvement with the work undertaken in completing the draft report and recommendations, each of the six CCGs in south east London, and the two neighbouring CCGs in Kent, have felt able to make a considered response to the TSA public consultation. It is important to note that the CCGs reference their responses having been developed after engaging with, and hearing the views of, their member practices, patients and other key stakeholders.
11. Each CCG has set out its view of the draft recommendations and have made suggestions for improvements, which have been essential to refining the final recommendations. While each has commented on issues that are specific to their immediate geography, there are many messages and calls for reassurance that are common, which can be summarised as:
 - maintaining the status quo is not an option;
 - any changes to the current service configuration should enable all services to meet the clinical standards developed in London through the London Quality and Safety Programmes over 2011/12 and 2012/13;
 - the six recommendations should be viewed as a package to address the challenges in south east London and not viewed as a ‘menu’ to choose from;

³ Explanatory memorandum to the SLHT (appointment of TSA) order 2012

- sufficient physical and staff capacity, based on detailed analysis of patient flows, and clear protocols should be in place to deliver safe, high-quality services before any changes are made;
 - all efforts should be made to make services as easily accessible as possible, particularly for high-volume users of services and those who traditionally find access a challenge;
 - the active participation of all parts of the system will be vital in securing the expected improvements, for which robust governance and programme management arrangements need to be in place to enable the transition through what is an extremely ambitious and complex programme;
 - detailed implementation plans should be developed and tightly aligned with CCGs' community-based plans and the necessary improvements in capacity and capability in primary and community care, owned and led locally with support from national organisations such as the NHS Commissioning Board; and
 - an effective communications strategy should be developed and implemented to ensure the public fully understand the benefits being sought and how and where to access the right services.
12. In considering whether this test is met, it is necessary to draw directly from the responses to the consultation from each CCG recognising that, within each one, further reassurances or recommendations for additional work were requested, some of which are highlighted above and below and all of which were given due consideration in finalising the TSA's recommendations to the Secretary of State. This is not meant in any way to oversimplify the CCGs' views nor underestimate some of the legitimate concerns they wish to see addressed, rather it is meant as an assessment of the overall level of support for the recommendations set out in the report.
13. **NHS Dartford, Gravesham and Swanley CCG** (Kent) describes the impact of the recent closure of maternity and emergency services resulting in increases in this activity at Dartford and Gravesham NHS Trust, which has been managed accepting it leading to, *"internal capacity pressures."* The response continues, *"In terms of the elective proposals outlined within the consultation document, the CCG supports the concept of developing a Bexley Health Campus on the Queen Mary site,"* and, *"The CCG is specifically concerned with quality improvements, and supports any reconfiguration that can provide and sustain improvements in quality for patients that are value for money, and affordable for the health economy."*
14. **NHS West Kent CCG** sets out that while the changes would not have a significant impact on its population, *"Overall the CCG is supportive of the proposals... failure to achieve a sustainable future for the Trust [SLHT] may have a detrimental impact... if there are increased patient [in] flows from South East as a result."* The CCG goes on, *"The one element of the scheme that... may benefit [its] local people is the development of an elective centre at Lewisham."*
15. **NHS Bromley CCG** responds, *"We fully recognise that the status quo is not sustainable. This report presents a significant challenge to the local health economy, but as a package of measures it offers the opportunity to develop a coherent and cohesive plan which will create the sustainable, high quality acute sector that the population of Bromley deserves."* The CCG makes clear its recommendations to the TSA in developing the final report, which are broadly captured in section 11 of this appendix.

16. **NHS Bexley CCG** clearly sets out, “supported,” against each of the first four draft recommendations, along with its recommendations. Against draft recommendation five for emergency care it makes comments including that, “if the changes proceed there is a need to make sure that capacity planning on QEH A&E services...is undertaken;” that, “LAS impact is modelled;” that, “additional planned usage of all local UCCs is assessed, ensuring thresholds and capacity...is consistent and robust;” and requests, “further clarification if possible of where and how these [ENT] services would be delivered [for Bexley residents].”

The CCG, “support safe and high quality care and the delivery of agreed maternity standards,” and supports the recommendations for elective care.

Finally, the CCG notes, “the TSA draft recommendation [six] and consider they are consistent with our requirements.”

17. **NHS Greenwich CCG** concludes, along with several recommendations, in its response that, “Given the scale of the current difficulties across the health system we believe that the recommendations in the draft report present a reasonable set of options to achieve a sustainable health system and we support the three year implementation timetable.”
18. **NHS Lambeth CCG** sets out, alongside its recommendations, “...we welcome the overall approach taken by the TSA which seeks to address improved health outcomes alongside financial viability.” The CCG supports all recommendations including, “the delivery of enhanced clinical standards in hospital emergency care...and the need to consolidate Accident and Emergency services to achieve this ambition;” and , “the key priority is to ensure the safety and quality of care for all women and their children across south east London throughout the delivery of agreed maternity standards.”
19. **NHS Southwark CCG** also makes recommendations in its response and states, “Overall [the CCG] recognises that no change is not an option in respect of SLHT and the wider health economy, and broadly supports the recommendations put forward by the TSA as a basket of solutions which, when taken together, will reasonably address the underlying clinical and financial issues in south east London.”
20. **NHS Lewisham CCG** is arguably the CCG whose population is most affected by the proposed changes. It, “recognises the financial and services challenges facing the local NHS and the need for change;” and acknowledges, “that the TSA in his final report should recommend to the Secretary of State that the changes to SLHT go ahead as suggested but only in the context of a model of local determination for service reconfiguration in a combined Lewisham and Queen Elizabeth Hospital partnership.”

To this end the CCG are consistent with Lewisham Healthcare NHS Trust, who support the need for change, and a merger of University Hospital Lewisham and Queen Elizabeth Hospital, but suggest that any service change should be developed by the new Trust at a later date. This is not supported by the TSA and the specific reasons for this are set out in the chapter 5.

As part of their response, the CCG raises some concerns particularly around the service change recommendations, which should be highlighted here. Specifically, that proposals for A&E services, “would lead to more expensive, complicated and longer journeys for Lewisham residents;” and the changes, “will result in less integration than currently.” The CCG challenges the number of current attendees at the Lewisham Hospital A&E who would appropriately be seen at the proposed Urgent Care Centre suggesting, “less than 50% and possibly as few as

40%.” The CCG is concerned that, “*there is a risk that acutely ill children who are seen at an urgent care centre will not receive the same quality of care currently offered by the paediatric A&E [currently at Lewisham Hospital].*” The CCG also has concerns regarding the impact of the changes to A&E service on training and attracting quality staff.

With regards to the options for the maternity models, the CCG that, “*the dispersal model would have a significantly damaging effect on...Lewisham women requiring maternity services,*” and prefers an obstetric-led unit, with community midwifery service at Lewisham hospital if the other TSA recommendations go ahead.

The CCG also describes its concerns, “*that even this [elective] element...which has the appearance of supporting a vibrant Lewisham site is unlikely to be deliverable.*”

The CCG does stress that, “*we recognise the need for change to achieve the London-wide clinical quality standards over time in an affordable way.*”

21. Lewisham CCG’s concerns are somewhat understandable due to the significant impacts the recommendations, if implemented, would have on services on the Lewisham hospital site and their perception that this would be detrimental. Similarly, the concerns and reassurances sought from the other seven CCGs are legitimate and have been considered in coming to the final report. However, they have all expressed the unequivocal view that changes must be made, and that such changes should enable the implementation of the agreed London-wide clinical quality standards, which are described in more detail under test three below.
22. It is fair to say that support for the recommendations consulted on have the broad support of GP commissioners with the exception of those regarding service change, which are supported by all bar Lewisham. Considering the proposals seek to address the challenges across the whole of south east London, it would not be appropriate to give undue weight to any particular locality. On this basis, it seems a reasonable assessment that taking the views of the CCGs across this area and those in Kent who would be impacted, the proposals consulted upon, on balance, have the support of GP commissioners.

Test 2 – strengthened public and patient engagement

23. The challenges for acute providers within south east London have a high profile locally as a result of the recent history of attempts to reconfigure local services. The TSA team has worked with stakeholders from across the region to engage patients and the local public from the outset of the programme, recognising the importance of ensuring that groups are well informed of any proposed changes and are given ample opportunity to have a say in shaping the recommendations.
24. 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 in individual meetings with representatives from Local Involvement Networks (LINKs) and a number of other patient organisations in the area.
25. 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 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.

26. 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 to test the evaluation criteria.
27. A workshop was held in early October, again with a representative sample of members of the public from the six south east London boroughs, plus members of the PPAG, to elicit their views of emerging thinking and proposed clinical standards.
28. Engagement with patients and the public has been strengthened by using members of the PPAG and communications and engagement working group, amongst other forums, to cascade information to local groups and networks.
29. A regular stakeholder bulletin has been established, which is distributed widely. Recipients are encouraged to cascade the bulletin on to colleagues and local networks to ensure as wide a distribution as possible. The bulletin provides an update on the TSA programme and signposts readers to where they can find further information. Information about the UPR and signposts to further information have also been cascaded through South London Healthcare NHS Trust's and other local NHS organisations' websites.
30. 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.
31. Recognising the importance of engaging with communities who do not ordinarily attend public meetings or events – the 'seldom heard' – the TSA worked with the PPAG and LINKs to identify the kinds of groups with which to engage. Particular regard was paid to those with the nine characteristics protected under the Equality Act 2010, as well as carers and those from socially deprived communities, and this informed the consultation plan. During the consultation, many meetings were held and events attended with a range of these groups across south east London, and two maternity focus groups were also held in Lewisham.
32. Over 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. The consultation generated over 8,200 responses, an encouraging figure given the time constraints within which the consultation was undertaken, whilst the consultation responses were not generally fully supportive of the draft recommendations, the level of interest in consultation material, and attendance at meetings, is a testament to the success of the engagement process.
33. All local authorities in south east London and LINKs (with the exception of Southwark) submitted their considered response to the consultation, describing the 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 continues, particularly in the implementation of any changes that the Secretary of State agrees.

34. 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 in Appendix G. Considering the timescales in which the TSA has to operate, it seems to be reasonable to assess that this test, on balance, is met.

Test 3 – clarity on the clinical evidence base

35. In the *Statutory Guidance for Trust Special Administrators appointed to NHS Trusts*, section 39 sets out that, “it is important that there is strong clinical evidence that the recommendations will deliver safe and effective care. Therefore, it is recommended that the Trust Special Administrator engages senior clinical expertise at an early state to ensure that the recommendations meet clinical guidelines issued by the National Institute for Health and Clinical Excellence (NICE) and the medical Royal Colleges.”

36. 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 clear and strong clinical evidence and the support of clinical experts.

37. A clinical advisory group (CAG) – 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 the work was clinically led and locally appropriate.

38. 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.

39. In carrying out its function, the external clinical panel has provided the programme with valuable insights, based on independent clinical expertise. The external clinical panel has played a key role in challenging the TSA, improving the development of the recommendations.

40. A series of clinically-led workshops were held in August and September 2012, with around 60-80 clinicians, commissioners and managers attending each. These workshops considered the financial and other challenges facing the health system in south east London and, in doing so, significantly informed the work programme and the development of the recommendations for change.

41. Participants discussed and recommended a vision for the future of both community-based and hospital-based (acute) care in south east London. 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 to deliver high quality and safe acute emergency and maternity services and also to meet clinical dependencies for these services; and
- a desire for innovative approaches to integrated care.

42. The agreed standards referred to in the previous paragraph are the clinical quality standards for hospital based acute emergency – adult and paediatric – and maternity services, which have been developed over 2011 and 2012 by clinicians from across London as part of the London-wide Quality and Safety Programme. This programme has consisted of the following workstreams:
- adult acute medicine;
 - adult emergency general surgery;
 - paediatric emergency medicine and surgery;
 - emergency departments;
 - critical care;
 - the fractured neck of femur pathway; and
 - maternity services.
43. Development of these standards was clinically led. A clinical director was appointed and clinical leads for each workstream led the development of each component of the programme. Each clinical lead chaired a multi-disciplinary clinical expert panel, appointed via an application process. Over 90 clinicians were involved in the clinical expert panels, which included representation from outside of London.
44. Clinical evidence and variation in current service provision and patient outcomes across acute emergency and maternity services in the capital was the foundation for the development of the standards.
45. Several recent reports from influential professional bodies, such as the Royal Colleges, the College of Emergency Medicine and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), have highlighted deficiencies of care in many areas. The reports also include recommendations to address poor standards of care and these messages are consistent across the board – there is often inadequate involvement from senior medical personnel in the assessment and management of acute emergency patients and women in labour, and this situation is worsened outside of core working hours.
46. There is hugely variable and inadequate involvement of consultants in the assessment and subsequent management of acutely ill patients, particularly at the weekend, when average consultant cover was found to be half of what it was during the week. The 2011 review of acute medicine and emergency surgery found that patients admitted to hospital as an acute medical emergency or for emergency general surgery at the weekend in London had a significantly increased risk of dying compared to those admitted on a weekday. Reduced service provision, including fewer consultants working at weekends, was associated with this higher mortality rate.
47. London's emergency departments see a large volume of cases of varying complexities and appropriate staffing is integral to a department's effective running. However, there is increasing difficulty in staffing emergency departments appropriately. Evidence suggests that consultant-delivered care brings benefits for patients receiving emergency care; however, significant variation exists in the numbers of hours that emergency medicine consultants are present in London's emergency departments. Input from experienced, senior doctors 24 hours a day, 7 days a week is required to ensure the delivery of high quality care and timely patient flow. However, this level of provision is uncommon in London⁴.

4 London Health Programmes (2012) Emergency departments: case for change

48. Evidence also demonstrates that the safe delivery of care across the emergency pathway depends on timely access to diagnostics and investigations as clinical diagnosis alone cannot be relied on to make safe diagnoses in many cases. Early access to diagnostics can prevent unnecessary admissions to hospital and facilitate safe and efficient patient pathways, therefore providing better outcomes for patients.
49. In surgical services such as emergency general surgery and the fractured neck of femur pathway, consultant involvement is crucial. A lack of early pre-operative consultant input can delay patients being optimised for theatre; a lack of consultant surgeon and anaesthetist involvement in operations can affect outcomes; and a lack of subsequent ongoing consultant input can delay post-operative recovery. Consultant availability is reduced at the weekend in these services and this impacts on outcomes.
50. The evidence is particularly clear for patients who suffer a fractured neck of femur. The key early indicator of a patient's outcome is the time to operation - operation delays have clear links to increased mortality rates. Avoidable delays are therefore unacceptable, yet poor performance in time to operation is found across London, with patients admitted to hospital in London on a Friday or a Saturday 18 per cent more likely to wait two days or longer for their operation, compared to those admitted Sunday to Thursday.
51. In critical care, whilst there is no difference between weekend and weekday mortality in critical care units in London, data shows variation in other outcomes for patients – variation exists in: lengths of stay; discharges occurring out of hours; the provision of critical care response to deteriorating patients outside of the unit; and timely access to critical care beds. These factors significantly impact on the level of care patients receive and importantly affect patient experience. This variation is most significant between weekdays and weekends.⁵
52. London has a higher mortality rate for paediatric emergency admissions when compared to the rest of the country and this is increasing when compared to mortality rates for other age groups in the capital. In addition, in-hospital mortality rates among children in London have been rising over the last five years, particularly for respiratory patients which accounts for almost two thirds of emergency medical admissions for children in London. This is in contrast to mortality rates for the same patient group among other regions.
53. There is significant variation in the provision of paediatric services between and within London hospitals. Hospitals need to ensure that the appropriate levels of trained staff are in place to ensure delivery of high-quality and safe care. However, there are significant workforce pressures on paediatric-trained surgical, anaesthetic and nursing staff, particularly out of hours, coupled with a variation in levels of training and an insufficient number of paediatric-trained nurses with appropriate skills in London.
54. London's paediatric emergency services are struggling to meet the Royal College of Paediatrics and Child Health minimum standards for acute, general paediatric care⁶. There is variable access to senior personnel who undertake and influence clinical decision-making and models of care are such that children are often admitted unnecessarily when alternative management plans might be appropriate.

5 London Health Programmes (2012) Critical care: case for change

6 Royal College of Paediatrics and Child Health (2010), *Facing the Future: Standards for Paediatric Services*, RCPCH

55. Additionally, hospitals are not currently meeting Royal College of Surgeons, Royal College of Anaesthetists and NCEPOD recommendations, which has resulted in: variable surgical and anaesthetic staffing levels out-of-hours; too many children being treated by surgeons who specialise in operating on adults; and the appropriate skill mix and environment to safely anaesthetise and recover children not always being available.
56. London's maternity services do not perform uniformly well, with unacceptable inequalities in maternity outcomes in areas of mortality, morbidity and experience. As the demands on London's maternity services are increasing, services face increasing challenges to provide safe, high quality care for the diverse needs of London's pregnant women and their babies. Although these rising challenges can be seen nationally, the trend is most acute in the capital.
57. The rate of maternal deaths in London has risen in the last five years; reaching more than twice the rate of the rest of the UK. The 2011 Centre for Maternal and Child enquiries report⁷ reviewed 42 deaths of women that died in London's hospitals or at home whilst pregnant or within 6 months of giving birth, over an 18-month period (January 2009 – June 2010). Seventy percent of the direct maternal deaths and 58 per cent of the indirect maternal deaths in London were found to have avoidable factors, described as shortfalls in care that, if managed differently, may have saved lives. These avoidable factors included delays in recognising a woman's high risk status, junior staff not being properly supervised or referring to an appropriate specialist leading to delays in, or inappropriate, treatment.
58. London's maternity services struggle to meet national standards for safety, outcomes and women's experiences - they are the least well performing nationally.⁸ Considerable evidence supports the need for consultant presence in order to reduce maternal mortality and poor outcomes, yet few units in London meet best practice recommendations for consultant labour ward presence. Additionally, it is widely acknowledged that experienced midwives have invaluable skills in recognising risk and referring appropriately; however, less than one third of London's maternity units meet midwifery staffing recommendations.
59. 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.
60. The TSA's 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.
61. In considering whether this test is met, it is helpful to draw from the relevant expert representative organisations, which responded to the TSA's consultation, recognising that within each further reassurances or recommendations for further work were requested, all of which were given due consideration in finalising the TSA's recommendations to the Secretary of State.

7 A review of maternal deaths in London January 2009 – June 2010 Commissioned by NHS London. Centre for Maternal and Child Enquiries. 2011

8 London Health Programmes (2012) Maternity services: case for change

This is not a test to show whether these organisation support the draft recommendations, although there is overall support, but rather to show the consensus from expert groups around the strength of the clinical evidence that informed the TSA's recommendations:

62. **The Royal College of Physicians (RCP)** states that, *"it is clear that many of the clinical issues identified are consistent with the RCP perspective. Similarly, the emerging solutions, particularly around integrated care and management of urgent and emergency care are supported."*

Furthermore there is acceptance that *"this is likely to require redesign of services both internally for healthcare organisations, and also reconfiguration across the system."* In summary RCP is *"able to support the general clinical principles for change that underpin the proposals."*

63. **The College of Emergency Medicine** states that its principle focus is on *"safe and effective delivery of Emergency Care"* and that *"rationalisation may offer benefits to this focus, with the ability to concentrate patient care in departments with the resources to allow high quality consultant delivered care, in purpose designed facilities with the backing of essential specialist care."*

The College expresses its support for the quality standards that underpin the draft recommendations stating: *"The London Health Care Program and the College of Emergency Medicine recognise the importance of Consultant delivered care, while accepting that this may require additional resources, benefits will be made to both clinical care and the healthcare economy as a whole over time."*

64. **The Royal College of Nursing** sets out that it, *"believes that the reconfiguration of South London Healthcare Trust (SLHT) needs to be well managed and focus on long-term sustainability,"* and that it, *"endorses the recommendation that efficiency of health care delivery in south London's NHS trusts is improved. It is clear that despite the best efforts of the trusts, the scale of the problem they faced is insurmountable."*

65. **The Royal College of Obstetricians and Gynaecologists (RCOG)** is understandably most interested in the recommendations around changes to maternity services. RCOG expresses its support for the maternity quality standards stating that *"a consultant-led service for women requiring obstetric care results in enhanced clinical leadership and decision-making with the added advantage of providing better supervision and mentoring of trainee doctors and increased support for midwifery colleagues. Similarly, women prefer to be treated by specialists at any time of the day."* The College also states that its research shows *"Women are willing to travel a little further to hospitals provided they know they will have access to appropriate levels of care throughout the day and night"*.

RCOG also offers a potential alternative to the draft maternity options that has been considered during the development of the draft report, in that, *"research has shown that women with low-risk pregnancies, having a second or subsequent baby, have good outcomes if they deliver in midwifery-led services or at home. These options should be offered to these women."*

66. **The Royal College of Midwives (RCM)**, *"acknowledges that it is desirable to provide women with equity of service provision over a 24 hour period and there are clinical benefits arising from some concentration of obstetric-led services,"* and that, *"Clearly 168 hours on all five sites is unaffordable."*

However, it goes on, *"the overwhelming number of women who currently give birth at Lewisham could do so if Lewisham became a standalone unit,"* and, *"In such circumstances, if the TSA recommends implementation of the four site option then the RCM would strongly argue for replacing the obstetric unit at Lewisham with a freestanding midwife-led unit."*

67. Whilst there are some concerns about the practicality and affordability of delivering the standards on the ground, 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.
68. 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.
69. It would seem to be reasonable to consider that, on balance, this test has been met.

Test 4 – consistency with current and prospective patient choice

70. 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, closely followed by choice of service. How the proposals impact on patient choice is complex and difficult to quantify.
71. 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 PPAG and the TSA's advisory group, will contribute to the development of services that meet this balance.
72. An independent Equality and Health Impact Assessment (EHIA) was commissioned to understand the impact the proposals will have, amongst other things, on patient choice and how best to enhance positive impacts and mitigate negative ones. This report has been given due consideration by the TSA in finalising recommendations to the Secretary of State and is referenced throughout the report and is included in full in appendix L.
73. With regards to emergency and urgent care, the EHIA report sets out that, "It is important to note that patient choice is not generally exercised for the most urgent cases (particularly, life threatening incidents). Generally, patients in these situations will be transported to hospital by ambulance and therefore do not decide where they will go; this is determined by the ambulance service. In this sense, there is not a material reduction in choice for the most urgent conditions.

Additionally, it is anticipated that the urgent care centre at UHL will be able to deal with 77% of the current A&E attendances at UHL. Given this, the majority of patients can continue to receive emergency and urgent care at UHL and will not face a reduction in choice. However, particular regard will need to be given to the needs of children as they may well be brought to the paediatric A&E department at UHL by their parents rather than by ambulance."
74. Following consultation response the planning figure for the percentage of patients still being able to be treated at Lewisham post the emergency changes has been fixed as at least 50%. This better reflects clinical experience and evidence from across London and means that more patients will need to travel but will do so in order to access a more clinically and financially sustainable service.

75. The report describes the recommendations for maternity services as, “the number of obstetrics led maternity units in south east London would reduce from five to four. This reduction in choice and increases in the number of mothers travelling to one of the full units is potentially offset by improved clinical outcomes, resulting from the concentration of obstetrics-led services onto fewer sites.” However, should a stand-alone midwife-led unit be developed at the Lewisham hospital site, in addition to those at Queen Elizabeth and Kings College Hospital, the choice of midwife-led units would increase. The HEIA report comments on the proposals for elective services that, “despite the apparent reduction in choice, patients will benefit from a centre with a large number of consultant surgeons and multidisciplinary teams and so retain a wide choice of surgeons.”
76. The advice offered by Co-operation and Competition Panel (CCP) should also be noted, which sets out, “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.”
77. The CCP did identify some potential negative impacts on choice with the merger between Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital as well as in elective care for Bexley residents if Dartford and Gravesham NHS Trust provide the day surgery service at Queen Mary’s Sidcup. Whilst potential concerns were flagged, the CCP also acknowledged that mitigations including improvements to clinical care could be set against this potential loss of choice and competition.
78. With any service change that seeks to drive up clinical quality by concentrating clinical skills on to fewer sites, at face value the choice patients will have if the recommended changes are implemented will reduce. However, the recommendations for service change in the TSA’s 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 and reflecting on comments from the HEIA and CCP, it seems reasonable to consider this test is, on balance, met.

