Open Agenda

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

to be held jointly with

Lambeth Council's Health and Adult Services Scrutiny Sub-Committee

Wednesday 5 December 2012
7.00 pm
Ground Floor Meeting Rooms G01B&C - 160 Tooley Street, London SE1 2QH

Membership	**Reserves**
Councillor Mark Williams (Chair)	Councillor Sunil Chopra
Councillor David Noakes (Vice-Chair)	Councillor Neil Coyle
Councillor Denise Capstick	Councillor Rowenna Davis
Councillor Patrick Diamond	Councillor Paul Kyriacou
Councillor Norma Gibbes	Councillor Jonathan Mitchell
Councillor Eliza Mann	
Councillor The Right Revd Emmanuel Oyewole	

Lambeth Council's sub committee members are listed below for information:

Membership	**Reserves**
Councillor Davie (Chair)	Councillor O'Malley
Councillor Marchant (Vice-Chair)	Councillor Patil
Councillor Kingsbury	Councillor Davies
Councillor Francis	Councillor Brown
Councillor Whelan	Councillor Brown
	Councillor Whelan

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Contact Julie Timbrell on 020 7525 0514 or email: julie.timbrell@southwark.gov.uk

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 27 November 2012

PRINTED ON RECYCLED PAPER

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

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7.00 pm
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Order of Business

Item No.	Title	Page No.
	PART A - OPEN BUSINESS	
1.	**ELECTION OF CHAIR**	
2.	**APOLOGIES**	
3.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.	
4.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members to declare any interests and dispensations in respect of any item of business to be considered at this meeting.	
5.	**TRUST SPECIAL ADMINISTRATOR'S DRAFT RECOMMENDATIONS: SOUTH LONDON HEALTHCARE NHS TRUST.** Trust Special Administrator's (TSA) draft recommendations for South London Healthcare NHS Trust and the wider South East London healthcare system are set out in the enclosed document. Matthew Kershaw; Special Trust Administrator, and Dr Jane Fryer; Medical Director, NHS South East London will be attending to present and take questions. Representatives of both acute trusts, Guy's & St Thomas and King's College Hospital, will be attending to give their views on the TSA's draft recommendations.	1 - 90

Item No.	Title	Page No.

6. PROPOSED MERGER OF KINGS HEALTH PARTNERS 91 - 137

The management boards of Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS foundation trusts are exploring plans for an organisational merger and a strengthened partnership with King's College London. The Strategic Outline Case is attached.

Professor John Moxham; Director of Clinical Strategy and Jill Lockett; Director of Performance and Delivery will be attending to present and take questions.

DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.

PART B - CLOSED BUSINESS

DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

Date: 27 November 2012

Office of the Trust Special Administrator

Draft Report

Securing sustainable NHS services

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

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

Draft report – securing sustainable NHS services

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

Contents

Foreword

By Matthew Kershaw, Trust Special Administrator

The population relies on the NHS being there when they need it most. Being a universal benefit, free at the point of delivery, is a fundamental element of the NHS. But in the current financial climate the service must ensure it is making the best possible use of the £100 billion of taxpayers' money it receives each year. Any waste, or shortfalls in efficiency, means money being taken away from patient care.

The Regime for Unsustainable NHS Providers was enacted in July 2012 and at that time South London Healthcare NHS Trust was spending around £1 million per week more than it had. This money was being unfairly and inappropriately drawn from other areas of the NHS. The size of this financial challenge is immense - last year, the Trust reported a deficit of £65 million and since it was formed in 2009 it has accumulated a deficit of £207 million. Throughout this process there has been acceptance from all quarters that the status quo is not an option.

I was appointed as Trust Special Administrator by the Secretary of State for Health to work up recommendations to resolve this problem in a way that would deliver a clinically and financially sustainable future for the population served by South London Healthcare NHS Trust and the south east London health system as a whole. Whilst the issues start with the Trust, there is a challenge across the system. This means the solutions cannot come just from within – rather they need to be developed with health and social care partners in the system to ensure long term sustainability. This means change across south east London, as was pointed out by commissioners, NHS London and the Trust itself before this process started.

This not the first time this health system has been reviewed and there have been repeated turnaround initiatives at South London Healthcare NHS Trust, not to mention strategic change programmes across south east London. None of them have delivered a sustainable NHS. This process needs to be and has been different due to the nature of the work and the timetable underpinning it.

Within this work I have received significant support from providers, commissioners and other stakeholders across south east London. This has helped to develop a deep understanding of these fundamental issues and without their very considerable

input I would not have been able to produce this draft report. By working together we have developed a set of draft recommendations that can genuinely ensure an NHS that will continue to deliver services to meet the needs of people across south east London now, and in the longer term.

The underlying issue in this system is the financial challenge. But it is imperative that this is addressed in a way that maintains and where possible improves the quality of clinical care. That is why the work has been underpinned by local clinicians as well as an external clinical panel. Crucially, I have used the best input from clinicians and clinical commissioners and all the information that is available to ensure decisions are evidenced based and informed by those who provide and use the services.

In addition to my role developing long term recommendations, as Trust Special Administrator I am also accountable for the day-to-day running of South London Healthcare NHS Trust during this period. Whilst there are substantial challenges faced by and within the Trust today, many of which will continue until a resolution has been implemented, staff have continued to show significant commitment and dedication in providing the best possible care to patients. This, and their willingness to engage in finding a lasting solution to the longer term problems, has been evident.

This report is draft and in publishing it I will consult on the draft recommendations it contains. These represent a coherent strategy that sets out how the longstanding financial challenges at South London Healthcare NHS Trust and the underlying sustainability issues across the NHS in south east London can be resolved. Just as we have sought to capture opinion in developing this document, I would now encourage people to read this report, consider my draft recommendations and respond to the consultation. All responses will be considered and new ideas reflected upon – it is after this that I will form my ultimate recommendations that, alongside detail on implementation and timescales, will be the core element of the final report to the Secretary of State.

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* which accompanied *The Case for Applying the Regime for Unsustainable NHS Providers*. 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) appointed, to be accountable officer for the Trust, and to develop recommendations for the Secretary of State that ensure all patients have access to high-quality, sustainable services.

2. The Order[1] sets out an exacting timetable for the UPR process, which has four key parts to it:

   - *Preparation of Draft Report* – The TSA must rapidly assess the issues facing the organisation, engage with a range of relevant stakeholders, including staff and commissioners and develop a draft report including draft recommendations for consultation. There have been 75 working days in which to do this – 16 July to 29 October 2012.
   - *Consultation* – The TSA must run a consultation over 30 working days to validate and improve the draft recommendations in the draft report. This will take place between 2 November and 13 December 2012.
   - *Final Report* – The TSA must use consultation responses to inform the final report to the Secretary of State. This will take place from the end of the consultation to 7 January 2013, when the final report is due.
   - *Secretary of State Decision* – The Secretary of State has 20 working days to determine what action to take in relation to the organisation. 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 published by 1 February 2013.

3. This document is the draft report of the TSA and represents the end of the first work phase. It provides an assessment of the position at South London Healthcare NHS Trust and the wider health system within which it operates, as was stipulated by the Secretary of State's directions. It describes the process and approach that has been used to arrive at the draft recommendations. It explains the analysis that has been undertaken to forecast what the position of the system would be without change and describes the draft recommendations

[1] Statutory Instruments 2012/1806 and 2012/1824

that will ensure that the Trust will be clinically and financially sustainable in the future while not undermining the wider NHS system in south east London. The draft report concludes with information on the consultation process and the next steps for work to be undertaken to further the analysis ahead of the final report in January 2013.

2. Context

4. 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.

5. The three Trusts had long-standing financial issues, recording annual deficits every year since 2005. Immediately before the merger in 2009 they had a total combined debt, arising from accumulated deficits, of £149 million[2]. Many attempts have been made to address these issues – more information on these can be found at the end of this section. The combination of 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 hoped to support the resolution of these problems. However, since its establishment the Trust has continued to operate at a loss and 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[3].

6. The Trust serves a population of approximately one million people, predominantly from the London Boroughs of Bexley, Bromley and Greenwich – from where over 91% of its income is generated – but also from other parts of south and south east London, such as Lewisham and Croydon, and from north west Kent. The Trust employs around 6,300 people and has an annual income of around £440 million, making it the 28th largest Trust, by income, in the country[4].

7. 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.

[2] South London Healthcare Trust: annual report and accounts
[3] TSA analysis
[4] Laing's Healthcare Market Review 2010-11

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

PRUH	QEH	QMS
Full admitting accident and emergency department	Full admitting accident and emergency department	Non-admitting urgent care centre*
24/7 surgical emergency admissions	24/7 surgical emergency admissions	
Obstetric and co-located midwife-led birthing unit	Obstetric-led birth unit	
Ante-natal and post-natal outpatient centre	Ante-natal and post-natal outpatient centre	Ante-natal and post-natal outpatient centre
Routine elective care and day cases	Routine elective care and day cases	Routine elective care and day cases
Inpatient paediatric service	Inpatient paediatric service	
Complex inpatient surgery	Complex inpatient surgery	
Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics
		Intermediate/rehabilitation beds*

*provided by Oxleas NHS Foundation Trust

8. South London Healthcare NHS Trust is a significant provider of hospital services within a wider health system in south east London. Over 1.7 million people live in the six boroughs that make it up: Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

9. The six primary care trusts (PCTs) that currently commission NHS services for this population are planning to spend £3 billion in 2012/13, of which £1.5 billion will be spent on acute hospital based services[6].

10. NHS services for the population in this part of London are commissioned by one PCT Cluster, NHS South East London, a PCT cluster which 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.

11. 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 cooperatives Grabadoc Healthcare Society, South East London Doctors Co-operative (SELDOC) and EMDOC Bromley Doctors On Call;
    - four community service providers across the six boroughs. Southwark's and Lambeth's community services are provided by Guy's and St Thomas'

[5] South London Healthcare Trust: about us
[6] TSA analysis

NHS Foundation Trust; Greenwich's and Bexley's by Oxleas NHS Foundation Trust; Lewisham's by Lewisham Healthcare NHS Trust; and Bromley's by a social enterprise Bromley Healthcare, a Community Interest Company;

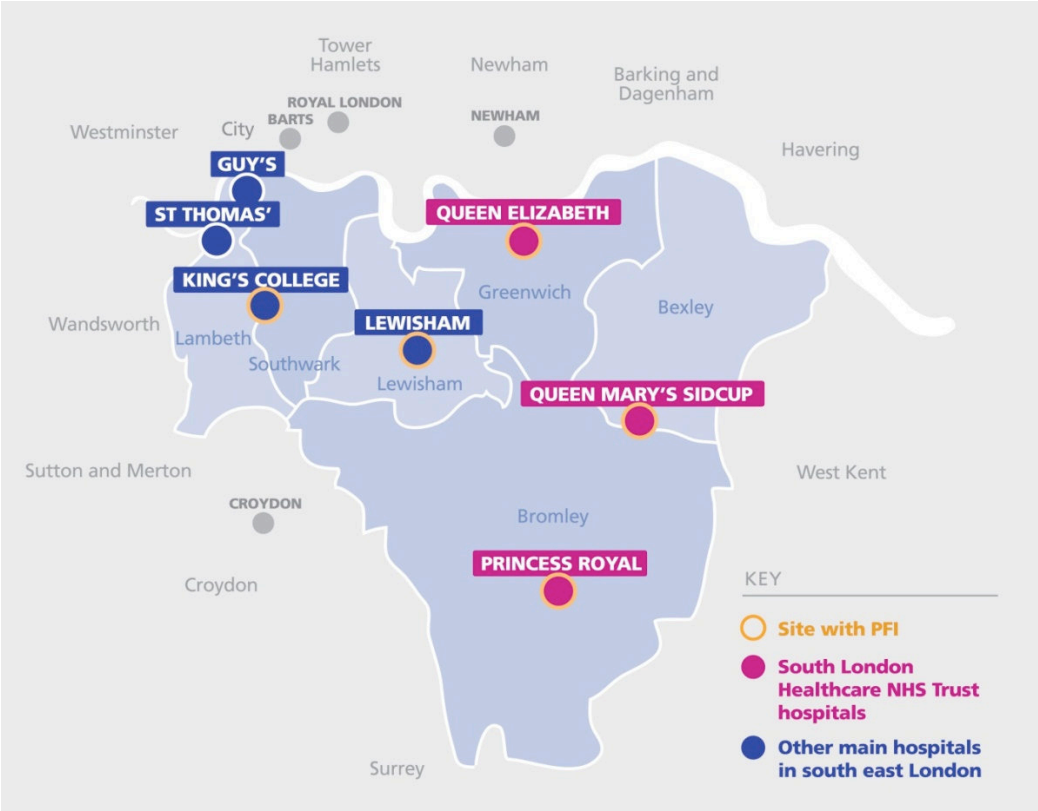
- two acute NHS Trusts – South London Healthcare NHS Trust and Lewisham Healthcare NHS Trust;
- two mental health NHS Foundation Trusts – South London and the Maudsley NHS Foundation Trust and Oxleas NHS Foundation Trust;
- two major teaching and research NHS Foundation Trusts – Guy's and St Thomas' 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; and
- an Academic Health Science Centre, King's Health Partners, which is a 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.

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.

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

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 in Dartford (part of Dartford and Gravesham NHS Trust) 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 Change

13. Concerns regarding the sustainability of services in south east London have been long-standing. This is not unique for London, where addressing the challenges of sustaining services for the long term has been the subject of many reviews.

14. Following the emergence of deficits in south east London Trusts in 2004/5, South East London Strategic Health Authority embarked on a review known as the *Service Redesign and Sustainability Project*. It concluded that efficiency improvements and service changes 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 2006. The aim was to secure improved, affordable and sustainable health services across the six boroughs in south east London. In 2007, in light of a lack of progress and continued financial pressures, the scope of the programme changed so that it only covered the outer boroughs - Lewisham, Bexley, Bromley and Greenwich. 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 provider landscape rationalised to create a 'borough' hospital at Queen Mary's Hospital in Sidcup, a 'medically admitting' hospital at Lewisham Hospital and two 'admitting' hospitals at Princess Royal and Queen Elizabeth Hospitals[7].

16. However, in the summer of 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 was to focus on planned surgery and become a base for community healthcare services, with a 24-hour urgent care centre. 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 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.

17. The merger of the three Trusts on 1 April 2009 was proposed as a means of implementing service change as well as to achieve cost and operational synergies across the three organisations, each of which were facing their own significant, individual challenges. Whilst the merger, alongside the service changes implemented through *A Picture of Health*, have delivered some improvements to the quality of care that patients receive, the financial benefits anticipated have not been realised[8]. 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.

[7] 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 an A&E department that can admit patients who may need some emergency monitoring, but would not provide inpatient maternity or inpatient paediatric services.

[8] The King's Fund Report: Reconfiguring Hospital Services, Lessons from South East London, Keith Palmer 2011

3. Approach

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

19. 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. This initial phase involved building appropriate governance structures to ensure that the draft recommendations set out in this report would be developed in line with the five principles of the UPR[9]:

- *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.

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

21. 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 collected views of the Trust's main commissioners: South East London PCT Cluster and Bexley, Bromley and Greenwich CCGs. In

[9] Statutory Guidance for Trust Special Administrators appointed to NHS Trusts

general the responses[10] welcomed the proposed enactment of the UPR and all explicitly suggested that 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.

22. Advisory and working groups, as well as an external clinical panel, were established immediately. These groups are outlined in figure 3. They have been integral in developing, improving and validating the draft recommendations as they have emerged. Each group had a clear understanding of their role and remit, bringing their specialist expertise to bear on relevant areas of the programme.

23. The nature of the UPR means that, whilst these groups have played a central role in developing, testing and validating recommendations, they have not functioned as more traditional programme boards. The TSA himself retains ultimate decision-making responsibility for the draft recommendations, before delivering his draft and ultimately final report to the Secretary of State.

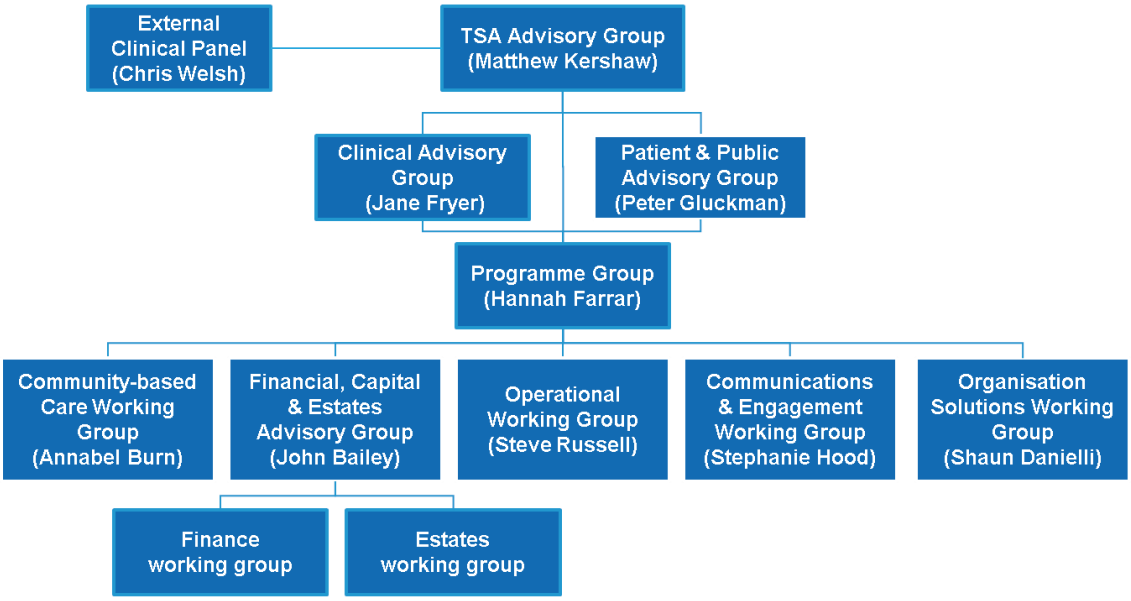
24. A clinical advisory group – composed of clinicians from all NHS organisations in south east London, and a patient and public advisory group – formed of representatives of Local Involvement Networks and patient councils – have fed directly into a TSA advisory group. Placing south east London's clinical leaders and leaders of patient representative groups at the centre of the programme ensured that work was clinically led and locally appropriate.

25. An external clinical panel has provided additional scrutiny to the development of the draft 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 provocative questions. In carrying out its function, the panel has provided the programme with valuable insights, based on independent clinical expertise. It has played a key role in challenging the development of draft recommendations, for example, to emergency and maternity services and is supportive of the proposals and options in this report.

26. A finance, capital and estates advisory group – comprised of finance and estates directors from all NHS provider organisation in south east London – has provided significant input to the forecasting of financial positions for commissioners and providers and validating options as they have emerged through the work.

[10] Statutory instrument 2012/1806

Figure 3: Programme governance arrangements



27. Appendix D sets out in detail the meetings schedule for each of these advisory and working groups, demonstrating the extensive involvement and engagement that has taken place during the development of the draft recommendations. Membership of the groups is also detailed in appendix D.

Work undertaken in preparing the draft report

28. In light of the fixed timescales for the UPR process, several lines of enquiry associated with understanding and resolving the issues facing the Trust and south east London were investigated in parallel. Acknowledging the feedback from the consultation ahead of enacting the UPR, four key areas of work were established to assess:
    - the Trust's operational performance;
    - the impact on the Trust of the costs associated with Private Finance Initiative (PFI) contracts;
    - options to deliver improved clinical care in the future within the financial envelope available; and
    - options for future organisational configurations.

Operational performance

29. Understanding the Trust's current operational performance, including the clinical and financial baseline and its potential to deliver improvements going forward, was a key starting point for the work. An assessment was undertaken

to determine the Trust's current financial baseline, understanding where the deficit has come from and the projections for the Trust over the coming years.

30. From this starting point, a detailed analysis of the potential opportunities within the Trust was completed, to assess how efficient the organisation could be 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 productivity opportunities across the set of cost categories defined in the NHS costing manual[11]. It also looked at opportunities to maximise the utilisation of estate across the Trust.

Impact of PFI costs

31. As well as considering opportunities to improve the internal efficiencies of the Trust, a review of the impact of the main PFI contracts held by the Trust was completed, identifying opportunities to address the fixed cost impact the PFI contracts have on the Trust.

Future service options

32. An analysis of the current and projected use of NHS services in south east London, including those currently provided by the Trust, was undertaken. Working with local commissioners and providers, the TSA's team established an understanding of the services commissioned across south east London and agreed a position for the current and future finances of the other NHS Trust, Lewisham Healthcare NHS Trust. As well as understanding the financial positions at Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust.

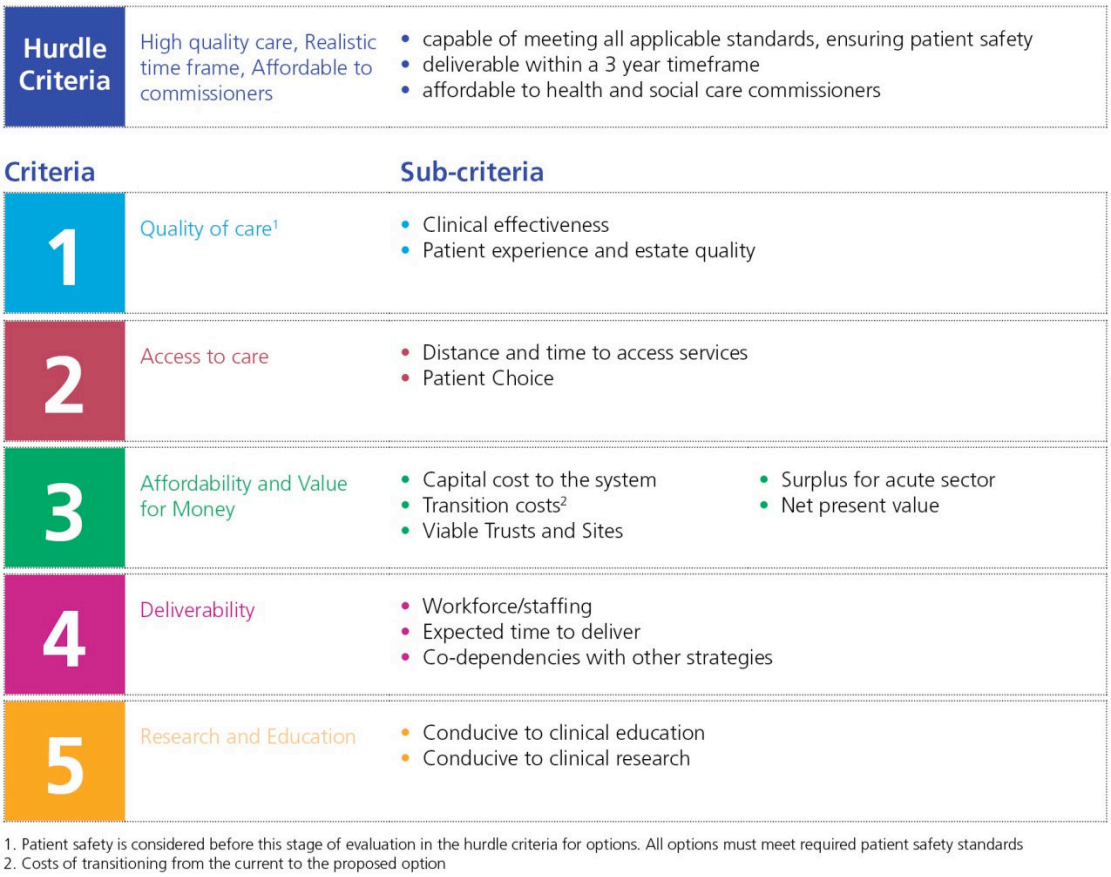
33. Alongside this, the team worked with commissioners, clinicians and other stakeholders to understand how the quality of service provision in the NHS in south east London could be secured. This included the development of a strategy for Community Based Care – outlining a set of aspirations for primary care and community services, integrated care and planned care services, and a recommendation that any future reconfiguration of services in south east London meet the London-wide acute emergency and maternity clinical quality standards.

34. Considering the impact of delivering these quality standards alongside the financial challenges to be addressed, a number of options for the future provision of services across south east London were developed. These were tested with the clinical advisory group, as well as with some of the

[11] NHS Costing Manual

organisations that responded to the market engagement process (described below). The options were then evaluated against a set of criteria (summarised in figure 4 and provided in detail in appendix E), the outcome of which were tested with the clinical advisory group, the finance, capital and estates advisory group and the TSA advisory group. This process identified a preferred service configuration for acute services in south east London.

Figure 4: 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

Organisational options

35. In considering the future of the Trust, a market engagement process was undertaken to seek input from other organisations – including those within the NHS and the voluntary and independent sectors – on the best organisational solution to deliver clinically and financially sustainable services. This process included seeking input from any interested party.

36. A large number and broad range of interested parties responded as part of this process. However, conversations were pursued only with those organisations looking to discuss solutions that could help resolve the challenge the TSA is tasked with addressing. For those interested only in providing a specific service, it was reiterated that the TSA was not undertaking a specific procurement at this stage, but focussing 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 determines should be put out for competitive tender.

37. A small number of organisations indicated 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.

38. 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 long 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 5).

Figure 5: Evaluation criteria for organisation 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 impace will the option have on patient choice, access and competition?
	• Stakeholder alignment	• How aligned are stakeholders (potential partners, patients, public, staff) behind the option?

39. The outcome of this was a short list of options, which are set out in section 6. These potential solutions will continue to be explored and worked up in more detail during the next phase of the UPR. Meanwhile, the formal consultation will be used to present the options to help in framing the final set of recommendations including testing them for stakeholder alignment.

Stakeholder engagement

40. The development of the draft recommendations in this report have been underpinned by the broad engagement of a wide range of stakeholders in south east London. This engagement has sought both to deepen people's understanding of the need to look again at how health services in south east London are delivered and to understand how best to make changes to secure safe, high quality health services for the local population in a way that is financially sustainable going forward.

41. The case for change and the process for assessing the emerging ideas for long-term solutions have both been tested with clinicians, commissioners, staff, other healthcare providers, representative groups of patients, the public, Members of Parliament and local Councils. Since 16 July the TSA and his team have led a number of stakeholder engagement events across south east London (see appendix F). The feedback, comments, contributions and suggestions have informed the development of the draft recommendations. This broad engagement will continue as part of the formal consultation that the TSA will lead to inform the development of final recommendations to the Secretary of State.

42. 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 are communicated. The bulletin provides an update on the work and signposts readers to where they can find further information. Information about the UPR and signposts to further information have also been cascaded through the Trust's website, and those of other local NHS organisations.

Engagement through a series of clinical workshops

43. 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 so doing, significantly informed the work programme and the development of the recommendations for change. These workshops were central to developing the Community Based Care strategy, which has been an important part of developing the draft recommendations.

44. 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; and
- a desire for innovative approaches to integrated care.

Engagement with staff

45. Executing a dual role – one, to develop a set of recommendations for the Secretary of State and two, to act as the board of, and Accountable Officer for the Trust, ensuring the day-to-day delivery of services for patients during the UPR period – the TSA has engaged 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, departments and teams to seek views, hear ideas and explain more about the work being done. This has also helped to understand the strengths of and challenges facing the organisation.

46. This engagement has been supported by a series of regular open staff meetings, attendance at the medical services and consultants' committees, one-to-one meetings with clinicians and others, meetings with staff side representatives and other opportunities to engage with staff in the Trust. It has been invaluable in informing the development of the draft recommendations in this report.

47. As part of the ambassadorial role of members of the TSA advisory group, leaders from other organisations were asked to engage with their staff. 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.

Engagement with patients and the public

48. Patients and the public have been involved in the process so far, both through a patient and public advisory group and in individual meetings with representatives from Local Involvement Networks and a number of other patient organisations in the area.

49. Feedback gathered from these groups has shaped the development of the programme, for example influencing the evaluation criteria used to assess potential options. The groups have also developed ideas on how to ensure the consultation plan can extend the reach of its activity to embrace the requirements of the Equality Act 2010 as well as other 'seldom heard' or 'hard to reach' groups.

50. In addition to this, focus group work has been undertaken with a representative sample of members of the public from all six boroughs in south east London, 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 as a critique and test for the evaluation criteria. The report from this work can be found in Appendix G.

51. Engagement with patients and the public has also been strengthened by using members of the patient and public advisory group and a communications and engagement working group, amongst other forums, to cascade information to local groups and networks.

52. The media (print, broadcast and digital) has been a significant means of supporting engagement during this first phase of work. It has 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.

53. A more detailed record of the most significant stakeholder engagement activity that has been undertaken during the 75 working days from the start of the regime can be found at Appendix F.

Health and equalities impact assessment

54. 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 independent health and equalities impact assessment (HEIA) has been commissioned to understand the potential impact of the draft recommendations in this report. The purpose of the HEIA is to contribute to the information available to support the development of the final report. The HEIA will enable the final recommendations to be based on an understanding of the impact of those recommendations on the population of south east London. The scoping report for the HEIA is provided in appendix H.

55. The HEIA, once it is completed, will help to answer four questions:

- what are the positive and negative impacts of the proposed changes on communities within south east London, particularly in respect of health, health inequalities, equalities and access to care, taking specific regard - but not exclusively - to the groups defined in legislation?
- what is the scale and duration of the impact, the probability of occurrence and the specific impact on those with protected characteristics?

- how can any adverse impacts be mitigated and positive impacts enhanced?
- how can the proposed changes best meet the requirements of the Equality Act 2010?

56. The HEIA will report in three broad phases:

- The first phase is published alongside this draft report (appendix H) and consists of the 'screening' and 'scoping' stages, which will seek to provide an initial view on the potential effect of the proposals being developed on those groups with protected characteristics. This also scopes the areas for further detailed work to be followed in the main HEIA.
- The second phase will consist of 'data capture' and 'engagement' stages, which will be integrated with the 30-day public consultation and consist of gathering information on the potential equality and health impacts, as identified by the scoping report. This will include direct stakeholder involvement, so that potential impacts, mitigations and enhancements can be properly considered. The output of this phase will be the draft HEIA report.
- The third phase will consist of reviewing the draft HEIA report in light of the outcome of consultation, before incorporating the HEIA findings and mitigations into the final report to the Secretary of State.

'Four Tests' Review

57. In 2010, the Secretary of State introduced 'four tests' to be applied to NHS service changes. In producing the final report the TSA is required to take these tests into due regard. The work to date has sought to satisfy the tests, a summary of this is outlined below.

The changes have support from GP commissioners

58. This began with commissioners supporting the application of the UPR at the Trust in response to the Secretary of State's initial consultation. GP commissioners' involvement in the development of the draft 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.

59. Support from GP commissioners for the draft recommendations will be sought through consultation and demonstrated in the final report.

The public, patients and local authorities have been genuinely engaged in the process

60. Patients have been involved in developing the criteria for evaluating options through the patient and public advisory group, Local Involvement Networks and other patient organisations, including those representing 'seldom heard' or 'hard to reach' groups. Focus groups, involving the public from across all six boroughs, were used to test the evaluation criteria. Local authorities have been fully engaged in the process, especially through the TSA advisory group and the TSA's meetings with local councils' overview and scrutiny committees. Furthermore, information has been shared by cascading through the patient and public advisory group and the communications and engagement working group, the Stakeholder Bulletins and the use of print, broadcast and digital media. The consultation period provides further opportunity for engagement.

The recommendations are underpinned by a clear clinical evidence base

61. The proposals for service change are derived from an evaluation of clinical models as they are currently configured across south east London. The proposed clinical models are, in turn, derived from a clinically-agreed set of clinical standards and reflect agreed clinical interdependencies. The evidence and expert opinion for the clinical standards and interdependencies comes from:

- the clinical evidence underpinning the agreement of clinical standards for acute emergency and maternity services in London, as part of the work undertaken by London Health Programmes' Quality and Safety Programme in 2011 to 2012;
- recommendations from Royal Colleges and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) to address poor standards of care – inadequate involvement from senior medical personnel in the assessment and management of acutely ill patients and labouring women, a situation that worsens outside of core working hours[12, 13, 14, 15, 16];

[12] Emergency admissions: A step in the right direction
[13] Acute Medical Care: The right person, in the right setting – first time
[14] Emergency Surgery: standards for unscheduled surgical care

- clinical expertise from within south east London, which underpinned the discussions of the clinical advisory group and the six clinical workshops; and
- the clinical expertise of members of the external clinical panel.

62. The proposals will continue to be tested, including with the Royal Colleges, through the consultation process.

The changes give patients a choice of good quality providers

63. 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. The draft 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.

64. Further work will be undertaken during the consultation phase and ahead of finalising the report to the Secretary of State, to enhance the assessment of the process and its outcomes against the 'four tests'. This will be done by continuing to test the assessment with patients, the public, local authorities, clinicians and staff and in response to feedback gathered during the consultation.

[15] Facing the Future: A Review of Paediatric Services
[16] Tomorrow's Specialist

4. Assessment of South London Healthcare NHS Trust and the broader health system

Introduction

65. The previous section explains 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 section explains, in detail, the outcomes of the TSA's assessments. It describes recent clinical and financial performance at the Trust and sets out the financial challenges that the Trust is projected to face over the next three years. Finally, it sets out the assessment of the broader health system in south east London.

Clinical performance

66. 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 over the last 12 months. However, the Trust still struggles to meet a number of standards consistently and the sustainability of these improvements is not clear.

67. 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 with the result that all essential standards were 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 concerning staffing and supporting workers at all three sites have been undertaken, and the Trust has been judged as being compliant with those standards. One outcome (11 – safety and suitability of equipment) remains non-compliant at Queen Mary's Hospital Sidcup, the report from the latest CQC review of this (week commencing 22 October 2012) is pending.

68. For Referral to Treatment Time (RTT) (admitted and non-admitted performance) the Trust failed to meet both the 90% and 95% standard for

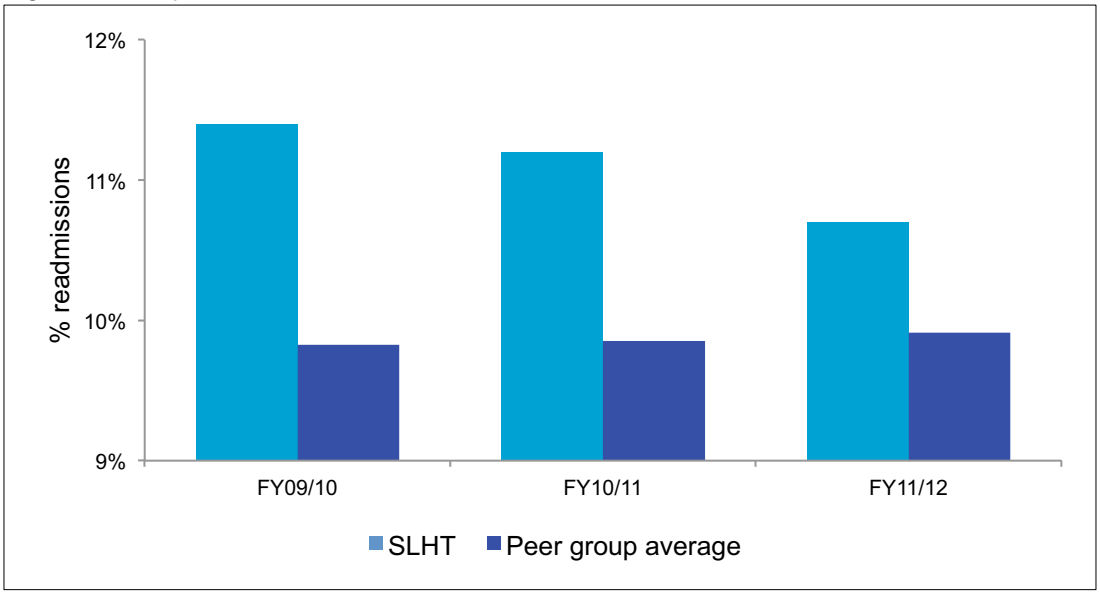
admitted and non-admitted waits throughout most of 2011/12. The Trust has made progress in clearing backlogs in recent months and data for May 2012 shows that the Trust is now meeting the RTT standards for admitted, non-admitted and incomplete pathways[17] and is on track to achieve the standards at speciality level by November 2012.

69. The Trust has a 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 has consistently underperformed against its peer group for A&E wait times, reaching a low of 89% in Q3 of 2010/11 against the four-hour wait target. This was due to planned changes in service delivery at Queen Mary's Hospital Sidcup. The Trust failed to meet the A&E 'all type' operational standard for 2011/12 - with 'all type' performance of 93.5% against the 95% standard.

70. Since February 2012 there has been a gradual improvement in the Trust's A&E performance as a result of action taken to strengthen ambulatory care, elderly care support to the emergency care pathway and weekend medical cover, as well as ongoing support from the national emergency care intensive support team. In Q1 and Q2 of this year the Trust achieved the A&E 'all type' operational standard, but there remains significant sustainability issues as evidenced by performance reductions in October due to pressure at both the Princess Royal University Hospital and Queen Elizabeth Hospital.

71. Re-admission rates, against a national peer group of comparable Trusts, have remained consistently high (as shown in figure 6)

Figure 6: Comparable SLHT re-admission rates, 2009/10-2011/12[18]



[17] SLHT Trust Board papers, 25 April 2012
[18] Dr Foster health & medical guides

72. The prevention and treatment of Venous Thromboembolism (VTE) is a key safety priority and is a measure of the level of care in a hospital. The Trust was below the national benchmark, but has been achieving the standard of 90% and above consistently since June 2012.

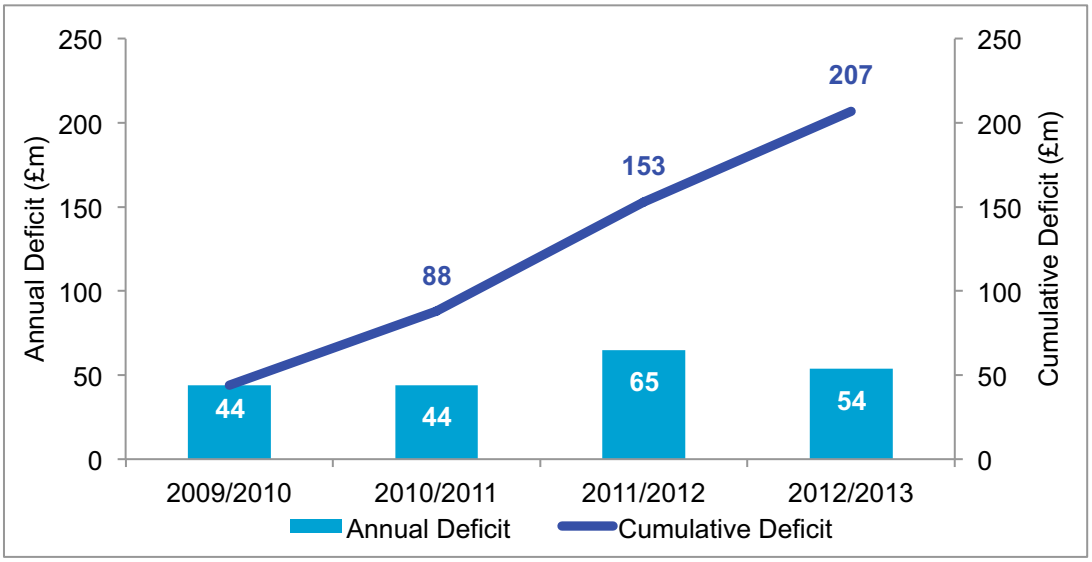
73. The efforts of the current leadership team in delivering improvements across key performance standards and the quality and safety of care should be acknowledged and commended. However, there is clearly a significant risk that recent clinical and performance improvements cannot be sustained unless the financial challenge is addressed. As the root causes of the challenges are complex, site-specific and both internal and external to the Trust, any solution will require changes in systems, processes and culture internally and action across the broader local health system to secure long-term financially and clinically sustainable services.

Financial Performance

74. Since its establishment in 2009, the Trust has accumulated deficits totalling £153m. By the end of this financial year, it 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[19]. 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 the financial year 2009/10.

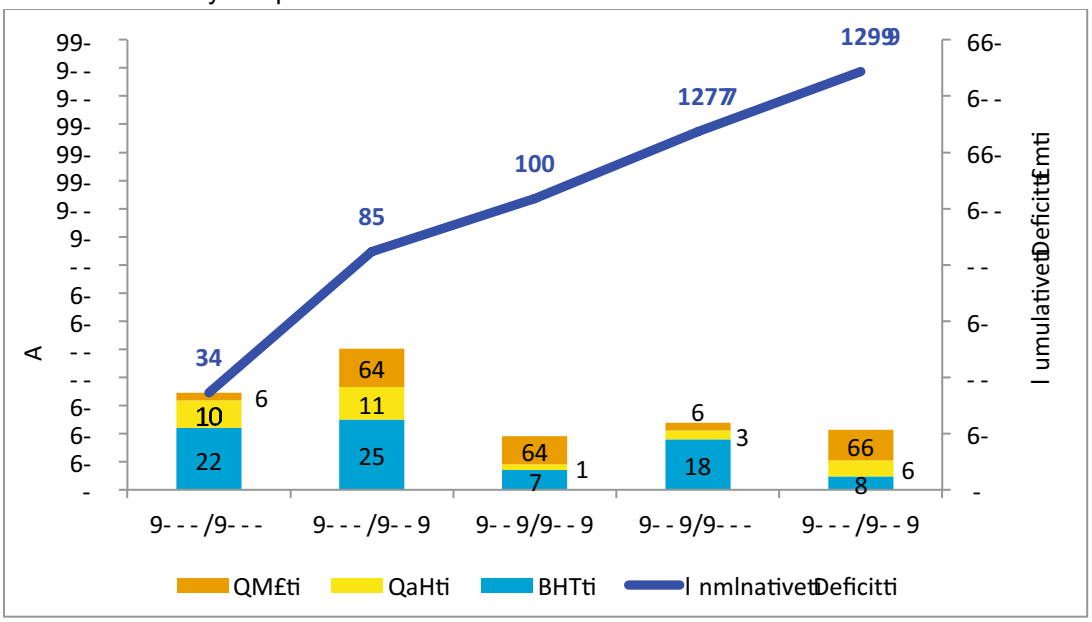
[19] Explanatory note: 9 of 104 NHS Trusts and 21 of 163 NHS Foundation Trusts reported a deficit

Figure 7: Normalised deficit of South London Healthcare NHS Trust 2009/10 – 2011/12 and forecast for 2012/13[20]



75. The financial issues of the Trust did not start with its establishment in 2009. The three predecessor organisations - Queen Mary's Sidcup NHS Trust; Queen Elizabeth Hospital NHS Trust and Bromley Hospitals NHS Trust - had overspent every year since 2004/05 (see figure 8). 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 (i.e. 2004/05-2012/13), the total forecast cumulative deficits is £356m.

Figure 8: Normalised deficit of Queen Mary's Sidcup NHS Trust, Queen Elizabeth Hospital NHS Trust and Bromley Hospitals NHS Trust 2004/05 – 2008/09[21]



[20] SLHT Annual Accounts and SLHT Financial Plan
[21] Annual Accounts for QEH, PRU and BHT

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

76. In making draft 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 would include its recent financial performance and how it has responded to the challenges it has faced since its establishment and its current financial position.

77. Figure 9 outlines the financial performance of the Trust since its formation and the forecast position for 2012/13. It shows deterioration over the period. The key points are:

- Total revenue has declined by £32.1m (6.9%) over the four years. The most significant decline took place between 2009/10 and 2010/11.
- Operating costs have reduced by £69.2m (13.2%) over the four years. This has not been a consistent reduction, as costs increased between 2010/11 and 2011/12 by £37.5m (8.3%), despite income remaining constant. The 2012/13 financial plan sees this being reduced by £37.2m so that costs return to a similar level to 2010/11. The fluctuation of these costs demonstrates a lack of financial control.
- Finance costs, which principally relate to the two whole hospital PFIs located at Princess Royal University Hospital and Queen Elizabeth Hospital, have increased by £6.4m (29.5%) over the last four years.
- The 'control total' operating deficit is forecast to be £54.2m in 2012/13. Whilst this is an improvement on the 2011/12 position, this still means the Trust is losing over £1m a week.

Figure 9: SLHT financial performance 2009/10 – 2011/12 and forecast for 2012/13[22]

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	(216.1)	(159.5)	(189.1)	(171.4)	(20.7)
Total operating costs	**(523.0)**	**(453.3)**	**(490.8)**	**(453.6)**	(13.3)
Investment revenue	0.0	0.0	0.0	0.0	
Other gains and losses	0.0	0.0	0.0	0.0	
Finance costs	(21.0)	(23.3)	(26.3)	(27.2)	29.5
Surplus / (Deficit) for the financial year	(81.4)	(38.8)	(78.2)	(50.3)	(38.2)
Public dividend capital dividends payable	(9.1)	(8.4)	(8.4)	(8.5)	(6.6)
Retained Surplus / (Deficit) for the financial year	(90.5)	(47.2)	(86.6)	(58.8)	(35.0)
Less 2009/10 and 2010/11 impairment IFRS adjustment	46.8	3.4	21.6	4.6	
Retained Surplus / (Deficit) for the financial year:- "Control Total"	(43.7)	(43.8)	(65.0)	(54.2)	24.0

Income

78. 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:

- the national tariff deflation, which drives an annual efficiency improvement 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 a reduction in other operating income.

Figure 10: Breakdown of income 2009/10 – 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)

[22] SLHT Management Accounts

Operating costs

79. Despite an overall reduction in the Trust's total cost base, the proportion related to employee cost has risen from 58.7% in 2009/10 to forecasted 62.2% in 2012/13 (see figure 11).

80. Temporary staff expenditure is a problem for the Trust. For example, in 2011/12 agency staff costs were budgeted to be under £3.4m, whilst the actual cost was £13.3m; SLHT's target for agency usage is 1.0% of total workforce and yet, in 2011/12, it was 4.4%. Compared to its peers, the Trust has consistently underperformed on its levels of usage of temporary staff[23]. In 2012/13, the Trust's plan was to spend £23.9m on temporary staff, but at the half year point the Trust's forecast has risen to £33.8m indicating that the Trust is still struggling to control temporary staff costs and the balance between permanent and temporary staff is sub-optimal.

Figure 11: South London Healthcare NHS Trust Employee costs 2009/10 – 2011/12 and forecast for 2012/13[24]

Currency: £m	Staff Cost			
	2009/10	2010/11	2011/12	2012/13
Total, excluding bank staff, locums and agency staff	268.2	259.5	262.2	248.4
Bank staff	17.8	18.5	22.2	20.5
Locum staff	2.7	3.1	4.0	3.8
Agency staff	18.2	12.7	13.3	9.5
Total bank, locum and agency staff	**38.7**	**34.3**	**39.5**	**33.8**
Total	**306.9**	**293.8**	**301.7**	**282.2**
% of expenses	58.7%	64.8%	61.5%	62.2%
% of bank, locum and agency staff	12.6%	11.7%	13.1%	12.0%

81. 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 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 an unattractive organisation for potential recruits.

82. Non-pay costs, before taking into account impairments, are forecast to increase by 0.8% over the four years to 2012/13 (see figure 12). This is despite an £11.5m reduction in 2010/11.

[23] TSA analysis
[24] SLHT Management Accounts

83. In 2011/12, these costs returned to levels above those seen in 2009/10. The £13.4m (9.3%) increase was driven by a £12.4m increase in clinical supplies and services. Such an increase could either indicate a lack of control over the purchasing of such supplies, high inflation, or a failure to turn additional activity into income. It should be noted that income was constant between 2010/11 and 2011/12. Despite the reduction in income shown in figure 10 between 2011/12 and the forecast 2012/13, the Trust has not been able to match this by a reduction in forecast non-pay costs in 2012/13.

Figure 12: Non-pay costs[25] 2009/10 – 2011/12 and 2012/13 forecast

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	(3.6)
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)
Other	19.8	13.3	7.8	5.5	(72.2)
Total operating expenses excluding employee benefits and non-trading expenditure	**156.2**	**144.7**	**158.1**	**157.4**	0.8
Impairments and reversals	44.1	1.6	17.5	0.0	(100.0)
Depreciation	16	13.2	13.5	13.9	(13.1)
Total operating expenses excluding employee benefits	**216.1**	**159.5**	**189.1**	**171.3**	(20.7)

Cost Improvement Plans (CIPs)

84. 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. Despite these significant cost reductions, the Trust has a history of underperformance against budget for its CIPs (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 or to reflect long-term changes in demand. In such circumstances, plans are often short-term reactions to pressures and demonstrate a lack of planning and / or awareness of the impact of changes in activity levels on the cost base.

[25] SLHT Annual Accounts

Figure 13: Summary of CIP savings, including forecast for 2012/13[26]

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

85. The key headlines underpinning the Trust's 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. In this area a large target was set, but the Trust only delivered 90% of the plan.
- 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 remain safe.
- In 2012/13, the Trust is £2.7m 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. Whilst 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 over £50m.

86. 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 for embedding 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 changes required. As a consequence opportunities to address some of the underlying issues have been missed.

Cash flow

87. The operating cash position has deteriorated since 2009/10, with a significant cash outflow in all years including a forecast of £58.8m in 2012/13. This has

[26] TSA analysis

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

88. Extensive analysis, assessment and modelling have been undertaken since 16 July to understand better the reasons the Trust is consistently in deficit. As part of this, the TSA 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 (before the International Financial Reporting Standards (IFRS) adjustment) to recognise a net £0.7m non-recurrent benefit available in 2012/13 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 sites make a deficit on an annual basis. The 2012/13 forecast deficit for the Trust consists of: Princess Royal University Hospital £20.3m, Queen Elizabeth Hospital £28.3m and Queen Mary's Hospital Sidcup £10.9m.

89. In the course of this analysis, three 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 in section 6. 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.
- *Leadership* – Many of the potential benefits of the merger that created the Trust have not been realised, including rationalisation of back-office and facilities management. Decision-making remains variable and distinct across the three sites and there are many examples of where Trust-wide policies have not been standardised (e.g. three separate HR policies

continue to be in place). As such, there are variations in payments and terms and conditions across the Trust. These variations continue to undermine attempts to streamline corporate-level reporting. The Trust has undergone a series of reviews and turnaround programmes over the last two years, resulting in short term leadership, but a lack of clinical and managerial leadership capacity and an appropriate organisational culture has meant lasting improvements have not been delivered.

90. The work has also looked at whether the Trust receives income at a level that is appropriate for the work it carries out. In the past, the Trust has had issues with the preparation and quality of its financial information, such as the late submission of its Annual Accounts for 2011/12. Although a programme for improving financial reporting began in 2011 and has made progress, some issues remain. Continued failings can be put down to poor financial governance, record keeping and difficulties with its 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.

91. 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

92. Having understood the drivers of the current deficit, the Trust's financial projection for the three years 2013/14 to 2015/16 (see figure 14) was produced. This projection has taken 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 (£79m). This assessment of opportunity has been made at the level of cost category (e.g. medical, nursing, scientific, therapeutic and technical staff (ST&T) and non-clinical pay and supplies and other variable costs) and the ability to deliver 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.

Figure 14: South London Healthcare NHS Trust financial projection 2013/14 – 2015/16[27]

Currency: £m	2013-14			
	Income	Total Cost	Defecit	Gap to 1%
PRUH	184.1	216.6	(32.5)	34.3
QEH	173.1	214.4	(41.3)	43.0
QMS	61.6	75.5	(13.9)	14.5
Total SLHT	**418.8**	**506.5**	**(87.7)**	**91.8**

Currency: £m	2014-15			
	Income	Total Cost	Defecit	Gap to 1%
PRUH	183.7	214.4	(30.7)	32.5
QEH	176.2	215.0	(38.8)	40.6
QMS	62.7	75.4	(12.7)	13.3
Total SLHT	**422.6**	**504.8**	**(82.2)**	**86.4**

Currency: £m	2015-16			
	Income	Total Cost	Defecit	Gap to 1%
PRUH	184.0	212.4	(28.4)	30.2
QEH	179.7	215.3	(35.6)	37.4
QMS	64.2	75.1	(10.9)	11.5
Total SLHT	**427.9**	**502.8**	**(74.9)**	**79.1**

93. This 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. Even if they deliver £43.3m in CIP savings over the next three years South London Healthcare NHS Trust will still face a gap of £79.1m to deliver a 1% surplus in 2015/16. This shortfall will need to be addressed. Work to consider the maximum productivity opportunities within the Trust (outlined in section 6) describe how this shortfall cannot be addressed within the bounds of South London Healthcare NHS Trust alone, which is why solutions across the broader health system are critical.

Assessment of the broader health system

94. The difficulty of securing a clinically and financially sustainable health system for south east London has been at the heart of the local NHS's strategic change agenda for many years as local commissioners, providers and health authorities have sought to respond to these challenges. There have been repeated attempts, involving different types and scale of intervention, to solve

[27] TSA analysis

the deep-rooted problems. The most recent attempts are described in section 2.

95. In response to the Secretary of State's consultation on the use of the UPR, all of the organisations that replied suggested the need to use the Regime in a way that would embrace a broader review of the NHS's challenges in south east London. In light of this, work has been undertaken to understand better the financial state of the broader health system.

Commissioners

96. The commissioning context is outlined in section 5. However, the highlights from the financial assessment can be summarised as:
    - the recurrent income for the commissioners in south east London is forecast to rise by £183m from the 2012/13 level to £3.2bn in 2015/16;
    - the commissioners' financial challenge by 2015/16 is £81m; and
    - investment in the acute sector rises from £1.5bn in 2012/13 to £1.6bn in 2015/16.

NHS Trusts and Foundation Trusts

97. As part of the work an understanding of all acute providers' financial context has been reached. All providers face challenges over the coming years. Detailed work with Lewisham Healthcare NHS Trust was undertaken and a financial projection produced. Using commissioners' current forecasts, the work undertaken by the TSA has exposed issues of financial sustainability for the Trust. Despite significant recent improvements in Lewisham Healthcare NHS Trust's financial position, the Trust has had a history of financial challenge:

    - In 2004/05 and 2005/06 the Trust had deficits. At the start of 2007/08, the Trust was one of 17 NHS trusts (as were the three Trusts in outer south east London that merged to form South London Healthcare NHS Trust in 2009) identified by the Department of Health as "financially challenged".
    - Since then, the Trust has generated operating surpluses. However, the impact of asset impairments and the implementation of IFRS accounting in 2009/10 has seen the Trust record deficits in its annual accounts. With pre-adjustment deficits shown for 2008/09 (£5.8m), 2009/10 (£1.2m) and 2010/11 (£0.4m), and a small surplus for 2011/12 (£44k); it is clear that whilst the Trust has been able to meet its financial obligations as an NHS trust, it has been challenging.
    - 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.

- With a projected turnover of around £240m, the Trust will always be seen as a small organisation, especially when compared to its neighbours - King's College Hospital NHS Foundation Trust, Guy's and St Thomas' Hospital NHS Foundation Trust and South London Healthcare NHS Trust. This means that small variations in income or expenditure have a disproportionate impact upon the financial performance and risk rating of the 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. That application was predicated on a more favourable commissioner settlement than has been included by the TSA following more recent discussions with the commissioners.

98. The financial projection produced through the TSA analysis (see figure 15) 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.

Figure 15: Forecast financial position for Lewisham Healthcare NHS Trust (£m)[28]

Currency: £m	2013-14			
	Income	Total Cost	Defecit	Gap to 1%
Lewisham Healthcare Trust	236.9	235.9	1.0	1.4

Currency: £m	2014-15			
	Income	Total Cost	Defecit	Gap to 1%
Lewisham Healthcare Trust	237.2	237.4	(0.2)	2.6

Currency: £m	2015-16			
	Income	Total Cost	Defecit	Gap to 1%
Lewisham Healthcare Trust	239.5	240.1	(0.6)	3.0

99. Added to the £79.1m shortfall at South London Healthcare NHS Trust, the total financial challenge for NHS Trusts across south east London will amount to £82.1m by 2015/16. In considering proposals for change that will secure safe, high quality and affordable services for the population, the draft recommendations in this report need to secure clinical and financial sustainability across the broader health system and address this gap.

[28] TSA analysis

5. The commissioning context in south east London

100. Developing the draft recommendations for resolving the sustainability challenges within South London Healthcare NHS Trust and the wider south east London healthcare system has been done with full regard to the commissioning intentions of the six CCGs in south east London.

101. As set out in section 3 of the report, the six CCGs and South East London PCT Cluster have played a critical role throughout this process. In addition to supporting the groups and providing advice, they have undertaken work to define their overarching aspirations for developing Community Based Care over the next five years and how they plan to use the money available to them across the broader health system.

102. A five-year time horizon was set to ensure the work adequately acknowledged the strategic intent of CCGs in terms of improving health and developing health services. In doing this they have engaged 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 is the shared intent of their local Health and Wellbeing Boards. Further progress is expected before completion of the final report in January 2013.

103. In 2012/13 the commissioners in south east London have a total resource allocation of £3.0bn to spend on the local population[29]. The projection of allocation for the population of south east London across the next five years, which will be split across the local CCGs, local authorities and the NHS Commissioning Board from April 2013, is outlined in figure 16.

Figure 16: 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**

[29] South East London PCTs' operating plans 2012/13

104. As figure 16 indicates, there will be growth in the resource available to the NHS in south east London, but growth is limited. The NHS Commissioning Board is yet to clarify its intent on the future allocation of resources. This is expected in December 2012.

105. The growth in the resource available to commissioners should be viewed against a background of a growing population in south east London that will see an increase of around 6% over the next five years, from around 1.7 million to around 1.8 million[30] particularly in the boroughs of Greenwich and Southwark. Alongside this, the demographics of the population are changing. Over the next five years the number of those over 65 will increase from around 180,000 in 2012 to around 195,000 by 2018. 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 in order to deliver safe, high quality healthcare within the budget available.

106. These changing requirements mean that commissioners need to reshape local services, which should be done in line with the broader NHS agenda for Quality, Innovation, Productivity and Prevention (QIPP). They must take into account not just changes to their population health needs, but also the advancement of medicine and the impact of improved specialist interventions and medical technology (e.g. 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). These improvements 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.

107. 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:

[30] Interim 2011-based subnational 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.
- 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.

Community Based Care

108. In line with this vision, and as a key building block in developing the draft recommendations, the CCGs 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 their homes, where possible. 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 (provided in figure 17 and detailed in appendix I) have been grouped into three areas of care:

- *primary and community care* – services that will provide easy access to high quality care for all to support people in staying healthy and are available to the whole population;
- *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 17: 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. ▪ 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 south east London-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 in south east London, 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

109. 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, 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 I, along with examples of success commissioners have already had in improving care for patients. 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.

110. More detail on how the Community Based Care strategy will be implemented will be included in the final report.

111. Improving the quality of community-based care has underpinned the work led by commissioners as they look to change the way services are delivered. The provision of care closer to people's homes and improved proactive care for people with long term conditions will reduce the length of stay for patients who need to be admitted to hospital. As well as providing 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 it limits the increase. This projected spend outlined in figure 18 has been factored into the work undertaken through this programme as outlined in section 4.

Figure 18: Commissioners' projected spend going to acute providers over the next 5 years[31]

Currency: £ m	2013/14	2014/15	2015/16	2016/17	2017/18
Bexley	192.1	198.2	201.2	205.30	209.5
Bromley	271.9	277.6	282.7	286.00	290.2
Greenwich	212.8	219.9	226.4	231.50	236.4
Lambeth	318.4	322.3	327.5	334.90	342.3
Lewisham	257.3	263.7	268.6	275.60	282.7
Southwark	291.3	297.0	304.0	311.20	318.6
Total	**1,543.8**	**1,578.7**	**1,610.4**	**1,644.5**	**1,679.7**

Standards for emergency care

112. It has been demonstrated[32] that patients, in London, admitted as an emergency at the weekend have a significantly increased (10%) risk of dying compared with those admitted on a weekday. Across London this accounts for 520 adult deaths a year. 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. As part of an ongoing piece of work across London, clinical expert panels developed and agreed a set of clinical quality standards for acute emergency adult and paediatric cases to address the variations in service arrangements and patient outcomes. These standards were further endorsed by the London Clinical Senate. These standards represent the minimum quality of care patients admitted as an emergency should expect to receive, wherever and whenever they are admitted to a hospital in London.

113. In south east London, addressing the variation in service arrangements and outcomes between weekday and weekend admissions could save around 100 lives.

114. 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]. The new standards that have been developed cover paediatric emergency services and adult

[31] Better for You, commissioning Strategy Plan 2012/13 and TSA analysis
[32] Adult emergency services: case for change
[33] Improving Health and Healthcare in London: Who will take the lead

emergency services including acute medicine, emergency general surgery, emergency departments, critical care and the fractured neck of femur pathway. Full details of the standards for each of these are outlined in appendix J. The key themes of the standards include:

- Increased consultant presence across all seven days of the week;
- Consultants on-take 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 24/7;
- 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.

Standards for maternity care

115. A 2011 study highlighted that the maternal death rate in London was twice the rate of the rest of the United Kingdom[34]. Additionally, in terms of women's experience, London's maternity services are the least well performing nationally[35]. 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. To address these issues, a clinical expert panel has also agreed a set of clinical quality standards that outline the minimum quality of care for women who deliver a baby in any unit in London. These standards have been endorsed by the London Clinical Senate and are provided in full in appendix J.

116. The key themes of the standards include:

- Obstetrician-led maternity services to be staffed to provide 168 hours (i.e. 24 hours a day, 7 days a week) of obstetric consultant presence on the labour ward;

[34] Rising Maternal Deaths in London
[35] Mother satisfaction measure from 2010 survey: Acute Trust Maternity Dashboard

- Midwifery staffing ratios to achieve a minimum of one midwife to 30 births, across all birth settings;
- All women are to be provided with one-to-one care during established labour from a midwife; 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.

117. Delivering the standards for emergency care and maternity care will be a significant challenge for providers in south east London as no trust currently meets all of them. To meet these standards, hospitals will need to increase the number of staff they have on their rotas, a challenge both due to the cost of additional staff and a lack of staff with the required skill set. However, simply increasing the number of doctors at every hospital is not the answer. Surgeons who perform a high volume of procedures tend to have better outcomes[36,37] so, even if there were the staff available to provide this increased level of cover at every hospital, doctors may not be undertaking a sufficient number of procedures to maintain their skills and expertise.

Quality benefits

118. The benefits of implementing the emergency and maternity standards as well as the community-based care proposes in south east London will be considerable, as outlined in figure 19.

[36] A systematic review of the impact of volume of surgery and specialization on patient outcome
[37] Meta-analysis and systematic review of the relationship between volume and outcome in abdominal aortic aneurysm surgery

Figure 19: Benefits of implementing the aspirations and clinical standards across south east London (Sources can be found in Appendix J)

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]	£68m investment in community based services planned to address issues[iv]
Significant health inequalities in part due to a lack of good preventative and primary care access	3.5 years difference in life expectancy between Greenwich and Bromley[ii]	37 heart attacks and strokes could be prevented each year through early detection of risk factors with improved use of NHS Health Checks[ix]
Increasing number of people living with long terms conditions which are not managed effectively	More than 1 in 4 people aged 75+ have one or more of the major long term conditions[iii]	700 lives could be saved each year through early detection and improved management of diabetes alone[x]
High rates of uncontrolled diabetes	Up to 27% of people with diabetes remain undiagnosed and 53% of those diagnosed do not have their condition controlled and therefore have a higher risk of exacerbation, amputation, stroke and other complications	The number of people with uncontrolled diabetes should be reduced by half[xi] Around 200 amputations a year could be avoided through improved diabetes management in the community[xii]
Variation in access to and quality of community based care	10% of admissions for older people could have been managed through better community based care[iv] 41% of patients do not feel they are supported enough by local services to manage their long term conditions[v]	10% reduction in emergency admissions for older people with long term conditions managed effectively in community care[iv] 85% of patients to feel supported to manage their long term conditions[xiii]
Insufficient access in primary care for urgent same-day or out-of-hours services	20% of patients do not believe that GP surgeries are open at convenient times[v]	6% reduction in A&E attendances[xiv]
High A&E attendance rates across hospitals Unnecessary admissions to hospital care	3 of the 6 boroughs are below the national average for out of hours access to primary care[vi] 44% of all emergency activity is coded as minor and could potentially have been dealt with in the community[vii]	Improvement in % of respondents to annual GP patient survey that are very or fairly satisfied with GP opening hours by 2015/16
End of life care is not always available in the patient's preferred place of death - too may people die in hospital which is not their preference	A local Coordinate My Care (CMC) pilot survey indicates that 82% of people would prefer to die at home. In 2010, just 20% of residents who died, died at home[viii]	A significant increase in the number of patients that will be supported to die in their preferred place of death by 2015/16[iv]

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

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]

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 21.5 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 19 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]

119. The application of both the community-based care aspirations and the acute clinical quality standards have been tested with the clinical advisory group, external clinical panel and the TSA advisory group, all of which supported the use of these as a platform from which to develop the draft recommendations. The use of these standards will be further validated through the consultation process.

120. The financial challenges faced by South London Healthcare NHS Trust and the wider south east London health economy set out elsewhere in this report limits the ability of providers to achieve the commissioners' standards for delivering safe and effective care. As the rest of London moves to improve the standard of care delivered, any solution for the Trust and other acute providers in south east London must not merely deliver what other health systems are doing today, but must aspire to meeting the standards that will be met across the whole of London.

6. Draft Recommendations

121. The draft recommendations put forward in this report propose a response to the long-standing issues at South London Healthcare NHS Trust (and its predecessor Trusts) and the sustainability challenges that are forecast to be facing the wider south east London system in the future. The recommendations are set in the context of the need to move towards a model of healthcare that ensures continued improvement in life expectancy and quality of life while addressing the challenges of an ageing population, the growth in the number people with long term conditions and constrained levels of funding to the NHS. Only through a response to all of these dimensions can safe, high quality, affordable health services be secured for the population of south east London in a sustainable way.

122. The scale of change required both in the Trust and across the wider health economy is significant and cannot be delivered instantly. A three-year transformation programme is recommended. Through this, the NHS in south east London will be able to deliver services within the resources available by the end of the financial year 2015/16. At this point of the UPR process, it is proposed that the transformation programme has six elements to it:

I. The operational efficiency of the hospitals that make up South London Healthcare NHS Trust needs to improve so that the Trust's costs are in line with strong performing NHS organisations.

II. Queen Mary's Hospital Sidcup should be developed into a Bexley Health Campus providing a range of services to the local population, including day case elective surgery, endoscopy and radiotherapy. The facility should be owned by Oxleas NHS Foundation Trust and services should be provided by a range of organisations.

III. Vacant and poorly utilised premises should be exited (leases) or sold (freeholds). The NHS should engage with the local authorities in Bromley and Bexley in the process of selling surplus estate to ensure its future use maximises regeneration opportunities.

IV. On an annual basis until the relevant contracts end, the Department of Health should provide additional funds to the local NHS to cover the excess costs of the PFI buildings at Queen Elizabeth Hospital and Princess Royal University Hospital.

V. In line with commissioner intentions to improve the quality of care for the local population, there should be a transformation in the way services

are provided in south east London. Specifically, changes are recommended in relation to community-based care and emergency, maternity and elective services:

- *Community Based Care* – The Community Based Care strategy for south east London should be implemented to deliver improved primary care and community services in line with the aspirations in the strategy. This will enable patients to receive care in the most appropriate location, much of which will be closer to, or in, their home.
- *Emergency care* – Emergency care for the most critically unwell patients should be provided from four sites - King's College Hospital, St Thomas' Hospital, Queen Elizabeth Hospital and Princess Royal University Hospital. Alongside this, services at University Hospital Lewisham, Guy's Hospital and Queen Mary's Hospital Sidcup will provide urgent care for those that do not need to be admitted to hospital. Emergency care for those patients suffering from a major trauma (provided at King's College Hospital), stroke (provided at King's College Hospital and Princess Royal University Hospital), heart attack (provided at St Thomas' Hospital and King's College Hospital) and vascular problems (provided at St Thomas' Hospital) will not change from the current arrangements.
- *Maternity care* – There are two options under consideration to ensure that a high quality of care is provided for women needing to be in hospital during pregnancy and for women when giving birth. Obstetric-led deliveries could be centralised in line with critical emergency care across King's College Hospital, St Thomas's Hospital, Queen Elizabeth Hospital and Princess Royal University Hospital; alternatively, there could also be a 'stand-alone' obstetric-led delivery unit at University Hospital Lewisham. All other maternity care will continue to be provided in a range of locations across south east London.
- *Elective care* – An elective centre for non-complex inpatient procedures (such as hip and knee replacements) should be developed at University Hospital Lewisham to serve the whole population of south east London. Alongside this elective day cases procedures should continue to be provided at all seven main hospitals in south east London; complex procedures should continue to be delivered at Kings' College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas' Hospital, and specialist procedures at Guy's Hospital, King's College Hospital and St Thomas' Hospital. Outpatient services should be delivered from a range of local locations.

VI. In order to deliver this transformation programme, South London Healthcare NHS Trust should be dissolved and other organisations should take over the management and delivery of the NHS services it currently provides. In addition to the proposals for Queen Mary's Hospital Sidcup outlined above:

- The Queen Elizabeth Hospital site should come together with Lewisham Healthcare NHS Trust to create a new organisation focused on the provision of care for the communities of Greenwich and Lewisham.
- There are two options for Princess Royal University Hospital. The first is an acquisition by King's College Hospital NHS Foundation Trust, which would enable the delivery of service change, enhance the services offered at the site and strengthen the capacity of the site to deliver the necessary operational improvements. This is the preferred option at this stage. However, an alternative option is to run a procurement process that would allow any provider from the NHS or independent sector to bid to run services on the site.
- It is important that these new organisations are not saddled with the issues of the past. To this end, it is recommended that the Department of Health writes off the debt associated with the accumulation of deficits at South London Healthcare NHS Trust. By 31 March 2013, this is estimated to be £207m.

123. Taken together, this proposed set of actions should improve outcomes for patients, resolve the financial issues within South London Healthcare NHS Trust and, more broadly, secure financial sustainability across the wider health economy. However, delivering this is a considerable task that will require strong leadership and implementation capacity. Further analysis will be undertaken to define the transition and implementation requirements before completion of the final report in January 2013 and in conjunction with the consultation process. However, it is already clear that transitional support will be required to allow time to implement change.

Draft recommendation I: operational efficiency

124. South London Healthcare NHS Trust is not currently using its resources efficiently. This includes the way it uses its staff, equipment and buildings. If the capability within the organisation was changed to support effective use of resources, the Trust could make savings of around £79m over the next three years. Delivering this £79m over the next three years would require the Trust

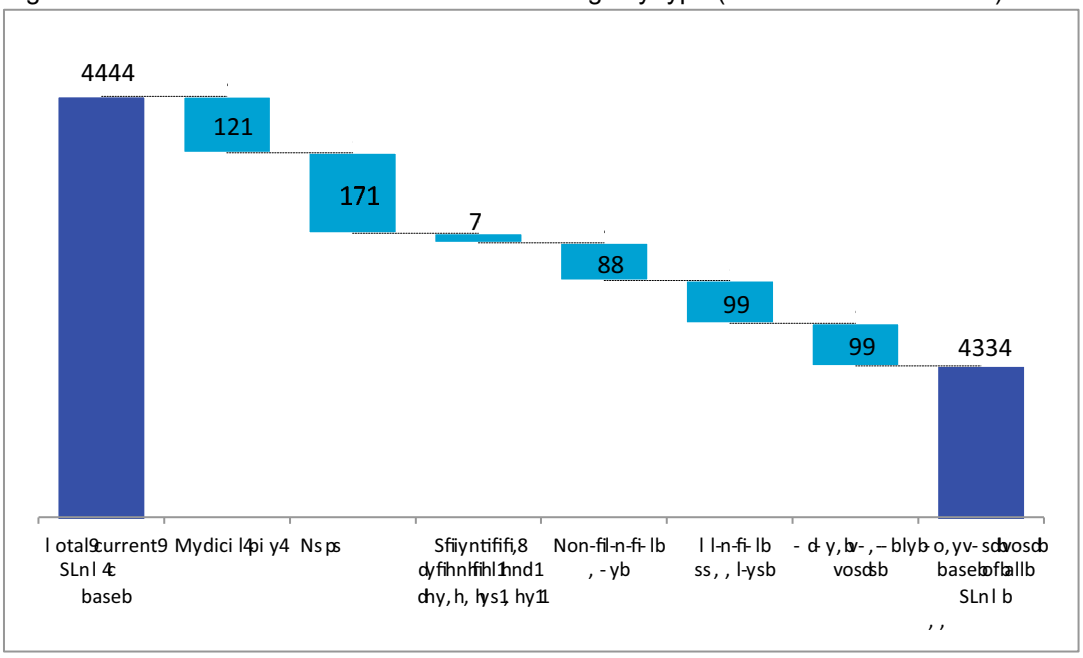
to implement a set of cost improvement programmes that realise around 16.2%, equivalent to around 5.4% per year[38].

125. This estimated productivity opportunity of £79m has been drawn from an assessment of what is required to match the productivity of peer trusts, with an additional assumption the Trust should deliver a further 2% savings per year – which represents the annual improvements delivered by top performing trusts.

126. The assessment of what the Trust would need to do in order to match its peers has been developed through two assessments of their current position (which is described in section 4). The first of these assessments benchmarked the Trust against a peer group of 18 multi-site hospital Trusts of a similar size, using a similar approach to the NHS London work on *Acute Hospitals in London: Sustainable and Financially Effective Trusts*[39].

127. Using this approach, and assuming the Trust could match the productivity of its top three peers, an opportunity of £57m was identified. Using nationally available data sets – which form the basis of this benchmarking – this £57m can be attributed to the key cost categories outlined in figure 20.

Figure 20: Breakdown of benchmarked cost savings by type (£m on 12/13 cost base)

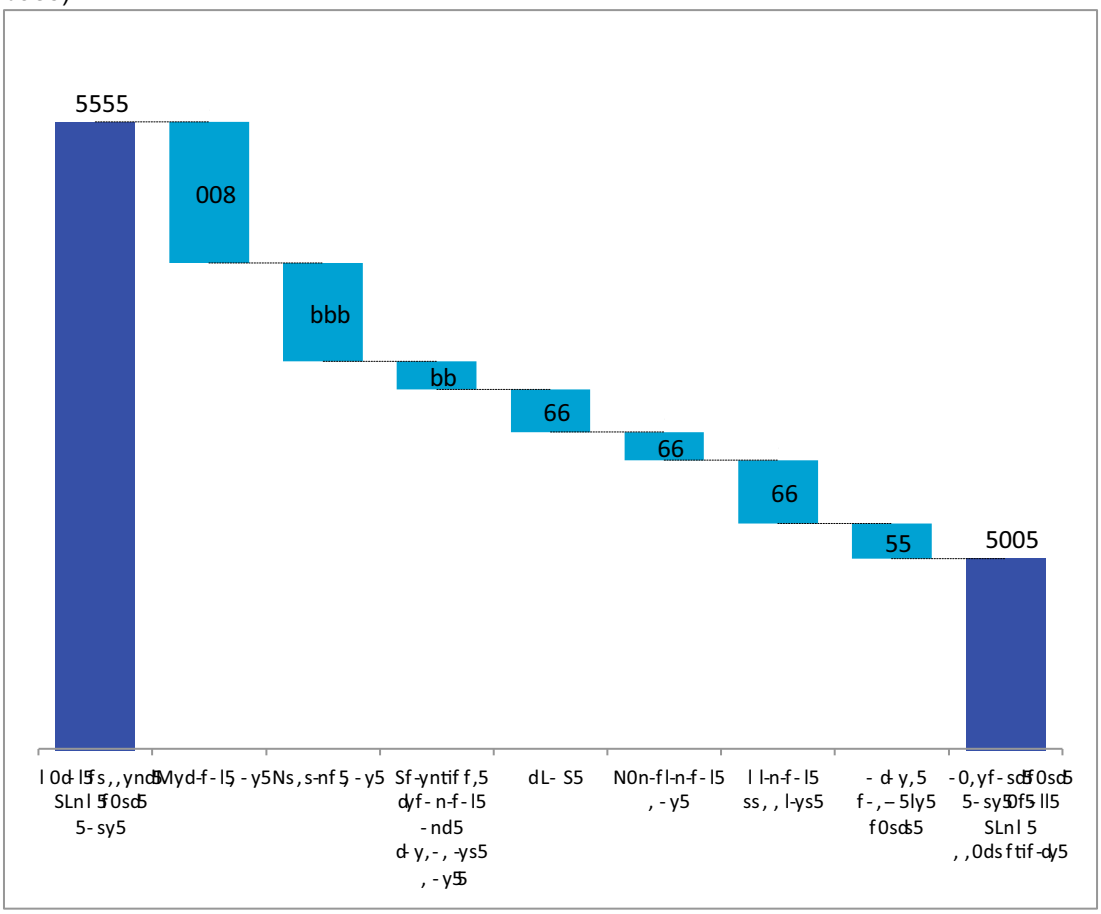


128. There are limitations to this type of analysis, not least the different mix of clinical work between peers, the quality and accuracy of the data as reported, and the potential for discrepancies in income can skew the analysis. A second assessment of the productivity opportunity was therefore also undertaken to

[38] Explanatory note: International evidence suggests that this is the maximum sustainable level of efficiency improvements over a period of more than a year, without significant service change.
[39] Acute Hospitals in London: Sustainable and Financially effective

supplement and validate the benchmarking. This process included a complete review of the variable cost base over a period of six weeks. The latest internal data, interviews and observations were used to support the assessment, which identified a savings opportunity equivalent to £62m. There were some important differences in the profile of these savings compared with the benchmarking, based on the Trust's specific opportunities. This breakdown is shown in figure 21.

Figure 21: Breakdown of cost savings from SLHT calculations, by type (£m on 2012/13 cost base)



129. The £62m savings described in figure 21 could be delivered through savings in the following areas:

- *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. This suggests that the level of activity delivered by the Trust could be achieved with a lower number of medical staff, if the productivity of other Trusts was matched. The number of medical staff relative to income should be brought into line with that of the high-performing comparator Trusts. This could allow the Trust to reduce its medical workforce by up to 140 full time staff, against a current establishment of 862

full time staff equivalents. The Trust has commenced work to ensure that the allocation of medical staff matches the patient workload and this should be accelerated. It is expected that through redesigning the way in which services are delivered there would also be a reduction in the use of locums, as well as moving to a more consultant-delivered service, which has obvious quality benefits.

- *Nursing pay (£14m):* Compared to its peer organisations, 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, which accounts for £2m of the opportunity. Nursing spend includes all nurses and midwives (including those not in ward-based roles), so there are a number of reasons for the remaining £12m gap, including a difference in the volume of non-ward based activity (for example A&E, specialist nurses). High level analysis has shown that the Trust has a lower number of A&E attendances per A&E nurse and does fewer operations per theatre nurse, supporting the view that there is a productivity opportunity. Further benchmarking at a more detailed level will need to be undertaken to identify the specific areas for action that will not compromise quality.

Within these, the review identified opportunities for savings from better theatre utilisation and more efficient use of outpatient capacity:

- *Theatre productivity:* The Trust's utilisation of theatres currently ranges from 67% to 76%. There is also considerable variation between consultants in the time it takes to complete procedures that are similar (e.g. the variation in the time taken to carry out a knee operation ranges from 103 to 200 minutes). Achieving 85% utilisation of theatres and improving the number of cases on theatre lists by reducing the procedure time by 10%, would save around £2m across medical and nursing spend and reduce the number of theatre hours required by approximately 8,000. The review has identified three key specialities in which to commence this work - these are general surgery, gynaecology and trauma and orthopaedics.

- *Outpatient productivity:* Similarly, a significant proportion of the medical productivity opportunity will be achieved by more efficient use of outpatient capacity. Reducing the number of wasted slots (when patients do not attend their appointments) to the same level as peer median or top quartile would save the Trust between £2.6m and £4.3m per annum. In other words, the Trust could treat the same number of patients with fewer resources if outpatient slots were not wasted as much as they currently are and the number of patients seen per clinic matched the top performing Trusts.

- *Scientific, Technical and Therapeutic 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. By bringing the number of full time equivalent staff in line with top performing peers, the Trust could realise around £2m in savings. In addition, the Trust has high bank spend for scientific, technical and therapeutic staff relative to its peers – and to other London Trusts – and high agency spend relative to peers.

- *Average length of stay (£6m):* Overall average lengths of stay (ALOS) 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[40]. However, there is still a gap to top quartile peers. Comparisons of overall length of stay can be misleading given differences in case-mix between Trusts. To estimate the actual opportunity in this area, the ALOS for individuals groups of patients (HRGs) in each specialty were benchmarked to peer values. 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. This opportunity in ALOS is supported by illustrating the significant variation in patient length of stay between consultants in the same specialty and for the same condition (HRG) and by estimating the considerable impact of mild reductions in ALOS for longer-stay patients. Realising this opportunity will require changes to both the internal medical model as well as improved joint working across the wider health system to reduce the time patients spend in hospital. The aspirations for this are set out in the Community Based Care strategy.

- *Non-clinical pay (£4m):* The £50m non-clinical pay spent on 'back office' staff (e.g. HR, IT and procurement) and 'middle office' staff (e.g. 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 have been assessed, using outsourcing as the primary alternative. This assessment took account of the areas that can be most easily addressed and used benchmarks for outsourcing benefits achieved in other hospitals, public sector bodies and private sector organisations. Discussions were held with potential suppliers (both on- and off-shore) for outsourced services.

[40] Explanatory note: 2011/12 South London Healthcare NHS Trust data was compared to 2010/11 peer data in calculating this, but peers may have improved during 2011/12

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

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

130. Taken together, these opportunities would reduce the Trust's costs by £62m. In addition to these productivity improvements an additional 2% per year improvement has been modelled to reflect the continuing improvement of peers over the period of the modelling, which the Trust should also deliver. These additional savings takes the productivity opportunity for the Trust over the next three years to £79m, which is equivalent to 5.4% a year.

131. Section 4 outlines that the Trust could deliver savings of only £43.3m over the next three years under current arrangements. Delivering the full £79m would require a strengthening of the current capacity and capability of clinicians and managers within the Trust. This would require cultural change across the organisation, which would need to be underpinned by a strengthening of performance and programme management and information systems. As a result of the transformation needed at the Trust, it is not plausible that it can deliver this level of operational improvement. This is a significant factor behind the draft recommendation that the Trust is dissolved.

Draft recommendation II: Queen Mary's Hospital Sidcup

132. The development of a Bexley Health Campus on the Queen Mary's Hospital Sidcup site should be supported. This should be done by transferring or selling the core part of the site to Oxleas NHS Foundation Trust who will continue to provide community and mental health services from the site.

133. Discussions around the potential to develop Queen Mary's Hospital Sidcup into a Health Campus for the local population have been ongoing for around two

years. Bexley CCG and the London Borough of Bexley now have a clear shared vision for the Health Campus, which they have shared with the TSA. This vision is supported by a set of commissioning intentions for the services to be provided from the site, which include:

- 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;
- being 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 Sidcup;
- 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.

134. It is recommended that these services are provided on the Bexley Health Campus. This should include the proposals put forward by Guy's and St Thomas' NHS Foundation Trust to provide a satellite radiotherapy unit.

135. Commissioners should also procure a range of other services including day case elective surgery (in F Block – see figure 22) which should be provided on an interim basis by Dartford and Gravesham NHS Trust while a procurement is carried out.

136. In addition to providing the services outlined by commissioners, Oxleas may wish to maximise the use of the site by providing other local services there. One example of how they could do this is to develop an inpatient mental health centre of excellence. In 2011, Oxleas created a dementia centre of excellence on the site, allowing them to develop high quality single sex wards providing clinical benefits and freeing up resources to invest in additional community services and support to care homes. In a similar way, Oxleas could establish an inpatient mental health centre of excellence for the patients of Bexley and Bromley. This would bring treatment benefits and improve patient experience. Developing the site in this way would also free up resources that could be invested in community-based services providing alternatives to admission. More detail on this proposal will be developed with Oxleas and Bexley and Bromley commissioners prior to agreeing the final recommendations.

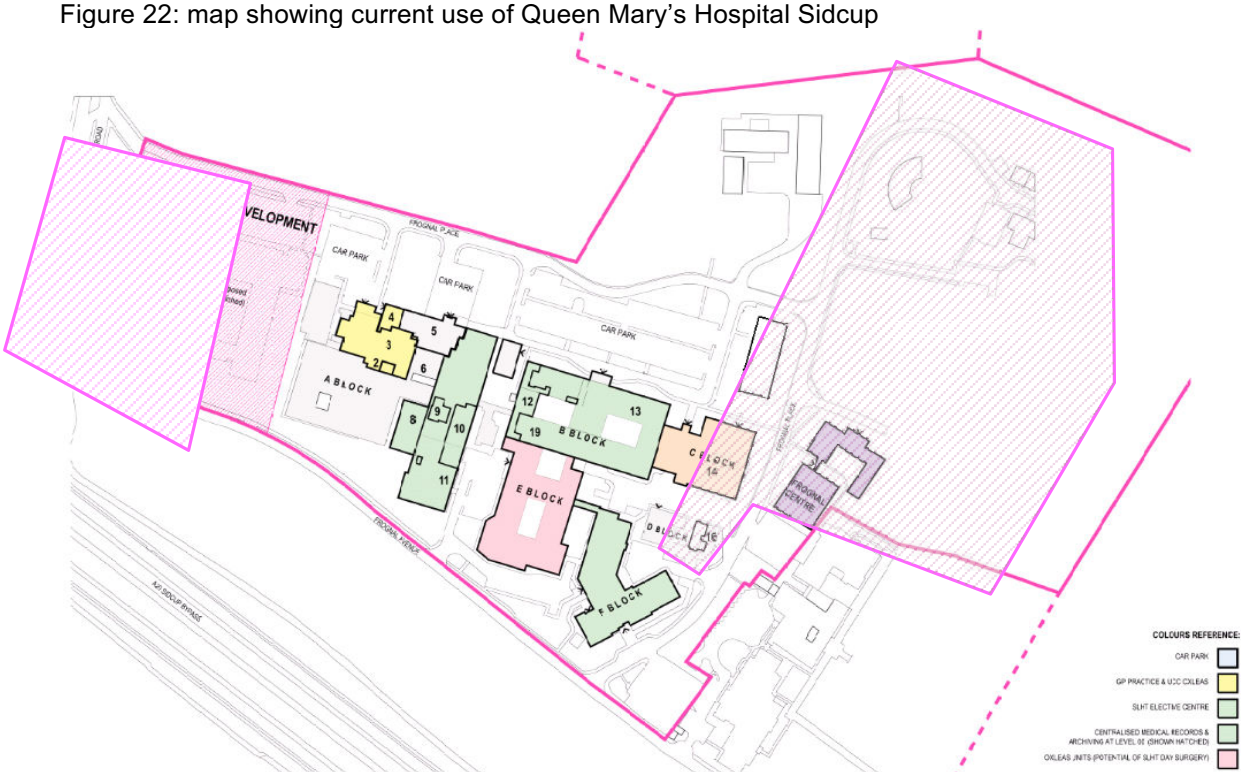
Surplus land

Surplus land

137. In implementing these proposal Oxleas would withdraw from their current lease on the Green Parks Unit on the Princess Royal University Hospital. However, they would continue to provide the recently procured psychological liaison services within the A&E in the Hospital.

138. Delivering the services that commissioners have outlined will require the current blocks A, B, C, D E and F (shown in figure 22). Following the discussions that have taken place as part of the work to develop the Bexley Health Campus and the market engagement process (see section 3), it is recommended that this core estate be transferred or sold to Oxleas NHS Foundation Trust. Oxleas already owns the PFI building on block E and currently provides urgent care, 'step up / step down' and mental health services across the site. Oxleas have also outlined that it can maximise the quality of the estate, as it has the capacity to invest in its development.

Figure 22: map showing current use of Queen Mary's Hospital Sidcup



139. Delivering the commissioner's vision for the Bexley Health Campus will mean other organisations, in addition to Oxleas, providing services from the site. Discussions on the terms of the transfer or sale of the land will therefore include a requirement for Oxleas to lease space to the other providers that win contracts to provide local health and social care services from the Health Campus. Specific examples of where this will be required are the cancer centre and the day case elective surgery and endoscopy unit.

Draft recommendation III: Estate utilisation

140. Even with the development of a sustainable Bexley Health Campus, there will be areas of the Queen Mary's Hospital Sidcup site that are surplus to NHS requirements. Sustaining vacant and under-used buildings is a waste of NHS resources, which could be better spent on patient care. Excess estate should therefore be disposed of. As the hospital has been built on 'green belt' land with a number of planning restrictions around the use of the land and the size of buildings on it, disposal of the land is more challenging than usual. However, South London Healthcare NHS Trust has already started a process of disposing of some of the excess estate and has attracted a number of expressions of interest. This process should continue and the remaining excess land (show in figure 22) should also be sold. Initial estimates suggest that this would generate a capital receipt, as well as recurrent savings of £0.7m.

141. In addition to providing services from Princess Royal University Hospital, Queen Elizabeth Hospital and Queen Mary's Hospital Sidcup, the Trust currently provides services from satellite sites that are predominantly within the boroughs of Bexley, Bromley and Greenwich. While some of these sites are owned by the Trust itself, others are paid for through long term lease arrangements, of which some attract a very high cost. Ineffective use of this estate is another area in which the Trust is overspending.

142. Work has been undertaken with the Trust and local commissioners to review the utilisation of these satellite sites. Two have been identified where a change in the Trust's use of the site is recommended at this stage. These premises are Orpington Hospital and Beckenham Beacon.

- *Orpington Hospital*: The Hospital is owned by the Trust, with a range of services and treatments provided by both the Trust and Bromley Healthcare[41]. The Trust has already recognised that the site is surplus to its requirements and has given notice to Bromley CCG and Bromley Healthcare that they intend to sell the site. This will generate recurrent savings of £1.5m.

  In order to secure the future of healthcare services in Orpington, Bromley CCG is currently consulting on proposals for a modern health service for Orpington that puts services in the best place[42]. The consultation, which is scheduled to finish on 29 October 2012, is looking to determine what the right services are for the local population and is considering from where those services should be provided. Following the consultation, the Trust

[41] Improving health services in Orpington
[42] Improving health services in Orpington

should continue to work with Bromley CCG and the London Borough of Bromley to ensure the local population continue to receive the care they need. This should include further discussions to agree the future of the site.

- *Beckenham Beacon*: The Trust currently only provides outpatient and diagnostics services from the site, but in doing so occupies around 45% of the total space. This makes the space very poorly utilised and comes at a cost of over £1.7m a year. By improving the utilisation of the space and services within Princess Royal University Hospital, the Trust will be able to provide the services considerably more efficiently from there. Discussions have therefore started with Bromley CCG on ending the lease, which will reduce the Trust's spend by £1.7m per year.

  As part of these discussions, the CCG will be considering how it can most effectively use Beckenham Beacon to support the delivery of its community-based care strategy. This may include the provision of some planned care, outpatients and diagnostics from the site. The CCG is also exploring opportunities to maximise the utilisation of the building for health and social care provision, which could include moving other local primary care and community services in as well.

Draft recommendation IV: National support in relation to excess PFI costs

143. 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%[43].

Figure 23: South London Healthcare NHS Trust PFI contracts

PFI	Site/size	Approximate Annual Cost - £m
PRUH	Bromley	30.0
PRUH – Equipment	Bromley	5.4
QEH	Greenwich	29.1
QEH – Equipment	Greenwich	4.6
QMS	Sidcup	0.8
Power	Bromley	0.1

144. The Department of Health[44] has previously recognised that the PFI contracts for the Princess Royal University Hospital and Queen Elizabeth Hospital cost

[43] Statutory Instrument 2012/1806
[44] NHS Trusts to receive funding support

the Trust substantially more per year than had they be financed through traditional public financing arrangements. These costs are not adequately recompensed by the income the Trust receives from local commissioners for the services it delivers from these buildings.

145. 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 will be submitted to the Secretary of State in January 2013, as part of the delivery of a final report. This information will remain confidential due to commercial sensitivities.

146. However, the draft recommendation is that the Department of Health provides direct support to the operator of these two sites to cover the excess costs of the PFI contracts. It is proposed that these payments cover the life of the contracts, but figure 24 sets out a draft schedule of payments covering the next seven years. A schedule covering all years will be included in the final report.

Figure 24: Draft proposed support schedule to cover (£m)

Site	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
PRUH	10.5	10.7	11.8	11.9	12.8	13.3	16.0
QEH	12.2	12.2	13.3	12.9	12.2	13.5	12.3

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

Draft recommendation V: Clinical transformation across south east London

148. Recommendations I to IV will enable a significant improvement in the financial position at South London Healthcare NHS Trust. However, implementing them neither bridges the financial gap entirely nor responds to the need to deliver improvements in the standard of healthcare, which is required to secure sustainable services for south east London. Meeting commissioners' aspirations and the standards set out in section 5 requires a major transformation in the way services are delivered.

149. The process for how options for change were considered and evaluated is outlined in section 3 and the outcome of the evaluation process is at appendix E.

Community Based Care

150. The six CCGs have developed a strategy for improving primary care and community services (appendix I). The aspirations set out in the strategy and the plans now being developed for delivering them highlight the importance of effective joint working. Integrating health and social care services to improve the co-ordination of care that patients receive is a critical component of the strategy. Effective integration of care will support 'high risk' patients to stay healthy and manage any long term conditions as effectively as possible. To deliver this, CCGs and the NHS Commissioning Board will need to work in partnership with local authorities, Health and Wellbeing Boards and providers.

151. The Community Based Care strategy includes aspirations for the future of primary care. The NHS Commissioning Board in London should work with local GPs and their CCGs to ensure that the quality of, and access to, primary care services is improved.

152. Implementation of these aspirations will see a change in the way patients receive their care. There will be more care delivered close to, or even in, patients' homes. This will stem the rising demand for hospital services and require hospitals to change the way they deliver care in order to support a more community-based, proactive model of service provision.

153. The CCGs' strategy is very much in keeping with the prevailing evidence about best models of care and advocated by leading patient charities such as National Voices. Delivering the strategy will also provide a key platform for the improvement to acute services in south east London. Detailed plans now need to be developed to ensure the clinical and financial benefits arise. Further work will be completed in advance of the final report.

Emergency care

154. In respect of emergency care, the clinical advisory group concluded that, given demand, the need to meet the clinical standards and the available financial resources, 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 should continue providing urgent care for those that do not need to be admitted to hospital.

155. Emergency care for those suffering from a major trauma, stroke, heart attack and vascular problems should not change. The location for each of these services is:
    - Major trauma services at King's College Hospital;
    - Hyper acute stroke services at Kings College Hospital and Princess Royal University Hospital;

- Heart attack services at St Thomas's Hospital and King's College Hospital; and
- Emergency vascular services at St Thomas's Hospital.

156. Building on this, a value for money assessment was reviewed by the finance, capital and estate advisory group and an assessment of options was completed by the clinical advisory group and the external clinical panel. In light of these, the draft 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 urgent care for patients that do not need to be admitted to hospital.

157. The urgent care services at Guy's Hospital and Queen Mary's Hospital Sidcup are already well established. The draft recommendation is for University Hospital Lewisham to have a 24/7 urgent care service that will treat around 77% of the people currently attending the A&E and urgent care services there[45]. This is because the vast majority of patients with urgent care needs do not need to be admitted. The types of conditions the services will be able to treat include:
    - Illnesses and injuries not likely to need a stay in hospital;
    - X-rays and other tests;
    - Minor fracture (breaks);
    - Stitching wounds;
    - Draining abscesses that do not need general anaesthetic; and
    - Minor ear, nose, throat and eye infections.

Maternity services

158. There are two options under consideration for draft recommendations relating to maternity services. In both options ante-natal and post-natal care would be provided, as now, at all hospital sites and in the community. The option of a home birth would remain open to women. The two options relate to women who need to be admitted to hospital during their pregnancy and those women who need, or wish, to have an obstetric-led delivery. The two options are whether south east London has four or five hospital sites providing obstetric-led services:

    - *The option of 4 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

[45] Explanatory note: this figure has been calculated by Lewisham Healthcare NHS Trust, based on the current activity that flows into the A&E and Urgent Care Centre at University Lewisham Hospital

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 4 sites would need to increase capacity which would require some investment.

- *The option of 5 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. However, the external clinical panel has expressed some reservations about the clinical sustainability of this model.

159. There are benefits and risks associated with each of these options (see figure 25). Therefore, the external clinical panel has recommended that further work is undertaken to examine each option. There are also different views on the expected population growth and birth forecasts within south east London over the next 3 – 10 years. Broader engagement in exploring these options will be sought through the consultation process. Agreement will be sought on the number of births forecast so that correct capacity requirements can inform the work. The outputs of this will be scrutinised by the external clinical panel and a recommendation will be made by the TSA in the final report in January 2013.

Figure 25: Benefits and risks of the two options under consideration for maternity services in south east London

Option of 4 hospital sites in south east London providing obstetric-led services	
Benefits	**Risks**
A comprehensive obstetric service with comprehensive clinical support services would be on each site that provides obstetric-led birth services.	Some women in south east London would have to travel further for obstetric-led birth services.
A critical mass of deliveries would enable hospitals to meet the 168 hour consultant obstetricians presence, as required by agreed clinical standards and supported by the Royal College of Obstetricians and Gynaecologists.	The units would need additional capital to provide additional maternity beds.
Option of 5 hospital sites in south east London providing obstetric-led services	
Benefits	**Risks**
Access and choice of location of where women give birth in south east London would be better than option of 4 hospital sites providing obstetric-led services.	In a very small number of cases women who develop complications before or during labour may need to be transferred to a hospital with full obstetrics and full support services.
The continued provision of obstetric-led service would enable the ongoing provision of a viable and sustainable co-located midwifery-led birth unit at the University Hospital Lewisham site.	Sustainability of medical staffing, particularly obstetric anaesthetists and neonatologists, at a standalone site without other emergency services, may be harder to maintain due to lower volumes of care.

160. Midwifery–led birthing units could stand alone but women generally do not choose to use them, making them financially unviable. Midwifery-led units that are co-located with obstetric units are popular and rate highly in patient satisfaction surveys. Therefore, co-located midwifery-led birthing units should be provided alongside all obstetric services in south east London.

Elective services

161. 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 or critical care support 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.

162. Options around the future provision of elective care across south east London were considered by the clinical advisory group and external clinical panel. Both groups 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 intensive or critical 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.

163. 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[46]. This separation could be provided on any hospital, subject to available capacity to develop the site to provide a dedicated elective centre.

164. 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 consider both the clinical and financial benefits of the options. Based on these considerations the draft recommendation is that an elective centre for non-complex inpatient procedures is developed at University Hospital Lewisham to serve the whole population of south east London. Alongside this, complex procedures should be provided at King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas' Hospital; and specialist procedures should continue to be provided at Guy's Hospital, King's College Hospital and St Thomas' Hospital. A range of procedures, including Day case procedures, should continue to be provided at all seven main hospitals.

[46] Elective surgery – cancellations, ring fencing and efficiency

165. It is recommended that the elective centre at University Hospital Lewisham be established in a similar way to the model at the South West London Elective Orthopaedic Centre (SWLEOC) in Epsom. SWLEOC provides a centre of excellence for the 1.5 million people in south west London. It is the largest state-of-the-art treatment centre for orthopaedic surgery in the UK and utilises the latest techniques and technology to provide high quality care, minimising infection and supporting patients return to normal in the shortest and safest way. The Centre is run through a partnership model across the four local acute trusts with a shared vision for world-class care. The four trusts provide a team of 28 consultant orthopaedic surgeons who deliver care in collaboration with the Centre's multidisciplinary teams.

166. It is recommended that the centre at University Hospital Lewisham utilises a similar model. Surgeons from across the hospital trusts within south east London could come together to share knowledge and experience, while still being employed by their 'home' trust. Funding will flow to the trust that the surgeon is employed by, with each trust participating in the partnership paying to use the services within the centre. It would also be possible to involve the independent sector in the partnership, brining further expertise and resource to develop a centre of excellence. This option requires further development ahead of the final report. However, all trusts have demonstrated real willingness to develop such an arrangement.

167. The proposed elective centre at University Hospital Lewisham would be the largest in the country, serving around 44,000 patients a year if established by 2015/16. All of these patients would continue to receive their pre- and post-surgical care at locations closer to home, in line with the CCGs' Community Based Care strategy. They would therefore only be required to travel to the elective centre for their operation. Testimonials from patients who have used 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[47].

168. The proposed elective centre provides an opportunity for the trusts across south east London to build a new centre of excellence for elective care that will deliver the population with improved outcomes and patient experience.

Impact of changes

169. Improvements to community-based care will be central to improving the quality of care across south east London. They are also key to supporting the

[47] The EOC; Orthopaedic Excellence, Annual Report 2010

implementation of the overall changes outlined in this draft recommendation. If it is implemented, the location of some services currently provided across south east London will change. These changes are outlined in figures 26 and 27. Figure 26 summarises the current location of services and figure 27 the proposed future location.

Figure 26: Services currently provided across the hospitals within south east London

PRUH	QEH	QMS	LEW	STT	Guys	KCH
Full admitting accident and emergency department	Full admitting accident and emergency department	Non-admitting urgent care centre	Full admitting accident and emergency department	Full admitting accident and emergency department	Urgent care centre	Full admitting accident and emergency department
24/7 surgical emergency admissions	24/7 surgical emergency admissions		24/7 surgical emergency admissions	24/7 surgical emergency admissions		24/7 surgical emergency admissions
Obstetric and co-located midwife-led birthing unit	Obstetric-led birth unit		Obstetric and co-located midwife-led birthing unit	Obstetrics and co-locatedmidwife-led birthing unit		Obstetrics and midwife-led birthing unit
Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	elective care and day cases	elective care and day cases	Routine elective care and day cases
24/7 emergency medicine	24/7 emergency medicine		24/7 emergency medicine	24/7 emergency medicine		24/7 emergency medicine
Critical care unit	Critical care unit		Critical care unit	Critical care unit	Critical care unit	Critical care unit
Routine elective care and day cases	Routine elective care and day cases	Routine elective and day case surgery	Day case surgery and procedures	Inpatient paediatric service		Inpatient paediatric service
Inpatient paediatric service	Inpatient paediatric service		Inpatient paediatric service	Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery
Complex inpatient surgery	Complex inpatient surgery		Complex inpatient surgery	Non-complex inpatient elective surgery	Non-complex inpatient elective surgery	non-complex inpatient elective 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
Hyper-acute stroke unit				Evelina children's hospital		Hyper-acute stroke unit
						Major Trauma Centre

Figure 27: Proposed services to be provided at south east London hospitals from 2015/16

PRUH	QEH	QMS	LEW	St Thomas	Guys	KCH
Full admitting accident and emergency department	Full admitting accident and emergency department	Non-admitting urgent care centre	Non-admitting urgent care centre	Full admitting accident and emergency department	Urgent care centre	Full admitting accident and emergency department
24/7 surgical emergency admissions	24/7 surgical emergency admissions			24/7 surgical emergency admissions		24/7 surgical emergency admissions
Obstetric and co-located midwife-led birthing unit	Obstetric-led birth unit		Potential obstetric and co-located midwife-led birthing unit	Obstetrics and co-located midwife-led birthing unit		Obstetrics and midwife-led birthing unit
Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Elective care and day cases	Elective care and day cases	Routine elective care and day cases
24/7 emergency medicine	24/7 emergency medicine			24/7 emergency medicine		24/7 emergency medicine
Critical care unit	Critical care unit			Critical care unit	Critical care unit	Critical care unit
Routine elective care and day cases	Routine elective care and day cases	Day case surgery	Day case surgery and non-complex elective surgery	Inpatient paediatric service		Inpatient paediatric service
Inpatient paediatric service	Inpatient paediatric service			Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery
Complex inpatient surgery	Complex inpatient surgery				Non-complex inpatient elective 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
Hyper-acute stroke unit				Evelina children's hospital		Hyper-acute stroke unit
						Major Trauma Centre

Access to emergency services

170. Ensuring fast and effective emergency and urgent care is essential for patients. The work already completed across London has made significant improvements to the services provided for patients needing emergency care for major traumas, strokes, heart attacks and vascular emergencies. The way these services are provided is not impacted by the draft recommendations. Patients will continue to be taken to the most appropriate location by the London Ambulance Service, based on agreed London-wide protocols.

171. Under this draft recommendation, emergency and urgent care will continue to be provided at King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas's Hospital. Patients will also still be able to access urgent care services across all seven main hospitals in south east London. The well established urgent care services at Guy's Hospital and Queen Mary's Hospital Sidcup will remain in place, and University Hospital Lewisham will continue to provide 24/7 urgent care services. It is estimated

that around 77%[48] of the patients that currently attend University Hospital Lewisham for emergency or urgent care would be able to continue receiving their treatment from the urgent care centre. This means that around 70 people per day, who would currently attend University Hospital Lewisham, will be taken to a different location by London Ambulance Service, self-select to attend elsewhere or will be treated, stabilised and then transferred. This treat-and-transfer approach is already used in many locations, including University Hospital Lewisham.

172. Currently around 315 patients arrive to be seen at University Hospital Lewisham's emergency and urgent care services each day[49]. Of these around 3 arrive in a 'blue light' ambulance[50] and will be taken to an alternative location, 79 arrive in an ambulance without a blue light, and the remaining arrive via private or public transport. Approximately 243 of the 315 patients would still attend the Hospital if the proposed draft recommendations are implemented.

173. The proposals for emergency care outlined in this draft recommendation would increase the journey time to reach an A&E across south east London by an average of approximately 1 minute for those in an ambulance, 2 minutes for those using private transport and 3 minutes for those using public transport. This is shown in figure 28, which also includes the impact on travel time for those who are most affected (the 95th percentile[51]).

Figure 28: Impact of draft recommendation V 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[52]	23.0	25.2	2.2	36.0	38.0	2.0
Public transport[52]	32.9	35.7	2.7	52.5	53.6	1.1

174. As the proposed changes are for those who are critically unwell, travel times to emergency services for 'blue light' ambulances are very important. The London-wide programme to improve stroke services[52] concluded that the journey time to the required emergency services should be 30 minutes or less

[48] Data provided by Lewisham Healthcare NHS Trust
[49] Data provided by Lewisham Healthcare NHS Trust
[50] 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
[51] 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.
[52] The shape of things to come

in a 'blue light' ambulance. Similarly, for major traumas it was recommended that the journey times should be 45 minutes or less[53].

175. Using 30 minutes as the benchmark for accessing emergency services, figure 29 shows how many patients in south east London can reach an A&E department within 30 minutes in a 'blue light' ambulance if draft recommendation V were to be implemented.

Figure 29: 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 V were implemented	>95	>85	>65

176. Recognising that the population of Lewisham are likely to be most impacted by the draft recommendation, as they make up 75% of the attendances at University Lewisham Hospital A&E, figures 30 and 31 outline the impact of the proposals on journey times if the draft recommendation were to be implemented.

Figure 30: impact of draft recommendation V 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[55]	19.7	30.7	11.0	27.0	40.0	13.0
Public transport[55]	26.7	40.8	14.1	40.1	51.2	11.1

Figure 31: 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 V were implemented	>95	>95	>70

177. Travel times to emergency services in south east London, including for the residents of Lewisham, would continue to be very good if this draft recommendation was implemented.

Clinical and financial benefits

178. The clinical benefits for implementing the changes in this draft recommendation have been described in figure 19, in section 5. Improving acute clinical

[53] The shape of things to come

standards for emergency services could save 100 lives a year just 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 and the number of cancelled appointments would reduce. Many more opportunities to improve quality of care, outcomes, patient experience and health inequalities could be realised.

179. Alongside the assessment of clinical benefits, the financial benefits of implementing this recommendation has 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.

180. Doing a value for money assessment of this draft recommendation has been considered using the assumptions outlined in appendix K. In order to maximise the use of current NHS buildings and equipment across south east London, the potential use of University Hospital Lewisham has been considered in more detail. This has identified that although some of the site will continue to be required (including the Riverside Building) in order to provide effective services for the local population, some of it will be surplus to requirement and would need to be disposed of. Further consideration has been given to how to maximise the use of existing estate across south east London.

181. The results of the value for money assessment of implementing draft recommendation V indicate that it would require as investment of capital that totals £77.3m (this does not take account of disposal proceeds that would reduce this number) and also transitional costs of £46.6m. However, as a result of fixed cost savings and operational improvements there would be an

annual benefit of £26.9m across the whole of south east London. Calculated as a Net Present Value this is equivalent to £257m for the whole of south east London.

182. These benefits will continue to be reviewed and developed to inform the final recommendations. This will take account of the feedback from the consultation and the ongoing work to develop the most effective clinical models.

Draft recommendation VI: Organisational solutions

183. It should be recognised that the staff within South London Healthcare NHS Trust have and do work hard to deliver high quality care to patients. Indeed, there have been significant improvements in the quality of care in recent years as set out in section 4. However, since 2009 the clinical and managerial leadership of the Trust has not been successful in integrating operations across the three main sites. Nor has it been able to transform and embed a culture capable of delivering operational efficiency and high quality care. Sustainable healthcare organisations need the capacity and capability to do both of these out of respect to both the patient and the tax payer.

184. Therefore, draft recommendation VI is that South London Healthcare NHS Trust be dissolved and the Trust's assets, services and staff become part of other organisations. The approach and process for how the market – NHS and non-NHS – was engaged and options for change evaluated is described in section 3. This process has informed the development of draft recommendations in response to the proposed dissolution of the Trust. The pace of implementing new organisational solutions will be critical to delivering the changes proposed in draft recommendations I to V. Delivering improvements in a three year period is critical to ensure organisations in south east London are able to respond to further financial constraint in the public sector. Meeting the challenging timetable will require appropriate leadership capacity and clarity for staff. As a result, the speed of being able to implement a new organisational arrangement has been a core component of this work.

Queen Mary's Hospital Sidcup

185. Draft recommendation II sets out the proposals for the future of Queen Mary's Hospital in the context of the development of a Bexley Health Campus. The site should be owned and run by Oxleas NHS Foundation Trust. Under Oxleas' leadership the hospital will have a sustainable future, providing the services that commissioners have identified are required for the local population and a centre of excellence for inpatient mental health services across Bexley and Bromley.

186. The majority of services currently provided from the site will continue to be provided there, with some new services being added – specifically a satellite radiotherapy unit to be provided by Guy's and St Thomas' NHS Foundation Trust. As per draft recommendation V, day case elective surgery and endoscopies, both 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 of care for the future. In the interim, the draft recommendation is for Dartford and Gravesham NHS Trust to be the provider of these services. The small number of inpatient elective procedures that currently take place at Queen Mary's Hospital (around 2,000 per year) should be consolidated with the elective surgical work for south east London in the proposed elective centre at University Lewisham Hospital. As outlined in draft recommendation V, further work will be undertaken to explore a partnership model for the delivery of services that would see services being provided by a range of organisations on the University Lewisham Hospital site, for which the outpatient services would be available on the Bexley Health Campus.

Queen Elizabeth Hospital

187. Through the market engagement process, Lewisham Healthcare NHS Trust expressed a strong interest in taking over the 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 section 4 have shown that Lewisham Healthcare NHS Trust will struggle to be financially sustainable in the long term. With the additional impact expected from the implementation of the service changes outlined in draft recommendation V, it is clear that Lewisham Healthcare NHS Trust would benefit from being part of a larger organisation.

188. Taking into account the financial projections, the need for sustainable services and Lewisham Healthcare NHS Trust's interest in contributing to the solution, the draft recommendation is to support the Trust in setting up a new organisation that provides services to the populations of Lewisham and Greenwich. This new organisation will need to be capable of implementing the final decisions of the Secretary of State in regards to this process. Through work with Lewisham Healthcare NHS Trust, a proposed model for the provision of clinically and financially sustainable healthcare services across Greenwich and Lewisham is being developed.

189. The developing proposal envisages an organisation that provides a range of acute and community services across Greenwich and Lewisham. A range of

hospital services will be provided at Queen Elizabeth Hospital. This will include emergency services (including surgery), complex elective and day case surgery and maternity services (including obstetric-led and midwife-led services). A different set of services will be provided at University Hospital Lewisham. This will include 24/7 urgent care services, rehabilitation (including patients recovering from strokes) and intermediate care and day case elective surgery. In addition to this, University Hospital Lewisham would host the proposed non-complex inpatient elective surgery unit for the whole of south east London. Subject to the discussions around maternity services, outlined in draft recommendation V, an obstetric-led maternity unit and co-located midwife-led birthing unit may also be at University Hospital Lewisham. Outpatient services will continue to be provided from both hospitals.

190. Work on the proposed model will continue, to inform the final recommendations. This will take into consideration the outcome of the consultation, as well as further discussions with the external clinical panel.

191. In line with the criteria for evaluating options for organisational solutions, this will deliver the standards for the quality of care set out by commissioners and address in full the efficiency challenges that are required to deliver the financial improvements. This would include delivering the productivity opportunities identified for the two hospitals. Drawing on the excellent leadership within Lewisham Healthcare NHS Trust will mean the proposed changes can be implemented at pace. Lewisham Healthcare NHS Trust 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, as outlined in the commissioners' Community Based Care strategy.

192. More detailed work on this will be undertaken between now and the final report in January 2013. But initial modelling demonstrates that this merged organisation will be clinically and financially sustainable going forward and ought to be capable of achieving foundation trust status. It also has, at this stage, the support of local commissioners.

Princess Royal University Hospital

193. Modelling on the potential of Princess Royal University Hospital as a future standalone organisation, after the implementation of service changes proposed in draft recommendation V, suggests that it could be a viable organisation, but only if it can fully capture the future productivity opportunities for the site that total £33.3m. Section 4 highlighted that the current leadership within South London Healthcare NHS Trust, including those responsible for managing services at Princess Royal, is not capable of delivering savings to this scale.

From the alternative options that were considered through the market engagement process, two options have emerged as potential future solutions for both owning the site and managing the services there.

194. The first (and preferred) option is for King's College Hospital NHS Foundation Trust to acquire the Princess Royal University Hospital site and its services. Under this option, King‘s would take on the ownership and management of the hospital and be responsible for delivering the productivity improvements identified in draft recommendation I, and the proposed service changes outlined in draft recommendation V. King’s is a well-established NHS Foundation Trust with a track record of delivering high quality acute care and 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, and experience of delivering significant productivity improvements, including £40m of cost improvement programmes over each of the last three years.

195. Options for implementing this, from as early as April 2013, are being considered, subject to the proposed acquisition meeting NHS regulatory requirements and meeting a timetable for Monitor to consider the proposed business case. Implementing to this fast timescale will enable King’s 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. King’s 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.

196. Discussions with King’s have indicated that they would be fully committed to the partnership model for the elective centre at University Hospital Lewisham proposed in draft recommendation V 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 Lewisham and Greenwich organisation to consider how to use rehabilitation services at University Hospital Lewisham effectively, where King’s currently uses a ward to provide inpatient rehabilitation services.

197. The second option is 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 are 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.

198. Under the option of the franchised model, NHS staff are 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.

199. 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.

200. 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.

Historic debt

201. 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 draft report recommends the writing off of the debt owing to the Department of Health due to the accumulation of deficits in South London Healthcare NHS Trust. It is estimated that this debt will be £207m by the end of March 2013.

Summary of impact of draft recommendations I to VI

202. Taken together these six draft recommendations provide a platform for delivering the commissioners aspirations for improved health and health outcomes whilst resolving the financial issues of the current hospital providers. The initial estimate of financial savings attributed to each of the draft recommendations is outlined in figure 32. The detail is provided in appendix K. The work is on the basis of a three year transformation programme, with the aim of ensuring financial viability by the end of 2015/16. There is clearly more work to be done prior to the final report. However, it is clear that this set of draft

recommendations has the potential for resolving the challenges of south east London that have plagued the health economy for many years.

Figure 32: Financial impact on a recurrent basis by 2015/16 of the draft recommendations

Currency: £ m	PRUH	QEH	QMS	SLHT Total	Lewisham	SEL Total
Recommendation I						
Future Productivity	15.0	15.0	5.4	35.4		35.4
Recommendation II						
Oxleas Acquisition			5.4	5.4		5.4
Recommendation III						
Sale of Surplus Capacity QMS			0.7	0.7		0.7
Exit Orpington	1.5			1.5		1.5
End Beckenham Beacon Lease	1.7			1.7		1.7
Recommendation IV						
PFI Support	11.8	13.3		25.1		25.1
Recommendation V						
Clinical Transfer	3.9	9.8		13.7	3.6	17.3
Total	**33.9**	**38.1**	**11.5**	**83.5**	**3.6**	**87.1**

203. Figure 33 demonstrates that through these draft recommendations the benchmark test for financial viability (achieving 1% surplus) could be achieved at all main hospitals in south east London.

Figure 33: Hospital financial viability in 2015/16

Currency: £ m	PRUH	QEH	QMS	SLHT Total	Lewisham	SEL Total
Gap to 1% in 2015/16	30.2	37.4	11.5	79.1	3.0	82.1
Impact of Recommendations	33.9	38.1	11.5	83.5	3.6	87.1
Distance over target to 1%	3.7	0.7	0.0	4.4	0.6	5.0

Transition and implementation

204. It will not be possible to implement these recommendations, if agreed, immediately as they involve change across the whole healthcare system in south east London. The draft recommendations set out that the changes should be implemented through a three-year programme of change. Achieving this will require the whole system to work together. This will involve making improvements to community-based care, including strengthening the provision of primary care and community services and ensuring services are integrated with social services, acute hospitals and other providers. It will also require a focus on operational efficiency, with hospitals operating effectively seven days a week.

205. Delivering these changes will require clear and detailed planning together with effective management of each strand of the implementation programme. Through the next stage of the TSA process, work will continue to understand the full impact of delivering the draft recommendations. This work will consider the requirements for delivery, including the key drivers and facilitators of change. This will include looking at requirements for workforce (including training and education), information and IT systems, organisational development, governance, performance management and incentives.

206. Successful delivery to realise the benefits outlined within the draft recommendations will also require significant leadership focus and resource.

207. It is expected that during the implementation programme Queen Elizabeth Hospital and Princess Royal University Hospital sites will deliver deficits for 2013/14 and 2014/15. Through the course of the consultation process and in advance of the completion of the final report, more work will be done to develop the final recommendations in regards to transition support and implementation requirements.

7. Developing the final report

208. A significant amount of work has been undertaken in the 75 working days since 16 July 2012. This has been possible because a large number of individuals and organisations have engaged in this programme and supported the work. This has included the active participation of people in working and advisory groups, clinicians and managers making the time to attend workshops, financial and estates colleagues from across south east London supporting the financial and capital analysis and a range of organisations providing input through the market engagement process.

209. This draft report outlines the output of these efforts at this stage. The next step is to seek broader engagement on this draft report through the consultation process. This should allow the draft recommendations to be validated and improved in advance of finalising it for the Secretary of State. It is also the opportunity for other evidence and ideas to come forward to support the resolution of the challenges facing south east London.

210. The requirements for consultation have been clearly defined within the legislation surrounding the Regime for Unsustainable NHS Providers. In line with the requirements and building on the advice from those who have engaged with the process so far, the detail of how this consultation will be delivered is provided in the TSA Consultation Plan at Appendix L. The consultation will take place over a 30 working day period, running from 2 November to 13 December 2012, after which the feedback will be analysed in order to inform the final report to the Secretary of State, due on 7 January 2013.

211. The importance of considering stakeholder opinion and the deliverability of the final recommendations has been highlighted through their inclusion as evaluation criteria for the recommendations (see section 3). Alongside the consultation, work with stakeholders will continue in developing the detail for each draft recommendation and in considering the most effective and efficient ways to implement them. Developing an implementation proposal for the delivery of the recommendations over the next three years will be a central part of this work.

212. Developing the draft recommendations further in this way will enable the final report to be as rich as possible, thereby supporting the Secretary of State to make his decision by 1 February 2013.

8. 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 services 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. References
B. The case for applying the regime for unsustainable providers – South London Healthcare NHS Trust
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F. Stakeholder engagement
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To download these appendices please visit www.tsa.nhs.uk/document-downloads

Southwark Council

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22 November 2012

Dear Community Leader

Call for Evidence: Kings Health Partners potential merger and the Special Administrator recommendations for the South London Healthcare NHS Trust

Southwark Council's Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee is inviting evidence on the proposed merger of Kings Health Partners and the Trust Special Administrator (TSA) recommendations for South London Healthcare NHS Trust and the wider South East London healthcare system.

The scrutiny committee will be jointly meeting with Lambeth Health Scrutiny committee on the evening of 5th December 2012 at 160 Tooley Street, London, SE1 2QH. This meeting will formally consider evidence on the proposals.

Kings Health Partners potential merger

The management boards of Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS foundation trusts are exploring plans for an organisational merger and a strengthened partnership with King's College London, their joint academic partner. The new organisation would have a turnover of about £2.6 billion and around 29,000 staff. The proposal is set out in a Strategic Outline Case, which was approved by each of the Boards and King's College London. The four organisations have collaborated for many years and were accredited by the Department of Health as an academic health sciences centre, King's Health Partners (KHP), in 2009.

KHP cite the good examples of better care for patients across the three trusts and better research being undertaken and translated into treatments that have already been achieved through the creation of an academic health sciences centre. Their proposal to merge is based on accelerating these benefits and removing what they consider are structural and cultural obstacles to greater collaboration.

The Strategic Outline Case can be downloaded at www.kingshealthpartners.org.

Southwark scrutiny is undertaking this work to ensure
both the potential risks and full costs are understood, as well as the benefits, and these are properly considered by everybody potentially affected by this proposed merger. Evidence is being invited from residents, service user groups, funders, local LINKs/ Healthwatch, unions, MP's and any other relevant stakeholders. The committee will consider all submissions before making our formal recommendations.

Trust Special Administrator recommendations for the South London Healthcare NHS Trust and south east London health system.

The South London Healthcare Trust is made up, principally, of Queen Elizabeth's Hospital in Greenwich, Queen Mary's in Bexley and Princess Royal in Bromley. The three hospitals have long-standing financial issues, including Private Finance Initiative (PFI) liabilities – which account for 16% of the Trusts income. The current deficit of the Trust is £207m.

In July 2012 the Secretary of State for Health enacted, for the first time, the "Regime for Unsustainable NHS Providers" on the Trust, dissolving the previous Board of the Trust and inviting a Trust Special Administrator (TSA), Matthew Kershaw, to develop recommendations.

The draft report is now out for consultation until 13 December 2012. The draft recommendations are for both the Trust and the wider south east London healthcare system. Southwark residents will be directly and indirectly affected.

Significant draft recommendations include:

1. An elective centre for non-complex inpatient procedures (such as hip and knee replacements) at University Hospital Lewisham to serve the whole population of south east London. The proposed elective centre at University Hospital Lewisham would be the largest in the country, serving around 44,000 patients a year if established by 2015/16. This could be delivered as a partnership between local trusts, and possibly an Independent provider.

2. A Community Based Care strategy for south east London.

3. Princess Royal University Hospital has two options. The first is an acquisition by King's College Hospital NHS Foundation Trust. This is the preferred option at this stage. The alternative option is to run a procurement process that would allow any provider from the NHS or independent sector to bid to run services on the site.

4. University Hospital Lewisham will no longer have an Emergency care centre, and instead the hospital would have an urgent care centre. Maternity services would also be downgraded.

5. It is recommended that the Department of Health writes off the debt associated with the accumulation of deficits at South London Healthcare NHS Trust. By 31 March 2013, this is estimated to be £207m. In addition to this there will be ongoing direct support to the operators of Princess Royal University Hospital for 25 years and Queen Elizabeth Hospital for 22 years. This will amount to approximately £564,000,000 to cover excess PFI payments for the lifetime of the PFI contracts.

The summary and full draft report can be downloaded here www.tsa.nhs.uk/ Our committee will also consider these recommendations on the 5th December, we are therefore also seeking your views on the TSA's proposals to inform our work on this issue.

The TSA will be holding a public meeting on the proposals on **Tuesday, 27 November 7 pm to 9 pm at Cambridge House**, 1 Addington Square, Camberwell, London SE5 0HF

How to give evidence

Written evidence can be submitted via email to scrutiny@southwark.gov.uk, or at the address at the top of the page, and should ideally be submitted by **30 November 2012**, in time for the meeting on 5 December. However, evidence can still be considered up until 10 December. This is to allow the committee to consider submissions before making our formal response to both the KHP merger, and the TSA recommendations for South London Healthcare Trust whose consultation period ends on 13th December 2012.

Further information

If you have any queries or access issues, please contact scrutiny project manager Julie Timbrell on 0207 525 0514 or julie.timbrell@southwark.gov.uk.

Yours faithfully

Cllr Mark Williams
Chair; Southwark Council's Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

King's Health Partners

Strategic Outline Case:
creating a single academic healthcare organisation

July 2012

CONTENTS

EXECUTIVE SUMMARY

1. King's Health Partners, accredited by the Department of Health as an Academic Health Sciences Centre (AHSC) in 2009, is a partnership between King's College London (KCL) and three NHS Foundation Trusts: Guy's and St Thomas' (GStT), King's College Hospital (KCH) and South London and Maudsley (SLaM). In February 2012 the four partners agreed to look at the case for creating a single academic healthcare organisation. The partners are in a position of strength but the proposition is that the new organisation could achieve more and at greater pace, allowing King's Health Partners to respond to a changing world and the future needs of patients.

2. If the health challenge of the last century was the treatment of infectious disease, this century's challenge is dealing with long-term conditions. Diabetes rates, for example, are expected to grow by 60% over the next 20 years. Many more people have both physical and mental health challenges. This is particularly the case in the kind of deprived and diverse communities that King's Health Partners serves across south London, where levels of health inequalities are high.

3. But the health system has not kept up with these changes. It remains focussed on disease and illness rather than promoting health and wellbeing. The mind and the body are treated separately. Services are fragmented and not always patient-centred. Research and education can appear quite distant from the reality of healthcare problems. As an integrated organisation, King's Health Partners would be better able to develop a new model of healthcare to help meet this challenge and improve the quality of life for our patients.

4. The academic world is also changing. Global competition for the best students, research talent and resources is increasing. At the same time, medical research is becoming increasingly complex, which requires organisational scale and a broad range of expertise.

5. The wider economic context presents a further serious challenge. While demand for healthcare and the costs of healthcare are rising, NHS funding may, at best, be held steady for the next decade. This means the NHS needs innovative new models of healthcare that radically improve value for the patients and the system.

6. So although King's Health Partners has achieved a great deal in its current form, we believe we could respond better to this changing environment if we created a more integrated organisation. This would enable us to align our priorities, give us greater financial flexibility, make it easier to work with local partners, and give us the organisational scale to transform how we work. As a result, we could more effectively achieve our vision.

7. **Our vision for the new organisation is to be a leader, locally and globally, in improving health and wellbeing**. **We aspire to be one of the top ten global academic healthcare organisations and to bring these benefits to our local communities, patients and students.**

8. King's Health Partners is uniquely positioned to do this because it brings together three successful trusts, with mental health at the core, with a leading university, all serving one of the most diverse and challenged communities in the country.

9. Working closely with partners across the health and care system and beyond, we have six goals for the new organisation:

   - **Provide care around people's needs.** We will aim to work in partnership across the health and care system to integrate care around the patient, and to overcome traditional distinctions between mind and body (for example, through routine screening for depression, alcohol and dementia). Better understanding people's full care needs will enable us to provide better value care in more appropriate settings.
   - **Keep people well.** Intervening earlier and working with our partners, including patients themselves, we hope to develop new approaches to the main health challenges of our local population, such as alcohol and childhood obesity.
   - **Provide the best specialist care when it is needed.** By bringing together our specialist services we aim to improve patient outcomes for the most pressing health challenges our communities face and to enhance our research.
   - **Train the workforce of today and tomorrow.** Through better teaching and facilities, we hope to produce the highest quality graduates and develop our staff to their full potential. To help shape the healthcare workforce of the future, we will develop new ways of learning and new professional roles.
   - **Turn world-leading research into treatments as quickly as possible.** We aim to speed up translational research to create new drugs and treatments that benefit our local patients first. We will seek to develop new research opportunities by working with our diverse local population and by using the strengths across our university.
   - **Build prosperity for our local communities and the UK.** We aim to attract new commercial, fundraising and grant income, which will help contribute to the local economy through new jobs and investment. We will seek to improve the productivity of all our services, and reinvest these savings in better care.

10. **To achieve this vision we propose creating a single organisation through the merger of the three NHS Foundation Trusts (with mental health at its core), enhanced by closer integration with KCL and a stronger academic ethos**. **This would create the UK's most integrated and innovative academic healthcare organisation.**

11. We envisage that the new organisation would deliver benefits for our patients, public, staff, students, commissioners and other providers, including:

    Better health

    - **More integrated care**. Integrating care across the new organisation would help ensure patients' full mental and physical needs are met, for example by addressing the physical health needs of patients with serious mental illness, and through earlier identification and treatment of the 40% of hospital inpatients with dementia.
    - **Better patient experience**. A shared electronic patient record across the new organisation could help engage patients in their own care, avoid them having to repeat information unnecessarily, and improve patient safety.
    - **Better patient outcomes**. Consolidating certain specialist services could lead to better patient outcomes, because of the close relationship between quality and numbers of patients treated.

Better research and education

- **Higher quality research**. Locating academic and clinical staff and services together would encourage innovation in research and new medical breakthroughs that can swiftly be turned into improved patient care.
- **Better educational experience**. Better teaching, facilities and career opportunities would improve the educational experience and help King's Health Partners attract the best students and staff.

Better value

- **Better use of physical space**. Working more closely with community and mental health services would enable services to be brought closer to patients, and help the new organisation to make more efficient and creative use of its estate, which is made up of more than 225 locations across south London and beyond.
- **More efficient services.** The new organisation would enable us to improve value for money for patients and taxpayers across the health and care system. Estimates suggest 3-5% savings in non-clinical support functions alone could be achieved in the new organisation, which could be reinvested in better care for patients.
- **New jobs and investment**. The new organisation would help to attract new investment in our local communities from industry, fundraising, and grant-makers, helping create new jobs and encourage regeneration.

12. We recognise that an organisational change of this scale is a significant undertaking and that people will have a number concerns and questions, some of which are set out below.

- **Would merger lead to local services closing?** Core local health services would continue to be provided on multiple sites, for example, the two Accident and Emergency departments and two maternity units would remain in their current locations.
- **Would mental health issues be less prominent?** Mental health is central to the vision of the new organisation. We would aim to lead the UK in demonstrating equal treatment for mental and physical health at every level of the new organisation, and develop new ways of caring for patients with both mental and physical health needs.
- **Would academic issues be neglected?** A defining characteristic of King's Health Partners is academic excellence. This would be reflected in the organisational model at every level.
- **Would this change affect organisational performance?** We would put measures in place to try and minimise disruption to business as usual, including a dedicated transition team to oversee the merger planning and implementation.
- **Would the new organisation be too inflexible?** Organisational scale gives us the opportunity to transform the business, for example by developing delivery arms organised around patient pathways or population groups, which could be more autonomous and flexible in how they work.
- **How would cultural and staff issues of integration be handled?** If we proceed to the next stage of the process, engaging with staff to understand their priorities and concerns would be a high priority. We would work with them to build the culture and values of the new organisation, drawing on the best of the existing institutions.

13. Further detailed work would need to be undertaken at the next stage, but on the basis of the preliminary assessment undertaken in this paper we believe that the benefits of the new organisation outweigh the costs and risks. If the partner organisations decide to proceed on the path to establishing this new organisation, the next step would be to create a Full Business Case by early 2013. We estimate that the new organisation could be in place at the earliest by late 2014.

1. BACKGROUND AND PURPOSE

1.1 King's Health Partners Academic Health Sciences Centre (AHSC) is a pioneering collaboration between King's College London (KCL) and three NHS Foundation Trusts (FTs): Guy's and St Thomas' (GStT), King's College Hospital (KCH) and South London and Maudsley (SLaM). King's Health Partners is one of only five accredited AHSCs in the UK and brings together an unrivalled range and depth of clinical and academic expertise, spanning both physical and mental health.

1.2 In February 2012 the four partner organisations unanimously endorsed a recommendation from the King's Health Partners Board to prepare a Strategic Outline Case (SOC) to assess the case for establishing a single academic healthcare organisation.

1.3 This recommendation followed two reviews commissioned by the King's Health Partners Board last year.[1] These reviews explored a number of organisational options for how King's Health Partners might accelerate its progress but concluded that creating a single academic healthcare organisation (i.e. merger of the three FTs and closer integration with KCL) was most likely to help us achieve our goals.

1.4 The partners, three successful Trusts and a leading university, are in a position of strength. Unlike many mergers this discussion is not being driven by the need for financial savings, although this could be a significant benefit. The proposition is that an integrated organisation could achieve more and at greater pace and that these benefits would translate directly into greater social value for the communities and patients that we serve.

1.5 This SOC is seeking to answer four questions:

- **What is the rationale for organisational integration?** (Sections 2 and 3)
- **What is the preferred organisational model?** (Section 4)
- **Do the benefits outweigh the costs and risks?** (Sections 5, 6 and 7)
- **What is the forward plan to achieve organisational integration?** (Section 8)

1.6 In the process of developing this SOC we have engaged a wide variety of groups and individuals to seek their views and to understand their concerns. They included staff, governors, commissioners, local authorities, MPs and other stakeholder groups. All have engaged in a thoughtful and constructive way. We hope this has helped us write a document that is clear about the benefits and addresses some of the concerns that have been voiced.

1.7 The next stage of the process would be accompanied by a broader and deeper engagement with all of our stakeholders, alongside a full public consultation at the appropriate stage. We hope to work in particular with our local partners in the health and care system to develop innovative ideas about how we might most effectively achieve our goals around integrated care and population health.

1.8 If the four partners agree to the recommendation of the SOC, we will proceed to the development of a Full Business Case. We recognise that further detailed work will need to be done at this stage, including quantifying the benefits and costs of the new organisation, and a detailed analysis and testing of the proposed organisational model.

2. CASE FOR CHANGE

Health needs are changing but healthcare systems are not keeping pace

2.1 If the health challenge of the last century was the treatment of infectious disease, this century's challenge is the prevention and management of long-term conditions. More than 15 million people in England have one or more such condition.[2] Rates of diabetes, for instance, are expected to grow by over 60% in the next 20 years. This challenge is particularly stark in the local communities that King's Health Partners serves, where one in four school children is already obese.[3]

2.2 The numbers of people with multiple long-term conditions ('multi-morbidity') is high and rising. More than one in three of this group have both physical and mental health challenges. New evidence suggests that the rates of people with multiple long-term conditions are highest in populations that are economically deprived such as Lambeth and Southwark.[4]

2.3 Multi-morbidity is particularly common amongst older people – and this population is growing fast. The number of people over 65 in the UK is set to increase to 20% by 2030 and the proportion of 85 year olds will double by 2032.[5]

2.4 Left unchecked, the likely cost to the system of these trends is extremely high – estimates suggest that around 70% of healthcare costs are already spent on people with long-term conditions.[6]

2.5 But healthcare systems around the world are not keeping pace. Health services are focussed on disease and illness rather than promoting health and wellbeing. They tend to be reactive and poor at planning ahead. The mind and the body are still treated quite separately.[7] In most healthcare systems, it often appears that the hospital rather than the patient is at the centre. One result of this is that care is not always provided in the best settings for patients. Services can be fragmented leading to worse outcomes and poorer experience for patients. This can have a particular impact on older people and those with long-term conditions who have to navigate this complex system.[8] Finally, research and education can appear quite distant from the reality of healthcare problems.

2.6 All of this points to the need for new models of healthcare delivery, including more integrated care, a new relationship between the patient and the system, changes to how the workforce is educated and trained (for example, considering the balance between generalist and specialist skills), and a more productive relationship between research and healthcare delivery. As an integrated organisation, King's Health Partners would be better able to develop a new model of healthcare to meet this challenge.

The academic world is becoming increasingly competitive

2.7 Competition for the best students and research talent is rising, as academia becomes a global market. The UK used to undertake 6% of clinical trial activity; the figure now stands at just 2%.[9] This has consequences for the country's overall economy and international standing in healthcare.

2.8 Universities increasingly need to demonstrate excellence to be able to compete. The upcoming Research Excellence Framework reinforces this trend – only the highest quality research will attract funding. It will also need to be able to demonstrate impact for social benefit. This offers a clear opportunity to organisations committed to translational research – as King's Health Partners is.

2.9 Meanwhile medical research is becoming more complex, as medicine continues to sub-specialise. One result of this is that is has become more difficult to sustain clinician-led research in traditional teaching hospitals.[10] This implies a need for greater organisational scale with larger academic facilities co-located with clinical services, supported by large scale specialist teams. It also raises the question of how organisations can undertake research in very different ways, including, for example, undertaking more research embedded in the communities we serve.

2.10 The demise of higher education block funding and the introduction of a new fees regime will further encourage competition for the best students. This is likely to raise student expectations about their experience which may take many forms – including demand for better teaching and better integration between academic learning and clinical placements. Successful universities will need to concentrate on delivering distinctive education and the best student experience.

2.11 Trends in teaching and courses suggest students are attracted to new ways of learning. This includes a greater number of inter-disciplinary courses, a greater emphasis on team working, problem solving and other general skills. AHSCs are well placed to benefit from these changes, by enhancing multi-professional elements within existing courses, and by developing new courses altogether that reflect emerging healthcare needs (for example, with management, humanities and informatics).

Economic and social pressures pose questions about how we work

2.12 The economic situation in the UK is an important part of the backdrop to the discussion about King's Health Partners' integration. Firstly, economic factors are closely related to health outcomes and health inequalities. In Lambeth and Southwark nearly 40% of children live in poverty, and the unemployment rate is above the national average.[11]

2.13 Second, with public finances under pressure, funding sources for health, education and research will inevitably be constrained. In particular, whilst the demand for and the costs of healthcare continue to rise significantly, NHS funding is likely to be, at best, held steady for the next ten years. This means the NHS needs innovative new ways of providing healthcare that radically improve productivity.[12] Organisations working in isolation will struggle to respond to this challenge.

2.14 Finally, the UK as a whole needs to find new sources of economic growth. As education, health and life sciences are among those industries in which the UK has a comparative advantage, there is a clear opportunity for King's Health Partners to contribute further to overall economic growth by realising the commercial potential of its business.[13] This in turn would contribute social value and employment opportunities to the south London economy (from which the majority of our workforce is drawn).

2.15 Alongside changes in the economy we will see significant social changes. In the future, we can expect a more informed and less deferential population. This offers healthcare providers the opportunity to develop a new, less paternalistic relationship with patients and service users. Technology could play a significant role in enabling this change. Technological advance in the last 20 years has been extraordinarily rapid, influencing many aspects of our lives. The rate of advance looks set to continue - with continuing growth in computing power and social media and a move towards ubiquitous access. Yet healthcare has been slow to benefit from these advances. King's Health Partners has the opportunity to tap into new technological opportunities to transform the care it provides (for example tele-medical monitoring for cardiac patients after surgery) and to encourage new research opportunities.

King's Health Partners has achieved much but there are further opportunities

2.16 King's Health Partners has achieved a lot in its current organisational form, for example:

- We have established 21 Clinical Academic Groups (CAGs) to help integrate patient care, research and education across the partners. The CAGs are driving service and academic improvement in a range of areas, including consolidating Bone Marrow Transplantation, Vascular Surgery and Stroke services.
- We are making progress on finding new ways to tackle local health challenges. In partnership with our local health and social care partners, the Lambeth and Southwark Integrated Care Programme is redesigning local systems of care to fit around the needs of patients, starting with care for older people.
- We are innovating in 'whole person care'. For example, the Psychological Medicine CAG is working with the Cardiovascular CAG implementing joint clinics for patients with chest pain as part of the King's Health Partners IMPARTS (Integrating Mental and Physical Healthcare: Research, Training and Services) programme.
- King's Health Partners is at the forefront of pioneering new medical techniques; for example, we host one of the largest Transcatheter Aortic Valve Implantation (TAVI) programmes in the world.
- We have put in place the building blocks for groundbreaking research. For example, the Department of Heath reaccredited our two National Institute for Health Research (NIHR) Biomedical Research Centres (BRCs) and established a new Biomedical Research Unit for Dementia, pledging over £112 million of funding over five years.
- King's Health Partners has established an Education Academy which successfully oversees the education and training activities of the four organisations to ensure consistent standards of excellence. In April 2012, all three Trusts were appointed lead providers to deliver £77 million worth of postgraduate training programmes to higher speciality trainees across south London in 15 different specialties, from renal medicine to forensic psychiatry. With local partners, we are leading the development of the South London Local Education and Training Board.
- We have created a single King's Health Partners fundraising team to join up the efforts across the four organisations.

2.17 However, current organisational arrangements are not allowing us to make progress towards achieving our vision at sufficient pace, not least because the financial incentives are not fully aligned.

2.18 The result is that we are slowed down or in some cases missing opportunities altogether. This has affected the Clinical Academic Groups, progress on bringing together corporate functions such as IT, and in some instances hindered the development of external partnerships.

2.19 Our Clinical Academic Groups are now telling us that a more integrated organisation would allow them to achieve more and at greater pace.

An integrated King's Health Partners would make it easier to achieve our goals

2.20 A more integrated organisation would offer a number of advantages that would help King's Health Partners overcome current organisational barriers, respond more effectively to the external opportunities described above, and help achieve our academic and healthcare goals.

- **Align priorities and decision-making.** A single organisation would help align organisational priorities. For example, King's Health Partners would be able to articulate a clearer set of healthcare and academic priorities to potential philanthropic donors.
- **More financial flexibility.** An organisation with a single balance sheet would enable greater resource flexibility, for example investing more in mental health interventions such as liaison psychiatry that can help reduce hospital length of stay. As a single organisation we could also make better use of our combined assets (£1.3billion across the three FTs) to release funds for investment in new models of healthcare.
- **Make it easier to work with external partners.** An integrated organisation would simplify relationships with external partners. For example, we could streamline our processes to reduce bureaucracy for referring GPs. With our external partners, King's Health Partners could help develop a shared electronic patient record that covered the whole health and care system.
- **Organisational scale to transform how we work and improve efficiency.** An integrated organisation would offer economies of scope and scale. For example, we might consider consolidating elective care for a number of specialties in a single centre, thereby improving patient experience, outcomes and efficiency.

3. VISION FOR THE NEW ORGANISATION

3.1 An integrated organisation would allow us to extend our vision – in particular to achieve a greater focus on physical and mental health integration; on prevention and population health; and on the academic opportunities associated with these two major challenges.

3.2 **Our vision for the new organisation is to be a leader, locally and globally, in improving health and wellbeing**. **We aspire to be one of the top ten global academic healthcare organisations and to bring these benefits to our local communities, patients and students.**

3.3 In pursuit of this vision, we aim to overcome some traditional distinctions. We hope that our local and global ambitions can reinforce each other: our large and diverse local population can help us make a global impact, and our global reach can help us improve the health of our local population. We hope to excel academically and provide consistently high quality care for all our patients. We hope that we can address both the mental and physical health needs of our patients. We hope we can provide system leadership, not just provide services.

3.4 King's Health Partners is uniquely positioned to do this because it brings together three successful Trusts, with mental health at the core, with a leading university, all serving one of the most diverse and challenged communities in the country.

3.5 Working in partnership with others in the health and care system and beyond, we have six goals for the new organisation:

i) Provide care around people's needs

3.6 By bringing together acute, community and mental health services the new organisation can provide more integrated care for our patients. But to be most effective we will need to work in partnership across the health and care system with providers and commissioners. Building on the work of the Integrated Care Programme, we hope to develop a new relationship with primary care and social care, overcoming the barriers that have existed since the NHS was formed. A key enabler of this will be developing a shared electronic patient record - helping King's Health Partners, our partners and our patients to work in fundamentally new ways with each other.

3.7 Providing more integrated care also has implications for how we educate and conduct research. We will consider what the future workforce might look like and what its educational needs might be, for example the balance between generalists and specialists in hospitals.[14] We will also look at how we can use our partnerships with others in the health and care system to change how we do research, for example by extending more trials into the community, and by investing more in understanding how to improve the delivery of healthcare. Our recent creation of King's Improvement Science, which seeks to find new solutions to real world problems in healthcare, is a key step in this direction.

3.8 By bringing together a mental health Trust with two acute care Trusts and community services in Lambeth and Southwark, the new organisation will help us

overcome traditional distinctions between mind and body, helping position King's Health Partners as a world leader on whole person care.

3.9 At present, patients with mental illness, particularly those with serious mental illness do not receive adequate physical care – these patients live on average 10 to 15 years less than expected – often rivalling the years of life lost to many major medical illnesses (such as breast cancer or heart disease).[15] Improving the physical health of the seriously mentally ill will require a joined-up approach across the healthcare spectrum and specific programmes, clinics and professional development to deal with this issue. King's Health Partners aims to be the national leader in the development, implementation and evaluation of these programmes.

3.10 At the same time, patients with long-term physical conditions receive sub-optimal mental health care: nearly 30% of people with long-term conditions have depression; half of all referrals to specialist services have 'medically unexplained symptoms' many of which are linked to psychiatric diagnoses.[16] King's Health Partners will seek to lead the way in developing innovative services and models of care (such as routine depression, alcohol and dementia screening) which lead to improved outcomes and lower costs of care.[17]

3.11 We recognise that the physical-mental integration is often held back by the lack of appropriate funding incentives. By bringing all these services within a single organisation, King's Health Partners will develop internal incentives to drive this integration.

ii) Keep people well

3.12 Through the scale of the new organisation and its academic strengths we will seek to develop new approaches to population health to address the stark healthcare challenges our populations face, such as alcohol and childhood obesity. We will do this in partnership with others in the healthcare system, local government, industry and the voluntary sector. We will aim to intervene earlier and avoid unplanned care where possible, for example through earlier interventions for people with long-term conditions such as Chronic Obstructive Pulmonary Disease (COPD) to avoid unnecessary hospital admissions.

3.13 We will seek to support people to manage their own health, for example by using telehealth to support self-care at home rather than in the hospital.[18] By offering patients greater access to their own health records we hope to empower them to better manage their own health. To this end, we will build on SLaM's MyHealthLocker, which is the first patient-held electronic health record in the field of mental health. Opening up a two-way flow of information between patients and their clinicians this represents a shift in the status of the patient from a passive recipient to active participant in their care.

3.14 To find new ways of addressing these public health challenges, we will draw on the strengths across the university. For example, cultural anthropologists and social geographers can shed light on 'lifestyle diseases' by better understanding the cultural context of people's lives. KCL's recent creation of a new Department of Social Science, Health and Medicine demonstrates our commitment to this issue.

3.15 We aim to do more to help our staff improve their own health. This is because they represent a significant proportion of the local population in their own right, and because we know that healthier staff provide better care. We are putting in place a range of measures to help our staff become healthier, for example through smoking cessation classes and mental health interventions to support their wellbeing. Through this and other measures we would like to support and encourage our staff to be effective advocates for health and wellbeing in the local community.

iii) Provide the best specialist care when it is needed

3.16 Our patients deserve excellent local services, but we believe that they also deserve excellent specialist services. We know that treating higher numbers of patients is associated with better outcomes in certain specialist services. So to improve the quality of care we provide, we will consider consolidating some of our specialist services across our sites. Our proposals may include co-locating these services with academic facilities to accelerate the translation of research into new drugs and treatments and to encourage further research innovation. This is relevant for some of the most pressing health challenges in our area, such as HIV and sexual health, sickle cell disease and alcohol-related liver disease.

3.17 In those specialist areas where we excel, we will continue to strengthen and expand our clinical networks. Based on clear protocols, data and pathways, these networks will help us to improve the quality of care across the country. We will consider how the greater use of technology can support our specialist networks, thereby enabling patients to be cared for safely and effectively closer to home.

iv) Train the workforce of today and tomorrow

3.18 Our ranking in the National Student Survey suggests we need to do more to improve student experience.[19] Closer integration between the university and the Trusts should help us improve teaching, student experience and the quality of graduates. Our ambition is that all King's Health Partners award-bearing education will be consistently high quality, and should take a common approach to quality assurance, training of teachers, performance management and student feedback. We will seek to improve the quality of our teaching through more efficient use of clinical time and better recognition of clinicians who make an academic contribution.

3.19 Greater flexibility in investment decisions will allow us to improve educational facilities across the King's Health Partners campuses, for example by creating a 'virtual learning environment' that enables students and staff to access all learning resources from all King's Health Partners sites.

3.20 Healthcare is changing and the new organisation will prepare the current and future workforce accordingly. We aim to do this by offering students and healthcare professionals a greater diversity of applied educational and research opportunities (including primary, community and mental health settings). Alongside this, we will extend the opportunity for students to undertake more joint or intercalated degrees with other academic disciplines. We will consider how to support new professional roles, such as integrated care practitioners, who work across physical and mental health, and social care. We will also offer more 'inter-professional' education (between doctors, nurses, mental health professionals) – professionals who work together should have the opportunity to train together.

3.21 Through the new organisation, we hope to offer enhanced career opportunities to our students and staff. Currently only about 20% of our clinical students end up working at King's Health Partners' healthcare providers. This is inefficient and a poor way of managing talent. We will work towards a point where the majority of our students are employed in King's Health Partners and see us as their natural employer. This will have benefits for the quality of healthcare that we provide by ensuring a more consistent level of training to future employees.

v) Turn world leading research into treatments as quickly as possible

3.22 Bringing together clinical and academic services will increase sub-specialisation in research, and encourage innovation between clinicians and academics. This should help speed up translational research. We will also aim to make research easier to conduct by improving the research infrastructure (such as bio-banking). An important dimension of this will be encouraging a greater number and range of healthcare professionals to get involved in research. This will both improve the quality of the research itself and help encourage a culture of improvement across King's Health Partners.

3.23 As a single organisation we will seek to make the most of our large and diverse local population with its global research implications. We will aim to make better use of patient data for research through a new electronic record. Leveraging our scale, we will seek to establish a larger number of patient trials addressing the health issues that matter to our local population. We will do this in partnership with others through the Academic Health Science Network we hope to develop across south London.

3.24 Closer working with the university can help us draw on the academic strengths across KCL's Schools. For example, researchers in the humanities and health might collaborate to better understand the different cultural experiences of pain.

vi) Build prosperity for our local communities and the UK

3.25 A single organisation will help us to generate new income through our own business and attract new commercial, fundraising and grant income. For example, closer integration with the university would allow us to commercialise better the value of our research and create more commercial spin-outs.

3.26 Attracting new income and investment will enable us to contribute to the local economy, helping regenerate some of the most deprived areas of the country. This will occur directly (e.g. by creating new jobs and developing new products) and indirectly (e.g. through building new facilities and offering new training opportunities to local people).

3.27 Our new organisation will also accelerate efforts to position the UK and London as one of the top global centres for life sciences, competing with places like Boston, San Francisco and Singapore.[20] Our organisational scale, increased patient base and improved administrative systems will make King's Health Partners an attractive partner to commercial and other research organisations.

4. ORGANISATIONAL MODEL

4.1 We are proposing that King's Health Partners AHSC should be embodied as the partnership of a single NHSFT formed through the merger of the three FTs, and closer integration with KCL. Full integration between an NHS organisation and a university is not feasible under the current statutory arrangements. Nevertheless, a partnership on the lines we envisage would enable us to create the UK's most integrated and innovative academic healthcare organisation. In taking it forward, we would:

- Honour and build on the strength and depth of the heritage and prestige of our current institutions and the strategic advantages of our current main hospital sites.
- Strengthen the links between KCL and the clinical-service delivery arms of the NHS organisation, so that all clinical services are supported by the strength in teaching and research that only an AHSC can provide.
- Put mental health at the centre of the mission and practice of the new partnership at all levels, and reflect this in the leadership (executive and non-executive) of the AHSC and its delivery arms.

Governance

4.2 In this form, King's Health Partners would consist of a partnership of two legal entities – KCL and the new NHSFT – which would nevertheless present to the world as a unified entity. This would be expressed through:

- **Merger of the three FTs**. We propose bringing together physical and mental healthcare in equal partnership in a single FT, with specific provisions to ensure adherence to the guiding principle that there should be parity between mental and physical healthcare. This should enhance the distinct national standing of SLaM and the Institute of Psychiatry (IoP), which is part of KCL. Such provisions should include ensuring that the overall balance of the Board and leadership of the new organisation appropriately reflect the parity between mental and physical health. This might include non-executive (for example, chair / vice chair), executive, clinical and academic leadership. Similarly, attention to the prominence and approach of mental health services should be reflected in the wider corporate structure.
- **Establishing a new King's Health Partners Board**. The Board would focus on the strategy and investment in order to deliver the AHSC vision. It would seek to embody the partnership values that have characterised King's Health Partners to date, including the parity accorded to mental and physical health. Membership would be drawn from the executives and non-executives of the NHSFT and KCL. Additional non-executives would be appointed to the Board, in order to bring in external perspectives and enhance the academic ethos of the organisation.
- **Establishing a new King's Health Partners Executive**. The objective of the Executive would be to ensure delivery of the King's Health Partners strategy and to reconcile any competing priorities between NHSFT and KCL. It would be led by the Executive Director of King's Health Partners, comprise key executives from the two partners (including the CEO of the NHSFT), and reflect the parity between mental and physical health.

4.3 Other governance arrangements would be considered to help cement the partnership, for example, reciprocal executive and non-executive representation between the NHSFT, KCL and the King's Health Partners Boards.

Organisation and operating model

4.4 We are conscious that in following this model of partnership, we would be proposing the creation of an NHSFT twice as big as any that exists at present. Indeed, Guy's and St Thomas' is already the largest FT by turnover in England. The relationship with KCL creates an even larger entity. We have been clear from the outset that this undertaking would be unacceptable – and would fail – if it resulted in a remote, centralised organisation which attempted to replicate the conventional NHS Trust governance, management and service arrangements at this scale. It would have to operate in a very different way to be effective.

Clinical academic delivery arms

4.5 Our proposed model for the organisation of the new NHSFT is that it would operate in a group structure, in which responsibility for delivery of the objectives of the AHSC would be devolved to a small number of clinical academic delivery arms which would:

- be of sufficient scale to have their own character, leadership and devolved budgets;
- nevertheless represent an opportunity to bring delivery of clinical services even closer to the patients and communities that they serve;
- be accountable for the quality of services for which they are responsible, and take responsibility for engaging with regulators, commissioners and other stakeholders;
- be coterminous with the relevant KCL Schools to more effectively support the AHSC goals; and
- take responsibility for progressing the research and teaching objectives of the AHSC within their area to support and enhance the clinical services that they lead.

4.6 These clinical academic delivery arms would be directly accountable to the NHSFT Board for NHS performance issues, for which the FT would be statutorily accountable. They would also have accountability to KCL through the relevant academic Schools for performance on academic issues, for which KCL is statutorily accountable, in a manner comparable to the way the IoP and SLaM currently interact. This will ensure that the operational issues have a clear line of accountability and can be swiftly resolved. Finally, the clinical academic delivery arms would report to the King's Health Partners Board for the shared agenda of the tripartite mission. This dialogue would focus on setting strategy and agreeing an integrated business plan, including budgets, against which they would be monitored. The SLaM-IoP relationship is the nearest existing analogue to how we envisage the clinical academic delivery arms working.

4.7 Each of these clinical academic delivery arms would have a management board, which would involve non-executive representation and a role for FT Governors. The

Board's leadership structure would respect the shared academic and healthcare goals of King's Health Partners, including the commitment to reflect the central role of mental health across the leadership of the organisation.

4.8 The number and composition of these clinical academic delivery arms have yet to be decided; and of course, they would evolve over time as the health system changes and new models of care drive different service delivery arrangements. However, the aim would be to begin building the new structure on the foundation of the current CAGs. So for example, at the point of launch of the merged organisation, it is possible to envisage cancer services, children's services and dentistry all operating as separate, single service delivery arms with their own character, leadership and budgets. Over time, other clinical service areas might also be grouped to a greater extent around patient pathways and population groups than they are under our current arrangements. However, we also recognise the importance of continuity over the transition period, in particular to ensure operational performance is maintained.

4.9 As part of our commitment to encourage a greater academic ethos, we would look in particular at how we develop our workforce. For example, the majority of future consultant appointments to the new NHSFT will simultaneously be given honorary academic appointments at KCL, helping support the development of an 'integrated faculty' across King's Health Partners.

Cross-cutting functions

4.10 The NHSFT Board will bring together the management of a number of central and support functions that appropriately sit at the corporate level. These functions might include, for example, finance, estates, human resources, IT and facilities management. While each of the separate clinical academic delivery arms may have some of its own support functions, these would operate under clear rules of discretion established by the FT Board.

4.11 There is also scope for establishing a number of cross-cutting functions across both the NHSFT and KCL, as is already the case with fundraising which is run by KCL. For example, we would leverage KCL's expertise in education and research management to lead the development of comprehensive frameworks for education and for research; and to coordinate our activities in these two areas, most urgently in relation to medical education.

Benefits of the new organisation

4.12 The new organisational model would help King's Health Partners deliver the vision in a number of ways, in particular by:

- aligning the interests of the separate organisations;
- bringing physical and mental health services together into a single organisation;
- simplifying the academic and healthcare relationship – KCL will have only one FT to work with;
- creating the organisational scale to help deliver the vision.

Transition to the new organisation

4.13 The full details of the operating model would be developed as part of the Full Business Case. While that is being compiled, we would also carry out further reviews of the ambitions of the current CAGs – particularly those in priority areas for the AHSC – which might impact on the emerging operating model for the AHSC.

4.14 Our transition to the new organisation would be evolutionary where possible, in order to ensure that performance against key operational measures is maintained where appropriate and improved wherever necessary. This will be essential for ensuring that we maintain the confidence and support of patients as well as the wider population and stakeholders.

4.15 As we develop the new organisation, we would like to engage further with our local commissioners, and our partners in primary care, to discuss how we might most effectively achieve our goals around encouraging more integrated care and strengthening community services. We genuinely believe that there is scope for innovation in this area, to the benefit of patients. But we recognise that if there is to be further integration involving primary care, it has to be on the basis of real partnership.

5. BENEFITS

Improving health

5.1 **Improving care outcomes.** The special emphasis on linking physical and mental healthcare would lead to an immediate improvement of care provided to patients – and would in time lead to better long-term outcomes (for example by decreasing years of life lost to schizophrenia). Consolidating our specialist services would lead to better patient outcomes because for many specialties quality is directly related to how many cases a centre does. For example, specialist endovascular aneurysm repair has lower mortality and shorter length of stay than open surgery but requires doctors to be doing a large number of cases to be proficient. Creating integrated clinical services could also help 'level up' performance across different services by putting in place the most effective practice.[21]

5.2 **Quicker access to new drugs and therapeutics.** We would be able to speed up access to new drugs and treatments through more effective research, supported by clinical and academic co-location; through more opportunities for patients to take part in trials as commercial partners are attracted to our larger patient base; and through investment in cutting edge technologies (for example, robotic surgery for complex mitral valve surgery), which may be unaffordable as separate organisations.

5.3 **Less wasted time for patients.** Greater separation of acute and elective services could prevent the admission of emergency patients from disrupting planned activity – reducing inconvenience for patients and improving efficiency of services.[22] For example, consolidation of fractured neck of femur surgery for elderly patients could reduce waiting times for theatres. Likewise, creating a single elective joint replacement centre would reduce cancelled operations and the length of stay in hospital.

5.4 **More integrated care.** More joined up working across acute, community and mental health services could improve patient care and experience. For example, an estimated 40% of inpatients in King's, Guy's and St. Thomas' hospitals have dementia, but recognition of dementia in secondary care is poor. The inclusion of dementia specialists in Accident & Emergency departments could lead to earlier diagnosis and more effective treatment.

5.5 **More convenient care**. A large proportion of King's Health Partners' 225 sites are based in the community. These could be used more effectively and creatively to support care closer to home.

5.6 **Better use of information technology**. Creating shared platforms such as a shared electronic patient record across King's Health Partners and our local partners could lower the risk of medical error, reduce outpatient appointment time, and improve patient experience by avoiding asking people to repeat basic information. At Brigham & Women's hospital (Boston, USA), e-prescribing and access to an electronic patient record including medical history decreased the incidence of preventable adverse drug events by more than 17%.[23]

Better research

5.7 **Quality of research.** First, bringing together academic and clinical services in specialties would encourage innovation and improve access to clinical trials. Second, the integrated organisation could improve access to and data about the vast patient population that the three healthcare providers serve, by developing a shared electronic record that is accessible to research, building on existing models like the Clinical Record Interactive Search (CRIS). For researchers aspiring to generate research with global applicability this is particularly important. Third, the scale and reach of the new organisation would offer new research opportunities, such as finding solutions to the problems of healthcare delivery through 'Improvement Science', or by linking physical and mental health research to better understand 'medically unexplained symptoms'.

5.8 **Making research easier**. The new organisation would be able to improve research infrastructure (including laboratories, IT, trial co-ordination, bioinformatics, data management and bio-banking). This would make it easier to conduct major clinical trials either for our own research or in conjunction with the pharmaceutical industry. New processes would encourage clinical and patient participation in research (for example by taking a consistent approach to obtaining patient consent) and reduce bureaucracy (such as by creating a single research approvals process).

5.9 **Attracting research talent and funding.** Closer links to the new NHSFT would help KCL demonstrate impact (a critical factor in how university research is assessed). New funding partners (whether commercial, not-for-profit or government) would find it more attractive and easier to do business with the new organisation. The enhanced scale, performance, and reputation of the organisation would help attract the best talent and resources, competing against the world-leading AHSCs.

Better education and training

5.10 **Improved student experience.** The new organisation would be able to improve the student experience (particularly for clinical undergraduates), for example through better coordination of clinical teaching, co-location of clinical and academic facilities, and improved student services.

5.11 **Greater opportunities for applied learning**. The new organisation would offer a wide range of applied educational opportunities for health and non-health students. It could do this through joint degrees, a wide range of real world learning opportunities (for example across community and mental health settings), and greater employment opportunities upon graduation. This would give students a more rounded education and KCL a comparative advantage in attracting the best students.

5.12 **Improved resources and facilities for students and staff**. Greater flexibility in investment decisions would allow us to improve educational and training facilities across the King's Health Partners campuses. All King's Health Partners students and staff would have access to common support services and facilities, such as the libraries.

5.13 **Attract the best students**. Enhanced experience, facilities, learning and employment opportunities would help King's Health Partners attract the best students in the UK and internationally.

Better value

5.14 **More efficient healthcare economy.** The new organisation would enable us to improve value for money for patients and taxpayers across the health and care system. Estimates suggest 3-5% of savings could be achieved from savings in non-clinical support functions alone in the new organisation.[24] We think significant further savings could be achieved through improved productivity across much of our business which will have benefits for the whole healthcare economy. For example, we could consolidate services where they are duplicated. A single heart attack centre could enable all patients to receive 24/7 care by combining the workforce and implementing a single on call rota. Likewise, a single diabetes service would enable King's Health Partners to reduce the number of specialist services and move more care closer to home. The Full Business Case will examine in detail the full range of productivity opportunities.

5.15 **Better use of assets.** The new organisation has the potential to make better use of its extensive estate, which comprises 225 sites with a combined value of over £1.8 billion. An integrated organisation could unlock more value from this estate, for example by rationalising facilities, freeing up space for re-use or reinvesting the capital in front line services. The Charitable Trusts associated with our organisations have combined assets of well over £600 million which could be used to greater effect if joined up.

5.16 **New jobs and prosperity.** The new organisation has the potential to generate new income by extending the geographic reach of its specialist services and by attracting new investment (commercial and not for profit). For example, we would aim to develop further initiatives such as the Cell Therapy Catapult centre at Guy's Hospital, the objective of which is to bridge the gap between academic invention and real life commercial products. This kind of development has the potential to create new employment opportunities and prosperity in the local economy.

6. FINANCIALS

The four partners are in financial good health but have challenging future plans

6.1 The finances of the three NHS Foundation Trusts reveal a combined organisation with an income of £2.1 billion and expenditure of £2.0 billion. KCL has total income of £532 million and expenditure of £507 million, of which around 45% is King's Health Partners related.

6.2 In their most recent annual accounts, each of the three FTs and KCL reported a financial surplus. Over the next three years, growth projections for both income and expenditure are approximately 1% across the three FTs. KCL is projecting around 5% growth in both income and expenditure. Collectively the FTs plan to find annual cost savings of approximately £200 million by 2015. Of this approximately half will be from pay costs, reflecting about 8% of the pay cost base.

6.3 Capital investment plans for each partner are significant. The FTs are planning approximately £480 million of capital expenditure over the next three years. KCL is midway through a £635 million ten-year capital programme (of which ca. 30% is at the three health campuses). The FTs' funding plans for their capital programmes are derived from a combination of existing cash reserves, additional borrowing and from future surpluses. Shortfalls in projected levels of cost savings or margin from income growth would threaten the ability to fund these capital plans in full. The projected drawdown on loans at the FTs will total £207 million over the next three years.

6.4 The combined property footprint of all four organisations comprises over 800,000 square metres across more than 225 sites, at a value of around £1.8 billion. Of the health sites, around one quarter is leasehold. The majority of KCL property is freehold.

6.5 The Charitable Trusts associated with our organisations have combined net assets of approximately £636 million. Whilst they will not be directly integrated with the FTs, a full merger of the FTs might necessitate a merger of the three Charitable Trusts.

The benefits of integration could be significant but are not fully quantified

6.6 We recognise that savings anticipated in advance of mergers are not always realised post-merger. Accordingly, we need to ensure that any merger savings identified are supported by robust and detailed plans in order to ensure the anticipated value of savings is realised. These detailed plans will be drawn up as part of the Full Business Case process. With this caveat in mind, our assessment is that across the FTs there is opportunity to achieve between 3-5% of cost savings from organisational synergies in some non-clinical support functions. These benchmark estimates will need to be supported by bottom-up analysis before being confirmed.

6.7 It is expected that there are further financial benefits, still to be assessed, which would only be realised through more transformational changes arising from integration. For example, the Integrated Care Programme is implementing a new model of healthcare delivery for older adults which could free up 16,000 bed days per annum (about 2% of the King's Health Partners' total).

6.8 A detailed analysis of the asset base would determine the extent to which capital could be released. To give an illustration of the order-of-magnitude, land and building assets across the FTs have a value of £1.3 billion. Increasing utilisation to release 5% would therefore free up £65 million of additional capital. Alternatively, the freed-up estate could be used for additional sources of rental income.

The costs are not yet fully assessed – particularly longer term restructuring costs

6.9 The detailed cost estimates of transition would be developed alongside the integration plans as part of the Full Business Case process. The main cost categories are described below.

- *Transitional costs.* The Full Business Case itself would require investment funding from the partners. A separate paper will develop robust costings including the cost of the project team and other costs (such as legal advice). In addition, project management resources would be required to both plan transition to the new organisation and subsequently to run post merger integration.
- *Restructuring costs*. There would be a need for both short-term and longer-term restructuring costs. For example, investment in systems would be required to help integrate the organisations. This might include short- term investment such as common payroll platforms, or longer term investment in IT systems such as e-prescribing.
- *Transformational costs*. The SOC has not sought to calculate longer term transformational costs such as the development of entirely new clinical or academic facilities. Where these developments are integral to the new organisation, they would be included in the Full Business Case.

The financial dynamics of the new organisation may need to adapt

6.10 The new organisation would need to build capability to succeed in a changing environment, including the possibility of new funding models in the future, such as capitation payments or personal health budgets. These new funding models may pose financial challenges but could also deliver significant productivity by stimulating innovation in healthcare delivery.

7. CONCERNS AND QUESTIONS

7.1 A number of concerns and questions associated with the proposed organisational change have emerged as we have developed the SOC, in part through discussions with our staff and stakeholders. We seek to address these below.

Would merger lead to closure of local services?

7.2 Core local services would continue to be provided on multiple sites. For example, the two Accident and Emergency departments and two maternity units would remain in their current locations. Rather than closing existing local services, the new organisation would seek to develop new local models of care with our partners to deliver more services, closer to patients' homes.

Would mental health issues be less prominent in the new organisation?

7.3 Mental health is key to the vision of the new organisation and would have a central place in it. The unique place of mental health and its parity of esteem would be enshrined in the principles of the new NHSFT. Specific provisions would be made in the Council of Governors of the NHSFT so that those with mental illnesses could be involved and engaged in this new organisation. In addition, specific provisions would be made to the governance and management model to reflect the centrality of mental health to the new organisation. This might include the creation of specific non-executive, executive and professional leadership roles in the new organisation. The experience of mental health systems would significantly inform the overall model of care of the new organisation, as mental health systems have pioneered the move from hospitalised care to the community. In addition, there is a body of evidence that suggests investment in mental health interventions can reduce demand for acute services.[25]

Would academic issues be neglected in the new organisation?

7.4 A defining characteristic of King's Health Partners is academic excellence. This would be reflected in the new organisational model at every level. A range of mechanisms would be considered to cement the partnership between the NHSFT and KCL, including joint appointments and reciprocal non-executive representation between NHSFT and KCL. The new organisation would commit to flourishing academic campuses at Guy's, St Thomas', King's College Hospital and SLaM/IoP. The new organisation would seek to make the most of the university's wide range of academic strengths (across culture, security, health and beyond), reinforcing KCL's position as a world leading centre for translational research in these areas.

How would operational performance be maintained during this process?

7.5 We recognise that a merger of this scale is a significant undertaking with many associated risks, particularly in the transitional period. To help ensure merger causes little disruption to business as usual, or result in a loss of operational focus, a dedicated transition team would be put in place to operate in parallel to everyday business. This team would ensure robust programme management of the pre- and post-merger activities as well as the active management of both internal and external stakeholders. We would structure and manage our new organisation so there is clear accountability for achieving NHS performance standards (such as

access times) and KCL's key performance measures (such as the National Student Survey and the Research Excellence Framework).

How would the cultural and staff challenges of integration be handled?

7.6 We recognise we would need to put significant investment into developing a strong organisational culture for the new organisation. This would draw on the best of each of the existing organisations. Working with staff to develop this culture and values would be a high priority if we proceed to the next stage of the process.

7.7 There would be significant career and development opportunities for staff in the new organisation. For example, we plan to develop new professional roles as we develop new models of healthcare that cut across existing boundaries. We would support staff with appropriate training as required, for example to better understand the needs of mental health patients in hospital settings.

7.8 In addition, we hope the new organisation would be able to offer better facilities and support services (such as ICT, library access and leisure facilities). Where it is necessary, we would make it easy for staff to work across locations, through improved transport, ICT, and through new ways of working.

Would merger create an inflexible or remote organisation?

7.9 Organisational scale gives us the opportunity to transform the organisation altogether, and make it more responsive, for example by developing new pathway or population based delivery arms. The NHSFT would devolve significant decision-making powers to these delivery arms, creating more autonomous and flexible units that allow the organisation to maintain its agility.

Would merger undermine local accountability through Governors?

7.10 The Council of Governors is a key part of the accountability structure of a Foundation Trust. Making sure that governance works is important to maintaining the independence and accountability of an FT. Governors may have concerns that the sheer size of the merged organisation would make it more difficult for them to fulfil their duties. The Full Business Case must address an appropriate structure for the new Council of Governors that enables the Governors to represent their communities of interest and to hold the Board to account.

Would merger lead to reconfiguration of services?

7.11 Some of the benefits of a new merged organisation may only be realised by changing or reconfiguring services. However, no decision has yet been made about what changes might be appropriate. Although some changes are put forward as examples in this SOC, it is recognised that these proposals would require engagement and/or consultation with stakeholders, including commissioners, public and patients and consideration of the guidance and law.

How will the costs of restructuring the organisation be managed?

7.12 In the Full Business Case resources would be dedicated to detailing costs of restructuring the new organisation and ways to manage these, such as pay differential between the end organisations. Transformation of the organisation would have costs but we believe these would be outweighed by the clinical and

academic benefits, would be offset by the savings that are achieved and would not all be immediate. Moreover, the new organisation would have greater financial flexibility than the individual organisations currently do to invest for the long term.

Would creating a single organisation affect the investment plans of the partners?

7.13 Each of the four partners has significant investment plans. Organisational integration cannot and should not impede future investment. However, the Full Business Case process would need to ensure that these investments are fully aligned with the shared goals for King's Health Partners. It may turn out that joint investments in the new organisation would be a more efficient way of delivering some of these plans (for example, to procure new IT systems).

Would organisational integration reduce patient choice and competition?

7.14 In nearly every other part of the country outside London, it is the norm that only a single teaching hospital would serve the size of population that King's Health Partners does. Nonetheless, it may be the case that the proposed integration of the NHS Trusts is deemed to require consideration by the relevant competition authorities. However, a preliminary review of evidence indicates that for acute services in this sector of London, significant choice and competition would remain. Some of the key arguments to support this assessment are laid out below.

- *Access to services would not be reduced.* Core local services such as maternity and Accident and Emergency departments would remain on the existing two sites. Due to the size of the units there is not a risk that services will be closed or reconfigured at a later date.
- *Many alternative providers would remain for routine services.* There are numerous other providers in the local area. King's College Hospital and Guy's and St Thomas' are two of 25 acute trusts in London. For non elective services there are significant alternatives. Within 30 minutes drive time (~6miles) 44% of the population have a choice of 2-5 Accident and Emergency departments. For elective service such as a knee replacement there are a number of alternative providers, all of whom conduct significant numbers of procedures.
- *Specialist services must be considered on a regional or national base*. For example, 68% of patients receiving Coronary Artery Bypass Grafts (CABG) are regional or national referrals and in this market there are a large number of other providers.
- *Any reduction of choice and competition would be outweighed by improvements in the quality of care.* The benefits case is detailed in section 5 of this document. A single organisation would improve patient care and experience in a number of ways. Without merger, the realisation of these benefits may not occur or would be much slower.

Would merger impede King's Health Partners' ability to respond to the external environment?

7.15 Significant changes are underway in the healthcare system (for example, the developments around the future of South London Healthcare Trust), in the academic world and in the wider economy. Part of the justification for organisational integration is to better equip King's Health Partners to respond to this changing environment. However, if we proceed with integration we would ensure that we do not become too inward focussed in the short term. For example, we would continue

to jointly lead the development of an Academic Health Sciences Network for south London, to help spread innovations in healthcare across the whole sector. Organisational integration would also better prepare us to deal with the challenging economic environment that all NHS organisations will be facing. This would help protect the interests of local patients.

What would be the risks of not proceeding?

7.16 There are also risks if the partners do not proceed to form a single academic healthcare organisation including the creation of one NHS Foundation Trust more closely integrated with KCL. First, King's Health Partners may need to adjust its ambition and/or the expectations about the pace of delivery. Second, King's Health Partners would be in a poorer position to respond to future trends in healthcare, the economy and the academic world. Third, not proceeding may itself require organisational restructuring to CAGs. Finally, alternative processes might need to be found to deliver financial savings in years to come.

8. FORWARD PLAN

8.1 There are five core sets of activities on the forward path to approval:

- creating a Full Business Case and integrated business plan for the new organisation (including detailed set of financials);
- designing the organisational and operating model;
- gaining approval from the regulatory and competition authorities;
- working with commissioners, engaging formally with the public and our members, and broader communications with our staff and stakeholders;
- planning for the transition to and implementation of the new organisation, including the appointments process and integration plans.

8.2 These activities would be managed as a programme separate from the 'business as usual' of both the King's Health Partners Executive and the various partner organisations. It would be led and managed by a Programme Management Office (PMO) and accountable to the King's Health Partners Board for designing and managing the work and co-ordinating the interactions with the key stakeholder groups. The PMO would be led by members of the King's Health Partners Board supported by a full-time Programme Director and team. It would report regularly to the King's Health Partners Board and a subset of this board between board meetings as required.

Regulatory and competition process

8.3 The current estimated path to regulatory approval runs to April 2014. During this period, the core milestones on this path are engaging with commissioners and stakeholders, the start of formal public consultation and formal engagement with Monitor and the competition authorities (beginning with pre-notification discussions in April 2013). The latter requires the five-year integrated business plan to be complete.

8.4 There are two key external uncertainties around this timeline which could potentially impact the timing by a year or more:

- the detailed implications of the recent Health and Social Care Act, including the licensing regime;
- the impact of the appointment of a Trust Special Administrator in respect of South London Healthcare Trust (SLHT) – a process in which the FT partners are keen to play a constructive part.

8.5 An important step following approval of this Strategic Outline Case by Partner boards and the KCL Council would be to seek further guidance from various authorities around these uncertainties.

Communications and engagement

8.6 Ahead of a public consultation and in conjunction with the development of a Full Business Case, we would need to communicate the positive case for a new

organisation, demonstrating to staff, members, governors, patients and stakeholders the benefits and explaining how we would manage the risks.

8.7 To achieve this communication, we would continue to use face-to-face methods and to use the media and our own publications, but we would also significantly increase our use of digital media channels and look to foster debates in other environments.

8.8 We would hold a further series of broad staff engagement events as well as with specific staff groups, both clinical and non clinical. We would produce communications materials to clearly outline the benefits of a new organisation and explain the proposals to our staff and stakeholders. We would continue to meet with local health scrutiny teams, MPs, commissioners, clinicians, patients and patient groups to understand their views, and we would work closely with regulators (including HEFCE and Monitor) and the Department of Health on the proposal.

8.9 It is recognised that some of the proposals in this document will require engagement and/or consultation with stakeholders. At the appropriate time, engagement and consultation, following best practice, will be undertaken. It is important that, at this stage, no decision has yet been made about what changes (if any) might be appropriate.

8.10 Each of the partners in King's Health Partners understands their obligations under the Equality Act 2010 and, in working through the detailed issues arising from this SOC and the development of any case for organisational change, will properly analyse and take into account the impact of any equality issues in order to meet the three main aims of the general equality duty.

9. CONCLUSION

9.1 The analysis undertaken in this SOC helps answer the four questions that were posed.

What is the rationale for organisational integration?

9.2 There are a number of significant external drivers for King's Health Partners to consider changing its organisational form - healthcare, academic, economic and social.

9.3 The internal driver for change is the King's Health Partners mission. The proposition is that a more integrated King's Health Partners could deliver more and at greater pace. A single organisation would achieve this through closer alignment of priorities, greater financial flexibility, simplifying partnership working, and organisational scale.

9.4 An integrated academic healthcare organisation could thereby help King's Health Partners realise an enhanced vision, with a particular focus on physical and mental health integration and on the challenges of population health.

What is the preferred organisational model?

9.5 Merger of the three Foundation Trusts and closer integration with KCL has been identified as the preferred organisational model.

Do the benefits outweigh the costs and risks of integration?

9.6 A number of clear benefits have been identified from organisational integration, including improved care for patients, enhanced academic performance and increased economic value. The costs of integration will include transitional costs and short and longer-term restructuring costs. Neither the costs nor benefits of integration have been fully assessed at this stage. The risks of organisational integration are significant, but we believe these could be managed. The Full Business Case would undertake a more detailed (and quantitative) analysis of the full benefits and costs of integration.

What is the forward plan?

9.7 If the Boards of the partner organisations decide to proceed, the next step is to assess fully the costs and benefits in a Full Business Case. We believe this could be completed by early 2013.

9.8 Depending on the regulatory process, the organisation could legally come into form by late 2014.

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KING'S HEALTH PARTNERS

London's Academic Health Sciences Centre

Pioneering better health for all

King's Health Partners
Progress & Update December 2012

KING'S College LONDON

Guy's and St Thomas' NHS
NHS Foundation Trust

King's College Hospital NHS
NHS Foundation Trust

South London and Maudsley NHS
NHS Foundation Trust

Overview

Prof. John Moxham, Director of Clinical Strategy
Jill Lockett, Director of Performance and Delivery

Will cover this evening:

1. Update: creating a new academic healthcare organisation

2. Strategic priorities in Lambeth, Southwark and beyond

Challenges for the UK health system

We need to:

- Cope with the rise in an ageing population with multiple conditions
- Improve service quality while reducing costs at a time of less money coming into the NHS
- Redesign our patient pathways – to shift emphasis from treatment to prevention and to help patients manage more of their own care
- Better meet the mental and physical health needs of all of our patients
- Accelerate the translation of research into patient benefit – building on investment in our BRC and CRF infrastructure

We have:

- A unique opportunity to create a global top 10 health organisation and make improvements to benefit patients in south London

What are we doing now?

- Proposal: a single academic healthcare organisation
- Working towards closer integration of the three Foundation Trusts with King's College London
- A Strategic Outline Case (SOC) was approved in July by King's Health Partners Board, trust Boards and College Council
- A Full Business Case (FBC) will begin soon, to be completed following the completion of the TSA's report
- Engaging with stakeholders to test benefits of integration and prepare for future public consultation

Next steps?

The Full Business Case

- Will describe the vision, benefits and how they will be delivered and clearly articulates the rationale for merger proposals and closer working with King's College London
- Allow partner Boards to consider the case and proceed to next phase of merger
- Provide input to stakeholder engagement and regulatory materials
- Will be the main activity over the next 6 months

Top level content to be included

- Vision and rationale for merger proposals
- How the vision will be delivered
- Quantified benefits and costs
- Risks and mitigations
- Forward plan

Next steps?

- **Conducting due diligence**
- **Stakeholder engagement / Communications**
  Including preparation for public consultation
- **Compiling material for our regulators – OFT / CC and Monitor processes**

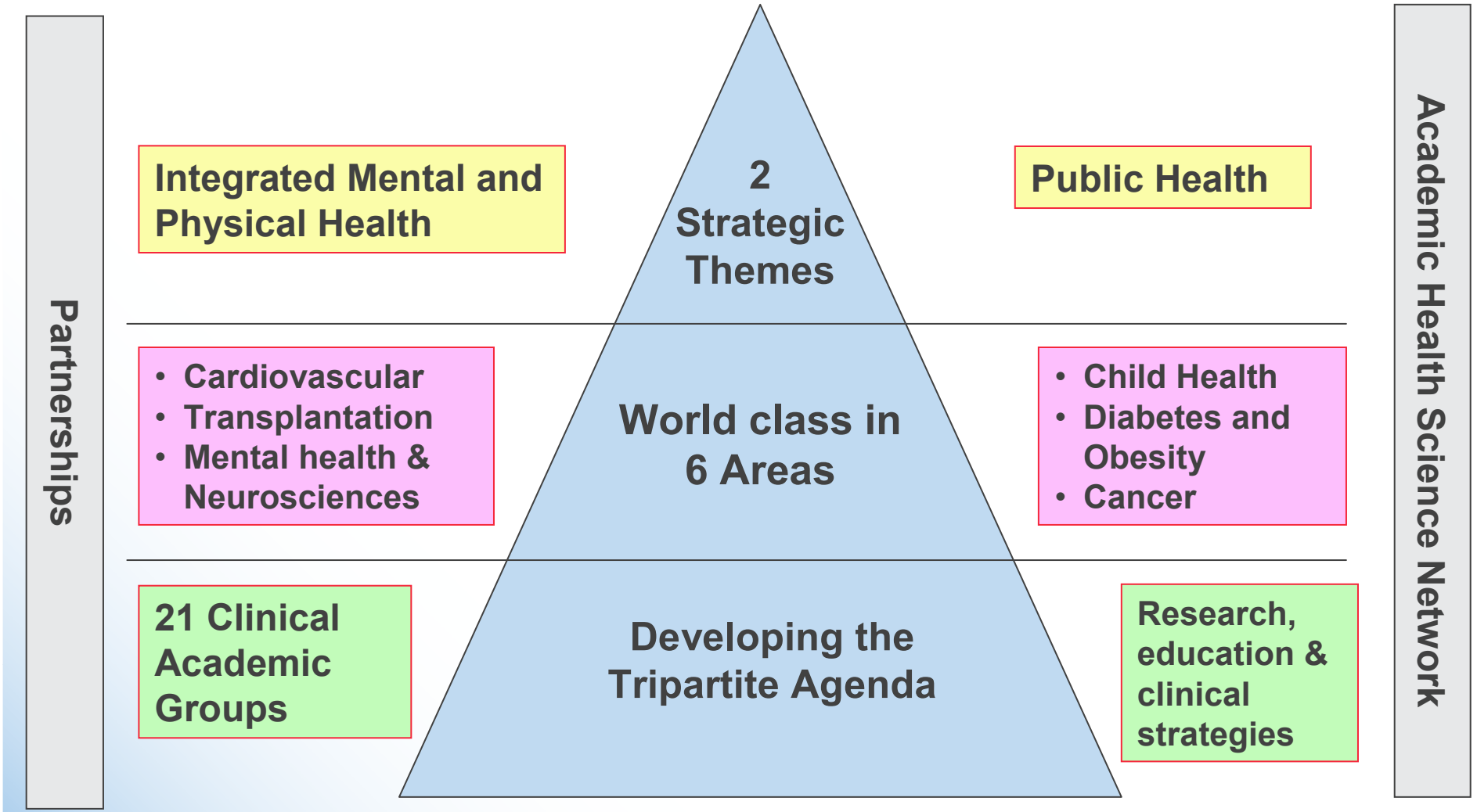
Benefits for patients

- Integrating care locally across primary, social, mental health and acute organisations
- Bringing together departments and clinical/academic teams would give us critical mass in terms of patients treated, and we would be able to develop much deeper sub-specialisation – locally important conditions, such as sickle cell disease, HIV and sexual health would benefit as would specialist services that many local patients need
- Treat the 'whole person' by integrating our physical and mental health services – an opportunity to treat those patients with physical disorders who have poor mental health and those with mental ill-health, whose physical health must also be improved
- The creation of a single integrated academic healthcare organisation will deliver greater 'value', resulting in better outcomes for patients and a financially stronger health and social care economy. Looking to the future this will support increased investment in services to the benefit of local patients.

TSA recommendations

- The KHP Partners' Board is united in its view that the partners' role in the solution to SLHT should be complementary to its own integration proposals
- Given the need to understand the implications of the Administrator's process, a Full Business Case would not be completed until after the Secretary of State has considered the TSA's final report
- SLHT problems serve to reinforce the need for KHP to continue to work together to help ensure a sustainable outcome for local patients in south London
- All partners remain committed to the proposals to create a single academic healthcare organisation

Working towards reaccreditation 2014



Proposed KHP Work Programmes for 2012-13

Developing our network

DH - establishing **Academic Health Sciences Networks**

KHP at the heart of a new South London AHSN:
Incorporating – 12 south London boroughs, 7 university partners (incl 2 medical schools); mental, acute, primary and social care; public health; local commissioners; industry; and third sector organisations.

Purpose - to improve the health of 3 million population in South London by:
1. bringing academic and scientific rigour to service improvement;
2. focusing on key public health issues in south London;
3. delivering lasting improvements on a wide scale across the whole of south London;
4. generating wealth for the local economy and improvements to patient care at the same cost or reduced investment.

Government funding up to £10 million per network.
Bid submitted 1 October, if successful licensed from April 2013.

Southwark Council

Scrutiny review proposal

1 What is the review?

King's Health Partner proposed merger.

The management boards of Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS foundation trusts are exploring plans for an organisational merger and a strengthened partnership with King's College London, their joint academic partner.

The four organisations have collaborated for many years and were accredited by the Department of Health as an academic health sciences centre, King's Health Partners (KHP), in 2009.

2 What outcomes could realistically be achieved? Which agency does the review seek to influence?

This review seeks to ensure that the costs and risks of the proposed merger are fully understand by KHP. Firstly, to ensure all risks are identified, understood and mitigated against in the proposals so that as full a picture can be achieved before any final decisions are made about the merger.

Secondly, for the committee to act as an additional forum to gather views from all interested parties. This will assist in the first objective named above.

Thirdly, to make sure that the trust is not over-optimistic of the benefits of the proposed merger and that 'optimism bias' is fully understood and accounted for in the development of the Full Business Case.

3 When should the review be carried out/completed? i.e. does the review need to take place before/after a certain time?

Completion by January 2013. If the trust proceeds with the proposed merger they would need to gain regulatory approval by April 2014, with pre-notification discussions with Monitor in April 2013. Therefore we need to complete our report in time to be considered before the KHP discussions with Monitor.

4 What format would suit this review? (e.g. full investigation, Q&A with cabinet member/partners, public meeting, one-off session)

Full investigation.

5 What are some of the key issues that you would like the review to look at?

Risk management, ensuring all risks are identified, treatment of optimism bias and the equalities impact of the proposed merger.

6 Who would you like to receive evidence and advice from during the review?

The three foundation trusts: Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS; King's College London; Kings Health Partners; Southwark Clinical Commissioning Group; Department of Health; Unions; patient groups; LINk; Southwark Pensioners Action Group; Southwark Council; local Independent Complaints Advocacy Service (ICAS) services, local representatives (drawing on their casework experience).

7 Any suggestions for background information? Are you aware of any best practice on this topic?

Any and all information about previous hospital mergers (including South London Healthcare Trust).

8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?
e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

Verbal or written submissions, meeting with stakeholders, survey, consultation event

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HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE **MUNICIPAL YEAR 2012-13**

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