Open Agenda

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

Thursday 31 January 2013
7.00 pm
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Membership

Councillor Mark Williams (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Denise Capstick
Councillor Norma Gibbes
Councillor Rebecca Lury
Councillor Eliza Mann
Councillor The Right Revd Emmanuel Oyewole

Reserves

Councillor Sunil Chopra
Councillor Rowenna Davis
Councillor Paul Kyriacou

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

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Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 22 January 2013

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

Thursday 31 January 2013
7.00 pm
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Order of Business

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3.	**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.	
4.	**MINUTES** To approve as a correct record the Minutes of the open section of the meeting held on 18 September 2012 and 5 December 2012.	1 - 13
5.	**REVIEW - MATERNAL HEALTH & EARLY YEARS: GYPSIES AND TRAVELLERS** Southwark Travellers Action Group (STAG) made two submissions to scrutiny, which are attached.	14 - 46
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8.	**TRUST SPECIAL ADMINISTRATOR'S (TSA) REPORT AND RESPONSES** The Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London is attached, along with responses from the committee, King's Health Partners (KHP) and the council.	81 - 237
9.	**WORK PLAN**	
	DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.	
	PART B - CLOSED BUSINESS	
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Date: 22 January 2013

Agenda Item 4 Open Agenda

SOUTHWARK COUNCIL HEALTH, ADULT SOCIAL CARE, COMMUNITIES AND CITIZENSHIP SCRUTINY SUB-COMMITTEE

held jointly with

LAMBETH COUNCIL HEALTH AND ADULT SERVICES SCRUTINY SUB-COMMITTEE

MINUTES of the meeting held on Wednesday 5 December 2012 at 7.00 pm at Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1 2QH

SOUTHWARK MEMBERS PRESENT:	Councillor Mark Williams (Chair) Councillor David Noakes (Vice-Chair) Councillor Denise Capstick Councillor Patrick Diamond Councillor Norma Gibbes Councillor Eliza Mann Councillor The Right Revd Emmanuel Oyewole
LAMBETH MEMBERS PRESENT:	Councillor Davie (Chair) Councillor Marchant (Vice-Chair) Councillor Kingsbury Councillor Francis Councillor Whelan

1. ELECTION OF CHAIR

1.1 The committees elected Councillor Mark Williams as chair.

2. APOLOGIES

1.1 There were none.

3. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

2.1 There were none.

4. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

5. TRUST SPECIAL ADMINISTRATOR'S DRAFT RECOMMENDATIONS: SOUTH LONDON HEALTHCARE NHS TRUST.

5.1 The chair welcomed Mathew Hunt, Trust Special Administrator, Stephanie Hood, Director of Communications, and Dr Jane Fryer, Medical Director NHS South East London, and invited them to take questions on the Trust Special Administrators (TSA) draft report.

5.2 The chair opened the question and answer session by asking how King's Hospital would cope with the proposed closing down of Lewisham Hospital's Accident and Emergency (A&E) department and maternity department; particularly given that King's maternity department recently closed down for four days as it had reached capacity. The Trust Special Administrator responded that they have done some modelling on both travelling and patient choice and the modelling does demonstrate that it would affect King's. He explained that if the draft recommendations were taken forward, then the report identifies that money would be needed to make the changes and that there will be time to make the adjustments. The Trust Special Administrator added that the report is not saying that the present level of activity would carry on – community care is there to prevent people going to hospital and improve discharge. Additional capacity would be provided by changes in hospital provision and in community care.

5.3 The Medical Director added that the modelling predicted that 37% of "Blue Lights" would go to King's and that the TSA process recognises that the hospital cannot absorb this in its present configuration. She went on to comment that there are two maternity options for Lewisham Hospital and that the safety issues surrounding deliveries posed by each possible plan are being deliberated on. She reported that there would also be a need to consider the neo natal provision.

5.4 The Medical Director and Trust Special Administrator noted that this is a three year transitional plan; the first year will have a full business case and the following two years will have a high level plan The chair queried the level of detail in the plan and asked if the proposals are being tested with people working on the ground. The Medical Director reported that they had met with the members of the governing bodies of the trusts that are affected and that there is an external clinical panel. The maternity side has representation from the Royal Collage of Nurses and a focus group has been held with women with babies and those likely to have babies soon. The Trust Special Administrator added that there is also an independent Competition and Collaboration panel. He explained that the full report will be ready by 7th January and then this will be scrutinised by the Secretary of State and he will take advice from senior Department of Health officials including Bruce Keogh, Medical Director of the NHS Commissioning Board, and Sir David Nicholson, Director of the NHS Commissioning Board.

5.5 A member then asked the Medical Director to confirm that the reports estimate that 37% percent of the emergency cases seen by Lewisham Hospital would go to King's, rather than the 37% of overall activity, so around 25 % of the current emergency total. He asked the Medical Director how many additional ambulance journey miles would take place because of these changes. The Medical Director said she did not have information on ambulance journeys to hand but she could find out. She confirmed that Lewisham Hospital think that it would continue to see 70 - 80 % of A&E cases as an urgent care centre. She went on to explain that some of the blue light cases would currently go to the stroke hyper acute unit at Bromley or King's, and similarly a heart attack would be seen in a specialised centre, and noted that there are good examples of how if you concentrate clinical practice and standards there are better outcomes for patients.

5.6 The Lambeth scrutiny chair commented that the report's draft recommendations for maternity units appeared to propose four full units and one not quite a full one at Lewisham. He went on to say that, while he would have thought that it is possible to filter out some of the higher risk births, surely this would not be possible for all deliveries. He went on to voice concerns that more ambitious medical practitioners might not want to work at unit which did not offer the full compliment of obstetric and emergency back up services. The Trust Special Administrator commented that all five, if this option is taken forward, will be consultant led, and went on to observe that none of the present maternity units meet all the maternity standards now.

5.7 The Director of Communications commented that the draft recommendations propose four maternity units at all admitting

(A&E) hospitals and the possibility of a fifth at Lewisham, and this would be obstetric led. She went on to note that this unit presently takes 4000 live births , and only around three a year have needed wrap around services, and these could be dealt with if there are appropriate protocol and management of risk that would enable the transfer of these patients. A member asked if this five-model proposal had support and the Director of Communications confirmed it did. The member suggested that might be qualified support given the limited options. He went on to query if the Lewisham Hospital's maternity proposal would be clinically safe and financially sustainable over the longer term, however, he noted that 4000 is a considerable number of births to be redistributed over the health system. He asked if the downgrading or closure of the maternity unit would have an effect on the Evelina children's hospital at St Thomas' and noted that there is a problem around neo natal capacity generally in London.

5.8 A member asked the Trust Special Administrator how it was decided that the scope of this process would encompass the South East London healthcare system and six boroughs of Greenwich, Bexley, Bromley Lewisham, Lambeth and Southwark, and who took the view; was it the Secretary of State or was it was it his decision. He also asked why the whole of London was not considered and asked for confirmation that the process is for five years.

5.9 The Trust Special Administrator responded that the Secretary of State took this decision on the basis of a consultation exercise that he commissioned with the three boroughs most affected (Greenwich, Bexley, Bromley), the South East London cluster and Health Authority London. The consultees responded that a truly sustainable solution would need to look at the Private Finance Initiative (PFI), productivity and wider connectivity of the South East London healthcare system. The respondents considered that the problem of South London Healthcare Trust could not be solved independently. The Trust Special Administrator emphasised that his accountability is to deliver a solution for South London Healthcare Trust and this is the starting point of the process, under the direction, and in consultation with the Secretary of State. He explained that that the solution proposed would set out a plan for five years, with a three-year change process. This, he said, would deliver a strong and sustainable system that any additional changes, as a result, for example, of workforce changes or clinical changes, could adapt too.

5.10 The Medical Director added that that if we had not been here because of money then the South East London healthcare system would have needed to make changes, particularly around Accident and Emergency and maternity services, and it would have been necessary to have these conversations.

5.11 A member commented that he has looked at the evidence, which is quite strong, and asked if this is the major change process envisaged for the next five years. The Trust Special Administrator commented that five years is quite a long time and it is not anticipated that a similar conversation would be needed for some time. He went on to emphasise that a loss of around £55 - £65 million pounds a year by South London Healthcare Trust was not sustainable.

5.12 A member asked if the Trust Special Administrator thought that including the wider London system would have been helpful. The Trust Special Administrator responded that this it is out of his remit, and noted that there are other pieces of work being done in London to look at different aspects of the health service.

5.13 A member asked about the clinical governance model being employed around the elective centre, pre/post operative care and if computer systems would be able to talk with each other. The Trust Special Administrator explained that care would be delivered locally. He responded that there were several computer systems at South London Healthcare Trust that did not integrate; and one of the early priorities of the new organisations formed will be to connect together hospitals and services.

5.14 He noted that 70% of elective operations can be done on a day care basis, and that the elective centre will be a purely planed centre, and so not at risk of cancellations. He noted that there is an elective centre at Guy's Hospital and that the TSA process is recommending an elective centre at Lewisham Hospital. The Trust Special Administrator commented that is he is planning further work on the clinical governance model. He said it is planned that surgeons from other trusts would come to this site, feel a sense of responsibility and purchase services available. A member asked for confirmation that the elective centre would have surgeons coming from different trusts and organisations. The Special Trust Administrator confirmed this was the plan and noted that this model has been used successfully, so there is an existing practice to draw from, and that initial conversations and discussions have taken place.

5.15 A member said that she thought that the Trust Special Administrator had come up with a constructive set of recommendations that will save lives; however, she asked if there were any recommendations that were put in with a heavy heart. She went on to enquire if it would have been helpful to include social care within the change process. The Trust Special Administrator commented that we are still in a consultation process, that there was a challenging session last night at a public meeting in Lewisham, and that the TSA administrator team are not

immune to the comments. He went on to explain that the draft recommendations form a set of changes that are broad and challenging. They are not straightforward and without risk, however he said that he believed that they are a good set of recommendations that made the best possible case for moving forward.

5.16 The Trust Special Administrator agreed that the TSA administrator team could have gone broader and looked at health and social care. He noted the importance of other partners in the voluntary and independent sectors, and the local authorities, and the importance of the Health and Wellbeing Boards. The Director of Communications commented that this is response to a difficult situation and not a traditional NHS solution. She went on to note that Public Health elements are just as important and more investment is needed in this area.

5.17 A member noted that these draft recommendations as very substantial solutions and most of the impact is going to fall on Lewisham Hospital and King's Collage Hospital, which are not failing organisations. He went on to remark that there are legacy issues of both debt and people that will not be easy to resolve, however the report says little about risk. He also enquired about the estimate of 40 minutes from King's to Lewisham A&E via public transport. Lastly, he asked about the financing of the elective care centre and the impact on King's.

5.18 The Special Trust Administrator said in his view the biggest impact was on South London Healthcare Trust members of staff. He noted that while there was a significant impact on Kings they had received representations from King's College Hospital Trust (KCH) that had led to KCH being identified as the preferred provider to acquire Princess Royal University Hospital (PRUH). He noted that Lewisham Hospital is not a failing trust, but that emergency standards are not being met by any of the providers. He acknowledged that there are people who vehemently disagree with the proposal however to close the Lewisham Hospital A & E, but change is needed and this is the opportune moment. He said the major risk, in his view, was to keep the status quo. The Director of Communications commented that planned change would allow for financial stability from which will flow clinical stability.

5.19 The Medical Director commented that this is a clinically led process to achieved standards around emergency and urgent care. The number of admitting departments needed was considered in order to reach these standards. She reported that each of the A & Es were considered and a range of factors were considered, including travelling time and the evidence is considered in some detail in the report.

5.20 The Medical Director reported that the elective care centre will use a partnership model and that all consultants and activities would stay connected to the host organisations. She noted that there would be costs and that these would be owned by that system. A member asked how the elective centre would be funded and the Medical Director explained that there would need to be capital development and this would be given an additional allocation of money. A member asked if the IT system will be compatible and if patient records will marry up. The Trust Special Administrator agreed that connectivity is important and he would like to see better integration in the new organisations going forward.

5.21 The Special Trust Administrator was asked why there was a second option in the report for there to be procurement process for PRUH, which could lead to private organisation taking over PRUH. He responded that the draft report contains options and the final report may contain a more positive recommendation that KCH take over PRUH. The member noted that the detail of the report flags up the pension liabilities. The Trust Special Administrator responded that the main issues are the passion from KCH to acquire PRUH and the connectivity across South London, and that the pension liabilities are not a big issue.

5.22 The issue of additional resources was raised and the Trust Special Administrator was asked where these would come from. He responded that there would be additional resources that would not come from within the current budget.

5.23 The chair thanked the TSA team for attending and the Trust Special Administrator explained that the consultation responses he anticipated from scrutiny, and other bodies, would be published on the website alongside the final report.

5.24 The chair of Lambeth scrutiny invited Kate Hoey, MP for Vauxhall, to speak briefly on the TSA recommendations and the merger of King's Health Partners (KHP). The MP began by commenting that she is representing all five of the local MPs in calling for the super trust merger of KHP to be put on hold as the TSA draft recommendations would have a big impact on Guy's & St Thomas' and KCH. She went on to say she appreciated the openness that the Trust Special Administrator has shown.

5.25 The MP voiced concerns with the drive for the merger of KHP, as she said it did not appear to be a bottom up process, but instead led by the senior executives of the respective trusts. She said that, so far, she has seen little that will improve the health care of her local constituents and that all the MPs have called for an independent report, which has been commissioned, and she looks forward to considering this.

5.26 The MP commented that she does not want to see elective care only available in Lewisham Hospital. She closed her comments by emphasising that while negotiations were ongoing regarding KCH acquiring PRUH it was not sensible to precede with the merger plans for KHP and urged these plans be put on hold until after the Secretary of State has made the final decision. The Trust Special Administrator commented that the KHP merger is not mentioned in the report because the TSA process had a very specific brief.

5.27 The chair invited the Kings Collage Hospital (KCH) Trust representatives, Tim Smart, Chief Executive, and Michael Marrinan, Medical Director, to give evidence on the TSA draft report. They reported that they have contributed to the clinical advisory board as part of the process. The Chief Executive explained that KCH have felt for some time a commitment to finding a solution. He explained that this is partly self-interest, the trust has been losing £65 million a year and this is money that will not reach other parts of the NHS, but also KCH is part of Kings Health Partners (KHP) who consider ourselves to be system leaders, as they are an Academic Health Science Centre. He reported that KCH / KHP submitted an interest in acquiring Princess Royal University Hospital (PRUH).

5.28 The Chief Executive remarked that although KCH has successfully delivered on its targets for sometime the organisation does on occasions feel close to the precipice. He reported that their had been some difficult conversations concerning A & E and that if Lewisham Hospital's A & E is closed King's think that the hospital will see a higher number of admissions than the report's estimates.

5.29 The chair asked if King's had the physical space to expand its services and the Chief Executive said that unless King's can acquire the EDF site then there would be no additional room and this could lead to additional waiting times and more cancelations of operations. He went on to remark that the acquisition of PRUH could allow King's to decompress and this makes the expansion of their services more sustainable. The Chief Executive explained that KCH /KHP are putting together a business case for 13 December to acquire PRUH and this will be submitted to Monitor and the TSA. He explained that Monitor may take sometime to respond. He commented that in terms of the populations of King's this is the least worst course of action and that this is not something that KCH would choose to do.

5.30 The chair asked how the proposed merger of KHP is progressing, given the implications of the TSA report, and the Chief Executive responded that KHP are not spending significant amounts of time and money during the TSA process.

5.31 A member asked what would be the impact of acquiring PRUH on

KCH governance and the Chief Executive responded they KCH would need to change their governing document, and they may consider their non-executive directors, however two already are representative of the PRUH local population so significant change of the directors is not anticipated.

5.32 The KCH Medical Director commented that KCH agree that concentrating emergency services can improve clinical outcomes. He said that King's have the clinical capacity, with equipment and staff; however, physical space is an issue. He reported that some services could relocate to Guy's, St Thomas, and PRUH.

5.33 A member referred to the proposed merger of KHP and voiced concerns that the uniqueness of each organisation might be lost and a possible consequence could be that each takes on the worst practices of each.

5.34 The Chief Executive responded said that the merger will need to take the best of all three. He commented that the most important benefit for local people would be the tying together of physical and mental health and noted that mental health is hardly given a mention in the draft TSA report. He reported that the rheumatology department have a psychiatrist present and they have started to include a question about how patients are feeling. Because of this they have diagnosed that 30% of patents are clinically depressed, but 75% of these had been undiagnosed. He reported that this was a significant healthcare gain. The KCH Medical Director added that KHP allows clinicians to support each other's specialities.

5.35 The Chief Executive was asked by a member if he saw the proposed acquisition by KCH of PRUH as a forced marriage and he responded that KCH could clearly have declined, however there has to be a solution and the taxpayer will benefit if PRUH is run as efficiently as King's and Guy's & St Thomas'.

5.36 A member referred to the lack of physical capacity to expand at King's and asked if KCH still have an interest in Dulwich Hospital and the Chief Executive responded that it is no longer owned by the KCH Trust. The Medical Director said that it is possible that this location could be utilised as a dialysis centre.

5.37 The Chief Executive was asked to expand on the pressure that A & E at King's is experiencing and he explained that King's until recently has seen around 25 to 30 patents a day, however this is now about 40 a day. The level of attendance has stayed as high as last winter. He explained that the average stay is 2 days; however, an 80 year old can stay much longer. This can have a knock on effect on elective care. He ended by saying that he thinks that the number using A&E could go up to 50 - 60 if Lewisham Hospital A&E closes. The KCH Medical Director

reported that King's do not meet all the clinical standards, and no hospital in London does, however King's and St Thomas' hospitals are closer. He commented that the earlier an emergency patient sees a consultant the better and that the A & E proposals have clinical value.

5.38 The chair then invited representatives from Guy's & St Thomas Trust; Jackie Parrott, Director of Strategy, and Dr John Scoble, Deputy Medical Director, to give evidence. They explained that they also sat on the clinical advisory panel of the TSA. The Director of Strategy noted that they could take on extra maternity cases; however, they would need additional capital investment. She reported that all local hospitals sometimes have to cap their maternity admissions to prioritise. She noted that there are additional implications on paediatric services if maternity at Lewisham Hospital closes and the report is silent on this.

5.39 A member asked if Guy's and St Thomas' Trust thought that their urgent care centre at Guy's Hospital was really working and they responded that they thought it was. They went on to note that the Lewisham Hospital's proposed urgent care centre would do more , however they questioned the modelling over numbers and said that they thought more anticipated patients would use King's and St Thomas' hospitals A & E.

5.40 The chair then invited Andrew Bland and Andrew Eyres, Southwark and Lambeth Clinical Commissioning Group executive officers, to comment on the TSA proposals. The CCG officers commented that no change is not an option and went on to comment that they would like to be assured that the patient flows are well planned out and that the plans for community care are important and that patient's choice will be optimised. They supported the move to treatment closer to the home and greater specialisation in hospitals, and noted the successful work on stroke centres.

5.41 A member asked about travel times to the proposed elective surgery centre at Lewisham and asked if patents and families will have the resources. The CGC officers remarked this raises important issues of quality and inequality, and that sometimes there is a trade between the need to travel and quality. The chair of Southwark CCG commented that the transition process is short and it is important that this is done well. A member asked if the CCG are consulting with their membership on the TSA proposals and the CCG executives responded that they are not holding specific events, as this process is led by the TSA; however, they are raising the issues at their usual events and passing on comments to the TSA, where appropriate.

5.42 The chair then invited Patricia Mobley, local resident, to give

evidence. She explained that she is the ex-chair of Guy's and St Thomas' Trust board. She spoke about the planned large elective centre at Lewisham Hospital and noted that Guys and St Thomas's elective care is second to none, and that urgent and elective were separated about a decade ago. She raised concerns that Southwark and Lambeth residents would have to use the elective centre Lewisham Hospital. She commented that the culture of the teaching hospital at Guy's is important, and that KHP is driven by the high clinical standards of an Academic Health Science Centre.

5.43 A member noted the success of concentrating clinical specialisms, such as heart centre, stroke and cancer care and suggested that elective care may benefit from this too. Patricia Mobley responded that a teaching hospital allows a good mix of complex and straightforward cases and, moreover, Guy's has seen significant investment in its elective centre.

RESOLVED

The committees both resolved to consider the evidence received and draft written submissions for the Trust Special Administrator.

6. PROPOSED MERGER OF KINGS HEALTH PARTNERS

6.1 The chair invited Professor John Moxton, KHP Director of Clinical Strategy, and Jill Lockett, KHP Director of Performance and Delivery, to introduce the discussion on the proposed merger of King's Health Partners (KHP). The Director of Clinical Strategy started by explaining that KHP is already an Academic Health Science Centre and the central motivation for this proposed merger is to improve the outcomes for our patients, many of whom have ordinary conditions.

6.2 The chair asked the Director of Clinical Strategy how confident he was in the proposals of the TSA and he responded that constructive reservations had been expressed. He noted that no patient is going to leave local providers to receive less good care elective. A member wondered if the Secretary of State had the power to dictate this and the Director of Performance and Delivery comment that she did not think the plan was that all elective care would go to Lewisham Hospital. She commented that we know the elective care at Guy's and St Thomas' is good.

6.3 A member asked the Director of Clinical Strategy if KHP are still

proceeding with the merger and he explained that they are moving forward, as KHP are keen to maintain momentum, but more slowly. He reported that they are waiting to hear the Secretary of State's announcement on the TSA report before they start the stakeholder consultations.

6.4 A member asked if there was equal enthusiasm across all four organisations, and commented that he had heard that SLaM were not so keen. The Director of Clinical Strategy commented that at the beginning the proposed merger was led by the two acute trusts (Guy's & St Thomas' and KCH) however, as the acute trusts have become more aware of the importance of mental health, and likewise clinicians working in mental health have become more aware of the physical health needs of their patients, all the trusts now see the great benefits of coming closer together.

6.5 It was noted by a member that the reports outlining the virtues of a KHP merger often emphasize the world-class nature of the clinical care that can be better delivered, rather than improvement to local people's health. The Director of Clinical Strategy commented that this is about driving up the value of health care. He commented that there are people in the health economy who are just talking about cost, others just about outcomes. He stated in his view both are useless and we need to talk about a value of an intervention.

6.6 A member commented that he would like to see more under-represented groups working in medicine, more black and working class people. He noted that the predeterminants of health are paramount and quality employment is one of these. The Director of Clinical Strategy agreed that jobs are of great importance and that a successful, expanding organisation driven by excellence will improve these prospects. He noted that there is a move to treat patents in the community, rather than hospital institutions, and better meet the needs of tertiary patents. However, at the same time he envisaged that hospital services such as bone marrow transplants would expand as people travelled to King's for treatment.

6.7 KHP staff were asked about improving quality and how the proposed merger would affect this. The Director of Clinical Strategy commented that they are measuring things constantly, such as outcomes and satisfaction, in different locations and settings. He reported that this enables patterns and variation to be identified and so drive up quality.

6.8 The chair ended by commenting that he is glad to hear the plans for merger will be slowing, because of the TSA report, albeit not stopping.

Southwark Council Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee

Exploring the issue of access to maternal health and early years services for the Gypsy and Traveller communities in Southwark

Who are Gypsies and Travellers?

While there is no fixed definition for Gypsies and Travellers, probably the most appropriate definition is:

'…persons of nomadic habit of life, whatever their race or origin.'[1]

Gypsies and Travellers is a commonly used term that includes people from a variety of groups, all of whom are or were nomadic. The main groups are:

- English Gypsies
- Romany Gypsy refugees and asylum seekers
- Irish Travellers
- Fairground and Show people
- Scottish
- Bargee and water craft Travellers
- Welsh
- New Travellers (people from the settled community originated in the 1960s Hippy movement and successive waves since)
- Circus people

Romany Gypsies, Irish, Welsh and Scottish Travellers are recognised in law as ethnic groups and are identified as having a shared culture, language and beliefs. Groups that are not currently recognised as an ethnic group, include New Travellers, Bargees and Travelling Circus and Show people. However, these are minority groups protected to some extent under general equalities legislation.

The history and culture of Irish Travellers and Romany, English, Welsh and Scottish Gypsies

The first Gypsy people migrated into Europe from India in the middle Ages, arriving here in the 15th Century. Due to the darkness of complexions, it was thought they had come from Egypt and were called 'Egyptians', hence the spelling of 'Gypsy' from 'Egypt'. Irish Travellers are said to have been people who took to the roads because of the hardships of Cromwell's campaign in Ireland or the Potato Famine.

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[1] Brighton and Hove City Council Scrutiny report on Travellers March 2012 and the Caravan Site and Control of Development Act 1960 and in addition the Caravan Sites Act 1968 http://www.legislation.gov.uk/ukpga/Eliz2/8-9/62 and http://www.legislation.gov.uk/ukpga/1968/52/pdfs/ukpga_19680052_en.pdf

While there are distinct traveller identities and cultural norms, there are also cross cultural and physical co-location between many different types of travelling and gypsy communities; this is a heterogeneous community.

Population
It has been estimated that there are around 300,000* Gypsies and Travellers in the UK.[2]

In the Gypsy and Traveller Caravan count for January 2011, which is carried out twice a year on behalf of the Government, the total number of Gypsy and Traveller caravans was 18,383 caravans, which represents a very marginal increase from 2010. The count indicated that 17% of Traveller caravans in England were on unauthorised land and 83% were on authorised land. [3]

Southwark has 41 authorised plots.

The census data has come back with a figure of 263 Gypsies and Travellers in Southwark, however STAG estimate the Traveller population is around 1250. Accurate figures for Gypsies are not known.

Southwark Traveller Action Group

Southwark Traveller Action Group (STAG), based at Peckham Settlement, have been vital to the council's engagement with Travellers, and successes have included liaison about site upgrading and engagement with Travellers about site planning issues. STAG used to get Working Neighbourhoods Fund money from the council until March 2011 when that funding stopped because of central government cuts.

Southwark Authorised sites

There has been a recent focus on solving engagement issues between housing agencies and Travellers, as site upgrading has been flagged up to the council as the highest priority need, and all 4 Traveller sites are going to be upgraded by 2013 (3 have already been upgraded).The council's focus on improving sites in order to improve all aspects of wellbeing amongst Travellers has been given support by a report commissioned by the GLA into Traveller's housing needs.[4]

These are the Southwark sites:

1.Brideale Close SE15 (Off Glengall Road)
16 Plots - 10 Single Plots and 3 Double Plots.
(Site Refurbishment 2008)

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[2] Commission for Racial Equality, 2003
[3] Gypsy and Traveller caravan count January 2011
http://www.communities.gov.uk/documents/statistics/pdf/1932949.pdf

[4] (GLA, 2008).

2. Burnhill Close SE15 (Off Leo Street, Behind Toys 'R' Us in Old Kent Road)
5 Plots - All Single Plots
(Site Refurbishment 2011)

3.Ilderton Road SE16 (Next to South Bermondsey Railway Station)
15 Plots - All Single Plots
(Site Refurbishment 2006)

4. Spring Tide Close SE15 (Off Staffordshire Street, Behind Peckham Police Station)
5 Plots - All Single Plots
(Site Refurbishment Planned for 2013)

There is a dedicated Travellers Housing officer, Paul Jeffrey, who since October 2011 has been working with Travellers. He is focused on improving the repairs service, council cleaning and refuse collections etc. A new allocations policy and pitch agreements are being devised and should be ready to be implemented early in 2013.

Southwark Council's Community Engagement work

Southwark Councils Community Engagement division works closely with STAG. The council has done some excellent engagement work in recent years through a focus on culture - specifically the Pavee Widden photography project, and work around Gypsy Roma Traveller History Month in June. Southwark won a major European award last year for its work with Traveller communities. Southwark was awarded second place in the Dosta Congress Prize (recognising work with GRT communities across Europe) by the Congress of Local and Regional Authorities (part of the Council of Europe). First place went to Finland and Serbia - and Southwark was just one point behind them. The awards ceremony was in Strasbourg on October 19 last.

Travellers and Gypsies; economic and social depravation and exclusion.

Most of the data and reports about social and economic deprivation are centred on The experience of Irish Travellers and Romany, English, Welsh and Scottish Gypsies. There is are some very limited studies on New Travellers, which indicate some social disadvantaged and exclusion. Only limited evidence exists on the health status and life expectancy of Show people but where data is available, it would appear that members of this population have generally better health and a longer life expectancy than Gypsies or other Travellers. [5]

The aspects of Gypsy Traveller health that show the most marked inequality are self-reported anxiety, respiratory problems including asthma and bronchitis, and chest pain. The excess prevalence of miscarriages, stillbirths, neonatal deaths and premature death

[5] Inequalities experienced by Gypsy
and Traveller communities: A review
Equality and Human Rights Commission Research Report

http://www.equalityhumanrights.com/uploaded_files/research/12inequalities_experienced_by_gypsy_and_traveller_communities_a_review.pdf

of older offspring was also conspicuous. There is less inequality observed in diabetes, stroke and cancer. [6]

Summary of some of the key health related inequalities experienced by Gypsy and Traveller communities

It needs to be noted that this information (and the more detailed information below about maternal health and early years) is drawn from a range of peer reviewed published research literature based on different gipsy and traveller groups. It is designed to introduce some of the common issues which have been established in a body of research into the health status and needs of gypsy and traveller population. Although it is a starting point for reflecting on the local situation, it should not be applied uncritically to the Southwark population. The 2011 Census included gypsies and travellers for the first time and once the data is available this should be helpful in increasing knowledge, assessing and meeting local needs more effectively**.**

- Gypsies and Travellers die earlier than the rest of the population.
- They experience worse health, yet are less likely to receive effective, continuous healthcare.
- Children's educational achievements are worse, and declining still further (contrary to the national trend).
- Participation in secondary education is extremely low:
- There is a lack of access to pre-school, out-of-school and leisure services for children and young people.
- There is an unquantified but substantial negative psychological impact on children who experience repeated brutal evictions, family tensions associated with insecure lifestyles, and hostility from the wider population.
- Employment rates are low, and poverty high.
- There is an increasing problem of substance abuse among unemployed and disaffected young people.
- • Within the criminal justice system – because of a combination of unfair treatment at different stages and other inequalities affecting the communities – there is a process of accelerated criminalisation at a young age, leading rapidly to custody.
- There are high suicide rates among the communities.
- Policy initiatives and local health strategies that are designed to promote inclusion and equality frequently exclude Gypsies and Travellers. This includes political structures and community development and community cohesion programmes.
- There is a lack of access to culturally appropriate support services for people in the most vulnerable situations, such as women experiencing domestic violence.
- Gypsies' and Travellers' culture and identity receive little or no recognition, with consequent and considerable damage to their self-esteem.

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[6] The Health Status of
Gypsies & Travellers in England
Report of Department of Health Inequalities in Health Research Initiative
Project 121/7500

Source: Research report 12: Equality and Human Rights Commission (2009)

The Equality and Human Rights Commission Research Report: Inequalities experienced by Gypsy and Traveller communities, states that one core theme which arises across all of the many of the reports they reviewed is the pervasive and corrosive impact of experiencing racism and discrimination throughout an entire lifespan and unemployment, social and public contexts.

Southwark Councils understanding of Gypsy and Traveller health inequalities

There is a good understanding of the needs of Gypsies and Travellers; the council's equalities and human rights scheme (2008 - 2011) stated that:

In the Traveller community; "there are higher than average rates of diabetes, high blood pressure, depression and anxiety, asthma and other chronic respiratory diseases, eczema, miscarriages (3 times more than average, possibly this is an underestimation), infant mortality is also 3 times higher than average, possibly more, low birth weight, bullying (Traveller children are the most likely to be bullied out of all ethnic minorities), there is a lower than average life expectancy (reduced by 10 – 14 years) and finally, it is estimated that Travellers are 20 times more likely to loose a child (in the course of a lifetime)."

The document argues that low wages/low incomes, housing standards, poor educational opportunities, being an "invisible ethnic minority", and problems with affordable childcare all contributed to higher levels of illness. The council intend to look at post census 2011 findings and the impact of these on Gypsies & Travellers

Why the focus on Maternal Health and Early Years (under 3)?

The review has chosen this focus for two reasons; to link the initiative with priorities identified by the Marmot review and the evidence that this is a significant maternal and early years health inequality experienced by Travellers and Gypsies**.**

Fair Society, Healthy Lives the Marmot Review

The first policy objective the Marmot Review identifies is to 'give every child the best start in life. The reports states that giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional– are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being–from obesity, heart disease and mental health, to educational achievement and economic status.

To report goes on to argue that to have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later

interventions, although important, are considerably less effective where good early foundations are lacking.

The report advocates reducing inequalities in early child development by continuing and sustained commitment to the Sure Start and the Healthy Child Programme. It is vital that this is sustained over the long term and the report recommends even greater priority must be given to ensuring expenditure early in the developmental life cycle (that is, on children below the age of 5) and that more is invested in interventions that have been proved to be effective. They call for a 'second revolution in the early years', to increase the proportion of overall expenditure allocated there. This expenditure should be focused proportionately across the social gradient to ensure effective support to parents (starting in pregnancy and continuing through the transition of the child into primary school), including quality early education and childcare

Priority objectives

1. Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.

2. Ensure high quality maternity services, parenting programmes, childcare and early year's education to meet need across the social gradient.

3. Build the resilience and well-being of young children across the social gradient.

Policy recommendations

1) Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early year's development is focused progressively across the social gradient.

2) Support families to achieve progressive improvements in early child development, including:
— Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
— Providing paid parental leave in the first year of life with a minimum income for healthy living
— Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families
— developing programmes for the transition to school.

3) Provide good quality early years education and childcare proportionately across the gradient. This provision should be:
— Combined with outreach to increase the take-up by children from disadvantaged families
— Provided on the basis of evaluated models and to meet quality standards.

The focus on Maternal Health and Early Years (under 3)
Detailed evidence of Traveller and Gypsy maternal health and early year's child inequalities

There are high rates of maternal death during pregnancy or shortly after childbirth. [7] The report of the Confidential Enquiries into Maternal Deaths in the UK1997-199923 found that Travellers have "possibly the highest maternal death rate among all ethnic groups."

The Health Status of Gypsies & Travellers in England Report of Department of Health reported that most studies on Traveller and Gypsy health are small, localised, descriptive, and focus on maternal and child health, including immunisation, consanguinity and congenital anomalies. Few studies involved Gypsy Travellers' active participation in the research process. The evidence from these studies suggests high infant mortality and perinatal death rates, low birthweight, low immunisation uptake and high child accident rate.

Their study therefore set out to do more comprehensive research matching Gypsy and Traveller women with age and children matched counterparts. They examined the rates in the two groups with children: 150 Gypsy Travellers and 141 comparators (although within these groups, the Gypsy Traveller mothers had more pregnancies and deliveries). There were no significant differences between the number of Gypsy Travellers and comparison women reporting a number of problems with pregnancy or childbirth, such as morning sickness, pre-term birth, breech presentation, or post-natal depression. However, more Gypsy Travellers experienced one or more miscarriages – 43 (29%) and Caesarean sections – 33 (22%) Gypsy Traveller women compared with 18 (16%), and 20 (14%) respectively of the non-Gypsy Traveller group with children. Conversely, hypertension was less commonly reported by the Gypsy Traveller women 2 (1%) compared with 11(8%) of comparators.

The study also looked at premature death of offspring, in response to the question "Are all your children still living?" 25 of 142 Gypsy and Traveller women **(17.6%)** had suffered the death of a child (of any age but excluding miscarriages) compared with one of 110 matched comparators (0.9%) ($\chi 2=16.9, p<0.001$). Information was missing for two Gypsy Travellers and six comparators. Eight Gypsy Travellers but no comparators reported one or more stillbirths or death of a neonatal infant, with one woman experiencing multiple stillbirths.

Comprehensive data in respect of children are lacking, but studies have found higher rates of illness among Gypsy and Traveller children as compared with others [8] with a reported higher rate of accidents among children, related to parental difficulties in accessing appropriate information on accident prevention and the impact of poor quality sites on injury rates. [9]

[7] Parry et al, 2004
[8] Pahl &Vaile, 1986
[9] Beach 2006

Southwark Council Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee

Project: Exploring Access to Maternal Health and Early Years Services for the Gypsy and Traveller Communities in Southwark

Notes of Stakeholder Workshop – 24th October 2012

Contributions from Health Inequalities Engagement Wheel Activity

See attached photographs of completed Engagement Wheel exercises including locations of statements.

- How many travellers are there in Southwark? How do we count them and is there self-identification?
- Accessing statistics on the population including from the sites, from housing statistics and from 2011 census (Check with Dan Gilby)
- Understanding the ethnic breakdown of the communities
- Building trusting relationships with individual health workers
- What level of engagement is there with services – health, education and children's centres?
- What are the immunisation issues – does the community want this service?
- Why is maternal health poor in these communities? Need to understand the underlying causes including possibilities such as not accessing care, poor housing, poor education or low incomes
- Taking an ethnology / medical anthropology approach – understanding cultural norms, assessing our own prejudices and norms about issues such as teenage mothers and family planning
- Extended families – issues such as overcrowding as families grow up and have difficulty finding sites
- Allocation policies for sites – what is being developed?
- Accommodation Needs Strategy
- Looking at good practice and research – what can we learn from this?
- Sex education – what are the outcomes?
- Planning applications issue – planning are reluctant to receive applications for additional sites because of a perception that there will be community resistance. This is something that needs to be tested. Community Engagement can play a role in relationship building. Southwark has small sites that allow better community integration and build on good practice as this is often preferred by Gypsy and Traveller communities
- Family Nurse Partnership – good outcomes following young mums and offering support and education. A programme that focuses on empowerment
- Create small sites – better practice, better neighborhood relations, networks into communities
- Good outcomes from mum and baby immunisation programmes

- Travellers in nursing homes – issues of deprivation, vulnerability and resilience
- Social support and extended networks for young mothers
- Density issues – sites have high density and the pitches as high density
- Knowledge gap – how many women in the local Gypsy and Traveller communities?
- Who makes referrals for Gypsy and Traveller women – understanding the pathways for referrals from GP, Health Visitors, and Midwives.
- Elder males may make the key decisions in the Gypsy and Traveller communities – it is important to appreciate this and build trust with services
- Could we have a meeting with Anne-Marie plus any mums and mums-to-be to ask them what they want? Could also involve midwives, health visitors and children centre workers
- Self-reliance an important value for the communities – wanting to look after themselves
- Understanding the nomadic traditions of Travellers and how many might be based on sites and how many may travel to and from Ireland
- Develop a dialogue with the community
- Mums may feel more comfortable in groups to access services – safer than going alone
- Domestic violence issues – link to Solace
- Cultural understandings of illness and disease
- Education issues – younger children accessing appropriate services and early intervention services at the early years baseline
- Inclusive services
- Understanding the education pathway – including from nursery to secondary school and academies
- Pregnancy – what is the take up of ante-natal classes?
- What data is there on infant mortality? Also understanding if babies have low birth weight
- What are the birth rates for the community
- Building on trust – professionals supporting the community to make new contacts including good signposting
- Registration issues with GPs
- Understanding the needs of the community including demographic structures
- Linking to a named contact person for each site – this may be easier for the settled population. Having a ‘go to person’ for each site
- Pitch provision
- Legal obligations
- Early engagement
- Engaging the Gypsy and Traveller communities in the scrutiny review itself
- Cultural issues around smoking and alcohol
- Lack of awareness in the wider community of the needs of Gypsies and Travellers – attitudes and local treatment of families

- Recruitment drive for more early years staff from the Gypsy and Traveller communities – making the application process accessible
- Employment issues
- Access to welfare provision and benefits
- How has immigration affected the casual work that may be part of the Gypsy and Traveller employment patterns?
- Socio-economic issues
- How have Gypsy and Traveller's been affected by transport issues and the rise in petrol prices?
- How accessible are bus routes for the sites and for the community?
- Need to understand how traveller families cope with illness and who helps them the most.
- Overcrowding issues - health needs of growing communities and accessibility of local services.
- Contact Sharon Dewar in Community Safety about her domestic violence project with travellers.
- Are Traveller women/clients accessing maternity services? What is the time trajectory for this – is it in good time or too late
- Health research indicates a higher mortality rate for the Gypsy and Traveller communities- 17.6% lost a child compared to 1% within the wider population.
- Is there any data from reports on child deaths in Southwark? Approach the child death overview panel to gain some insight. Key contact Rory Paterson
- Issues about permanent housing and the need for long-term planning
- Sites good but overcrowded
- Understanding the history of the sites and the communities' experiences is important
- Many local families have been on sites for decades and there are inter-generational experiences

Record of flipcharts from the Effective Scrutiny activity

Effective scrutiny of maternal health and early years services for the Gypsy and Traveller communities will…	**Effective scrutiny of maternal health and early years services for the Gypsy and Traveller communities does not…**	**Ways to measure how the scrutiny review has made a difference**
• Do no harm • Avoid preconceptions • Adds value • Shows impact and positive outcome • Giving a voice to Gypsy and	• Alienate by using impenetrable language • Import our views and values on the community • Forget Gypsies and Travellers are people and	• Building organisational knowledge • Immunisation rates • Action plans and indicators • Access to family services

Traveller communities • Meaningful and purposeful for community • Results in action plan and recommendations (followed up and executed) • Improving mainstream practices and long-term solutions • Improves on-going sites/pitches, management e.g. repairs, improvements and educational outcomes. • Improve access to all council and other services/employment • Break down barriers/increasing understanding • Appreciative Inquiry • Identity issues • Improve outcomes • Good engagement – access to the community (meeting of different agendas – finds a middle ground) • Being culturally sensitive – e.g. bereavement counselling • Identify	does not marginalise them • Ignore poor environment and basic services • Ignore the degree of statistical significance • Make promised it cannot keep • Raise expectations	• GP registration rates • Access to child care – registration, attendance, progress and development • Access to apprenticeships • Maternal and child health • Early access • Tailor services to meet families perceived needs • Obesity in children rates • Verbal interviews and questionnaires to access traveller client satisfaction

contradiction of goals e.g. immunisation • "Listening" meeting with Midwife/Health Visitor /Children Centre outreach workers • Identify priorities e.g. law versus choice issues • Asks how far national evidence is locally relevant in Southwark – looks at child mortality rate 17.6% • Is access to services similar or different between the local and national picture. • Identify common ground between local government and the Gypsy and Traveller communities		

Record of issues raised during the plenary discussions

- Explore the possibilities of taking tools from an appreciative Inquiry approach
- All participants felt that the next stage of preparing for the review should consider sensitive ways to engage the local Gypsy and Traveller communities and hear their voices and experiences. Expert advice from the community and from trusted professionals would help inform this engagement
- Identify which stakeholders were not able to attend the workshop and follow up with discussions about the issues raised to further inform the scrutiny review
- Gender will be a key dimension of the review and understanding the experience of women
- Questions were raised about the continuation of funding for Stag

- There was a general consensus in the workshop that the scrutiny review could play and important role in synthesising the range of data about the Gypsy and Traveller communities in Southwark and using this to identify key issues 'in the round' – including where the gaps are, what data is not currently being collected and where the data identifies counter-intuitive issues
- A key question is how far does local Southwark data and experience reflect the national pattern.
- Further work is needed to access public health data and a variety of statistical measures including maternal and infant mortality rates
- There was a proposal for the development of one named Health Visitor for each site – ideas were also raised for a one-stop health shop for each site to mirror the current provision of named housing officers for each site
- The review could usefully consider the issue of Gypsy and Traveller housing and site needs in the current consultant on the Southwark 30 year housing strategy
- Rates of domestic violence will need to be considered by the review
- There was discussion about schooling experiences for young people and the pattern of drop out from education at 13 or 14 years particularly for young men to begin work
- Ideas were proposed for immunisations being offered on the sites
- A general consensus was established in the workshop that more on site health provision would have the potential to be beneficial
- Questions were raised about access to GP and other health services for families that do not have a telephone landline

Collated feedback from the questionnaire

a) What were the most useful aspects of the workshop?

- Learning from those with experience of the traveller communities
- Group work
- Sharing perspectives and issues affecting Travellers
- Talking to each other
- Meeting and mixing with other professionals
- Discussion groups and collating of ideas/suggestions…
- Meeting colleagues working with the Gypsy and Traveller community
- Fruitful discussion from a range of disciplines
- Seeing people's commitment
- Understanding the service provision for Gypsy families.
- The different approved sites available in the Southwark borough
- Meeting people from different perspectives on the issues – sharing experiences and ideas

b) Any gaps in the topic of maternal health that the workshop did not address:

- Engagement/views of travellers (qualitative data)

- Qualitative data – actual numbers
- Personally I think there could have been a deeper consideration of 0-8 years issues
- Statistical evidence and data both nationally and locally would have been useful
- Gap in what the community itself thinks and feels – but plans are in place for that. This needs to be a starting point.
- Men
- We did address but numbers were not known – e.g. death rates etc

c) What should a scrutiny review do next to take forward the review?

- Engage with Travellers
- Formulate detailed objectives
- Keeping individuals included of the outcomes and impact of the workshops
- Perhaps a follow-up workshop
- More detailed information re: demographics; pitch conditions; numbers settled in houses; This data needs to be quantified and explicit for the review
- Provision of services on sites
- Ensuring that health visitors, midwifes, educators are on sites
- Provision and making sites suitable for families
- Meet again, perhaps with further information but also with a plan to take forward

d) Any further comments:

- A useful exercise could be to ask ourselves about our prejudices/'middle-class – centric' outlook, for example, values associated with level of formal education, age of mothers, income, family size etc.
- Thanks
- Please ensure that the final reports and any documents for this workshop are sent to the participants
- Really enjoyed the workshop and engagement of the group
- A nice delivery

Attachments:

1. **Photographs**
2. **Facilitation Plan and Timetable**
3. **Pre-workshop briefing sheet and summary of data and evidence provided to participants**

Paul Cutler
Centre for Public Scrutiny
5th November 2012

Scrutiny review on maternal health and early years services for the Gypsy and Traveller communities in Southwark

Notes of mini stakeholder meeting on 17th December 2012

Present:

Cllr Mark Williams
Jin Lim
Rahala Manna
Kevin Dykes
Julie Timbrell

Summary

1. **Report on follow up work from Stakeholder day**

Southwark Irish Traveller Group (STAG) have compiled a paper summary of issues of concern; some of which relate directly and indirectly to the maternal health and early years services.

There will be a consultation event on 18th December with Traveller women.

The child death overview panel has been contacted and reported that were a very small number of gypsy and traveller families affected but too small a number to draw any statistical conclusions. Transience and early access to anti natal care was an issue identified.

Domestic Violence emerged as an issue of concern at the stakeholder day and during later discussions with STAG. Community Safety and SOLACE will be contacted and follow up work done on this by Rahala and Julie. Issues include the referral process to a refuge used by Traveller women, supporting STAG, and working with perpetrators.

2. **Additional work needed**

OSC / framework
The Overview and Scrutiny Committee (OSC) 'called in' the new site agreements being developed because of concerns over inadequate consultation and because of the restrictions on travelling. This is now being reviewed and the Council will be working with STAG and others on this. Cllr Mark William recommended that an overarching framework for Gypsies and Travellers be adopted, and this had support at OSC.

Health
Follow up work with Health Visitors is recommended – the ones who attended the stakeholder event made a good contribution. Access to GPs was an area of concern, and it would be good to know if this is an area of concern with Travellers. The

Clinical Commissioning Group should be contacted. Training in cultural sensitivities was discussed as a recommendation.

Early Years
Neil Gordon – Orr has identified, from Southwark's 2102 Early Years Foundation Stage data, that of 3389 children, only three children were categorised as 'Travellers of Irish origin', two at Pilgrims Way school (near Ilderton Road site) and one at Ann Bernadt Nursery School and Children's Centre in Peckham. Two children were defined as 'Gypsy/Roma', both Polish speaking - one at Kintore Way Children's Centre in Bermondsey and the other at Pilgrims Way. There was a discussion about increasing the number accessing the universal early years offer at three years, and how to support eligible families from these communities in accessing the free two-year-old places, which come on stream in September 2013 and will initially be targeted at families eligible for a range of worklessness benefits. There was discussion about prioritise at a time of reducing resources. There is a parliamentary report that indentifies the impact of accessing Early Year provision and the potential savings in later year, which would link with the Return on Investment.

3. Return on Investment – measurement and outcomes

Paul explained that this process identifies three key concepts: input, outputs, and outcomes.

The inputs measure the amount of hours invested by members, officers and the voluntary sector and then multiplies these by an average salary to get a cash value. The outputs are the process, networks, relationships, plans and frameworks. The outcomes are the impacts on early years or maternal health of Gypsies and Travellers. Outcomes could be measured over the shorter term and initially cost more (accessing more Early Years or anti-natal services) but save money in the longer term.

4. Scrutiny review date Westminster venue (Westminster City Hall) 25th January - 11 am to 3 pm

Paul reported that this event is being organised by the Centre for Public Scrutiny. This review is part of a series of scrutiny reviews being supported that focus on marginalised groups. Other groups are homeless and sex workers. Common themes are attitudes to excluded groups. There will be a publication identifying good practice drawing on all the reviews. Southwark's review will contribute, and we will need to prepare a presentation. A government minister from CLG is expected to attend. There are themed groups: engaging communities; process of model and return on investment.

It was agreed to meet on Friday to review the workshop-taking place on Tuesday.

Maternal Health and Early Years consultation event with Gypsy and Traveller mothers, mothers to be and female family members.

Tuesday 18 December 2012

Willowbrook Centre
48 Willowbrook Road
SE15 6BW

Present:

Ann-Marie O'Brien - Southwark Travellers Action Group (STAG)
Anna Rawlinson - Children's Centre midwife
Jo Anne Gould - Southwark Council Early Years
Julie Timbrell - Southwark Council Scrutiny
Rahala Manna - Southwark Council Community Engagement
Traveller Participant
Traveller Participant
Traveller Participant
Traveller Participant

The aim of the session was to listen to the community about their experiences of Maternity and Early Years services, discuss the services available, start to explore how to better meet the needs of the community and promote access to services, and build relationships.

This is a summary of the discussion:

Midwifery

Anna explained that the midwives look after women from ten weeks after conception, during birth and for the postnatal period. Women can refer themselves directly to the service. The midwife will look after the pregnant woman, whatever her health condition, and in partnership with other professionals if there are any existing or emerging medical conditions. Midwives support women to access the type of birth that they would like. This can be in hospital or at home.

Women spoke about their experience of maternity care. This ranged across a poor experience at St Thomas's hospital with an induced birth, a good experience with King's and a supportive midwife, a good experience for an expectant mum at her GP practice and a good experience of an anti-natal clinic staffed by a King's midwife, based at the now closed one o'clock club at Leyton Square.

Anti-Natal classes

Women did not take up anti-natal classes and instead relied on the support of mothers and other female relatives. Husbands did not traditionally attend birth, but now sometimes they would come along, but the women would take a more active role. Often a couple of female relatives would attend the birth, but occasionally there would be more women. One or two of the women showed a tentative interested in attending anti natal classes.

Early Years

The Leyton Square O'clock club used to hold a weekly session, specifically for Traveller women, on a weekday morning at 10:30 am. This initiative was well regarded. The session provided a space for women and children to meet and access Early Years provision. There were crèche facilities so that the women could attend the anti natal clinic and do parenting classes. Supplementary activities were also held, such as talks on obesity, dentistry, the toy library visited etc. The women particularly praised the parenting skills classes, and the certificate received on completion was appreciated. Women who used this club went on to use other activities at the one 'o'clock club. The mothers and STAG noted that this session provided a route to access other provision, such as nursery school and the Early Years offer, by helping to get the children ready for school , and the mothers comfortable with services.

The club was initiated to replace a play scheme and funded by Sure Start. Sure Start funding has now ended, however Leyton Square has been taken over by Nell Gwyn Nursery School and East Peckham Children's Centre and it could be worth exploring if they have the resources to restart this activity, particularly if a similar session would be well used.

Jo Anne spoke about the Early Year services and Children's Centre magazines were handed out. The women reported that that they did not use Children's Centres, and they did not think other Gypsy and Traveller women did, although a few women did send their child to nursery school.

Breast Feeding

There was a discussion about breast-feeding. The midwife spoke about the benefits of breast-feeding. The women explained how virtually all the women bottle fed and the main reason was concerns over modesty, both a reluctance to feed in public and because male relatives were likely to pop into their homes frequently. Some ways around this concern were discussed, such as using a shawl. There was a discussion about bottle-feeding being a relatively new cultural practice and the women agreed with this and said that their grandmothers and great grandmothers did breast feed. Some of the women said that they did understand the advantages of breast-feeding, through discussions with their midwives.

Weaning

The current advice to wean your baby at 6 months was discussed. The advice on the age to wean your child has increased with time, and there was a discussion about taking cues from your baby. A few women said that taster amounts of food were sometime introduced from 2 1/2 to 3 months. Food intolerances were also discussed.

Sexual health

Sex for women before marriage was taboo. However, it is culturally more acceptable for men to be sexually active prior to marriage. There was concern that women could be a risk of urinary tract infections etc on marriage. Often, but not always, marriage was quickly followed by a pregnancy. There was a discussion on the benefits of health screening, either at marriage or in early pregnancy. Taveller teenagers are

usually removed from sex education classes at school. Young women will often access health advice from older female relatives, such as aunts.

Miscarriage, still birth, neo natal and child deaths

There was brief discussion that nationally the rates for miscarriage, still birth, neo natal death and child deaths are high for gypsy and traveller women. However, it was not thought child deaths were that prevalent, however there was anecdotal evidence that miscarriage and stillbirths were high (although it was noted that around half of all women will typically experience a miscarriage). There is a high level of smoking within the community, and smoking by men and women can increase the likelihood of miscarriage.

Domestic violence

It was noted that a referral to the police or other agency for domestic violence automatically generated an alert to social services and to the child's school. There was concern that this could lead to breaches of confidentially, through friends and family finding out, and also concern that Social Service's involvement in a family could lead to children being removed. More information about the role of Social Services in domestic violence would be helpful, as would more information about Domestic Violence service such as SOLACE, and how these would link up with a refuge that gypsies and travellers feel most comfortable accessing. There were questions about accessing re-housing and the process for removing a perpetrator. Anger management courses were suggested.

Employment support

Around 11 Traveller women had accessed childcare training over the last few years, with five women becoming level three qualified. One woman was a manager at a local setting. STAG now particularly promote health and beauty courses to younger women. Older women do not tend to work, but younger women were becoming more accustomed to taking up maternity benefits and returning to work part time, making good use of the extended network of aunts and grandmothers who were available to look after the younger children. STAG is funded through the Safer Southwark partnership to provide work support programmes and this includes voluntary work at Nell Gwynn Nursery School and East Peckham Children's Centre and driving lessons. This was specifically aimed at men, but women were benefiting most. This was a successful programme. Men wanted to undertake training to increase their chances of legitimate paid employment, but found it hard to access employment support, as they were reluctant to sign on, and so ineligible for many of the courses on offer. Economic stress increased the chances of domestic stress.

Scrutiny review on maternal health and early years services for the Gypsy and Traveller communities in Southwark

Notes of stakeholder meeting 21st December 2012

Julie Timbrell
Alex Trouten
Archie Utley
Rahala Manna
Kevin Dykes

1 Report on follow up work

The census data has come back with a figure of 263, however STAG estimate the population is around 1250.

Barbara Hills is the best person to contact for Health Visitors.

Accessing primary care is important. Archie reported that there are problems with late access and the attitude of receptionists can be issues. An event promoting primary care such as a mini MOT in the summer near a site was discussed. Archie, Alex and Rahala will follow this up this and links with GPs.

Economic development is an important area of concern for Travellers and this should be followed up, in particular Traveller want to ensure young people get information on apprenticeships and school leaver options, such as the Thames Reach Employment Academy. More young people are completing school and it is important that this be translated into opportunities.

2 Report on consolation event

The event went well. One of the key recommendations was to that Nell Gwyn children's centre restart a session for Gypsy and Traveller for parents and children to replace the popular session that used to take place at the Leyton One o' Clock club.

Pilgrims Way children's nursery is also close to more northern sites and links should be made with them to see what outreach, inclusion or dedicated work they do with Gypsies and Travellers.

Smoking was identified as risk in miscarriage, which was identified as an issue of concern. Smoking cessation services for women and men will be followed up.

Sexual health and contraceptive service could be better promoted and a restarted playgroup would provide an opportunity for this.

Domestic Violence is being followed up.

Scrutiny review on Maternal Health and Early Years services for the Gypsy and Traveller communities in Southwark.

Notes of mini stakeholder meetings on 16th January 2013

Present:

Cllr Mark Williams - Chair
Cllr David Noakes - Vice chair
Jin Lim - Public Health
Kevin Dykes - Community Engagement
Julie Timbrell - Scrutiny
Alex Trouten - Public Health
Archie Utley - Southwark Travellers Action Group (STAG)
Ann-Marie O'Brien - Southwark Travellers Action Group (STAG)
Eva Gomez - Community Safety
Paul Jeffery - Housing
Paul Cutler - Centre for Public Scrutiny

1. **Apologies, introductions & welcome.**

2. **Review of work done so far & emerging recommendations.**

Julie and Ann Marie fed back on the consultation event on 18 December with Traveller women.

Access to Children's Centre activities & Nursery Schools
The Leyton Square O'clock club used to hold a weekly session, specifically for Traveller women, on a weekday morning at 10:30 am. This initiative was well regarded. The session provided a space for women and children to meet and access early years activities. There were crèche facilities so that the women could attend the anti natal clinic and do parenting classes. Supplementary activities were also held, such as talks on obesity, dentistry, the toy library visited etc. This activity was well regarded. Leyton Square has been taken over by Nell Gwyn Nursery School and East Peckham Children's Centre and it could be worth exploring if they have the resources to restart this activity, particularly if a similar session would be well used. There are good links with Nell Gwyn Children's centre to build on and better links could be forged with Pilgrims Way children's centre. Data and anecdotal reports are that very few families access the Children's Centers, and only a few children access the Early Years offer/ nursery schools. The midwife at the session was from Peckham and the Early Years and Childcare Development Officer, also present, covered Bermondsey and Rotherhithe.

Draft Recommendations:

Nell Gwyn Nursery School and East Peckham Children's Centre to work, with the support of STAG, to restart a dedicated session for Traveller parents and children. This will focus on improving access to Children's Centres activities, Nursery school

(Early Years offer), anti natal care, health and social care (such as weaning, parenting skills, immunisation etc)

Pilgrims Way Children's centre nominate a dedicated officer to build outreach links with the Gypsy community and the Traveller community to improve access to Children's Centre activities and Nursery schools.

Domestic Violence

Domestic Violence has been raised as an issue and contact has been made with Community Safety who are the lead commissioner for domestic abuse services within the council and Solace Women's Aid who are the council's commissioned domestic abuse service provider. Archie and Eva explained that a Safer Southwark Partnership funded programme is already running with one of its aims being to reach out to young men and prevention, including addressing perpetrator behaviour. STAG explained that they do not want to be put in a difficult position and deal with domestic violence incidents directly, as they need to work across the community. They explained how in the past, the lack of an adequate service response had led to a family seeking shelter in their office for some time whilst a Refuge space was allocated, which compromised their position. Eva explained that in April 2012 SOLACE Women's Aid was appointed the council's domestic abuse service provider, offering a wide range of services, and although access to a particular shelter might not always be possible or appropriate, now that Solace is the lead agency in our borough, responses to situations like the one mentioned above have improved. Eva explained that SOLACE has a dedicated London wide worker for Travellers (Bernie). Referrals concerning members of the Traveler community to MARAC for serious incidents will also be looked into. Eva will continue to work with STAG and provide a briefing note for members.

Draft Recommendation:

Community Safety & SOLACE to work with STAG to improve access and referrals to the domestic abuse service (including MARAC referrals where appropriate) and to minimise STAG involvement in domestic abuse cases.

Primary care

At a previous meeting access to primary care had been raised as an area of interest and possible concern, because of this STAG consulted with to Travellers more about their experiences. Experience at GP practices are very variable; some Travellers are experiencing a poor service and prejudice form health staff, such as receptionists, however others are receiving a good service. People not accessing primary care are more likely to use A &E and receive treatment for health conditions late. Ilderton Road practice was identified as offering a good service to Travellers, but East Street Practice and Acorn Practice on Meeting House Lane less so. Alex is advising STAG on doctor's practices and have put STAG in touch with Lynn Lock of PALS to advise on alternative GP surgeries that may suit people better where they are dissatisfied with the service or making frequent use of SELDOC and A and E. The key NHS service is Patient Advice and Liaison Service (PALS):
http://www.southwarkpct.nhs.uk/patient_information/patient_advice)

Draft recommendations:

Public Health to work with STAG to improve access to doctor's practice by providing information and support.

Southwark Clinical Commissioning / Public Health / STAG to develop a training programme for health professionals.

Safeguarding and Social Services

Safeguarding and relationships with Social Services were discussed. There had been incidences where the consequences of liaising with Social Services has raised concern. For example, when a Domestic Violence incident is reported to police it is standard practice for a MERLIN alert to go to Social Services – this may lead to children's schools being contacted. STAG reported that on an occasion this had led to local gossip because of possible breaches of confidentiality. The consequences of reporting domestic violence could also inhibit a report to the police. Likewise, there was concern about health incidents leading to a Social Service referral. People in the community had fears of their children being unjustly removed, and that had led to a breakdown in at least one relationship between a family and Social Service. STAG also reported that child and health professional sometimes did not understand that space on site was viewed differently by Travellers : a child playing in the yard outside would be looked after by the whole community.

Draft Recommendations:

Social Service/ Community Safety organize hold a session on their safeguarding role and explain how referrals work , ensuring that accurate information is given and myths death with.

Social Services / Community Safety identify lead officers to work with Travellers, who are appropriately trained, and understand issues such as Health and Safety on site. This will enable relationships to established and promote understanding.

The importance of confidentiality in child protection is emphaised with Social Workers on all occasions, but particularly where there are extended and close nit communities.

Miscarriages and stillbirths

The national data for child deaths, stillbirths and miscarriages is very high. Local anecdotal evidence does not indicate that child deaths are a problem (and this might be partly because the sites are of an above average standard) , however there is some evidence, though not conclusive, that miscarriages and stillbirths could be high locally. The level of smoking is high for men and women and this can raise the risk of miscarriage.

Draft Recommendation:

S*moking cessation courses are offered to Travellers*

Sexual health.

This was an issue of concern and best discussed in same sex groups, such as via starting the parent and child group at Nell Gwyn.

Breast-feeding , weaning and obesity
Breast feeding rates are low in Traveller communities and weaning can start earlier than recommended – through taster foods being introduced at two and a half to three months. These are practices, alongside healthy eating and exercise , that it was thought could be best addresses at the proposed parent and child group at Nell Gwyn

Draft Recommendation:

Breast-feeding , weaning and obesity are raised at the proposed parent and child group at Nell Gwyn.

Mental Health was briefly discussed; there is a national awareness campaign being conducted by the national Irish Travellers group.

Enterprise and Employment
Enterprise and Employment was raised by STAG as an issue of concern and that could affect family wellbeing . STAG has provided a number of recommendations on how to improve the situation , including increasing access to apprenticeship for young people.

Draft Recommendation:

STAG proposals on improving employment support are implemented ; where feasible. (See STAG consultation submission for details)

Housing strategy and site provision.
STAG fed back that site provision is very good. Overcrowding is an issue that has been identified at previous events. Provision of sites/ housing is not picked up on in the recently produced Housing Commission report, which is a gap in an otherwise excellent report. This report is out for consultation.

Draft Recommendation:

The final report of the Housing Commission sets out a site strategy for Gypsies and Travellers .

Framework.
The Overview and Scrutiny Committee (OSC) recently proposed that a framework for Gypsies and Travellers is developed. Mark asked Archie to send in his thoughts on how this could be most usefully developed**.**

Draft Recommendation:

The council develops a framework for Gypsies and Travellers

3. **Drafting the final report**

The recommendations from the meeting will be circulated for comment. The chair (Mark) and the vice chair (David) will liaise regarding the final recommendations. The committee will receive background information, followed by the draft final report to agree.

4. **Return on Investment – measurement and outcomes**

Paul Cutler spoke about the Return on Investment model used by the Centre of Public Scrutiny to estimate the value of a scrutiny review. Paul circulated an illustrative draft, which can be developed. All contributors to the review are asked to estimate the hours they have contributed to the review, and help estimate the value of the changes proposed, so this exercise can be completed.

5. **Scrutiny review date Westminster venue (Westminster City Hall) 25th January - 11 am to 3 pm**

The scrutiny review will be presented and the poster is requested to illustrate the review. Mark and Julie will be attending.

6. **AOB**

Southwark Health & Adult Social Care Scrutiny sub-Committee

[DRAFT REPORT]

Access to Maternal Health and Early Years Services for the Gypsy and Traveller Communities in Southwark

January 2013

Section 1: Background to the report

This scrutiny report forms part of a wider review in Public Health that the committee is undertaking this year. This piece of work has been separated out as we are taking part in a programme run by the Centre for Public Scrutiny. The programme includes supports from the CfPS and includes HASC committees from across the country looking into health inequalities suffered by marginalised communities (other strands include sex workers and the homeless).

Why the focus on Maternal Health and Early Years (under 3)?

The committee has chosen this focus for two reasons: to link the initiative with priorities identified by the Marmot review and the evidence that this is a significant maternal and early years health inequality experienced by Travellers and Gypsies.

The Marmot Review: Fair Society, Healthy Lives

The Marmot Review's findings and main policy recommendations are summarised below.

The first policy objective the Marmot Review identifies is to "give every child the best start in life". The report states that giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional– are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being–from obesity, heart disease and mental health, to educational achievement and economic status.

The report goes on to argue that to have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking.

The report advocates reducing inequalities in early child development by continuing and sustained commitment to the Sure Start and the Healthy Child Programme. It is vital that this is sustained over the long term and the report recommends even greater priority must be given to ensuring expenditure early in the developmental life cycle (that is, on children below the age of 5) and that more is invested in interventions that have been proved to be effective. They call for a 'second revolution in the early years', to increase the proportion of overall expenditure allocated there. This expenditure should be focused proportionately across the social gradient to ensure effective support to parents (starting in pregnancy and continuing through the transition of the child into primary school), including quality early education and childcare

Priority objectives
1. Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
2. Ensure high quality maternity services, parenting programmes, childcare and early year's education to meet need across the social gradient.
3. Build the resilience and well-being of young children across the social gradient.

Policy recommendations
1) Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early year's development is focused progressively across the social gradient.

2) Support families to achieve progressive improvements in early child development, including:
— Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
— Providing paid parental leave in the first year of life with a minimum income for healthy living
— Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families
— developing programmes for the transition to school.

3) Provide good quality early years education and childcare proportionately across the gradient. This provision should be:
— Combined with outreach to increase the take-up by children from disadvantaged families
— Provided on the basis of evaluated models and to meet quality standards.

Section 2: What we discovered

Access to Children's Centre activities & Nursery Schools

The Leyton Square 1 'o' clock club used to hold a weekly session, specifically for Traveller women, on a weekday morning at 10:30 am. This initiative was well regarded and used. The session provided a space for Gypsy and Traveller women and children to meet and access early years services and activities. There were crèche facilities so that the women could attend the anti-natal clinic and attend parenting classes. Supplementary activities were also held, such as talks on obesity and dentistry, the toy library also visited. Leyton Square has been taken over by Nell Gwyn Nursery School and East Peckham Children's Centre. It should be explored whether they have the resources to restart this activity.

There are good links with Nell Gwyn Children's centre to build on and better links could be forged with Pilgrims Way children's centre. Data and anecdotal reports are that very few families access other Children's Centres, and only a few children access the Early Years offer/ nursery schools.

Recommendation 1:

Nell Gwyn Nursery School and East Peckham Children's Centre to work, with the support of STAG, to restart a dedicated session for Traveller parents and children. This will focus on improving access to Children's Centres activities, Nursery school (Early Years offer), anti natal care, health and social care (such as weaning, parenting skills, immunisation etc)

Recommendation 2:

Pilgrims Way Children's centre to nominate a dedicated officer to build outreach links with the Gypsy and Traveller community to improve access to Children's Centre activities and Nursery schools.

Domestic Violence

Domestic Violence was raised as an issue during the course of our evidence gathering. Contact was made with Community Safety (who are the lead commissioner for domestic abuse services within the council) and Solace Women's Aid who are the council's commissioned domestic abuse service provider. They provided information on current practice.

Southwark Traveller Action Group (STAG) and Community Safety explained that a Safer Southwark Partnership funded programme is already running with one of its aims being to reach out to young men with the aim of preventing domestic violence, including addressing perpetrator behaviour. STAG explained that they do not want to be put in a difficult position and deal with domestic violence incidents directly, as they need to work across the community. They explained how in the past, the lack of an adequate service response had led to a family seeking shelter in their office for some time whilst a Refuge space was allocated, which compromised their position. Community Safety informed us that in April 2012 SOLACE Women's Aid was appointed the council's domestic abuse service provider, offering a wide range of services, and although access to a particular shelter might not always be possible or appropriate, now that Solace is the lead agency in our borough, responses to situations like the one mentioned above have improved. It was explained that SOLACE has a dedicated London-wide worker for Travellers.

Referrals concerning members of the Traveller community to MARAC for serious incidents will also be looked into. Community Safety agreed to work with STAG and provide a briefing note for members.

Recommendation 3:
Community Safety & SOLACE to work with STAG to improve access and referrals to the domestic abuse service (including MARAC referrals where appropriate) and to minimise STAG involvement in the handling of domestic abuse cases

Access to Primary Care Services
Access to primary care was raised as an area of concern. STAG consulted with Travellers about their experiences of accessing this service. The experience of travellers at GP practices were very variable, some are experiencing a poor service and feel they are prejudiced against by health staff, for example GPs receptionists. However others are receiving a good level of service and treatment.

Members of the community who are not accessing primary care are more likely to use A&E and receive treatment for health conditions late. This has obvious repercussions for their health and wellbeing.

The Ilderton Road practice was identified as offering a good service to Travellers, but East Street Practice and Acorn Practice on Meeting House Lane less so. Public Health are advising STAG on doctor's practices and have put STAG in touch with PALS to advise on alternative GP surgeries that may suit people better where they are dissatisfied with the service or making frequent use of SELDOC and A&E. This is welcome, but is only a short term solution. Staff of all NHS organisations, in particular at GP's surgeries, must treat all patients with respect.

Recommendation 4:
Public Health to work with STAG to improve access to doctor's practice by providing information and support

Recommendation 5:
Southwark Clinical Commissioning / Public Health / STAG to develop a training programme for health professionals to understand the needs of the Gypsy and Traveller communities in Southwark.

Safeguarding and Social Services
Safeguarding and relationships with Social Services arose as an issue of concern for the community during the course of our evidence gathering. There had been incidences where the consequences of liaising with Social Services had raised concern. STAG reported that on an occasion there had been a breach of confidentiality by a social worker in a personal social setting which had resulted in local gossip which eroded trust between social services and the family concerned, as well as the wider community.

We also heard that the consequences of reporting domestic violence could also inhibit a report to the police. This is an issue which stretches beyond the Gypsy and Traveller Community.

There was concern about health incidents leading to a Social Service referral. People in the community had fears of their children being unjustly removed, and that had led to a breakdown in at least one relationship between a family and Social Services. STAG also reported that child and health professionals sometimes did not understand that space on site was viewed differently by Travellers: for example a child playing in the yard outside the family's accommodation was not unsupervised as they would be looked after by the whole community.

Recommendation 6
Social Services and Community Safety to organise and hold a session for the Traveller community in Southwark on their safeguarding role and explain how referrals work, ensuring that accurate information is given and myths dealt with.

Recommendation 7
Social Services and Community Safety to identify lead officers to work with the Traveller community in Southwark. These officers should be appropriately trained and understand issues such as Health and Safety on site. This will enable relationships to be established and promote better understanding between all parties.

Recommendation 8
That the importance of confidentiality in child protection is emphasised with all Social Workers on all occasions.

Miscarriages and stillbirths
The national data for child deaths, stillbirths and miscarriages amongst Gypsies and Travellers is very high. Local anecdotal evidence does not indicate that child deaths are a problem (and this might be partly because the sites are of an above average standard), however there is some evidence, though not conclusive, that miscarriages and stillbirths could be high locally. The level of smoking is high for men and women and this can raise the risk of miscarriage.

Recommendation 9
Smoking cessation courses are offered to Travellers

Sexual health.
This was an issue of concern and was felt that due to cultural differences this was best discussed in same sex groups. One possible route would be via starting the parent and child group at Nell Gwyn.

Recommendation 10
The proposed parent and child group at Nell Gwyn to include sexual health sessions for parents.

Breast-feeding , weaning and obesity
Breast feeding rates are low in Traveller communities and weaning can start earlier than recommended – through taster foods being introduced at two and a half to three months. These are practices, alongside healthy eating and exercise, that it was thought could be best addressed by health visitors and other practitioners through the proposed parent and child group at Nell Gwyn

Recommendation 11:
Breast-feeding, weaning and obesity are raised at the proposed parent and child group at Nell Gwyn.

Enterprise and Employment
Enterprise and Employment was raised by STAG as an issue of concern that could affect family wellbeing. STAG has provided a number of recommendations on how to improve the situation, including increasing access to apprenticeship for young people.

Recommendation 12:
STAG proposals on improving employment support are implemented ; where feasible. (See STAG consultation submission for details)

Housing strategy and site provision

STAG fed back that site provision in Southwark is very good. Overcrowding is an issue that has been identified at previous events. The Council will shortly be consulting on the future of housing provision within the borough, this follows the publication of the Independent Housing Commission's report. Any consultation on the future of housing provision in the borough must include reference to future need and pitch provision for the Gypsy and Traveller communities in Southwark. As part of the consultation the council must engage with the Gypsy and Traveller communities.

Recommendation 13:

The consultation that is due to be launched into the future of housing provision in the borough should include future provision for Gypsy and Traveller sites and these groups should be consulted.

Over-arching Framework

During our evidence gathering it became clear that the council needs to develop and implement a framework for engagement with, and providing services for, the Gypsy and Traveller communities in Southwark. This should be developed in partnership with groups like STAG and individuals from these communities.

Recommendation 14:

The council develops an over-arching framework for engagement with, and providing services for, the Gypsy and Traveller communities in Southwark.

Section 3: Draft Recommendations

Recommendation 1:
Nell Gwyn Nursery School and East Peckham Children's Centre to work, with the support of STAG, to restart a dedicated session for Traveller parents and children.This will focus on improving access to Children's Centres activities, Nursery school (Early Years offer), anti natal care, health and social care (such as weaning, parenting skills, immunisation etc)

Recommendation 2:
Pilgrims Way Children's centre to nominate a dedicated officer to build outreach links with the Gypsy and Traveller community to improve access to Children's Centre activities and Nursery schools.

Recommendation 3:
Community Safety & SOLACE to work with STAG to improve access and referrals to the domestic abuse service (including MARAC referrals where appropriate) and to minimise STAG involvement in the handling of domestic abuse cases

Recommendation 4:
Public Health to work with STAG to improve access to doctor's practice by providing information and support

Recommendation 5:
Southwark Clinical Commissioning / Public Health / STAG to develop a training programme for health professionals to understand the needs of the Gypsy and Traveller communities in Southwark.

Recommendation 6
Social Services and Community Safety to organise and hold a session for the Traveller community in Southwark on their safeguarding role and explain how referrals work, ensuring that accurate information is given and myths dealt with.

Recommendation 7
Social Services and Community Safety to identify lead officers to work with the Traveller community in Southwark. These officers should be appropriately trained and understand issues such as Health and Safety on site. This will enable relationships to be established and promote better understanding between all parties.

Recommendation 8
That the importance of confidentiality in child protection is emphasised with all Social Workers on all occasions.

Recommendation 9
Smoking cessation courses are offered to Travellers

Recommendation 10
The proposed parent and child group at Nell Gwyn to include sexual health sessions for parents.

Recommendation 11:
Breast-feeding, weaning and obesity are raised at the proposed parent and child group at Nell Gwyn.

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STAG proposals on improving employment support are implemented ; where feasible. (See STAG consultation submission for details)

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The consultation that is due to be launched into the future of housing provision in the borough should include future provision for Gypsy and Traveller sites and these groups should be consulted.

Recommendation 14:
The council develops an over-arching framework for engagement with, and providing services for, the Gypsy and Traveller communities in Southwark.

Section 5: Next Steps

This draft report will be considered by the Health and Adult Social Care scrutiny committee on Thursday 31st January 2013. If it is agreed upon it will be submitted to the next available meeting of the Overview and Scrutiny Committee, if agreed upon by OSC it will be presented to the Cabinet and other relevant public bodies. They will have to formerly respond and then implement any recommendations that are agreed upon.

Agenda Item 6

Item No:	Classification:	Date:	Meeting Name:
7	OPEN	31 January 2013	Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee
Report Title:		Preparing for the scrutiny interview	
Ward(s) or Group affected:		All	
From:		Scrutiny project manager	

BACKGROUND INFORMATION

1. The Cabinet member for health and adult social care: Cllr Catherine McDonald annual interview with the Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee is scheduled for31 January 2013.

CONTENT

2. Members of the committee have chosen 9 themes to structure the interview around

a. Preparation for assuming public health responsibilities.

b. Trust Special Administrator (South London Healthcare Trust & South East London health care system) final recommendations and the council's response.

c. Kings Health Partner merger (with a focus on impact adult services provided by council and public health).

d. Progress with personalisation

e. Accessing support from Social Service.

f. Older Peoples Day Care Services.

g. Redesign of the pathways of care for learning disabilities and mental health.

h. The reduction in residential and nursing care placements

i. Safeguarding

3. The committee will also use the cabinet member interview to consider the Local Account .The Local Account is a new locally driven public report on adult care which all local authorities are being encouraged to produce, although it is not compulsory. The purpose of the report is to give a transparent public facing account of the council's performance and outcomes achieved over the last year, and the council's priorities going forward. The Local Account is seen as filling the gap left by the CQC annual review of adult social care services. Please see appendix A.

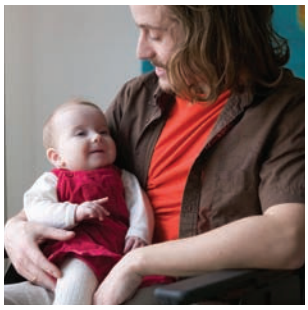
Fairer future
Delivering our promises

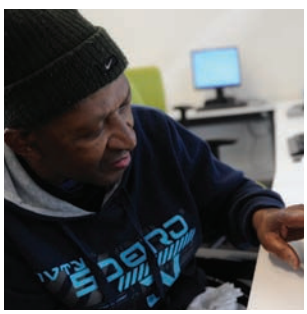
Southwark Council

Adult Social Care

Local Account 2011/12

Review of performance and priorities in adult social care





Contents

Adult Social Care

Local Account 2011/12

Review of performance and priorities in adult social care

1 Foreword

Catherine McDonald
Cabinet member for health and social care

Welcome to our first Local Account of adult social care services in Southwark. This is a new form of public performance report, setting out the progress we have made in delivering national and local adult social care priorities. Previously the Care Quality Commission provided an annual assessment report of council care services, on which Southwark's last rating was "good" overall. This approach has now been replaced by a locally driven account which provides an opportunity to focus on local priorities and increase transparency and accountability, which I very much welcome.






As you will see we are able to highlight excellent progress in a number of key areas in line with our vision to support people to live independent lives and encouraging more people to take control over their own care. This is all in line with the Fairer Future promises this administration has made. Of particular note is the large number of service users now with personal budgets, the reduction in the price people pay for meals on wheels, the increase in reablement services, the new charter of rights for service users, low delayed hospital discharge rates and the shift in the balance of care away from care homes to community support. This is in line with what people tell us they want and ensures more choice and control for local residents.

However we know there is still much to do and we set out our priorities in this Local Account. We are particularly keen to ensure that people are supported to gain real choice and control through their personal budget arrangements and that this translates to better outcomes. We also wish to see these improvements reflected in satisfaction levels and quality of life measures reported by service users and their carers in our customer surveys.

This is all despite the council having received large cuts in its budget from central government; a real terms reduction of over £90m in its budget from government since 2010, including a reduction of £34m in 2011/12.

There are a number of exciting opportunities for the service over the coming year, in particular the forthcoming transfer of the public health function to the council, and the associated Health and Wellbeing Board arrangements. These give us a great opportunity to work in an integrated way with other agencies to promote health and well being and improve preventative services, which in turn will help us deliver the goals of the council plan and the adult social care vision.

I would welcome your views on this first Local Account using the survey form on the back page. Your views will be noted for the next Local Account and taken into account in planning future service developments.

2 Fairer future

the Council Plan and our vision for adult social care

The Southwark Council Plan, "A fairer future for all", states that:

"The council will create a fairer future for all in Southwark by: protecting the most vulnerable; by looking after every penny as if it was our own; by working with local people, communities and businesses to innovate, improve and transform public services; and standing up for everyone's rights".

The plan contains a specific pledge for adult social care to:

"Support vulnerable people to live independent, safe and healthy lives by giving them more choice and control over their care".

You can see more detail about the Council Plan and 2011/12 performance via the following link:
www.southwark.gov.uk/councilplan

Our **vision for adult social care** describes in detail how we are seeking to deliver these goals. Supporting people to live independent lives and encouraging more people to take control over their own care is fundamental to securing a fairer future for all. For the most vulnerable in our society we must also ensure there are sensible safeguards against the risk of abuse or neglect, striking the right balance between managing risk and promoting independence.

Our vision includes a strong focus on reablement services, which provide cost effective short term support to restore people's independence wherever possible. Where a longer term support service is required we aim to maximise people's choice and control through the provision of personal budgets.

People tell us that they want to stay living in their own homes and connected to their communities, for as long as possible, and to avoid going into residential care unless it becomes necessary. We aim to shift the balance of care from residential provision to more effective support for people in their own homes. Transforming day services, as more people take up personal budgets and, for example, through creating a new centre of excellence for older people, will also allow a more personalised and outcome focused approach and contribute to this goal.

We will improve access and information by providing a dedicated telephone line for all queries about help for older and vulnerable people and their carers, including information about universal access and voluntary sector services for those not eligible for higher levels of care.

There will be enhanced focus on targeting services to better meet the needs of carers.

Partnership working with health services will remain a key priority. In particular, we will continue to ensure people who receive both health and social care services do so in an integrated, seamless way.

See the full vision document via the following link:
www.southwark.gov.uk/healthandsocialcare

3 Our charter of rights

for adult social care

The charter was agreed by the council's cabinet. It reflects the adult care vision and highlights what people in Southwark with adult social care needs can expect from adult social care services.

- We will provide you with good information and advice about all the support and services that are available in Southwark.
- You should be treated with dignity and respect and be treated fairly.
- Vulnerable people, those who are at risk due to disability or frailty, have the right to be safeguarded from abuse.
- You are entitled to request an assessment of your social care needs to help you maintain your health and wellbeing and you will be encouraged to complete this yourself.
- Carers are entitled to a separate assessment of their needs to identify what support would enable them to continue in that role.
- Our aim is to assist you to regain your independence so that you do not need long term support.
- If you have longer term eligible needs we aim to give you control over your social care support so that you can make choices about what works for you.
- We will let you know who to contact in the council if required.
- We aim to have skilled and trained staff to provide timely, clear and high quality responses.
- You will be given information about your statutory rights (for example, access to your records, confidentiality, how information about you is shared with other organisations and how to feedback comments during your assessment).

Case study

Our learning disabilities shifting the balance project team has been recognised nationally as an example of best practice. It empowered a vulnerable group of residents with learning disabilities to have greater input into how services are provided to them, so that services better reflected their individual needs and aspirations. At the same time, the project delivered savings of over £3m over three years.

B is a young person with learning disabilities who turned 18 last year. He had been living in a care home outside of London for some time, but following the suggestion of his new adult services social worker, he was keen to move into accommodation where he could live independently. Together with his social worker he drew up a plan, and after a few months he moved into a housing association flat with a support package as an interim measure, with a view to obtaining a suitable supported living placement in the longer term. This was a big change for B but with the support he received, his independent living skills increased quickly. A few months later, following a review, a reduction in his support package was agreed. He also obtained voluntary work in a charity shop during this time.

When the opportunity came to consider a supported living placement B decided that in fact he wanted to live on his own without any form of support, as he had obtained paid work to support himself and had developed a network from his work place and the community which helped to build his confidence and skills. He completed a trial period of about two months without direct support from his service provider and coped very well.

As well as producing a good outcome for B, who is pleased with his independence, it is a good use of resources for the council, providing a substantial saving, enabling us to focus resources on those most in need of support.

4 Review of 2011/12

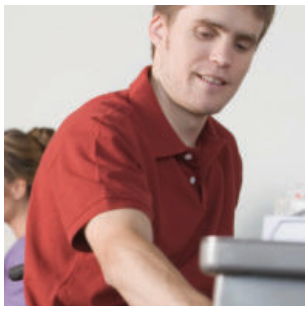
our achievements and priorities for improvement

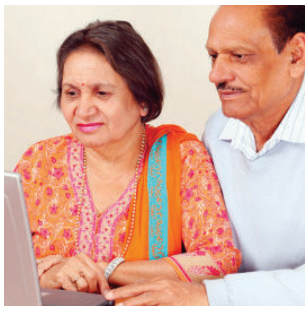
This Local Account summarises our progress on the priorities in the council plan and the vision grouped under the key outcomes of the national Adult Social Care Outcomes Framework as follows:

1. **Enhancing quality of life for people with care and support needs**
2. **Delaying and reducing the need for care and support**
3. **Ensuring that people have a positive experience of care and support**
4. **Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm**

Outcome 1:

Enhancing quality of life for people with care and support needs





This means:

- People live their own lives to the full and achieve the outcomes which matter to them by accessing and receiving high quality support and information
- Carers can balance their caring roles and maintain their desired quality of life
- People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs
- People are able to find employment when they want, maintain a family and timely, clear and high quality community life, and avoid loneliness or isolation.

This year our key achievements have been:

- We have expanded access to personal budgets, which increase choice and control by giving people the opportunity to determine how their care is delivered. Around 2,600 community services users and carers had some form of personal budget by the end of 2011/12, meeting our 60% target
- The council set up an Innovation Fund programme which has helped voluntary and community sector providers to set up a range of personalised support opportunities that will help develop the market to meet people's support preferences, for example, assistance with using public transport
- Good progress has been made in reducing the usage of residential care provision for people with learning disabilities where is it appropriate and in line with what people want, enabling service users to live in their own home. This is a major step towards personalising services for this client group and is a key equalities objective of the council
- The opening of the Southwark Resource Centre last year for physically disabled people has enabled a more personalised approach to day services in a modern building
- Reducing the price of meals on wheels paid by users by 26% so far, in line with our commitment to halve the price people pay by 2014, despite budget constraints.

Southwark Resource centre

The Southwark Resource Centre, designed to help and support disabled people officially opened its doors to the public in January 2012. The £3.6m centre located at 10 Bradenham Close in Walworth, will help disabled people access local services across the borough and ensure that they can live independently and integrated in the community for as long as possible.

"The council's new Southwark Resource Centre has been designed to help and support disabled people. It has great design features, high tech equipment and a wonderful team of staff to support users. In addition this will be the base for the centre for independent living being developed by disabled people for disabled people to enable them to regain confidence and develop new skills."

Sean, service user at the Southwark Resource Centre

Personal budgets

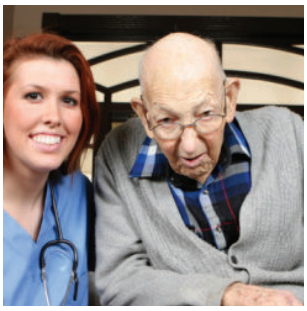
M' s parents became concerned that he was too socially isolated from his peer group and developing mental health problems as a result. He was originally referred to adult social care with a view to using specialist learning disability day services to meet his needs. Following assessment and a discussion about what aspirations he had, M and his family decided they preferred the idea of using a personal budget to employ a Personal Assistant (PA) to enable M to do things in his local community. M was referred to an organisation called Cool 2 Care who provide support planning and were able to identify suitable candidates for the PA role. These were interviewed by M and his family, who now directly employ the PA and manage the personal budget. M's support plan includes 25 hours per week support from the PA to help M engage in a range of activities including music, cooking, swimming and other sports in the community, art therapy and travel training. M's family are very pleased with the way the personal budget has enabled M to live the life he wants to lead.

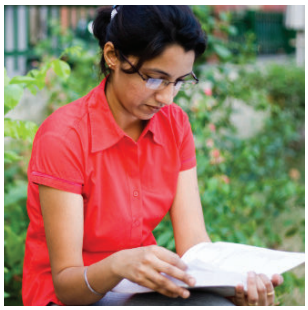
Our priorities for the future:

- We plan to move all eligible community service users to personal budgets by 2013/14. We want to ensure that people are able to use their personal budget in a way that really puts them in the driving seat
- We want to support service users and carers to experience a higher quality of life and feel more in control, and see this reflected in the results of the 2012 surveys of users and carers
- We will continue to transform day services to allow a more personalised and outcome focused approach, reviewing mental health, learning disability and older people's services
- We will increase the number of carers who benefit from a carers assessment
- We will further reduce the charges for meals on wheels, bringing the total reduction to 50% since 2010.

Outcome 2:

Delaying and reducing the need for care and support





This means:

- Enabling people to stay healthy and independent for longer
- Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs
- Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services
- When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence.

This year our key achievements have been:

- The balance of care continues to shift in favour of community based provision, with new permanent admissions to residential care homes 17% below previous year's rates and services are changing to enable more people to live at home for longer, in line with what people say they want
- We have set up and expanded reablement services, which provide cost effective short term support to restore people's independence wherever possible. Some 90% of people discharged from hospital with the help of reablement services were still living at home three months later and had not needed to go into a care home or return to hospital
- Our performance on preventing delayed discharges from hospital is strong compared to other boroughs
- We have redesigned supported housing services to secure greater value for money, whilst still supporting independence.

Our priorities for the future:

- We wish to make further progress in supporting people at home and avoid the use of institutional care homes wherever appropriate
- We plan to substantially increase capacity in reablement services and enable many more people to benefit from these services directly after being in hospital
- We will work with the NHS on our integrated care pilot, which seeks to improve the health of the local population, and reduce unnecessary admissions to hospital and care homes
- We will work with public health services to promote wellbeing, and plan ahead for the transfer of these functions to the council in 2013 to ensure maximum impact.

Reablement

Mr S is a 76 year old man who was admitted to hospital and subsequently underwent an operation to deal with the compression of his spinal cord. Prior to admission he had been independent in respect of self care but once back in the community he reported difficulties with managing day to day tasks eg doing up buttons, washing and dressing, preparing and eating meals and completing domestic chores. Following assessment an initial care package of six hours per week with a reablement plan was provided. Soon into the implementation of the reablement plan, which included support from an occupational therapist and the provision of equipment and regular support from reablement staff in regaining daily living skills, these problems had greatly improved. Upon leaving reablement six weeks later, his needs were being met with a small ongoing personal budget used for providing 1.5 hours of homecare per week.

Telecare

J is 90 and has started to suffer from dementia. His family were concerned about clear risks to his health and wellbeing due to falling, wandering and the risk of fire. There was a concern that it may be necessary to move to a care home. However following an assessment a range of relatively simple telecare equipment was identified to reduce these risks. This included a lifeline and pendant alarm, externally monitored smoke detectors and extreme temperature detectors, and motion sensors that turn on the lights. In addition to the telecare J benefitted from a reablement programme and now attends a day centre. Thanks to this and the telecare J is now able to live more safely at home and the need for residential care has been avoided.

Outcome 3:

Ensuring that people have a positive experience of care and support

This means:

- People who use social care and their carers are satisfied with their experience of care and support services
- Carers feel that they are respected as equal partners
- People know what choices are available to them locally, what they are entitled to, and who to contact when they need help
- People, including those involved in making decisions on social care, respect the dignity of every person and ensure support is sensitive to the circumstances of each person.

This year our key achievements have been:

- We have delivered the ten point charter of rights for adult social care which highlights the standards people in Southwark with adult social care needs can expect from adult social care
- The latest national user survey tells us 83% of people are satisfied with the social services they receive, and 49% are very or extremely satisfied, although our aim is to improve on this
- My Support Choices, an online guide to adult social care and community services, has been rolled out enabling people to easily explore the options for obtaining support
- In the user survey 71% of people reported that they find it easy to find information about services, a significant improvement on previous results
- Older people's services have been reorganised to simplify access to the system and make it easier for people to find the information they need.

Catherine McDonald, cabinet member for health and social care (behind, left) and Councillor Althea Smith, mayor of Southwark (behind, right) attending an event during carers week.

Carers week

Hundreds of carers from around Southwark joined together to celebrate National Carers Week in June with the aim of highlighting the vital work being done by those who provide care for someone who is ill, frail or disabled. The theme was 'In sickness and in health'.

As part of a week of events, around 100 people visited Southwark Council's advice and information stand at the Tooley Street headquarters where staff from the council, Southwark Carers and Carers UK were on hand to talk to people about carer assessments, how to access free health checks and where to get support if they, or someone they knew, was a "hidden carer".

My support choices

Earlier in the year Southwark launched its online guide that provides information about adult social care and other services in the community. My Support Choices is designed to help local people easily explore the options and choices available to help them keep well and live safely and independently.

Regularly updated, My Support Choices enables people to find the information that they need both easily and quickly. However we recognise that some people may not have internet access or may need help to use the internet, so local residents are being encouraged to visit their local library and seek support from library staff.

This information is still available in other formats, for example leaflets, posters in GPs' surgeries, face to face advice from social workers and advice from telephone support lines. However the online guide provides another option that we believe will substantially improve access to information for many people.

To use the My Support Choices visit: **www.southwark.gov.uk/mysupportchoices**

Our priorities for the future:

- We aim to improve the user satisfaction levels reported by our customers
- The experience carers have of the support they receive is to be improved by taking forward the carers strategy following our work with Carers UK. The forthcoming national carer survey will give us information to track progress
- We will provide a dedicated telephone response service for all queries about help for older and vulnerable people and their carers, including information about universal access and voluntary sector services.

Outcome 4:

Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

This means:

- Everyone enjoys physical safety and feels secure
- People are free from physical and emotional abuse, harassment, neglect and self harm
- People are protected as far as possible from avoidable harm, disease and injuries
- People are supported to plan ahead and have the freedom to manage risks the way that they wish.

This year our key achievements have been:

- We have improved our response to safeguarding concerns by improving quality assurance procedures and training arrangements and improving awareness of safeguarding issues
- New independently chaired Safeguarding Board arrangements have overseen whole system performance
- We have used our influence as commissioners to secure improvements in a number of local care homes relating to the quality of services, including arrangements in place to protect the dignity and safety of residents. Residents and relatives have reported substantial improvements since the changes.

Safeguarding

J is a woman in her late twenties who suffers from schizophrenia and has substance misuse problems. She is not detainable under the provisions of the Mental Health Act. She had been living in a supported housing unit but often went missing from the unit. She became pregnant after being forced into prostitution by drug dealers who said she owed them money.

J disclosed to her social worker that she had become pregnant and explained the circumstances. In the first instance the social worker arranged for her to be transferred to another supported living unit in an attempt to break her free from the drug dealers who knew where she lived. The social worker then organised a multi disciplinary strategy meeting involving children's services, the police, Southwark antisocial behaviour unit and the woman's mother. A plan was developed to attempt to protect J from the drug dealers and also to manage her pregnancy and childbirth. The woman refused to cooperate with the police in pursuing a prosecution of the drug dealers. Towards the end of her pregnancy the woman moved into a mother and baby unit and subsequently gave birth to a healthy baby. The baby was taken into foster care where she remains. J returned to the supported living unit where she continues to receive support to address safeguarding concerns.

Safeguarding: financial abuse

B is a 79 year old woman living with her 52 year old son, who is an alcoholic. She is physically frail and receives a small domiciliary care package for personal care from Southwark Council. Her care worker reported they were concerned that there was usually little food in the flat and the rent was in arrears. The suspicion was that her son was taking her pension to spend on alcohol. B confirmed to the social worker this was the case. However, she did not want to involve the police as she loved her son and did not want to see him get in to trouble.

The social worker obtained the woman's agreement to call a family conference and together with the other family members developed a plan to both protect the woman's finances and get help for her son. A daughter who lived locally agreed with her mother's consent to manage her mother's financial affairs and the son agreed to seek treatment for his addiction.

Our priorities for the future:

- We will work with all Southwark services and the community to help ensure all our service users feel safe
- We plan to increase the speediness of our safeguarding processes, as measured by the case completion rate
- We will ensure there are sensible safeguards against the risk of abuse or neglect in our personal budget arrangements.

5 Budget issues

How we are managing the cuts

Southwark Council needs to cut expenditure in the face of government funding reductions of 29% (around £90m) being made since 2010. As a result adult social care is required to reduce spending accordingly over this period.

We are committed to implementing savings in a fair and transparent way in line with the council's budget setting principles. Most importantly, we aim to minimise the impact on those most in need of support wherever possible.

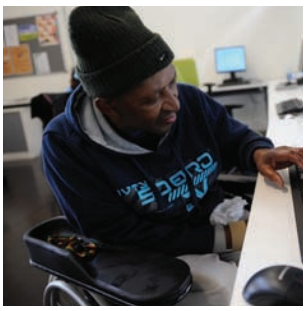
In line with our vision for adult social care we are seeking to reduce expenditure by transforming services to improve quality and outcomes, in particular by promoting the independence and wellbeing of people, and reducing or delaying the need for intensive support. It is important to note that we are not seeking to deliver savings by tightening eligibility criteria for services. All people with substantial or critical needs remain entitled to a service.

2011/12 budget was £112.9m

2012/13 budget of £107.7m

included savings of £7.7m

requires savings of £8.1m



In 2011/12 our budget was £112.9m, which included savings of £7.7m. The main source of savings was:

- Efficiency savings from contracts for Supporting People housing support for people with lower levels of need, and other commissioning improvements
- Reducing reliance on residential care, especially for people with learning disabilities and older people who are increasingly supported in their own homes
- Reduced block funding for some voluntary sector open access services
- Moving all users of Holmhurst day centre for older people to other day centres and closing Holmhurst day centre
- Workforce redesign to promote a more personalised approach.

In 2012/13 our budget of £107.7m requires savings of £8.1m. Savings are being made from the following main areas:

- Further reductions in Supporting People costs
- Further shifts away from residential care to home and community based support
- Redesign of learning disabilities day services
- Redesign of mental health services, including day services
- Workforce initiatives to reduce management costs
- Savings from improved contracting arrangements.

In our next Local Account we will report back on how we have delivered savings.

6 Our services

The tailored services we provide directly to service users include:

2,559
Personal budget holders

3,830 Community based service users receiving eg homecare, day care, meals, equipment, transport and personal budgets

2,792
People receiving alarm scheme or telecare

630
People receiving reablement or intermediate care after being in hospital

665
People receiving specialist occupational therapy equipment

4,609
People in Southwark are receiving a full community care package following an assessment

1,127
People supported in residential or nursing care

1,110
Mental health users receiving professional support

97
Places in Extra Care

422
People received Meals on wheels

1,124
Carers Assessments leading to a service, or advice or information

People who are not eligible for formal tailored support are given information and advice and signposted to universal access services that may help them retain independence. We fund a range of voluntary sector services to provide community support services. We also provide simple services that promote independence at the point of contact such as equipment and alarms.

More information about adult social care and community services, including "My Support Choices" is available at:
www.southwark.gov.uk/healthandsocialcare

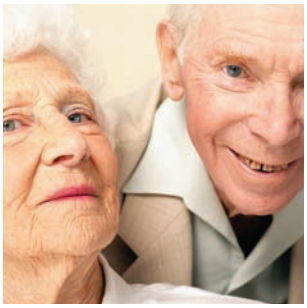
7 Feedback

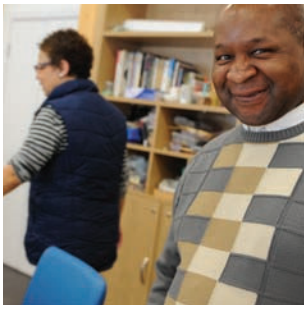
We would welcome your views of this Local Account, which is the first of its sort in Southwark. We want future Local Accounts to contain the information that you would like and find useful so please take the time to **complete our short online survey**.

If you have any comments or would like to raise any queries regarding this Local Account please email adrian.ward@southwark.gov.uk or call 020 7525 3345.

If you have a query or would like more information on adult social care services in Southwark please call 020 7525 3324 or visit www.southwark.gov.uk/mysupportchoices

Southwark Council





Dear Councillor Williams

We are grateful for the opportunity to outline concerns and views on the pre-consultation business case which your committee will be considering on the 31st January. My husband, Jim (75) and I (64), are residents of East Dulwich with care responsibilities. We have been attending SCCG meetings since October and have heard the findings of the Engagement Exercise presented at a meeting in Dulwich on the 24th July 2012. We have met with Andrew Bland, Malcolm Hines and Rebecca Scott and we welcome the dialogue which they have offered so far. This includes an opening for the consultation to invite proposals which extend beyond Options 1 and 2.

We made a submission to the South East London PCT Board Meeting (24th January 2013). What follows captures a number of the points made and the SCCG replies. We ask you to steer a consultation which truly reflects the scale of the challenges posed **across health, social care and public health** of the large and growing elderly population. We ask you to consider the opportunity offered by this unique site (Dulwich Community Hospital) to create an innovative model of integration and humane treatment. To make the site sustainable by widening the geographic target populations beyond Dulwich to include more of Southwark, Lambeth and Lewisham. We ask you also to steer this consultation towards seeking benefactors, leaders and champions for Health, Care and Public Health, just as the Arts did in the 1980's when public funding for the Arts was poor. We face here a world wide problem of the aged absorbing ever increasing portions of funds for health and care and of a growing resentment towards that elderly population. This consultation exercise could deliver something unique and imaginative; but to do so, its Terms of Reference should be broadened to seek those solutions. The constrained financial position should simply be laid out for the public to consider. We all need to be involved in and to feel that we own part of the solutions. It is our NHS and these are our Public Services. They must not be handed over to corporate interests.

This is the time for strong cases to be made which do indeed draw on the findings of the Engagement Exercise. However, that exercise was merely a 'wish list'. What are now needed are submissions, views, well-thought out proposals. So, we ask you to reconsider your agreement to consultation under Paragraph 244 and to steer the Terms of Reference and the Consultation Document towards solutions which are up to the task required.

You will find below what we have said to the SCCG, a summary of their reply, and what we are asking you to consider:

The (SEL) Boards are asked to steer the consultation process and content to fully reflect:

The unique opportunity which the Dulwich Community Hospital site represents to provide the revolution in treatment and care of the elderly, which Sir David Nicholson calls for (today) 21st January 2013:

> ...our modern hospitals have a highly technological way of operating. They are fast-moving and are organised around getting a diagnosis, referring the patient to the right place and getting treatment. They are very bad places for old, frail people." (Sir David Nicholson, the Independent 21st January 2013)
>
> We need to find alternatives. We need to put as much focus on that as we do on telling nurses to be more compassionate."

[Here the SCCG is showing openness in its response; however it adds the caveat of needing a critical mass of activity to remain clinically safe and to be cost effective.] ***Councillor Williams, would you please look at what that critical mass should be?***

The unique opportunity which the Dulwich Community Hospital site represents to provide the revolution in integrated treatment and care of priority groups across health and social care and public health:

Enclosure 10: Transitions and Closures in South East London and specifically Page 230 (SEL PCT BOARD PAPERS):

Lambeth and Southwark LAs are setting up a shared public health function. This is a complex transfer and a new joint working arrangement between the councils is underway. It isproposed that staff consultation starts week 14th January 2013. " (The SEL PCT Boards and Bexley Health Care Trust should recommend discussions for co-location of Public Health on the Dulwich Community Hospital site)

[Here the SCCG tells us that the location of the public health teams is a matter for the respective local authorities and that they are currently intending to stay in their existing office space.] ***Councillor Williams, we would be most grateful if you would scrutinise this from the point of view of an integrated health, care and public health perspective.***

The unique opportunity for integration and efficient and effective service to the numbers and use of premises which the Dulwich site represents.

Include **Monitor** (not mentioned in the text at all) and its role within the 2012 Act. Demonstrate compliance with Monitor's major role by providing evidence of where and how **integration** of Health and Social Care will be made to happen.

Make the case for Social Care for priority areas and groups as defined in the Pre-Consultation business case and specify stakeholder consultations. Who the stakeholders are; current arrangements and cost-benefit analyses of some co-location, where co-location would strengthen integration and the impetus **fo**r co-ordination and effective communication. (Too many reports of catastrophic failures within the care system have shown that these failures are down to silos bred by structures and barriers)

Make the Case for the Sector Skills Bodies responsible for Training and Development of Care Workers to locate a centre of Training Excellence on the Dulwich Community Hospital Site for best practice dissemination of care practice within residential care settings **and** home visits.

Make the case for Third Sector Health and Well-being organisations for priority groups (Priority Areas 3.4) on the Dulwich site and demonstrate **how** the hub and spokes service models will make integration happen.

[Here the SCCG has accepted the importance of appropriate reference to the future role of Monitor. It has also confirmed its commitment to us to further explore points we made in reference to social care, training and the contribution of the third sector. This is good.] C*ouncillor Williams, please use your good offices to ensure that all the impetus is towards integrated treatment and care and that the many silos and barriers are pulled down, not more erected. I think there is a good reason why IT companies still feel the need for co-location in Silicon Valley. People still need to see each other and meet for the best 'hubs' and 'spokes' to be modelled. We see the Dulwich Community Hospital site as a potential <u>National</u> model of integrated community based treatment, care and support for the elderly.*

This document is strong in how it defines intentions and aspiration. It states the strategic underpinning upon which its evidence is based. It does not make that evidence explicit. **The Boards should require the consultation documents to make their evidence obvious and clear to the lay reader.**

Specify with numbers and planning assumptions the priority populations and the demand they could generate using the 2011 Census for each priority area and their attendant populations. **Widen the geographic area and populations** to include contracts from North Southwark, Lambeth & Lewisham.

Describe the potential for income from that wider geographic and population area. **Present a cost benefit analysis of these broadened sources of revenue and how they would protect the sustainability of the Dulwich Community Hospitalsite.**

Make explicit the current demands for services by the priority populations covered by the priority areas. For example, give the numbers of 65+ patients currently referred by all Southwark, Lambeth and Lewisham GPs to the Department of Clinical Gerontology at King's (Betty Alexander). KCH Annual Accounts (2011/12) give its outpatient income as £ (000), 87,771. What proportion of that sum is for GP referrals from Southwark, Lambeth and Lewisham for Geriatric Medicine? Schedule 2 (2012) KCH Services lists 1533 First Attendance outpatients in Geriatric Medicine, and 4643 outpatient follow-up attendances. How many of these patients are on the lists of Southwark, Lambeth and Lewisham GP Practices? **This document needs tables to analyse the populations, evidence demand and show how integration will address and control the build up of demand.**

Specify National Priorities and Campaigns, such as Dementia, Obesity. State what the current funding streams are for these and how these are channelled. Has any work been done to seek "Health and Care Benefactors and Champions" as the Arts have done so successfully? **The consultation should be asked to invite Civic Champions and Benefactors within the consultation process.**

[Here the SCCG acknowledges in general terms the need for more detailed analysis, but its reply is 'mindful that we commission services for Southwark residents only.']
Councillor Williams, we are making the case to you to look more widely. Southwark, Lambeth and Lewisham can and do work together. They draw on common acute services and feel the impact, when pressure is applied on acute services shared in common. We attended the 26th January march regarding Lewisham Hospital and were shocked to learn of the current impact on King's (let alone what will happen if Lewisham A&E and Maternity Services are closed). We were also concerned to learn (Item 4 of the SEL PCT Board 24th January 2013) of board members already anxious about the impact on King's of closure at Lewisham. Hence in our view, the case for creating a more appropriate space for the elderly so they may be removed from pressured acute settings grows ever greater

The two case studies of people with Long Term Conditions and Older People do not illustrate the complexity of need requiring specialist, GP and Care integration. The work of King's Department of Clinical Gerontology, working as a bridge between the acute and the primary and community needs to be seen very clearly. **The following case study is offered. (Happy for its authenticity to be checked):**

Mrs MR is 89 with deep vein thrombosis, heart failure, bilateral pulmonary emboli, hypertension, hyper-cholesterolaemia, type II diabetes, peripheral vascular disease, Parkinsonism and overflow diarrhoea.

She is referred by her Southwark GP to King's Department of Clinical Gerontology (Betty Alexander Unit) whilst in the full-time care of her relative. King's have been providing her GP, Mrs MR and her carers with clear, exemplary and full guidance on how to manage these complex needs: full guidance on medication and the reduction of unnecessary medication leading to the avoidance of several A & E admittances. Mrs MR has been offered specific, practical advice understandable to the lay carers, on diet, medication management, physiotherapy, record keeping etc. Southwark Council's Handy Person Service and King's Occupational Therapist worked together to modify her home environment to the specialist's guidance. Mrs MR has lived for over three years at home and in residential care with quality of life since her referral.

The important perspective from the patient and carer experience has been that the clinical support was best delivered within the Dulwich Hospital site and has not, for most of the treatment, ever required the acute hospital setting. **In short, the King's site is often not needed. The Dulwich site is. Back to Sir David Nicholson... (See above)**

[Here the SCCG replies that although not a requirement, case studies are extremely useful. We welcome this.] ***What we are trying to say here is that as the population ages and so increasingly is not presenting as having lived healthy lives, there is complexity to be recognised. A real push for public health to reduce demand is needed. We thought that the recent research from Imperial College evidencing reduced paediatric A&E admissions as a result of banning smoking in public places shows that we are public creatures and that if we have a visible public space (in this case showing how best to care for the elderly), then we can get more people to change behaviour and reduce the pressure on services. Here, Councillor Williams, we are asking you to stress test with a broad range of realistic examples which properly address the demands Southwark Council does and will face.***

Given that such a site as the Dulwich Community Hospital will not be available again, the Boards are asked to question the assumptions and statements by both the SCCG and perhaps Southwark Council which lead them to affirm in Para 1.19: "Discussions with the HOSC (Health, Adult Social Care, Communities and Citizenship Scrutiny Committee) to date indicate agreement that the proposed changes are not deemed to be a major change

under Section 244 of the NHS Act 2006 and will not require formal consultation with the HOSC. " This section goes on to say that the SCCG will consult under Section 242 of the Act.

Not a major change?..! We are not lawyers. What we do see is a unique opportunity for an imaginative solution to major and intractable problems and **we affirm that the consultation should do its utmost to seek champions and leaders and support from the widest most practically located patient groups and carer populations and from civic society**. We are therefore pleased that the version (7) which the SEL PCT Boards and the Bexley Care Trust are considering here does now include the statement in the section on Decision making quoted below:

9.12 It is important to note that the CCG wishes to consult upon a proposed clinical model that addresses the case for change and responds to the feedback of patients and local people through the engagement exercise. Moreover, the consultation will seek to gain views on delivery options that the CCG believe are feasible and affordable. It is clearly the case that should, in the course of that consultation, alternative proposals and/ or delivery options that achieve or exceed those same objectives are brought forward or arrived at, they would also be considered within any future decision making process.

However, the consultation design and content needs to be explicit that the public are indeed invited to submit proposals in addition to Options 1 and 2 whilst continuing to make it clear that these are the options arrived at within the current financial planning assumptions. **Therefore, the Boards should invite the SCCG to give prominence and space for Options 3.** We truly believe that if the public finally feels properly consulted such as to allow them to own some of the solutions, the outcomes will be better accepted.

[Here the SCCG says "…that the pre-consultation business case states the plans for consultation and the CCG believes that these are aligned to the breadth and depth that is requested here. In response to submissions made to the SCCG in January 2013, the Project Board did not believe strong enough reference to the opportunity to hear and consider views of other options that may arise from the consultation had been made. This was reflected in the final document presented to the board."] ***Councillor Williams: we welcome that amendment to the document which you will see in the text presented to your Committee. We are asking you to ensure that the consultation document and process are indeed so designed as to be wide and that your committee gives itself the means to scrutinise closely***

Section E and Paragraphs 7.30-7.35: (This is a vitally important section where implications for the transfer of the site to NHS Property Services Ltd and for what Southwark Council's actual powers may indeed be are both complex and evolving.)

Therefore, we ask the Cluster meeting to insert two markers within this section. Firstly indicating that no staff resources will be diverted to options outside of Health, Care and Public Health until the consultation process is fully exhausted and all decisions have been taken. (We are already concerned to see active Liberal Democrat lobbying for a free school on the site.) Secondly, that strong representation will be made to the NHS Property Services Ltd **not to sell any part of the land.** A forward-looking exploration of the site requirements for health, care and public health must **first** be exhausted and some allowance made for future unplanned requirement.

Given that not much is known about this powerful new central body, it is important to give all members of the 6 PCT Boards and Bexley Care Trust some indication of the sheer size, power and ambitions of this new organisation. What is known about the power of the Local Authority vis -ā - vis the powers assigned to NHS Property Services Ltd? (Include as a minimum, the fact that NHS Property Services Ltd will employ 2500 staff and will be owning up to £7bn of NHS assets.)

The 6 PCT Boards and the Bexley Care Trust are making decisions within the most radical change of structures and landscapes in NHS history. This Cluster isa sked to include a tight timetable of frequent scrutiny meetings with it and with its successor structures to ensure that none of the developments are allowed to happen without full scrutiny and especially without full public involvement(242). **Our NHS is just that. It belongs to all of us**

[Here the SCCG gives a detailed and long response and I quote part of it: "NHS Southwark CCG's commissioning focus will be upon the health of its population and upon the quality and development of health services they receive… The CCG will also remain clear on its intentions for the areas to which it holds responsibility…etc"] ***Councillor Williams, we are not lawyers and I have no doubt that each statement is correct. Inadvertently, though, the SCCG builds another bunker. What we, the public need, is a solution which can reflect real lives. We are a retired couple who look after an elderly parent; we are ourselves parents. We are not unique. We may, however, be the last generation who were able to retire 'early' to provide care. We need you please to scrutinise across health, care and public health and across ages. We are hugely worried about the unknown impact of NHS Propco Ltd and of Mr Pickles' 'muscular localism.' We sense the 'guiding hand' of McKinsey's in ensuring that corporates gain as many contracts as possible and as much public money from the implementation of the Health and Social Care Act. We are an Anglo-American family with experience and fear of what***

American health care means for those without deep pockets and social standing

In summary, the thrust of the consultation should seize the unique congruence of opportunities and threats actively to invite additional submissions within the consultation. It will be clear from the above that the Pre-consultation Business Case should:

Allow for a wider population

Estimate the additional income derived from this wider population, from national priorities, and from champions and benefactors.

Include a more specified account of integration.

Use the consultation to explore whether more health and care sustainability is possible.

Give a prominent and strong role for Public Health.

The Boards should authorise the consultation to explore a wider range of stakeholders and champions, and to invite other technical submissions within the consultation. The outcomes of a fuller and wider consultation may well indeed produce other and better solutions for consideration within the constrained financial climate.

[Here the SCCG, confirms that points made in summary are valid..will help to shape and be reflected in the consultation and subsequent business case. They make a commitment to ensuring the appropriate role of public health in the project going forward.] ***Councillor Williams, we hope you will see that there is evidence of a good dialogue. At this stage, your role please is critical to protect the case for Health, Care and Public Health, to make certain that a practical and wide target population of Southwark, parts of Lambeth and Lewisham are accessible to Dulwich Community Hospital, and to protect that site for Health, Care and Public Health! At this moment, we do not need opportunistic lobbying for a 'Free' School from the Liberal Democrats.***

Thank you for your attention. We shall be in the public area of the meeting of your committee on the 31st January.

With Regards

Elizabeth Rylance-Watson and Jim Watson

50 Dovercourt Road, London SE22 8ST

Office of the Trust Special Administrator

Securing sustainable NHS services:

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

Securing sustainable NHS services

Final report
Volume 1 of 3
7 January 2013

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

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

Volume 1 of 3

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

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Foreword

By Matthew Kershaw
Trust Special Administrator

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

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

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

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

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

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

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

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

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

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

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

Matthew Kershaw
Trust Special Administrator

Foreword

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

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

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

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

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

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

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

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

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

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

Foreword

By Dr. Chris Welsh
Chair of the External Clinical Panel

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

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

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

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

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

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

Dr. Chris Welsh
Chair of the External Clinical Panel

1. Introduction

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

2. The Explanatory Memorandum to the Order and the Case describe a long-standing challenge in south east London, with the recurrent deficits in South London Healthcare NHS Trust (SLHT) existing prior to the organisation's establishment in 2009, its creation being one of several attempts to resolve them. The Case states that *"over the last five years there have been repeated attempts, involving different types and scale of conventional intervention to address the deep-rooted challenges faced not only by SLHT but by the wider health economy in south east London. This has included a major commissioner-led review of service reconfiguration, the merger of three previous Trusts into one and numerous organisational reviews and management changes. None have succeeded in bringing about the required level of change"*[2].

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

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

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

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

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

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

2. Context

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

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

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

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

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

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

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

▲Provided by Oxleas NHS Foundation Trust

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

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

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

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

* TSA analysis

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

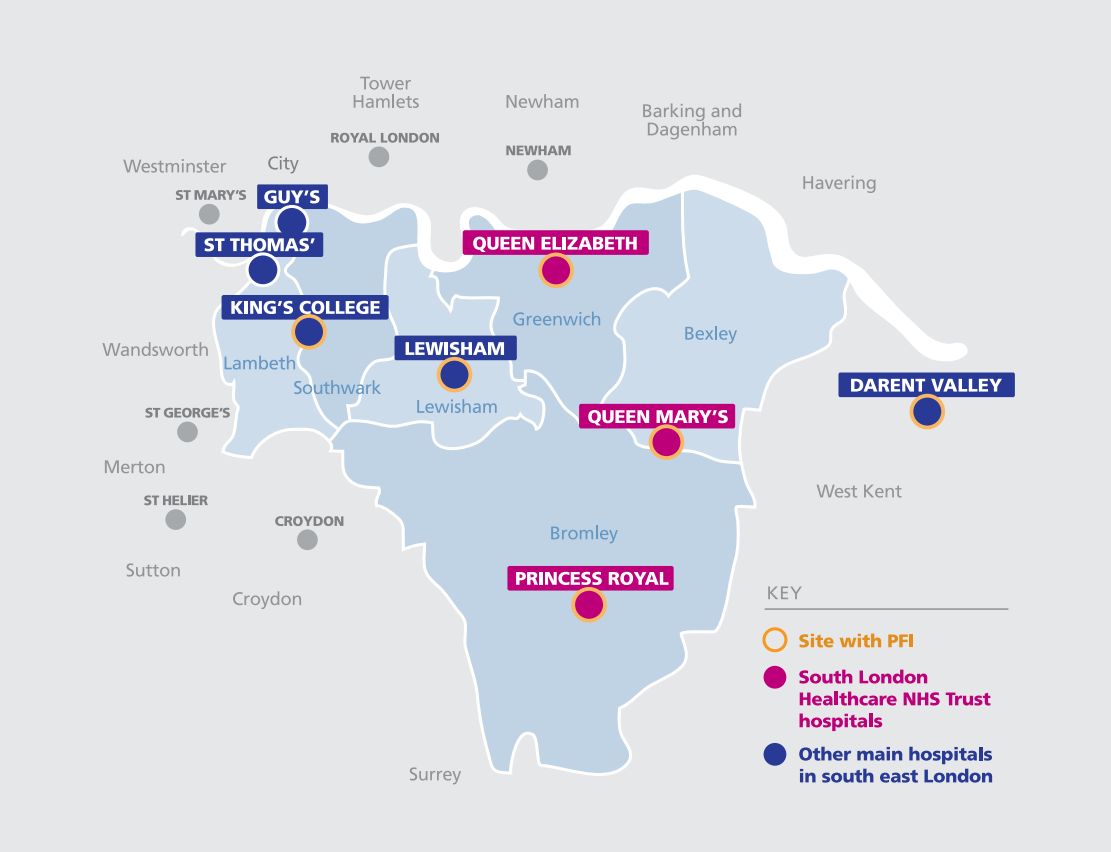
9. The NHS also funds a number of charitable and voluntary sector organisations such as the five hospice organisations: Greenwich Hospice, Bexley Community Hospice, Harris Hospice Care, St Christopher's Hospice and Trinity Hospice.

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

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

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

Figure 2: Map of acute hospitals in south east London



A History of Strategic Reviews

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

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

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

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

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

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

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

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

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

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

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

3. Approach

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

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

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

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

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

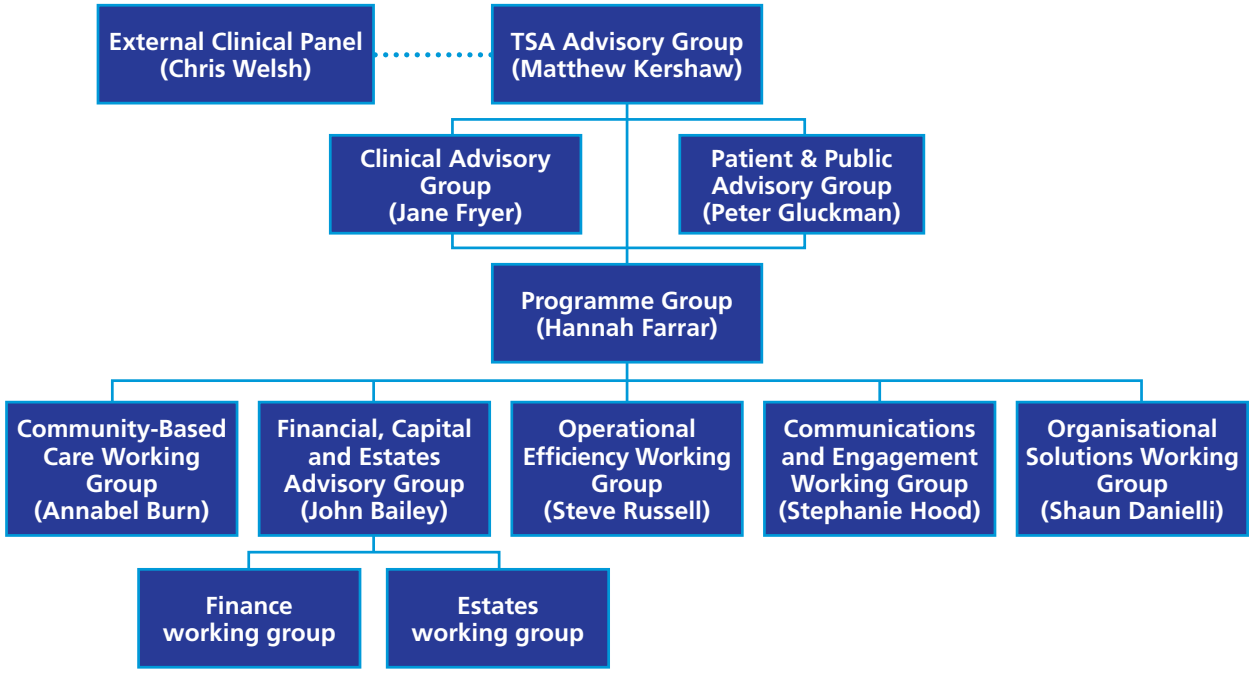
5. Advisory and working groups were established immediately. They have been integral to developing, improving and validating the recommendations as they emerged, both for the draft report and this final report. Each group has had a clear understanding of its role and remit, bringing specialist expertise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

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

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

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

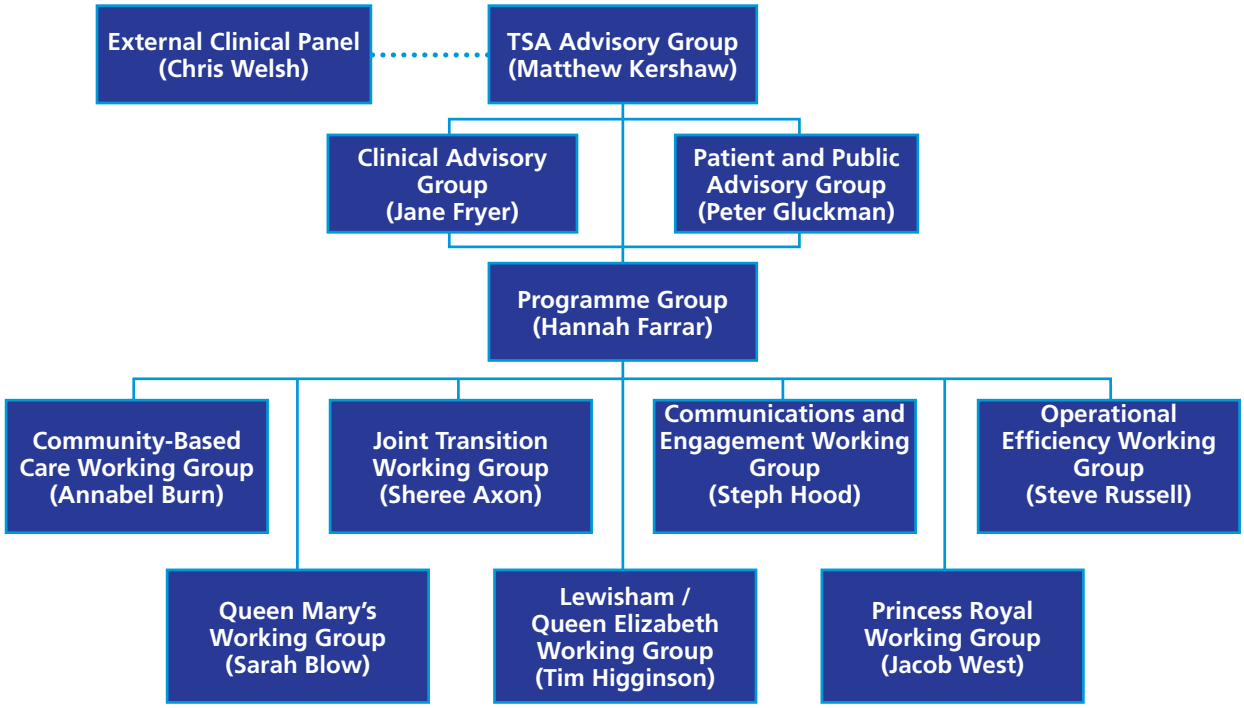
Figure 3: Draft report programme governance arrangements



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

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

Figure 4: Final report programme governance arrangements



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

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

Work undertaken in preparing the report

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

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

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

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

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

Assessing the financial position of South London Healthcare NHS Trust

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

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

Operational efficiency

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

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

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

Impact of PFI costs

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

Understanding the south east London health economy

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

Developing service options

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

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

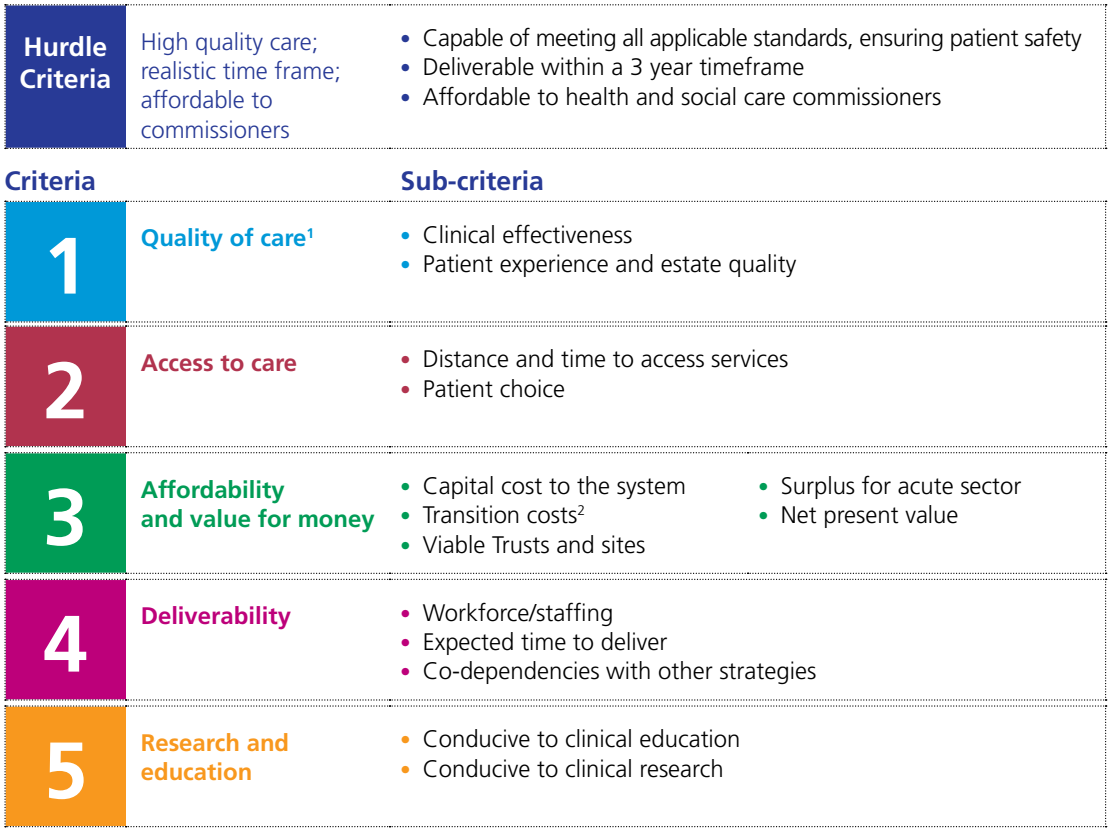
25. Some respondents to the consultation have argued that the TSA team's assessment of services did not go far enough, for example by excluding mental health services (although this is included in the community-based care aspirations). On the other hand, others suggested that any work that challenged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

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

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

28. The approach adopted for evaluating the options, including the evaluation criteria, was challenged by various advisory groups including the clinical advisory group, the patient and public advisory group, the finance, capital and estates advisory group and the TSA advisory group. The approach and the criteria were refined on the basis of feedback. The final criteria against which options were evaluated are summarised in figure 5 and provided in detail at appendix E. The evaluation of options was completed by the clinical advisory group and the finance, capital and estates advisory group. The outcome of this process was tested with the TSA advisory group and reviewed by the external clinical panel. The evaluation identified only one clinically and financially viable configuration for emergency and obstetric-led maternity services in south east London.

Figure 5: Service configuration evaluation criteria



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

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

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

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

Developing organisational options

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

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

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

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

Figure 6: Evaluation criteria for organisational solution options

	Criteria	Description
Hurdle Criteria	• Viability, clinical synergy and market interest	• Are providers financially sustainable? • Can providers demonstrate an ability to deliver acute clinical care to the local population? • Is there market interest?
Evaluation Criteria	• Quality of acute care	• To what extent does the option meet the quality envisioned in the site strategy or offer enhanced quality?
	• Productivity	• To what extent does the option deliver or exceed the required productivity gains?
	• Integrated care	• To what extent does the option enable better integration between primary, community, acute and social care?
	• Deliverability	• Over what time frame will benefits be realised?
	• Choice and competition	• What impact will the option have on patient choice, access and competition?
	• Stakeholder alignment	• How aligned are stakeholders (potential partners, patients, public, staff) behind the option?

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

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

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

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

Stakeholder engagement

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

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

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

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

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

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

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

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

Engagement with staff

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

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

Engagement with patients and the public

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

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

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

Formal consultation

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

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

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

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

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

'Four Tests'

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

The changes have support from GP commissioners

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

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

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

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

Strengthened public and patient engagement

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

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

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

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

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

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

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

The recommendations are underpinned by a clear clinical evidence base

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

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

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

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

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

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

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

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

The changes give patients a choice of good quality providers

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

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

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

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

Health and equalities impact assessment

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

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

76. The HEIA is intended to answer three questions:

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

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

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

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

79. Negative impacts and mitigations include:

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

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

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

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

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

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

Introduction

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

Clinical performance

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

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

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

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

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

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

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

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

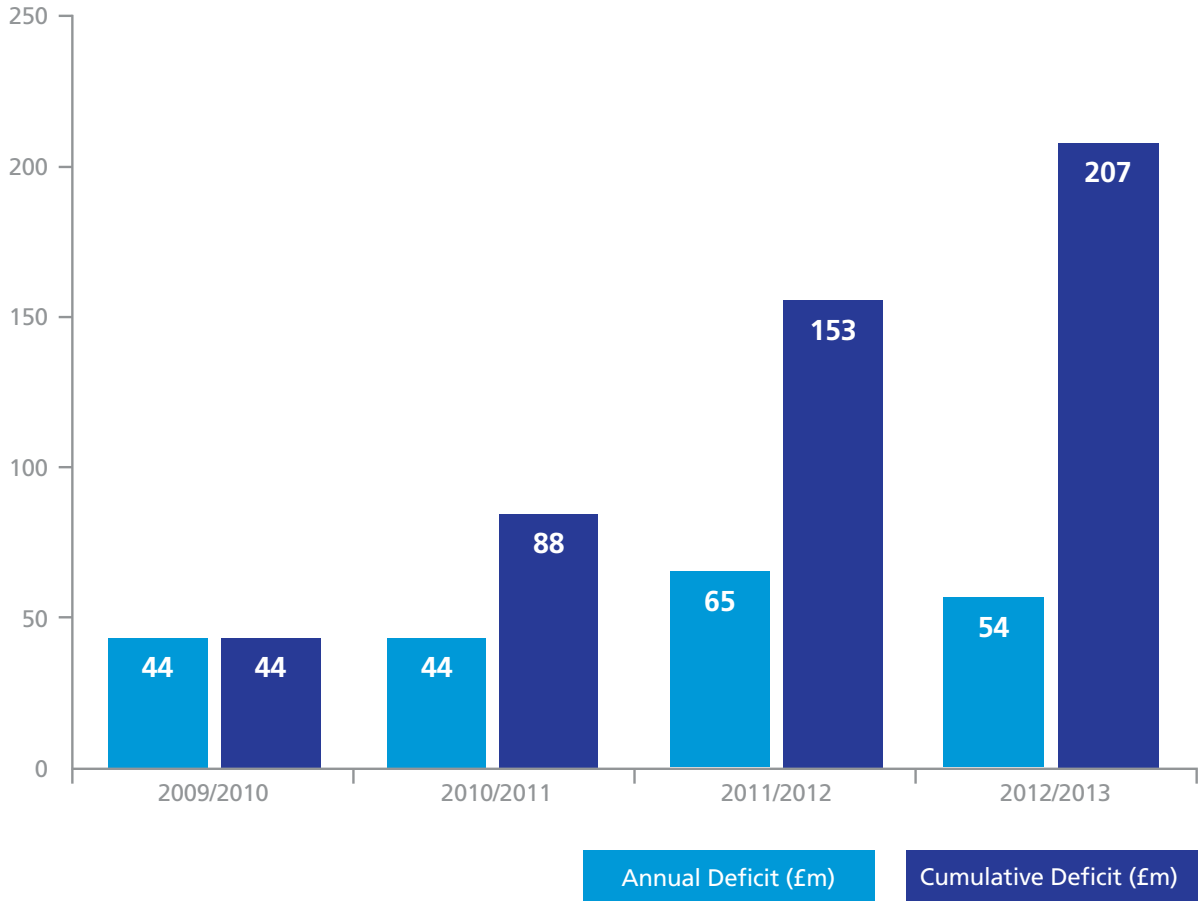
Financial performance

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

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

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

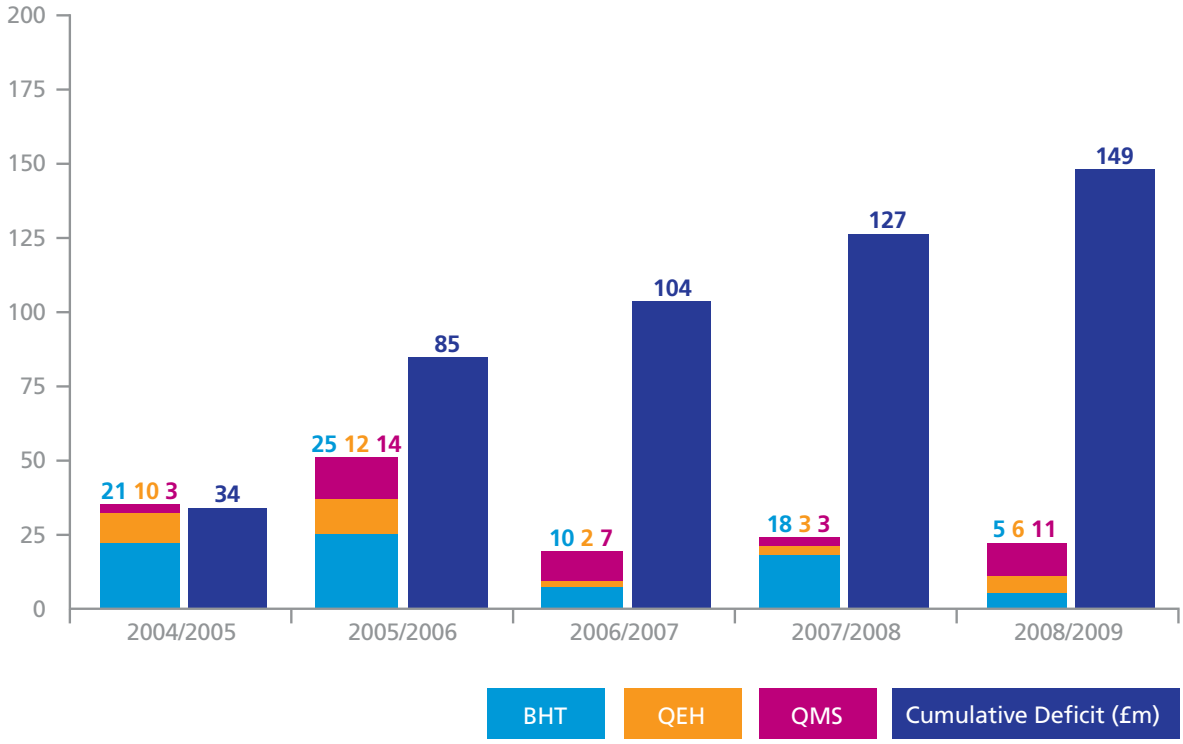
Figure 7: Normalised deficit of South London Healthcare NHS Trust 2009/10 to 2011/12 and forecast for 2012/13[14,*]



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

* NHS Control Total basis excluding impairments and IFRS impact.

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



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

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

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

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

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

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

Income

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

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

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

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

Operating costs

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

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

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

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

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

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

20. The gains made through a concerted turnaround programme in 2010/11 proved to be unsustainable, and non-pay costs returned in 2011/12 to levels above those seen in 2009/10. The £12.7m (8.0%) increase was driven largely by a £12.4m increase in clinical supplies and services. Such an increase could either indicate a lack of control over the purchasing of such supplies, high inflation, or a failure to turn additional activity into income. The operational efficiency assessment has identified a lack of capacity and capability in the Trust's procurement function, with the same products being purchased from different suppliers and at different costs.

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

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

Cost improvement programme schemes (CIPs)

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

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

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

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

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

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

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

- In 2009/10, 61% of savings were generated from clinical cost reduction, half of which were from clinical headcount and staffing costs. This area was also one of the key drivers for the underperformance against the CIP.
- The 2010/11 savings plan was the largest (as a proportion of total costs) in London. Key areas of focus were restrictions on temporary / agency staff and controls on discretionary spending.
- In 2011/12, the Trust underperformed by £9.9m against its CIP. The Trust's primary explanation for this was the changing nature of activity and the desire to ensure services remained safe. As noted above, the overall operating cost evolution in this year (+4.5%) would also suggest that many of the gains from the 2010/11 programme were reversed, in part for similar reasons of safety concerns.
- In 2012/13, the Trust is £1.1m behind its CIP at the half-year point, but actions are in train to ensure the full delivery of the CIP by the year end through the identification and delivery of additional schemes since the appointment of the TSA. While this will ensure the Trust will achieve its financial plan for 2012/13, it would still be in the context of a deficit for the year of more than £50m.

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

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

* TSA analysis

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

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

Cash flow

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

Deficit analysis

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

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

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

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

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

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

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

Financial projections – 2013/14 to 2015/16

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

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

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

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

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

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

Implications and recommendations for action

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

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

* TSA analysis

Recommendation 1: Operational efficiency

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

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

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

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

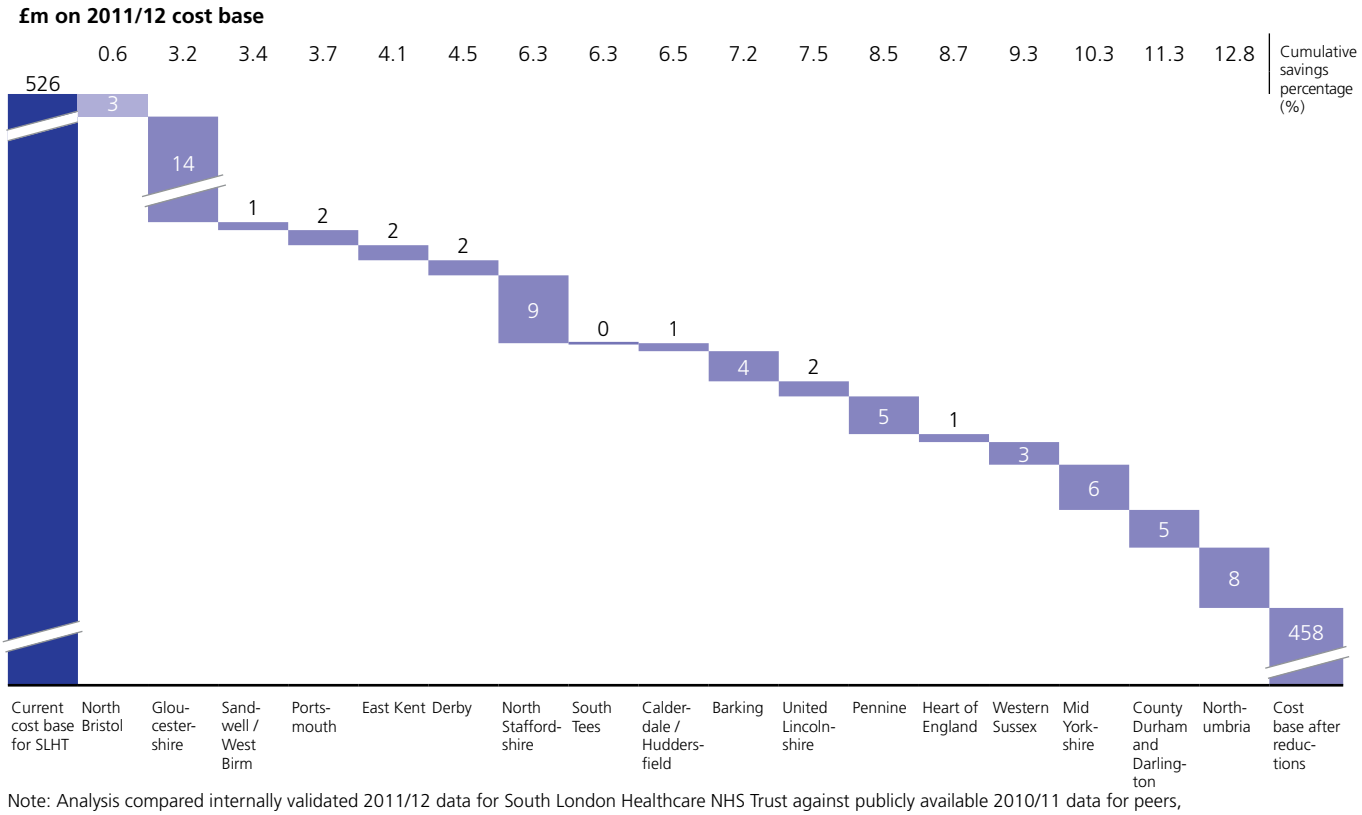
39. Figure 16 shows how the cost base of the Trust would reduce if it matched the productivity levels of 17 of its 18 peer Trusts. Eight of the 17 Trusts that perform better than South London Healthcare NHS Trust are foundation trusts and the other nine are NHS trusts.

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

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

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

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



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

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

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

- *Medical pay (£20m)*: The Trust has the lowest income per consultant in its peer group, a very high ratio of junior doctors to consultant staff and high use of locum and agency staff.
- *Nursing pay (£14m):* Compared to its peers, the Trust has a high nursing spend relative to the number of occupied bed days (the sum of all the days spent in hospital by patients). The Trust also has a higher proportion of senior staff than its peers.

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

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

- *Scientific, Technical and Therapeutic (ST&T) staff pay (£4m):* Compared with its peers, the Trust has a higher number of full time equivalent staff relative to the income of the Trust in multiple professional groups. These include pharmacy, speech and language therapy and various sub-specialities of pathology. In addition, the Trust has high bank spend for scientific, technical and therapeutic staff relative to its peers.
- *Average length of stay (£6m):* Overall average length of stay for the Trust is lower (and therefore better) than the peer median for elective spells and only slightly higher (and therefore worse) than peer median for non-elective spells. However, there is still a gap to the top three peers. To estimate the actual opportunity in this area, the average lengths of stay for individual groups of patients in each specialty were benchmarked to peers. This more detailed analysis reveals a potential savings of 90-100 beds (on top of recent changes) if the Trust were to achieve top quartile performance.
- *Non-clinical pay (£4m):* The £50m non-clinical pay spent on 'back office' staff (eg. human resources, IT and procurement) and 'middle office' staff (eg. medical secretaries, ward clerks and receptionists) has been reviewed. This cost base represents approximately 1,300 full time equivalents. Opportunities for more efficient and effective running of the processes performed by these staff groups were assessed, using outsourcing as the primary alternative.
- *Supplies (£9m*): The review of non-pay spend at category level (eg. prosthetics, dressings, disposable items and other consumables) concluded that there was the potential for a saving of £9m across the Trust, through a combination of supplier consolidation, better negotiation, managing demand and reducing stock levels.
- *Other variable costs (£5m):* A high-level review was carried out to establish the savings potential from outsourcing clinical support functions. Pathology and pharmacy were identified as offering the greatest benefit.

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

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

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

44. Between the publication of the draft report and the completion of the final report, a second phase of work was undertaken in which the identified opportunities were translated into detailed CIPs for the three year period 2013/14 to 2015/16. The schemes were all developed over an intensive five-week process in which the external advisors from phase one continued to work with the leadership teams of the four clinical care groups and corporate services. Dedicated finance, workforce and information management resources were provided to work alongside each group to develop and validate all initiatives. The teams developed CIPs to full business case standard for year one (2013/14) and to outline business case standard for years two and three (2014/15 and 2015/16).

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

46. Throughout the work, the importance of safeguarding service delivery, quality and safety has been recognised and is paramount. A combination of internal clinicians from the key professional groups and external clinicians, including the external clinical panel, have been involved in the development of many of the schemes. An initial review of the schemes has been undertaken by the Chief Nurse and Medical Director for South London Healthcare NHS Trust and by the external clinical panel. It was noted during this process that there is a very significant scale of change proposed in totality when the combined effect of all the schemes are considered.

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

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

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

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

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

51. A total of £74.9m of savings have been developed through the phase two work (see figure 17), which closes the identified productivity gap of £62m over the three-year period, as well as delivering the majority of the additional efficiency gains required to keep pace with national expectations. CIPs for all three years have been broken down by year, by site and by cost category and have been collated into a single programme plan to describe the recommended sequence for implementation.

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

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

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

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

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

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

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

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

* In year % savings are shown as a percentage of the total estimated cost base at the start of the year.
** £164m costs not included in the initial analysis in benchmarking include other clinical pay, premises establishment and non-operating costs (PDC interest depreciation)

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

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

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

Recommendation 2: Queen Mary's Hospital Sidcup

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Figure 20: Annual impact of recommendation 2

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

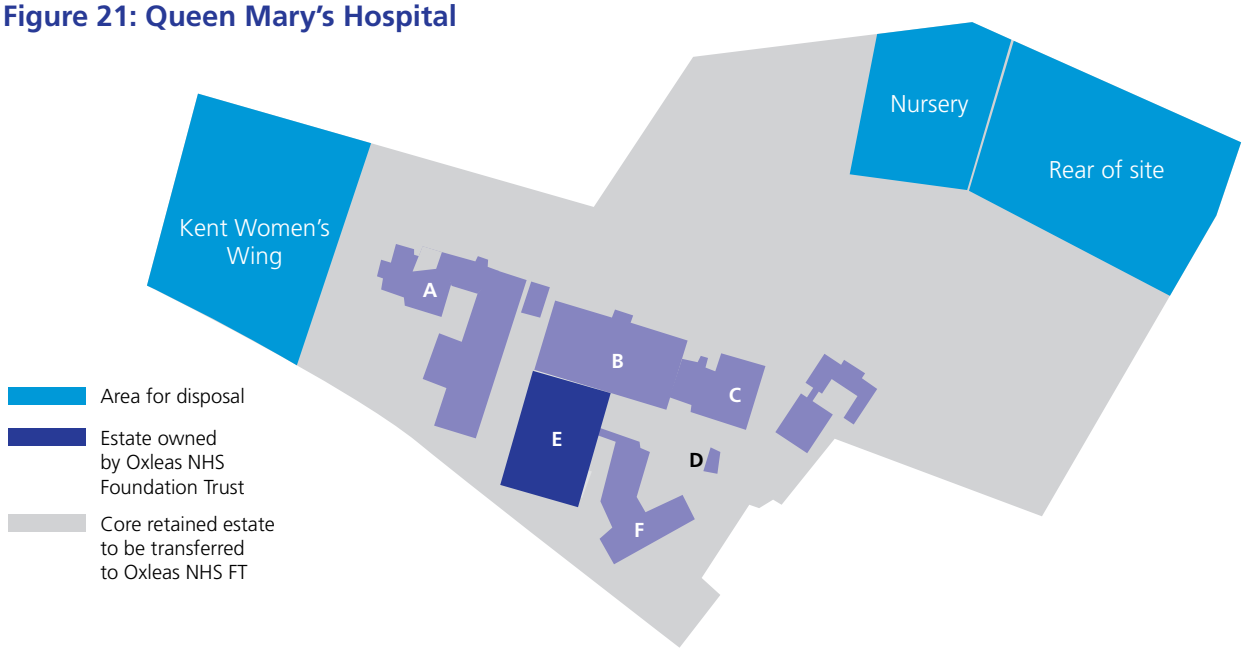
Recommendation 3: Estate utilisation

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

Queen Mary's Hospital

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

Figure 21: Queen Mary's Hospital



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

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

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

Orpington Hospital

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

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

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

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

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

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

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

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

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

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

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

Beckenham Beacon

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

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

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

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

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

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

Figure 22: Annual impact of recommendation 3

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

Recommendation 4: National support in relation to excess PFI costs

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

Figure 23: South London Healthcare NHS Trust PFI contracts

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

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

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

Before TSA Recommendations

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

2013/14 Full year effect

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

2014/15 Full year effect

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

2015/16 Full year effect

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

Changes in I&E

2013/14	Rec 1 Further productivity	Rec 2 QMS site change	Rec 3 Estates	Rec 4 PFI support	Total changes	Surplus/ deficit	Gap to 1% (positive = below 1%)
PRU	4.9			10.5	15.4	-7.6	9.4
QEH	5.2	0.6		12.2	18.0	-14.6	16.3
QMS	2.1	-0.6	0.7		2.2	-8.5	9.1
Total	**12.2**	**0.0**	**0.7**	**22.7**	**35.6**	**-30.7**	**34.8**

2014/15							
PRU	8.5		2.8	10.7	22.0	-4.7	6.6
QEH	9.9	0.6		12.2	22.7	-12.2	13.9
QMS	4.2	2.1	0.7		7.0	-4.7	5.3
Total	**22.6**	**2.7**	**3.5**	**22.9**	**51.7**	**-21.6**	**25.8**

2015/16 Full year effect							
PRU	12.6		4.0	11.8	28.4	0.0	1.9
QEH	13.8	0.6		13.6	28.0	-7.5	9.3
QMS	5.2	3.9	0.7		9.8	-1.3	1.9
Total	**31.6**	**4.5**	**4.7**	**25.4**	**67.5**	**-8.8**	**13.1**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Figure 27: Lewisham Healthcare NHS Trust normalised financial performance

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

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

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

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

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

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

* TSA analysis

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

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

Community-based care

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

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

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

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

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

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

24. To address these issues and meet south east London commissioners' vision, and as a key building block in developing the recommendations, the CCGs themselves have produced a Community-based Care Strategy for south east London. At the heart of this strategy is a set of aspirations for how care will be delivered in the future, so that the population of south east London receives the best possible care in the community, including in their homes, where feasible. This will support people to live healthier and more independent lives. These aspirations are essentially a set of shared standards of care, which will be delivered locally as determined by each CCG. These aspirations (summarised in figure 29 and detailed in appendix O) have been grouped into three areas of care:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hospital-based care

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

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

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

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

Adult emergency services

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

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

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

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

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

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

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

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

- Increased consultant presence across all seven days of the week;
- Consultants on call to be freed from all other clinical duties to focus on emergency admissions;
- All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital;
- Consultant involvement, for patients considered 'high risk', to be within one hour – 24 hours a day, 7 days a week;
- A clear multi-disciplinary assessment, including input from nursing, physiotherapy, occupational therapy, pharmacy, and acute pain management (where appropriate) to be in place within 24 hours of admission;
- All patients to be seen and reviewed by a consultant during twice-daily ward rounds;
- 24-hour timely access to key diagnostic imaging and reporting; and
- Clear patient communication and information and patient experience data to be routinely collected, reported at board level, and acted upon.

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

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

Figure 33: Quality and safety audit in south east London, 2012

No	Standard	KCH		SLHT-PRUH		SLHT-QEH		GSTT-ST		UHL	
		Medicine	Surgery	Medicine	Surgery	Medicine	Surgery	Medicine	Surgery	Medicine	Surgery
1	All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital.	✗	✗	✓	✗	✓	✗	✓	✗	✗	✗
2	A clear multi-disciplinary assessment to be undertaken within 12 hours and a treatment or management plan to be in place within 24 hours (for complex needs patients see 23 and 24).	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
3	a) All patients admitted acutely to be continually assessed using a standardised early warning system (EWS).	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	b) Consultant involvement is required for patients who reach trigger criteria. Consultant involvement for patients considered 'high risk' to be within one hour.	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.	✓	✓	✓	✗	✓	✗	✓	✓	✗	✗
5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical/ surgical unit to cover extended day working, seven days a week	✗	✗	✓	✗	✓	✗	✓	✗	✗	✗
6	All patients on acute medical and surgical units to be seen and reviewed by a consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate.	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
7	All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: • Critical – imaging and reporting within 1 hour; • Urgent – imaging and reporting within 12 hours; • All non-urgent – imaging and reporting within 24 hours.	✗	✗	✗	✗	✗	✗	✓	✓	✗	✗
8	All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week: • Critical patients – 1 hour; • Non-critical patients – 12 hours.	✓	✓	✗	✗	✗	✗	✓	✓	✗	✗
9	Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical or surgical unit. Subsequent transfer or discharge must be based on clinical need.	✗	✓	✓	✗	✓	✗	✓	✓	✓	✓
10	A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialties throughout the emergency pathway.	✓	✓	✗	✗	✗	✗	✓	✓	✗	✗
11	Patients admitted for unscheduled care to be nursed and managed in an acute medical or surgical unit, or critical care environment.	✓	✓	✓	✗	✓	✗	✓	✗	✓	✗
12	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. A policy is to be in place to access social services seven days per week. Patients to be discharged to their named GP.	✗	✓	✓	✗	✓	✗	✓	✓	✗	✓
13	All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night.		✗		✓		✓		✗		✓
14	All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.		✗		✗		✗		✗		✓
15	All patients considered as 'high risk' to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. High risk is defined as where the risk of mortality is greater than 10%.		✓		✗		✗		✗		✓
16	All patients undergoing emergency surgery to be discussed with consultant anaesthetist. Where the severity assessment score is ASA3 and above, anaesthesia is to be provided by a consultant anaesthetist.		✗		✓		✗		✗		✓

No	Standard	KCH		SLHT-PRUH		SLHT-QEH		GSTT-ST		UHL	
		Medicine	Surgery	Medicine	Surgery	Medicine	Surgery	Medicine	Surgery	Medicine	Surgery
17	a) The majority of emergency general surgery to be done on planned emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded.		✓		✗		✓		✗		✓
	b) Any operations that are carried out at night are to meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.		✗		✗		✗		✗		✓
18	All referrals to intensive care to be made from a consultant to a consultant.	✗	✗	✗	✗	✗	✗	✗	✗	✓	✓
19	A structured process to be in place for the medical handover of patients twice a day. These arrangements to also be in place for the handover of patients at each change of responsible consultant/medical team. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions.	✗	✓	✓	✗	✓	✓	✓	✓	✗	✓
20	Consultant-led communication and information to be provided to patients.	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
21	Patient experience data is captured, recorded and routinely analysed and acted on. Is a permanent item on board agenda and findings are disseminated.	✗	✓	✗	✗	✗	✗	✓	✓	✗	✓
22	All acute medical and surgical units to have provision for ambulatory emergency care.	✗	✓	✗	✗	✓	✓	✗	✓	✓	✓
23	Prompt screening of all complex needs inpatients to take place by a multi-professional team which has access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy.	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
24	Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes.	✗	✗	✗	✗	✓	✓	✗	✗	✓	✓
25	Hospitals admitting emergency patients to have access to comprehensive 24 hour endoscopy services that has a formal consultant rota 24 hours a day, 7 days a week	✓	✓	✗	✗	✗	✗	✓	✓	✗	✗
26	a) All hospitals dealing with complex acute medicine to have onsite access to levels 2 and 3 critical care (i.e. intensive care units with full ventilatory support).	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	b) All acute medical units to have access to a monitored and nursed facility.	✓		✓		✓		✓		✓	
27	Training to be delivered in a supportive environment with appropriate, graded consultant supervision	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓

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

Figure 34: Shortfall in consultant workforce in south east London*

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

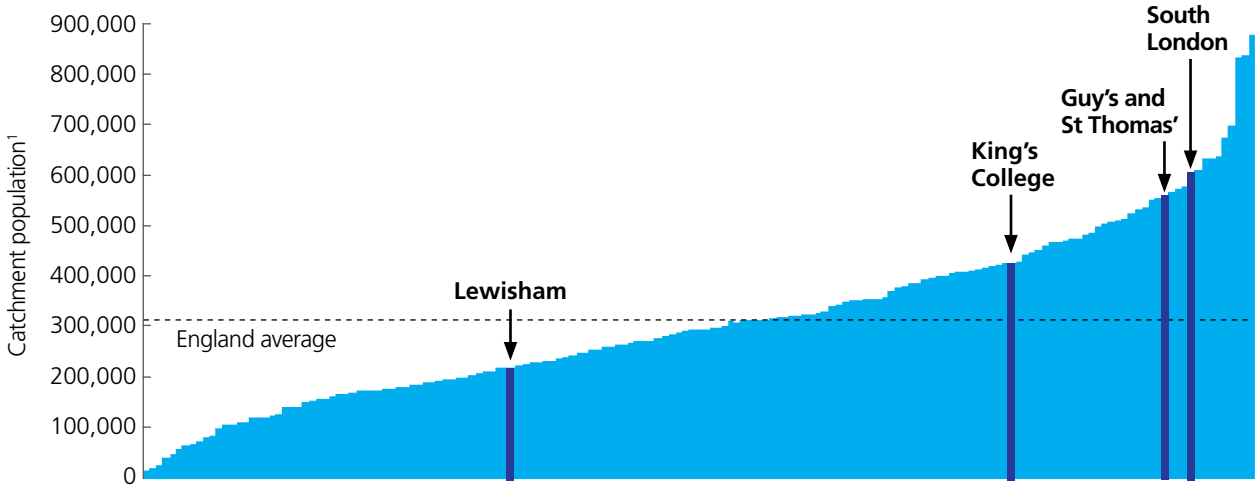
42. However, simply increasing the number of doctors at every hospital is not the answer. In addition to meeting the standards services also need to be delivered where there are sufficient activity volumes to ensure that clinical teams can keep their expertise and skills up to date by treating a sufficient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

* Trust Data Submissions

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

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

Figure 35: Catchment population by hospital trust in England 2009



[1] 2009 catchment populations for all admissions by Trust

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

45. As part of the overall work to address the issues facing South London Healthcare NHS Trust, and coupled with the drive to meet the clinical standards whilst ensuring activity levels are sufficient to maintain skills, the clinical advisory group concluded that the population of south east London would be best served by four hospitals providing emergency care for the most critically unwell. The other three main hospitals in south east London would continue providing a range of services for those that do not need to be admitted to hospital on an emergency basis. The types of conditions these services will be able to treat include:

- Many illnesses and injuries not likely to need a stay in hospital;
- Minor fractures (breaks);
- Stitching wounds;
- Draining abscesses that do not need general anaesthetic; and
- Minor ear, nose, throat and eye infections.

46. These services will be equally applicable to adult and paediatric patients and where patients need to be admitted to hospital, robust treat and transfer protocols will apply. Such protocols currently exist and have been found to be effective in ensuring patients are transferred to the correct location for their condition – for example, heart attack patients who are transferred to one of eight heart attack centres for appropriate treatment.

47. The multiplicity of offerings for urgent and emergency care is currently the subject of work being undertaken by the Medical Director of the NHS, the aim of which is to eradicate the confusion that many people experience in understanding which emergency and urgent care services are provided at different places. Reflecting on what the public said during the TSA's consultation, emergency and urgent care services across all sites in south east London should be developed in line with the output from the Medical Director's work as it emerges.

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

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

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

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

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

53. The analysis demonstrates that recommending that University Hospital Lewisham should not have an emergency department is the only viable option. An alternative option that Queen Elizabeth Hospital, rather than University Hospital Lewisham, should operate in this way was fully considered but discounted, as implementing that option would have a more detrimental impact both on access and on the financial viability of the health economy.

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

55. Analysis included in the TSA's draft report suggested around 77% of University Hospital Lewisham's current A&E activity would remain at the hospital under this scenario. However, a number of responses to the consultation suggested that this estimate was too high. Therefore, further analysis was undertaken and, based on practice elsewhere in London, a revised figure of 50% has been used for the modelling that underpins the TSA's recommendation.

56. The recommendation also means that the locations of services for those suffering from a major trauma, stroke, heart attack and complex vascular problems should not change, which means:

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

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

Paediatric emergency services

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

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

* Dr Foster analysis

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

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

62. Throughout discussions it was clear that sustaining the current number of paediatric inpatient units in south east London would not be viable, due to the volumes of patients and the shortfall in consultant workforce as outlined in paragraphs 40 and 41 and figure 34. The clinical advisory group and the external clinical panel considered whether the units should be consolidated further than the recommended consolidation of acute admitting sites and options for two or three inpatient units were considered.

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

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

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

Health and Equalities Impact Assessment – emergency care

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

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

68. This section of the population will also be impacted by increased costs of both private and public transport journeys and this point is particularly relevant for relatives and carers who may have to make multiple journeys. In order to mitigate these impacts, more information should be made available on cost support schemes and any Transport for London journey changes that would reduce costs.

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

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

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

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

73. When considering disability, the HEIA shows that mental health problems and coronary heart disease are disproportionately prevalent for people with learning disabilities, but the proposed changes will have no negative impact for these patients. South east London as a whole has high rates of emergency admissions for patients with respiratory disease, another significant issue for people with learning disabilities. As many of these conditions could be better managed in primary and community settings, implementation of the Community-based Care Strategy will therefore have a positive impact on the quality of care provided to this group.

Maternity services

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

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

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

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

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

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

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

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

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

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

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

82. The external clinical panel – with extended membership to include obstetric and midwifery representatives, as well as representatives from the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives – considered the benefits and, in particular, the risks and proposed mitigating actions for each option.

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

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

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

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

87. The Royal College of Midwives representative and other members of the panel suggested that, in this case, it would likely be an attractive choice for women due to the popularity of the current midwifery-led birthing unit at University Hospital Lewisham, which is rated highly in patient satisfaction surveys. Evidence of successful free-standing midwifery-led birthing units elsewhere in the United Kingdom added further support to the external clinical panel's recommendation.

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

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

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

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

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

93. For low risk births, there are also potential benefits in terms of health outcomes; midwife-led care is associated with improved experience for mothers and fewer interventions[41].

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

Alternative approach for proposing changes to emergency and maternity services

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

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

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

98. Feedback received from Lewisham CCG during consultation did recognise the need to improve the quality and safety of services by delivering the clinical quality standards and therefore the need for acute configuration in line with the London dependency framework (appendix E). While the recommendation for University Hospital Lewisham to cease providing emergency services and potentially changing obstetric-led births was not supported by Lewisham CCG and other local stakeholders during consultation, they were unable to put forward a viable alternative. All other local commissioners were broadly supportive.

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

Elective care

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

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

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

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

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

103. With this in mind, options for the development of one or more dedicated elective centres for the population of south east London were considered by all of the advisory groups in order to assess both the clinical and financial benefits of the options. Based on these considerations the recommendation is for an elective centre for non-complex inpatient procedures to be developed at University Hospital Lewisham and for non-complex inpatient procedures to continue to be provided at Guy's Hospital, together serving the whole population of south east London. Alongside this, complex procedures should be provided at King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital, Guy's Hospital and St Thomas' Hospital; and specialist procedures should continue to be provided at Guy's Hospital, King's College Hospital and St Thomas' Hospital. Day case procedures would continue to be provided at all seven main hospitals.

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

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

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

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

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

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

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

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

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

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

113. The HEIA also outlines that journey travel times and costs will increase for many patients. While pre- and post-surgery appointments will take place closer to patients' homes, the increased journey times and costs are only likely to be for the operation itself. Additionally, for non-complex elective inpatient admissions at University Hospital Lewisham patients, their relatives and carers may benefit from the proposed development of a new car park.

114. In relation to the recommended change in services, the HEIA states that it may be more difficult for some people from BAME groups to understand the changes in service provision and where they need to go to access a particular service. It will therefore be important that patients, their relatives and carers receive clear information along the care pathway.

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

Impact of changes

Impact on Lewisham site

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

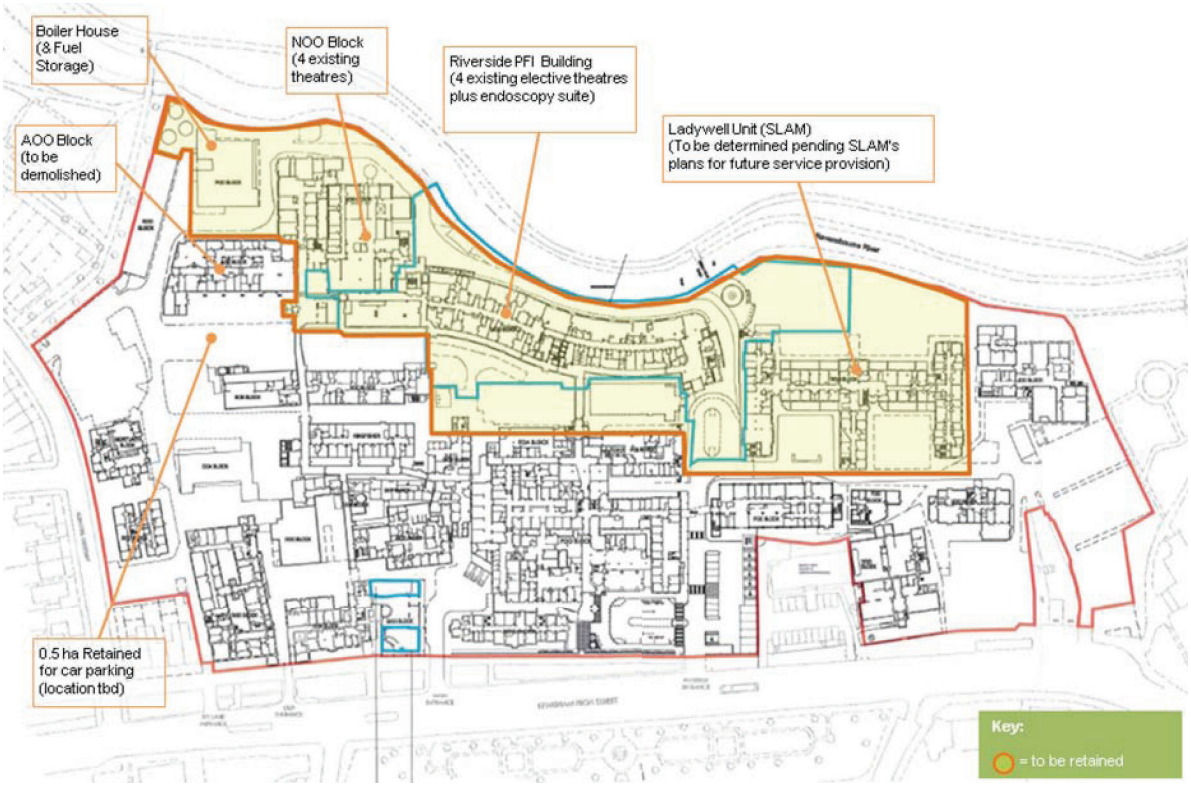
117. Under the recommendation, many services will be retained at University Hospital Lewisham and others developed to provide local access to a wide range of services that meet patients' needs and to maintain the well developed integrated care pathways in Lewisham. The services that will be retained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

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

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

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

Figure 36: Proposed estate usage at Lewisham



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

Impact on all south east London sites

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

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

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

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

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

Impact on access

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

123. Journey times have been analysed in detail using Transport for London's Health Service Travel Analysis Tool, and the proposals for emergency care outlined in this recommendation would increase the journey time to reach an A&E across south east London by an average of approximately one minute for those in a 'blue light' ambulance, two minutes for those using private transport and three minutes for those using public transport. This is shown in figure 39, which also includes the impact on travel time for those whose journeys are relatively long currently (the 95th percentile***).

Figure 39: Impact of implementing the proposals on travel times for the population of south east London

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

124. As the proposed changes are for those who are critically unwell, travel times to emergency services for 'blue light' ambulances are very important. Clinicians advising the London-wide programme to improve stroke services concluded that the journey time to the relevant emergency centre should be no more than 30 minutes in a 'blue light' ambulance[44]. Similarly, for a major trauma, clinicians concluded that the journey time should be no more than 45 minutes.

125. Using 30 minutes as the benchmark for accessing emergency services, figure 40 shows the proportion of patients in south east London within 30 minutes of one or more A&E department in a 'blue light' ambulance if the recommendation were to be implemented.

Figure 40: access to A&E services for the population of south east London

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

* Data provided by Lewisham Healthcare NHS Trust

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

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

126. Many of the concerns raised during consultation focused on access to A&E services for Lewisham residents to the proposed four acute emergency admitting hospitals. As shown in figure 41, travel time analysis undertaken confirms that travel times to A&E departments after implementation of the recommendation are within the acceptable limit. However, there are increases in travel times for some residents of Lewisham, with the weighted average travel time for 'blue light' ambulance journeys increasing by seven minutes, as shown in figures 41 and 42.

Figure 41: Impact of recommendation on travel times for the population of Lewisham

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

Figure 42: Access to A&E services for the population of Lewisham

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

127. A large number of responses to the consultation expressed concerns that the changes, if implemented, would mean increased travel times to access A&E services. However, travel times to emergency services in south east London, including for the residents of Lewisham, would continue to be very good after the changes have been implemented. Put in the context of access to A&E services nationally, while access for many residents of Lewisham is worse than at present under this recommendation, it is still much better than the access many residents across England currently have to A&E services.

Clinical and financial benefits

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

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

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

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

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

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

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

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

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

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

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

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

Figure 44: Summary of recommendation 5: service reconfiguration

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

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

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

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

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

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

Before TSA Recommendations

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

2013/14 Full year effect

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

2014/15 Full year effect

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

2015/16 Full year effect

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

Changes in I&E

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

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

2015/16 Full year effect								
PRU	12.6		4.0	11.8	1.7	30.1	1.7	0.2
QEH	13.8	0.6		13.6	9.5	37.5	2.0	-0.2
QMS	5.2	3.9	0.7		0.0	9.8	-1.3	1.9
Total	**31.6**	**4.5**	**4.7**	**25.4**	**11.2**	**77.4**	**2.4**	**1.9**
Lewisham					0.8	0.8	0.1	2.3

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

Summary

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

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

141. These recommendations can be summarised as follows:

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

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

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

6. Recommendations relating to organisational solutions

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

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

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

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

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

6. The process described in chapter 3 and detailed in appendix F helped to identify options for organisational change which, in turn, have informed the development of recommendations in response to the proposed dissolution of the Trust. The pace of implementing new organisational solutions will be essential to delivering the changes proposed in recommendations 1 to 5. Delivering improvements in a three-year period is critical to ensuring organisations in south east London are able to respond to further financial constraints in the public sector. Meeting the challenging timetable will require appropriate leadership capability and engaged staff. Eliminating organisational uncertainty as quickly as possible and ensuring clear lines of accountability is therefore critical to success. As a result, the potential speed of being able to implement a set of new organisational arrangements has been a core component of this work. The proposed date for dissolution of South London Healthcare NHS Trust and the establishment of new organisational arrangements is recommended to be 1 June 2013. This balances the pace of change required with the importance of ensuring that changes affecting staff are clear and can be completed with sufficient involvement of staff themselves.

Queen Mary's Hospital

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

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

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

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

11. There are a number of services currently provided at Queen Mary's Hospital, which commissioners have outlined as part of their vision of the future, that Dartford and Gravesham do not currently provide or are highly specialised services. These include specialist outpatient and day case services for oral surgery, ophthalmology and chemotherapy. Following discussions with local clinical and operational experts King's College Hospital NHS Foundation Trust are being recommended as the provider for oral surgery and ophthalmology. King's College Hospital already provides the majority of clinical staff to deliver South London Healthcare's oral surgery services and are the prime provider of ophthalmology services in south east London. It is also recommended that the chemotherapy service currently provided by South London Healthcare NHS Trust should be provided by Guy's and St Thomas' Trust NHS Foundation Trust alongside the proposed satellite radiotherapy service on the site which would allow the integrated provision of cancer services.

Queen Elizabeth Hospital

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

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

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

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

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

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

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

19. The Co-operation and Competition Panel has noted that the recommendation that the Queen Elizabeth Hospital, currently operated by South London Healthcare NHS Trust, should come together with Lewisham Healthcare NHS Trust could potentially give rise to adverse effects on patients and taxpayers in respect of elective and non-elective services under Principle 10 of the Principles and Rules of Co-operation and Competition. However, the panel note that this will not be the case, if there are sufficient countervailing benefits to offset the likely reduction in patient choice and competition that it has identified.

20. The Co-operation and Competition Panel has also recommended, and the TSA concurs, that in order to remove or mitigate this risk, safeguards be included in the recommendations, which include the requirement for commissioners to specify and monitor detailed service indicators to preserve or enhance the level of quality that would have existed in the absence of this merger.

Princess Royal University Hospital

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

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

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

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

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

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

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

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

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

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

31. The Co-operation and Competition Panel has noted that the recommendation that King's College Hospital NHS Foundation Trust should acquire the site and services currently provided by South London Healthcare NHS Trust at the Princess Royal University Hospital is likely to be consistent with the merger provisions of the Principles and Rules.

Health Equalities Impact Assessment

32. The HEIA has not identified specific impacts for patients and the public, based on the changes proposed in draft recommendation 6. However, there are potential impacts on staff which have been considered in developing the final recommendations. Staff could be affected by potential reductions in workforce due to operational efficiencies and movements in activity, meaning services are now delivered at other sites, and from altered rotas needed to deliver more expert care 24/7. These changes in turn could impact on staff health, training, travel and morale. For example, 80% of South London Healthcare NHS Trust's staff are women, and 35% are from ethnic minority groups. Appropriate HR policies and procedures should be reviewed, established if required, and followed to ensure these groups do not suffer or are disadvantaged.

33. Throughout the TSA process there has been extensive engagement with staff as described in chapter 3. This will need to continue throughout the transition period to ensure that staff are fully apprised of any changes. The broader NHS is also currently undergoing a transition process. In order to ensure that learning and experience from this programme can be brought to bear on any future changes, a transition working group has been established, chaired by the Transition Director responsible for the wider London NHS transition programme.

34. During the consultation, concerns were also raised regarding training and education. In order to better understand and mitigate against any negative impacts on staff training, and to enhance positive impacts, the TSA team has been in regular contact with NHS London's people and organisation development directorate, the London Deanery and the south London Local Education and Training Board (LETB).

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

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

Historic debt

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

Transition Support

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

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

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

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

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

41. The Department of Health will need to agree transition support payments for Oxleas NHS Foundation Trust, the new organisation combining Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital, and Kings College NHS Foundation Trust. These payments should be made conditional on the delivery of the planned operational improvements and the engagement of the new organisations as active partners in the delivery of the necessary service change. For King's College NHS Foundation Trust support to a level that would maintain its Monitor Financial Risk Rating of 3 will be needed to the extent that this Risk Rating is affected by the transaction.

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

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

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

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

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

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

Changes in I&E

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

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

7. Recommendations relating to transition and implementation

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

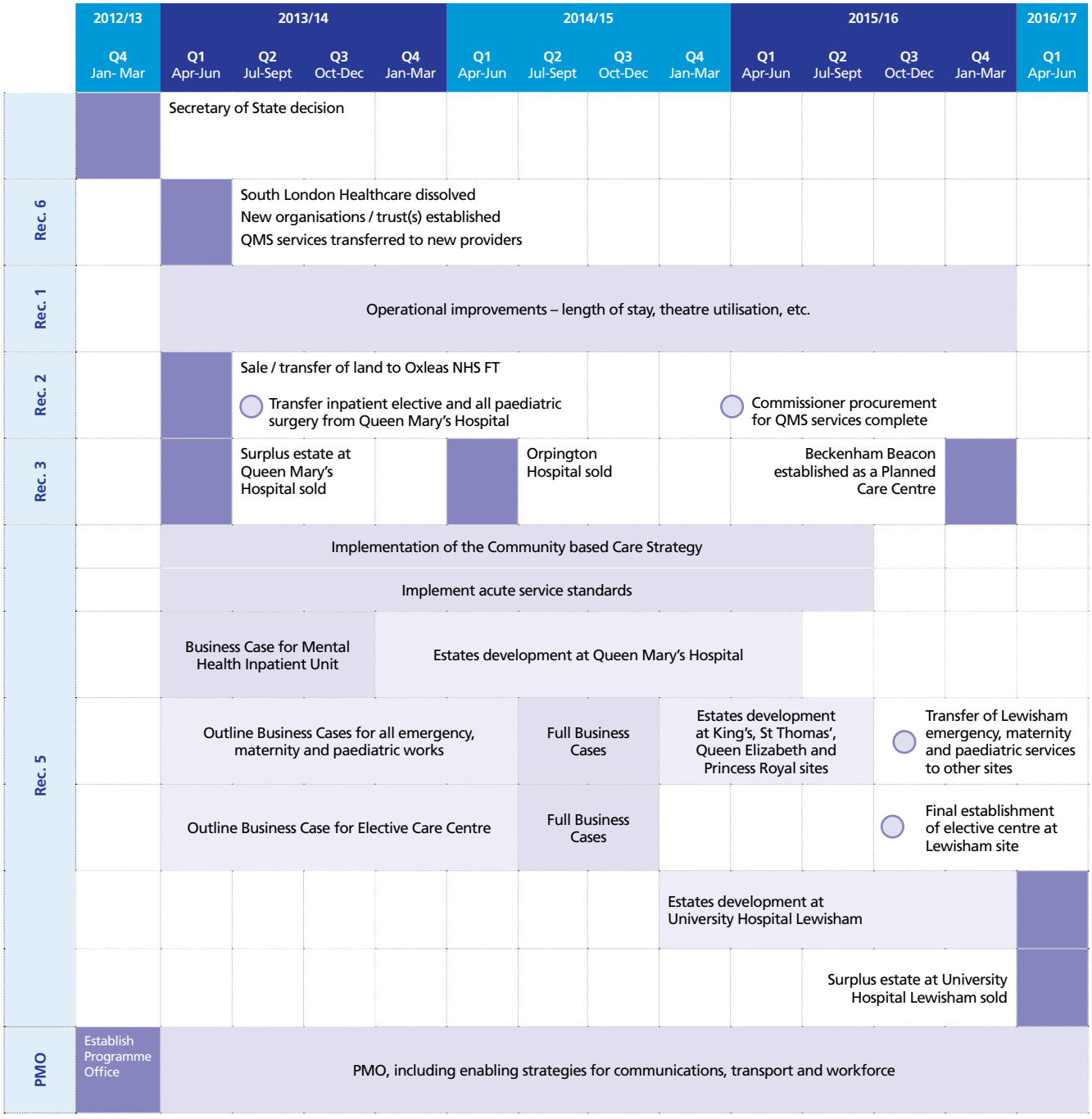
2. The ongoing financial constraint in the NHS – and broader public sector – means that all NHS providers need to make efficiency improvements year on year. If the proposed successor organisations to South London Healthcare NHS Trust are not able to deliver the changes recommended in this report quickly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

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

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

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

Figure 48: Timeline



Transition costs

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

Recommendation 1

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

Recommendation 2

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

Recommendation 5

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

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

Figure 49: Forecast capital costs for recommendations 2 and 5

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

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

Recommendation 6

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

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

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

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

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

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

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

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

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

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

Risks and risk mitigation

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

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

Accountability and oversight of implementation

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

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

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

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

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

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

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

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

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

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

8. Conclusion

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

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

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

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

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

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

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

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

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

8. References

1 *The South London Healthcare National Health Service Trust (appointment of a Trust Special Administrator) 2012.* SI 2012/1806, London: HMSO and *The South London Healthcare National Health Service Trust (extension of time for Trust Special Administrator to provide a draft report) 2012.* SI 2012/1824, London: HMSO

2 *Explanatory memorandum: The South London Healthcare National Health Service Trust (appointment of a Trust Special Administrator) 2012.* SI 2012/1806, London: HMSO

3 South London Healthcare NHS Trust Annual Accounts

4 Laing and Buisson, 2011. *Laing's Healthcare Market Review 2010-11.* London, Laing and Buisson.

5 South London Healthcare Trust, 2012. *About Us.* Available at: https://www.slh.nhs.uk/?section=aboutus&id84

6 National Clinical Advisory Team, 2007. *Outer South East London Service Reconfiguration: Review of Clinical Case for Change.* Professor KGMM Alberti on behalf of the National Clinical Advisory Team

7 Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health, October 2012, *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*

8 Independent Reconfiguration Panel, 31 March 2009. *Advice On Proposals For Changes To The Distribution Of Services Between Bromley Hospitals, Queen Elizabeth Hospital Greenwich, Queen Mary's Hospital Sidcup And University Hospital Lewisham And The Associated Development Of Community Services.*

9 Palmer, 2011. *Reconfiguring Hospital Services, Lessons from South East London,* London: The King's Fund

10 Department of Health, 2012. *Statutory Guidance for Trust Special Administrators appointed to NHS Trusts.* Available at: https://www.wp.dh.gov.uk/publications/files/2012/07/statutory-guidance-trust-special-administrators.pdf

11 Department of Health, 2012. *NHS Costing Manual.* Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132398.pdf

12 Department of Health, 2012. *NHS Trusts to receive funding support,* Available at: http://mediacentre.dh.gov.uk/2012/02/03/nhs-trusts-to-receive-funding-support/

13 South London Healthcare NHS Trust, *Trust Board papers,* November 2012

14 South London Healthcare NHS Trust *Annual Accounts 2009/10, 2010/11, 2011/12 and South London Healthcare NHS Trust Financial Plan 2012/13*

15 Annual Accounts for Queen Elizabeth Hospital NHS Trust, Queen Mary's Sidcup NHS Trust and Bromley Hospitals NHS Trust

16 NHS London, 2012. *Acute Hospitals in London: Sustainable and Financially effective.* Available at: http://www.nhshistory.net/SaFE-report-February-2012.pdf

17 NHS Bromley, 2012. *Improving health services in Orpington,* NHS Bromley. Available at: http://www.selondon.nhs.uk/documents/2470.pdf

18 Department of Health, *Foundation Trust pipeline assessment*

19 South East London PCTs' operating plans 2012/13

20 The King's Fund, 2012. *General practice in London Supporting improvements in quality,* The King's Fund

21 Public Health Observatory analysis, National Centre for Health Outcomes Development

22 Gregory S (2009). Briefing: General practice in England. An overview. London: The King's Fund.

23 Starfield B (1998). *Primary Care: Balancing health needs, services and technology.* Oxford: Oxford University Press

24 King's Fund, 2012, *Improving GP Services in London.* Available at: http://www.kingsfund.org.uk/publications/improving-gp-services-england

25 NHS South East London PCT Cluster, 2012. *Better for You, Commissioning Strategy Plan 2012/13–2014/15*

26 Nafsi et al., 2007. *Audit of deaths less than a week after admission through an emergency department: how accurate was the ED diagnosis and were any deaths preventable?* Emergency Medicine Journal. 24: 691 – 695

27 National Confidential Enquiry into Patient Outcome and Death , 2009. *Caring to the end? Review of patients who died within 4 days of hospital admission.* NCEPOD

28 National Confidential Enquiry into Patient Outcome and Death , 2007. *Emergency admissions: A step in the right direction, NCEPOD*

29 National Confidential Enquiry into Patient Outcome and Death, 2007. *Emergency admissions: A step in the right direction, NCEPOD*

30 National Confidential Enquiry into Patient Outcome and Death, 2010. *An age old problem? Elective and emergency surgery in the elderly.* NCEPOD 2010

31 National Confidential Enquiry into Patient Outcome and Death, 2009. *Caring to the end? Review of patients who died within 4 days of hospital admission.* NCEPOD

32 London Health Programmes, 2011. *Adult emergency services: case for change,* London Health Programmes

33 Appleby et al., 2011, *Improving Health and Healthcare in London: Who will take the lead?* The King's Fund

34 Chowdhury *et al.* 2007. *A systematic review of the impact of volume of surgery and specialization on patient outcome.* British Journal of Surgery, 94: 145-161

35 Holt, P.J.E. *et al. 2007, Meta-analysis and systematic review of the relationship between volume and outcome in abdominal aortic aneurysm surgery.* Britsh Journal of Surgery, 94: 1-9

36 The Royal College of Surgeons of England, 2006. *Delivering High-Quality Surgical Services for the Future,* Royal College of Surgeons

37 Monroe, K. *et al.,* 2011 *Patient safety factors in children dying in a paediatric intensive care unit (PICU): a case notes review study* BMJ Quality and Safety; 20:963-868

38 Bewley, S. Helleur, A., 2012. *Rising Maternal Deaths in London, UK.* The Lancet Vol. 379.

39 East Midlands Quality Observatory, 2011. *Mother satisfaction measure from 2010 survey: Acute Trust Maternity Dashboard.* East Midlands Quality Observatory

40 East Midlands Quality Observatory, 2011. *Mother satisfaction measure from 2010 survey: Acute Trust Maternity Dashboard.* East Midlands Quality Observatory

41 BMJ, 2011. *Birthplace in England Collaborative Group Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prosepctive cohort study* 343:d7400

42 Aaserund, M. *et al*. 2001. Elective Surgery – Cancellations, Ring Fencing and Efficiency. Available at: www.ncbi.nlm.nih.gov/pubmed/11875930

43 South West London Elective Orthopaedic Centre, 2010. *The EOC; Orthopaedic Excellence, Annual report 2010* SWLEOC

44 Healthcare for London, 2009. *The Shape of Things to Come* Healthcare for London

9. Glossary

111	A new 24/7 contact number that's being introduced to make it easier to access local NHS healthcare services
24/7	Twenty four hours a day, seven days a week
A&E	Accident & Emergency: a service which provides care for emergency conditions – illness and injury of all severities – of all types and for patients of all ages, twenty-four hours a day, seven days a week
Acute care	Acute care refers to short-term treatment, usually in a hospital, for patients with any kind of illness or injury
Acute trust	NHS acute trusts manage hospitals. Some are regional or national centres for specialist care, others are attached to universities and help to train health professionals. Some acute trusts also provide community services
ALOS	Average Length of Stay, is an average of the length of time patients stay in a hospital when admitted
BHT	Bromley Hospitals NHS Trust
Care pathway	The care and treatment a patient receives for a particular illness or condition from start to finish, irrespective of which part of the health service or social care services deliver that treatment or care. Good care pathways follow consistent principles and protocols based on clear scientific evidence of what works
CCGs	Clinical Commissioning Groups: health commissioning organisations which will replace primary care trusts (PCTs) in April 2013. CCGs are led by GPs and represent a group of GP practices in a certain area. They are currently shadowing the PCTs and will be responsible for commissioning healthcare services in both community and hospital settings from April 2013 onwards
CHD	Coronary Heart Disease: the narrowing or blockage of the coronary arteries
CIP	Cost Improvement Plan: plans to meet the cost savings target levied on NHS bodies by the government
Commissioning	The planning, procurement and contract management of health and health care services for a local community or specific population
CQC	Care Quality Commission: an organisation funded by the Government to check all hospitals, care homes and care serices in England to make sure they are meeting government standards, and to share their findings with the public
Day case or day surgery	Patients who have a planned investigation, treatment or operation and are admitted and discharged on the same day
Deficit	The net financial position of an organisation where expenditure is greater than income
ECG	Electrocardiogram: A test of the electrical activity of the heart
Elective centre	A hospital which provides elective (planned) care
Elective surgery	Planned surgery (i.e. not immediately necessary to save life) carried out in a hospital either as a day case or an inpatient
Emergency admission	A patient who is admitted on the same day that admission is requested due to urgent need (also known as urgent admission and unplanned care)
Financial surplus	The net financial position of an organisation where income is greater than expenditure
Foundation Trust	Foundation Trust: NHS hospital that is run as an independent, public benefit corporation, controlled and run locally. Foundation Trusts have increased freedoms regarding their options for capital funding to invest in delivery of new services. They are regulated by Monitor – The Independent Regulator of NHS Foundation Trusts

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

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

9. List of appendices

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

B Directions to the Trust Special Administrator

C Programme Governance in the development of recommendations

D Operational efficiency opportunities within South London Healthcare NHS Trust

E Hospital service change proposals

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

G Stakeholder Engagement

H Securing sustainable NHS Services Consultation document

I Ipsos MORI Independent Consultation Feedback Report

J TSA Response to Consultation feedback

K Applying the four tests for reconfiguration

L Deloitte Independent Health & Equalities Impact Assessment

M Finance, capital and estate evaluation

N The future of Queen Mary's Hospital

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

P London acute emergency and maternity clinical quality standards

Q Approach to implementation

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13 December 2012

Dear Mr Kershaw,

I am writing on behalf of Southwark Council's Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee in response to your draft recommendations for the future of South London Healthcare NHS Trust and the NHS in south-east London. I would like to thank you for attending our joint meeting with Lambeth Health Scrutiny last week and answering a number of our questions and concerns in person.

Below I set out our response to your recommendations, these have been agreed unanimously by our cross political party committee. We would like to thank you for highlighting the need of additional capital and revenue funding to make these proposals work, as well as recognising that for these proposals to work the debt of SLHT needs to be written off by the Department of Health and not transferred to any of the local (new or existing) NHS bodies.

Our primary concern during this process has been to ensure the quality of the health care provision received by Southwark's residents does not diminish as a result of your recommendations, and if possible to improve them. As committee chair I will be writing separately to King's Health Partners regarding their work on a proposed merger, the details of which are outlined below in our full response.

Yours sincerely,

Councillor Mark Williams
Chair Southwark Health & Adult Social Care Scrutiny sub-Committee

Southwark Health and Adult Social Care scrutiny sub-committee (HASC) response to the Trust Special Administrator (TSA) draft report for the South London Healthcare NHS Trust

King's College Hospital NHS Foundation Trust (KCH) acquisition of the Princess Royal University Hospital (PRUH), Bromley

We support in the strongest possible terms the proposal for King's College Hospital NHS Foundation Trust (KCH) to acquire the Princess Royal University Hospital (PRUH), Bromley, as opposed to the PRUH being tendered out to the independent or private sectors.

KCH have an excellent track record of financial and clinical management and are keen to extend this expertise to the running of the PRUH. As well as improving and making the Bromley site sustainable KCH assured the committee that the acquisition will enable them to improve care provided to residents on the Denmark Hill site by freeing up space in their existing premises and giving medical students better experience.

In contrast to the hospital potentially being handed to a competing private sector provider a properly resourced acquisition will help secure the financial viability of KCH thereby helping ensure a comprehensive health service for Southwark residents into the future.

For this reason we do not support the second proposal for a tendering exercise for the hospital or any other parts of the South London Care Trust. This would risk a private sector provider cherry-picking more lucrative work from NHS providers leading to financial instability and putting at risk the comprehensive service for Lambeth residents.

We recommend KCH acquire the PRUH and the option of a tendering process for the PRUH is removed from the final proposals submitted to the Secretary of State.

Community Care

The committee welcome's the TSA's recommendations to shift more care from hospital buildings out into the community. When used appropriately care in the community can be cheaper, safer and more desirable to residents. It also prevents unnecessary hospital stays and stops a relatively minor ailment becoming a confidence and life-shattering event. This transition must be properly resourced and monitored to ensure it is working successfully, so that secondary care is not overwhelmed if there are problems. We recommend the TSA works closely with the Southwark Clinical Commissioning Group and Southwark Social Services to establish if this is viable.

We support the recommendation to shift care into the community where appropriate but want this to be properly resourced and monitored.

Elective Care moving to Lewisham

We are deeply concerned by the proposal for a south-east London Elective Care Centre and remain unconvinced it is necessary to deliver a better service for Southwark's residents. If this proposal is taken forward we recommend the following work is undertaken.

Given the emphasis on delivering care closer to people the recommendation to shift elective care to Lewisham, a greater distance from Southwark residents than current provision, does not seem to be consistent with this direction of travel.

On the positive side the committee understands that such a move would free up space, particularly at the Denmark Hill KCH site, for more acute, emergency department and maternity services. We also accept that outcomes and efficiency are often improved by concentrating specialist services, as demonstrated by the London stroke care reconfiguration. However we are not convinced that all Southwark residents would be as well served by having to travel to Lewisham for routine surgery.

Public transport is already prohibitively expensive for many Southwark residents, fares are about to rise above inflation again in January. The committee feels that moving elective care to Lewisham, without providing free transport, would unfairly and disproportionately disadvantage the poorest, and therefore some minority groups, and those with existing mobility problems.

It is also unclear whether patients will be forced to attend the new Elective Care Centre or have the option of attending an existing local centre. We feel this requires further clarification and consideration.

Losing the well established and high quality elective surgery units at Guys and King's College Hospitals completely also seems like a retrograde step.

We recommend the TSA works closely with KCH and GSST to develop this proposal and establish if it is viable. Further we recommend more work is undertaken to develop how pre and post operation appointments and care will be managed with a large number of GPs, CCGs, Hospital Trusts and local authorities. Including whether patient records will be able to be shared on a common IT system.

We also have deep reservations about including the private sector in the management of any new Elective Care Centre and recommend this approach is not adopted. This is due to

the potential for conflicts of interest between the private provider and the needs of our hospital trusts and Southwark's residents.

Due to the lack of clarity of whether all elective care will be moved to Lewisham and its potential impact on Southwark's residents we are unable to give support to this recommendation. We feel this recommendation needs further work, but if it is included in the final recommendations we think it should include a free patient transport arrangement for Southwark elective care patients if the Lewisham elective care centre proposal is taken forward.

The impact of replacing the Lewisham emergency department with an urgent care centre

Having taken evidence from KCH the committee is not convinced with the TSA's estimate of increased blue-light and non blue-light patient flows to the KCH emergency department. The KCH estimate the 'medical take' of patients could increase from 35-40 currently to 50-60 per day if this proposal goes ahead. We are also concerned that downgrading Lewisham A&E to an Urgent Care Centre would impact patient flows in unexpected ways. We are not confident that the 78% of cases that could be treated at an Urgent Care Centre in Lewisham would necessarily present there in the future. We believe that many patients would instead travel to their nearest A&E just in case something was more seriously wrong with themselves or their family members/friends. The majority of people do not have medical training and do not approach these matters in an entirely rational manner. We therefore urge the TSA to undertake further work with all A&Es in south-east London to better understand potential patient flows and to look at patient flows in comparable areas of the country where an A&E has been downgraded.

KCH informed the joint scrutiny meetings that they think they have the clinical and staffing capacity to deal with additional A & E capacity, but do not have the physical capacity to do so. For this they will need to move some services out to make room or to acquire the EDF site near Denmark Hill. To make this draft recommendation work KCH will need additional investment.

We urge the TSA, if they have not already done so, to engage with the London Ambulance Service about their ability to cope with re-routing blue-light cases to other A&Es and how this will affect cover across south London.

More work should be done on this to establish patient flows and if it is viable, and to ensure that if this proposal is taken forward KCH's emergency department is properly resourced to cope with the additional patients and that they have adequate provision for admitting them.

Maternity services

The committee is also concerned about the knock-on effect of closing or downgrading Lewisham's maternity service. The committee is deeply concerned at the impact of redistributing the c4,000 births that take place at Lewisham A&E across other maternity units in south east London. Already Lambeth and Southwark's provision is very stretched and Lambeth, Southwark and Lewisham's already high birth rate is projected to increase rapidly. As London already suffers from worse maternal outcomes than the rest of the country, we agree that further work is undertaken to establish whether both options have sufficient capacity and welcome the TSA's acknowledgement of this in his draft report.

Any extra burden on KCH in particular must be matched with proper resources and physical space.

Paediatric and Neo-Natal Services

We are concerned that the report is silent on these services and the impact of the loss of these services in Lewisham. We recommend the TSA develops detailed proposals on paediatric and neo-natal services, in particular the impact on the Evelina Centre at St Thomas's and KCH, and that such proposals are included in the final recommendations to the Secretary of State.

Funding the draft recommendations

We welcome the TSA's acknowledgement that additional capital and revenue resources will be required to make his recommendations work. We urge the TSA to include this in his final recommendations to the Secretary of State. Further, we ask for the TSA to make clear to the Secretary of State that the provision of additional national funds should not impact on current health funding to south-east London. With the current savings already being demanded of the NHS under the QIPP programme and the flat funding settlement from central government we do not feel that local NHS services and providers could find the level of resource required from within existing budgets. Further, we strongly believe that if the necessary additional funds are not made available then either deficits will be run up in the future or patient care and outcomes will suffer considerably.

Implementation Plan

We are concerned that the implementation plan has not been publicly consulted on. While we were reassured to an extent when the TSA gave evidence to our committee last week that the implementation plan has been tested, we nonetheless would have preferred for this to be done in public. We recommend that the Implementation Plan is tested as robustly as possible with as wide a range of stakeholders as possible before the final recommendations are published in January. We further recommend that the TSA/DH reviews the implementation plan on a rolling basis with local partners and updates it as needed – including any additional resources that may be required.

We are also concerned that the recommendations make virtually no reference to public and mental health. It is unclear how these recommendations fit within a "whole system approach" to healthcare (i.e. public health - primary care - acute care - secondary/tertiary – recovery - public health). This report is heavily focused on the acute sector, which while understandable given the financial situation at SLHT, it is disappointing that a wider view of the health economy and patient pathways was not considered. Given the commitment by King's Health Partners to work towards parity of care for mental and physical health we recommend that the TSA works with KHP to identify any possible opportunities to improve mental health provision in Southwark as part of your final recommendations to the Secretary of State. Given the tight timescales of this process, we further recommend that the TSA/DH continues to work closely with KHP to monitor the Implementation Plan to identify possible opportunities in the future to achieve parity of care for mental and physical health patients.

Impact on King's Health Partners

Whilst not having adopted a formal position on the King's Health Partners proposed merger, the committee were pleased to hear from their representatives at the joint meeting with Lambeth Scrutiny that KHP will significantly slow down their work on developing the Full Business Case for the merger. We strongly feel that until the final recommendations have been made and the Secretary of State has ruled on what he will do it is premature to develop a Full Business Case. Given the scale of uncertainty that exists over the future of the NHS in south east London, not least the potential expansion of KCH into the PRUH and the significant potential overhaul of elective, emergency and maternal care, we feel it is inappropriate to commit any significant resources to developing the case for the merger. Whilst acknowledging the deeply held concerns of all our local MPs, we do not feel it is appropriate to formally ask KHP to stop all work on their proposed merger as some background work and analysis can still continue.

As committee chair I will be writing separately to KHP to inform them of our view. As per the committee's work programme for this municipal year we will continue to scrutinise in detail the proposed merger, in particular making sure the full costs and risks are properly understood and that the changes will be beneficial to Southwark's residents and will not diminish the standard of care they receive.

Southwark Council

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13 December 2012

Dear Matthew Kershaw
Trust Special Administrator

Thank you for the opportunity to comment on your recommendations for the South London Healthcare NHS Trust and the NHS in the south east of London.

It is important that the entirety of the health and care system, including the key role of public health and mental health in the south-east of London is at the core of the work of the TSA. The health and care providers in the south-east of London have a common cause to provide the best possible outcomes to the patients and communities which they serve, and it is essential that a detrimental impact on the quality of services for these communities, including the residents of Southwark, is not the outcome of the work of the TSA.

The TSA recommendations have the potential to significantly change the way that health and care services are delivered in the south east of London. It is crucial, as these changes are implemented, that the key organisations that will deliver this transformation have excellent patient care and choice at the heart of their work, that the changes set out are appropriately resourced and that there is professional and clinical leadership to deliver these. Throughout this change, it is essential that the Council and NHS are fully committed to our common cause to improve the health and wellbeing of local populations, and to tackle health inequalities.

Shifting the balance of care towards a community-based and preventative model where people can be provided with treatment and support closer to their homes could have a transformative impact, improving services and outcomes for individuals, communities and families. The Council believes that any change programme in community care should place the quality and needs of patients and the most vulnerable at the heart of its work, and to ensure that there is sufficient capacity in the community and social care to manage a different approach to delivering services. It is therefore crucial that the transformation of community care, as proposed by the TSA, is fully resourced, and that all partners, including the local acute and mental health Trusts contribute to this work.

In consideration of your report, I would like to set out four key issues:

- The Council has reservations that the impact of changes set out in the TSA report, including emergency, planned and maternity care, may result in a negative impact on the capacity of the acute, community health and care system. There are risks that this will have a detrimental impact on the quality of patient care for Southwark residents, and for the quality and choice of healthcare provision. The Council believes that there should be further detailed modelling of realistic expected patient movements in order to understand the impact of the TSA changes on healthcare in this area, patient choice and capacity, and for Southwark residents.

- The Council welcomes in principle the development of a strategy for community based care. It is however crucial that the transformation of community care, as proposed by the TSA, is fully resourced, and that all partners are fully engaged in the changes and share the benefits, including the local acute and mental health Trusts.

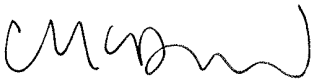
- The Council believes that the available clinical and financial resources for healthcare should be focused on patient care, choice and excellent health outcomes, within the context of collaboration and community leadership of the wider health economy. Entering into a procurement exercise would create instability and uncertainty with no guarantee of a successful outcome as this market is untested. The Council therefore is opposed to the acquisition of the Princess Royal University by a private sector organisation.

- The Council believes that the TSA should recommend that the Department of Health ensure that the provision of national funds should be in addition to current and future health funding in the south-east of London. Without this recommendation there is a risk that local or regional funds are utilised to resource the changes required by the TSA, with an impact on current healthcare programmes, and the capacity of other providers in the area.

I attach the Council's consultation response to the TSA report.

Yours sincerely

Catherine McDonald



Cabinet Member for Health and Adult Social Care
Southwark Council

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

Southwark Council – consultation response

OVERALL

This is Southwark Council's consultation response to the Trust Special Administrator's (TSA) report for South London Healthcare NHS Trust and the NHS in south east London.

Q1. To what extent do you agree or disagree that the efficiency of the hospitals that make up South London Healthcare NHS Trust needs to improve to match that of top performing NHS organisations?

Tend to agree

Q2. To what extent do you agree or disagree that the areas outlined in Chapter 5 of the consultation document for improving efficiency at the hospitals that make up South London Healthcare NHS Trust are appropriate?

Tend to disagree

Q3. What further comments, if any, do you have on any of the proposals outlined around recommendation one in the consultation document, including the reasons for your answer to questions 1 and 2? Please also include any improvements you would like to suggest to this recommendation.

The TSA recommendations include an improvement in the efficiency of the South London Healthcare Trust, on the basis of an improved productivity standard, within a set timescale, as developed by the TSA in consideration of other similar Trusts.

The Council supports the principle that all NHS Trusts should perform at the highest level. However, the TSA should provide assurance that the productivity target is achievable in the timescales without negatively impacting on patient care or choice for Southwark residents.

The Council believes that there is a need for further consideration by all key partners as to whether the productivity standard, as set out by the TSA, is achievable within existing timescales and appropriate considering the current health and care context in this area.

The productivity standard agreed should ensure that the quality of patient care is of the highest possible standard, and that the future health services deliver the best outcomes for the communities that they serve.

The TSA should also recommend that future funding allocations must be based on genuine achievable efficiencies rather than theoretical maxima.

Q4. How far do you support or oppose the proposal for Queen Mary's Hospital, Sidcup to be turned into a Bexley Health Campus?

No views either way

Q5. How far do you support or oppose the proposal for the land and buildings required for Bexley Health Campus at the Queen Mary's Hospital, Sidcup site to be transferred or sold to Oxleas NHS Foundation Trust?

No views either way

Q6. What further comments, if any, do you have on any of the proposals outlined around recommendation two in the consultation document, including the reasons for your answers to questions 4 and 5? Please also include any improvements you would like to suggest to this recommendation.

The Council believes that local clinical leadership, with the Council, working with the communities of this area are best placed to lead any changes to healthcare locally.

Q7. How far do you support or oppose the recommendation that South London Healthcare NHS Trust should sell or no longer rent poorly used or empty buildings?

No views either way

Q8. What further comments, if any, do you have on any of the proposals outlined around recommendation three in the consultation document, including the reasons for your answers to question 7? Please also include any improvements you would like to suggest to this recommendation.

The Council believes that any changes to the health estate should be directed by the priorities set out in emerging local Joint Health and Wellbeing Strategies and commissioning plans. In addition, any changes to the local NHS estate should consider health and community usage as a priority.

Q9. How far do you support or oppose the recommendation that the Department of Health provides additional annual funds to cover the additional costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth Hospital and Princess Royal University Hospital until the relevant contracts end?
No views either way

Q10. What further comments, if any, do you have on any of the proposals outlined around recommendation four in the consultation document, including the reasons for your answers to question 9? Please also include any improvements you would like to suggest to this recommendation.

The TSA recommendations include both a one-off write-off for part of the South London Healthcare PFI liabilities, and also further ongoing national financial support to service the costs within any future Trusts for the duration of the lifespan of the PFI contracts.

The Council believes that the TSA should recommend that the Department of Health ensure that the provision of national funds should be in addition to current and future health funding in the south-east of London. Without this recommendation there is a risk that local funds are utilised to service these liabilities, with an impact on current healthcare programmes, and the capacity of other providers in the area.

The draft TSA report does not clarify how future liabilities will be serviced, and it needs to be clear that this additional funding will not impact on the overall health budget allocation in the south-east of London or services for Southwark residents.

Q11. How far do you support or oppose the recommendation to implement the community based care strategy as outlined in Chapter 8 of the consultation document?

Tend to agree

Q12. What further comments, if any, do you have on any of the proposals outlined around care in the community and closer to home in the consultation document, including the reasons for your answers to question 11? Please also include any improvements you would like to suggest to this recommendation.

The Council welcomes in principle the development of a strategy for community based care.

The Council believes that shifting the balance of care towards a community-based and preventative model where people can be provided with treatment and support closer to their homes could have a transformative impact, improving services and outcomes for individuals, communities and families.

The Council believes that any change programme in community care should place the quality and needs of patients and the most vulnerable at the heart of its work, and to ensure that there is sufficient capacity in the community and social care to manage a different approach to delivering services

It is therefore crucial that the transformation of community care, as proposed by the TSA, is fully resourced, and that all partners are fully engaged in the changes and share the benefits, including the local acute and mental health Trusts.

There are significant pressures on community health services and social care in Southwark. The Council is implementing changes in line with a significant budget reduction, with further reductions expected in the coming period. The proposals in the TSA report, if under-resourced, would therefore impact on the quality and provision of current services at an already challenging time.

The Council believes that a community health and care strategy, jointly developed and owned by the Council and the NHS, is the right approach to making the transformative change towards a more preventative, community-based approach to health and care. The Council however has reservations that the current model instigated by the TSA does not represent a fully resourced partnership approach with the Council, including public health and social care.

The Council in addition believes that the community based care strategy should be phased, in order to develop the additional capacity required in community and social care system prior to the planned shift from the acute sector.

The Council believes that, in order to deliver the aspirations of the community based care strategy, that there needs to be a fully resourced partnership led by the Council and local CCG. This partnership will require the support of the wider NHS and public health systems, but should be led at a borough level through local Health and Wellbeing Boards.

Q13. How far do you support or oppose the proposed plans for delivering urgent and emergency care in south east London? The following shows how urgent and emergency care would be delivered:

Emergency care for the most critically unwell – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital

Urgent care – Guy's Hospital, Queen Mary's Hospital, Sidcup, University Hospital Lewisham

Tend to disagree

Q14. What further comments, if any, do you have on any of the proposals outlined around urgent and emergency care in the consultation document, including the reasons for your answers to question 13? Please also include any improvements you would like to suggest to this recommendation.

The Council has reservations that the impact of changes in emergency care as set out in the TSA report may result in a detrimental impact on the quality of patient care in the Lambeth and Southwark acute sector, and for the quality and choice of healthcare provided for Southwark residents.

Changes to emergency and urgent care should ensure that patients are provided with the highest quality of care, and that there is sufficient capacity to manage changes to services.

The Council believes that the TSA should set out that the changes to emergency and urgent care will need to be fully resourced, including in the acute sector in Lambeth and Southwark, in order to mitigate against a detrimental impact on the quality and capacity of acute services across the region.

The shift proposed by the TSA by which patients would increasingly access urgent care, as opposed to Accident and Emergency Services, requires a transformation in the current ways of working of primary and secondary care, but also in terms of

public understanding of each service and where to access the right level of care. The TSA should clarify how this change programme will be resourced and led, and set out that it is essential that the communities of south-east London are involved in this.

The changes to emergency and urgent care will require patients to, in many cases, travel greater distances in order to access care and treatment. It is uncertain whether the current transport infrastructure in south-east London, notably with the recent closure of the south London train line, has appropriate capacity and links in order to support this change. The TSA should clarify how Transport for London (TfL) will support these changes, and the plans in place to manage the implications for those in need of care and treatment.

The Council believes that there should be further detailed modelling of expected patient movements, in consideration of the TSA recommendations, in order to understand the impact of these changes on healthcare in this area and for Southwark residents. This modelling should involve all key partners, including local authorities, CCGs and communities.

Q15. Which of the following options would you prefer, if any, for providing obstetric-led services?

I do not support either of these options

Q16. What further comments, if any, do you have on any of the proposals outlined around maternity services, including the reasons for your answers to question 15? Please also include any improvements you would like to suggest to this recommendation.

The Council has reservations about both of the proposed options for obstetric-led services.

There are significant pressures on maternity services in the south-east of London, and there are risks with the proposals in the TSA report that, with the establishment of a four-site model, that this further impacts on a current service which is already at or close to capacity. This risks quality, choice and provision of care in this service and may have an impact on the quality of care for pregnant women, new mothers and families, including those who live in Southwark.

It is unclear, in addition, whether the addition of a site in Lewisham, but without the wider support provided by a fully resourced hospital capability on the same site, would provide robust and sustainable provision in this service.

Changes to obstetric-led services should ensure that patients are provided with the highest quality of care, and that there is sufficient capacity to manage changes to services.

It is crucial that changes to obstetric-led services, as proposed by the TSA, are fully resourced. The TSA report should clarify how this programme of transformation will be funded, and should be clear that additional funding will not impact on the overall current or future health budget allocation in this area.

The Council believes that the TSA should take full account of both clinical evidence and the views of the community in any changes that are proposed.

The TSA report should also clarify how Transport for London (TfL) will support these changes, and the plans in place to manage the implications for those in need of maternity support.

Q17. How far do you support or oppose the proposed plans for providing planned care services in south east London? The following shows how planned care would be delivered:

Day case surgery – Guy's Hospital, King's College Hospital, Queen Elizabeth Hospital, Queen Mary's Hospital Sidcup, Princess Royal University Hospital, St Thomas' Hospital, University Hospital Lewisham

Complex operations – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital

Specialist non-complex operations – Guy's Hospital, King's College Hospital, St Thomas' Hospital

Routine non-complex operations that require a stay in hospital – University Hospital Lewisham

Tend to disagree

Q18. What further comments, if any, do you have on any of the proposals outlined around planned care in the consultation document, including the reasons for your answers to question 17? Please also include any improvements you would like to suggest to this recommendation.

The Council believes that there are risks that the proposed changes to planned care will impact on both quality of care, with additional clinical and professional capacity required to implement these changes, but also will significantly impact on patient choice for residents in Southwark.

The TSA report should ensure quality of care and patient choice are at the heart of these proposals.

The TSA report should also clarify how Transport for London (TfL) will support these changes, and the plans in place to manage the implications for those in need of maternity support.

Q19. How far do you support or oppose the recommendation for South London Healthcare NHS Trust to be dissolved, with current NHS services managed and delivered by other organisations?

No views either way

Q20. How far do you support or oppose the plan for the Queen Elizabeth Hospital site and Lewisham Healthcare NHS Trust to come together to create a new organisation?

Tend to disagree

Q21. Which of the following options would you prefer, if any, for the running of the Princess Royal University Hospital?

I do not support option B (procurement process) and provide only qualified support to option A.

Q22. To what extent do you agree or disagree with the recommendation for the Department of Health to write off the debt accumulated by South London Healthcare NHS Trust?

Tend to agree

Q23. What further comments, if any, do you have on any of the proposals outlined around recommendation six in the consultation document, including the reasons for your answers to questions 19, 20, 21 or 22? Please also include any improvements you would like to suggest to this recommendation

Ensuring appropriate provision of services, patient choice and the quality of patient care should be at the heart of the TSA proposals for this area. It is essential that a detrimental impact on the quality of health care for south-east London communities, which include areas with significant areas of deprivation and health inequalities, is not the outcome of the work of the TSA.

The transformation of health and community healthcare provision in the south-east of London, which is expected to follow the implementation of the TSA recommendations, will require clinical and professional leadership by the CCG, Council (including public health and social care), acute Trusts and others. It is crucial that the expertise of these groups is able to deliver on these changes, and to work together on the key challenges set out in the TSA report.

The TSA recommendations include both a one-off write-off for part of the South London Healthcare PFI liabilities, and also further ongoing national financial support to service the costs within any future Trusts for the duration of the lifespan of the PFI contracts. The TSA report does not clarify how future liabilities will be serviced.

The TSA should be clear that this additional funding will be provided throughout the lifespan of the TSA change programme and PFI contracts and in addition to the overall health budget allocation in the south-east of London.

The TSA report includes a recommendation to merge the Queen Elizabeth Hospital site and Lewisham Healthcare NHS Trust. This proposed change could have a significant impact on the clinical and leadership capacity of these Trusts at a time of change, which has the potential to impact on patient care and financial sustainability.

Any change to the organisation of healthcare should be locally determined. The Council believes that working together, the local authorities, CCGs and the communities of Lewisham and Greenwich are best placed to put forward a new model for the organisation of healthcare services in these areas.

The clinical and professional leadership of the south-east of London, including Kings College Hospital Trust, will be crucial in ensuring that the changes in the acute landscape in the south-east of London set out in the TSA report are delivered.

The Council expects the outline business case for Kings College Hospital to acquire the Princess Royal University (PRU) Hospital to set out the impact on Kings College Hospital as well as the PRU, in the context of the proposed Kings Health Partners (KHP) merger.

The Kings College Hospital business case for the acquisition of the PRU needs to set out a robust model for how this change will improve the quality of care and patient choice. The TSA should set out these as principles for the consideration of this business case. The TSA should also recommend that the views of key stakeholders, including the local CCG, Council and local community, with be at the forefront of any consideration of this business case.

The Council believes that the available clinical and financial resources for healthcare should be focused on patient care, choice and excellent health outcomes, within the context of collaboration and community leadership of the wider health economy. Entering into a procurement exercise would create instability and uncertainty with no guarantee of a successful outcome as this market is untested. The Council therefore is opposed to the acquisition of the Princess Royal University by a private sector organisation.

Q24. Is there anything else you want to say about the consultation or the issues it covers? If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so here. Please also say if there are any improvements you would like to suggest to the recommendations.

It is important that the entirety of the health and care system, including the key role of public health and mental health in the south-east of London is at the core of the work of the TSA. The Council believes that a more holistic approach, considering all aspects of health and care, could have provided a more innovative and sustainable response, helping to improve treatment and care in this area, and may have mitigated against a number of the issues that the Council has raised in this consultation response.

The unsustainable providers regime, in seeking to address issues that are specific to the South London Healthcare NHS Trust, has set out policies that will determine the health and social care landscape for the whole of the south-east of London, including boroughs and communities that have little or no contact with this Trust. The assumption made is that the whole of the south-east of London is one “healthcare system”. However this does not resonate in terms of the movements of patients, or the experiences of communities in seeking healthcare provision. The Council does

not agree with the TSA assumption that the south-east of London is one health system.

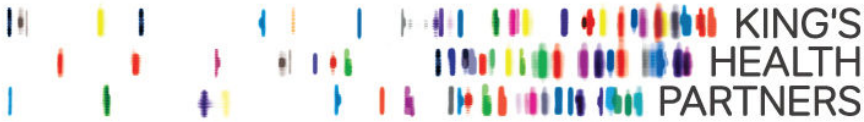
The TSA recommendations have the potential to significantly change the way that health and care services are delivered in the south east of London. It is crucial, as these changes are implemented, that the key organisations that will deliver this transformation have excellent patient care and choice at the heart of their work, that the changes set out are appropriately resourced and that there is local professional and clinical leadership to deliver these, and that, throughout this change, that the Council and NHS do not lose our common focus on improving health and wellbeing locally, and tackling health inequalities in this part of London.

There is a common cause between the Council and local NHS to improve the health and wellbeing of our local populations, and to reduce health inequalities. In order to ensure that these key principles are supported by the TSA recommendations, the Council believes that a full health and equalities impact assessment of this work should be undertaken. This work should take place prior to the submission of the TSA report to the Secretary of State.

The TSA report should consider the whole health and care system from the perspective of patients. It is not clear that the current proposals will improve the patient experience in terms of considering a holistic approach to health and social care, with a greater emphasis on preventative approaches to deliver the best outcomes. Rather there are risks that the changes set out will reduce the capacity of the current health and social care system to deliver services, and could significantly impact on health outcomes in this area.

The Council believes that there should be further detailed modelling of expected patient movements, in consideration of the TSA recommendations, in order to understand the impact of these changes on healthcare in this area, patient choice and capacity, and for Southwark residents. This modelling should involve all key partners, including local authorities, CCGs and communities

Whilst a public engagement exercise has been undertaken on the TSA recommendations, the Council believes that the NHS should additionally consult on the programme of change that will need to take place to implement any recommendations on this, and for which a significant amount of preparatory work has commenced. At the heart of this work should be the involvement of the communities and patients that the councils and NHS serve. This will help to ensure that the quality of patient care and patient choice is a key principle in the undertaking of any future changes to health and care services.



An Academic Health Sciences Centre for London

Pioneering better health for all

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13 December 2012

Dear Matthew,

We attach a full response to your draft report from King's Health Partners. It represents the common view of all the organisations that make up King's Health Partners. The questions outlined in the consultation booklet limit responses by design and so this letter outlines our additional comments.

We recognise the scale of the financial challenge facing South London Healthcare NHS Trust and the analysis that it is unsustainable in its current form. We are strongly supportive of the requirement to reach a clear and sustainable future that delivers high quality, affordable healthcare as soon as possible to give confidence to patients, the public and healthcare staff in south east London. We have also been clear all through this process that we accept our responsibility to play a part in the solution and we remain committed to this in parallel with our plans for King's Health Partners.

We are disappointed that your draft report fails to acknowledge sufficiently two factors that we feel merited greater attention:

- King's Health Partners, one of only five Academic Health Sciences Centres in the UK, was formed in 2009 as a collaboration between Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London. We are beginning to test the case for becoming a single academic healthcare organisation which would significantly improve care for our local populations. The report does not reflect the potential benefits of this approach and the new models of care which it might help to deliver; nor does it acknowledge or weigh the risk that the proposals in the report might run counter to the interests of the people of south London by cutting across this development;

- Your report is very focused on acute care. The lack of consideration of mental health is regrettable. South London and Maudsley NHS Foundation Trust, one of our partners, provides services in the whole of the area covered by South London Healthcare NHS Trust, including wards at University Hospital Lewisham. At King's Health Partners we have a vision for the integration of physical and mental health which is world-leading. The absence of consideration of the issues around mental health represents both a missed opportunity to improve care and a real risk to current patient care.

Looking specifically at your recommendations, you suggest that King's College Hospital acquires the Princess Royal University Hospital. King's Health Partners' support for this proposal is subject to the detailed operational and financial Outline Business Case which is being prepared by King's College Hospital and which will naturally take account of the potential impact on our organisations. As this is developed, we will gain a greater understanding of the levels of financial support required to deliver the outcome desired by all parties, and we would expect that further discussions will be required at this stage. The proposal also has wider implications for the way we take forward our plans for

progressing our Full Business Case for creating a single academic healthcare organisation, which we will consider separately.

The proposal to downgrade the Emergency Department at University Hospital Lewisham would have a significant impact on the provision of emergency and non-emergency care at King's College Hospital and St Thomas' Hospital.

With regard to the proposals for maternity services, King's Health Partners' clinicians would have significant reservations about the option for a standalone obstetric unit at Lewisham, if it does not have access to a co-located intensive care unit on site and the other support services of an A&E admitting hospital. Even low risk women can suddenly need these services immediately, and we do not believe this would be a clinically safe and sustainable option.

It is our expectation that for all scenarios, significant numbers of women would either choose or be directed towards St Thomas' and King's College Hospital. The maternity units at both King's College Hospital and St Thomas' Hospital are close to maximum capacity and would require significant capital investment, for which we have no provision.

The proposal for an elective centre at Lewisham would need to be based on a collective decision across south east London. Given that there is an elective centre at Guy's Hospital, it is critical that the model for such a centre is clinically and financially sustainable, with a business model that all providers can sign up to and underpinned by workable clinical governance. At present we are not reassured on these issues. We are, for example, unconvinced about a split between complex and non-complex work and see a concentration of work around specialties as a model that might merit consideration.

More broadly, we are concerned that the time constraints you have worked under mean that inadequate consideration has been given to care pathways for older people, children and those with mental health conditions. For instance, there is a strong relationship between psychiatric liaison and the paediatric A&E. Future pathways of care would need to be worked through to ensure that children and young people do not have to report at the point of crisis to a facility outside the borough that is not related to the community services they are linked to.

By their nature, the arrangements across a wide geography, such as south east London, will be complex and involve many organisations in relationships that are long-standing and valuable to patients. Your report, for reasons of time, has been unable to consider these at a service level, but your recommendations have profound implications for some of the services that we know our patients cherish most. Without more detailed analysis and reliable data we cannot be satisfied that these recommendations are viable.

Finally, we are concerned about the impact of your proposals on the quality of medical education. A significant number of our students spend time at University Hospital Lewisham and gain valuable experience from the mix of patients and conditions they see. In the context of the proposed changes it will be important to ensure that the placements we provide continue to offer a high quality of experience for our undergraduates, both within acute and community settings.

This is the first time that the TSA provisions have been used and we have reservations about the process. Given that the provisions are likely to be used again it would be helpful if there could be an evaluation, with lessons learned. We understand that you have commissioned the King's Fund to undertake an external review and we would be happy to engage with this process.

We are clear that our organisations remain committed to playing a constructive part in the solution to the difficulties at South London Healthcare NHS Trust and will work with you to ensure a sustainable financial future for the NHS in south east London that continues to provides patients with the best care.

Yours sincerely,

Rt. Hon. Lord Butler of Brockwell KG, GCB, CVO
Chair, King's Health Partners

Sir Hugh Taylor
Chair, Guy's and St Thomas' NHS Foundation Trust

Madeliene Long
Chair, South London and Maudsley NHS Foundation Trust

Professor Sir George Alberti
Chair, King's College Hospital NHS Foundation Trust

Professor Sir Rick Trainor
Principal, King's College London

On behalf of King's Health Partners Board

King's Health Partners
Trust Special Administrator draft report into South London Healthcare Trust consultation response

Q1: To what extent do you agree or disagree that the efficiency of the hospitals that make up South London Healthcare NHS Trust needs to improve to match that of top performing NHS organisations?

The efficiency of all hospitals will need to improve significantly in the coming years to cope with an ageing population, rising demand and the cost of the introduction of new medicines and technologies. The hospitals of South London Healthcare NHS Trust will, in common with all other providers, need to demonstrate these improvements in productivity and efficiency to ensure financial sustainability and keep pace with the improved performance of hospitals across the UK.

The scale of the efficiencies required makes it vital that they are based on valid, reliable data, agreed and transparent assumptions and appropriate estimates where necessary. Inaccuracies or the widespread application of high level assumptions can easily result in solutions not being practical or achievable. We have reservations about some of the assumptions relating to the efficiency improvements which underpin the Trust Special Administrator (TSA) modelling and where they are not realistic and therefore not deliverable this will have an impact on the ability of current and new organisations in south east London to deliver the financial savings in the timescale assumed. If efficiencies are not delivered it is important that these costs are not transferred to community or mental health services through savings on block contracts.

For each efficiency gain the target needs to be carefully selected with an understanding of the drivers behind the challenge. For example the differences between hospitals based on their teaching profile is relatively well understood, but the effects of the combined recommendations on the ability of University Hospital Lewisham to deliver its highly regarded undergraduate medical education programme will need to be worked through. We cover this issue in further detail under Q14 and 18.

Q2: To what extent do you agree or disagree that the areas outlined in Chapter 5 of the consultation document for improving efficiency at the hospitals that make up South London Healthcare NHS Trust are appropriate?

We agree that the areas for improved efficiency appear consistent with the areas we are also focusing on, in attempts to drive continued productivity improvements across King's Health Partners. We believe there are ways in which our organisations can work to support productivity improvements in south east London, including through proposals for more efficient procurement which we are discussing with other providers in south east London.

We have, however, raised a number of concerns since the publication of the TSA's report about the validity of some of the assumptions which underpin the modelling of future capacity requirements. Some of the organisations within King's Health Partners have written formally to the TSA specifically to raise these issues and it is essential that the TSA clarifies and resolves outstanding areas. For example, assumptions have been made about the split of activity between the Guy's and St

Thomas' Hospital sites and this leads to inaccuracies in the modelling for the activity that could transfer to any proposed elective centre.

Q3: What further comments, if any, do you have on any of the proposals outlined around recommendation one in the consultation document, including the reasons for your answer to questions 1 and 2? Please also include any improvements you would like to suggest to this recommendation.

No further comments.

Q4: How far do you support or oppose the proposal for Queen Mary's Hospital Sidcup to be turned into a Bexley Health Campus?

We note the proposal for a Bexley Health Campus and think it could bring significant opportunities particularly in the integration of mental and physical health needs to support the overall well-being of patients. There are also opportunities for a Bexley Health Campus to provide new and different training opportunities on the site. We think that further consideration needs to be given to the interplay between the services provided on the site and the proposed elective centre at Lewisham to ensure that the elective centre remains a viable proposition.

If the recommendation for a Bexley Health Campus is accepted, King's Health Partners would expect to work with the owner of the site to agree the role that our organisations would play in the delivery of services on that site and the business model that would be used. This could include innovative models of stakeholder collaboration and ownership of the site that might encourage collective flexibility and responsiveness to future challenges.

There are a range of surgical services that are currently provided or are planned at the site and we intend to discuss these with the future owner of the site. For example there is a 10/12 Chair Dental Clinic that currently provides Oral Surgery, Oral and Maxillofacial Surgery, Restorative and Orthodontic services through linked appointments with King's College Hospital and Guy's and St Thomas' Hospitals. In these specialties we also provide some linked specialist training with rotating trainees and would wish to consider the opportunity to establish an additional clinical academic training facility such as we already operate at Portsmouth and in future will provide at Norwood Hall.

If, as recommended in the draft report, King's College Hospital acquires the Princess Royal University Hospital, we would wish to discuss with commissioners which of the services currently provided by the Princess Royal University Hospital staff on the Queen Mary's Hospital site might continue as well as other possible services. Examples include a number of surgical and medical day cases.

Given the above, we are concerned about the proposal for Dartford and Gravesham NHS Trust to become the interim provider of day case surgery and endoscopy services at the site whilst a procurement process is being carried out. In particular it is very important not to disrupt established cancer treatment pathways for patients diagnosed with cancer who access services on the Queen Mary's Hospital, Sidcup site.

Discussions have been taking place for many months, with both providers and commissioners, on the provision of a satellite radiotherapy unit on the site in conjunction with a private provider. Guy's and St Thomas' NHS Foundation Trust will continue to discuss this with the relevant parties, as well as the continued provision

of renal dialysis on the site, and would want to ensure through the broader conversations about the future of the Queen Mary's Hospital, Sidcup site that the required infrastructure and capital to support the service were available within appropriate timescales.

Q5: How far do you support or oppose the proposal for the land and buildings required for Bexley Health Campus at Queen Mary's Sidcup site to be transferred or sold to Oxleas NHS Foundation Trust?

The information available makes it difficult to assess the benefit for the taxpayer of such a sale or transfer. We will work with any future owner and commissioners of the site to discuss services that could be provided on the site with the involvement of King's Health Partners and the business model under which it would operate.

Q6: What further comments, if any, do you have on any of the proposals outlined around recommendation two in the consultation document, including the reasons for your answer to questions 4 and 5? Please also include any improvements you would like to suggest to this recommendation.

No further comments.

Q7: How far do you support or oppose the recommendation that South London Healthcare NHS Trust should sell or no longer rent poorly used or empty buildings?

It is desirable to make the best use of publicly owned NHS buildings.

Q8: What further comments, if any, do you have on any of the proposals outlined around recommendation three in the consultation document, including the reasons for your answer to questions 7? Please also include any improvements you would like to suggest to this recommendation.

No further comments.

Q9: How far do you support or oppose the recommendation that the Department of Health provides additional annual funds to cover the additional costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth Hospital and Princess Royal University Hospital until the relevant contracts end?

We welcome the proposed funds from the Department of Health to support the additional costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth Hospital and Princess Royal University Hospital throughout the life of the relevant contracts. The level of support to the PFI contracts must be sufficient to ensure a sustainable financial future. King's College Hospital has been developing an Outline Business Case for the acquisition of the Princess Royal University Hospital. The King's College Hospital Board has made clear that it will only accept arrangements for acquisition of the Princess Royal University Hospital if funds are tracked to the PFI inflationary uplift expectations and supports the transitional needs identified.

Q10: What further comments, if any, do you have on any of the proposals outlined around recommendation four in the consultation document, including the reasons for your answer to questions 9? Please also include any improvements you would like to suggest to this recommendation.

No further comments.

Q11: How far do you support or oppose the recommendation to implement the community based care strategy as outlined in Chapter 8 of the consultation document?

We support the vision and the direction of travel indicated by the community based care strategy and agree that the effective implementation of the proposed community based care strategy is integral to the success of the south east London health economy. For example, the approach to integrated care for older people across Lambeth and Southwark is a strong basis for the extension of the integrated care model we have developed with our stakeholders as a means of delivering the community based care strategy, as is the key strength of King's Health Partners in integrating mental and physical health services.

It is our experience that achieving full clinical buy-in to the proposed model will be critical to achieve the anticipated levels of progress in this area. We have significant concerns about the level of success that has so far been achieved, for example on reducing demand and A&E admissions. We remain concerned that the Quality, Innovation Productivity and Prevention assumptions that underpin the strategy extend beyond what is achievable through efficiency while shifting care to community settings. In the past there has not been sufficient investment in mental health and community services to support the delivery of these objectives.

Attaining the transformation outlined in the strategy will require transitional funding including investment in training and intensive development for existing staff to enable them to develop new skills which will support the changing models of care. The longer term workforce implications will also be challenging, so links to the South London Local Education and Training Board to achieve this will be vital.

We agree that it is important to make best use of all NHS sites and having completed a site utilisation review agree with the conclusions of the TSA that work can be done to rationalise community care sites. It must be recognised, however, that the transfer of ownership of these buildings away from Primary Care Trusts adds complexity.

In considering how the recommendations link to models of community care provision in south east London, there is a need to consider how the proposed merged Trust formed from Lewisham Healthcare and Queen Elizabeth Hospital would interact with Greenwich Community Health Services provided by Oxleas NHS Foundation Trust. Equally changes to services at University Hospital Lewisham may affect pathways in relation to older people with implications for how acute trusts, mental health, community services and social care work together locally to support them. The integrated systems that University Hospital Lewisham have in place to support older people's pathways are extremely well regarded in south east London and it is important that the impact of these recommendations on them is assessed and provision put in place to continue the learning generated from those service developments.

We are also interested in the opportunities that may exist to place medical students in community settings with greater integration between services.

Q12: What further comments, if any, do you have on any of the proposals outlined around care in the community in the consultation document, including the reasons for your answer to questions 11? Please also include any improvements you would like to suggest to this recommendation.

No further comments

Q13: How far do you support or oppose the proposed plans for delivering urgent and emergency care in south east London? The following shows how urgent and emergency care would be delivered:

- **Emergency care for the most critically unwell – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital**
- **Urgent care – Guy's Hospital, Queen Mary's Hospital Sidcup, University Hospital Lewisham**

Please see response to Q14 below.

Q14: What further comments, if any, do you have on any of the proposals outlined around urgent and emergency care in the consultation document, including the reasons for your answer to questions 13? Please also include any improvements you would like to suggest to this recommendation.

As King's Health Partners we agree that we must deliver the clinical quality standards for emergency care to ensure the best quality care is delivered for patients. This includes the availability of consultant doctors 24 hours a day, seven days a week to allow high risk patients to be seen by a consultant within an hour. We recognise the challenge these standards entail, and that they set a new bar for the quality of services in London.

The recommendation to concentrate emergency care for the most critically unwell on four major sites in future would have a significant impact on the provision of emergency and non-emergency care at King's College Hospital and St Thomas' Hospital.

Whatever decisions are then reached regarding emergency department configuration, there are a number of implications that must be considered. While we recognise the challenges inherent in modelling the impact of changes to urgent and emergency care, we think it likely that the effect of the service changes proposed at Lewisham will have a significantly larger impact on King's Health Partners' sites than has been acknowledged, in particular at King's College Hospital. For example, we need to understand the estimates that suggest 77% of the Lewisham attendances could continue to be seen by the Urgent Care Centre. King's College Hospital's modelling suggests that the proportion of patients that would continue to be seen at University Hospital Lewisham in the urgent care centre could be as low as 30%. The large variance between these estimates raises significant questions about the understanding of the implications of the clinical flows under this recommendation.

Regardless of the precise numbers, we are confident that the resultant flows to King's College Hospital and also to St Thomas' Hospital would be significant if this recommendation was accepted. The capacity available on both of these sites is

limited and we have so far been unable to confirm our ability to treat these additional patients within clinical standards and access times required. Accommodating the additional unplanned activity would require significant revenue and capital investment, particularly at the King's College Hospital site. As a result, if this recommendation was accepted then the transition path towards the changes proposed in Lewisham's urgent and emergency care services would need to be managed carefully over a staged period. Significant work would be needed with GPs to agree appropriate pathways for south east London patients to both A&E and Urgent Care Centres.

South London and Maudsley NHS Foundation Trust provides a psychiatric liaison service in A&E and on the wards at University Hospital Lewisham to ensure that patients presenting with a mental health crisis receive access to timely and effective care and treatment. South London and Maudsley also provides mental health inpatient services for adults and older adults in the Ladywell Unit at University Hospital Lewisham. This includes a well-established triage facility to provide a timely and comprehensive assessment of need for adults of working age who require hospital admission, a successful service model that has been extended by the Trust to residents of Croydon and Lambeth. Over the last year, South London and Maudsley has also developed an integrated psychological therapy service with the full range of therapies available from one team at the Ladywell Unit.

South London and Maudsley remains fully committed to providing mental health services for Lewisham residents. From this perspective, it is vital that the proposals under consideration do not disrupt the care pathway for patients presenting in crisis who need a mental health assessment and an admission to South London and Maudsley's mental health inpatient services at the Ladywell. Equally, should the proposals for changes to the Lewisham site be implemented, there is a risk of a reduced quality and experience for elderly patients with mental health issues requiring medical or surgical services, particularly if these are not provided onsite. Furthermore, St Thomas' and King's College Hospital might need to develop closer links with Lewisham social services to facilitate discharges of older people.

We also need to understand what is proposed on the model for Urgent Care at the Lewisham site and whether it would be able to accommodate the appropriate level of emergency activity and the extent to which it can provide medical support to mental health wards on the University Hospital Lewisham site. For instance, it is not clear whether there would be an older person's assessment unit and a selected medical take.

Further attention also needs to be paid to the potential disruption to well developed pathways, meeting patients' physical and mental health needs. For instance there is a strong relationship between psychiatric liaison, through Child and Adolescent Mental Health Services (CAMHS), and the paediatric A&E. Young people who present to University Hospital Lewisham A&E are currently assessed by the local CAMHS service who offer follow up appointments. Future pathways of care would need to be worked through to ensure that children and young people do not have to report at the point of crisis to a facility outside of the borough that is not related to the community services they are linked to.

Overall, we are concerned that there has been very little focus on the potential implications for the provision of mental health services in Lewisham resulting from the draft recommendations. The modelling has concentrated on the potential impact on acute patients rather than the impact on mental health. This should be addressed by the final report.

Further consideration also needs to be given to the service model for paediatric services through the Urgent Care Centres at University Hospital Lewisham and Queen Mary's Hospital Sidcup, and how these link not only to secondary care provision, but also to specialist provision. The South Thames Paediatric Retrieval Service's involvement in this work is essential.

The proposed changes to urgent and emergency care, maternity services and elective work at Lewisham are all likely to have a significant impact on education. We expect that the proposed changes will reduce the overall number of student placements that are appropriate, as many placements require medical students to be exposed to the full range of clinical services and to all degrees of acuity. The consequence of this change therefore would be a need to identify and properly support student placements of comparable quality at other locations, including within the community setting. This may require investment in infrastructure to facilitate the changes. It would be a challenge to find high quality placements, but there would also be opportunities to improve the range and quality of medical student education by consolidating the majority of placement students at a smaller number of locations.

Q15: Which of the following options would you prefer, if any, for providing obstetric-led services:

- **Obstetric-led services should only be provided at the four major hospitals that will offer care for those who are most critically ill (King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas'**
- **Hospital)**
- **A stand-alone obstetric-led unit should also be provided at University Hospital Lewisham, in addition to the four above**
- **I do not support either of these options**
- **Not sure / don't know**

Please see responses to Q16 below.

Q16: What further comments, if any, do you have on any of the proposals outlined around maternity services in the consultation document, including the reasons for your answer to questions 15? Please also include any improvements you would like to suggest to this recommendation.

Our organisations have engaged with the TSA in considering the options proposed for maternity services in south east London. We agree that the clinical quality standards for maternity must underpin maternity services provided in London in the future, to improve the clinical outcomes and the experience of the populations we serve. We are clear that as King's Health Partners we must deliver these standards in our maternity services. We believe that the organisations within King's Health Partners have considerable expertise and can be part of the solution for the provision of sustainable maternity services, but we have considerable physical capacity constraints. All options provide the opportunity to move towards a network approach to managing maternity services across south east London.

King's Health Partners' clinicians would have significant reservations about the option for a standalone obstetric unit at Lewisham, if it does not have access to a co-located intensive care unit on site and the other support services of an A&E admitting

hospital. Even low risk women can suddenly need these services immediately, and we do not believe this would be a clinically safe and sustainable option.

A recent clinical workshop led by the TSA about maternity services made clear there are a number of possible options for the provision of support services to a standalone obstetric unit. If all support services, including an intensive care unit, anaesthetic and full surgical services are available at all times, this would clearly change the nature of the clinical risk. We assume, however that this is unlikely to be financially viable.

We appreciate that reducing the number of obstetric led services to four major hospitals would concentrate resource and expertise at a smaller number of sites and would facilitate units meeting the clinical quality standards.

The assumptions underpinning the flows of maternity were not clear in the consultation report, but it is our expectation that significant numbers of women would either choose or be directed towards St Thomas' and King's College Hospitals. Both King's College Hospital and Guy's and St Thomas' Hospitals are not able to provide additional capacity currently due to the agreed "capping" policy. This cap represents the number of women who can be delivered without compromising safety. We would expect these numbers to be further increased due to the level three neonatal intensive care units on both the King's College Hospital and St Thomas' Hospital sites, since the Queen Elizabeth Hospital site only has a level one special care baby unit. Therefore under either scenario that is proposed substantial capital investment would be required to accommodate extra deliveries, including additional neonatal and supporting capacity, at other sites.

A significant lead-in time of two to three years would be required before additional capacity is available, which means that it is vital that the TSA works with both King's College Hospital and Guy's and St Thomas' as they develop their final proposals and throughout the implementation of any recommendations. We believe that deciding where extra capacity should be placed should be underpinned by independent work similar to that involved in the Gateway project.

It should also be noted that there are well established perinatal pathways in place across inpatient and community services and with the South London and Maudsley services to support mothers with mental health issues and the disruption of these vital pathways may have implications for quality and costs.

We support the proposal that antenatal and postnatal care continues to be delivered in a dispersed model. However further consideration needs to be given to the effect of the wider recommendations on secondary care paediatrics and the quality of tertiary paediatric networks which have not been considered in the draft report. If there is a consolidation of inpatient paediatrics at Queen Elizabeth Hospital, and the Princess Royal University Hospitals then this should be implemented in ways which enable quality improvements through the development of local expertise at these two sites. Specialist paediatric outreach services should be organised to support this development of local expertise, replacing the current sub-scale dispersed distribution, in line with the proposed development of a specialist children's services network, with the Evelina Children's Hospital at its heart.

The proposed changes to maternity services at Lewisham mean that if the recommendations were accepted, and our assumptions as to the acuity of services provided are correct, maternity student placements would be impacted.

In relation to education more generally, more complex experiences would no longer be available as they are currently, meaning that rotation within an already crowded placement circuit would need to be relocated. The numbers of placements that will need to be relocated will depend on the end mix and acuity of elective services that are hosted at Lewisham, carefully considering the differential impact on medical and nursing students as well as allied health professionals. Lewisham currently has some of the best and most experienced clinical educators that we rely heavily upon, and we would urge that efforts are made to retain this talent within the south east London system.

Q17: How far do you support or oppose the proposed plans for providing planned care services in south east London? The following shows how planned care would be delivered:

- **Day case surgery – Guy's Hospital, King's College Hospital, Queen Elizabeth Hospital, Queen Mary's Hospital Sidcup, Princess Royal University Hospital, St Thomas' Hospital, University Hospital Lewisham**
- **Complex operations – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital**
- **Specialist non-complex operations – Guy's Hospital, King's College Hospital, St Thomas' Hospital**
- **Routine non-complex operations that require a stay in hospital – University Hospital Lewisham**

Please see response to Q18 below.

Q18: What further comments, if any, do you have on any of the proposals outlined around planned care in the consultation document, including the reasons for your answer to questions 17? Please also include any improvements you would like to suggest to this recommendation.

Our organisations will continue to work with the TSA and other providers in south east London to consider sustainable proposals for the organisation of planned care services in south east London. We would expect to play a key part in developing a successful model for planned care in south east London if this recommendation was accepted, building on our expertise in delivering elective centre models. It is critical that the model for such a centre is clinically and financially sustainable, with a business model that all providers can sign up to and is underpinned by workable clinical governance. At present, King's Health Partners' organisations are not reassured on these issues.

The draft report makes clear that Guy's Hospital will remain as an elective centre which we welcome. The draft report fails, however, to acknowledge that the Guy's Hospital site undertakes specialist complex activity such as kidney transplants and thoracic surgery for cancer patients as well as general complex and non-complex inpatient and day case surgery. This is possible because the clinical infrastructure required to safely treat this range of patients, including an intensive care unit, are all available on the Guy's Hospital site.

The draft report makes reference to the SWLEOC and that such a model will be replicated on the Lewisham site. SWLEOC has 24/7 on site consultant intensivist support and intensive care and high dependency beds which enables the centre to treat all levels of complexity and obviates the need for case selection. The Lewisham elective care centre, as per the draft report, will not have such facilities on site which

will lead to difficulties in achieving case mix selection. We do not believe the separation of complex and non complex cases is desirable or feasible in specialties such as major joint replacements because in our view this is not a safe clinical model. An elective centre model without an intensive care unit or high dependency unit support would not, in our view, be an appropriate setting for the co-morbidities that exist for a significant proportion of these patients. The addition of intensive care support to the proposed centre will add substantial cost and is unlikely to be affordable.

In addition we do not think that establishing an additional elective site in particular for major orthopaedics for the sector makes sense financially – either with or without intensive care support. The centre of excellence established at Guy's Hospital means we believe there would be both clinical and financial benefits from consolidating major hip and knee procedures there. This would generate the supply chain efficiencies, through leverage with suppliers of high cost consumables, necessary to drive productivity and the volume of work to ensure exceptional patient experience and quality. Lewisham is relatively close to Guy's Hospital, so does not improve geographical coverage of the sector significantly, whilst the location of Guy's Hospital at London Bridge station makes it easily accessible.

Should an elective centre be established in south east London, we suggest that it could be planned around an alternative proposition, focusing either on particular specialties or subspecialties, and/or working more flexibly to consider day case activity, especially given that much non complex inpatient elective activity may become day case activity over the coming years. This would open up alternative routes for consolidation of elective activity which would provide clinical and productivity benefits and improve patient experience. Where quality and efficiency can be improved through consolidation we think it is important these principles are balanced against requirements for local access, given that not all services can be provided on a borough basis.

In order to support inpatient elective care in a possible elective centre at Lewisham we would require a detailed understanding of the proposed clinical and governance model.

The draft report does not articulate the business model which would operate in relation to the elective centre i.e. the distribution of costs and income between participating providers. It is essential that the TSA works closely with King's College Hospital and Guy's and St Thomas' Hospitals to identify a business model which is sustainable for all organisations. We have referred above to the inaccuracies in the modelling in relation to the split of work between the Guy's and the St Thomas' sites. This has led to an overestimate of the elective surgical workload undertaken on the St Thomas' Hospital site. In addition, the assumption that 85% of the elective work is "non-complex" appears to have little basis, and ignores the fact that the case mix of inpatient elective work undertaken at St Thomas' Hospital includes substantial volumes which come to us in our role as a cancer centre treating many of the less common cancers such as upper-gastrointestinal and gynaecological cancer.

We have previously asked for clarification on the assumptions made about elective surgery for children. Surgeons from both Guy's and St Thomas' Hospitals and Lewisham Healthcare currently undertake significant volumes of paediatric day surgery at University Hospital Lewisham.

Once it is clearer on the portfolio of services which may be provided in the elective centre at Lewisham then a reassessment can be made on the level of capital development required on that site.

We are aware that there is currently poor access to specialist rehabilitation for patients from south east London. There is the potential to develop a high quality centre for patients with a range of needs. King's Health Partners would be happy to have conversations with the TSA and other local providers about the scope for establishing such services.

King's Health Partners believes that it can improve the delivery of planned care in relation to the delivery of chemotherapy services for solid tumours. Guy's and St Thomas' will be submitting a Case for Change proposing that the Trust delivers all chemotherapy via a unified service across south east London. Expected changes to the tariff for chemotherapy mean there is a necessity to reduce costs, improve the quality of care and support care closer to home where clinically appropriate. We will be looking to have early conversations with commissioners and the TSA to take this work forward.

The proposed merger of University Hospital Lewisham and Queen Elizabeth Hospital will necessitate review of palliative care service provision in the hospitals (where models currently differ) and the community. King's Health Partners supports the provision of hospital palliative care by the NHS and regards end of life care services as core board responsibilities as per the Department of Health End of Life Care Strategy. We also support provision of local community palliative care services by integrated trusts such as University Hospital Lewisham and Guy's and St Thomas'. In any consideration of service reconfiguration for palliative care services King's Health Partners would expect to be part of those discussions as the Guy's and St Thomas' community palliative care team would be well placed to support a wider population.

There is a significant issue relevant to all the changes proposed at the Lewisham site related to education and training. King's Health Partners, through King's College London, places students at all South London Healthcare Trust Hospitals, as well as University Hospital Lewisham. They include undergraduate medicine students, nursing and midwifery undergraduates and a small number of dental postgraduates.

Q19: How far do you support or oppose the recommendation for South London Healthcare NHS Trust to be dissolved, with current NHS services managed and delivered by other organisations?

We support this recommendation and King's College Hospital expects to be able to offer a sustainable solution through its acquisition of the Princess Royal University Hospital to deliver high quality care subject to the points made in Q21.

Q20: How far do you support or oppose the plan for the Queen Elizabeth Hospital site and Lewisham Healthcare NHS Trust to come together to create a new organisation?

We support changes in organisational form that will lead to improvements in the quality of care. King's Health Partners looks forward to working with the new organisation if this recommendation is accepted. It is vital that the business cases for any new organisations consider carefully the interrelationships between local flows of activity to ensure that any proposed elective centre remains financially viable.

Q21: Which of the following options would you prefer, if any, for the running of the Princess Royal University Hospital?

- **The Princess Royal University Hospital should be acquired and run by King's College Hospital NHS Foundation Trust**
- **A procurement process should be run allowing any provider from the NHS and/or independent sector to bid to run NHS services on the Princess Royal University Hospital site**
- **I do not support either of these options**
- **Not sure / don't know**

The draft report recommends that King's College Hospital acquires the Princess Royal University Hospital. King's Health Partners' support for this proposal is subject to the detailed operational and financial Outline Business Case which is being prepared by King's College Hospital and which will naturally take account of the potential impact on our organisations. As this is developed, we will gain a greater understanding of the levels of financial support required to deliver the outcome desired by all parties, and we would expect that further discussions will be required at this stage. The proposal also has wider implications for the way we take forward our plans for progressing our Full Business Case for creating a single academic healthcare organisation, which we will consider separately.

Q22: To what extent do you agree or disagree with the recommendation for the Department of Health to write off the debt accumulated by South London Healthcare NHS Trust?

We agree that this recommendation is vital to ensure financially sustainable organisations and local health economy in future. As King's College Hospital develops its detailed operational and financial Outline Business Case for the acquisition of the Princess Royal University Hospital, we will gain a greater understanding of the levels of financial support required to deliver the outcome desired by all parties, and we would expect that further discussions with the TSA would be required at this stage.

Q23: What further comments, if any, do you have on any of the proposals outlined around recommendation six in the consultation document, including the reasons for your answers to questions 19, 20, 21 or 22? Please also include any improvements you would like to suggest to this recommendation.

We believe that King's Health Partners has significant expertise, including in commercial partnerships, across a range of areas that could be part of providing wider solutions in south east London. For example, we might be able to make a significant contribution to efficiency by maintaining integrated infrastructure services across the sector through Guy's and St Thomas' healthcare infrastructure services department "Essentia". Examples would include patient transport and decontamination, where new partnerships would deliver increased efficiencies, cash releasing savings, and provide new opportunities for all of the participating organisations.

King's Health Partners concurs with the TSA's finding that there is scope for efficiency gains from pathology rationalisation at South London Healthcare NHS Trust. Guy's and St Thomas' and King's College Hospitals are already working

together to modernise pathology across King's Health Partners and we recommend the establishment of a "hub and spoke" pathology network across the south east London sector in line with the NHS London strategy (*Modernising Pathology in London*, June 2011). GSTS is a majority NHS–owned joint venture which delivers pathology services to its NHS owners, Guy's and St Thomas' and King's College Hospital NHS Foundation Trusts. It is a public private partnership and Serco has a one third share. We would welcome the opportunity to explore the feasibility for rationalising pathology capacity across the south east London sector to meet the future service needs and financial objectives of the NHS. This will be covered in more detail in the GSTS response to the TSA draft report.

It is also the case that in line with national recommendations, all hospitals should actively support clinical research. King's Health Partners, as the academic hub for south east London has a leadership role in this regard; both working with the Comprehensive Clinical Research Network and emerging Academic Health Science Network to streamline and consolidate research governance, and in supporting patient recruitment to clinical trials at all hospital sites. It will be important that we take advantage of opportunities to extend the reach of clinical trials and studies where appropriate, which King's Health Partners intends to do, working through the Academic Health Science Network and its individual organisations.

Q24: Is there anything else you want to say about the consultation or the issues it covers? If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so here. Please also say if there are any improvements you would like to suggest to the recommendations.

We are concerned about the lack of comment about mental health pathways across the TSA report. In particular, charts 66 and 67 do not reflect mental health services and indeed in section 2 page 8 of your report (and in page 2, section 2 of Appendix B) you do not acknowledge the South London and Maudsley as a major teaching and research Foundation Trust, this is unhelpful. With regard to local access, mental health services are provided by South London and Maudsley NHS Foundation Trust from a self-contained building on the University Hospital Lewisham site called the Ladywell Unit. It provides six wards over three floors with the basement and fourth floor providing ancillary facilities. Outpatients and social services are provided from within the three main clinical floors. All bedrooms are single rooms, some with en-suite facilities.

We note that the Ladywell Unit is listed in Appendix K on map 5 *Estate Consolidation at Lewisham* and that it is shown on the map within a yellow shaded area separated from the Riverside PFI by a blue line. We are unsure what that categorisation indicates but if it means that at some later stage it might to be considered for estate consolidation then we need to register some key points. There are some very important statutory responsibilities and service requirements which would be a challenge to provide from, for example, the Riverside PFI building and hence the potential capital costs of accommodating a move could be significant. Together with the potentially higher running costs this could introduce significant additional financial pressures into the system for South London and Maudsley services. We would of course be willing to consider the alternative estates options which may be available but our working assumption is that any additional one-off or recurrent financial consequences for mental health services would be taken into account in the remodelling of the finances. South London and Maudsley does not have any specific proposals for significant changes to the configuration of the services currently

provided on the University Hospital Lewisham site at this stage, however there may be circumstances (such as the indirect consequences of the TSA's proposals) where South London and Maudsley may need to consider reconfiguration options and it is therefore appropriate to register concerns in this response.

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

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