

## Public Document Pack

# Joint Meeting of Mayor and Cabinet, Healthier Communities Select Committee and the Overview and Scrutiny Business Panel Agenda

Monday, 10 December 2012

**6.30 pm,**

Council Chamber, Civic Suite  
Lewisham Town Hall  
London SE6 4RU

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### Part 1

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# **Mayor and Cabinet, Healthier Communities Select Committee and Overview and Scrutiny Business Panel Members**

Members of the committees, listed below, are summoned to attend the meeting to be held on Monday, 10 December 2012.

Barry Quirk, Chief Executive  
Tuesday, 4 December 2012

Mayor Sir Steve Bullock (Chair)	Chair Mayor and Cabinet
Councillor Alan Hall (Co-Chair)	Chair Overview and Scrutiny Business Panel
Councillor John Muldoon (Co-Chair)	Chair Healthier Communities Select Committee
Councillor Kevin Bonavia	Vice Chair Overview and Scrutiny Business Panel
Councillor Stella Jeffrey	Vice Chair Healthier Communities Select Committee
Councillor Anne Affiku	
Councillor Pauline Beck	
Councillor Chris Best	
Councillor Liam Curran	
Councillor Janet Daby	
Councillor Damien Egan	
Councillor Alexander Feakes	
Councillor Peggy Fitzsimmons	
Councillor Julia Fletcher	
Councillor Vicky Foxcroft	
Councillor Helen Gibson	
Councillor Carl Handley	

Councillor Ami Ibitson  
Councillor Chris Maines  
Councillor Paul Maslin  
Councillor Joan Millbank  
Councillor Pauline Morrison  
Councillor Crada Onuegbu  
Councillor Jacq Paschoud  
Councillor John Paschoud  
Councillor Alan Smith  
Councillor Alan Till  
Councillor Susan Wise

# Agenda Item 1

<b>Mayor and Cabinet, Healthier Communities Select Committee and Overview and Scrutiny Business Panel</b>			
<b>Title</b>	Declarations of Interest	<b>Item No.</b>	1
<b>Contributors</b>	Chief Executive		
<b>Class</b>	Part 1	<b>Date</b>	10 December 2012

## **Declaration of interests**

Members are asked to declare any personal interest they have in any item on the agenda.

### **1 Personal interests**

There are three types of personal interest referred to in the Council's Member Code of Conduct :-

- (1) Disclosable pecuniary interests
- (2) Other registerable interests
- (3) Non-registerable interests

### **2 Disclosable pecuniary interests** are defined by regulation as:-

- (a) Employment, trade, profession or vocation of a relevant person\* for profit or gain
- (b) Sponsorship –payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).
- (c) Undischarged contracts between a relevant person\* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.
- (d) Beneficial interests in land in the borough.
- (e) Licence to occupy land in the borough for one month or more.
- (f) Corporate tenancies – any tenancy, where to the member's knowledge, the Council is landlord and the tenant is a firm in which the relevant person\* is a partner, a body corporate in which they are a director, or in the securities of which they have a beneficial interest.

(g) Beneficial interest in securities of a body where:-

- (a) that body to the member's knowledge has a place of business or land in the borough; and
- (b) either
  - (i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or
  - (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person\* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

\*A relevant person is the member, their spouse or civil partner, or a person with whom they live as spouse or civil partner.

**(3) Other registerable interests**

The Lewisham Member Code of Conduct requires members also to register the following interests:-

- (a) Membership or position of control or management in a body to which you were appointed or nominated by the Council
- (b) Any body exercising functions of a public nature or directed to charitable purposes , or whose principal purposes include the influence of public opinion or policy, including any political party
- (c) Any person from whom you have received a gift or hospitality with an estimated value of at least £25

**(4) Non registerable interests**

Occasions may arise when a matter under consideration would or would be likely to affect the wellbeing of a member, their family, friend or close associate more than it would affect the wellbeing of those in the local area generally, but which is not required to be registered in the Register of Members' Interests (for example a matter concerning the closure of a school at which a Member's child attends).

**(5) Declaration and Impact of interest on member's participation**

- (a) Where a member has any registerable interest in a matter and they are present at a meeting at which that matter is to be discussed, they must declare the nature of the interest at the earliest opportunity and in any event before the matter is considered. The declaration will be recorded in the minutes of the meeting. If the matter is a disclosable pecuniary interest the member must take not part in consideration of the matter

and withdraw from the room before it is considered. They must not seek improperly to influence the decision in any way. **Failure to declare such an interest which has not already been entered in the Register of Members' Interests, or participation where such an interest exists, is liable to prosecution and on conviction carries a fine of up to £5000**

- (b) Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in consideration of the matter and vote on it unless paragraph (c) below applies.
- (c) Where a member has a registerable interest which falls short of a disclosable pecuniary interest, the member must consider whether a reasonable member of the public in possession of the facts would think that their interest is so significant that it would be likely to impair the member's judgement of the public interest. If so, the member must withdraw and take no part in consideration of the matter nor seek to influence the outcome improperly.
- (d) If a non-registerable interest arises which affects the wellbeing of a member, their, family, friend or close associate more than it would affect those in the local area generally, then the provisions relating to the declarations of interest and withdrawal apply as if it were a registerable interest.
- (e) Decisions relating to declarations of interests are for the member's personal judgement, though in cases of doubt they may wish to seek the advice of the Monitoring Officer.

## **(6) Sensitive information**

There are special provisions relating to sensitive interests. These are interests the disclosure of which would be likely to expose the member to risk of violence or intimidation where the Monitoring Officer has agreed that such interest need not be registered. Members with such an interest are referred to the Code and advised to seek advice from the Monitoring Officer in advance.

## **(7) Exempt categories**

There are exemptions to these provisions allowing members to participate in decisions notwithstanding interests that would otherwise prevent them doing so. These include:-

- (a) Housing – holding a tenancy or lease with the Council unless the matter relates to your particular tenancy or lease; (subject to arrears exception)

- (b) School meals, school transport and travelling expenses; if you are a parent or guardian of a child in full time education, or a school governor unless the matter relates particularly to the school your child attends or of which you are a governor;
- (c) Statutory sick pay; if you are in receipt
- (d) Allowances, payment or indemnity for members
- (e) Ceremonial honours for members
- (f) Setting Council Tax or precept (subject to arrears exception)

# Agenda Item 2

JOINT MEETING OF MAYOR AND CABINET, HEALTHIER COMMUNITIES SELECT COMMITTEE AND OVERVIEW AND SCRUTINY BUSINESS PANEL			
<b>Report Title</b>	Response to the consultation on the Trust Special Administrator's draft report		
<b>Key Decision</b>	Yes		Item No.
<b>Ward</b>	All		
<b>Contributors</b>	Chief Executive, Executive Director for Community Services		
<b>Class</b>	Open	Date: 10 December 2012	

## Reason for urgency

The Mayor, Healthier Communities Select Committee and the Overview and Scrutiny Business Panel are asked to consider this item even though a copy of the agenda including a copy of this item has not been open to inspection by the public for a period of five days before the meeting.

The reason for urgency is that the timetable for the Council to respond to the Trust Special Administrator is very demanding and the Council has sought external advice to inform its response. Given the tight consultation timetable, it was not possible for that advice to be considered and for the Council's response to be drafted in time to comply with the usual access to information requirements.

As the Council's response must be delivered to the Trust Special Administrator by 13 December 2012, it is not possible to delay consideration of it to enable compliance with section 100B Local Government Act 1972. The Mayor and the Chairs of the Healthier Communities Select Committee and the Council's Overview and Scrutiny Business Panel are asked to agree that, because of these special circumstances, the matter be considered as one of urgency in accordance with Section 100B (4) (B) Local Government Act 1972.

### 1. Purpose

- 1.1 This report sets out a draft of the Council's response to '*Securing Sustainable NHS Services – Consultation on the Trust Special Administrator's draft report for South London Healthcare NHS Trust and the NHS in south east London*'. The paper seeks comments on the response from the Healthier Communities Select Committee and from the Overview and Scrutiny Business Panel, and approval from the Mayor for the collective response to be submitted to the Trust Special Administrator.

## **2. Recommendations**

- 2.1 It is recommended that the Mayor:
- a) notes the views of the Council on this issue, as expressed at the meeting of 28 November 2012; and
  - b) agrees the response at Appendix A.
- 2.2 It is recommended that Healthier Communities Select Committee:
- c) notes the decision of Mayor and Cabinet of 10 December 2012;
  - d) notes the views of the Council on this issue, as expressed at the meeting of 28 November 2012; and
  - e) agrees the response outlined at Appendix A.
- 2.3 It is recommended that the Overview and Scrutiny Business Panel:
- f) notes the decision of Mayor and Cabinet of 10 December 2012;
  - g) notes the views of the Council on this issue, as expressed at the meeting of 28 November 2012;
  - i) notes the views of Healthier Communities Select Committee of 10 December 2012; and
  - j) agrees the response outlined at Appendix A.

## **3. Policy context**

- 3.1 The Council is committed to improving the health and wellbeing of citizens in Lewisham. In *Shaping our future – Lewisham’s Sustainable Community Strategy*, one of the priority objectives that all partners will work towards is that the borough and communities within the borough should be '*Healthy, active and enjoyable – where people can actively participate in maintaining and improving their health and wellbeing*'.
- 3.2 The Council's Corporate Strategy also identifies specific priorities related to the health and wellbeing of its citizens, specifically *Caring for adults and older people* and *Active, healthy citizens*. In responding to the Trust Special Administrator's consultation and facilitating others to do so, the Council is also meeting its commitment to deliver *Community leadership and empowerment*.

## **4. Background**

- 4.1 Lewisham hospital is a key part of the fabric of public service provision in Lewisham. Its long history in the borough stretches back well before the creation of the welfare state to the emergence of poor law provisions in south east London.
- 4.2 Following the formation of the National Health Service in 1948, the hospital continued to expand with new buildings opened in the 1950s and 1960s. In 1991 the Sydenham Children's Hospital closed and

moved to Lewisham Hospital. In 1996 the Women's and Children's Wing was opened at Lewisham by Princess Alexandra. In 1997 Hither Green Hospital closed, and the Elderly Care service was transferred to Lewisham Hospital. In 2007 the new Riverside Building opened, providing modern elective and health care services and, most recently, the Accident & Emergency suite was refurbished.

- 4.3 Over the past decade Lewisham Hospital has established itself as a highly effective general district hospital, in both clinical and financial terms, with an annual turnover of some £240m serving a local population of some 300,000 people.
- 4.4 In 2010, the hospital was commissioned to provide community health services. This has allowed for the vertical integration of acute and community services and has provided stronger links to Lewisham Council's services and other primary care services. Its links within the health economy of south east London are positive and strong and the nature of its work with Lewisham Council's adult social care system is highly effective. It has played a key role in contributing to Lewisham's achievement of an "outstanding" rating for children's safeguarding.

**5. South London Healthcare NHS Trust, the establishment of the Unsustainable Provider Regime and the appointment of the Trust Special Administrator**

- 5.1 The previous Labour Government made provision in law for NHS intervention in the case of hospital failures: the so-called "unsustainable provider regime" (UPR) that relies upon a Trust Administrator being appointed, who is then afforded governance and management powers over the failing hospital so that rectifying measures can be developed and adopted swiftly to prevent resource losses from the NHS.
- 5.2 In 2009 three failing hospitals in outer south east London - Princess Royal (Bromley), Queen Elizabeth (Woolwich) and Queen Mary's (Sidcup) - were merged into one Trust (the South London Healthcare Trust, SLHT). This merger has not been successful, as the operating deficit of the combined hospital has continued to climb such that, by 2012, it was losing the NHS over £60m of resources each year and is forecast to have a cumulative deficit of £207m by April 2013.
- 5.3 According to the TSA, the SLHT "struggles to meet a number of (clinical) standards consistently and the sustainability of these improvements is not clear." According to the TSA, the "root causes of the challenges are complex, site-specific and both internal and external to the Trust" such that any solution will require broader changes to the local health system.
- 5.4 Since its establishment SLHT has accumulated deficits of £153m - which will have risen to £207m by the fiscal year end. Of the 266

hospital trusts in England, 30 reported a deficit and of these, SLHT's was the largest (at nearly 15 per cent of its income).

- 5.5 On 12 July 2012, the then Secretary of State for Health, Andrew Lansley, announced that South London Healthcare Trust (SLHT) was to be put into the regime for unsustainable NHS providers after it ran into serious financial difficulties.
- 5.6 Matthew Kershaw, an experienced NHS Foundation Trust Chief Executive, who had been appointed as the Department of Health's national director for provider delivery, was appointed as Trust Special Administrator (TSA), with effect from 16 July 2012.
- 5.7 Mr Kershaw's brief was to assume full control of the trust, replacing the functions of the trust's board and assuming the role of the accountable officer. He was also made responsible for developing recommendations to secure a sustainable future for services provided by the Trust for the Secretary of State to consider. However, once appointed, it became clear that he had adopted a wider scope than simply sorting out the finances of SLHT and extended this to include a review of healthcare provision across south east London.
- 5.8 The legal timeframe for the UPR at South London Healthcare Trust is:
  - an initial 75-working-day phase (up to 29 October) developing recommendations and drafting a report;
  - a 30-working-day public consultation period (from 2 November to 13 December) on that report and its recommendations; followed by
  - a 15-day period to finalise the report of recommendations for the Secretary of State for Health. The final report therefore needs to be submitted to the Secretary of State by 8 January 2013.

The Secretary of State then has 20 working days to consider the report and make a decision on the way services will be delivered in the future. The decision will be made by 4 February 2013.

- 5.9 The TSA conducted an intensive process of clinical meetings and stakeholder deliberations from August through to October in an attempt to arrive at his conclusion as to a way forward.

## **6. The TSA's draft report and recommendations**

- 6.1 On 29 October 2012, the TSA published the draft report '*Securing Sustainable NHS services*'<sup>1</sup> in which he set out six recommendations:
  - Improve the operational efficiency of the hospitals that make up SLHT.

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<sup>1</sup> Full report available online at <http://www.tsa.nhs.uk/sites/default/files/TSA-DRAFT-REPORT-WEB3.pdf>

- Queen Mary's Hospital Sidcup should be developed into Bexley Health Campus.
  - Surplus and under-utilised premises should be disposed of across the Trust.
  - The Department of Health should provide additional funds to cover the excess costs of the PFI building at Queen Elizabeth Hospital and Princess Royal University Hospital.
  - There should be a transformation in the way services are provided in south east London, with changes recommended in relation to community-based care and emergency, maternity and elective services..
  - SLHT should be dissolved and other organisations should take over the management and delivery of the NHS services which it currently provides.
- 6.2 The full draft report of the TSA has been circulated to all members of the Council in hard copy. Additional hard copies will be available at the meeting. The report is also available on-line at <http://www.tsa.nhs.uk/sites/default/files/TSA-DRAFT-REPORT-WEB3.pdf>
- 6.3 The specific impact of the TSA's draft recommendations on Lewisham include:
- Emergency care would no longer be provided at University Hospital Lewisham. It would continue to provide 'non-admitting urgent care'.
  - Lewisham would have either reduced critical care or no critical care for women who require hospital admission during pregnancy or an obstetric-led delivery.
  - Lewisham would develop as a centre of excellence for non-complex elective surgery, serving the whole of south east London.
  - Lewisham Healthcare Trust would join with Queen Elizabeth Hospital Woolwich to create a new Healthcare Trust.
  - The proposed changes would mean that while some of the buildings at University Hospital Lewisham site would continue to be required, the major part of the estate would be surplus to requirements and would need to be sold.

## **7. Consultation on the draft report and the development of London Borough of Lewisham's response**

- 7.1 Public consultation on the draft report opened on 2 November 2012 and will close on 13 December 2012.
- 7.2 The TSA published a consultation document summarising the draft recommendations and setting out specific questions on which he is seeking people's views. In addition the TSA is holding a series of public consultation meetings.

- 7.3 The Council sought independent expert opinion on the draft report of the TSA to provide a qualified and expert perspective. Alongside, analysis has been undertaken by officers on the likely impact of the proposed changes on Council services.
- 7.4 Accordingly, the Council engaged Frontline Consulting with a brief to establish whether:
- the problem had been framed correctly;
  - the assumptions used in developing the options were reasonable;
  - an appropriate range of options had been considered;
  - the preferred option had been fairly chosen;
  - the preferred option could be delivered.

The Frontline report is attached at Appendix B.

- 7.5 Drawing upon the Frontline report, and building on it with particular emphasis on the likely impact of the proposals on the provision of local authority services, the Council has developed its response to the TSA draft report. A copy of the response is included as Appendix A.
- 7.6 The response includes reference to:
- The impact of the proposals on Lewisham's residents
  - The impact on Council services, in particular Adult Social Care services and Children's Services
  - Concerns regarding the assumptions on which the TSA's draft recommendations are based, in particular the options appraisal, financial modelling and proposals for the Lewisham site.

## **8. Legal implications**

### Powers

- 8.1 The legal implications associated with the powers of the TSA and the Secretary of State in relation to South London Healthcare Trust and Lewisham Healthcare Trust are set out in the proposed response to the TSA at section 8. Members' attention is drawn to those implications.

### Call in and urgency

- 8.2 The decision that Mayor is being asked to make is a key decision under the Council's constitution. The Council's Overview and Scrutiny Business Panel would normally have the right to ask the Mayor to reconsider a decision made, but not implemented, under the Council's constitution ("call in") in accordance with Part IV Rule E18. However, there is provision for decisions which are urgent not to be subject to the usual procedure.

- 8.3 Rule E19 at Part IV provides that there shall be no requirement for call in where the decision being taken is urgent. A decision will be urgent where the delay to be caused by the call in process would seriously prejudice the interests of the Council or of the public. The Chair of the Council or, in his absence, the Vice Chair, must agree in writing that the decision proposed is reasonable in all the circumstances, and to its being treated as a matter of urgency. Decisions taken as a matter of urgency under this rule must be reported to the next ordinary meeting of the Council with the reason for urgency.
- 8.4 The Chair of the Council has consented in writing in accordance with Rule D19 to this matter being taken as a matter of urgency.
- 8.5 This item was included in the Council's Notice of Key Decisions published in November 2012, covering meetings scheduled to take place from December 2012 to March 2013, as is required under Part IV G17 of the constitution. However, at the date of publication, it was anticipated that the Mayor and Cabinet meeting would take place on 5 December, which was the date published for the meeting in the Notice. As it proved impossible to hold the joint meeting on that date, the matter has been treated as if it were not included in the Notice. Part IV paragraph G19 of the Council's constitution provides that the decision may nonetheless be taken if the Chair of the Business Panel agrees that the taking of the decision is urgent and cannot reasonably be deferred. The Chair of the Business Panel has so agreed and a notice setting out the reasons why the decision cannot reasonably be deferred has been published on the Council's website.

#### The role of the Healthier Communities Select Committee

- 8.6 The Healthier Communities Select Committee is a statutory consultee on significant health service reconfigurations proposed by the appropriate commissioning body (PCT now; CCG post-April 2013). As the legal implications in the attached response set out, the TSA's proposals do not fall under that statutory regime. However, the Head of Law advises that it would in any event be within the terms of reference of the Healthier Communities Select Committee to comment on the TSA's proposals.

#### The role of Overview and Scrutiny Business Panel

- 8.7 This would be the normal forum for considering whether to ask the Mayor to reconsider a decision made but not implemented, but given that the decision is being considered under Part IV Rule E19 of the constitution, the Panel has no formal role. However, the Business Panel is asked for its views in any event, in recognition of its role in relation to call in of executive decisions. This decision would have been subject to call in if the timing of the response to the TSA had not meant that this item had to be treated as an urgent matter.

## Equalities legislation

- 8.8 The Equality Act 2010 (the Act) brings together all previous equality legislation in England, Scotland and Wales. The act includes a new public sector equality duty (the duty), replacing the separate duties relating to race, disability and gender equality. The duty came into force on 5 April 2011.
- 8.9 The duty consists of the ‘general equality duty’ which is the overarching requirement or substance of the duty, and the ‘specific duties’ which are intended to help performance of the general equality duty.
- 8.10 The duty covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
- 8.11 In summary, the Council must, in the exercise of its functions, have due regard to the need to:
  - Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
  - Advance equality of opportunity between people who share a protected characteristic and those who do not
  - Foster good relations between people who share a protected characteristic and those who do not.

These are often referred to as the three aims of the general equality duty, or the statutory needs.

- 8.12 As was the case for the original separate duties, the new duty continues to be a duty to have “due regard” to the statutory needs. The weight to be attached to countervailing factors is a matter for members, bearing in mind the issues of relevance and proportionality. The duty is not an absolute requirement to eliminate unlawful discrimination, advance equality of opportunity or foster good relations.
- 8.13 The Equality and Human Rights Commission (EHRC) has issued five guides for public authorities in England giving advice on the equality duty:
  1. The essential guide to the public sector equality duty
  2. Equality objectives and the equality duty
  3. Equality information and the equality duty
  4. Meeting the equality duty in policy and decision-making
  5. Engagement and the equality duty
- 8.14 All the guides have now been revised and are up to date. The essential guide provides an overview of the equality duty requirements including the general equality duty, the specific duties and who they apply to. It covers what public authorities should do to meet the duty, including steps that are legally required, as well as recommended

actions. The other four documents provide more detailed guidance on key areas and advice on good practice. Further information and resources are available at:

<http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/guidance-on-the-equality-duty/>

- 8.15 The EHRC guidance does not have legal standing, unlike the statutory Code of Practice on the public sector equality duty which was due to be produced by the EHRC under the Act. However, the Government has now stated that no further statutory codes under the Act will be approved. The EHRC has indicated that it will issue the draft code on the duty as a non-statutory code following further review and consultation but, like the guidance, the non-statutory code will not have legal standing.
- 8.16 Members' attention is drawn to contents of paragraph 9 below.

## **9. Financial implications**

- 9.1 There are no specific financial implications associated with this report or the development of the Council's response. However, the response itself highlights the Council's serious concerns as to the financial assumptions on which the TSA's draft recommendations are based and makes reference to the possible implications on the Council's budget and services were the draft recommendations to be implemented.

## **10. Equalities implications**

- 10.1 There are no specific equalities implications associated with this report or the development of the Council's response to the consultation. However, the response itself highlights how the TSA's draft recommendations could negatively affect Lewisham's communities and specifically some of its most vulnerable citizens. The TSA's Health Inequalities Impact Assessment was not available for this meeting.

## **11. Conclusion**

- 11.1 The response incorporating the views of the Healthier Communities Select Committee and Overview and Scrutiny Business Panel will be submitted to TSA prior to the consultation deadline.

## **12. Background documents**

Draft report – Securing sustainable NHS services – Consultation on the Trust Special Administrator's draft report for South London Healthcare NHS Trust and the NHS in south east London

<http://www.tsa.nhs.uk/sites/default/files/TSADRAFT-REPORT-WEB3.pdf>

TSA consultation document

<http://www.tsa.nhs.uk/sites/default/files/documents/TSA-Consultation-web.pdf>

Department of Health press release – South London Healthcare Trust to be put into the regime for unsustainable NHS providers.

<http://mediacentre.dh.gov.uk/2012/07/12/south-london-healthcare-nhs-trust-to-be-put-into-the-regime-for-unsustainable-nhs-providers/>

For further information please contact Sarah Wainer, Head of Strategy and Performance, Community Services on 0208 314 9611.

## Appendix A

### **London Borough of Lewisham’s (“the Council’s”) response to *Securing sustainable NHS services – Consultation on the Trust Special Administrator’s draft report for South London Healthcare Trust and the NHS in south east London***

#### **1. Introduction**

- 1.1 Lewisham Hospital (UHL) is a key part of the fabric of public service provision in Lewisham. Its long history in the borough stretches back before the creation of the welfare state to the emergence of poor law provisions in south east London.
- 1.2 Following the formation of the National Health Service in 1948, the hospital continued to expand with new buildings opened in the 1950s and 1960s. In 1991, the Sydenham Children’s Hospital closed and moved to Lewisham Hospital. In 1996, the Women’s and Children’s Wing was opened at Lewisham by Princess Alexandra. In 1997, Hither Green Hospital closed and the Elderly Care service was transferred to Lewisham Hospital. In 2007, the new Riverside Building opened providing modern elective and health care services. Most recently the Accident & Emergency suite was refurbished.
- 1.3 Over the past decade, Lewisham Hospital has established itself as a highly effective general district hospital, in both clinical and financial terms, serving a local population of some 300,000 people and with an annual turnover of some £240m. In 2010, the hospital was commissioned to provide community health services. This has allowed for the vertical integration of acute and community services and has provided stronger links to the Council’s services and other primary care services. The hospital’s links within the health economy of south east London are positive and strong. Its work with the Council’s adult social care system is highly effective. It has also played a key role in contributing to Lewisham’s achievement of an “outstanding” rating for children’s safeguarding.
- 1.4 The strength of clinical and public sentiment evidenced in public meetings and responses to the TSA reflects the professional and public esteem in which the institution is held not only for the quality of its healthcare provision, but also its role and place in the local community over a number of generations. In addition to the services that it

provides, Lewisham Hospital is a well-regarded public institution, contributing to the fabric of civic life and a key element of people's sense of place and wellbeing. The hospital is a major local employer and acts as a hub for volunteering and community activities.

## **2. Key areas of concern**

- 2.1 The Council strongly doubts whether the UPR regime enables changes to be made to University Hospital Lewisham.
- 2.2 Additionally, the Council queries the methodology, and a number of the assumptions which have led to the TSA's draft recommendations. It also wishes to highlight the inadequacy of engagement and consultation on what amounts to a major service reconfiguration.
- 2.3 In this response, the Council sets out key areas of concern which it feels call into question the legality and viability of the TSA's recommendations in relation to Lewisham.
  - Supported by independent analysis, the Council believes that the problem has not been framed correctly. The regime for unsustainable providers was designed to remedy failing hospitals. It was not designed to establish in fine detail the health care needs of a given population. It is acknowledged that changes are required for acute health care to be organised effectively in south east London. However, such changes need to start with the needs of the population of south east London and not the financial and productivity needs of the health care providers. Throughout his draft report, the TSA has adopted a strict provider focus and failed to take into account or assess any impact of his recommendations on the local population or the extent to which these changes destabilise other local systems and processes.
  - The TSA's draft report fails to take into account the range of effective arrangements already in place locally which have been developed to improve outcomes and experiences for residents. In particular, the TSA seems unaware of the successful integration between the hospital and the Council's Adult Social Care and Children's services. The TSA's narrow focus on improving economies of scale threatens to dismantle many of these arrangements with no regard to their achievements, the economies they deliver and the extent to which they represent a better model for meeting local people's health and care outcomes.

- A number of the assumptions and processes employed by the TSA appear flawed and call into question the robustness of his draft recommendations.
  - The financial case put forward by the TSA lacks sufficient detail and the financial modelling appears to be inconsistently applied across the Trusts.
  - The 30 per cent reduction in secondary care workload resulting from the implementation of the Community Based Care Strategy is an essential condition for the effective functioning of the rest of the system recommended by the TSA but it is based upon limited evidence.
  - The TSA's "options appraisal" fails to meet the requirements of HM Treasury guidance (which applies to NHS options analysis). This failure applies at two levels: the way in which options are constructed (i.e. the extent to which options are ruled in or out); and in the way that they have been evaluated by weighting the respective criteria which have been adopted by the TSA.
  - The estate and land use assumptions regarding the Lewisham Hospital site appear flawed. Both the amount of land available for disposal, and the value of that land are overestimated. The proposals also fail to provide sufficient space for the clinical support services required for the proposed elective centre.
- The TSA has not reported on, or analysed the impact of, any risks that might apply to the successful implementation of his preferred option. The risk of failure is significant and yet it is not assessed nor are the inter-dependencies of different risks assessed. In the report, the TSA has given no consideration to the risks of future institutional failure attendant on different organisations taking on responsibility for, or merging with, others.

2.4 These considerations are compounded by the sheer scale of "behaviour change" that is needed on the part of patients and their doctors - for people to "counter-commute" to attend hospitals to their East rather than to attend London's highly accessible "teaching hospitals". It is estimated that 58 per cent of Lewisham residents attend Lewisham Hospital; 17 per cent attend Guys & St Thomas'; 11

per cent attend King's, and just 4 per cent attend Queen Elizabeth Hospital.

- 2.5 With these reservations in mind, the following response questions and challenges some specific assumptions in the TSA report and urges the TSA to recommend to the Secretary of State that he should not decide upon any change in health service provision without adopting the principles set out in NHS London Reconfiguration programme guide.

### **3. Overview**

- 3.1 In making this response, the Council recognises the exacting timetable that is laid down by the *South London Healthcare NHS Trust (Appointment of Trust Special Administrator)* Order. The TSA's consultation process seeks responses "*which validate and improve recommendations in the draft report*". Lewisham considers that this constitutes a commentary/contribution framework for the report and that while this approach might be appropriate to recommendations which seek to turn around the performance of a single unsustainable provider, it does not afford a real opportunity to consult on substantial health service reconfiguration, particularly when reconfiguration proposals relate to a provider to which the TSA has not been formally appointed, and in respect of which he has not been given formal powers of governance or management.
- 3.2 The Council takes the view that the report recommends changes in healthcare for Lewisham residents which are a substantial variation to current provision. At the outset, reassurances were given by Government that the TSA report would not be used as a vehicle to reconfigure health provision by the "back door" and the Council is extremely disappointed that the report would appear to attempt to do just this.
- 3.3 The Council is not convinced that the regime established for unsustainable health care providers can be used to reconfigure health care services beyond the ambit of the failing Trust concerned. It questions whether the TSA has the powers in law to go beyond addressing the governance, management and finances of the Trust to which he has been appointed.
- 3.4 Given the short period of time which the TSA has had to develop his draft recommendations, it is apparent that he has based his proposals on a large number of interlocking assumptions and projections. The Council is of the view that it has been difficult to assess the validity of these assumptions and that the public have been given insufficient time, information and opportunity to appreciate fully the basis on which certain recommendations have been weighted over others. There is little evidence in the TSA's draft report as to how the clinical judgements and assessments have been challenged or risk-assessed.

- 3.5 In light of the limited information made available by the TSA, the Council sought independent analysis of the TSA report (see attached). Frontline Consulting were appointed to undertake this work and establish whether:
- the problem had been framed correctly;
  - the assumptions used in developing the options were reasonable;
  - an appropriate range of options had been considered;
  - the preferred option had been fairly chosen; and
  - the preferred option could be delivered.
- 3.6 Frontline's analysis informs many elements of this response. The Council therefore requests the TSA considers the Frontline report in its entirety and responds to the points that it has raised. Some of Frontline's key conclusions include:
- Restricting the detailed analysis to the delivery of accident and emergency services and the associated emergency medicine means that the analysis in the report does not consider the inter-relationships of the full health system.
  - No analysis has been carried out on the impact of either widening the geographical scope of the appraisal or limiting it to South London Healthcare Trust's three sites.
  - There has been no agreement from clinicians in surrounding trusts that they would operate at the proposed elective centre at University Hospital Lewisham.
- 3.7 In addition to the Frontline assessment, the Council has received thousands of representations from residents and health professionals who are dismayed by the draft recommendations for fundamental changes to local healthcare services. They feel that the very limited opportunity for engagement and consideration has not been commensurate to the magnitude of the proposals. The Council believes that for stakeholders and residents to be able to contribute to a change of this scale it is essential for there to be a full and comprehensive process for building confidence and trust, and engaging clinicians, patients, and the wider public.
- 3.8 In Lewisham, the Council has already implemented a model of partnership working between the Council and health partners to achieve better health outcomes for Lewisham residents. This recognises the need to improve and develop community based

services and decrease the reliance on unnecessary and delayed hospital stays. This approach provides a more effective basis for the future reconfiguration of acute health services. The TSA's proposals, by contrast, stem from a narrow analysis of, and respond to, institutional instability.

#### **4. The impact on the people of Lewisham**

- 4.1 The Council is committed to ensuring that public resources are used to best effect and believes that all residents should have access to high quality, safe and effective services which maintain and improve their health and wellbeing. The Council seeks to ensure that such services are available to all its residents and it has a long history of working with health partners to achieve that outcome. However the recommendations, as outlined in the TSA report, appear to be framed less around the health and wellbeing needs of Lewisham's residents and much more around organisational requirements. The Council is particularly concerned that the TSA, in adopting a provider focus on this issue, has omitted any real assessment of the needs of Lewisham residents and in particular children and older people.
- 4.2 Any change to the configuration of health services in the south east of London must put the needs of residents at its heart. Lewisham is a diverse borough with a population of around 278,000 people. As a proportion, children and young people aged 0-19 comprise about 25 per cent of the borough's population, whilst those aged over 65 comprise some 9.5 per cent of the population. Moreover, the borough's population is forecast to grow by 49,000 people over the next 20 years. The projected change in population stems mostly from an increase in birth rate.
- 4.3 Lewisham is the 15<sup>th</sup> most ethnically diverse local authority in England. Over 170 languages are spoken in the borough, and two out of every five Lewisham residents are from a black or minority ethnic background. Within Lewisham schools the proportion is even higher, with 74% of pupils from a black or minority ethnic background. Lewisham has areas of affluence but also high levels of socio-economic deprivation. Lewisham is ranked as the 31<sup>st</sup> most deprived local authority in England and this deprivation is characterised by a high rate of lone parent households (17.8% of households compared to 11.6% for Inner London) and a quarter of young people being eligible for free school meals.
- 4.4 The Council contends that the draft recommendations have not been built with the aim of achieving better outcomes for the Lewisham population against the five key areas for improvement in the NHS Mandate. As Frontline note, "*the proposals are not aligned with the Lewisham Joint Strategic Needs Assessment, they are not focussed on*

*prioritising local resources so as to maximise the health improvement impact for Lewisham, they focus on single points of delivery rather than whole pathways and they will lead to fragmentation.”* Given that the Secretary of State for Health has recently established the NHS Mandate as identifying the areas for improvement across the NHS, the Council is surprised that the TSA’s draft recommendations do not appear to have taken it into account.

- 4.5 Given that in Lewisham life expectancy for men and women is lower than the London average, it seems unconscionable that meeting the needs of our residents is not at the forefront of any service changes. Solutions must be built by local partners in such a way as to address those needs in the most efficient and effective way.
- 4.6 There is an extremely high level of public concern in relation to the recommendations on the closure of A&E and the changes to the maternity provision at University Hospital Lewisham. This level of concern is not only related to the loss of access to local facilities that people value and depend upon, but also relates to the lack of engagement and consultation that has taken place with the public.
- 4.7 This is unsurprising given the range and reach of the hospital’s services into the local community. 113,000 people attended A&E in 2011/12 UHL also had 54,000 admissions across both urgent and planned care and day cases and over 4,000 mothers gave birth at the hospital.
- 4.8 The TSA’s draft report also shows that, were Lewisham A&E to close, regardless of mode of transport, journey times would increase by more than 50 per cent for Lewisham residents seeking accident and emergency services. Given the low level of car ownership in Lewisham and the severe limitations on public transport, particularly between Lewisham and Queen Elizabeth hospital, the Council feels that the TSA’s draft report does not sufficiently recognise the negative impact of his draft recommendations not only on patients but also on carers and relatives.

## **5. Lewisham's services**

- 5.1 The Council is responsible for securing a range of services, some of which are attendant to and link to healthcare services including hospital-based services. In discharging its statutory responsibility for securing quality, cost-effective services the Council jointly plans and budgets with healthcare partners to improve health outcomes and to reduce health inequalities. This requires both strategic alignment and join-up of operational practices. This is especially important in Lewisham as almost 60 per cent of the local population attend Lewisham Hospital for their acute healthcare needs.

### *Integration of systems and practices*

- 5.2 The creation of an integrated care trust in Lewisham brought together local acute and community health services. The Council welcomed this integration which enables the Council and its partners to exploit the advantages of place and local connections to improve services and pathways. This integration and joint working have enabled significant progress to be made locally in improving outcomes and experiences for older people, children and young people and their families.
- 5.3 The strength of this integration in Lewisham is built upon being able to provide complementary services from different organisations and breaks down the barriers that often exist between acute and community based provision. The Council believes destabilising and unpicking these arrangements would have a significant negative impact on these groups.
- 5.4 As Frontline note, "*Three of the five dimensions of NHS improvement – better management of long-term conditions, better rehabilitation and recovery, and better patient experience – are heavily dependent on having strong patient pathways in place. By requiring current arrangement to be re-formed across borough boundaries, the TSA proposals will hinder rather than help the delivery of these objectives.*"

### *The impact on older people*

- 5.5 Older people (aged 65+) comprise a relatively small proportion of all patients attending the emergency department but form a much higher proportion in the Acute Medical Unit and a substantial proportion (60-70%) of overall hospital in-patients. The oldest people are often

physically, cognitively or socially frail and prone to significant deterioration after apparently minor stresses.

- 5.6 The Clinical Commissioning Group, Lewisham Healthcare NHS Trust and the Council have, over the past year, formally agreed a new integrated model for community based health and social care services. This will increase further the ability of the whole system to reduce admissions and length of stays. The focus of this work has been primarily on older people with long-term conditions.
- 5.7 Lewisham Hospital and the Council has also created multi-agency neighbourhood clusters, led by GPs and Adult Social Care, to care for more patients in the community and to break down barriers between acute and community provision. The cluster teams bring together hospital social work staff, occupational therapists, physiotherapists, district nurses, community matrons and GP practice staff. This work has been greatly progressed with the input and support of a Consultant Geriatrician.
- 5.8 The Council is committed to continuing this work to prevent older people having unnecessary admissions and lengthened hospital stays. Very often a short admission is required to stabilise the patient. However, such an admission, can be brief if high quality, reactive community services and appropriate clinical support - which works across the acute and community sector - is in place.
- 5.9 The Council believes, however, that it would be extremely challenging to continue to build community based provision in this way if older people's hospital stays were to be dispersed across south east London. Partners recognise that increased community based care places additional burdens on social care expenditure and provision. In Lewisham, this is being managed through the locally integrated system which has allowed efficiencies to be made across the health and social care economy. This has also enabled reinvestment and expansion of social care provision to support more older people in the community.
- 5.10 The impact on adult social care and primary care provision of dismantling this level of integration has not been assessed in the TSA's draft report. There is an assumption that a similar service could be replicated across other acute providers, but the Council believes that this would not be cost effective, or provide the required quality of service. Moving from a borough-based approach to a multi-borough

approach increases the resource requirement on local adult social care systems. This has not been adequately addressed or acknowledged in the TSA's draft report.

- 5.11 The TSA's draft report states that Lewisham's non-elective average length of stay and rates of delayed discharge were some of the highest among the Trusts in south east London. In 2007, the Council and UHL recognised that the number of delayed discharges from the hospital were unacceptably high. A partnership, established between the PCT, hospital and Council, developed a "whole systems approach" to ensure that patients were discharged much more quickly and efficiently. Consequently, in 10/11 and 11/12, this resulted in Lewisham's performance for delayed transfers of care from hospital being the best in its statistical comparator group and well above the average for England and London as a whole.
- 5.12 There has been a recent issue with the assessment of patients for category one healthcare which has resulted in a spell of poor performance. This aspect of the delayed discharge process is being addressed. However, it should be noted that locally there are no other delays in the discharge of patients into community care provision. Therefore, the Council feels that the TSA is wrong to use this uncharacteristic downturn in performance as a proxy measure for assessing the overall effectiveness of integrated services locally.
- 5.13 Many of the TSA's recommendations are intrinsically linked with the assumption that high quality community care will be readily available. What is not obvious is how this expansion of community care is to be provided. As highlighted above, the provision of social care is a crucial element of community care, not only to prevent admission or readmission into hospital but also for example to maintain the health of people living with long term conditions. Successful diversion from health services is unlikely to result in a reduction in social care support. Indeed, to enable people to receive treatment without the need for admission to hospital will require higher levels of social care support both in reablement services and in ongoing packages of care. In his assessment of the resources required to implement the Community Based Care strategy, the TSA's modelling does not appear to include any additional resources for primary care, let alone for the increased demand on social care.

#### *Impact on children and families*

- 5.14 The TSA's draft recommendations, if implemented, would have an impact on all those currently delivering children's services in Lewisham. The Council contends that this impact is not adequately acknowledged or addressed within the TSA's draft report.

*Closure of Paediatric A&E*

- 5.15 UHL was one of a very small number of Trusts, and the only one in London, to gain an "Excellent" rating from the Health Care Commission for the quality of its care of newborn infants and children. This quality continues in the provision of a Children's A&E on the Lewisham site.
- 5.16 Direct access to specialist staff explains the low rates of admission of Lewisham children to hospital. Children's needs are identified and met quickly without the need for distressing and avoidable admissions. Admission rates for gastroenteritis, for example, are the lowest in the sector and less than half the average London rate.

*Closure or curtailment of maternity services in Lewisham*

- 5.17 The current birth rate of over 4,000 per annum is expected to rise by 4 per cent, year on year. Both options presented in the TSA's draft recommendations are problematic.
- 5.18 The strong integration between children's social care services and maternity staff allows for early identification of families at risk. A safeguarding midwife lead and a vulnerable pregnancies pathway have been established to ensure the better coordination of care for vulnerable women. This resource would need to be replicated across QEH, Kings and St Thomas's hospitals, as a minimum.
- 5.19 Both options mean that all but the lowest risk mothers would be giving birth away from effective antenatal and postnatal partnership arrangements. There is strong concern that quality would suffer; "hand-overs" from one service to another increase the chance of care and communication breaking down.
- 5.20 Antenatal and neonatal screening often involve complex pathways that can fail, as demonstrated by the number of Serious Untoward Incidents reported in London recently. Lewisham has worked hard to ensure that families access these services: where babies need further follow up

this is achieved through local coordination with community services and general practice. This early identification and targeting of families is critical to improving the outcomes for children and young people. The proposed changes pose a significant threat to this early identification and support.

- 5.21 Reducing the number of places where women can give birth at a time of increasing birth rate means that the size of those units will need to increase. Unlike stroke and cardiac care, there is no evidence that bigger is better for maternity services. In fact the reverse is true, with better outcomes being associated with smaller and medium-sized units.
- 5.22 Women locally have not traditionally chosen to go to the QEH to give birth – their clear alternative preference (to Lewisham Hospital) is for Kings and St Thomas's. Increasing the distance that women need to travel for their care has implications for both access and quality outcomes. Best practice recommends that women with a normal pregnancy should remain at home in the early stages of labour. Option 1 will have a disproportionate and adverse impact on the most vulnerable and socially excluded women resident in Lewisham. Increased journey time and cost may make them less likely to use regular antenatal care, but there is also a high risk that some women, having made a relatively difficult and long journey, will not be willing to be discharged home again, even in circumstances where best practice indicates that they should be. Distance from hospital may also discourage women who are low risk from choosing a home birth.
- 5.23 The Council is strongly in favour of retaining services that enable the majority of women to have the choice of giving birth locally and would urge the TSA to give serious consideration to the alternative proposals for maternity services that Lewisham Healthcare NHS Trust is proposing. These would offer safe high quality personalised care to 80 per cent of women with only the highest risk 20 per cent needing to deliver their babies in more specialised settings.

#### *Community Services for children*

- 5.24 The TSA's report gives insufficient detail on the future of community services for children to enable the Council to assess the opportunities or risks posed to existing partnership arrangements within the borough.

Any model of care must be designed to meet the needs of children and adults.

- 5.25 For example, existing partnership arrangements have enabled children with highly complex health needs to be supported at home by a specialist community nursing team with rapid access to in-patient support when needed. It has supported the development of vulnerable families pathways from A&E and maternity, to community support from health visiting, the Family Nurse Partnership and local GPs. These partnership arrangements have enabled early access to a range of services such as Targeted Family Support and Children's Centres that are designed to increase families' resilience, capacity and access to their local community. Ofsted described the "*robust arrangements in place for effective joint commissioning to drive forward new initiatives and ensure the most effective use of combined resources*".

#### *Mental Health*

- 5.26 The co-location of UHL with a significant mental health service in the shape of the on-site psychiatric inpatient unit allows for close working relationships with liaison psychiatrists and nurses and results in effective management and early discharge.
- 5.27 There are on average 150 people who are seen by the SLaM psychiatric liaison team based in UHL A&E. 20 per cent of these patients are admitted to the Ladywell unit. The Council is concerned that repatriating people to the Ladywell unit from other A&E sites will result in increased staff and transport costs.
- 5.28 A protocol for psychiatric inpatients at Ladywell that require emergency medical attention has been agreed between SLaM and the Hospital. This protocol ensures that those with mental health problems receive prompt medical treatment and are returned to the Ladywell Unit as soon as possible. The Council is concerned that the TSA's draft recommendations will result in patients having to travel by ambulance to another hospital where processes may not allow them to be responded to as quickly or effectively and causing them and potentially other patients unnecessary distress.

#### *Safeguarding residents*

- 5.29 Destabilising the integrated arrangements and the strong partnerships that currently exist may well jeopardise the important pathways through which some of Lewisham's most vulnerable residents can be identified and supported into a range of alternative services.
- 5.30 The A&E department provides an opportunity for the early identification of safeguarding concerns that might otherwise be overlooked or missed. Robust local arrangements are in place to ensure that where allegations or evidence of abuse comes to light, while patients or clients are under the care of Lewisham NHS healthcare Trust, they are responded to quickly and effectively.
- 5.31 The Safer Lewisham Partnership has successfully established an information-sharing protocol with staff in University Hospital Lewisham so that anybody admitted with a stab wound has their details automatically passed onto the Crime Reduction service. The patient can then be contacted to see if they require support or additional interventions. In addition, the Council supports a Drug and Alcohol triage worker on the hospital site, able to work with patients who regularly attend A&E due to drink and/or drugs and divert them from acute services to more appropriate rehabilitation and intervention services.
- 5.32 In February 2012, Ofsted's report on its inspection of Lewisham's services for Looked After Children and Safeguarding concluded "*Safeguarding outcomes for children and young people are outstanding*". Ofsted's findings acknowledge the strength of the partnership arrangements that have been developed in Lewisham.
- 5.33 The Council believes that the current arrangements that have been established to deliver a safe, co-ordinated service response to adults and children at risk would be destabilised and damaged by the removal of the A&E.

## **6. Assumptions within the report**

- 6.1 A number of assumptions employed by the TSA appear flawed and call into question the robustness of the draft recommendations. In some cases the TSA has made available insufficient information to allow for any detailed analysis.

### *Financial modelling*

- 6.2 As Frontline concluded in their report, “*It is difficult to comment in detail on the assumptions used in the TSA report as little information on the financial modelling has been released.*”
- 6.3 Frontline also note that “*The financial modelling in the TSA report is based on a 30 per cent reduction in secondary care workload resulting from the implementation of the Community Based Care Strategy. The evidence from other programmes in the UK is that realising such shifts has proved very difficult to deliver in practice. The assumptions are based on a number of small-scale pilots and there are questions about whether these can be generalised and can be extrapolated to the levels contained in the Community Based Care Strategy.*”
- 6.4 The financial viability of the proposed elective centre relies upon a level of activity that would require sub-regional agreements and does not take into account patient choice and competition.
- 6.5 The Council queries the way in which the TSA has dealt with Lewisham’s PFI. If this were considered on the same basis as the PFI costs of South London Healthcare Trust then Lewisham Healthcare NHS Trust would appear not to be in deficit.

### *Options appraisal*

- 6.6 The Council contends that the options appraisal conducted by the TSA is flawed in its methodology, inconsistent in the application of its assumptions and not compliant with HM Treasury’s “Green Book: Appraisal and Evaluation in Central Government”.
- 6.7 The TSA’s draft report and its appendices do not provide a sufficiently clear audit trail to allow the full options appraisal process to be scrutinised. There is no information as to how the possible 16,384 configurations of hospital services options was arrived at, nor any clear

definition of the how the “hurdle criteria” were defined or applied in order to enable allowed over 16,000 options to be reduced to six.

- 6.8 The TSA’s report does not demonstrate an open approach to all relevant and feasible options. For example, the report clearly states that recent changes that have improved healthcare would not be reversed. This closes down options which could provide better and more cost effective healthcare, on overly path-dependent grounds.
- 6.9 This assumption contradicts the “Green Book” which would identify the cost of making recent changes as “sunk costs” and therefore not relevant to the decision-making process. Indeed, by holding to this assumption, the TSA appears to have restricted his ability to consider solutions which are potentially better than the recent changes and could be open to the challenge of predetermination. Given the TSA’s opinion of the limitations of the changes of “A Picture of Health” as highlighted in his draft report, this appears to be an inconsistent position from which to be making recommendations.
- 6.10 Second, this assumption that recent changes will not be reversed is inconsistently applied. Whereas certain changes, for example Queen Mary’s Hospital’s not having a 24/7 acute emergency admitting service, are identified as fixed points, other activity which has improved healthcare in south east London, such as the vertical integration between Lewisham Healthcare NHS Trust and Lewisham Council’s adult social care services appear to be open for reversal.
- 6.11 The TSA states that the “*nature of the exercise...does not lend itself to a precise scoring system.*” However, the corollary of this assumption is that equivalency is implied across each of the criteria, i.e. they are all weighted the same.
- 6.12 The limitations of this assumption are compounded by the subsequent decision to rate all options equally for education and training, patient experience, and estate quality, and the advice from the Clinical Advisory Group that ‘data on current indicators would not indicate the quality of care that would be provided in the future’.
- 6.13 Such limitations reduce the differences between the options that could be considered but also imply additional weighting of the financial criteria. Such implied weighting is compounded when it is recognised that Criterion C appears to double count and therefore to double-weight

the financial impact of the options. The cumulative effect of these errors in the appraisal and weighting of options is to give primacy in the overall consideration to the calculated net present value of the Lewisham Hospital site.

- 6.14 The Council feels that the flaws identified in the options appraisal and evaluation model undermine the credibility of the TSA's draft recommendations as to the most appropriate means to resolve the problems of South London Healthcare NHS Trust. In light of this, the Council asks the TSA to re-run the options appraisal.

*Lewisham Hospital land, site and space utilisation*

- 6.15 The Council queries whether the draft recommendations are based on a realistic assessment as to whether they are deliverable.
- 6.16 As an example, the successful implementation of the TSA's preferred option would result in significant changes to the Lewisham Hospital site, including a reduction of almost 60 per cent in the size of the site, and the major refurbishment of the remaining buildings, so that the hospital becomes a centre of excellence of elective care. The TSA presumes that such changes will free up a substantial package of land for sale.
- 6.17 Frontline identified substantial problems with these proposals and with the assumptions on which they have been based. The Council feels that these problems point to a wider failure on the part of the TSA accurately to identify the risks to his preferred options, or to examine their viability with any rigour.
- 6.18 The TSA does not appear to have taken into account basic site considerations in his estimates, for example the clinical support that would be necessary to make the proposed elective centre feasible e.g. pathology, medical records etc; and the retention of an obstetric service (despite the fact that the TSA has proposed this retention as one of the options in his draft recommendations). The theatre requirements of the proposed elective centre appear to be based on optimistic and unproven working practices. Looking across the NHS, Frontline was unaware of any other NHS elective centre which has adopted or maintained the working practices proposed by the TSA. Anything less than the productivity assumed would require additional theatre space, again reducing the land available for disposal.

- 6.19 If all these issues are taken into account, an indicative assessment indicates that 25 per cent of the land currently shown for disposal would need to be retained. When considered in combination with the Council's assessment that a more realistic disposal price per hectare would be £3.3m, not £5m as suggested by the TSA, the savings that the TSA can expect to make from the site are substantially reduced.
- 6.20 Given the substantial investment that Lewisham Healthcare NHS Trust has already made in its buildings and facilities, including a refurbishment and rationalisation of its urgent care centre and adult emergency department, the Council recommends that the TSA considers fully the viability of removing provision from Lewisham Hospital and the feasibility of his intentions for an elective care centre.

## **7. Risks**

- 7.1 The scale and magnitude of the changes proposed across the seven hospital sites in south east London, and the public resources which are involved (over £3bn annually), require commensurate appraisal of the risks of implementation. This is not confined to the risks to services and to patients that flow from these recommendations (as identified above), but also includes the risk of future institutional failure if the proposed mergers and reconfigurations do not succeed.
- 7.2 Even if due allowance is made, for the speed with which these draft recommendations were produced, it nonetheless appears reckless to propose such substantial changes without evidence of a thorough risk appraisal in the report. The TSA appears neither to have undertaken any assessment of the risks contingent on the options, nor to have identified the actions that could be taken to mitigate these risks. The absence of any risk assessment by the TSA severely limits the opportunity for stakeholders, patients and the public to assess whether the recommendations are in their best interests.
- 7.3 Given that the merger of three trusts in SLHT did not succeed in creating a sustainable NHS trust, the TSA's draft recommendations fail to outline why de-merging and subsequently remerging in different configurations is likely to succeed.
- 7.4 Presumably the TSA has analysed the factors that contributed to the failure of SLHT, and the steps that would need to be taken to ensure that any new merger would avoid any repetition of these failings. Studies of failure among hospitals that have been merged suggest that their failure results from: (1) poor leadership that fails to address strategic challenges of performance and control; (2) problems with merged hospitals' internal culture and a lack of clinical engagement; (3) senior management becoming distracted by organisational project management; and (4) chronically persistent poor operational management.
- 7.5 The Council would call on the TSA to make his risk analysis available so that the Council can have confidence in the deliverability of his draft recommendations.

## **8. The legal position**

- 8.1 The Council's position is that the TSA's powers extend only to making recommendations about the future of the NHS trust to which he is appointed. For the reasons given below, it seems that this is the clear effect of statutory regime under which the TSA was appointed. The TSA does not have power to make recommendations which would affect Lewisham Healthcare NHS Trust, nor does the Secretary of State, in response to any such recommendation, have power to do so, either, under this statutory regime.
- 8.2 If that is wrong, and the TSA may make recommendations which affect an organisation, such as a different NHS trust from the trust to which he has been appointed, then any such recommendations which are of the scale and nature set out in the draft report trigger the public involvement and consultation duties in sections 242 of the National Health Service Act 2006 ("the 2006 Act"). Those are onerous obligations and have been supplemented by extensive guidance from the Secretary of State.
- 8.3 In other words, there is an entirely separate process by which significant reconfigurations of health services can lawfully be effected. It involves proposals being brought forward by the appropriate commissioning body/bodies (PCTs now, and, from April 2013 CCGs). Such changes would also trigger the involvement of local overview and scrutiny committees under the regulations made under section 244 of the 2006 Act. Those regulations are the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. The effect of these is that proposals which represent a substantial development or a substantial variation of a service are subject to consultation with the relevant Council's Overview and Scrutiny Committee (or joint committee if there are several). There is a 12-week consultation period, and the possibility of referral to the Secretary of State if the Overview and Scrutiny Committee is of the view that consultation has been inadequate, or where consultation has not taken place.
- 8.4 The Council does not understand from the draft report whether or not the TSA recognises that the draft recommendations which he makes, and which affect other NHS bodies, will, if pursued, attract such obligations. The Council would expect him, and the Secretary of State

in his eventual decision, to make clear their respective views on this point.

- 8.5 However, the way in which the draft report is expressed indicates that there may be a risk, and the Council puts it no higher than that, that the TSA will make ultra vires recommendations to the Secretary of State, and the Secretary of State may purport to implement those. The Council makes clear now that if the Secretary of State does makes a decision, without further consultation or public involvement, to implement draft recommendations of the TSA (if any) which do affect other NHS bodies, the Council will have to consider whether or not to apply for judicial review of that decision.
- 8.6 Such an application would, for reasons similar to those given by the Court of Appeal in *R (Royal Brompton and Harefield NHS Foundation Trust) v Joint Committee of Primary Care Trusts* [2012] EWCA Civ 472, be wholly premature at this stage. First, the Secretary of State, not the TSA, is the decision maker under Chapter 5A of the 2006 Act; and second, it is entirely possible that the TSA will not, in his final report, make any recommendations to the Secretary of State which are ultra vires. Indeed, it is to foreclose this risk that the Council is responding, now, to the TSA's offer to consult, and drawing the TSA's attention to this point.

*The reasons for the Council's position*

- 8.7 Chapter 5A of the 2006 Act, added by the Health Act 2009, makes provision for the Secretary of State to appoint a TSA to exercise the functions conferred by Chapter 5A. This has been referred to in many of the documents as "the unsustainable providers' regime", or "UPR". For convenience, the Council will also use the abbreviation "UPR".
- 8.8 Some of the provisions of Chapter 5A affect foundation trusts, and are not relevant here. The UPR is wholly statutory. This means that a TSA has no powers to act other than those which were conferred by Parliament in Chapter 5A. The Secretary of State is in the exactly the same position, when he decides what action to take in response to the recommendations of a TSA made when the UPR has been invoked.
- 8.9 The relevant provisions show that the TSA's powers are clearly specific to the NHS to which the TSA is appointed. The Council draws attention to 3 groups of provisions in particular. First, a TSA is appointed to

exercise the functions of the chairman and director of a particular NHS trust (section 65B). Second, an important function of a TSA appointed to a particular NHS trust is to provide the Secretary of State with a draft report “stating the action which the [TSA] recommends that the Secretary of State should take *in relation to the Trust*” (emphasis supplied); section 65F(1) of the 2006 Act; echoed in sections 65I(1) and 65K(1). Third, the consultation obligations are correspondingly narrow, and focussed on persons or bodies who have defined relationships with the NHS trust to which the TSA has been appointed (for example, sections 65F(2), and 65H).

## **9. Conclusion**

- 9.1 The Council recognises the need for change across healthcare provision and in particular recognises the pressure on acute services. There is a pressing need to address the failings of South London Healthcare Trust.
- 9.2 The TSA's draft report and recommendations have negative implications for residents of Lewisham and undermine the existing strong and effective partnership arrangements that support people locally. The TSA is asked therefore to give full and careful consideration to this response and the attached report from Frontline.

**Review of the Trust Special  
Administrator's Report on the  
Future of South London  
Healthcare NHS Trust**

**Report for**

**London Borough of Lewisham**

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## **1 Summary**

### **1.1 Context for this report**

On 30 October 2012, the Office of the Trust Special Administrator (TSA) for South London Healthcare NHS Trust published its “Draft Report”. The report has implications for NHS hospital provision across the whole of south east London, including Lewisham, and the recommendations arising from the draft report conclude that a change in service provision at Lewisham Healthcare NHS Trust is required to contribute to reversing the clinical and financial unsustainability of the three hospitals that make up South London Healthcare NHS Trust.

This is the first time that a Special Administrator has been appointed under the legislation which enacts the Regime for Unsustainable NHS Providers (UPR). This means that this is, as yet, an untested process, and one that might be thought to require adequate input from stakeholders to ensure that the right decisions are being made for the right and justifiable reasons. South London Healthcare has experienced financial problems before and these have been dealt with in a number of ways, without success. It is now recognised that there must be significant change to drive inefficiencies out and to ensure that a sustainable, high quality NHS is available to the patient population across south east London. The TSA, in his introduction to the draft review, highlights the need for a collaborative approach to change:

“Whilst the issues start with the Trust, there is a challenge across the system. This means the solutions cannot come just from within – rather they need to be developed with health and social care partners in the system to ensure long term sustainability. This means change across south east London, as was pointed out by commissioners, NHS London and the Trust itself before this process started”. (Matthew Kershaw, October 2012)

The overarching aim of the TSA report is to identify cost saving and clinically viable options for taking south east London’s healthcare forward sustainably. Frontline was asked by the London Borough of Lewisham to undertake an independent review of the report from the point of view of the people of Lewisham. It is no part of our remit to comment on the legal scope of the UPR and we do not do so. The purpose of this report, rather, is to analyse the merits of the TSA’s approach and proposals.

### **1.2 Scope of our work**

The Council is submitting its own response to the TSA and this review is intended to help inform and shape that response.

The rationale behind this review was to test several elements of the TSA’s findings and to understand how the proposed recommendations had been reached. Specifically, Frontline was asked by the London Borough of Lewisham to establish whether:

- the problem had been framed correctly (i.e. had the TSA looked at the right geographical and service areas in developing his report)
- the assumptions used in developing the options are reasonable
- an appropriate range of options has been considered
- the preferred option had been fairly chosen from the range considered
- the preferred option could be delivered

Frontline has considered the TSA report from a number of aspects:

- **clinical/service requirements** – assessing compatibility of the proposals with the five key Department of Health areas for NHS improvement, and considering the implications of the proposals for secondary, primary and community care
- **the option appraisal process** – a review of the option appraisal at the heart of the report against best practice
- **financial analysis** – reviewing the key assumptions behind the income and costs in the financial modelling
- **estates requirements** – including both the estate which needs to be retained by the NHS to deliver services into the future, and the feasibility of the disposal of surplus estate
- **patient flows/travel times** – considering the impact of the options on the population of Lewisham

The consultation period allocated for interested parties to present a response to the TSA is short and therefore the need to gather information and consensus quickly is imperative. Within a period of two weeks, we have engaged with a number of key stakeholders in Lewisham to gauge reaction to the TSA's draft proposals and to better understand the potential impact that change may have on service provision and the effectiveness of care for Lewisham and its residents.

It should be noted that in many areas of the TSA report, the evidence to support the analysis carried out by the TSA and the working groups has not been released. This lack of detail means that it is difficult to make constructive recommendations which would improve the outcomes for Lewisham from the implementation of the report. We have included recommendations where appropriate.

Our approach has concentrated on assessing the impact of the proposals on the population of the London Borough of Lewisham. We have therefore not looked at the changes proposed in the TSA report which will apply outside Lewisham, such as the feasibility of the QIPP plans for South London Healthcare NHS Trust.

### **1.3 Structure of this summary**

The following sections contain summaries of our findings under the following headings:

- a description of the **preferred option** in the TSA report

- **framing the issues in south east London** – has the TSA report covered an appropriate geographical area and range of services?
- **process underlying the TSA report** – how has the preferred option been reached?
- **delivery of the preferred option** – how feasible is the preferred option?
- **impact of the preferred option on Lewisham** – what will the impact be on the local population and institutions in Lewisham?
- **recommended steps from here** – what could be done to mitigate the risks to Lewisham?

We will demonstrate that the option appraisal has been carried out in such a way that the results are not valid, the conclusions drawn from the option appraisal cannot be backed up by clinical or estates data, and that the report should be seen as a starting point for deciding the future of healthcare in south east London, rather than providing an immediately workable solution. Lewisham Healthcare NHS Trust has put forward a local solution for healthcare in Lewisham and Greenwich involving the trust taking on Queen Elizabeth Hospital and working with stakeholders to rationalise services. We conclude that this approach is likely to lead to a better solution for healthcare within Lewisham than the proposals in the TSA report, and we recommend that the London Borough of Lewisham supports Lewisham Healthcare NHS Trust in finding a local solution for Lewisham and Greenwich, as this is more compatible with national policy and more likely to lead to improved healthcare outcomes for the people of Lewisham.

Subsequent sections of the report set out the detailed analysis underlying our findings.

#### 1.4 Description of the preferred option

The TSA's preferred option consists of:

- **community-based care**: improvements in primary care and community services, with the aim of implementing challenging demand management schemes and reducing the demand for acute services
- **emergency care**: provided from four sites for the most critically ill patients (King's College Hospital, St. Thomas' Hospital, Queen Elizabeth Hospital and Princess Royal University Hospital); urgent care provided at Lewisham University Hospital, Guy's Hospital and Queen Mary's Hospital Sidcup; specialist emergency services (such as major trauma or stroke) to be provided by King's College Hospital or St. Thomas' Hospital, depending on the service
- **maternity care**: two options are still under consideration – either to centralise maternity care in line with emergency care or to leave a "stand-alone obstetric-led delivery unit" at University Hospital Lewisham
- **elective care**: development of an elective centre for non-complex inpatient procedures at University Hospital Lewisham to serve the whole of south east London; day case procedures to be provided from all seven main hospital sites; complex procedures delivered at King's College

Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St. Thomas' Hospital; specialist procedures at Guy's Hospital, King's College Hospital and St. Thomas' Hospital; outpatients to be delivered at "a range of local locations"

## 1.5 Framing the issues in south east London

### 1.5.1 Services covered

The proposals draw a boundary around the 'system' in south east London which is very narrowly defined and does not take account of key related services – maternity services, children's services, adult social care services, elective services, mental health services and ambulance services

Removing maternity services from Lewisham would have an impact on capacity elsewhere. Local commissioners are aware that the natural patient flow from Lewisham is toward Kings' College Hospital and St Thomas' Hospital, yet there appears to have been no analysis of the magnitude of any potential impact this may have and the feasibility of increasing capacity at the surrounding maternity units. There are currently 4,000 births per annum at University Hospital Lewisham, and local modelling shows that this could rise to 5,500 births per annum within three years. If King's College Hospital and St. Thomas' Hospital take these births on, this will take them to over 7,000 births per year. It is not clear whether the capacity exists at these two hospitals for these additional births.

Children's services have not been mentioned in the report and so it does not take into account the impact that the loss of a fully-functioning admitting accident and emergency department would have on the paediatric accident and emergency services and on children's services more generally. The TSA report is silent on whether Lewisham would maintain this service. Lewisham is regarded as having one of the best paediatric services in the country (Care Quality Commission assessment). Lewisham has been rated "outstanding" by the Care Quality Commission and OFSTED for its child safeguarding (one of only five local authority areas in England with this rating). The structures and processes that underpin this excellent service have been developed over many years but could be lost overnight by the proposals.

Elective services are largely excluded from the option appraisal – only featuring at the end when the idea of centralising non-complex inpatient work at the Lewisham site is brought in.

Lewisham has a higher than average prevalence of people with mental health conditions. Excluding mental health services from the analysis means that key interactions with physical health services will be missed. This is important as there is a very strong correlation between physical and mental health, and there is a need to consider integration of the services. As an example, good care in cases of post natal depression requires integration of services – but the maternity unit proposals have focused purely on the acute point of delivery rather than the wider pathway

impact and the interaction between hospital midwives, community midwives, health visiting, primary care and mental health services.

Restricting the detailed analysis to the delivery of accident and emergency services and the associated emergency medicine means that the analysis in the report does not consider the inter-relationships of the full health system. There is a risk that implementing the preferred option may have unintended consequences on the parts of the health and social care system which were excluded from the analysis.

### *1.5.2 Geographical scope*

The TSA report looks beyond the areas covered by South London Healthcare NHS Trust (Greenwich, Bexley and Bromley) to consider the wider south east London system. Paragraph 12 of the report notes that patients from south east London also flow to other hospitals outside south east London, including to Kent (Darent Valley Hospital), Tooting (St. George's Hospital) and to Croydon (Croydon University Hospital).

No analysis has been carried out of the impact of either widening the geographical scope of the appraisal, or limiting it to South London Healthcare NHS Trust's three sites.

### *1.5.3 Rationale for including Lewisham Healthcare NHS Trust*

Lewisham Healthcare NHS Trust is currently making a small surplus and delivering good quality acute and community care to its local population. The TSA justifies including University Hospital Lewisham in the detailed analysis and proposals for south east London on the basis that the trust's current financial position is not sustainable and that by 2015/16 it will be making a £0.6m deficit (based on the TSA's re-working of the trust's financial plans), with a £3m per annum gap to the 1% surplus seen as ensuring the sustainability of the trust. This is in addition to the £74.9m deficit predicted for South London Healthcare NHS Trust.

It can be argued that Lewisham Healthcare, with a turnover of around £240m, is too small to survive in the current NHS. However, local stakeholders do not fully recognise the assumptions used by the TSA to justify this view of Lewisham Healthcare, including commissioner income growth assumptions.

## **1.6 Process underlying the TSA report**

### *1.6.1 Option appraisal*

The option appraisal used in the TSA report is not compliant with HM Treasury's "Green Book: Appraisal and Evaluation in Central Government" in a number of areas. The Green Book is widely acknowledged as the most authoritative manual on appraisal available to the wider public sector in the UK, and all Department of Health guidance on option appraisal is Green Book compliant.

The effect of the methodology employed for the option appraisal is to make the choice of the preferred option contingent on two factors:

- the assessed similarity between the clinical impacts of the options
- the financial gains from disposing of part of the Lewisham site - the other options do not contain the same level of land release

Whether these two factors hold is considered in detail in this review.

### **1.6.2 Local engagement**

While some local stakeholders were part of the option appraisal process, as they sat on the various groups convened as part of the process, this engagement process has not extended beyond this (as evidenced by local clinicians' lack of recognition of the assumptions used in the report). In order to ensure the success of changes in south east London, an extensive programme of engagement will be required.

There has been no agreement from clinicians in surrounding trusts that they would operate at the proposed elective centre at University Hospital Lewisham. Without clinical buy-in, the centre will not receive sufficient referrals to ensure its long-term financial sustainability. This has the potential to destabilise the merged Lewisham-Greenwich trust, leading to continuing long-term financial issues in south east London. It is worth noting in this context that King's College Hospital is currently building new operating theatre capacity and St. Thomas' Hospital has recently done so. Therefore these two trusts are unlikely to want to give up elective work to the new elective centre at Lewisham.

## **1.7 Delivery of the preferred option**

### **1.7.1 Demand management**

The TSA report requires a reduction in acute activity of 30%. It is expected that this will largely come via demand management in primary and community care, with the aim of reducing emergency presentations. While reducing unnecessary emergency presentations and inpatient stays should be an important element of any changes to south east London, there is concern that the assumptions contained in the case are not deliverable, due to the scale of change required. Currently, much of the community care strategy is aspirational, although the CCGs across south east London are currently working on filling out the details, and there is no evidence from elsewhere that shows that this level of change can be achieved through community-based services alone.

It is worth noting that there are already good examples of demand management occurring in Lewisham. For example, care of the elderly physicians at University Hospital Lewisham actively work with the London Borough of Lewisham and elderly patients who have been admitted as emergencies to ensure early discharge and admission avoidance in the future. This is having an impact, as evidenced by out-of-borough patients having a length of stay which is 2.7 days longer on average than

elderly Lewisham residents. Thus Lewisham would not be starting from a base of no demand management, making the 30% target even harder to achieve.

Inability to achieve the demand management required in the assumptions represents a risk to commissioners – any major shortfall in the plans will put the financial stability of the local CCGs at risk.

#### *1.7.2 Assumptions underlying the future need for accident and emergency at University Hospital Lewisham*

The TSA report states that 77% of patients who currently attend the accident and emergency department at University Hospital Lewisham could safely be treated in an urgent care centre setting (UCC), and that therefore the change in status of the department at Lewisham would have a relatively small impact on healthcare in the borough. The assumptions that the 77% figure are based on are disputed locally, with points made including:

- the available skill mix at a standalone UCC would not be the same as for the current centre which means that some patients who are not now admitted would require a full emergency department response
- it does not take into account the patients admitted to the Rapid Assessment and Treatment Unit under the care of the emergency department for periods of up to 48 hours or the 1,498 paediatric attendances who require admission to the Short Stay Unit in the children's emergency department
- it assumes that, under the future configuration, paramedics, ambulance technicians and GPs will make the same decisions (about the appropriate pathway for the patient) before they are seen in the emergency department as are currently being made in the department – this is flawed because the very reason they are sent to the emergency department is so that the emergency practitioners can make these decisions

#### *1.7.3 Continuity of care*

The proposed model of service delivery would mean that patients are passed between providers more frequently than currently:

- in emergency medicine, more serious Lewisham cases would be handled at an emergency department outside the borough, requiring cross-boundary work during the discharge phase of their care
- in non-complex elective medicine, the patient will probably receive outpatient care near their home, travelling into Lewisham for the procedure, which will require either cross-organisational communication between consultants, or medics travelling around south east London to deliver continuous care
- depending on the maternity option adopted, Lewisham women may find that they receive their ante and post natal care locally but have to travel

for the delivery, requiring communication between the different parts of the pathway

While cross-organisational or cross-boundary communication is not impossible, experience in health and social care has shown that working across boundaries is harder than working locally. In order to ensure that continuity of care for Lewisham patients does not suffer, the NHS and social services will need to devote considerably more resources to ensuring communication occurs. It is not clear that any allowance for these resources has been made in the analysis.

#### *1.7.4 Patient flows*

More complex emergency requirements for Lewisham residents will need to be catered for outside the borough. Where an ambulance is involved, re-routing the patient will not be problematic. However, some emergency patients reach hospital without using an ambulance (for example, where they deteriorate after arriving at the accident and emergency department). These will choose where to present, and based on the patient flow data made available to us, they are likely to choose to go into inner London, e.g. to King's College Hospital, rather than to Queen Elizabeth Hospital at Woolwich.

In order to change the usual patient flow pattern, the CCG, Lewisham Healthcare NHS Trust and the local authority will need to engage widely across the borough, ensuring GPs and the public understand that they should now use the Queen Elizabeth Hospital. This will not be a quick process and experience elsewhere has shown that historic flow patterns are extremely difficult to change.

Similarly, if maternity services are not provided at University Hospital Lewisham, the natural flow will be to King's College Hospital or Guy's and St. Thomas' Hospitals. This will require expansions to the maternity units at those hospitals, and it is not clear that this cost has been included in the analysis.

#### *1.7.5 The elective care model*

Concern has been expressed about the use of the South West London Elective Orthopaedic Centre (SWLEOC) in Epsom as a best practice comparator for the proposed elective centre. There are some problems with the suitability of this as a reference site, as it:

- covers only orthopaedic activity
- is much smaller than the proposed Lewisham centre
- is in an area where the demographics and case mix are totally different to south east London
- does not have so many providers in the immediate vicinity as the seven near Lewisham

There are also questions around how Lewisham Healthcare NHS Trust will get sign up from commissioners, providers and clinicians in other boroughs, especially where other providers are expanding, and in context of patient choice and competition.

### *1.7.6 Estates implications*

The preferred option requires major changes at the University Hospital Lewisham site:

- withdrawal from the front part of the site with consolidation of the services in the newer buildings at the back of the site (including the PFI unit)
- disposal of the freed-up parts of the site to reduce the fixed running costs of the Lewisham site by approximately 65%
- development of an elective unit capable of handling 44,000 procedures per annum in parts of the Riverside and Ravensbourne Units

Analysis of the feasibility of delivering the estates changes at Lewisham has revealed a number of areas where concerns exist around the deliverability of the plans:

- there are planning restrictions relating to the site which limit the development potential
- the area of the site which is likely to be surplus may be overestimated due to:
  - a need for pedestrian and vehicle access from the High Street
  - space requirements for the obstetric service (if it remains on site)
  - some doubt over whether sufficient space is planned for clinical and non-clinical support services
- the land sale receipts may be lower than forecast because:
  - the disposal area will be smaller
  - the planning restrictions will reduce the land values
- the potential savings in fixed costs will be limited by the reduction in the area for disposal
- the timescale for the redevelopment has not been substantiated

## **1.8 Impact of the TSA's preferred option on Lewisham**

### *1.8.1 Impact on population health*

The proposed changes and their impact on Lewisham are difficult to defend as being a response to local needs. There is recognition, locally, that there needs to be some restructuring of services in south east London. However, local patient needs require further consideration. The proposals are not aligned with the Lewisham Joint Strategic Needs Assessment, they are not focused on prioritising local resources so as to maximise the health improvement impact for Lewisham, they focus on single points of delivery rather than whole pathways, and they will lead to fragmentation that is not insurmountable but will require more resources to overcome. The proposals will also dismantle arrangements that have led to good progress, for example around maternity and care of the elderly.

Lewisham has done good work over recent years in integrating care within the borough. This is illustrated by the “Outstanding” score given to the child safeguarding services, which include a dedicated social worker within the accident and emergency department at University Hospital Lewisham. This is leading to gains in well-being for the population of Lewisham which could be lost when the existing networks are changed.

#### *1.8.2 Impact on patient and carer travel*

The TSA report shows that removing the accident and emergency facility at Lewisham will increase travel time on all modes of transport by more than 50% for Lewisham residents. This increase will impact considerably on patients, carers and visitors.

#### *1.8.3 Impact on the CCG, Lewisham Healthcare NHS Trust and the London Borough of Lewisham*

The implications of a poor implementation of the proposals will be an increase in the risk of financial instability either for the commissioners or for the providers in Lewisham. This could manifest in the need for more mergers locally within a relatively short time, either between NHS providers or NHS commissioners. Further disruption is likely to impact detrimentally on the health and wellbeing of Lewisham residents.

### **1.9 Recommended steps from here**

#### *1.9.1 Lewisham Healthcare NHS Trust*

Lewisham Healthcare NHS Trust has expressed an interest in taking on Queen Elizabeth Hospital. However, the challenges in Lewisham and Greenwich can be better met by allowing a greater degree of freedom to local initiatives to get clinical buy-in to the process and facilitate a greater sense of ownership for the change than the TSA Report proposals allow. The trust recognises that this is not a way of “ducking” the difficult issues – services will need to be rationalised across the two sites within a relatively short period.

#### *1.9.2 Clinical planning*

The TSA report rightly highlights that change is required in the commissioning and delivery of health and social care services in south east London, in order to deliver better outcomes within a tighter financial envelope. However, to deliver sustainable change, plans need to be developed from the bottom up, with full involvement of all partners locally. Within the context of bringing together Lewisham Healthcare NHS Trust and the Queen Elizabeth Hospital, and in partnership with commissioners, social services and primary and secondary care clinicians, there will be opportunities to better design services around the needs of the local population, so as to reduce demand, improve quality and make efficiencies. Such plans should build on the

strength of existing arrangements, but also include a thorough examination of service reconfiguration options across the Lewisham and Queen Elizabeth sites.

It is recommended that local organisations in Lewisham and Greenwich are given the go-ahead to make the local plans as necessary, without being constrained to the recommendations made in the TSA report. Lewisham and Greenwich CCGs should be provided with a clear financial envelope and asked to provide their commissioning plans as soon as possible.

### 1.9.3 Estates planning

Before any decisions relating to the University Hospital Lewisham site are made, we recommend that a detailed analysis of its estate is carried out, including discussions with the planning authorities in Lewisham, to establish realistic aims for any site changes or disposals.

In terms of capacity planning, we believe it would be prudent to develop a detailed activity model for elective cases across south east London. This, together with robust forecasts for growth, should allow for 'variations' to the proposed elective centre to be developed. These 'variations' should seek to review the potential for pre-operative assessment and post-operative outpatient work to be undertaken either in new community hospitals or the hospital closest to where the patient lives. Establishing robust care pathways for elective work should ensure the efficient use of existing facilities and, wherever possible, reduce the impact of significant/unnecessary work flows to the proposed elective centre.

## 1.10 Conclusions

The TSA report makes a good start at unravelling the long-standing issues in south east London. All of the stakeholders we spoke to agreed that the current situation is unsustainable and that radical change is required. However, issues with the way the analysis was framed and carried out, partly due to the limited time available to the TSA to carry out the work, means that additional work is required to produce plans which will:

- solve the long-standing financial issues in south east London
- ensure all of the population of south east London receive safe, high quality clinical and social care on a sustainable basis
- can be implemented within a reasonable timescale
- do not expose any part of the health and social care sector to unreasonable amounts of risk of failure in the future

Our report sets out a number of areas where additional work is required, and recommends some next steps for the TSA, including allowing Lewisham Healthcare NHS Trust to work up its local solution for healthcare in Lewisham and Greenwich.

## 2 Services, Quality and Improvement

### 2.1 Policy context

In this section we consider some of the key elements of health and social care policy in the UK that are relevant to the TSA report, providing a frame of reference for examining its recommendations.

#### 2.1.1 Integrated and personalised care

This government has placed a sustained emphasis on integration as a key priority within health and social care. This is underlined in the recent White Paper *Caring for Our Future: Reforming Care and Support* which says:

"People often feel 'bounced around' and have to fight the system to have the joined-up health, care and support they need....Fragmented health, housing, care and support are letting people down. A failure to join up also means that taxpayers' money is not used as effectively as possible, and can lead to increased costs for the NHS."<sup>1</sup>

In short, fragmented services lead to poor experience and outcomes and are a poor use of taxpayers' money.

Research by National Voices found that a lack of joined up care is the biggest frustration for patients, service users and carers, and they concluded that:

"achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety" (National Voices 2011).

Quality and safety are therefore not just about what happens at any particular point of delivery of a health or social care service, but what happens across the whole of the pathway.

Research by the King's Fund underlines the need for integrated services, particularly for older people and those with complex needs:

"The ageing population and increased prevalence of chronic diseases require a strong re-orientation away from the current emphasis on acute care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated."<sup>2</sup>

"To achieve integrated care, those involved with planning and providing services must impose the user's perspective as the organising principle of service delivery"<sup>3</sup>

<sup>1</sup> Department of Health (2012) Caring for our future

<sup>2</sup> Kings Fund (2012) Integrated care for patients and populations: Improving outcomes by working together

<sup>3</sup>Lloyd and Wait 2005; Shaw et al 2011 – in Kings Fund 2012, cited above

The policy direction is therefore away from making decisions about services that are predicated on the needs of the system – but on designing the system around the needs of the individual. Ultimately this is seen as both good for the individual and good for the system.

### *2.1.2 Localised, clinically led commissioning*

The DH White Paper Equity and Excellence (2010) set out the intention to devolve decision-making to frontline health professionals and to empower them to commission and deliver services that best meet the needs of patients.

“...we will empower health professionals. Doctors and nurses must be able to use their professional judgement about what is right for patients. We will support this by giving frontline staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients.”<sup>4</sup>

A key point to note here is the emphasis on bottom up rather than top down solutions – thereby increasing ownership of decision-making by professionals and patients. One of the mechanisms intended to support this aim is the development of GP consortia (now clinical commissioning groups), who should have the local freedom to commission services that best meet the needs of their patients, through redesigning pathways in partnership with secondary care:

“In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning services to local consortia of GP practices...GP consortia will need to have sufficient freedoms to use resources in ways that achieve the best and most cost-efficient outcomes for patients....Commissioning by GP consortia will mean that the redesign of patient pathways and local services is always clinically-led and based on more effective dialogue and partnership with hospital specialists. It will bring together responsibility for clinical decisions and for the financial consequences of these decisions.”<sup>5</sup>

The policy direction is therefore towards more locally focused, clinically-led commissioning of services that is driven from the bottom up rather than the top down.

### *2.1.3 The QIPP challenge*

Meeting the Quality, Innovation, Productivity and Prevention (QIPP) challenge remains central to the government's aspirations for the health service. QIPP is described as:

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<sup>4</sup> Department of Health (2010) Equity and Excellence: Liberating the NHS

<sup>5</sup> Department of Health (2010) Equity and Excellence: Liberating the NHS

"a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector. It will improve the quality of care the NHS delivers while making up to £20billion of efficiency savings by 2014-15, which will be reinvested in frontline care."

There are three important elements to the stated policy aims of QIPP which can be drawn out of this statement:

- it must be based on full and wide involvement of all partners
- it must improve quality of care as well as making savings
- that it must strengthen frontline care

In other words, maintaining the balance between the elements of QIPP is considered to be very important. If the focus sways more towards one of the elements to the detriment of another, the result is an unbalanced approach and solutions that may not fit the aspirations for both quality improvement and financial savings.

In reality, because of the current financial climate in the NHS, the key driver behind QIPP has often become making financial savings through improved productivity. But this should not detract from the underlying principle that the best models of care deliver both high quality and high productivity simultaneously.

It is helpful to think about the quality component of QIPP in terms of three key dimensions as summarised below (originally proposed by Lord Darzi):

**Figure 1: Three dimensions of quality**



When achieved together, these three dimensions result in a service that we can define as high quality.

Research points to a correlation between QIPP and delivering integrated services, as highlighted by the King's Fund:

"If executed well, moving towards a new model of integrated care will help to create the foundations for sustainable delivery against the quality,

innovation, prevention and productivity (QIPP) challenge in the longer term” (King’s Fund, 2012)

This is because so much of the QIPP challenge is predicated on taking a whole-system approach and streamlining pathways across organisations in the system: it is seen as the only way to generate sustainable improvement on the scale required.

#### 2.1.4 Priorities for NHS improvement

The government has set out new directions and structures for the NHS. Key themes are that the NHS should improve outcomes and the patient experience. There is emphasis on meeting patient need through improved communication: “No decision about me without me”.

The NHS Mandate reiterated the Government's commitment to an NHS that remains “comprehensive and universal....and that is able to meet patients' needs and expectations now and in the future.”

The NHS Mandate is structured around five key areas for improvement (illustrated in the figure below):

**Figure 2: The five key areas for NHS improvement in the NHS Mandate**



These areas point to some clear duties for commissioners - they must seek to use the funding for local populations to advance these aims:

“Through the mandate, the NHS will be measured for the first time, by how well it achieves the things that really matter to people”.

Against this policy background we now explore the local context of health and social care needs and services in Lewisham.

## 2.2 Local context

This section examines the local context in Lewisham, providing a frame of reference for examining the extent to which the TSA proposals have been developed to meet the health and social care needs of the local population.

### 2.2.1 *The health and social care needs of the people of Lewisham*

A review of the Joint Strategic Needs Assessment (JSNA) for Lewisham reveals the following key demographic features:

- Lewisham's population of about 270,000 people is relatively young, with one in four residents aged under 19 years; the population aged 60 years and over represents one in seven people in the borough (contrasted with one in five in England overall)
- between 2010 and 2015 the population is expected to grow by 11,000, or 4%
- Lewisham is the 15th most ethnically diverse local authority in England, and two out of every five residents are from a black or ethnic minority background
- live births to Lewisham residents have risen annually in the last few years, and this is expected to continue, though at a slower rate
- Lewisham is the 31st most deprived Local Authority in England, and relative to the rest of the country Lewisham's deprivation is increasing
- common mental illnesses are estimated to afflict 19.8% of Lewisham's population at any one time; this prevalence is higher than London and England with 18.2% and 16.6% respectively

In summary, Lewisham has a relatively young and ethnically diverse population, with higher than average levels of deprivation and prevalence of mental health conditions, and an increasing birth rate. This presents particular challenges in relation to addressing health inequalities, and the pressures on maternity services, services for children and young people, and mental health services.

A brief review of the needs of the people of Lewisham against the five key areas for improvement set out in the NHS Mandate highlights the following:

#### **Helping people live longer**

Lewisham has some very serious challenges in improving premature mortality.

The difference in life expectancy at birth between Lewisham and more affluent London neighbourhoods is stark. On average, a man in Lewisham Central ward lives for 70.8 years. In the Queen's Gate ward, in the borough of Kensington and Chelsea, this figure is 88.3 years, almost 17.5 years more. The national average lies in between these two extremes, with the average male expected to live 78.1 years.

The JSNA provides some very clear evidence on mortality, based on the most recent data:

- during the period 2007-9 premature mortality from cancer in Lewisham was significantly higher than in England as a whole for males and there was no improvement in premature mortality between 2001 and 2009
- for 2007-9 premature mortality from circulatory diseases was 26 per cent higher for males than in England and 38 per cent higher for females: "Cardiovascular disease is the main contributor to the life expectancy gap between Lewisham and England. It makes up a greater proportion of the gap for Lewisham than for other spearhead areas, especially in women"
- mortality from chronic obstructive pulmonary disease (COPD) is higher in Lewisham; COPD is the third leading cause of death in Lewisham and is responsible for significant numbers of emergency admissions
- mortality from heart failure is also higher in Lewisham

Lewisham therefore has significant concerns about premature mortality. In terms of the NHS Mandate, future prioritisation of resources and commissioning of services must be such that it provides a coherent approach towards reducing premature mortality.

### **Helping people manage their on-going physical and mental health conditions**

The JSNA shows that Lewisham has high levels of longer-term conditions, especially COPD, diabetes and heart failure. These results are particularly striking as Lewisham has a relatively young population and the high prevalence cannot be mainly attributed to the usual cause of population aging. Lewisham also has high levels of childhood obesity which is a marker for risk factors in the future.

The need in Lewisham is for programmes which will give timely help to people who already have long term conditions while strengthening prevention in the future so that the young population of Lewisham does not suffer from continuing high rates of long term illness.

### **Helping people recover from episodes of ill health or injury**

Many people in Lewisham face the challenge of securing or retaining employment. The recession has increased deep-lying problems of narrowing opportunities in the labour market for lower skills and older skills. It is vital that services should offer rehabilitation in order to promote speedy recovery. For intensive support local access is important.

### **Ensuring people experience better care**

Like all NHS services those in Lewisham are seeking to be more personal and responsive. Such aims require stability for teams in order to develop strong

relationships with local patient groups. This is extremely critical in an ethnically diverse area such as Lewisham, where 187 active languages are spoken.

It also requires development of new kinds of communication involving remote monitoring and telehealth. Services all over the UK now face a challenge of redesign in order to use new technologies and to deliver more and different service for lower cost.

Commissioners and providers in Lewisham face a challenge of adapting care to meet local needs. Lewisham has already made progress in improving experience as recent reports by the CQC both for the Trust and for joint services show.

### **Providing safe care**

Lewisham has an excellent record in this domain, both in children's services and in health services for adults. Recent examples are the highly positive OFSTED/CQC report on safeguarding, and University Hospital Lewisham's excellent performance on maintaining low levels of hospital acquired infection.

#### *2.2.2 Existing health and social care services and performance*

There are good and developing relationships between primary, secondary, and community health services and social services. Lewisham has a range of teams which have shown that they can develop services to meet local needs. In particular, Lewisham has a good record in promoting integrated care. The emphasis has been on joint management between the PCT and local government to deliver programmes. There has been steady progress in key areas. For example OFSTED and the Care Quality Commission recently rated Lewisham's services for safeguarding children as "outstanding." Lewisham has already been a pioneer in joint commissioning.

Lewisham Healthcare NHS Trust has a good track record over the last 5 years of embracing clinical change, and clinicians and managers have developed an improved range of services which are securing strong approval from regulators and attracting choice from patients. There have been significant improvements in maternity services since the combination began of a midwifery-led unit with obstetric cover. Previous assessments of the service had revealed that the experience of mothers giving birth at Lewisham was relatively poor. This has been completely turned around and maternity services are now delivering a good experience and this is reflected both in patient satisfaction surveys and in increasing demand for the service through choice.

Meanwhile, accident and emergency services in Lewisham are performing well, with the department achieving clinical quality indicators and consistently exceeding the 4-hour national standard:

- 98.7% of patients seen within 4 hours in 2009/10 (against a standard of 98%)

- 98.2% in 2010/11 and 96.4% in 2011/12 (against a revised standard of 95%)

If the TSA recommendations are not implemented, the future for health and social care in Lewisham will be based on the real opportunities to develop services further, ensuring close alignment to local need through joint working between health and social care commissioners. As noted above, Department of Health policy stresses the development of integration and of shared budgets. Lewisham already has great experience in these areas and the natural course of development is to build on these strengths for improving services for an inner city population. Lewisham Healthcare NHS Trust is keen to explore the opportunity of forming a joint organisation with the Queen Elizabeth Hospital in Greenwich.

## **2.3 Critique of the TSA proposals for services**

### *2.3.1 The TSA report and Lewisham*

The TSA report was commissioned to resolve the financial problems of South London Healthcare NHS Trust in a way that would deliver a “clinically and financially sustainable future for the population served by South London Healthcare NHS Trust and the south London strategic change programmes across south east London, none of which have produced sustainable change”. The proposed solutions to these problems have taken a different approach from the organisation-specific approach used in the past. Consequently the solutions are system-wide and affect most of the healthcare providers in the region. Lewisham Healthcare NHS Trust, being on the border of the South London Healthcare territory, has several proposals for alteration of clinical services, absorbing some from the South London Healthcare NHS Trust but also losing some clinical services to other providers in the region.

### *2.3.2 Alignment of the TSA proposals with national health and social care policy*

#### **Integration**

As noted in section 2.1.1, integration in essence means planning and delivering services around the needs of the individual rather than around organisations in the system. The TSA proposals are essentially system-driven and do not align with government policy on integration in a number of ways:

- they focus on organisational structures and performance (top down) rather than on the needs of the population (bottom up)
- they draw a boundary around the ‘system’ which is very narrowly defined and does not take account key related services – children’s services, adult social care services, mental health services and transport being striking examples
- they will lead to the dispersal of patient flows away from Lewisham to a set of other hospitals in the vicinity, damaging the strong relationships and ways of working on the ground that are essential to delivering continuity of care throughout the whole pathway – this is particularly pertinent in

relation to older people, patients with long term conditions, and the safeguarding of children and vulnerable adults

### **Localised, clinically-led commissioning**

The TSA proposals go against the grain of empowering local commissioners to commission pathways rather than imposing top down solutions. The clear policy direction is about bottom-up commissioning based on local need, and for clinicians to be driving this process based on what is best for patients and for the health needs of the local population.

### **QIPP**

Each of the elements of QIPP is evident within the TSA proposals. For example, from a quality perspective a key element of the rationale for moving to four accident and emergency departments rather than five is the expectation that this will increase the availability of 24-hour-a-day, seven-day-a-week consultant cover. Innovative approaches are mentioned as part of the community-based care strategy that underpins the report, and will be essential if the level of benchmarked efficiency savings is to be achieved. Preventing people from attending hospital based services unnecessarily is a key component of the community-based care strategy. Productivity is the key driver behind the report – with the need to make significant savings at South London Healthcare.

However a balance is not maintained in each of the QIPP elements throughout the TSA option appraisal process, and criteria within each of these elements are not applied consistently.

In relation to the quality dimension, quality of care is listed as criterion A in the option appraisal process, and is said to incorporate clinical effectiveness, patient experience and estate quality. A set of quality criteria is agreed and applied, but there are two fundamental problems with the way these have been applied:

- a very secondary-care-centric view of quality drives the process – meaning that the wider implications for the impact of the proposals on the quality of the whole of the pathway are not adequately considered
- when it comes to decision making between the three options, consideration of quality is essentially put to one side: “the Clinical Advisory Group noted that it would be difficult to empirically prove that one hospital in its entirety would have a higher overall quality of care than another. The variation by particular service line or dimension of quality was too high”

Meanwhile, the area of prevention is not adequately developed within the TSA proposals. The solution proposed is about top-down organisational change rather than managing demand from the bottom up. Taking capacity out of the system without having in place the required changes on the demand side could present substantial challenges to remaining services and risks to patients. The report is

predicated on the delivery of reductions in demand through the community-based care strategy, but as yet there is a lack of detail on how the reductions in hospital activity and associated savings will be delivered in practice.

### **Priorities for NHS Improvement**

Three of the five dimensions of NHS Improvement – better management of long-term conditions, better rehabilitation and recovery, and better patient experience – are heavily dependent on having strong patient pathways in place, with excellent multi-agency working to deliver seamless care across the pathway. By requiring current arrangements to be re-formed across borough boundaries, the TSA proposals will hinder rather than help the delivery of these objectives. The health and social care partners in Lewisham have invested considerable energy in improving the integration of services. Safeguarding is a good area to probe to see whether this is working well in practice – because it is so dependent on effective multi-agency working. OFSTED/CQC rated Lewisham as outstanding in this area, one of only five areas in the country to achieve the highest rating.

Meanwhile, the ‘helping people live longer’ improvement domain is absolutely critical for the people of Lewisham, as highlighted by the JSNA. But to address this area of improvement requires starting with the JSNA, then developing programmes and prioritising resources in such a way that will have the most impact in relation to the identified needs. The TSA proposals are in direct contradiction to this policy objective – because they are driven by the need to turn around an organisation rather than turn around the long-term health prospects for the people of Lewisham.

This is explored further in the following section.

#### *2.3.3 Alignment of the TSA proposals with the health needs of Lewisham*

The starting point for making changes to health and social care services in Lewisham should be “what will be best for the health and wellbeing of the people of Lewisham?” rather than “how can we resolve the problems at South London Healthcare?”.

The TSA proposals cannot be justified as a prudent and effective use of the funding and health resources available to Lewisham. As summarised above, the government has set out its aims in relation to the integration of services, the commissioning of services, QIPP and the five improvement areas in the NHS Mandate. In pursuit of short-term financial objectives these aims have been completely ignored. The proposals set out by the TSA are a top-down solution driven by the short-term financial needs of acute trusts. They cannot be justified in terms of a responsible use of resources to meet local needs.

This is apparent when the TSA report is considered in light of some of the key attributes of the Lewisham population:

- **it has a high and increasing birth rate** – and yet the proposals are to remove or downgrade maternity services, without clarity about where and how additional capacity will be put into the system to deal with this
- **it has a young population** – and yet children and young people are not specifically mentioned in the report, even though the proposals have clear implications for them
- **it has an ethnically diverse and transient population** – highlighting the need for extremely strong integration of services, and yet the TSA proposals cut against this
- **it has higher than average prevalence of mental health conditions** – and yet mental health is not covered by the report, even though there is a very strong correlation between physical and mental health, and the need for integration between these services is paramount

Good progress has been made in improving the performance of maternity and accident and emergency services in Lewisham through investment and service redesign. The proposals do not provide any evidence that it is in the best interests of the short, medium, or long-term health prospects of the people of Lewisham to dismantle these arrangements. The direction of government policy is that power is increasingly being given to localised commissioners to prioritise and channel resources to commission services to best meet the needs of their local population. The TSA proposals have therefore been developed in a way that runs in direct contradiction to the government's own policy agenda in this respect.

#### *2.3.4 Examining the assumptions on which the TSA proposals are based*

##### **Emergency and urgent care**

The TSA report assumes that 77% of patients currently seen in the emergency department (ED) could be seen in the urgent care centre (UCC) in future, and therefore that 23% of patients require admission, specialist treatment or referral to a tertiary centre. This assumption is flawed for the following reasons:

- the figure has been generated purely from existing data rather than carrying out predictive modelling based on assumptions about the changed service configuration
- the available skill mix at a standalone UCC would not be the same as for the current centre:
  - patients are currently seen by an integrated department consisting of emergency nurse practitioners (ENPs), GPs and emergency department (ED) doctors, with ENPs sometimes using ED doctors for advice and decision-making input
  - therefore even if patients are seen by an ENP it may not necessarily be the case that they could be seen by an ENP in a standalone centre
- it does not take into account the approximately 6,036 patients per annum admitted to the Rapid Assessment and Treatment Unit under the care of

- the ED for periods of up to 48 hours or the 1,498 paediatric attendances who require admission to the Short stay Unit in the children's ED
- it assumes that under the future configuration paramedics, ambulance technicians and GPs will make the same decisions about the appropriate pathway for the patient before they are seen in the ED as are currently being made within the ED – this is flawed because the very reason they are sent to the ED is so that the ED can make these decisions

The report also assumes that the ED receives on average two 'blue light' ambulance attendances per day currently. The clinical team in the ED challenge this figure, and also points out that it does not take account of the considerable number of patients admitted through other areas of the ED who subsequently deteriorate and require transfer to the resuscitation room. The ED has supplied data showing that a daily average of 10-11 patients are being admitted to the resuscitation room – which is a truer indication of the number that would need to be transferred to a neighbouring ED by blue light.

A broader issue here is that the data, and the interpretation of the data, presented in the TSA report are not recognised by the local clinical team at the ED at Lewisham. This raises questions about the extent to which clinicians working on the ground in the areas that are affected by the TSA proposals have been involved in the review, option generation and option appraisal process. For example, errors in assumptions made in the TSA report which are discussed elsewhere in this review would have been avoided through fully involving clinicians working on the ground throughout the process. The lack of clinical involvement this points to also calls into question the extent to which the proposals have been robustly tested from a clinical safety and outcomes perspective.

### **Maternity services**

The TSA report implicitly assumes that there will be sufficient capacity at surrounding maternity units to handle the births that are dispersed from Lewisham.

Analysis from the JSNA highlights that, based on historical trends, the majority of women are likely to choose Guy's and St Thomas's Hospitals, King's College Hospital, and to a lesser extent the existing South London Healthcare hospitals:

"The majority of births to Lewisham women took place in University Hospital Lewisham (UHL), but there is clear effect of proximity on choice of provider hospital. Women who live in North Lewisham (Brockley, Evelyn, New Cross and Telegraph Hill wards) tended to choose Guy's and St Thomas's Hospitals, and a large proportion of women from Crofton Park, Forest Hill Perry Vale and Sydenham gave birth at King's College Hospital (KCH). A smaller number of women, mostly from South Lewisham (Downham, Bellingham, Grove Park, and Whitefoot wards) and Blackheath gave birth at South London Hospitals."

This is confirmed by those who understand maternity services in Lewisham well, who believe only small numbers of mothers will choose to give birth at Queen Elizabeth Hospital.

The TSA report does not supply evidence around how capacity for births will be increased at surrounding units, and whether it is feasible to do so (see section 2.3.5 below).

### **Elective surgery**

Two key assumptions underpin the proposals regarding an elective care centre:

- that it will be possible to create physical capacity for the centre on the Lewisham site
- that commissioners and providers in other parts of south east London will agree to treat their patients at the centre

The first of these is examined in the estates section of this report. The second is a significant assumption and will require agreements to be made and enacted across south east London. In a context of choice and competition, this seems unlikely, and in the time frame required to build the elective centre other hospitals would be continuing to establish and build on their existing elective capacity. Upon agreement from other partners being reached, and the centre being opened, the result would be less elective capacity being required at other hospital sites. This is in a context where other hospitals are increasing their surgical capacity – for example King's College Hospital is in the process of building new operating theatres, and St Thomas' Hospital has recently done so.

South West London Elective Orthopaedic Centre (SWLEOC) in Epsom is referred to as a best practice comparator for the proposed elective centre. There are some problems with the suitability of this as a reference site as SWLEOC:

- covers only orthopaedic activity, whereas what is being proposed in Lewisham would cover a broader range of elective activity
- is much smaller than the proposed Lewisham centre
- is in an area where the demographics and case mix are totally different to south east London
- does not have so many providers in the immediate vicinity as the seven near Lewisham

Therefore it would be risky to assume, without further evidence, that the proposed elective centre at Lewisham would develop along similar lines or achieve comparable results to SWLEOC.

### **Community based care**

The TSA report assumes that the Community Based Care Strategy (CBCS) will be delivered and that therefore the anticipated QIPP savings will be realised.

The financial modelling in the TSA report is based on a 30% reduction in secondary care workload resulting from implementation of the CBCS. The evidence from other programmes in the UK is that such shifts have proved very difficult to deliver in practice. The assumptions are based on a number of small-scale pilots and there are questions about whether these can be generalised, and can be extrapolated to the levels contained in the CBCS.

Given that Lewisham Healthcare NHS Trust is now an integrated provider of acute and community services, a large proportion of the change would involve internally moving resources around the trust – with less staff based in hospital and more in the community. The trust has made good progress in this area already on the COPD pathway, but is sceptical about its ability to make changes to reduce admissions of the order of magnitude proposed by the CBCS in other areas. If anything, it is likely that should the TSA proposals be adopted, it would make this more difficult, for two key reasons:

- the fragmentation of pathways in Lewisham as a result of considerably more medical patients being treated out of borough, therefore making it more difficult to work right across the pathway to avoid admission and readmission
- the merger between Lewisham and Queen Elizabeth Hospital would take significant management time and attention, with a major focus on improving the quality and efficiency of hospital-based services at the Queen Elizabeth site, and could potentially take focus away from the required changes in community services

## **Integration**

Under the TSA option appraisal process, one of the contributing factors to Lewisham being selected for downgrading to an urgent care centre is because it is said to have poorer levels of integration than Princess Royal University Hospital or Queen Elizabeth Hospital (TSA report, Appendix E, paragraph 46).

This assumption is flawed for the following reasons:

- only looking at average non-elective length of stay and delayed discharge does not give a full and rounded assessment of the quality of integration of services in an area – for example in Lewisham other indicators of strong integration have been ignored
- average length of stay in itself, without supporting analysis, is a very poor indicator because it does not reveal the spread or variation in the data – which is absolutely critical in understanding the drivers for long length of stay – for example in Lewisham the average length of stay is 2.7 days longer for out-of-borough patients
- only looking at non-elective length of stay as a whole does not highlight where the real problems lies – analysis at speciality and HRG level is required and this analysis is not provided in the report

These weaknesses in the assumptions used in the TSA report call into question whether the best solution for service configuration has been arrived at. We now consider the feasibility of implementing the proposals from a service perspective (estates and financial feasibility are covered in other sections of this report).

### *2.3.5 Feasibility of the TSA proposals from a service perspective*

Under the ‘dispersal model’ for maternity services presented in the report, the approximately 4,000 mothers currently giving birth at Lewisham (estimated to rise to 5,500 in the next 2-3 years) would be dispersed to other hospitals.

As noted above, those responsible for commissioning and providing maternity services in the area consider that the largest flows of patients will be to St Thomas’ Hospital and King’s College Hospital, with other smaller flows to other surrounding hospitals, and this is backed up by historical patterns as summarised in the JSNA.

The TSA report does not provide any supporting analysis regarding the feasibility of this model from a capacity perspective. No modelling or evidence is provided regarding how the demand at other hospitals will be affected by this service change, combined with additional demand pressures on these units anyway as a result of increasing birth rates in some areas. Nor is evidence provided regarding whether it is feasible to increase capacity at the other hospitals to meet this increased demand.

Regarding the elective care centre, there are some key issues that call into question the feasibility of what is being proposed:

- the case mix is not specified and therefore the necessity for on-site supporting services cannot be assessed
- if 80% of the patients are to attend from out-of-area then vehicular access becomes an issue
- there is no agreement from clinicians in surrounding trusts that they would operate at this proposed centre
- a centre on the scale proposed - in effect the largest in the UK - would need extensive funding and development of new staff teams, and at best it would take years to develop for a service where most of the patients would in fact come from outside the borough

The uncertainty the proposals would generate around the implications for accident and emergency, maternity and elective services would also affect existing services which for the most part are running well and in a position to attract high quality staff teams. They would be seen as having little long-term future and would soon start to lose staff.

Regarding community-based care, much of the strategy is aspirational and there is a lack of detail on how it will be delivered in practice. As noted above, the implementation of the TSA’s proposals is largely based on the success of moving

patients into the community, something that has proved difficult in other parts of the country.

In summary, the developments are at high risk of not proving feasible: and with this has to be taken into account the very real losses of existing services.

## 2.4 Implications of the TSA proposals for services in Lewisham

### 2.4.1 Emergency and urgent care services

The loss of a fully-functioning accident and emergency department would have several knock-on effects:

- the loss of an integrated approach to the care of patients with complex needs, particularly older people and those with long-term conditions
- whilst children have not been mentioned in the report the loss of a fully-functioning accident and emergency department would seriously impact on the paediatric accident and emergency services
- the local population will have increased journey times to the proposed accident and emergency sites
- Lewisham hospital may struggle to retain some elements of its existing staff base, and is likely to struggle recruit high-calibre staff in some areas

Primary, secondary, community and social care services in Lewisham have developed good arrangements for managing people with complex needs, and have opportunity to develop these further.

For example, an innovative integrated approach to the management of older people with complex needs has been developed. This is proactive, seeking older patients who have been admitted to the hospital and facilitating their early discharge whilst having an active admission avoidance scheme using intermediate beds managed by the care of the elderly physicians. The success of this venture should not be underestimated. Out-of-borough patients discharged from Lewisham Healthcare have on average a 2.7 day longer length of stay in hospital. The numbers of admissions of older patients has only been kept constant by this initiative and loss of this would lead to further pressure on inpatient care within Lewisham. The integrated nature of the venture, crossing primary, community and social care has also been utilised with the management of older patients admitted with fractured neck of femur. The same system has reduced their length of stay by 8 days (from 25 to 17 days). Loss of the team approach, which starts in accident and emergency, would produce additional stresses on Lewisham Healthcare NHS Trust.

Lewisham is regarded as having one of the best paediatric services in the country (Care Quality Commission assessment). Unlike many paediatric departments there are no medical recruitment difficulties. Those who understand the system well doubt that the proposed patient flow to Queen Elizabeth Hospital will occur. The natural axis for patient flow out of borough is to King's College Hospital or Guy's and Thomas's NHS Foundation Trust.

Lewisham has been rated “outstanding” by the Care Quality Commission and OFSTED for its children’s safeguarding. The structures and processes that underpin this excellent service have been developed over many years but to a large extent would be undone by the TSA proposals.

#### *2.4.2 Maternity services*

The proposals for maternity services have a number of implications that are not adequately addressed or mitigated within the TSA report:

- under option one for the maternity unit at Lewisham all approximately 4,000 women (expected to rise to 5,500 in the next 2-3 years) who currently give birth at Lewisham will be dispersed – based on historical flows, and in the judgement of those working in the system, it is likely that they will go to St Thomas’ Hospital or King’s College Hospital, taking those centres up to about the 7,000 mark – which will put a major strain on capacity
- there is no evidence either way regarding whether larger centres are good or bad in terms of patient outcomes, and therefore it appears that the proposal to close the Lewisham unit is purely financially driven
- the loss of a centre at Lewisham has implications for continuity of care between antenatal, delivery and postnatal care which could negatively impact on health and social outcomes for the people of Lewisham – this is particularly key for vulnerable women and vulnerable children
- option two proposes an obstetric led ‘low-risk birth’ unit at Lewisham that appears to be a much stronger option, and we understand has the support of obstetricians at the Trust

#### *2.4.3 Elective surgery*

As noted above, there are some key questions that are yet to be addressed regarding the feasibility of the proposed elective care centre. However, assuming that these were overcome and the centre went ahead, the main impact would be for patients outside of Lewisham rather than those in Lewisham. Patients from out of borough would in general have further to travel for their operations. This would impact them in terms of convenience and travel costs.

### **2.5 Proposed way forward**

The TSA report rightly highlights that change is required in the commissioning and delivery of health and social care services in south east London, in order to deliver better outcomes within a tighter financial envelope. However, to deliver sustainable change, plans need to be developed from the bottom up, with full involvement of all partners locally.

The TSA is right to highlight the potential opportunities presented by a merger between University Hospital Lewisham and Queen Elizabeth Hospital, and this should be explored further. Within this context, and in partnership with commissioners, social

services and primary and secondary care clinicians, there will be opportunities better to design services around the needs of the local population, so as to reduce demand, improve quality and make efficiencies. Such plans should build on the strength of existing arrangements, but also include a thorough examination of service reconfiguration options across the Lewisham and Queen Elizabeth sites.

Using the health and social care needs of the population as the starting point for change, building services around user needs rather than organisational requirements, and ensuring the local development of solutions with full involvement of partners, will provide a much more solid platform for sustainable improvement.

## 2.6 Conclusions

The TSA proposals are not well aligned with the overall direction of government policy, specifically:

- they will lead to greater fragmentation rather than integration of health and social care services
- they have been built from the top down, around the needs of provider organisations, rather than from the bottom up to address the health and social care needs of the population of Lewisham
- they are heavily financially driven and, although quality has supposedly been a key underpinning requirement of the option development and appraisal process, a narrow definition of quality has been applied that fails to take account of whole pathways of care
- the proposals have not been built with the aim of achieving better outcomes for the Lewisham population against the five key areas for improvement in the NHS Mandate, and the indications are that they do not make the best use of resources in Lewisham in the achievement of these objectives

The TSA proposals are not closely aligned with the health needs of the population of Lewisham, for example:

- Lewisham has a comparatively young population and is demonstrating success in its services for children and young people, and yet the TSA report will lead to the dismantling of some of the good joined-up work that has been done
- Lewisham has comparatively high levels of long-term conditions, despite its comparatively young population – and the effective management of such conditions is heavily dependent on effective service integration
- Lewisham has a higher than average prevalence of mental health conditions, and yet mental health is not mentioned in the report – even though there are clear knock-on impacts on the management of mental health conditions

There are a number of weaknesses in the assumptions underpinning the TSA proposals regarding service reconfiguration:

- assumptions around existing activity and case mix in the emergency department at Lewisham and around the potential movements in this activity under the proposed service configuration are not robust
- assumptions around the changes to patient flows that would result from the proposed maternity service reconfiguration and knock-on impact on capacity at other hospitals have not been adequately worked through
- assumptions around the ability to secure agreement of other providers in south east London to channel elective activity through the proposed new elective care centre are weak
- assumptions around deliverability of the quantum of demand reductions and financial savings outlined in the community care strategy are poorly evidenced, and there is a lack of detail around implementation plans and timescales

The key implications of the TSA proposals for the population of Lewisham, should they be taken forward in their current form, are:

- shift of medical admissions out of borough, presenting significant challenges for continuity of care and delivery of effective pathways
- likely increases in length of stay for Lewisham patients
- weakening of the currently excellent paediatric services at Lewisham hospital
- mothers having to travel to another maternity unit to give birth, and the loss of the excellent improvement that has been in the unit at Lewisham
- dismantling of existing strong relationships in relation to safeguarding

The TSA report is right to highlight the need for change, the need to examine reconfiguration options and the need to explore organisational solutions. However, to deliver sustainable improvement in the health and social outcomes for the local population, change should start with the needs of the population and solutions be built by local partners in such a way as to address those needs in the most efficient and effective way.

It is recommended that local organisations in Lewisham and Greenwich are given the go-ahead to make the local plans as necessary, without being constrained to the recommendations made in the TSA report. Lewisham and Greenwich CCGs should be provided with a clear financial envelope and asked to provide their commissioning plans by as soon as possible.

### 3 Review of the Option Appraisal Methodology

#### 3.1 Context

The TSA report is built around an option appraisal which considers five options for the secondary care configuration in south east London. All of the options leave Guy's Hospital as a specialist hospital, King's College Hospital as a 24/7 emergency admitting hospital and Queen Mary's Hospital as a non-24/7 emergency admitting hospital. The five options relate to the number of full 24/7 emergency admitting hospitals which should sit alongside King's College Hospital:

- four hospitals (University Hospital Lewisham, Princess Royal University Hospital, Queen Elizabeth Hospital, St. Thomas' Hospital)
- three hospitals – University Hospital Lewisham not a 24/7 admitting hospital
- three hospitals – Princess Royal University Hospital not a 24/7 admitting hospital
- three hospitals – Queen Elizabeth Hospital not a 24/7 admitting hospital
- three hospitals – St. Thomas' Hospital not a 24/7 admitting hospital

#### 3.2 Methodology adopted by the TSA

The TSA adopted a two-stage approach:

- establishing hurdle criteria to reduce the initial long list to a manageable short list
- assessing the resulting short-list against a number of evaluation criteria

##### 3.2.1 Hurdle criteria

The TSA report claims that the every possible combination of hospital service configurations on existing sites would lead to 16,384 options. No information is provided on how the figure of over 16,000 options was arrived at and there is some confusion in paragraphs 14 and 15 of Appendix E whether this initial list of options included the creation of new hospital sites. The hurdle criteria adopted were:

- **high quality care** - capable of meeting all applicable standards including patient safety
- **realistic time frame** – deliverable within a 3-year timeframe
- **affordable to commissioners** – affordable to health and social care commissioners

No information is given in the report on the way these criteria were defined. The report also notes that the clinical expert group established some "fixed points":

- Guy's Hospital would remain a specialist and elective centre, and not be considered as a possible site for a 24/7 emergency admitting hospital

- King's College Hospital would not be considered for significant service reconfiguration and would remain as a 24/7 emergency admitting hospital – as it is already a major trauma centre within the London trauma network
- Queen Mary's Hospital will not be considered for development as a 24/7 emergency admitting hospital as A&E and associated emergency services had been closed recently under the A Picture of Health programme

### 3.2.2 Evaluation criteria

The short list was assessed against the following criteria, sub-criteria and indicators:

**Table 1: Appraisal criteria, sub-criteria and indicators**

Criterion	Sub-criteria	Indicators
Quality of care	<ul style="list-style-type: none"> <li>• Clinical effectiveness</li> <li>• Patient experience and estate quality</li> </ul>	<ul style="list-style-type: none"> <li>• Standardised mortality rates (in and out of hours), time to operate for fractured neck of femur, infection rates, readmission rates, conversion rates of A&amp;E attendance to admission</li> <li>• Consultants on rota (emergency surgery, paediatrics)</li> <li>• Key patient satisfaction scores, complaints, patient safety, medication error rates</li> <li>• Age and quality of the estates</li> </ul>
Access to care	<ul style="list-style-type: none"> <li>• Distance and time to access services</li> <li>• Patient choice</li> <li>• Access to integrated services</li> </ul>	<ul style="list-style-type: none"> <li>• Impact on population weighted travel (blue light travel, off-peak car, peak car, public transport)</li> <li>• Number of sites delivering emergency, obstetrics, elective outpatients, diagnostics</li> <li>• Number of trusts with major hospital sites</li> <li>• Delayed transfers of care in vs out of borough; length of stay &gt;75s, readmission rates trend</li> </ul>
Value for money	<ul style="list-style-type: none"> <li>• Capital cost to the system</li> <li>• Transition costs</li> <li>• Fixed costs &amp; operational savings</li> <li>• Net present value</li> <li>• Provider viability</li> </ul>	<ul style="list-style-type: none"> <li>• Up front capital required to implement acute reconfiguration</li> <li>• Non-recurring costs (excluding capital build and receipts) to implement changes</li> <li>• Estimate of fixed cost savings derived from cost rationalisation initiatives</li> <li>• Overall value to the system</li> <li>• Assessment of the on-going viability of the individual sites</li> </ul>
Deliverability	<ul style="list-style-type: none"> <li>• Workforce</li> <li>• Expected time to</li> </ul>	<ul style="list-style-type: none"> <li>• Workforce experience/quality, e.g. turnover, sickness, satisfaction</li> <li>• Scale of change (bed movements)</li> </ul>

<b>Criterion</b>	<b>Sub-criteria</b>	<b>Indicators</b>
	<ul style="list-style-type: none"> <li>deliver</li> <li>• Co-dependencies with other strategies</li> </ul>	<ul style="list-style-type: none"> <li>• Assess strategies [sic] impact e.g. cancer, stroke, King's Health Partners merger</li> </ul>
Research and education	<ul style="list-style-type: none"> <li>• Conducive to education</li> <li>• Conducive to research</li> </ul>	<ul style="list-style-type: none"> <li>• GMC national training survey and staff training survey</li> <li>• Disruption to education and research spend</li> <li>• Qualitative assessment of impact on existing strategies (alignment with GMC training plans)</li> </ul>

The options were not scored against these criteria. Instead, an indication of how they would score against each other was shown on a scale ranging from ++ to --.

### 3.3 Review of the methodology

The option appraisal used in the TSA report is not compliant with HM Treasury's "Green Book: Appraisal and Evaluation in Central Government" in a number of areas. The Green Book is widely acknowledged as the most authoritative manual on appraisal available to the wider public sector in the UK, and all Department of Health guidance on option appraisal complies with the Green Book.

#### 3.3.1 Overall approach

The report states that the option appraisal makes the assumption that recent changes will not be reversed where they have improved healthcare. There are two issues with this assumption:

- incorrect approach to sunk costs
- inconsistent use of the assumption

According to HM Treasury's Green Book:

"Costs of goods and services that have already been incurred and are irrevocable should be ignored in an appraisal. They are 'sunk costs'. What matters are costs about which decisions can still be made. However, this includes the opportunity costs of continuing to tie up resources that have already been paid for."

The option appraisal in the TSA's report used the rule that "solutions that would see the reversal of recent reconfigurations of services that had improved outcomes were [...] ruled out". In our opinion, this is an incorrect approach – where a new solution is potentially better than the recent changes, this should be considered. The cost of making the recent changes is a sunk cost, and should not be part of the decision-making process now.

However, the TSA has not applied this principle consistently in the analysis of the options. Some recent changes, such as Queen Mary's Hospital not having a 24/7 acute emergency admitting service, are seen as untouchable. However, other recent changes which have improved healthcare in south east London do seem to be open to reversal. These include the work that Lewisham has done to integrate its healthcare system, particularly around the care of the elderly/emergency admissions and health and social care for children (resulting in an OFSTED classification of "outstanding").

In addition, at paragraph 24 of Appendix E, having already set up the fixed points and reached a shortlist, the Clinical Advisory Group brought in another option – to develop St. Thomas' Hospital as a 24/7 acute emergency admitting hospital. It seems that this additional option was not assessed against the hurdle criteria or the fixed points, and was simply inserted into the analysis at this point. At an even later stage, as described at paragraph 61 of Appendix E, the option to remove the 24/7 acute admitting emergency service at the Princess Royal University Hospital was removed by the Clinical Advisory Group, on the basis that the Hyper Acute Stroke Unit is based there (again, this is a sunk cost and should not have been treated in this way).

This change to the developed rules for the appraisal introduces inconsistency and removes any rigour from the approach. When the Clinical Advisory Group made recommendations such as these, the initial shortlisting decision should have been revisited in the light of the new information.

The impact of the inconsistent use of the "fixed points" around Guy's Hospital, King's College Hospital and Queen Mary's Hospital while ignoring other beneficial changes is to the limit the range of options which can be considered.

Despite very clear guidance in HM Treasury's Green Book around the need for sensitivity testing in option appraisal, no sensitivity analysis has been carried out on the results from the option appraisal. It is clear that the results depend on two factors:

- the essential similarity of the shortlisted options on the quality of healthcare in south east London
- the beneficial financial impact of reducing the services available on the University Hospital Lewisham site

The TSA report should have considered the impact on the conclusions if these factors do not hold or vary significantly.

### *3.3.2 Scope of the appraisal*

The appraisal explicitly excludes the effect of changes on paediatrics, maternity services and mental health, although delivery of acute and community care will impact on their delivery (as described in other sections). It is likely that including the

full scope of healthcare in south east London would have led to alternative options being considered.

Although in theory the option appraisal addresses the whole scope of acute care, it actually only addresses changes to emergency care, with the resulting major changes to elective care (the major elective centre at University Hospital Lewisham) seemingly a by-product of the emergency care changes. It is a fallacy to believe that emergency care and elective care can be considered separately. The recognition that the changes to emergency care must be supported by changes to community care and general practice implicitly recognises this. Therefore, the option appraisal should have been carried out at a system-wide level. It is also worth noting the important point that education and training systems are built around the delivery of both emergency and elective care. The option appraisal steps around changes to education and training by assuming all options are the same for this, but changes to care networks in south east London will impact on education and training, and this should have been considered properly as part of the analysis.

No risk analysis of the options seems to have been carried out. Given the huge impact on the healthcare of the people of south east London that these changes are likely to have, it is vital to understand where the risks are, and to have considered mitigations. This is particularly important given the clinical evidence on the effect of consolidation and of economies of scale on quality of care is scarce (beyond the literature on the number of procedures an individual clinician should carry out to practise safely).

There are a number of costs which seem to be pushed outside the scope of the appraisal and are not counted as part of the cost of the solution. This approach is incorrect – HM Treasury guidance is very clear that an option appraisal should include all the costs of the options, whether they fall on the affected organisations or on other organisations or individuals. Specifically in this case, the option appraisal seems to exclude the following costs:

- passing services on the Queen Mary's Hospital site to Oxleas NHS Foundation Trust
- 23 beds which are assumed to move to Croydon (i.e. out of sector) – in this case it is not clear what assumptions have been made about both the income and costs for these beds

### *3.3.3 Hurdle Criteria*

The TSA report is correct that an initial trawl for long list options should be reduced to a manageable shortlist before detailed analysis. However, as the report does not reveal how the theoretical 16,384 variations were arrived at, and does not show how the analysis moves from this initial long list to the shortlist, it is impossible to say whether the hurdle criteria have been applied appropriately and consistently.

### *3.3.4 Evaluation Criteria*

#### **Scoring and weighting**

The report states that the “nature of the exercise...does not lend itself to a precise scorings system”. It is not at all clear why this statement is made – it is the nature of benefits scoring and weighting systems that they are subjective, bringing together the views of a wide group of stakeholders, but they allow a real discussion of the relative merits of options. This approach would have been eminently suitable for this option appraisal.

It should be noted that the five benefits criteria and the fifteen sub-criteria are not weighted in the report. However, not applying an overt weighting means that the benefits criteria are implicitly weighted the same (at the sub-criteria level) – this implicit weighting should have been assessed by the evaluation group.

Criterion C, value for money, has been split into 5 sub-criteria:

- C1: Capital cost
- C2: Transition cost
- C3: Fixed cost savings and operational improvement
- C4: Net present value
- C5: Site viability

Note that the impact of this is to double-weight the financial impact of the options, as C4 includes C1, C2 and C3.

#### **Quality and patient experience**

Paragraph 38 of Appendix E states that the Clinical Advisory Group advised all options should be rated equally for patient experience and estate quality as “each Trust was constantly striving to improve the quality of their estate and enhance patient experience”. However, this does not take account of starting points, as sites will have differing abilities to be enhanced (for example, some will have a better building stock base or more available space for development). In addition, trusts which already provide a good patient experience start from a better position, and over the three-year time limit set in the report they are unlikely to be caught by trusts starting from a poorer position. This limitation has the impact of reducing the differences between the options. The analysis of quality also ignores some important measures which could easily be obtained, such as infection rates.

The decision to ignore quality as a differentiator is not applied consistently during the appraisal exercise. Paragraph 34 of Appendix E says “the Clinical Advisory Group advised that data on current indicators would not indicate the quality of care that would be provided in the future.” However, paragraph 46 uses the Clinical Advisory Group’s view that “Lewisham’s non-elective ALOS and rates of delayed discharge were some of the highest among the trusts in south east London” to differentiate between the options on access to integrated services.

The analysis of the impact on patients is very limited. Choice has been reduced to the number of sites available, but it has been established that patients consider such factors as ease of reaching a site by public transport and ability to park at the site as part of their choice decision. These factors could have been evaluated as the information is available.

At paragraph 41 of Appendix E, which considers the distance and time to access services by patients, it was felt that changing University Hospital Lewisham has less impact on patient access than changing the Princess Royal University Hospital and Queen Elizabeth Hospital. We would like to see justification of this, as page 68 of the main document shows that Lewisham patients are quite heavily disadvantaged by the travel time changes.

### **Financial analysis**

We have been unable to obtain the underlying detailed financial analysis, and therefore we have not been able to assess the reasonableness of the approach adopted to costing the options. For example, the report states that the analysis does not include a terminal value for the sites, but the sites will have value at the end of the analysis and this decision may impact the NPV of the options. In addition, the analysis is reported to have been done over a period of 20 years (possibly to align with the PFI contracts), but it should be noted that HM Treasury's Green Book says that option appraisals should be carried out over 30 or 60 years. Again, changing the length of the analysis is likely to change the results and this should be evaluated through sensitivity testing.

### **Timetable for options**

At paragraph 57, the report states that "the expected time to deliver the proposed options was not evaluated". Given that time to deliver was a hurdle criterion, some analysis of this must have been carried out, and therefore this should have been included in the appraisal.

### **3.4 Conclusions**

Close analysis of the option appraisal carried out as part of the TSA report reveals a number of deviations from best practice as set out in HM Treasury "The Green Book: Appraisal and Evaluation in Central Government", including:

- a restriction of the scope of the appraisal to emergency care across south east London
- incorrect application of the concept of sunk costs
- a lack of audit trail through the process from long list to short list
- a seeming lack of consideration of the implicit weighting of the appraisal criteria
- double-counting of the financial impact of the options
- no use of sensitivity testing or risk analysis

In addition, the option appraisal was not carried out consistently, with options being removed or added to the shortlist throughout the process without proper application of the hurdle criteria or the fixed points set up by the Clinical Advisory Group.

The option appraisal turns on:

- the apparent lack of difference between the clinical impact of the options
- the financial gains from disposing of part of the Lewisham site

Other parts of our report address whether these two key assumptions can be justified.

Despite the criticism of the approach set out above, we feel that the work that was carried out around the option appraisal provides a good introduction to the issues underlying the sustainability of healthcare in south east London. We recommend that the current analysis is used to inform a re-run option appraisal which complies with best practice and addresses the weaknesses highlighted in this report. This could be carried out through two or three workshops which brought together all of the workstreams.

## 4 Financial Assumptions Review

### 4.1 Context

The TSA report is based around an activity and income model for the PCT/CCGs in south east London, and costings for South London Healthcare NHS Trust and Lewisham Healthcare NHS Trust. While the report contains high-level results of the modelling, the TSA has not released the detailed modelling and assumptions. We have therefore been unable to test the reasonableness of many of the assumptions. We have obtained information from Lewisham CCG and Lewisham Healthcare NHS Trust on the data they provided and their views on the use of that data. This section is based on the limited information we have, and therefore conclusions are necessarily limited.

Note that this section does not comment on the assumptions underlying the capital costs, land sales income and sizing of the new elective centre on the Lewisham site, as this is covered in more detail elsewhere in the report.

### 4.2 Commissioners' position

The CCGs provided the TSA with their commissioning plans for the next three years, and this was used as the basis on the modelling. However, the TSA challenged and changed some of the assumptions underlying the local modelling:

- growth assumptions
- tariff deflation
- distance from target
- split of financial challenge between commissioners

The overall impact of the changes to the modelling described below was to increase the QIPP challenge in Lewisham from around £20m over five years to £37.7m, increasing the pressure on the local commissioners and showing the financial position in Lewisham to be more serious than had been expected.

#### 4.2.1 Growth assumptions

Growth in future demand for healthcare is made up of two parts – demographic, which depends on changes to the age and deprivation profile of the local population, and non-demographic, which picks up all other changes. These other changes will include trends for increasing presentations at accident and emergency, changes in the way the population presents for healthcare (e.g. being more likely to ask for treatment for a condition), and developments in healthcare technology which increases or reduces the need for healthcare. The non-demographic trend over recent years in the NHS has been upwards, for reasons which have not been fully explained. Commissioners have sought to control this non-demographic trend through such measures as demand management.

Lewisham CCG's view of non-demographic growth over the next three years is around 0.8% per annum. The TSA disputed this figure as being too low, stating that it is lower than rates being experienced elsewhere in the country, and replaced the local non-demographic growth rate with a figure of 2%, said to be an "average" of the national position. No source for this figure has been provided and we have not been able to substantiate this assumption. The information we have found shows that 2% is at the top end of recent experience in London rather than the average.

#### *4.2.2 Tariff deflation*

The south east London CCGs had used the NHS London advised rate for the tariff deflator of approximately 1.1%. The TSA replaced this with the Monitor assumption of 1.3% per annum to 2013/14 then 0.9% thereafter, which is more aggressive than the London assumption. However, given Monitor is taking on the role of setting the tariff, it seems reasonable to use its assumption rather than a local assumption.

Note that a more aggressive tariff deflator assumption will reduce the QIPP challenge for the commissioners, but increase the savings which providers need to make.

#### *4.2.3 Distance from target*

Lewisham CCG is 6.6% over target. No information has been provided by the Department of Health on the trajectory for CCGs to return to target, and historically movement towards target for those who are over has been relatively small to avoid disruption to local health services. However, the TSA is of the opinion that CCGs will be required to move more quickly than historically towards target, and nominal allocation growth for Lewisham is limited to 1.7% per annum in the modelling to take account of this. It should be noted that the PCT received an uplift of 3% in 2012/13 and 2% in 2011/12.

It is expected that the NHS Commissioning Board will finalise the future allocation of resources in the near future.

#### *4.2.4 Split of financial challenge*

The CCG has noted that no allowance has been made for specialist commissioning. Therefore all of the financial challenge has been allocated to the CCGs.

### **4.3 Activity**

The TSA model depends on a major activity change – a reduction of 30% in emergency presentations. This is to be supported by improvements in community services and changes in primary care. The ability to deliver these changes is commented on elsewhere in this report. However, it should be noted that this level of change has not been achieved elsewhere in the country and will require a considerable amount of resource to be made available in the community. The CCG is currently working on its plans to deliver this change.

It is not clear that the TSA modelling includes any additional resources for primary care, although implementing the demand management required to reduce emergency activity by 30% will require primary care to take a leading role.

The TSA report excludes all paediatric activity from its analysis. Given the young demographic profile of Lewisham, both commissioners and the trust are assuming growth in this area, linked with the integrated service provided across social services, community and secondary care. This exclusion means that a source of additional income for the trust is ignored by the TSA analysis.

#### 4.4 Trust income and costs without implementing the TSA's recommendations

The basis of Lewisham Healthcare NHS Trust's financial information is the foundation trust-format business plan produced by the trust at the end of May. The TSA has largely used this without change, but new sources of income growth have been removed. For example, the trust had assumed that it would be able to grow bariatric service income.

Trust income in 2012/13 is expected to be £236.4m. The main changes expected by the TSA before 2015/16 if the changes in the report are not implemented are an increase £19.6m of demand growth balanced by £11.9m reduction due to demand management, and a tariff deflator of £7.6m. Other small increases lead to an income of £239.5m in 2015/16.

Lewisham Healthcare's costs for 2012/13 are expected to be £236.2m, leading to a small surplus position. Changes due to activity are expected to add £7.5m to costs (note from above that activity is due to add £7.7m to income, so an extremely small margin seems to have been assumed). Inflation (at 3.2% per annum) adds £23.6m, and the trust is assumed to make £30.2m savings over the period. This savings figure is similar to the trust's assumptions. With other small changes, the trust's running costs in 2015/16 are £240.1m leading to a small deficit of £0.6m.

#### 4.5 Trust income and costs after implementation of the TSA's recommendations

Appendix K of the TSA report shows the impact of the recommended changes on the net financial position of the hospitals affected. Lewisham Healthcare's net position moves as shown in the table below:

**Table 2: Impact of TSA recommendations on Lewisham Healthcare NHS Trust's financial position**

Cost area	Impact	Comment
Loss in margin due to activity movement	-£18.3m	Net position of reducing acute activity and increasing community activity
Consolidation savings	£3.3m	Due to the larger units for delivering services
Avoid cost of new service standards	£3.0m	Relates to the avoidance of additional staffing in the emergency

<b>Cost area</b>	<b>Impact</b>	<b>Comment</b>
		department
Reduction in fixed costs due to land disposals	£22.6m	Pro rata to the percentage of the site disposed of
Additional fixed costs due to new build	-£7.0m	Elective centre works
<b>Net change</b>	<b>£3.6m</b>	

The section of this report on the estate impacts of the recommendations covers the changes to fixed costs in more detail.

The £18.3m net reduction in margin covers the impact of reducing emergency activity, adding elective activity and additional community work. Lewisham Healthcare NHS Trust has requested additional information in order to assess the reasonableness of this figure, but this has not been received from the TSA, and this report is unable to comment on the way this figure has been built up.

#### 4.6 Conclusions

It is difficult to comment in detail on the assumptions used in the TSA report as little information on the financial modelling has been released. The CCG and Lewisham Healthcare NHS Trust agree that the figures are based on locally-prepared plans, but the TSA has applied a range of more rigorous assumptions, including a much higher assumption about non-demographic growth in activity, and the removal of all new income sources from the trust's plans.

It is reasonable in the context of modelling major service change to challenge local assumptions and ensure the proposed solutions are robust in a "downside" scenario – this is how Monitor approaches its assessments, and it allows organisations to develop mitigations to the downside risks. In this case, only one case has been modelled, and this seems to be a downside scenario from Lewisham's viewpoint. The effect of taking this approach may be to paint a blacker picture for Lewisham than might be expected.

It is clear that the reduction in activity of 30% assumed to follow from demand management across south east London is very challenging, and has not been delivered elsewhere on such a large scale.

## 5 Review of the Estates Proposals for University Hospital Lewisham

### 5.1 Context

The TSA report proposes significant changes to the Lewisham University Hospital site. Fundamentally, the three major implications are:

- **a large (58%) reduction in the size of the hospital site:** the plan envisages the NHS retrenching to the rear/west of the site, into the new PFI unit and adjacent buildings and the sale of the remainder of the site; the site currently measures 5.8 ha and the TSA plans envisage it reducing to 3.39 ha in the future
- **a major refurbishment programme in the PFI block:** the existing building is approximately 22,000 sqm and the plan proposes refurbishing 11,687 sqm in the Riverside and Ravensbourne buildings
- **significant savings in fixed costs** arising from the retrenchment and land sales

### 5.2 Local perspective

The Trust has recently completed a rationalisation of the urgent care centre and adult emergency department which are located off the main High Street entrance. The Head of Planning at Lewisham Borough Council commented that this rationalisation had made significant improvement to the access, signage and layout of the site.

The Trust has had on-going discussions with the local planning authority regarding the potential disposal of the northern corner of the site which houses the Owen Centre, Education Centre and some car parking. However, the local planners had advised that, whilst not opposed in principle to the disposal, it would be sensitive as one of the buildings is listed (Grade II) and the area is in a conservation zone.

Part of the site (the Ladywell Unit) is leased to, and occupied by, the South London and Maudsley NHS Foundation Trust (SLAM) which provides acute mental health services from the premises. SLAM has no plans to vacate or significantly change the services provided from the Ladywell Unit. The area occupied by the Ladywell Unit does not form part of the TSA's proposed land disposal.

### 5.3 Alignment of TSA proposals with local circumstances

The TSA proposals are not consistent with the Trust's plans or the Local Authority's assumptions for the site. Although, the Trust has contemplated releasing a small portion of the site, it had no plans for a major retraction.

From the local authority perspective the hospital is located between the two main towns in the borough (Catford and Lewisham) and is well served by public transport in a densely populated inner London borough. We understand that up to the 1980s

the NHS had five hospital sites in the borough. Only the Lewisham Hospital site now remains and the proposal to retrench even further would leave the NHS with no local flexibility to meet changes in service demand in the future.

#### **5.4 Challenging assumptions**

We have considered the TSA's assumptions as set out in the report in a number of areas:

- town planning
- site configuration
- capacity planning
- site area
- fixed cost calculations
- land sales income
- PFI refurbishment
- timescale

Our conclusions are set out in the following sections.

##### *5.4.1 Town Planning*

#### **Area available for disposal**

The plan as drawn shows no access to the retained NHS uses on the rear of the site. Access would not be permitted off the side road (Albacore Crescent) and must come off the High Street. This would reduce the land available for disposal. Approximately 25% of the land shown for disposal would be severely restricted in its use – there is a Grade II listed building and conservation area status in parts of the site. The Council also owns the Registry Building which is on the eastern boundary of the site alongside the High Street. Any development would have to retain the frontages of the buildings which have facades onto the High Street.

The council is concerned that disposal of such a large proportion of the site would leave the trust with no contingency space for any future clinical developments.

#### **Usage of land for disposal**

The hospital is a major employer in a deprived borough. Therefore the Council would want to see a mixed 'housing and business use' on the site (to help generate employment) rather than solely residential usage. This would reduce the land value. Retail usage would be completely rejected. The council would expect any housing development to provide up to 50% social housing. This would also affect the disposal value.

#### **Impact on travel**

The council is concerned that the proposed elective surgery centre would generate more car journeys to the site by patients from outlying boroughs. The proposed elective surgery centre could generate an additional 88,000 visits to the site (44,000 patients each having a journey to and from the site). Although this would be offset by some degree by the emergency patients being re-routed away from the hospital the elective patients would also generate visitors. Bearing in mind that the vast majority of elective patients would not come from within the borough, there would be an rise of car journeys to the site. The figure of 88,000 journeys is predicated on the assumption that pre and post-operative outpatient care would remain at the 'sending' trust. If this were not the case, the figure of 88,000 would be an underestimate. The trust would have to submit a green travel plan and prove to the Council that it is able to cater for the additional travel to and from the site.

### **Timing**

The NHS should allow at least two years to work through the planning process including the need for extensive public consultation.

#### *5.4.2 Site configuration*

As noted above, there is no pedestrian or vehicular access shown to the retained NHS estate in the TSA's plans. Essentially the TSA report shows the NHS retrenching to the western third of the site adjacent to the local park, Ladywell Fields. Although there is a pedestrian access from the park this is the portion of the site furthest from the High Street. This means that the area shown for disposal will have to be bisected by a road for vehicular access to the hospital. This will reduce the area available for disposal and become a constraint on the developers' proposals.

The Trust's estate department has advised us that the TSA's plans do not allow space for several functions which would be required to make the service feasible. We understand that the TSA plans took no account of clinical support services for example pathology, medical records, etc. This means that a larger footprint will be required than is shown in the TSA drawings.

#### *5.4.3 Capacity planning*

No data has been made available to validate the sizing of the proposed new elective surgery centre on the Lewisham site. We would have expected to have seen the projected activity plan for 2014/15 and its projections for growth through to 2024/25.

The site plan as shown makes no allowance for the retention of the obstetric service.

The theatre requirements, etc. are based on very optimistic, unproven working practices. We understand that a total of 44,000 cases per year will be treated. Assuming the six-day week (12 hour day) predicated in the TSA report this equates to 147 cases per day. If a five-day week is worked (and still allowing for high productivity) the rate would rise to 176 cases per day. This would equate to an

increase in theatre requirements from the 18 set out in the TSA report to 22. The lack of information in the TSA report makes it difficult to assess the realism of these assumptions. However, we have calculated that that to carry out 44,000 inpatient cases in 216 beds (number taken from TSA report), and assuming 85% occupancy (as a more likely figure than the 90% target used in the TSA report) and seven day working (to cover patients who receive their treatment at the end of the working week), the average length of stay is 1.3 days. This seems low bearing in mind that day cases will be carried out elsewhere. We are not aware of any other NHS elective centre which has adopted and maintained the working practices proposed by the TSA. If average length of stay rises to 2.0 days, then the size of the centre would need to increase by approximately 66 beds, which would cost an additional £21.5m in capital to provide and increase the running costs of the elective centre.

In terms of capacity planning, we believe it would be prudent, as a next step, to develop a detailed activity model for elective cases across south east London. This, together with robust forecasts for growth, should allow for 'variations' to the proposed elective centre to be developed. These 'variations' should seek to review the potential for pre-operative assessment and post-operative outpatient work to be undertaken either in new community hospitals or the hospital closest to where the patient lives. Establishing robust care pathways for elective work should ensure the efficient use of existing facilities and, wherever possible, reduce the impact of significant/unnecessary work flows to the proposed elective centre.

#### *5.4.4 Fixed cost calculations*

It appears from the table on page 43 of the estates appendix that the TSA is attributing £22.6m of revenue savings to the "Lewisham Asset disposal". This figure is can be challenged as set out below.

As noted above the area of the site which will need to be retained is larger than the TSA has assumed and the area available for disposal correspondingly smaller. The precise areas have not been measured but an indicative assessment indicates that 25% of the land currently shown for disposal will need to be retained. This would mean that the area for disposal reduces from 3.39 ha to 2.54 ha (44% of the site rather than 58%). This will impact on the premises costs, PDC/capital charges and depreciation.

We understand, from the trust, that some of the TSA's savings have been predicated upon a pro-rata saving of approximately 65% of costs dependent upon releasing 58% of the land. This is not tenable given that costs in the NHS are largely driven by activity rather than floor area. It is reasonable to assume that some costs, for example heating, lighting and rates will fall proportionate to floor area. However, it appears that the TSA calculations work on land area rather than floor area. The TSA plan envisages losing 58% of the site area. However, the retained areas of the site are largely high rise buildings and therefore represent a larger proportion of floor area. By calculating the savings by reduction by site area pro rata rather than by floor area, this overstates the savings that can be made.

We understand that the TSA's figure for fixed site costs also includes some costs which are not driven by site or floor area, for example, portering, catering, housekeeping, waste and linen. These will not change proportionately when site area is reduced.

#### *5.4.5 Land sales income*

The TSA report assumes the land can be sold for £5m per hectare. In our view, this figure represents the value of an unencumbered, prime site in Lewisham with a reasonable element of social housing (say 30%) with a fully developable site area and a relatively high density. Therefore, given the restrictions on the site set out in section 6.4.1 above, it is unlikely that the assumed £5m per hectare could be achieved, and it is estimated that a more likely figure in today's market would be £3.3m per hectare.

#### *5.4.6 PFI refurbishment*

The TSA report is ambiguous in terms of the sizing of the PFI refurbishment. The details of the estates option on page 42 show a total of 11,687 sq m, in the column headed Riverside building, to be refurbished. A check of the arithmetic shows that the total of 11,687sqm is achieved by adding the figures for the ground, first, second and fourth floors of the Riverside building plus the figures for the first and second floors of the Ravensbourne building.

The TSA report shows a figure of £4,000 per sq m for these refurbishment costs. This is assumed to be an 'all in' cost which includes professional fees (architects, engineers, etc. and VAT).

It is not clear from the TSA report how the building contract within the curtilage of the PFI building will be handled. We have assumed there are two options. Either the NHS can allocate the capital and manage the contract itself via the trust or the NHS can negotiate with the owners of the PFI building for them to design and implement the works to the Truss's specification. In either eventuality the implications are twofold:

- there will need to be a detailed legal agreement to reflect the contractual arrangement
- the revenue consequences of the capital investment need to be reflected in the TSA financial model (the report seems to use a simple percentage of capital costs in the modelling)

#### *5.4.7 Timescale*

The three-year timescale set out in the TSA report to achieve the estate rationalisation is ambitious for the following reasons:

- as noted above, the town planning process is likely to take two years and potential buyers would want to see a valid planning consent before finalising a deal
- the TSA report does not show any detailed plans for the design, tender, procurement and implementation of the refurbishment of the Riverside and Ravensbourne buildings
- there is a need to develop a business case for any development on the site, and take that through the appropriate approval process
- there is no decant space available on site, and the refurbishment may involve the fit out of decant space before any work on the Riverside and Ravensbourne buildings can start

Bearing in mind that the work will have to be undertaken within an operational hospital, three years is an optimistic timeline for completing such a complex project.

## 5.5 Feasibility / deliverability

For the reasons set out above, we believe there are significant challenges to the feasibility of the TSA report as it stands. These can be summarised as follows:

- the planning restrictions which would be placed on the site mean that the development potential is limited
- the area of the site which is likely to be surplus has been overestimated because of:
  - the failure to identify pedestrian and vehicle access
  - the failure to identify accommodation for an obstetric service
  - the apparent failure to provide space for clinical and non-clinical support services
- the land sale receipts may well be lower than forecast because:
  - the disposal area will be smaller
  - the planning restrictions will reduce the land values
- we have not seen any activity data to back up the sizing of the proposed elective surgery centre, but it is likely that it will not have sufficient capacity unless very significant shifts in efficiency and working patterns are implemented
- the potential savings in fixed costs will be prejudiced by the reduction in the area for disposal
- the timescale for the redevelopment has not been substantiated

## 5.6 Conclusions

Our analysis has shown that the assumptions used in developing the plans for the University Hospital Lewisham site are either extremely challenging (in terms of ways of working in the elective centre) or incorrect (in relation to the amount of site available for disposal). This undermines considerably the analysis carried out the TSA report, and it is recommended that a detailed health estates planning exercise is carried out before any decisions are made.

## 6 Lewisham Patient Flow Data

We have obtained data from Public Health Lewisham which details patient admissions across the hospitals in south east London. By manipulating this data, we can gain a better understanding of where patients are going for treatment and establish the natural flows that exist in south east London. Data has been broken down into:

- inpatient admissions
- emergency admissions
- elective admissions

### 6.1 Travel times and distances – Lewisham

#### 6.1.1 Hospital distances from Lewisham

The table below shows the distance of each of the south east London hospitals from Lewisham.

**Table 3: Hospital distance from Lewisham**

	Queen Elizabeth Hospital	Bromley Hospital	Queen Mary's Hospital Sidcup	Guys' and St Thomas' Hospitals	University Hospital Lewisham	King's College Hospital
Lewisham wards (average distance in miles)	5.5	8.1	7.5	6.6	2.1	5.1

Public Health, Lewisham (2004)

All Lewisham ward travel data were combined and an average distance calculated from anywhere in Lewisham to alternative hospitals. As shown, in terms of distance, after University Hospital Lewisham, Kings' College Hospital and Queen Elizabeth Hospital are closest in terms of absolute distance to the population of Lewisham. Looking at available public transport, there is one direct bus service that links Lewisham with Queen Elizabeth. Otherwise getting there by public transport would involve a combination of train, Docklands Light Railway or tube and bus. There is a direct train from Lewisham to Denmark Hill, where King's College Hospital is situated. There is also a direct train to Guys' Hospital at London Bridge from Lewisham.

Much of the relevance of travel times and distances does not relate to patients themselves, but their visitors. Certainly, if patients are incapacitated and would struggle to get to hospital, they would go by ambulance. Due to the demographic make-up of Lewisham, with high representation from elderly, ethnic minority and economically disadvantaged groups, where patients go has a potentially considerable knock-on effect on their families.

### 6.1.2 Accident and emergency travel time changes

The TSA report details the impact that the proposed changes will have on Lewisham residents in terms of their journey time to accident and emergency. This is reproduced below for average journey times.

**Table 4: Emergency travel time with and without University Hospital Lewisham accident and emergency department**

	Current average (min)	Proposed average (min)	Change (min)	% change
Blue light ambulance	13.2	20.6	7.4	56%
Private transport	19.7	30.7	11.0	56%
Public transport	26.7	40.8	14.1	53%

Regardless of mode of transport, journey times increase by more than 50% for Lewisham residents seeking accident and emergency services. Car ownership in central London in general is low. This is mirrored in Lewisham where approximately 57% of households had access to a car (2001 Census). This varies across the borough with wards in the north (Brockley, Evelyn, New Cross, Lewisham Central and Telegraph Hill) showing lower levels of car ownership than the rest of the borough and so relying much more on public transport.<sup>6</sup> Shifting accident and emergency services away from Lewisham will have a significant impact on current travel patterns and journey times for those living in Lewisham.

## 6.2 Patient flow data

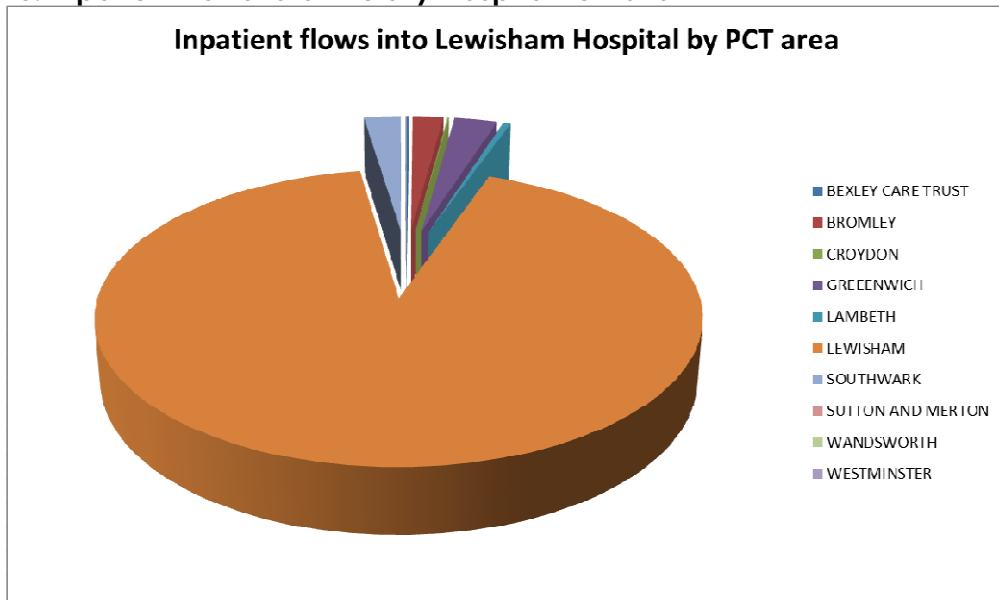
Public Health data from 2011/12 has been used to examine the patient flows for admissions across South London.

### 6.2.1 Inpatients

Inpatient flows into University Hospital Lewisham show that 92% of patients are local to the area. 3% came from Greenwich and 2% from Southwark.

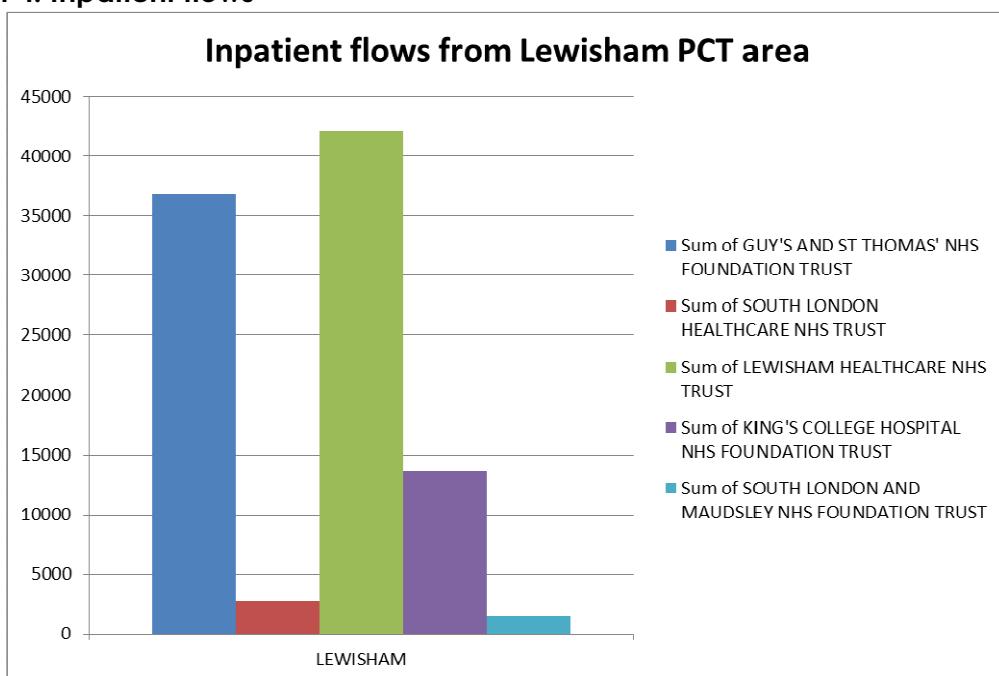
<sup>6</sup> London Borough of Lewisham: Local Implementation Plan 2011-2013

**Chart 3: Inpatient flows to University Hospital Lewisham**



Although 92% of inpatient flows into University Hospital Lewisham are Lewisham residents, the local population also travels to other hospitals, as shown below. The chart shows the top 5 destinations for patients from Lewisham. Guys' and St Thomas' Hospitals accounted for nearly 37,000 inpatient admissions from Lewisham. King's College Hospital received 13,621 Lewisham residents as inpatients and South London Healthcare NHS Trust received 2,784.

**Chart 4: Inpatient flows**

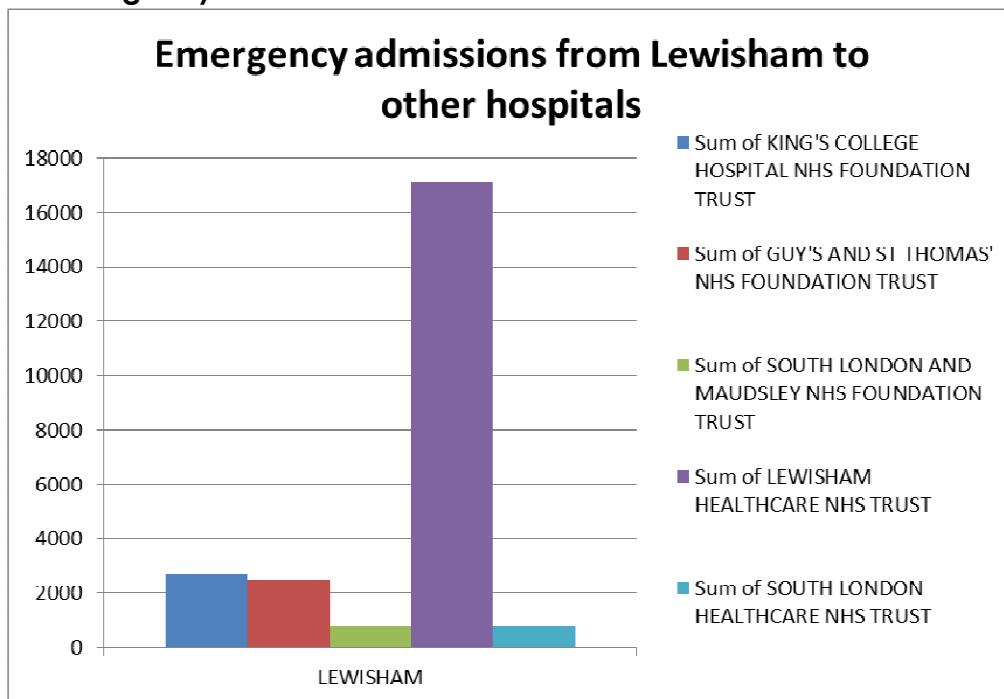


## 6.2.2 Emergency admissions

In terms of emergency admissions, almost all admissions into University Hospital Lewisham came from the local residents (17,133 of 18,422) with small inflows from both Greenwich and Southwark. Patient outflows from Lewisham for emergency

care are shown in the chart below. Main outflows go to King's College Hospital and Guy's and St Thomas' Hospitals with only a small portion going to South London Healthcare.

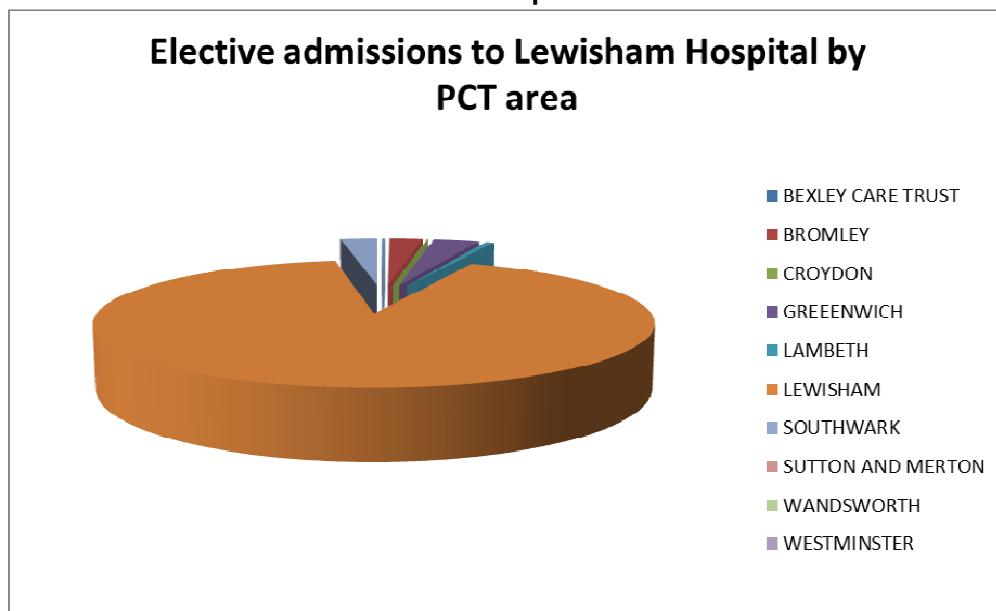
**Chart 5: Emergency admissions**



#### 6.2.3 Elective admissions

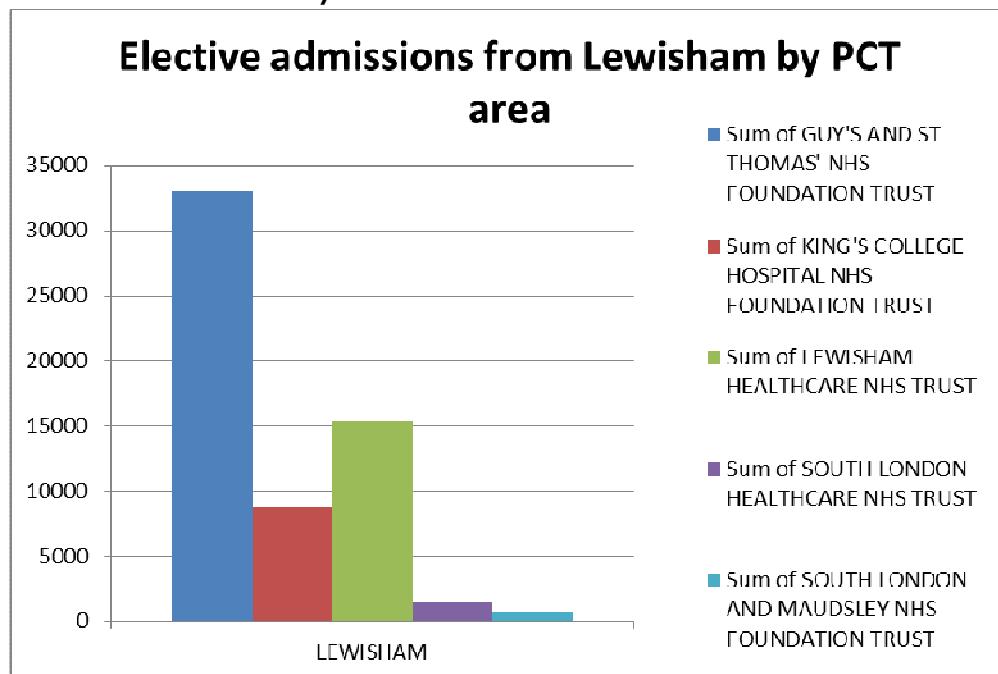
Currently, elective admissions to University Hospital Lewisham are predominantly made up of Lewisham residents, with 3% coming from Southwark and Greenwich and 2% from Bromley.

**Chart 6: Elective admissions to Lewisham Hospital**



Patient outflows from Lewisham for elective procedures are illustrated below. This is the one area where at the moment more patients go elsewhere for hospital care. Guy's and St Thomas' Hospitals see the majority (54%) of Lewisham patients for elective admissions, with University Hospital Lewisham seeing less than half that percentage (25%). King's College Hospital takes 14% of Lewisham residents with just 2% going to South London Healthcare hospitals.

**Chart 7: Elective admissions by Lewisham residents**



This pattern of patient flows has held over time. Analysis carried out ten years ago by Public Health Lewisham shows the same natural flow which indicates either an unwillingness to flow elsewhere or that going elsewhere is difficult.

**Table 5: Inpatient flows, Lewisham, 2000-2002**

	KING'S COLLEGE HOSPITAL (DENMARK HILL)	KING'S COLLEGE HOSPITAL (DULWICH)	PRINCESS ROYAL UNIVERSITY HOSPITAL	QUEEN ELIZABETH HOSPITAL NHS TRUST	QUEEN MARY'S HOSPITAL	SOUTH LONDON AND MAUDSLEY NHS TRUST	UNIVERSITY HOSPITAL LEWISHAM
Grand Total	17%	11%	2%	5%	4%	2%	1% 58%

APC FCE data supplied by SSP

### 6.3 Conclusion

There is limited inflow from surrounding areas into Lewisham for hospital services. There is a considerable outflow of Lewisham residents to other hospitals in South London, particularly for elective care. However people tend to travel towards the centre of London – to Guys' Hospital, St Thomas' Hospital and King's College Hospital and not elsewhere. This may cause problems given the underlying assumption that Lewisham residents will divert to services at Queen Elizabeth Hospital.