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 be 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 15th 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 31st 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 heath 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 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 give 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.