

30 January 2013

The Secretary of State
DH

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Dear Secretary of State,

You asked me to provide an independent clinical view on the recommendations made by the Trust Special Administrator (TSA) for South London Healthcare NHS Trust (SLHT). Specifically, you asked me to review the final report of the TSA and consider:

1. Is there strong evidence that there was a sufficient level of clinical input into developing the recommendations?
2. Is there a strong case that the recommendations are likely to lead to improved patient care in the local area?
3. Are the recommendations underpinned by a clear clinical evidence base as required by test 3 of the "four tests" on reconfiguration?

You asked me to focus particularly on the recommendations made by the TSA in relation to A&E and maternity services at Lewisham Healthcare NHS Trust, where you were clear that your decision in relation to these recommendations must be compatible with improving care for local patients.

I have now had the opportunity to review the evidence and my recommendations are set out below.

Summary

I consider that you should support the broad recommendations in the report, subject to some modifications and conditions, which I outline in this letter. A summary of my view is below:

- The issues of SLHT should be seen in the wider context of the provision of high quality health services for the whole population of South East London.
- A core concept in this scheme is to adopt the consensus based London-wide clinical standards, which would place South East London healthcare ahead of most of NHS in England.

- Planning assumptions for changes in patient flows always carry uncertainty. The sequencing of implementation of the changes, with check points, by the TSA will be critical. The TSA must ensure there is no risk to patients by inadvertent under provision at hospitals receiving displaced Lewisham activity. This is particularly applicable to the impact on the Community Based Care programmes and for the provision for acute medical emergencies in the receiving Trusts.
- Consideration should be given to the development of direct admission step-up facilities in Lewisham Hospital for unscheduled attendances.
- The addition of senior Emergency Medicine doctors would add a further level of safeguard to the assessment, diagnosis and initial treatment of patients.
- In this context, although it would provide less specialist emergency care, it would remain a small but safe A&E department.
- I would expect to see nearer 75% of previous unscheduled attendances at Lewisham being managed on that site with the combined effect of these additions, rather than the 50% proposed in the final TSA report.
- Full provision of paediatric services has been made in the plan but is dependent on clear definition and adoption of protocols of primary ambulance conveyance, an ambulatory paediatric urgent care service at Lewisham and rapid transfer protocols for ill self-presenters. This must be considered a priority by the TSA for implementation.

I will now turn to your three questions. I will answer questions two and three together, given there is an intrinsic link between improved patient care and the clinical evidence base.

Is there strong evidence of sufficient clinical input?

I can confirm that there is strong evidence of wide clinical input.

Operationally the TSA programme was supported by a Clinical Advisory Group led by a local GP, Dr Jane Fryer which built on two years of preceding clinical engagement. This group included 8 Trust Medical Directors, 6 clinically qualified CCG Chairs, the London Ambulance Service Medical Director, the local Director for Trauma, and 3 Directors of Nursing.

An additional External Clinical Panel, chaired by Professor Chris Welsh, SHA Medical Director for Midlands and East of England, provided additional scrutiny and challenge, including from the Royal College of Midwives and the Royal College of Obstetrics and Gynaecology.

Both the local Clinical Advisory Group and the External Clinical Panel included respected local and national clinicians as part of their membership.

There was also wider clinical engagement through a series of workshops in August and September 2012.

However, you will be aware that the Lewisham CCG and many clinicians in Lewisham Hospital do not support the proposal. Their main concerns about clinical quality relate to the proportion of patients who can be definitively treated at Lewisham Hospital without the input of senior doctors trained in emergency medicine and in-patient specialty medical staff. Furthermore, there are concerns about the adequacy of provision of care for acutely ill patients in the other hospitals and the provision of care for acutely ill children presenting to the Lewisham centre. The TSA has recognised these concerns and this resulted in some modifications. I acknowledge these are ongoing concerns and hence the conditions attached to my recommendation.

Is there a strong case that the recommendations are likely to lead to improved patient care in the local area?

Are the recommendations underpinned by a clear clinical evidence base as required by test 3 of the "four tests" on reconfiguration?

Whilst the case for change in South East London is predominantly financial, this is an opportunity to redesign and improve the delivery of health care services in the South East of London to the benefit of the public. The key element to this is the rationalisation of sites delivering acute in-patient care, since none of the South East London hospitals meet the 2012 pan-London standards for acute care.

The recommendations of the report provide for the adoption of these London-wide clinical standards which are central to the quality improvement model for South East London. They were developed by over 90 clinicians working in multiple expert panels, before the special administration process was initiated. The standards define best clinical practice and have set the bar higher than that currently provided in most other acute providers in England. Because they define excellent clinical practice and service delivery they have become a key aspiration of CCGs in South East London and their adoption, via the TSA proposals, will address the significant variations in availability of senior clinical expertise.

It is my view, that the adoption of these standards could not be achieved without a reduction in sites delivering acute inpatient care to enable better co-location of services and critical mass of senior clinicians. There will be more consultants in the designated hospitals for more hours which will be particularly beneficial for acute medical and surgical care in these proposals. We have already seen evidence in London of how centralised services with a high level of consultant input can improve stroke, major trauma and cardiovascular disease services.

The TSA and local clinicians must be able to articulate clear and understandable plans for the public to reassure them that acutely ill patients, particularly from the Lewisham area, will be able to access high quality services in an emergency. We will need reassurance that there are sufficient critical care services for the receipt of acutely ill medical and surgical patients in receiving hospitals.

I am satisfied that no evidence has been found for any significant increase in emergency conveyance of 'code red' 999 calls to a point of definitive care in the final model proposed; the whole population of South East London will continue to be within 30 minutes of a blue light transfer of an A&E Department. There is no quality of care impact from the very small increase in conveyance time to hospital.

I am, however, concerned that the recommendation for a non-admitting Urgent Care Centre at Lewisham may not lead to improved patient care in all instances. I agree that patients with serious illness or injury will be better served from concentrating specialised emergency care in specialist centres that achieve the London wide clinical standards. However, I believe that consideration should be given to the further development of direct access to step-up admission facilities in Lewisham Hospital. This would be appropriate for patients requiring short duration, relatively uncomplicated treatments or a temporary period of supervised care, for example as a result of a minor infection. It is illogical to transfer **all** patients elsewhere.

This would be comparable to admitting and managing patients in a community hospital based on experienced clinical judgement. This would better serve the needs of patients who are often frail and elderly and who arrive by non-blue light ambulances.

To add another level of clinical safeguard to the operational model, I believe Lewisham should retain senior Accident and Emergency medical cover. In this configuration, although Lewisham would provide less specialist emergency care, it would retain a small but safe A&E department. It must be part of a wider network of urgent and emergency care within the sector. Rotation of staff will be essential to ensure that the right levels of skills are maintained at the Lewisham site.

If the admission option and senior Emergency Medicine cover modifications were agreed, I would expect the combined effect to result in nearer 75% of the previous unscheduled attendances at Lewisham could be managed on site, rather than the 50% proposed in the TSA report. I should make clear that patients who have a potential to deteriorate or who require more sophisticated or lengthy treatment would not be appropriate for this facility. I also consider that this option would help reduce demand in those hospitals with more comprehensive A&E services.

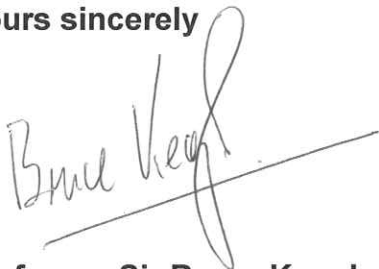
I am satisfied that there was substantial clinical input and external scrutiny of the maternity options. The Expert Clinical Panel was not willing to endorse the risk, be it small, for an obstetrician-run unit at Lewisham in the absence of intensive care services. This is because obstetrician run units attract higher risk mothers and babies. However, in light of the recent Birthplace research study I support the proposal for a free-standing midwifery-led birthing unit at Lewisham.

The development of a major elective facility for non-complex surgery on the Lewisham site is much less contentious. There are examples of where this has worked well in the NHS including the South West London Elective Orthopaedic Centre.

The only other area of clinical risk I wish to highlight relates to paediatric care. Over the years, Lewisham has developed a respected high quality paediatric service. Any alternative should be designed to be even better in terms of clinical outcomes and patient and parental experience. This is possible but is dependent on very clear protocols for primary ambulance conveyance, an ambulatory paediatric urgent care service at Lewisham and rapid transfer protocols for any sick children who would be better treated elsewhere. This will require careful pathway planning particularly with the ambulatory paediatric service. This need is recognised in the proposals but must be considered a priority by the TSA in the next stage of implementation.

With these caveats, I would be content to assert that there is a strong case that the recommendations are likely to lead to improved care.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Bruce Keogh', with a long horizontal stroke extending to the right.

**Professor Sir Bruce Keogh
NHS Medical Director**