

# Appendix J

## TSA Response to Consultation Feedback



**Securing  
sustainable  
NHS services**

## Introduction

1. This appendix to the final report of the Trust Special Administrator (TSA) appointed to South London Healthcare NHS Trust provides a summary of the TSA's response to consultation feedback.
2. A number of solutions have been tried over many years to overcome the challenges faced by the Trust, however, none have delivered the scale of change required to secure clinically and financially sustainable services for the long-term for the people served by South London Healthcare NHS Trust.
3. As a result, on 16 July 2012 a Trust Special Administrator (TSA) was appointed to South London Healthcare NHS Trust by the Secretary of State for Health under the Regime for Unsustainable NHS Providers (UPR).
4. The TSA's task was to make recommendations to address the challenges that South London Healthcare NHS Trust faces in a way that would mean that clinically and financially sustainable services could be secured for the long-term for the communities served by the Trust, as well as the wider NHS across south east London.
5. The TSA and his team had 75 working days to develop a set of draft recommendations. On 29 October 2012 these were published in the TSA's draft report which was then formally consulted on for a statutory 30 working days between 2 November and 13 December 2012.
6. Patients, the public, staff and stakeholders were given the opportunity to put forward their views and comments. The consultation's aim was to validate and improve the TSA's draft report. The statutory guidance required the TSA to request written responses from any relevant SHAs and any commissioner that commissions services from the provider, if directed to do so. The legal framework sets out specific meetings the TSA must hold during the consultation period:
  - at least one meeting with staff and unions;
  - at least one public meeting to allow anyone with an interest to give their views;
  - with the SHA or any commissioner to whom the provider provides goods and services that the Trust Special Administrator has requested a written response from; and
  - any persons that the Secretary State directs the Trust Special Administrator to meet.
7. Over 27,000 full consultation documents and 104,000 summary documents were distributed during the consultation period – these were sent to 2,000 locations across south east London including hospital sites, GP surgeries, libraries and town halls. A

dedicated website was established to support the consultation, which has received over 25,000 unique visits since going 'live' on 29 October. During the consultation period, the TSA team attended or arranged over 100 events or meetings, which included 14 public meetings organised by the TSA team, meetings with a range of community groups and other stakeholder organisations and events for staff.

8. Ipsos MORI, independent experts in research and polling, were commissioned to collate and analyse all consultation feedback. In total 8,224 responses were received to the consultation. An analysis of these has been produced by Ipsos MORI and can be found at Appendix I of the TSA's final report.
9. The TSA has used the analysis undertaken by Ipsos MORI to inform the final report; this appendix provides a summary overview of how this has been incorporated.

## Consultation feedback – a summary

10. A total of 8,224 responses were received to the consultation. The breakdown of these can be seen in Figure 1.

Figure 1: Breakdown of consultation response type

Method	Total
Hard copy response forms	884
Online response forms <sup>1</sup>	6,327
Written comments from individuals (letters and emails) <sup>2</sup>	842
Written comments from stakeholders (letters and emails)	156
Petitions	15
<b>TOTAL</b>	<b>8,224</b>

11. Overall there was opposition across all six draft recommendations from individuals, with the most significant opposition being shown for draft recommendation 5. Analysis of the feedback from those providing additional comments has revealed some key themes around each recommendation that may explain people's opposition. These are reviewed in more detail in this appendix.

<sup>1</sup> Multiple responses were accepted from individual Internet Provider (IP) addresses to ensure, for example, that a family sharing a home computer were all able to submit individual responses. In some cases, a large number of responses were received from an individual IP address. There were ten IP addresses where over 10 responses were received from that one address. The highest number of responses from one IP address was 247, although the rest were significantly lower. Eight of the 10 IP addresses were registered to NHS bodies.

<sup>2</sup> This figure includes 515 forms created by Save Lewisham Hospital Campaign, with pre-printed statements and respondents' own responses to three questions on the recommendations. Please see chapter 10 for further details.

12. Individuals providing feedback on behalf of a group or organisation, via the consultation response form, tended to be more supportive, as were those who currently or have previously worked in the NHS.
13. Over 150 stakeholders responded to the consultation covering a wide range of different groups and organisations including national bodies such as the NHS Commissioning Board and Monitor, local NHS commissioning and provider organisations, staff representative groups and unions, Royal Colleges, MPs and politicians, local authorities and scrutiny committees, local involvement networks, community and voluntary groups, expert patient groups, clinicians as well as the independent sector.
14. Stakeholders on the whole were much more supportive of the recommendations than general members of the public with the majority agreeing there is a need for change. Stakeholders from Lewisham and some in Greenwich tended to be less supportive however. Most provided general feedback or focused on draft recommendation 5, with a large number seeking assurances around planning, capacity and implementation. Where stakeholders referred to the clinical standards for acute care, most were supportive of them.
15. As well as being invited to comment on the draft recommendations, all consultees were asked to provide improvements to the recommendations and / or alternatives if they did not agree with them. They were also asked to provide additional evidence they thought the TSA and his team should consider in their work. Some stakeholders raised issues that they thought should be addressed in the final report, helped to strengthen and validate the available data and / or provided different ideas on some of the draft recommendations. However, no viable alternative solutions were put forward during the consultation to address the challenges faced by South London Healthcare NHS Trust and how that impacts the wider NHS in south east London in their entirety.
16. The following sections of this appendix provide a high level summary of the key themes raised by individuals and stakeholders during the consultation for each of the six draft recommendations, and how the TSA has aimed to address these in the final recommendations.
17. It should be noted that the majority of stakeholders did not respond using the response form and did not comment on every recommendation in their written responses. Therefore, stakeholder themes outlined in the following sections are not exhaustive and for a full review of stakeholder responses, and indeed those from individuals, the full consultation feedback report from Ipsos MORI should be reviewed. This can be found at Appendix I of the TSA's final report.

## Recommendation 1 – Improve the efficiency of South London Healthcare NHS Trust

18. The consultation asked whether people agreed or disagreed with the need to improve the efficiency of the hospitals that make up South London Healthcare NHS Trust to match that of top performing NHS organisations. It then went on to ask whether the areas that had been identified for making efficiencies by the TSA were appropriate.
19. Individual respondents were divided in their support for the recommendation to improve the operational efficiency of the hospitals, with similar proportions agreeing and disagreeing (42% and 37% respectively). Four in five individuals felt that the specific areas identified to improve efficiency were not appropriate.
20. A more positive response was observed from those responding on behalf of an organisation or group via the consultation response form, both about the need to make efficiencies and the specific areas for improvement suggested. More agreed than disagreed with each element of this recommendation.
21. Free-text comments suggested that the efficiency of the hospitals within South London Healthcare NHS Trust could be improved. However, some concerns were raised, particularly around potential reductions to the number of staff, the potential and / or perceived impact on quality of care and patient outcomes, and a feeling that patient care should be the key driver for change rather than efficiency considerations.
22. Overall, stakeholders who commented on this recommendation were supportive of the need for South London Healthcare NHS Trust to become more efficient, however, some expressed a need for more assurance that increased efficiency would not result in a reduction in quality of care
23. The TSA's final recommendation around operational efficiency is that the three main hospital sites that make up South London Healthcare NHS Trust need to make significant operational efficiencies. A total opportunity of £74.9m has been identified over the three years and this should be delivered to bring the Trust in line with similar trusts across the country. This is set out in Chapter 4 and in more detail in Appendix D of the final report.
24. Since publication of the TSA's draft report the Trust supported by the TSA team has developed cost improvement programme schemes (CIPs) for the next three years to achieve these savings.
25. Recognising concerns raised during the consultation around efficiency savings leading to a potential reduction in quality of care, the CIPs have been reviewed by an internal and external clinical panel.

26. Together the two panels made four major recommendations:

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

The Trust is currently working to implement these recommendations as part of its annual cost improvement plan implementation. This will include a process of review and assurance. Significantly, the clinical review panel highlighted the need for both strong clinical and managerial leadership to deliver this ambitious programme.

## **Recommendation 2 – Developing a Bexley Health Campus**

27. The consultation asked about two elements of the draft recommendation for developing a Bexley Health Campus, firstly whether consultees supported or opposed the proposal that Queen Mary's Hospital should become a Bexley Health Campus, and then whether or not the land and buildings required for this should be sold or transferred to Oxleas NHS Foundation Trust.
28. Individual respondents were broadly opposed to the development of a Bexley Health Campus, with 45% opposing both proposals and 15% supporting them. Bexley residents were more supportive, although a majority of each group still opposed the recommendation.
29. Those responding on behalf of organisations or groups via the response form were more in favour of the proposals than individuals. One in three supported the proposal that Queen Mary's Hospital should become a Bexley Health Campus (35%), while 3 in 10 opposed it (29%). They were also supportive of the proposal to sell or transfer the required land and buildings to Oxleas NHS Foundation Trust, with 38% in support and 27% opposed.
30. A common theme emerging from the free-text comments was confusion regarding the plans for Bexley Health Campus, often with a fear that the proposals could lead to privatisation of healthcare services. Where there was opposition, it tended to oppose privatisation rather than the sale or transfer of land and buildings to Oxleas NHS Foundation Trust. There was also some confusion about what the term 'Health Campus' means.

31. A number of stakeholders commented on draft recommendation 2 including local clinical commissioning groups, some MPs, a number of NHS provider trusts and local authorities as well as union and staff representatives. The majority of stakeholders that commented on the proposals expressed support for the recommendation however, in line with individual feedback which echoed views heard at the Bexley public meetings, some disagreed with the proposed name stating that the current affiliation and loyalty to the 'Queen Mary's' name should remain. Others expressed concerns that the procurement process to secure a provider of day case surgery in the long-term could lead to private sector provision.
32. However, the Co-operation and Competition Panel (CCP) concluded in their advice to the TSA that a formal procurement process to appoint a provider of day case elective and endoscopy services at Queen Mary's Hospital would avoid concerns in relation to patient choice and competition.
33. The TSA's final recommendation is set out in Chapter 4 of the final report and in Appendix N of the final report. In summary, it is to support the development of Queen Mary's Hospital as a 'hub' for the provision of health and social care in Bexley, facilitated by the transfer of the required portion of land and estate from what is currently owned by South London Healthcare NHS Trust to Oxleas NHS Foundation Trust. Taking into account consultation responses, but also evidence from the working group, the TSA decided to continue with the recommendation as the option most likely to deliver effective health services and a financially viable site.
34. In direct response to consultation feedback, and following discussion with local stakeholders, the TSA recommends that the site continues to be known as Queen Mary's Hospital.
35. To provide continuity of service for patients and certainty for staff, Dartford and Gravesham NHS Trust is recommended as the interim provider of day case surgery at the site with King's College Hospital NHS Foundation Trust providing some specific services. It is proposed that a full procurement process should be run by local commissioners for day case surgery within 22 months of South London Healthcare NHS Trust being dissolved, should the Secretary of State accept the TSA's recommendation. As with any NHS procurement process, the NHS commissioners will develop a detailed contract specification which NHS organisations will be able to bid for, as will independent and third sector providers. The supplier that is best able to meet the requirements of the contract will be appointed. However, whichever provider is selected, these will be NHS services delivered free at the point of need. This is in line with the NHS principles of cooperation and competition<sup>3</sup> intended to ensure best value for the taxpayer and follows the advice provided to the TSA by the Cooperation and Competition Panel.

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<sup>3</sup> Principles and Rules for Cooperation and Competition, Department of Health, 1 October 2010

### **Recommendation 3 – Making the best use of buildings owned and leased by South London Healthcare NHS Trust**

36. Respondents were asked whether they supported or opposed the recommendation that South London Healthcare NHS Trust should sell or no longer rent poorly used or empty buildings.
37. Individual respondents were, on the whole, opposed to the recommendation that poorly used or empty buildings should be sold or no longer leased (70% opposed, of which 63% were strongly opposed). A more positive response was noted for those responding on behalf of an organisation or group; almost half supported the recommendation (48%) with 39% opposing it.
38. Free-text comments showed opposition to the sale of any assets or buildings, and a concern was raised that once assets were sold they may not be recovered should a need for extra capacity arise in the future. Emphasis was often placed on the fact that services may need to expand in the future to accommodate a changing population. Others felt that if there was space available within the NHS, then it should be filled and used to provide services.
39. In addition, some responses related to this specific recommendation received via letter or email registered concern about the provision of services for the local community at Beckenham Beacon.
40. Stakeholders commenting on this recommendation were generally supportive of the proposals. However, and similarly to the comments made by individual respondents, some stakeholders raised questions about the need for additional space in the future and had this been considered in the modelling undertaken by the TSA and his team. Questions around the future of Beckenham Beacon were also raised.
41. The TSA's final recommendation is that any poorly utilised South London Healthcare NHS Trust land or buildings should be sold if owned, and exited if leased. This is because it is an integral component of the overall solution and viable alternatives to it were not proposed during the consultation. Specific proposals are outlined for Queen Mary's Hospital, Orpington Hospital and Beckenham Beacon. Full details can be found in Chapter 4 of the TSA's final report.
42. In developing all of the recommendations the TSA has taken account of the forecasts in population growth. Data has been taken from the Office of National Statistics as well as the Greater London Authority. The analysis on population growth has taken the upper of the two so that the assumptions used to develop the recommendations did not underestimate the future requirements.

43. In response to specific concerns raised around the provision of services for the local community at Beckenham Beacon the TSA team has worked with Bromley Clinical Commissioning Group (CCG). The final recommendation states that there should be a three year transitional period during which South London Healthcare NHS Trust should continue to pay for some of the space within Beckenham Beacon and provide services from the site. This transition period will enable the local commissioners to specify what they want to be provided from Beckenham Beacon in the future and further develop their plans to create a planned care centre at the site that could include:
- an extended range of outpatient services, diagnostic facilities and simple procedures, to increase the volume of patients flowing through the existing space and support an extension of clinical hours;
  - integrated services for older people at the site, including rapid access clinics, a day hospital for the elderly and therapy support;
  - an extension of primary care on the site; and
  - improvements to the current minor injuries and ailments services.

#### **Recommendation 4 – National support in relation to excess Private Finance Initiative costs**

44. The consultation asked to what extent people supported or opposed the recommendation for the Department of Health to provide additional funds to the local NHS to cover the additional costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth Hospital and Princess Royal University Hospital until the relevant contracts end.
45. There were mixed views regarding this recommendation, with 42% of individual respondents supporting it, and 35% opposing it.
46. Those responding on behalf of organisations or groups were more in favour of the proposal, with 61% supporting it.
47. Free-text comments suggested that opposition stemmed mainly from a resistance to paying the PFI debts back at all; or at least a desire for the contracts to be re-negotiated. Many respondents felt very strongly about the negative impact of PFI generally on the NHS. Respondents supporting the recommendation felt that the local NHS should not have to suffer because of previous decisions by central government, and so agreed that the Department of Health should provide funds for the relevant PFI debts.

48. Stakeholders commenting on this recommendation were mainly in strong support of the proposal.
49. The TSA has no power to change national policy on PFI, however, to ensure the gap to affordability on the PFI contracts is closed, the final recommendation, set out in Chapter 4 of the TSA's final report, is that the Department of Health provides direct support to the future operators of the Queen Elizabeth Hospital and Princess Royal University Hospital to cover the excess costs of the PFI contracts on an annual basis until the relevant contracts are modified or end.
50. The TSA team has undertaken an analysis to review the costs of the PFI contracts and their impact on South London Healthcare NHS Trust's financial position. The details of this review have been submitted to the Secretary of State as part of the delivery of the final report. This information will remain confidential due to commercial sensitivities.
51. The Department of Health has several options in regards to the PFI contracts, each of which provides different levels of value to the public sector. These options are covered in the confidential paper provided to the Secretary of State.

## **Recommendation 5 – Transform the way services are delivered across south east London**

52. Draft recommendation 5 concerned service provision across the wider NHS in south east London due to the consequences on the wider health system from the issues and earlier recommendations impacting on South London Healthcare NHS Trust. This draft recommendation was split into four care areas, and respondents were asked whether they supported or opposed the proposals in each of these areas:
  - Care in the community and closer to home
  - Urgent and emergency care
  - Maternity services
  - Planned care

Each of these areas is taken in turn below.

### *Care in the community and closer to home*

53. On the whole, individual respondents opposed the community based care recommendation (47% vs. 23% in support), although 31% did not offer an opinion. However, the polar opposite response was received from organisations and groups with 47% in support of the community based care recommendation compared to 23% in opposition.

54. In the free-text comments some support was given to the proposed community based care strategy, though this support tended to be conditional on the basis of increased funding and improvements to care in the community, while also not occurring at the apparent expense of other services such as hospital services.
55. Stakeholders commenting on this element of draft recommendation 5 were generally supportive welcoming a shift of care closer to home. However, some commented that it would only work if the appropriate level of investment was made in advance, others said whilst they were supportive the plans looked 'aspirational' whilst others were concerned about the pace of change.
56. The Health and Equalities Impact Assessment (HEIA) undertaken on the draft recommendations set out clearly a range of significant benefits to large sections of the population in south east London if the changes outlined in the community based care strategy are delivered.
57. The TSA's final recommendation on care in the community and closer to home is set out in Chapter 5 of the TSA's final report. In summary, it is that implementation of the community based care strategy should be taken forward as it will deliver significant clinical benefits including saving around 700 lives a year just through early detection and management of diabetes alone and underpins other recommendations on emergency care and operational efficiencies.
58. Since publishing the draft report at the end of October 2012, the TSA and his team have worked with clinical commissioning groups across south east London to further develop the community based care strategy, ensuring it is robust and deliverable, thus addressing concerns raised by some in the consultation that it is too aspirational. The detailed strategy can be found at Appendix O of the TSA's final report.
59. It should be noted that the strategy is in keeping with national policy and direction. Many other clinical commissioning groups in London, and indeed elsewhere in the country, have higher aspirations for service improvement.
60. Both the TSA and local commissioners recognise that delivering the community based care strategy at the pace required will need investment and robust programme management, not least of all because until these changes are delivered in community care, the proposed changes in the acute sector cannot be delivered successfully.
61. It is expected that CCGs will need to pump-prime their investment to deliver at pace and to ensure that primary care and community based care in south east London is transformed. The CCGs have identified the requirements for this pump priming and start-up costs of £42m over 3 years in order to achieve the commissioner savings, as identified by the TSA, of £128.7m. In order to deliver this it will require funding from

non-recurrent sources across south east London which has been factored into the modelling.

62. In addition to the start-up costs and pump priming, there will be ongoing recurrent costs of the redesigned services. Once the programme is fully implemented these costs are estimated to be £30m per annum. These will build up throughout the implementation period and will, in part be funded from reinvestments of QIPP savings.

### *Urgent and emergency care*

63. Regarding the proposed changes to urgent and emergency care, the vast majority of individual respondents opposed the changes (90%), while amongst Lewisham residents (who make up a large proportion of the consultation responses received), the level of opposition rose to 96%. Overall, there was limited support for these proposed changes (8%). Amongst organisations and groups responding via the consultation response form, there was greater support for the proposed changes to urgent and emergency care though, on balance, the majority opposed them (24% support vs. 67% oppose).
64. A large proportion of the free-text comments provided stated that University Hospital Lewisham should keep its A&E department. The reasons underpinning this were good perceptions of the current service and not wanting to waste money from the refurbishment; the need for a large population to be served by an A&E; seeing it as unfair to penalise University Hospital Lewisham when it is performing well financially compared to South London Healthcare NHS Trust; concerns about capacity at other A&Es; concerns about travelling to other A&Es, including increased travel times and the impact on safety.
65. The majority of stakeholder responses focused on this element of draft recommendation 5. Generally stakeholders were more supportive than individual consultees, with a number supporting the need for change and service change that would deliver the desired clinical standards, in particular NHS organisations including local commissioners and some local provider organisations as well as NHS London and those Royal Colleges commenting on the case for change. However, other stakeholders were strongly opposed to the proposals, especially those based within the Lewisham area. A number of petitions were also received around these particular proposals opposing the changes set out.
66. Stakeholder concern and questions chimed with those raised by individuals. In addition workforce planning, education and training, modelling assumptions as well as understanding the detail of services to be provided by the urgent care centre and communicating this to the public were also key themes of some of the stakeholder responses.

67. The Health and Equalities Impact Assessment (HEIA) is clear that reduced access to emergency care can disproportionately impact on economically and socially deprived groups as well as the elderly. However, this is outweighed by the positive benefits derived from the improvement in the quality of care at those hospitals that will continue to provide emergency care.
68. The HEIA also states: “The change in travel time, relating to emergency and urgent care currently at Lewisham Hospital, is not statistically correlated with economic and social deprivation”, although there is an impact on those considered in the broader category of “health deprivation”. This does not ignore the fact that there will be longer journeys for some patients.
69. When considering race, the HEIA identifies that stroke and hypertension are disproportionately prevalent amongst people from black and minority ethnic groups. However, these services are already centralised in south east London and, as such, there is no expected impact of the proposed changes on health outcomes for these patients.
70. When considering disability, the HEIA shows that mental health problems and coronary heart disease are disproportionately prevalent for people with learning disabilities, but the proposed changes will have no negative impact for these patients.
71. The HEIA also identified that older people are also relatively frequent users of A&E services and are more than twice as likely as others to be admitted to hospital following an A&E attendance. Therefore, the proposed changes have significant implications for the continuity of care for these patients.
72. Whilst there was significant opposition to the draft recommendation that University Hospital Lewisham should no longer have an admitting emergency department, on the basis of the full clinical and financial evaluation of options and after taking into account the consultation responses, including the fact that no viable alternative option was suggested, the final recommendation is that King’s College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas’s Hospital should provide inpatient emergency care for the most critically unwell. University Hospital Lewisham, Guy’s Hospital and Queen Mary’s Hospital Sidcup should provide a full range of services for patients who do not need to be admitted to hospital. This is set out in detail in Chapter 5 and Appendix E of the TSA’s final report.
73. The detailed analysis that has been undertaken demonstrates that the recommendation proposed is the only viable option. Alternative options, including one that Queen Elizabeth Hospital, rather than University Hospital Lewisham, should operate in this way was fully considered but discounted, as implementing that option would have a more detrimental impact both on access and on the financial viability of the health economy. This is set out in Appendix E of that TSA’s final report. Similarly,

leaving service changes to be determined by the merged Lewisham and Queen Elizabeth Hospital Trust would not address the issue facing the organisation.

74. Urgent care services are well established at Guy's Hospital and Queen Mary's Hospital Sidcup. The final recommendation is that University Hospital Lewisham provides a full range of services, with a view to treating at least 50% of the people currently attending the A&E and urgent care services at the site. This would mean that urgent care services will continue to be available locally and it will also help to minimise the impact on the four remaining A&E departments in south east London.
75. Analysis included in the TSA's draft report suggested around 77% of University Hospital Lewisham's current A&E activity would remain at the hospital under this scenario. However, a number of responses to the consultation suggested that this estimate was too high. Therefore, further analysis was undertaken and, based on practice elsewhere in London, a revised figure of 50% has been used for the modelling that underpins the TSA's recommendation thus addressing concerns raised during the consultation. Through implementation and working with the local community, more people should be encouraged to attend the service.
76. The multiplicity of offerings for urgent and emergency care is currently the subject of work being undertaken by the Medical Director for the NHS, the aim of which is to eradicate the confusion that many people experience in understanding which emergency and urgent care services are provided at different places. Reflecting on what the public said during the TSA's consultation, emergency and urgent care services across all sites in south east London should be developed in line with the output from the Medical Director's work as it emerges. It is also recommended that strong communications will be needed to support the public in understanding these changes and how and where to access care, and this should be linked to the development of the 111 urgent care phone service roll-out.
77. The capacity of the remaining four hospitals to take on additional activity if the proposed changes to emergency care are implemented was challenged during consultation and has been considered in detail by the TSA team. A capital investment of £37m for remodelling A&E departments and the number of emergency beds to cope with additional demand at these hospitals, has been factored into transition costs. It is also expected that some staff will also transfer, so that there will be sufficient capacity in the system to ensure no negative impact on the quality of services or waiting times in A&E departments. Other changes, including a reduction in average lengths of stay and improvements in the provision of community based care, will also help to reduce the demand and therefore minimise the increased pressure on the other hospital sites.
78. The TSA and his team have undertaken a detailed analysis of the impact on access to emergency care services should this recommendation be taken forward. Currently, around 315 patients arrive to be seen by University Hospital Lewisham's emergency

and urgent care services each day<sup>4</sup>. Of these, around three arrive in a 'blue light' ambulance<sup>5</sup> and would need to be taken to an alternative location in the future, 79 arrive in an ambulance without a 'blue light', and the remaining arrive via private or public transport. Over 150 of the 315 patients would still be able attend the hospital if the proposals were to be implemented.

79. Journey times have been analysed in detail using Transport for London's Health Service Travel Analysis Tool, and the proposals for emergency care outlined in this recommendation would increase the journey time to reach an A&E across south east London by an average of approximately one minute for those in a 'blue light' ambulance, two minutes for those using private transport and three minutes for those using public transport.
80. The HEIA recognised that the entire socially and economically deprived population in south east London will continue to be within around a 30-minute 'blue light' ambulance journey of an A&E department and will still have much better access to A&E services than the majority of the population in England.
81. When considering age, the HEIA showed that children (defined as aged up to 16) are associated with high – and growing – levels of A&E usage. The HEIA report states: "...the majority of children currently attending A&E at Lewisham hospital could continue using the urgent care services. Through streamlining A&E attendances and ensuring that children with minor conditions are treated at the urgent care centre or by their own GP in primary care, there is a potential positive impact on health outcomes overall as critical A&E paediatric specialists are freed to deal with the most serious conditions in a smaller number of hospitals". Throughout the transitional period, improved information would need to be supplied to parents to ensure they are aware of the range of services for children that will be provided at University Lewisham Hospital in the future. Paediatric consultants would also be present in the paediatric ambulatory care service in University Hospital Lewisham if the changes are accepted and implemented.
82. To address potential negative impact on the elderly, if this recommendation is implemented older people who would currently present with problems at University Hospital Lewisham could benefit from being admitted to a step-up facility there, or will need to be transferred and admitted to another hospital, before being transferred back to a step-down facility at University Hospital Lewisham. These multiple interfaces will require clear protocols and robust systems in place to ensure adequate continuity of care is maintained.
83. In order to better understand and mitigate against any potential negative impacts on staff training, and to enhance positive impacts, the TSA team has been in regular

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<sup>4</sup> Data provided by Lewisham Healthcare NHS Trust

<sup>5</sup> Explanatory note: London Ambulance Service define a 'blue light' ambulance journey as one that is required when a patient is identified as having life-threatening or abnormal vital signs

contact with NHS London's People and Organisation Development Directorate, the London Deanery and the south London Local Education and Training Board (LETB). The LETB is supportive of the TSA recommendations and has offered further support to ensure the subsequent design and development of the workforce is underpinned with high quality education. While this will be challenging, not least for University Hospital Lewisham, the recommendations, if accepted, provide an opportunity to redesign, modernise and improve training. Following discussions with the London Deanery and LETB, it is clear that review and redevelopment of training for acute and community services could be undertaken in a joint, coordinated fashion and presents an opportunity to deliver significant improvements. This opportunity has generated substantial interest and will therefore be taken forward if the recommendations are accepted by the Secretary of State.

84. Full details of all the analysis, modelling and options evaluation can be found in Appendix E of the TSA's final report.

### *Maternity services*

85. For both individual respondents and organisations/groups, there was no clear support for either option for providing maternity services across south east London. Amongst individual respondents, nearly 7 in 10 supported neither option (69%) and where they did choose between the two options, more preferred an additional stand-alone obstetric-led unit at University Hospital Lewisham (24%). A similar proportion of organisations/groups also selected this option (26%), but one in four said they weren't sure which option they would prefer (23%). There was minimal support among individuals or organisations/groups for obstetric-led services at the four major hospitals only (3% and 7% respectively).
86. The majority of free-text responses emphasised the need for maternity services to be co-located with emergency care, with concern about the risk of providing obstetric-led services without A&E at the same site. Respondents mentioned the high quality maternity services they thought were already available at University Hospital Lewisham and the recent investments; the growing population; concerns about capacity at other hospitals; concerns about distances and travel times including the impact on safety; and wanting maternity care to be provided locally.
87. Stakeholders commenting on this element of draft recommendation 5 were mixed in their views with some supporting the need for change and an increase in consultant cover but not providing a preferred option. Others supported the option of an additional stand-alone obstetric-led unit at University Hospital Lewisham but expressed concerns about safety if not co-located with emergency services. Concerns were raised about capacity planning given the expected population growth and challenges with capacity across maternity services in south east London currently.

88. In the face of such responses it is not possible to find a consensus view. The pros and cons of the two options - including the importance of the agreed clinical standards and how each of the two options would meet those standards - were debated in full during the consultation. It is clear from the responses to the consultation that people have strongly-held views about the future of maternity services, even if many did not favour one option over the other. On the whole, Lewisham stakeholders came out in favour of the five-site model; while other stakeholders, especially the professional bodies, continued to emphasise the importance of meeting agreed clinical standards and how this meant a four-site model was preferred.
89. During consultation, the external clinical panel assessed the benefits and risks (and potential mitigating actions) associated with each of the options. Further clinical engagement was sought via a workshop of obstetricians, midwives, paediatricians, anaesthetists and intensivists from each of the five current maternity units in south east London. Feedback was also received from the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, through service user focus groups, from consultation responses and through meetings with providers and clinicians in south east London. All of this further informed the assessment of both options.
90. The external clinical panel - with extended membership to include obstetric and midwifery representatives, as well as representatives from the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives - considered the benefits and, in particular, the risks and proposed mitigating actions for each option.
91. The disadvantage of four hospital sites providing obstetric-led services is the negative impact on some women of access and the capacity at remaining units in the face of additional demand. The disadvantage of five hospitals providing obstetric-led services is the increased clinical risk associated with the unit at University Hospital Lewisham – while it would have critical care facilities for women requiring high dependency care, it was not proposed to have full intensive care facilities. The external clinical panel recognised that the need to transfer women to a facility with full intensive care facilities would happen infrequently; however, this is a risk that the external clinical panel was not willing to endorse, even for a small number of women. For this sole reason, the panel agreed that this model was not clinically sustainable and therefore that an obstetric-led unit at University Hospital Lewisham was not a viable option.
92. The panel's decision, endorsed by the representatives from the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, was therefore to recommend to the TSA a configuration of four obstetric-led services. In reaching its decision, the external clinical panel further endorsed the proposal to develop midwifery-led birthing units alongside all remaining obstetric units and also

recommended developing a free-standing midwifery-led birthing unit at University Hospital Lewisham.

93. The final recommendation with regards to maternity services in south east London is that four obstetric-led units with co-located midwifery-led birthing units should be provided in south east London and a freestanding midwifery-led birthing unit be provided at University Hospital Lewisham.
94. The HEIA signalled that implementing this recommendation could improve maternity outcomes by concentrating obstetric-led maternity services on to fewer sites and enabling greater consultant presence. The report recognises that a critical mass of deliveries could be achieved under the proposal, thus justifying 168 hours (24/7) consultant presence each week.
95. The HEIA also endorses the recommendation that all obstetric units should be co-located with midwifery-led birthing units and that all units need to meet in full the clinical quality standards developed for London. In particular, this will benefit women with high risk pregnancies.
96. For low risk births, there are also potential benefits in terms of health outcomes; midwife-led care is associated with improved experience for mothers and fewer interventions.
97. However, the HEIA echoed many of the responses to the consultation, namely that a significant number of people are concerned that implementing the proposals will reduce choice for women, have a negative impact on access to services and threaten continuity of care, particularly for women in Lewisham. The proposals were also identified as likely to impact negatively on economically deprived groups, BAME groups and teenage mothers. As per emergency care, the entire socially and economically deprived population in south east London will continue to be within a reasonable journey time of a maternity unit and will still have much better access than much of the population elsewhere in England. Continuity of care will need to be carefully considered during implementation planning to ensure robust pathways and protocols exist across health and social care providers through the whole maternity pathway.
98. In response to concerns raised during the consultation, the TSA is recommending that capital investment of £36m is factored into transition costs to provide additional capacity; this includes the development of midwifery-led birthing units at Queen Elizabeth Hospital and King's College Hospital.
99. Similar to the transition plan for emergency services, a plan for the transition of some staff will be needed to support changes to maternity services thus ensuring there is an appropriate increase of medical, midwifery and support staff at each unit, so that

there will be sufficient capacity in the system to ensure no negative impact on the quality of services.

### *Planned care*

100. Individual respondents tended to oppose the proposed changes to planned care (68%). Organisations/groups completing the consultation response form were more supportive, with 3 in 10 supporting the recommendation (31%), although more opposed it (50%). The most frequent theme emerging in the free-text responses was concerns about increased difficulties in accessing care as a result of the proposed changes.
101. Stakeholders commenting on this element of draft recommendation 5 were generally supportive with a number stating that there are benefits for patients in separating planned and unplanned care. Lewisham Healthcare NHS Trust was especially supportive of the proposals stating that an elective centre of excellence could deliver improvements in patient outcomes and experience. Some stakeholders did require more detail on the planning and business model. Stakeholders that were not supportive of the proposals tended to cite increased travel times for local people as their main concern.
102. The HEIA, in relation to the elective centre, highlighted that patients treated there could benefit from the centralisation of non-complex elective procedures, both in terms of health outcomes and patient experience. These benefits result from the separation of elective and emergency care and include the reduction and elimination of hospital-acquired infections and a reduction of cancellations in procedures.
103. The final recommendation is outlined in detail in Chapter 5 of the TSA's final report and in Appendix E. In summary, for non-complex planned care in south east London an elective centre at University Hospital Lewisham should be established as a centre of excellence, utilising the latest techniques and technology to provide high quality care, minimising infection and supporting patients to return to normal in the quickest and safest way. The elective centre in Lewisham will be the largest multi-speciality centre in the country, serving around 20,000 patients a year. It should operate for a minimum of six days a week.
104. Complex planned operations should be undertaken at the four major hospitals where they can be supported by full intensive care services. Day case surgery should continue to be provided from across the seven hospital locations in south east London as is the case today. Specialist planned operations will continue to be provided at specialist hospitals.
105. Commissioner and provider support for the elective centre of excellence was tested during the development of the final recommendations. Commissioners were largely in favour of the development of the centre; this was again restated in their responses to

the consultation. Concerns were raised in Lewisham CCG's response that the success of the centre was dependent on other trusts in south east London referring to the centre. With strong commissioner support, this risk is in part mitigated. This risk can be further mitigated by provider support, which was expressed by some during consultation in terms of the benefits the centre could bring by separating emergency and elective services. However, the detail of the clinical and business model would need to be developed further during implementation to provide further assurance to provider trusts.

106. In line with concerns raised during the consultation with regards to increased travel times for some patients should this recommendation be accepted, the TSA is proposing that patients using the new elective centre would continue to receive their pre- and post-operative care at locations closer to their homes in line with the community based care strategy. Patients would therefore only be required to travel for their operation, but would reap the benefits of bringing together knowledge and experience from across south east London to create a new centre of excellence.
107. The TSA accepts that the recommendation will lead to greater travel times for some patients to receive treatment and that this could particularly impact on people with disabilities, on the economically and socially deprived population and on older people. Also, carers and relatives could also be impacted. However, the Health Equalities Impact Assessment (HEIA) has shown that public transport access to University Hospital Lewisham is rated as very good by the Transport for London Public Transport Accessibility Level score.
108. The HEIA also outlines that journey travel times and costs will not increase for many patients. As pre- and post-surgery appointments will take place closer to patients' homes, the increased journey times and costs are only likely to be for the operation itself. Additionally, for non-complex elective inpatient admissions at University Hospital Lewisham patients, their relatives and carers may benefit from the proposed development of a new car park.

## **Recommendation 6 – Delivering service improvement through organisational change**

109. Draft recommendation 6 concerned organisational solutions for South London Healthcare NHS Trust. Four separate questions were asked of respondents about the proposed plans in order to gauge support or opposition for them:
  - Dissolution of South London Healthcare NHS Trust;
  - The Queen Elizabeth Hospital site should come together with Lewisham Healthcare NHS Trust to create a new organisation focused on the provision of care for the communities of Greenwich and Lewisham;

- There were two options posed for Princess Royal University Hospital. The first, and preferred option, was an acquisition by King's College Hospital NHS Foundation Trust, which would enable the delivery of service change, enhance the services offered at the site and strengthen the capacity of the site to deliver the necessary operational improvements. An alternative option consulted on was to run a procurement process that would allow any provider from the NHS or independent sector to bid to run services on the site, and
- The Department of Health to write off the £207m debt accumulated by South London Healthcare NHS Trust to the end of 2012/13.

110. The majority of individual respondents opposed the plan to dissolve the current South London Healthcare NHS Trust (65%), with some (in the free-text comments provided) believing that the Trust could be rescued with better management and without the need for extensive reorganisation. Organisations and groups completing a response form were more positive, with 1 in 3 supporting the move to dissolve the Trust (34%) compared to around 16% of individuals.

111. Individual respondents showed a similar level of opposition in relation to the plan for Queen Elizabeth Hospital and Lewisham Healthcare NHS Trust to merge (71%). While Lewisham residents were particularly likely to oppose this proposal, those living in Bexley and Bromley were more positive (although still opposed overall). Free-text comments revealed some concerns about the failure of previous mergers and the perceived risk to Lewisham Healthcare NHS Trust in joining with a failing hospital. Organisations and groups were slightly more positive than individual respondents with 47% opposed (compared to 71% of individuals) and 27% in support.

112. Of the two options put forward by the TSA for the future running of the Princess Royal University Hospital, nearly 2 in 5 individual respondents were in favour of the hospital being acquired and run by King's College Hospital NHS Foundation Trust (37%). Around 3 in 10 individual respondents supported neither of the two options suggested by the TSA (31%). The key issue for many in the free comments provided was a concern that running a procurement process would lead to private providers of NHS services, something that was strongly opposed. For those who said the Princess Royal University Hospital or King's College Hospital was their nearest hospital there was greater support for an acquisition of Princess Royal University Hospital by King's College Hospital NHS Foundation Trust. Around 3 in 5 respondents who said Princess Royal University Hospital (58%) or King's College Hospital (62%) was their nearest hospital preferred this option.

113. The views of organisations and groups were slightly more in line with those of individuals for this question; 41% were in favour of the plan for King's College Hospital NHS Foundation Trust running the Princess Royal University Hospital.

114. The overwhelming majority of individual respondents agreed with the recommendation for the Department of Health to write off debts accumulated by South London Healthcare NHS Trust (77%), with little variation observed across sub groups. Free-text comments showed that respondents felt this was the only solution to ensure success in the future and to maintain services for residents of south east London. However, some queried the need for organisational and service restructuring, if the debt was written off and effective management put in place. Four in five organisations/groups agreed with the recommendation for the Department of Health to write off South London Healthcare NHS Trust's accumulated debts (81%).
115. Stakeholders who commented on draft recommendation 6, in contrast to those views put forward by individuals and groups, were generally in support of the organisational solutions proposed in the draft recommendations. No stakeholder respondent opposed the proposal that South London Healthcare NHS Trust be dissolved.
116. Whilst generally supportive, some stakeholders did raise concerns around pace of implementation and the need for strong leadership, as well as funding to support changes. Lastly, stakeholders who commented were supportive of the proposal that the Department of Health should write off South London Healthcare NHS Trust's accumulated debt.
117. The final recommendation is outlined in Chapter 6 and Appendix F and is summarised in paragraphs 118 to 128 below.
118. In summary, South London Healthcare NHS Trust should be dissolved and new organisational arrangements should be put in place to drive improvements and take the proposed changes forward.
119. The proposed date for dissolution of South London Healthcare NHS Trust and the establishment of new organisational arrangements is recommended to be 1 June 2013. This balances the pace of change required with the importance of ensuring that changes affecting staff are clear and can be completed in a timescale that allows sufficient involvement from staff themselves thus addressing concerns raised by some stakeholders.

### *Queen Mary's Hospital*

120. Recommendation 2 sets out the proposals for the future of Queen Mary's Hospital. The site should be owned and run by Oxleas NHS Foundation Trust. The transfer of the site to Oxleas NHS Foundation Trust will include provisions in relation to future use of the land and access for other providers. Under the Trust's leadership, the hospital will have a sustainable future, providing the services that commissioners have identified as being required for the local population and creating a centre of excellence for inpatient mental health services across Bexley and Bromley. It is also being recommended that Oxleas NHS Foundation Trust is the interim provider of the

Children's Development Centre and the Children's and Young Person's Assessment Unit currently delivered by South London Healthcare NHS Trust. As Oxleas NHS Foundation Trust already delivers a range of community paediatric services, this recommendation will support the better integration of children's services.

### *Queen Elizabeth Hospital*

121. Taking into account the proposed dissolution of South London Healthcare NHS Trust, the financial projections, the need for sustainable services and Lewisham Healthcare NHS Trust's interest in contributing to the solution, the final recommendation is that Lewisham Healthcare NHS Trust comes together with Queen Elizabeth Hospital to form a new organisation that provides services to the populations of Greenwich and Lewisham.
122. It is envisaged that the new organisation should provide a range of clinically and financially sustainable acute and community services in Lewisham and acute services for the population of Greenwich which will work in partnership with primary care, the local authority and Oxleas NHS Foundation Trust to ensure integrated services are provided across the primary and acute care interface. This new Trust should also host the proposed elective surgical centre at University Hospital Lewisham.
123. Concerns were expressed through the consultation process regarding the potential for University Hospital Lewisham to be destabilised as part of the creation of the new organisation. In addition, experience from the creation of South London Healthcare Trust shows that in the first year as a merged Trust it reported a normalised deficit of £44m, double that of the corresponding figure of the three predecessor trusts (£22m). Therefore, it is recommended that the NHS Trust Development Authority provides support and close oversight during the creation of the new organisation.
124. A number of consultation responses, including from Lewisham Healthcare NHS Trust and from Lewisham CCG, have supported the establishment of this new organisation. However, their stated preference is for the new Trust to determine its own plan for services. While they recognise the need for change, to replace one deficit Trust with another one, without an agreed strategy for improving clinical services, does not address the underlying structural issue and merely postpones the difficult decisions for another day. This new Trust would be reliant on financial support, with no plan to bring this to an end. There would be a consequential impact at Princess Royal University Hospital where operating losses would also continue as outlined at the end of Chapter 4 in the TSA's final report. In any case, in line with the Government's policy, commissioners – and not the Trust – would need to bring forward proposals for service change. All other local commissioners are broadly supportive of recommendation 5.

### *Princess Royal University Hospital*

125. The final recommendation is that King's College Hospital NHS Foundation Trust acquires the Princess Royal University Hospital site and its services as this was the preferred option coming through the consultation feedback. King's College NHS Foundation Trust is a well-established NHS Foundation Trust with a track record of delivering high quality acute care. It has a strong management team, its financial performance is sound, and it has extensive experience of delivering significant productivity improvements.
126. Options for implementing this acquisition from as early as April 2013 were considered, subject to the proposed acquisition meeting NHS regulatory requirements and meeting a timetable for Monitor to consider the proposed business case. Further work has been undertaken on this, and it is now recommended that this is implemented from 1 June 2013, as with all of the other proposed organisational solutions.
127. Implementing to this timescale will enable King's College Hospital NHS Foundation Trust to provide clear leadership and support to the staff and services at the Princess Royal University Hospital, which will assist in the effective delivery of both final decisions for service change and necessary productivity improvements, and allow the necessary preparatory work to be completed in advance. King's College Hospital NHS Foundation Trust will also be able to draw on the wider expertise within King's Health Partners in order to bring wider clinical and research benefits to staff and patients.
128. The success of these new organisations will be essential for the local population. They will have a significant agenda to implement in order to secure safe, high quality and affordable services for the long-term. The TSA believes they should be allowed to dedicate themselves to that effort and not be burdened with the issues of the past. To facilitate this, it is recommended the new organisations are not faced with any repayment requirements relating to historic debts and that the Department of Health should write off South London Healthcare NHS Trust's accumulated debt.

### **Other themes emerging from the consultation non-specific to the draft recommendations**

129. The consultation itself was criticised by some, both during consultation events and through consultation responses. Key complaints included:
- the length of the consultation being too short, and much shorter than the 'usual' 12 weeks;
  - low awareness of public meetings and other engagement opportunities; and
  - limited availability of hard copy consultation materials.

130. The TSA team followed and met all of the statutory guidance from the Department of Health, and the commitments made in its own consultation framework published alongside the draft report, in publicising the consultation and distributing materials. The statutory requirement was to make the consultation document and the public meeting dates available online by 2 November which was met by the TSA.
131. In addition, over 27,000 full consultation documents (see appendix H) and 104,000 summary documents were distributed during the consultation period – these were sent to 2,000 locations across south east London including hospital sites, GP surgeries, libraries and town halls.
132. Awareness was raised amongst local residents through the media, hard copy documents and posters as well as online channels:
- The consultation was publicised in over 110 separate news stories – over a third of which were in the local south London papers - including national TV, radio and online news sites.
  - Adverts were also placed in local papers across all of south east London publicising the consultation meetings and how people can have their say on the draft recommendations.
  - A dedicated website was developed ([www.tsa.nhs.uk](http://www.tsa.nhs.uk)) which received 25,000 unique visits since going 'live' on 29 October.
  - The TSA team attended or arranged over 100 events or meetings, which included 14 public meetings organised by the TSA team, meetings with a range of community groups and other stakeholder organisations and events for staff.
133. A number of different channels were developed for people to have their say.
- attending a public meeting;
  - completing an online response form ([www.tsa.nhs.uk](http://www.tsa.nhs.uk));
  - completing a hard copy response form from within a consultation document;
  - telephoning the freephone enquiries line;
  - emailing to TSA team; and/ or
  - writing to the TSA team.
134. The length of the consultation is set down in legislation and as such the TSA had no power to extend the consultation period.

135. It is the view of the TSA that the process of distribution and engagement during the consultation was comprehensive and thorough, and was in line with what was set out in the consultation framework published as part of the TSA's draft report.
136. In addition to criticism around the consultation process itself, a key theme of feedback through the public meetings and consultation responses was around the health and equalities impact assessment and queries as to why this hadn't been undertaken before the consultation commenced so the outcome could be considered as part of the consultation.
137. All public sector bodies have to give due regard to the "public sector equality duty" that arises from the Equality Act 2010 as part of their decision making. A combined HEIA has been independently undertaken to understand the potential impact of the initial recommendations published in the draft report as well as assessing the third maternity option, which emerged during the consultation period. The purpose of the independent HEIA is to contribute to the information available to support the development of the TSA's final report and enable the TSA in meeting the formal requirements of the Equality Act 2010.
138. The HEIA is intended to answer three questions:
- What are the positive and negative impacts of the proposed changes on communities within south east London, particularly in respect of health inequalities, equalities and access; taking specific regard, but not exclusively, to the groups defined in legislation?
  - What is the scale of each impact; its likelihood and duration i.e. whether the impact is long term or temporary; and the impact on those with protected characteristics?
  - How can any adverse impacts be mitigated and positive impacts enhanced?
139. A three phase approach was adopted: Initial screening and scoping report (that was published alongside the TSA's draft report, followed by data capture and engagement (which ran in parallel with consultation activity) and lastly the Health and Equalities Impact Assessment taking onboard findings from phase two as well as findings from the TSA's consultation.
140. The HEIA could not have been undertaken ahead of the consultation period as the draft recommendations were not published until a few days before the consultation started. In addition, and crucially, the HEIA needed to take account of feedback received during the consultation.
141. In drawing up the final recommendations, the TSA is required to give due consideration to the impact on protected groups. The HEIA has enabled the final

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

## Conclusion

142. This consultation was conducted under the UPR and as such there were a number of differences from other formal consultations conducted by the NHS which usually seek views on significant service changes. These differences were managed but presented some significant challenges.
143. First, the statutory requirements of the consultation were different to those of 'usual' NHS consultations. The requirement was for the TSA to consult on the draft report and recommendations – this meant every draft recommendation was included and consulted upon. It is not normal practice for NHS bodies to consult on elements of change such as ongoing cost improvement programmes, Private Finance Initiative contract re-negotiations or smaller changes to the way NHS estate and buildings are used and managed. This was challenging as it created another level of complexity, and in some cases, for example with draft recommendation 4 relating to the proposal for the provision of national financial support for existing local Private Finance Initiative contracts, provoked a swell of negative reaction against the national PFI policy itself, rather than anything relating to South London Healthcare NHS Trust.
144. Second, the duration of the formal public consultation period was much shorter than would normally be expected of an NHS consultation at just 30 working days. Indeed, as stated above, the TSA team was criticised locally in this respect for seemingly not following government-wide Cabinet Office guidance on best practice for the length of public consultations, despite the fact that the 30 working day consultation period was set out in statute as part of the Unsustainable Provider Regime. The rationale for this shortened timetable – which stretches across the entirety of the regime period, not just consultation - is to ensure focused energy and attention on determining rapid and transformational solutions to sizeable challenges. It is purposefully not 'the norm'. However, the shortened consultation timeline presented some practical and logistical challenges in terms of raising awareness amongst a large population across south east London to ensure as many people as possible who wanted to comment had the opportunity to do so. The TSA believes this was addressed with the large number of consultation engagement events and opportunities for contribution.
145. Third, and arguably the most significant, the TSA's draft report which was being consulted on was developed as a result of a 'last resort' intervention by the Secretary of State for Health. Significant issues of financial and clinical sustainability have existed across the NHS in south east London since 2004/05 and although a number

of solutions have been tried, none have delivered the scale of change required to secure clinically and financially sustainable services for local people for the long-term. This context means that the status quo is not an option. Analysis of the consultation responses shows there was general opposition across the recommendations from individuals showing people would prefer no change, however because of the context outlined here, this is not viable and not possible for the TSA to recommend.

146. Many stakeholders responding to the consultation, including the NHS Commissioning Board, all local commissioners, relevant strategic health authorities, those Royal Colleges commenting and many local providers including Lewisham Healthcare NHS Trust, agree that change is necessary to ensure sustainability of services in the future and doing nothing is not an option.
147. However, looking at each recommendation in turn there was not a consensus of opinion across stakeholders highlighting why a local resolution to south east London's longstanding issues has not been reached during previous attempts to agree long-term strategic plans across the local health system. This strongly reinforces the need for effective leadership and oversight to successfully implement any decision for change made, as outlined in Chapter 7 and Appendix Q of the TSA's final report.
148. The TSA has used the issues, perspectives and feedback received from the consultation and the HEIA to help improve and refine the recommendations where possible and to inform the transition planning necessary to deliver safe, high quality, affordable and sustainable health services for the people of south east London into the future.
149. The seven recommendations presented in the TSA's final report do not stand alone. They are interlocking, and only when taken together is there a sufficient response and solution to the scale of the challenges that have resulted in the continuous deficits, and risks to quality of care, in South London Healthcare NHS Trust and its predecessor organisations.
150. The set of seven overarching recommendations, set out in detail in chapters 4, 5, 6 and 7 of the TSA's final report, is believed to be the only viable option identified that has the potential to address the scale of the challenge.