The London Ambulance Service is integral to service reconfiguration across London and welcomes the opportunity to comment on the draft report by the office of the Trust Special Administrator at South London Healthcare NHS Trust.

The Trust has commented on each recommendation as laid out in the draft report.

1. **The operational efficiency of the hospitals that make up South London Healthcare NHS Trust needs to improve so that the Trust's costs are in line with strong performing NHS organisations.**

   The London Ambulance Service agrees with this recommendation as a general principle that applies to all NHS organisations.

2. **Queen Mary's Hospital Sidcup should be developed into a Bexley Health Campus providing a range of services to the local population, including day case elective surgery, endoscopy and radiotherapy. The facility should be owned by Oxleas NHS Foundation Trust and services should be provided by a range of organisations.**

   The mixed provider model provides an opportunity for a diversity of operating models and the potential for a large number of relatively small contracts. The London Ambulance Service's main concern is regarding the Patient Transport Services contracts held by each of the provider organisations. Our suggestion would be for a combined contract that is as comprehensive in its provision as possible. This would include the ability to transfer patients out of a day centre facility, to the appropriate alternative, for patients who may not be suitable for full discharge at the time of the day care facility closing.

   In our experience transformations of this nature can lead to an increase in referrals from Health Care Professionals. The London Ambulance Service is not commissioned to routinely transfer such patients unless there is an emergency presentation.

3. **Vacant and poorly utilised premises should be exited (leases) or sold (freeholds). The NHS should engage with the local authorities in Bromley and Bexley in the process of selling surplus estate to ensure its future use maximises regeneration opportunities.**

   The London Ambulance Service agrees with this recommendation as a general principle that applies to all NHS organisations.

4. **On an annual basis until the relevant contracts end, the Department of Health should provide additional funds to the local NHS to cover the excess costs of the PFI buildings at Queen Elizabeth Hospital and Princess Royal University Hospital.**

   The two PFI sites located at Princess Royal University Hospital and Queen Elizabeth Hospital have clearly made a substantial impact on running costs. There appears to be little discussion within the report on how the Trust Special

Administrator has come to the conclusion that the DH should directly finance the additional funds. What other options have been considered?

Clearly the London Ambulance Service would need to understand the impact on the local economy and our ability to deliver services if a greater proportion of the finite health resource is given to support the private finance initiatives.

5. **In line with commissioner intentions to improve the quality of care for the local population, there should be a transformation in the way services are provided in south east London. Specifically, changes are recommended in relation to community-based care and emergency, maternity and elective services:**

   - **Community Based Care – The Community Based Care strategy for south east London should be implemented to deliver improved primary care and community services in line with the aspirations in the strategy. This will enable patients to receive care in the most appropriate location, much of which will be closer to, or in, their home.**

     The vision of providing more services locally is wholly supported by the London Ambulance Service. However, our experience of working across London reveals that these objectives are much harder to realise than initially thought. Our main concern would be for the acute bed base and other acute services to be scaled back before the community based changes have been made thereby creating an increase in the number of 111/999 calls and creating additional pressure on other parts of the health care system and health economy.

   - **Urgent and emergency care – Emergency care for the most critically unwell patients should be provided from four sites - King's College Hospital, St Thomas' Hospital, Queen Elizabeth Hospital and Princess Royal University Hospital. Alongside this, services at University Hospital Lewisham, Guy's Hospital and Queen Mary's Hospital Sidcup will provide urgent care for those that do not need to be admitted to hospital. Emergency care for those patients suffering from a major trauma (provided at King's College Hospital), stroke (provided at King's College Hospital and Princess Royal University Hospital), heart attack (provided at St Thomas' Hospital and King's College Hospital) and vascular problems (provided at St Thomas' Hospital) will not change from the current arrangements.**

     In our opinion, in terms of clinical safety, the vast majority of patients who currently require a time critical response are unaffected by this recommendation. We already routinely take cardiac, stroke, trauma, and vascular patients to specialist centres which do not appear to be directly affected by the suggested transformation. However, there are potentially indirect consequences for these time critical patients. They fall into two issues.

1. Delay at the Front Door for time critical patients

It must be acknowledged that the vascular, stroke, cardiac and trauma centres use their Accident & Emergency departments as their front door and there is an opportunity to cause an indirect delay to time critical patients if the increased demand in any patient group (minor, standard & major) is not met through capacity adjustments. This is particularly relevant for King's College Hospital who already experience capacity challenges and are a centre for all of the time critical specialties.

We do have concerns regarding the assumptions being made around the figures used to predict the changes in demand and therefore the impact on these Accident & Emergency departments.

The A&E flows that are supporting the recommendations in the draft report are as follows:

A&E attendances at Lewisham Hospital are forecast to be 120,000 in 2015/16 (based on the 315 per day figure forecast to 15/16), of which

- 60k are 'minor'
- 25k 'standard'
- 35k 'major'

For the modelling the assumptions are that Lewisham Hospital retains all of the 60,000 minor cases and 50% of standard cases making a total of 72,000. The remaining 48,000 are redistributed based on the patient flows as follows;

- 37% to King's: 18,000
- 29% to Queen Elizabeth: 14,000
- 23% to Princess Royal: 11,000
- 6% to St.Thomas': 3,000
- 5% to Croydon: 2,000

These flows and calculations work on a single assumption: that Lewisham Hospital can continue with approximately 60% of its current workload and this proportion will continue to present to the hospital in the same way as it currently does. Consideration does not appear to have been given for factors that persuade patients to self present at alternative Accident & Emergency departments, for example, the proportion of patients that will present elsewhere as they do not understand what an Urgent Care Centre can treat.

In the experience of the London Ambulance Service it is a lower percentage than the 60% that is retained at an Urgent Care Centre that was once an Accident & Emergency department.

The draft report appears silent on how the other organisations will adjust to the increased demand. If the assumption is that these organisations can absorb any increase then this will undoubtedly lead to delay at the front door of the Accident & Emergency department.

There is no indication on the intended hours of opening. Clearly if there is no provision at night then this will create additional pressures on other services during these hours.

2. Delay in sending clinicians and a vehicle to time critical patients

Any delay at the front door also extends the amount of time our staff and vehicles are unavailable to attend another call.

The lengthening of time, no matter how small it seems, significantly impacts on our ability to respond to patients within the 8 and 19 minute time frames as staff and vehicles get tied up with longer cycle times. In other words this pushes our utilisation beyond our efficiency threshold.

Additionally, any 999 call in the area that would have previously been conveyed to Lewisham Hospital will get an extended journey time to an Accident & Emergency department further afield. Whilst this may not be detrimental to the individual patient it increases the length of time it takes the Ambulance Service to complete the care episode. This further impacts on our vehicle and staff availability to respond to new calls.

In our opinion, in terms of clinical quality, there are potentially direct consequences of the recommendations in the draft report. These are broken into two issues.

1. Delay in sending clinicians and a vehicle to non time critical patients

Inevitably any potential delay will force us to prioritise clinical safety and we will divert our available resources to our time critical patients. This means those patients that will experience the most significant delay will be those that are not time critical. This is a clinical quality issue.

However, within this patient group are a number of patients who have not been identified as time critical, for example patients with gastrointestinal bleed, where it would not be helpful to have an extended delay. This group of patients would have been received by Lewisham Accident & Emergency and will also undoubtedly travel further to the next nearest receiving hospital.

2. Out of area

Whilst mainly an issue for other providers it is worth noting that any decisions that move patients further from their locality by diverting them further afield leads to complexities for discharge and makes it more difficult for family members to be involved in their care.

The Ambulance Service has encountered patients who simply refuse to be conveyed out of area. This potentially means vulnerable people being left at home with a referral to their GP. This may not be the best treatment option for this group of patients.

There is very little mention of paediatric services. Lewisham Hospital Accident & Emergency sees a relatively high volume of paediatrics and many of these do not come through the 999 system and are taken directly by parents. There is a possibility that parents may call 999 if they know their child is going further afield. This would raise the Trust's 999 call volume. In addition the consequences on inpatient paediatric units and neonatal units are more significant than for adults and this would need further exploration.

The Accident & Emergency department also supports patients with chronic diseases. Whilst every effort is made to ensure patients with chronic disease have alternatives to Accident & Emergency the nature of some chronic diseases mean some acute phases require treatment within Accident & Emergency. Those patients currently being treated by Lewisham Hospital would be conveyed to another provider unless the patient could make their way to The Queen Elizabeth Hospital. The effect and the mitigation on the management of chronic disease needs further clarification.

Mitigation
Essentially all of the above can be mitigated through an accurate impact assessment. We suggest a thorough testing of the recommendations with both provider Trusts and with Acute and Ambulance commissioning. This will allow the impact on the London Ambulance Service to be quantified and thoroughly understood and the necessary funding adjustments be made.

The ambulance service will need to be appropriately resourced to ensure there is no impact to patients receiving an ambulance service response

- **Maternity care – There are two options under consideration to ensure that a high quality of care is provided for women needing to be in hospital during pregnancy and for women when giving birth. Obstetric-led deliveries could be centralised in line with critical emergency care across King's College Hospital, St Thomas's Hospital, Queen Elizabeth Hospital and Princess Royal University Hospital; alternatively, there could also be a 'stand-alone' obstetric-led delivery unit at University Hospital Lewisham. All other maternity care will continue to be provided in a range of locations across south east London.**

  The Ambulance Service employs a Consultant Midwife. In our experience the bigger units can be more cost effective and adhere to the standards for cover. However closing local smaller units means further to travel for patients and many patients desire a local service for their midwifery care. Women sometimes see the larger units as offering an impersonal service and more medicalised (and therefore more interventional). In this case some women may choose a home birth when there is no real local alternative.

  The main issue for the ambulance service is the potential increase in travel time in any emergency that could arise.

- **Elective care – An elective centre for non-complex inpatient procedures (such as hip and knee replacements) should be developed at University**

Hospital Lewisham to serve the whole population of south east London. Alongside this elective day cases procedures should continue to be provided at all seven main hospitals in south east London; complex procedures should continue to be delivered at Kings' College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas' Hospital, and specialist procedures at Guy's Hospital, King's College Hospital and St Thomas' Hospital. Outpatient services should be delivered from a range of local locations.

There appears to be no mention of the intensive care facilities at Lewisham Hospital and how any changes to emergency access would impact on such a unit and the subsequent implications of maintaining clinical safety to a wholly elective intensive care unit. Clearly if there was to be no intensive care facility this would have potential implications for the ambulance trust for emergency hospital transfers.

6. **In order to deliver this transformation programme, South London Healthcare NHS Trust should be dissolved and other organisations should take over the management and delivery of the NHS services it currently provides. In addition to the proposals for Queen Mary's Hospital Sidcup outlined above:**

- **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.**

  The London Ambulance Service has no comment to make for this recommendation

- **There are two options for Princess Royal University Hospital. The first is 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. This is the preferred option at this stage. However, an alternative option is to run a procurement process that would allow any provider from the NHS or independent sector to bid to run services on the site.**

  The London Ambulance Service has no comment to make for this recommendation

- **It is important that these new organisations are not saddled with the issues of the past. To this end, it is recommended that the Department of Health writes off the debt associated with the accumulation of deficits at South London Healthcare NHS Trust. By 31 March 2013, this is estimated to be £207 million.**

  Our response is the same as recommendation 4 in that the London Ambulance Service would need to understand the impact on the local

economy and our ability to deliver services if a greater proportion of the finite health resource is given to support the private finance initiatives.

7. Miscellaneous/Other Comments

The London Ambulance Service is becoming increasingly concerned about the absence of a London wide overview of all the various transformation schemes. For example, there appears to be no consideration on the potential impact of Croydon University Hospital from the transformation changes in South West London; specifically the possible closure of St Helier Accident & Emergency Department.

In addition there appears to be no consideration on how possible changes outside of London may impact on the work of South London transformation. For example, potential service reconfiguration for the coming together of Dartford & Gravesham and Kent & Medway to a merged North Kent Hospitals NHS Foundation Trust.

Summary

The London Ambulance Service is confident it can support the proposed transformation of care within South East London. However, the ambulance service is already undertaking a capacity review jointly with commissioners due to concerns about the rising demand and the capacity to manage this whilst maintaining safe high quality care. Further impact analysis of the proposed South London health care changes is critical to ensure that the London Ambulance Service can provide the appropriate resource in response to those changes.

We can not absorb the additional demand and guarantee no impact on quality. It is critical that further impact analysis is undertaken and that this is supported by the appropriate resource.