Advisory

Lewisham and Greenwich NHS Trust and NHS Greenwich Clinical Commissioning Group

Review of the financial, clinical and operational impact of the musculoskeletal services ("MSK") recommissioning on Lewisham and Greenwich NHS Trust – At a Glance only

Strictly Private and Confidential
16 February 2017
Final

pwc

Important notice

This At a Glance has been prepared under our engagement letter with Lewisham and Greenwich NHS Trust ("the Trust") and NHS Greenwich Clinical Commissioning Group ("the CCG") dated 11th January 2017.

This At a Glance summarises our findings as set out in our final report dated 16th February 2017. As explained in our engagement letter, we accept liability only to specified parties and only in relation to our final report. We do not accept liability to anyone in relation to this At a Glance in isolation, and reference should be made to our final report to understand the full details of our work and our findings.

This At a Glance, which is being made available to the Trust and the CCG, must not be made available or copied in whole or in part to any other person without our express written permission.

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The Trust and the CCG agree to pay due regard to any representations which PwC may make in connection with such disclosure and to apply any relevant exemptions which may exist under the Legislation to such reports. If, following consultation with PwC, the Trust or the CCG disclose this report or any part thereof, they shall ensure that any disclaimer which PwC has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

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We report to Lewisham and Greenwich NHS Trust ("the Trust") and NHS Greenwich Clinical Commissioning Group ("the CCG") in accordance with our agreement dated 11 January 2017.

This report has been prepared in relation to the financial, clinical and operational impact of the musculoskeletal services ("MSK") recommissioning on Lewisham and Greenwich NHS Trust, and represents our final report.

By nature of the situation, our analysis and findings are based on a range of assumptions, and we have assessed the impact through a range of scenarios in the aim of providing both the Trust and CCG as clear a view as possible. We discussed and agreed these assumptions and scenarios with both the Trust and the CCG early in our work.

We draw your attention to important comments regarding the scope and process of our work, and note the commercially sensitive nature of this impact assessment and its content.

Save as described in the agreement or as expressly agreed by us in writing, we accept no liability (including for negligence) to anyone else or for any other purpose in connection with this report, and it may not be provided to anyone else.

Yours faithfully

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Background and context

We set out the background to this impact assessment and wider context.

Background

NHS Greenwich Clinical Commissioning Group ("the CCG") tendered the MSK service which it commissions from Lewisham and Greenwich NHS Trust ("the Trust"), in April 2016.

The CCG is not the only commissioner of MSK services from the Trust, however this report only considers the MSK services commissioned from the CCG. These services currently represent 5.6% of total Trust income from the CCG.

The CCG has confirmed during this impact assessment that the primary drivers in procuring the new MSK service are to produce better quality care and outcomes for all patients and to create a financially sustainable health care system that delivers better value.

The Trust, in partnership with Greenwich GPs and other local providers, and CircleHealth ("Circle") both submitted tender responses, with Circle selected as preferred bidder in July 16.

New provision of these MSK services had originally been intended to begin on 17 October 2016, however was delayed until 1 December 2016 and then to 1 March 2017, following scrutiny from local stakeholders and agreement of terms.

Specifically, finalisation of the draft contract which we understand to be in place between the CCG and Circle has been put on hold while this impact assessment is undertaken, and we understand that there is no draft contract or terms agreed between Circle and the Trust.

Wider context

There are other orthopaedic initiatives and changes being discussed and planned across the local geography and wider Sustainability and Transformation Plan ("STP") footprint. We have not directly considered the impact of these changes in our analysis, but we summarise a number of them below as they may influence the operating environment for the Trust in the future. These may increase or mitigate the risks which we have identified in this report.

- The Trust has a significant and growing backlog of elective orthopaedic patients to be treated due to capacity constraints, particularly on the Queen Elizabeth Hospital ("QEH") site. There are also RTT performance issues at other providers in south east London. These waiting lists may influence patient choice now and under the future contract. This has contributed to the Trust's relatively low outpatient to surgery conversion ratio.
- The Trust is currently planning to make changes to the delivery of orthopaedic care as a result of stopping day case surgery on the Queen Mary's Hospital site in Sidcup. As a result of this, its surgical plan indicates that inpatient surgery will move to the University Hospital Lewisham ("UHL") site at their new arthroplasty centre, with day case and trauma activity remaining at QEH.
- The Trust is part of south east London's STP footprint, in which it is proposed that elective orthopaedic care is consolidated into two or three elective orthopaedic centres. The Trust has highlighted significant concerns associated with moving to a two site model and that any further transformation could have a significant impact on its sustainability of services.

The Trust has expressed that it is unclear as to the flow of payment in relation to treatment of patients as part of its backlog. Based on subsequent discussions with the CCG, we understand that within its draft contract with Circle, patients who have been referred to the Trust (prior to or after their first outpatient appointment) will continue on their existing pathway. From the contract start date, Circle will have responsibility for payment to the Trust for this activity, which we have assumed to be under PbR tariff arrangements (in line with other acute activity they sub-contract to the Trust).

Scope of impact assessment

We set out the scope of this impact assessment.

Our scope

We have been engaged jointly by the Trust and the CCG to provide an independent assessment of the impact on the Trust of losing MSK services. Our scope of work is:

- to review and comment on the Trust's financial outturn in FY16 and forecast financial outturn for FY17 to give a baseline against which the impact of the MSK service loss can be assessed;
- to review and comment on the financial assumptions and impact arising from changes to existing MSK service provision at the Trust, to the proposed new service model; and
- to investigate and comment upon operational and clinical implications attributable to the changes to MSK service provision.

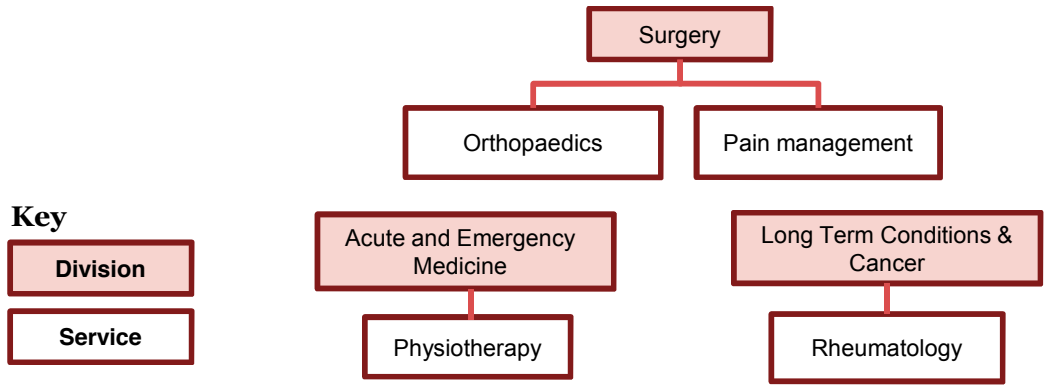
During the course of our work, and to facilitate our ability to perform scenario analysis on the impact, we have sought to:

- gain clarity on the scope of the tendered services;
- extract and document activity reduction and potential mitigation and repatriation assumptions (as well as any guarantees) being put forward by Circle; and
- agree a range of scenarios with the Trust and the CCG from which to consider the potential impact on the Trust.

We understand that prior to our work, there have been a number of discussions between the Trust, CCG and Circle, to clarify the above items, but that no definitive documentation had been agreed and shared between these three parties. As a result we have kept both the CCG and the Trust sighted on the assumptions used in our analysis (based on our discussions with, and information from, Circle), as well as progress of our work.

It is important to highlight that this impact assessment has been conducted based on information available at a point in time and using a number of available assumptions. Further, our scope does not include commenting on the tender process.

The diagram below details services, confirmed with the Trust, Circle and the CCG, that were in scope of the tender, and will form part of the new MSK contract.



In scope services and proposed service model

We set out the areas being impacted by the tender of the Trust's MSK provision.

Services in scope of the new contract

The table below summarises the services currently delivered by the Trust, which were in scope of the tender, and would form part of the new MSK contract with Circle. We note, that while fracture clinic first appointments are excluded, follow-up appointments are in scope.

The table also shows the planned income, in FY18 prices, for the scope areas within the contract. This represents 53% of the tendered activity by the CCG. We discuss in the pages that follow the current assumptions of levels of activity (and related impact on income) to potentially leave the Trust.

This information on activity and income (note, not the assumptions) has been provided to us by the Trust, which we have relied upon, and have not audited.

Service	Tendered MSK services	Planned Income £m (FY18)
Trauma and orthopaedics	Elective, day case and outpatient activity for patients aged 18 and over, including fracture clinic follow-up appointments. *	4.7
Rheumatology	Elective, day case and outpatient activity patients aged 18 and over. *	1.0
Pain management	Elective, day case, outpatient and community activity for patients aged over 18, lower back and chronic pain only. The community service does not currently exist. *	0.7
Physiotherapy	Outpatient activity for patients aged over 18. *	1.0
Total		**7.4**

* some specific exclusions apply, such as suspected cancer patients.

Scenarios developed and used as part of impact assessment

We set out the scenarios developed and used in our analysis.

The following scenarios have been developed to support this impact assessment, based on information provided by the Trust, CCG and Circle as well as our experience and judgement.

By nature of the situation, our analysis and findings are based on a range of assumptions, and we have assessed the impact through a range of scenarios in the aim of providing both the Trust and CCG as clear a view as possible. We discussed and agreed these assumptions and scenarios with both the Trust and the CCG early in our work.

We understand that the information provided by Circle has been informed by their experience of delivering MSK services in Bedford since 2014. We note that this is a different geography and therefore may not be directly comparable to the one which this report relates.

In our meeting with Circle it was indicated that they would contract with the Trust on a PbR basis for secondary care activity, but with no guarantees for the level of activity that the Trust would receive under the new service model as a result of the impact of losing these MSK services. Clearly, as a principal and under standard PbR contracts there are no guarantees on the levels of activity or income which trusts will receive, nor over patient choice.

Scenario One

This scenario assumes that:

- activity at the Trust will be impacted consistently with system-wide assumptions provided by Circle. Specifically, the impact will be a 14% reduction for inpatient activity and a 47% reduction for outpatient;
- Circle (or their sub-contractors other than the Trust) will provide community activity, where this has been shifted from an outpatient setting;
- there is no repatriation of activity from other providers (inpatient or outpatient); and
- There will be a 7% increase in average unit price to take account of casemix shifting towards higher tariff patients. This is per assumptions discussed with Circle, and applies to elective inpatients and day case only. We note that the Trust does not consider this to be in line with their expectations for the activity impacted. However for consistency within our approach and methodology, i.e. to base Scenario One on Circle's working assumptions, as agreed with both CCG and Trust, we have maintained this for our analysis.

We consider this scenario to be the "base" case, as the assumptions that underpin it are currently the best available, given these are based on Circle's business plan and experience of activity reduction.

Scenario Two

This scenario assumes that:

- activity and the unit price increase at the Trust will be impacted consistently with Scenario One; and
- the Trust will provide community activity, owned by Circle, (on a sessional basis) where this has been shifted from an outpatient setting. It is assumed that the 47% of outpatient activity lost will be replaced by outpatient activity in the community. This activity is assumed to be provided by Trust Consultants and Extended Scope Practitioners ("ESPs"), recognising that the sessional payments only partially mitigate the lost income from outpatient activity.

Scenario Three

This scenario assumes that:

- activity and the unit price increase at the Trust will be impacted consistently with Scenario One, and that the

Scenarios considered and used as part of impact assessment

Trust will provide community activity in line with Scenario Two; and

- the Trust will increase its market share by eight percentage points for the in scope elective activity from the CCG. This growth in market share was chosen as it broadly offsets the lost activity. This is in line with Circle's expectations of activity flows to the Trust and represents a maximum possible repatriation given capacity constraints at the Trust.

Tables found in the Appendix on pages 69-71 summarise the scenarios in terms of percentage change implications for different types of activity.

Downside Case

We note that a further reduction in inpatient and day case activity could be possible. This may be due to either increased admission avoidance or loss of market share for the Trust. In this case a 28% reduction is assumed.

As such, we have considered the financial, operational and clinical impact of a downside case on the basis of a 28% reduction in inpatient activity on pages 38 and 47.

This represents an illustrative position that reduces the level of orthopaedic activity at the Trust significantly below that of any comparable peers.

We have not flexed the 47% outpatient reduction assumption on the basis that these represent a shift from outpatient to community provision, as opposed to a reduction in the actual amount of activity taking place.

At a glance

PwC view

Given the assumed start date of 1 March 2017, there is a considerable amount of work to be done by Circle, the Trust and the CCG if the new contract is to start on time.

Through our work, we have extracted and documented the exact scope areas within the new contract, as well as system-wide assumptions discussed with and provided by Circle. We understand that this is the first time that this has been done, and we have shared this with both the Trust and the CCG on 25 and 26 January 2017.

❶ There is a draft contract between the CCG and Circle, however, signing of the contract has been put on hold pending this impact assessment. The contract is due to start on 1 March 2017.

We understand that there is a draft contract between the CCG and Circle, however signing of this has been put on hold until completion and agreement of this impact assessment. Our understanding is that there is currently no draft contract between Circle and the Trust.

Noting the assumed start date of the contract of 1 March 2017, there is a considerable amount of work to be completed by Circle, the Trust and the CCG if the new contract is to be signed and commence on time.

❷ Through our work, we have extracted and documented the exact scope items and assumptions in relation to the new contract, and shared these with the Trust and CCG. This is the first time this has been done.

During the course of our work, and to facilitate our ability to perform an impact assessment on the Trust, we have sought to gain clarity on the services in scope as part of the tender. Specifically:

- fracture clinic first attendances are excluded but follow-ups are included; and
- we understand that discussion surrounding specific system-wide assumptions relating to activity reduction against each area of scope have been on-going. We have extracted these from Circle, documented them, and subsequently shared this with the Trust, CCG and Circle, on 25 and 26 January 2017.

This is the first time that this has been done, and therefore we felt it important that the Trust, CCG and Circle were all sighted on this, on a consistent basis, and clear on the assumptions being used in our work.

Importantly, as detailed in the previous section, no guarantees over levels of activity that the Trust would receive as a result of this change in service provision have been proposed. The mitigations assumed within our scenarios have been based on our discussions with Circle, as well as our understanding of discussions between Circle and Trust clinicians about work on a sessional basis within the MSK integrated hub at Eltham Community Hospital and community clinics. We note that this has not been formalised or agreed in terms of payment levels and volume of activity.

At a glance

PwC view

The impact of the Trust losing these MSK services must be taken in the context of the fragile financial position of the Trust.

Given the Trust's forecast deficit for FY17 of £(34.6)m, the financial impact of losing these MSK services may compound the Trust's deficit position.

The Trust has been heavily reliant upon non-operating income. Loss of these MSK services, will result in decreased cash flow, which will also further compound these issues.

❸ The financial impact on the Trust of losing these MSK services must be taken into account in the context of the Trust's overall, underlying, financial health.

The Trust has forecast a deficit of £(34.6)m for FY17 (£14.4m behind plan), which translates to a significant underlying position once non-recurrent items are removed (e.g. sustainability and transformation funding, run rate transitional funding and winter resilience funding).

There are a range of sensitivities which we have identified through our work, some of which may further adversely impact the forecast deficit of £(34.6)m. Should they materialise, these may represent a range of potential upside of £1.8m or downside of £(5.4)m to this forecast deficit.

Should the financial position of the Trust continue to deteriorate, there will be an increasing risk of regulator attention and potential intervention, for example being placed into the Financial Special Measure regime. The implications of this are potentially severe, such as increased regulatory scrutiny and restricted financial parameters for the Trust to operate within.

❹ The Trust has liquidity issues and intense cash flow pressures. Furthermore, it is heavily dependent upon non-operating income in order for it to forecast a positive liquidity position.

The Trust has been reliant on external cash support since FY15, and is managing its cash position closely given its liquidity issues.

To date, Department of Health cash support is £20.5m more than originally planned for FY17, and the Trust is working with its commissioners on run rate support funding which it has not yet received this year.

The loss of MSK services will serve to reduce the Trust's cash receipts, and in turn may result in further reliance upon its external funding and increased interest charges. Indeed, given the fact that the Trust is managing its cash close to an overdraft position, any loss of receipts poses a threat to its income and expenditure position and could mean the management of its cash position becomes even tighter.

At a glance

PwC view

Scenario One may result in the Trust losing £1.6m at a contribution level, i.e. contributing to the Trust's deficit in year one of the contract (year one represents M12 of FY17 and FY18).

Should Scenarios Two or Three transpire, the adverse year one impact is £0.9m or £0.5m respectively. However, in the Downside Case the impact increases to £2.2m.

We have calculated cost reductions against the loss of income on a pro-rated basis, specifically the variable elements of direct and indirect non-pay costs. As the impact on income reduces, the impact on non-pay costs also reduces.

Our rota analysis concludes the impact on pay costs will be minimal, i.e. not lending itself to enable to the Trust to remove consultant headcount.

5 The Trust may lose £1.6m contribution in year one of the contract, as a result of losing the MSK services.

Based on our modelling of Scenario One, the financial impact on the Trust of losing these MSK services could be £1.6m, on a contribution basis, in year one of the contract (year one represents a 13 month period, M12 of FY17 and FY18).

The impact assumes a loss of income of £1.8m across the areas detailed previously as in scope, as well as the assumptions (full detail shown on pages 40-42).

To get to a contribution level, we have assessed the impact on direct and indirect non-pay costs only, as our analysis on rotas shows that the impact on pay costs is likely to be minimal.

In looking at non-pay costs, we have used information provided by the Trust (such as Service Line Reporting) to determine the proportion of non-pay spend for income earned, and to determine the proportion of variable costs and semi-variable costs within those. Our analysis has assumed a pro-rated reduction of all variable costs and 50% of semi-variable costs. This has been determined at Point of Delivery ("POD") and site level.

The impact assumes a reduction in costs of £0.2m across areas detailed previously as in scope (full detail shown on pages 40-42).

We note that there are potential efficiency opportunities for the Trust to evaluate its cost base for the impacted specialties, which may result in the ability to remove further costs.

6 The Trust could mitigate the year one £1.6m loss by £0.7m if Circle uses Trust resources to deliver community care, and a further £0.4m by repatriating other orthopaedic activity. There is no contractual commitment to this at present.

Scenario Two assumes all lost outpatient activity will be provided as community activity by Trust clinicians (noting that there is no guarantee in respect of this).

We have calculated this to have a net contribution loss to the Trust of £0.9m in year one. We have assumed there will be no change in the cost of providing these services in the community.

In addition to Scenario Two assumptions, Scenario Three also assumes the Trust will increase market share by eight percentage points from the system-wide assumptions from Circle. Repatriated activity will be delivered by consultants in the time that has been released through assumed activity level reductions. Under this scenario, we have calculated a net contribution loss to the Trust of £0.5m in year one.

7 A further reduction in inpatient activity, to an indicative 28%, would result in a loss of contribution in year one of £2.2m, with greater levels of mitigation required to offset clinical and operational risk.

Our Downside Case assumes reductions in inpatient activity beyond 14%, to 28%, which represents a double

At a glance

PwC view

Our impact assessment over the next five years shows that there is a cumulative impact on the Trust of £6.6m, under Scenario One.

Our benchmarking shows that with reduced elective orthopaedic activity under Scenarios One and Two, safety and quality could be adversely impacted. Under Scenario Three the loss in activity would be made up through repatriation.

There is the potential for increased casemix at the Trust in the number of complex cases. The Trust must optimise its current HRG coding system to obtain appropriate payment for this.

the activity reduction assumed by Circle.

From a financial perspective the impact in year one increased from £1.6m loss of contribution (per Scenario One) to £2.2m. Greater levels of mitigation would also be required in order to offset the risk of impact on clinical and operational sustainability. Overall, moving beyond a 14% reduction, coupled with no level of certainty around involvement in community provision and repatriation, could result in a material impact which may risk destabilising the Trust.

8 The cumulative impact of Scenario One over five years could be £6.6m.

Under Scenario One, we have modelled the impact of the loss of contribution from MSK services over a five year period, against the Trust's financial plans, where available.

In addition to the assumptions on Scenario One, we have applied demographic growth, tariff inflation and tariff efficiency to future years to reflect changes in activity as well as changes in tariff. We have applied these assumptions in line with the Trust's STP Our Healthier South East London ("OHSEL") planning assumptions. As a result of the above, the impact in future years marginally reduces.
The result of a cumulative impact, without further mitigating actions, will result in a contribution loss of £6.6m to the Trust.

£millions	FY18*	FY19	FY20	FY21	FY22
Trust forecast	(22.7)	(26.0)	Not yet modelled		
MSK impact in year	*(1.6)*	*(1.3)*	*(1.3)*	*(1.2)*	*(1.2)*
Cumulative MSK impact		(2.9)	(4.2)	(5.4)	(6.6)
Revised deficit	**(24.3)**	**(28.9)**	**Not yet modelled**		

9 Benchmarking shows that a reduction in activity risks adversely impacting safety. The change in casemix may also have implications for the Trust.

Our benchmarking identified examples of sites operating at similar levels of activity as would be the case at University Hospital Lewisham ("UHL") under Scenarios One and Two. We were not able to identify other sites operating at the levels of activity implied at Queen Elizabeth Hospital ("QEH") under these scenarios. As a result, the loss of activity means QEH would be the smallest site delivering both trauma and orthopaedic services in the country which may impact the delivery of quality and safe care. In Scenario Three, this loss in activity on both sites would be made up through repatriation.

The Trust's surgical plan should be further considered to determine whether activity from Queen Mary's Hospital ("QMS") could mitigate this potential impact at QEH.

In Scenarios One and Two, the inpatient casemix at the Trust will become more complex as a result of more proactive treatment in the community. It will be important for the Trust to optimise its current HRG coding system to accurately reflect this change, so that appropriate payment for this complex work can be obtained. In the repatriation case of Scenario Three, the casemix could be partially re-balanced, although is likely to remain largely complex. We have not assessed the Trust's capture and coding accuracy in our work.

Table source: Management information and PwC analysis
** Year one represents a 13 month period, M12 of FY17 and FY18.*

At a glance

PwC view

Our trauma rota analysis shows that the impact of reduced elective orthopaedic activity should be manageable by the Trust.

If no agreement is reached on sessional community input by Trust clinicians, there could be a rota coverage impact on the smaller number of rheumatology and pain consultants.

Training requirements may be compromised without opportunities for community work and potentially more complex casemix.

While there is a lack of clarity for the Trust around Circle's community staffing service model, it has the potential to pose a challenge for the recruitment and retention of clinical staff, notably under Scenario One.

❿ Current rota arrangements could be impacted, but this would not be enough to warrant a reduction in staff.

The Trust currently operates a 1-in-8 trauma rota. Our analysis and test with PwC clinicians shows that the impact on the rota across the three scenarios is not significant, ranging from a reduction of 0.77 to 0.26 PAs per consultant for Scenarios One, Two and Three respectively. This is not enough to warrant a staff reduction from the current level of ten consultants, however we note that any reduction in PAs and the manner in which consultant time is spent has the potential to impact on job satisfaction.

In Scenario One, there would be a reduction of 0.77 PAs for each 12 PA T&O consultant. There are smaller numbers of rheumatology and pain consultants, for whom a greater proportion of their PAs are already allocated to outpatient work. The loss of PAs here could be more significant. However, provided sessional input to the Eltham integrated hub and community clinics is agreed under Scenario Two, there should be no material adverse impact on the delivery of job plans. An increase in activity through market share in Scenario Three would further mitigate this.

Our rota analysis has identified that a loss of income would not be accompanied with a corresponding reduction in pay costs. Pay forms a significant proportion of cost base for service delivery, and without mitigation this could add additional financial pressures to the Trust, as it loses income however maintains the same level of staffing. This has been reflected in our financial modelling.

⓫ Meeting training requirements may be compromised under Scenario One, which has implications for recruitment and retention.

Reductions in activity and change in casemix under Scenario One could impact negatively on the Trust's ability to train new doctors. PwC clinicians highlighted this specifically, as the impact of reduction in non complex cases could be fewer procedures for trainees to adequately fulfil their training requirements.

The Trust reports that it already experiences difficulties in filling deanery positions. However, if arrangements were agreed for sessional input by Trust staff to the Eltham integrated hub and community clinics, per Scenario Two, this could help mitigate this risk, especially if trainees were given the opportunity to shadow consultant staff in their community work. Activity increases per Scenario Three could provide further training opportunities.

Dependent on individual consultant's personal areas of interest and work motivations, they could see possibilities for more complex work (per Scenario One) as providing increased or more limited career opportunities (as no community work opportunities) and in-turn influence job satisfaction. Similarly, this could also impact upon physiotherapists who may lose out on opportunities to work in the community under Scenario One.

This could be mitigated in part under Scenario Two, as the introduction of the Circle service model should provide wider career opportunities for clinical staff such as consultants and physiotherapists to work in new and different ways, and on a far more integrated basis. In Scenario Three, activity coming back to the Trust through elevated market share should also promote greater career opportunities.

At a glance

PwC view

There is a risk to clinical governance, specifically continuity of care, if outpatient activity is provided by a provider not also providing inpatient services.

Moving services to the community has implications for co-location of clinical services, against which the Trust may need to put a range of steps in place to mitigate the risk.

The loss of MSK services at the Trust could have a detrimental impact on the Trust under all three scenarios.

This Downside Case could impact the Trust's contribution by £2.2m in year one, which may risk destabilising the Trust.

⓬ The implications of moving services into the community need to be worked through, in order to support integration with services that remain at the Trust.

In all three scenarios, there will be a move of outpatient activity to the community (irrespective of the provider). This will change the co-location of clinical services currently facilitating cross and multi-disciplinary team ("MDT") working for Trust staff. New ways of working will need to be established.

In particular, the risk posed to clinical governance and continuity of care would be mitigated by consistency between outpatient assessment and treatment. If Trust clinicians do not work in the Eltham integrated hub and community clinics on a sessional basis, as per Scenario One, this could be compromised. It is important that agreement is reached and formalised around this, as in Scenario Two. Otherwise issues of continuity of care, consent and potential duplication will have more bearing.

Conversations with Trust staff suggest that although there has been some dialogue on sessional input to the integrated hub and community clinics, no plans have been finalised.

Alongside this, no formal discussions have been held around the transfer of diagnostic images. In terms of clinical IT systems, while use of SystmOne (Circle system) in the community clinic location of QEH has been discussed, adherence to LGT information governance requirements means interfacing with iCare (LGT system) would not be permissible (as the community activity will be owned by Circle). As a result, given that different elements of the pathway could be held on different IMT systems, further work is required and it is important that this is prioritised to support effective service transition.

⓭ Conclusion

Based on the assumptions provided by Circle, which have formed the basis for our scenarios, we consider that there could be an adverse impact on the Trust of losing MSK services without mitigation.

Taking account of the wider financial health and size of the underlying deficit of the Trust is key, as under all three scenarios there could be a detrimental impact on the Trust's finances.

There may also be an adverse impact on the Trust in operational and clinical terms in Scenarios One and Two, with activity lost from an already low position relative to peers.

Should the inpatient activity reduction be greater than 14% assumed in Scenarios One and Two, the financial consequences could significantly worsen, as modelled in the illustrative Downside Case, resulting in a £2.2m contribution loss in year one. Further, moving beyond a 14% reduction, coupled with no level of certainty around involvement in community provision and repatriation, could result in a material impact which may risk destabilising the Trust.

This said, Scenario Three may be "manageable" for the Trust, as this would enable it to provide a sufficient level of inpatient care at its QEH site from a sustainability perspective, which is not the case in Scenario Two. However, crucially the community provision and repatriation assumptions underpinning Scenarios Two and Three have no guarantees in place. This poses a risk to the Trust which would be exacerbated if further activity loss was to occur.

Area / risk highlighted within our clinical and operational review of the scenarios on a Red, Amber, Green basis.	Financial impact in year one ** (£m)	Clinical / operational impact (RAG rated)	Financial impact in year one ** (£m)			Clinical and operational impact (RAG rated)		
	Scenario One		Scenario Two	Scenario Three	Downside Case	Scenario Two	Scenario Three	Downside Case
Financial impact from Scenario One brought forward			***(1.6)***	***(1.6)***	***(1.6)***			
Trauma & Orthopaedic inpatients	**(0.2)**		**0.0**	**0.4**	**(0.5)**			
Reduced volume leading to quality and safety issues		🔴				🔴	🟡	🔴
Reduced trauma cover and risk to sustainability of two trauma units*		🟢				🟢	🟢	🟢
Increased burden from potential change in casemix		🟡				🟡	🟡	🟡
Trauma & Orthopaedic outpatients	**(0.4)**		**0.0**	**0.1**	**0.0**			
Impact on clinical governance if outpatient clinics are provided by a different provider		🔴				🟡	🟡	🔴
Potential duplication of work		🟡				🟡	🟡	🟡
Time out of hospital setting		🟡				🟡	🟡	🟡
Rheumatology and Pain Management	**(0.5)**		**0.0**	**0.1**	**(0.1)**			
Potential impact on quality of care		🟡				🟢	🟢	🟡
Delivery of job plans for rheumatology and pain		🔴				🟡	🟡	🔴
Physiotherapy	**(0.5)**		**0.0**	**0.0**	**0.0**			
Reduced income for physiotherapy		N/A				🟡	🟡	N/A
Impact on quality of care		N/A				🟡	🟡	N/A
Risk of duplication with Oxleas physiotherapy		🟡				🟡	🟡	🟡
Community Physiotherapy	**0.0**		**0.7**	**0.5**	**0.0**			
Clinical adjacencies, and boundaries between services								
Impact of a reduction in physiotherapy activity on women's health		🟡				🟡	🟡	🟡
Impact on non-MSK services		🟡				🟡	🟡	🟡
Impact on multidisciplinary working		🟡				🟡	🟡	🟡
Overarching operational issues								
Capability and capacity for training		🔴				🟡	🟢	🔴
Recruitment and retention		🟡				🟡	🟡	🟡 / 🔴
Asset use		🟡				🟡	🟡	🟡
Information integration and governance		🟡				🟡	🟡	🟡
Total	**(1.6)**		**(0.9)**	**(0.5)**	**(2.2)**			

Source: PwC analysis

The ratings shown above are defined as follows:
- 🔴 Would pose risk to the Trust without mitigation
- 🟡 Implementable mitigation can be identified and/or more information may be required to fully understand the impact
- 🟢 There is no additional risk identified beyond that which currently exists in the service

* Assuming current model is sustainable
** Year one represents a 13 month period, M12 of FY17 and FY18

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NHS Greenwich Clinical Commissioning Group
The Woolwich Centre
35 Wellington Street
Woolwich
London SE18 6ND
For the attention of Diane Jones, Director of Integrated Governance

Lewisham and Greenwich NHS Trust
Lewisham Hospital
Lewisham High Street
London SE13 6LH
For the attention of Lynn Saunders, Director of Strategy, Business and Communications

11 January 2017

Dear Diane and Lynn,

Review of financial, clinical and operational impact of the musculoskeletal services ("MSK") recommissioning on Lewisham and Greenwich NHS Trust

Thank you for engaging us to provide you with services on terms which are described in this letter and the attached terms of business (version ToB 10/16). These together form the agreement between us. For the purposes of the agreement "you" means NHS Greenwich Clinical Commissioning Group (the "CCG") and NHS Lewisham and Greenwich NHS Trust (the "Trust"). Our joint duty of care will be to you, and this does not include CircleHealth ("Circle").

Background and purpose

The CCG has tendered the MSK service at the Trust, and has identified its preferred bidder as CircleHealth. The award, which is for five years, of this service to a provider other than the Trust will have an impact on the Trust's financial and clinical operations and the extent of this impact is currently unknown.

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You are now seeking external support for an independent assessment of the financial and clinical impact of this service change, having halted the signing of the new contract pending the completion of this assessment.

The services

You have instructed us to provide the services set out in schedule 1.

Timetable and duration

We propose to start work on 10 January 2017 and have agreed that we will submit our draft deliverables to you for discussion by 3 February 2017. As also discussed with you, our completion by this date is heavily dependent upon prompt access to information and the availability of (in particular) Trust and CCG staff, as well as clinical engagement, so as to be able to complete our work in a thorough and diligent manner. Should we experience delays, we shall highlight these to you immediately.

Staffing

Quentin Cole (Partner) is the person in charge of providing the services to you, assisted by Tom Hampshire (Partner), Shamil Ganatra (Director) and such other staff as we believe are required. If we believe that it is necessary for us to change any of the named individuals we will let you know. Quality assurance will be provided by Damien Ashford (Partner).

Client contact

You have designated Diane Jones (CCG), Lynn Saunders (Trust) and Ben Maguire (Trust) to be our primary contacts when delivering the services as a people with the knowledge, experience and ability to make decisions in relation to the services and our recommendations.

Fees

Our fees will be fixed at [redacted], subject to Client responsibilities as detailed below, and exclusive of expenses and VAT. If Client responsibilities are not met, then this may impact

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Contract

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our timeline and fees. We will keep you both informed of progress and any issues faced on a weekly basis.

Our fees will be calculated in accordance with the "Basis of fees" clause in the attached terms of business, unless alternative arrangements are agreed.

Grade Daily Rate	(£)
Partner / Director	£2,100
Managing Consultant	£1,875
Principal Consultant	£1,625
Senior Consultant	£1,450
Consultant	£1,040

Terms of business

Liability limitation

We draw your attention to clause 8 and 12.3 in the attached terms of business which amongst other things limit (i) our total liability for all claims connected with the services or the agreement, which we have agreed will be 3 times fees or £1,000,000, whichever is greater, and (ii) the time for bringing any such claim.

Additional provisions

Our advice is not the only factor you should take into account when deciding whether or not to proceed with a course of action and it is your decision alone as to whether or not to proceed. As an adviser we are not responsible for the management of the business or operations or the implementation of our advice, and you, your employees and other contractors must use professional business judgement regarding retender.

If you receive a request under freedom of information legislation to disclose any information we provided to you, you will consult with us promptly before any disclosure.

Confirmation of agreement

Please confirm your acceptance of the agreement by signing the enclosed copy and returning it to us.

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Yours faithfully

Quentin Cole

for and on behalf of PricewaterhouseCoopers LLP

Copy letter to be returned to PricewaterhouseCoopers LLP

I accept the terms of the agreement for and on behalf of NHS Greenwich Clinical Commissioning Group

.....

Signed

D. JONES

Position

DIRECTOR OF INTEGRATED GOVERNANCE

Date 12.01.2017

Copy letter to be returned to PricewaterhouseCoopers LLP

I accept the terms of the agreement for and on behalf of NHS Lewisham and Greenwich NHS Trust

.....

Signed

Director of Strategy, Business & Comms.

Position

12/1/17

Contract

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Schedule 1

1. Financial review

We will review and comment on the impact that a service change may have on the Trust's wider financial position. This will focus on which costs are reasonable for the Trust to remove as a result of losing the MSK services, and whether there is any other short or long term mitigation. This will be taken in the context of the overall financial position of the Trust, for which we will perform a high level financial baseline review. This will include:

- review and comment on the Trust's financial position for 2015/16 and the forecast outturn for 2016/17 to give a financial baseline against which the impact of the MSK service loss can be assessed, including:
  - the methodology used to prepare the forecast outturn and sensitivity analysis in the event of variations in key assumptions;
  - the robustness of key assumptions supporting the short-term forecasts;
  - the Trust's short-term cash management arrangements and the overall liquidity position; and,
  - baseline activity and income levels for the Trust, including MSK services and for trauma.

- review and comment on the financial impact and assumptions from the MSK service loss to the proposed new operating model, including:
  - review of the directorate financial position within which MSK services sit, including expected impact on income, expenditure, and activity;
  - review of the MSK directorate's contribution to the Trust wide position; and
  - review of findings with Trust and CCG finance leads.

2. Clinical and operational review

We will investigate and comment upon which operational and clinical concerns are attributable to the loss of the MSK services, and which are reflections of the organisational or individual clinician preferences. Specifically, We will:

- review and comment on the Trust's current clinical models for orthopaedics and trauma. This will include a review of rotas, and current staffing and activity levels;
- assess the impact of the loss of MSK services on the current clinical model, which will review and comment on the:

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  - the impact of activity change on clinical staffing models and operational asset use (including theatres);
  - a review of the potential impact on clinical safety and quality, including clinical governance, volume-linked quality, and outcomes;
  - a review of the operational impact on training, recruitment and retention; and
  - a review of the impact on residual activity and clinically adjacent services, for example, imaging.

The services will require close working with clinicians and operational staff in order to ascertain the clinical and operational impact on services. As such, we will require:

- access to key members of staff, including clinical staff, early in the process;
- access to Trust activity data; and
- access to additional data such as rotas, job plans

We will review findings with key clinical and operational stakeholders from the Trust and the CCG.

Deliverables

We will provide a brief written report to the Trust and CCG outlining our findings from the reviews, including recommended next steps.

Client responsibilities

The Trust and CCG will:

- Provide all relevant information pertaining to the scope outlined above, including (but not limited to) information from the preferred bidder in respect of the new service;
- Provide adequate access to additional personnel on an ad hoc or regular basis so that the progress of the work is not hindered;
- Provide PwC access to a suitable working office with access to internet or our email systems via a VPN connection;
- Allocate a secretarial point of contact to assist in the arranging of meetings and other administrative elements;
- Facilitate PwC access to Circle; and
- Work with PwC to progress these services, including appropriate cross-organisational working and decision making.

If there is any failure or significant delay in meeting our information requirements or if your key personnel are unavailable or uncooperative, this may impact on our ability to perform the services or may lead to delays in the proposed timetable. We will keep you regularly appraised of our progress and any issues faced.

We will not assess the quality of the data provided to us, unless, and only then to the extent that, we have explicitly agreed in this letter to perform defined data validation procedures as part of our work.