South East London Integrated Care System

South East London Acute Services Review

Summary Report

8 October 2026

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1. Introduction

Context

The South East London acute system is under significant pressure with an underlying financial deficit of £256m in 2025/26.[1] Approximately 52% of ICB spend is on acute services and current efficiency programmes are carrying delivery risk, with CIPs largely unidentified for the next five years and unlikely to bridge the financial gap.[2] Within this context, the Acute Services Review was jointly commissioned by the ICB and acute providers to identify the system-wide transformation needed to move from structural deficit to financial balance.

The Acute Services Review builds on existing system-wide work, including by the System Sustainability Programme, Acute Provider Collaborative, and South London Office of Specialised Services. Aligned with the NHS 10 Year Plan, the Acute Services Review sets out the case to fundamentally shift and transform the way that care is delivered to improve outcomes and ensure future sustainability. The findings span commissioner-led population health planning, provider productivity, and collaborative transformation that extends beyond individual trust boundaries.

Scope and purpose

This report outlines the findings and recommendations of the Acute Services Review. Its purpose is to define the system-wide action required to deliver the long-term financial sustainability of acute services in South East London.

There were five core components to the Acute Services Review:

1. Establishing the case for change through population health and financial modelling of the medium- to long-term do-nothing position for South East London;
2. Scoping the opportunity for commissioner-led transformation and the potential impact of prevention initiatives and new models of care;
3. Identifying the productivity opportunity within each acute provider;
4. Aligning on key cross-provider transformation programmes that unlock value beyond individual trust efficiency programmes; and
5. Exploring wider opportunities for transformation and the appropriate geographical planning levels for future review.

Approach and limitations

The Acute Services Review draws on quantitative analysis from the CF Health Strata© patient-level segmentation model, provider and ICB financial plans, NHS England productivity assessments, and demand and capacity modelling. Quantitative analysis has been supplemented by extensive engagement across the system.

The following areas have not been considered in the Acute Services Review and should form part of future phases of work:

- Detailed design of transformation programmes and potential service configurations;
- Assessment of the workforce, estate, technology, resources, and capital required to deliver service change; and
- Options appraisal and impact assessments that form part of formal service change processes.

[1] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[2] Ibid; Acute provider CIPs (May 2026).

2. Making the case for change

The case for change underscores the impact of deteriorating health, growing activity, and financial pressures across South East London. It establishes the need to transform the way services are planned, commissioned, and delivered to improve health outcomes and achieve future financial sustainability.

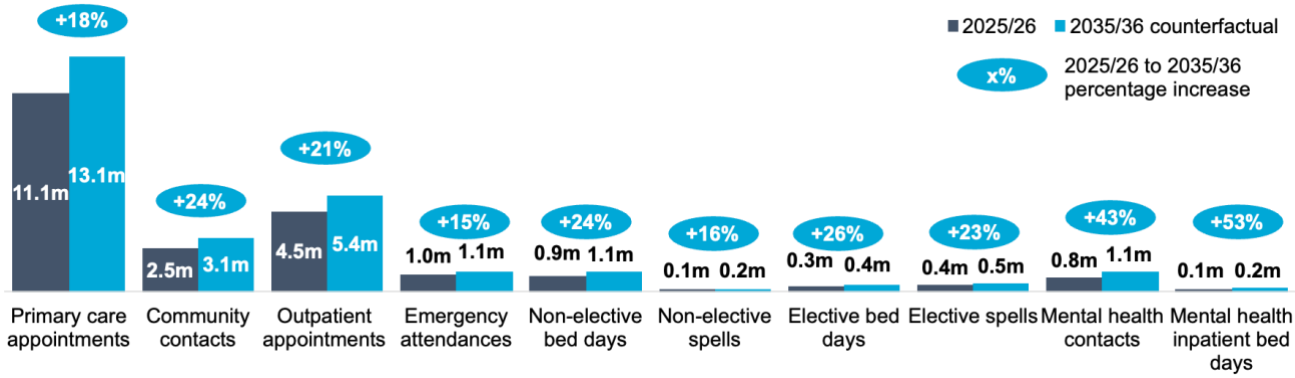
Impact of ageing and deteriorating health

While the population in South East London is projected to grow by 4% over the next decade,[3] the over-65 population will increase by 24%, with the fastest growth in the inner boroughs, which currently have the youngest populations.[4] With the over-65 population currently accounting for almost four times the per-person cost of working-age residents, this shift in the age profile will increase financial pressures for South East London.[5]

In combination with an ageing population, demand for healthcare services will further increase in response to the projected deterioration of health. In 2025/26, the 43% of the total population in moderate and high need cohorts accounted for 82% of total commissioner spend of £4.9 billion.[6] This included people with long term conditions, cancer, severe mental illness, frailty or dementia, and end of life care needs. By 2035/36, these cohorts are projected to reach 54% of the population and 87% of spend, with total healthcare spend rising to £6.2 billion.[7]

In the do-nothing scenario, demand grows across every point of delivery (**Figure 1**). Emergency attendances rise by 15% between 2025/26 and 2035/36, outpatient appointments by 21% to 5.4 million a year, and non-elective and elective bed days by around 25%.[8] This outpaces population growth of 4%, indicating that rising health needs rather than demographic change is the principal driver. The modelled bed requirement for the GP registered population reaches 4,572 by 2035/36 against 3,914 general and acute beds currently open, a shortfall of around 650 beds that cannot be met within current capacity without major transformation to deliver service change.[9]

Figure 1: Projected do-nothing activity volumes by point of delivery, 2025/26 – 2035/36



Source: © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).

[3] ONS, Population projections 2025 – 2035, (2022-based edition).
[4] Ibid.
[5] © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] Ibid; NHS England, Bed availability and occupancy – KH03, Quarter 4 2025-26.

Do-nothing financial position

In the do-nothing scenario, the South East London ICB financial position deteriorates to a £293 million deficit by 2030/31 even after the impact of deconstruction of the block and system efficiency requirement.[10] This is driven by a combination of factors, including demographic growth, non-demographic growth, and cost inflation. South East London is also 3.62% above target for core services and 18.32% above target for specialised services, and annual convergence will reduce the allocation growth while demand rises.[11]

The combined deficit for the acute providers is projected to rise from £256 million in 2025/26 to £1 billion by 2030/31 before CIP delivery.[12] Further, deficit support funding is to be phased out from 2026/27 and the acute providers will be required to navigate the income impacts of deconstruction of the block.

These pressures are encountered nationally, but three factors amplify them locally: the case-mix complexity of a largely tertiary and specialised provider base, significant productivity gaps against peers estimated by NHS England across the three trusts,[13] and higher pay and estate inflation as London providers.

Returning acute services to sustainability will require system-wide change that extends beyond existing programmes. The following pages of this report set out the interconnected role of commissioner-led transformation, productivity improvements, and cross-provider service change to achieve sustainability. It builds on national policy, and the body of improvement work already underway in South East London with the aim of increasing the scale and pace of change.

[10] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[11] NHS England, ICB allocations 2026/27 – 2028/29, (December 2025).
[12] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[13] NHS England, Productivity Improvement Packs, (2025).

3. Maximising the value of the NHS allocation

In the new operating model for the NHS, the ICB is accountable for securing the best value from its allocation. The South East London ICB Strategic Commissioning Plan sets the direction for delivering allocative efficiency in line with the three shifts outlined in the NHS 10 Year Health Plan: sickness to prevention, hospital to community, and analogue to digital. There is the opportunity for commissioner-led transformation to improve health outcomes and system sustainability.

Opportunity to reduce the growth in prevalence and progression of ill health

Targeted focus and investment in prevention is key to long-term health gain, slowing the growth in avoidable ill health, and reducing the demand it places on the system. Five conditions were prioritised for modelling in the Acute Services Review, based on the forecasted increase in burden and the available evidence on modifiable risk factors: cardiovascular disease, diabetes, respiratory disease, anxiety and depression, and obesity.

The South East London Prevention Framework is built on three interconnected tiers of universal prevention, targeted early detection and intervention for high-risk communities, and at-scale secondary and tertiary prevention for the population.[14] The modelling covers the NHS-deliverable elements, including case finding, pharmacological management, structured behavioural and digital programmes, and smoking cessation pathways.

The prevention modelling targets a 15% decrease in transition rates to higher-needs segments to reduce future incidence of disease. On that basis, 13,800 fewer residents develop anxiety and depression by 2035/36, 9,300 fewer respiratory disease, 6,600 diabetes, 6,100 cardiovascular disease, and 4,200 obesity, resulting in a gross saving of £160 million.[15]

Opportunity to improve care for the population

The NHS 10 Year Health Plan establishes the case for shifting towards more community-based and digitally enabled care to achieve sustainability. The Acute Services Review builds on that ambition by examining variation in the cost of meeting similar needs across South East London. Commissioner-spend per person varies materially across the six boroughs after controlling for age, health need, deprivation, and inner or outer London. Where that variation is unwarranted and addressable, scaling proactive and integrated community-based care offers a means of meeting the same level of need at lower cost.

Core20 and non-Core20 populations were benchmarked separately, in each case against the inner or outer London borough with the lowest spend per person that also scores at or above average on an index of quality and outcome measures. Fifteen non-Core20 cohorts agreed with the ICB represent a potential gross variation opportunity of £375 million, and fourteen Core20 cohorts has an opportunity of £110 million.[16]

The scale of the variation indicates substantial potential to improve value from existing commissioner spend. Realising it depends on the shift from hospital to community, delivered largely through the integrated neighbourhood team model set out in the ICB's Strategic Commissioning Plan. Care that is proactive, integrated and digitally enabled will meet need earlier and in lower-cost settings, reducing demand and cost pressure on acute providers.

Impact of commissioner-led transformation

Delivering targeted prevention initiatives and transforming models of care to address variation generate a gross potential opportunity of £645 million in terms of commissioner spend

[14] SEL ICB Strategic Commissioning Plan, (February 2026).
[15] © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).
[16] Ibid.

(**Figure 2**).[17] Realising it requires an estimated investment of £230 million, giving an annual net opportunity of £415 million when implemented and realised at full scale.

Delivery of commissioner-led transformation depends on population health management analytics to target intervention, digital tools and shared care records, workforce development for cross-organisational and enhanced roles, and contracting and financial mechanisms that support multi-year change. Acute providers are central to this, contributing specialist expertise to integrated neighbourhood teams and, in all cases in South East London, hosting the integrator function that allows partners to operate them at scale.

Figure 2: Opportunity size of commissioner-led transformations

	Potential gross opportunity	Investment required*	Investment rate	Potential net opportunity
Reducing the growth in prevalence and progression of ill health	£160m	£62m	39%	**£99m**
Transforming models of care: non-Core20 population	£375m	£122m	33%	**£252m**
Transforming models of care: Core20 population	£110m	£45m	41%	**£65m**
Total	**£645m**	**£230m**	**36%**	**£415m**

Note: *Investment calculations are estimated based on prior work conducted by CF in other systems where similar cohorts and conditions have been selected for allocative commissioning opportunities.

[17] Ibid.

4. Targeting provider productivity improvements

The 2025 Spending Review settlement requires the NHS to deliver annual productivity improvement of at least 2% over the next three years.[18] This section of the report outlines the productivity targets for the purposes of the Acute Services Review, developed with provider finance teams, and the potential delivery risk attached to them.

Productivity targets and current CIPs

Each provider's Medium Term Financial Plan sets a productivity requirement over three years, in line with the national shift from annual to multi-year planning. Working with each finance team, these plans have been extended across the full five-year period and expressed as a percentage of operating expenditure:

- GSTT with 3.7% in 2026/27 declining to 2.0% by 2030/31;
- KCHT with 4.3% in 2026/27 declining to 3.3% by 2030/31; and
- LGT with 5.0% in 2026/27 declining to 3.4% by 2030/31.

These trajectories meet the national requirement for at least 2% annual productivity improvement and reflect both confirmed plans for year one and assumptions agreed with finance teams for subsequent years.

Current trust CIP plans do not extend across the full five-year period, and the outer years are largely unidentified. Confirmed 2026/27 CIPs across the three providers total £185 million as at March 2026: GSTT £143 million, KCHT £26 million and LGT £16 million.[19]

Closing this gap will require further productivity opportunities to be identified in each year. This may be partly achievable through individual provider efforts to reduce length of stay, headcount or band/agency spend, and non pay costs. However, system-level transformation will be required to address structural challenges and unlock additional productivity opportunities beyond what is achievable by individual trusts.

[18] NHS England, Productivity plan – update, (February 2026).
[19] Provider CIPs, (March 2026). Note these figures have likely increased or changed since the development of this report.

5. Delivering cross-provider transformation

The purpose of cross-provider transformation is to address structural challenges across the system, including sub-scale services, workforce fragility, fragmented pathways, and inefficient use of resources. By collaborating as a system, the ambition is to drive productivity and quality beyond the level achievable locally.

Engagement and workshops identified four cross-provider opportunities that are explored further in this section of the report:

- Transforming outpatient care into a new model of planned specialist care, which has the potential to deliver material savings for the acute system through avoiding or shifting first and follow-up appointments;
- Establishing elective surgical hubs for high volume specialties, which has the potential to mitigate projected capacity shortfalls through productivity improvements and could deliver savings by releasing bed and theatre session capacity if commissioner-led transformation is also achieved;
- Consolidating breast surgery to strengthen service quality and resilience, which should be explored alongside other surgical consolidation to ensure the appropriate distribution of system capacity; and
- Pursuing alternative ways forward for oral and dental care that have less significant capital implications (e.g., consolidation of specialist activity where possible and shifting of residual and non-specialist activity into the available community estate).

Outpatient transformation

Outpatient services are the largest single point of acute contact in South East London, with 3.0 million appointments delivered in 2025/26 to the GP-registered population.[20] While there has been some improvement in recent years, the providers in South East London still perform inconsistently against the national median for key performance metrics:[21]

- Pre-referral specialist advice is used at 5.1 to 6.4% against a median of 7.8%;
- Missed appointment rates of 8.0 to 9.7% compare with a national median of 6.3%;
- Patient-initiated follow-up rates are above the national median at GSTT, but below it at KCHT and LGT; and
- Remote consultation rates are above the national median at GSTT and KCHT, but below it at LGT.

There is scope to build upon the work of individual trusts and embark on a significant transformation programme to define the future model of planned specialist care for South East London. The move to a shared Epic platform across South East London makes this a timely opportunity to design once and deliver new models for the three providers that is tailored to patient need and consists of:

- Standardised pathways and guidelines;
- Single points of access (SPOA) into planned specialist care, standardised, and in some cases shared, across providers; and
- Straight to test model for harmonised clinical pathways.

The potential impact of redesigning planned specialist care was analysed using the population health segmentation model, grouping appointments by patient need and applying reducibility assumptions to each group. The modelling identifies 506,000 appointments that

[20] © Carnall Farrar Limited, Health Strata segmentation model of SEL GP-registered population based on proprietary methods, SEL database, (July 2026).
[21] NHS England, Model Hospital – Outpatients, (February 2026).

could be avoided or shifted in 2025/26, comprising 217,000 first appointments and 289,000 follow-ups, and a gross annual saving of £80.0 million on National Cost Collection basis.

Undertaking a cross-provider outpatient transformation programme presents additional opportunity to address sub-scale or fragmented medical specialties that would benefit from consolidation to strengthen service resilience and quality. Further financial benefit may also be realised through rationalising the estate in which outpatient services are delivered.

Elective surgical hubs

Currently, surgical activity is delivered across multiple sites for six elective specialties: orthopaedics, gynaecology, urology, ENT, ophthalmology, and general surgery. The configuration of this activity across South East London is associated with several sites performing below the national average or recommended productivity targets for:

- Theatre utilisation where the majority of sites fall below the 85% target (e.g., urology ranges from 53% to 78% between South East London sites);[22]
- Cases per four-hour session which are below the national median for 17 of 34 site-specialty combinations;[23] and
- Daycase rates which are below the national mean for high volume, low complexity (HVLC) ENT, urology, and general surgery.[24]

In the do-nothing scenario, growth in demand is projected to become increasingly unsustainable. By 2030/31, South East London is estimated to be short of 52 weekly theatre sessions for elective orthopaedics, gynaecology, urology, ENT, ophthalmology, and general surgery.[25] The projected bed and theatre session deficits establish a clear case for change as the acute system in its current configuration will be unable to financially sustain the capacity shortfalls in the six specialties.

Significant transformation will therefore be required to change the way services are delivered across the system to ensure future sustainability. Surgical hubs are a national priority supported by GIRFT that concentrate elective activity and ring-fence capacity to deliver significant productivity improvements. GIRFT sets out the conditions for realising the benefits, including separating high volume from complex work, day case surgery as the default, standard case durations, and theatre utilisation of 85%.

Illustrative scenarios were modelled to test the plausibility and impact of establishing high volume and complex surgical hubs in South East London by 2030/31. Reconfiguring and delivering the productivity improvements associated with surgical hubs move the system from a shortfall of 52 theatre sessions to a surplus in the strongest scenario.[26] The modelling demonstrates that establishing surgical hubs can mitigate the projected capacity shortfalls, with further system-wide transformation required in parallel to close the remaining gaps.

Within this context, additional surgical hub scenario modelling was undertaken that incorporates the impact of commissioner-led transformation and broader productivity improvements. System-wide transformation delivered in tandem with surgical hubs moves every scenario into surplus on beds and theatre sessions, with an indicative annual opportunity between £16 and £28 million from released bed and theatre session capacity.[27] However, achieving these benefits are conditional on prevention initiatives and community-based care models reducing acute demand growth in the next five years, and the system working together to drive productivity beyond the level achievable locally.

[22] NHS England, Model Hospital – Theatre utilisation by speciality and site, (February 2026).
[23] NHS England, Model Hospital – Average number of cases per equivalent 4-hour valid elective session by speciality and site, (February 2026).
[24] HES APC, Daycase rates by speciality and site, 2025.
[25] SEL demand and capacity modelling, (September 2026).
[26] Ibid.
[27] Ibid.

As next steps, further work is required across South East London to assess the suitability of the theatre estate against GIRFT standards. Any change to the configuration of services would then need to follow a service change process in compliance with NHSE guidance, HM Treasury Green Book, and legal duties. More detailed demand and capacity modelling is also required that accounts for patient complexity and extends to wider surgical specialties including cancer, as these have not been included in the above demand and capacity outputs.

Breast surgery consolidation

The breast service pathway has challenges spanning screening, referral, one-stop diagnosis, surgery and plastics, and follow-up. In particular, screening coverage in inner South East London sits around 10 percentage points below the England average,[28] and breast cancer mortality has risen in Bexley and Greenwich over the last decade.[29] Sixty-two day combined performance has remained below the 85% standard at GSTT and KCHT since April 2023.[30]

Noting the performance and quality challenges, work is currently being led across the system to redesign of the wider breast pathway, covering mastalgia, one-stop triple assessment and a single plastics pathway. The Acute Services Review examined the specific opportunity to consolidate breast surgery only. Its findings sit alongside existing redesign programmes and do not substitute broader work.

Breast surgery is delivered from four sites, with around 1,700 admitted spells in 2025: 762 at Guy's, 367 at the PRUH, 297 at Denmark Hill and 294 at QEH.[31] Delivered as a single service, that volume would rank fifth nationally and sit above the top decile of 1,300 spells, against a national median of 634 per provider.[32] Three of the four sites operate at less than half the national median provider volume. Stakeholders further reported workforce fragility challenges at the sites, with reliance on insourcing.

Scale is the foundation for establishing service excellence and delivering high quality care, training, and research.[33] Three of the four current breast surgery sites are sub-scale in South East London, which limits the patient population, workforce resilience, and infrastructure. Consolidation of breast surgery to achieve scale may therefore support improvements in quality, and together with the surgical hubs, simplify the organisation of surgical activity across South East London.

Illustrative scenarios were modelled to test the plausibility and potential financial benefits of consolidating breast surgery, with complex activity consolidated onto one or two centres, routine day case activity retained locally, and screening and diagnostics maintained locally in every scenario. Modelling of potential reconfiguration scenarios and assumed productivity benefits suggest a possible saving of up to £1 million a year when delivered in conjunction with commissioner-led transformation.[34] Although this is a small figure, there are also potential benefits in terms of improving service resilience and quality. It should also be considered alongside other surgical consolidation to ensure the appropriate distribution of system capacity.

In line with the next steps for elective surgical hubs, an assessment of estate suitability and detailed demand and capacity modelling should be undertaken for breast surgery alongside plastics. Any change to the configuration of services would then need to follow a service change process in compliance with NHSE guidance, HM Treasury Green Book, and legal duties.

[28] Fingertips (OHID), Indicator: breast cancer screening coverage, 2015 – 2025.
[29] Fingertips (OHID), Mortality rate from breast cancer, 2012-14 – 2022-24.
[30] NHS England, Cancer Waiting Times Statistics, April 2023 – May 2026.
[31] HES APC, Breast surgery spells by site, 2025.
[32] Ibid.
[33] CF, World Leading Services Framework, (July 2026).
[34] SEL demand and capacity modelling, (September 2026).

Oral and dental health

Specialist dental, oral surgery and maxillofacial services are delivered from two acute sites two miles apart, in partnership with King's College London. Combined admitted activity is more than nine times the national median, and GSTT is the largest provider of oral and dental outpatient care in England.[35] Estate condition is the primary driver for change: the Denmark Hill Dental Institute retains limited serviceable life and Guy's Tower is constrained in space and suitability for high-footfall ambulatory care.[36]

A 2023 Strategic Outline Case preferred a purpose-built centre with community satellites at an outturn capital cost of £226.1 million, identifying the capital requirement but deferring value for money testing.[37] Modelling for the Acute Services Review applies an indicative cost per dental chair to the reduction in chairs under each option, giving a cost reduction of £10.5 million a year for the preferred option. Consolidation onto a single existing site was costed at £86.6 million[38] and modelled to deliver £9.7 million, within 8% of that saving for just over a third of the capital. Both figures depend on chair reductions that assume an extended working pattern already piloted and judged unsustainable, so should be treated as indicative.

The scale of capital requirement has halted progress on this programme, and a lower capital route is needed. Changing models of care would allow the service to be delivered from a materially smaller acute footprint, with specialist activity consolidated where clinically appropriate and residual activity moved into community estate. This releases acute estate and avoids further capital spend on facilities that are not fit for purpose.

Planning should begin now that involves assessing estate suitability, developing a full set of options, and undertaking detailed demand and capacity modelling. Any change to the configuration of services would then need to follow a service change process in compliance with NHSE guidance, HM Treasury Green Book, and legal duties.

[35] HES APC and OPS, 2024/25.
[36] SEL, Dentistry 2030 Strategic Outline Case, (2023).
[37] Ibid.
[38] Ibid.

6. Analysing the impact of transformation

Without transformation and service change, the acute system deficit is projected to rise from £256 million in 2025/26 to £1 billion by 2030/31 before efficiency delivery.[39] As outlined in this report, returning acute services to sustainability will therefore require system-wide change that extends beyond existing programmes.

Commissioner-led transformations generate substantial financial benefit for the system. These transformations impact the activity profiles by suppressing demand for acute services and result in income and cost effects across the system. For the ICB, the transformation opportunities close the do-nothing position almost entirely. Applying the prevention, inequalities and models of care opportunities, net of the investment each requires, returns the commissioner from a £293 million deficit to a £3 million surplus in 2030/31.[40]

For the providers, the significance of the transformation opportunities is not only the financial impact, but their mechanism in reducing activity. Prevention and new models of care reduce the growth in demand rather than reducing below the current baseline levels of activity, so the majority of the income and cost reduction offsets forecast growth. The providers are committed to delivering £1.1 billion of efficiency over the period, most of which remains largely unidentified, and a significant proportion of which is currently absorbed to meet the costs associated with rising demand. By flattening the growth line, commissioner-led transformation reduces the volume of activity that the demand related provider efficiency programmes must absorb, allowing those programmes to deliver genuine reductions in the costs associated with care rather than holding the position against demand. The two are complementary rather than additive: commissioner-led transformation creates the headroom in which provider productivity plans become credible and deliverable.

Taken together, the commissioner-led transformation and full efficiency delivery move all three acute providers closer to financial sustainability by 2030/31. They move from do-nothing deficit positions of £440 million at GSTT, £369 million at KCHT, and £201 million at LGT to a residual position of a £29 million deficit, breakeven (with a remaining £149 million residual disaggregation), and a £18 million deficit respectively.[41]

The cross-provider transformation programmes are intended to reduce that residual gap and to mitigate the delivery risk attached to efficiency requirements that remain unidentified in the outer years. Outpatient transformation presents gross opportunity of £80 million on National Cost Collection basis, with the financial benefits distributed between the commissioner and the providers. Elective surgical hubs deliver £16 and £28 million from released bed and theatre session capacity when delivered in conjunction with commissioner-led transformation and productivity improvements. Similarly, consolidation of breast surgery to improve overall quality has an opportunity of £0.8 million to £0.9 million. The reconfiguration of oral and dental services delivers a gross annual opportunity of £9.7 million to £10.5 million through chair based cost-reduction, depending on the option pursued.

Unlike the commissioner led opportunities, which are phased over the planning period, these figures are stated as in-year values when delivered at full scale, as no delivery timescale has been assumed. Realisation will depend on investment and the pace at which each programme is implemented, and earlier delivery would generate a greater recurrent benefit over the period to 2030/31.

[39] SEL ICB and acute provider financial modelling 2025/26 – 2030/31, (July 2026).
[40] Ibid. Note: Includes net impact of outpatient transformation.
[41] Ibid. Note: Includes net impact of outpatient transformation.

7. Considering wider opportunities for future review

The Acute Services Review explored five further areas where scale or changing demand indicates a case for change. These areas provide direction for future sustainability review programmes and their appropriate geographical level for planning.

Maternity

Maternity is spread across ten sites in South London. Deliveries have decreased by 14% since 2019 and fertility rates continue to decline. As volumes decline, more sites will fall below viable scale, and over half are projected to drop under the 2,500-delivery sustainability threshold by 2035.[42] This will further exacerbate the current financial challenge as every maternity site in South London is loss-making, with a combined deficit of over £140m.[43]

While there is need to review maternity in both the South East and South West London systems, any changes in South East London should derive from planning on a South East London footprint. This mitigates the risk of delay in both systems that joint planning could create, and recognises that South West London already has work underway.

General paediatrics

Acute general paediatric activity is predominantly addressing local needs, with limited flow between South East and South West London. Around 89 beds are needed across 7 sites in South East London, with the PRUH, UHL and QEH each requiring less than 15 beds almost entirely for non-elective activity.[44] At these volumes, the cost of 24/7 consultant cover may not be proportionate to activity. Overall, there is opportunity to plan general paediatrics and maternity together across South East London to address the sustainability challenges given the clinical interdependencies between the services.

Non-tertiary surgery for cancer

Surgical treatment for cancer shows a long tail of low-volume provision, with sub-scale services scattered across South London. However, admitted cancer activity is predominantly local, with South East London patients making up 78% of activity across the three trusts and most South West London providers serving their local populations.[45] As such, it should be planned on a South East London basis, with consideration of inward flows from Kent, Medway and Sussex.

Specialised paediatrics, cancer and cardiothoracic

Specialised paediatrics, cancer and cardiothoracic services have significant activity flows across London and wider catchments (e.g., in specialised paediatrics, GSTT draws 65% of activity from outside of South East London).[46] Activity is also concentrated in a few large providers with long tails of sub-scale services (e.g., in specialised cancer, 60% of providers in London make up 7% of activity).[47] The London Specialised Services Review was commissioned in 2026 to review the case for planning services to improve quality of care and sustainability of services. Within this context, planning of these specialised services should occur collaboratively across London's ICSs, rather than at a South London footprint.

Major trauma

Specialised major trauma services are delivered by four London providers: Barts (727 spells), KCHT (654), St George's (493) and Imperial/St Mary's (1.5k).[48] The co-dependency requirements for major trauma are resulting in potentially unsustainable services at the four major trauma sites, including vascular surgery. These sustainability challenges should be considered through a London-wide review of the co-dependency framework.

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[42] HES APC, (2025); National Advisory Team, Guidance on reconfiguration of maternity and children's services, (2015).
[43] HES APC and OPS, (2025).
[44] HES APC, (2025).
[45] Ibid.
[46] SUS, (2025/26).
[47] Ibid.
[48] Ibid.

8. Conclusions and recommendations

South East London has a significant financial and demand challenge that is growing and beyond what existing improvement programmes can close. System-wide action is required to deliver the long-term financial sustainability of acute services in South East London. This spans commissioner-led transformation, neighbourhood health, provider productivity, and collaborative change programmes that extend beyond individual trust boundaries.

Recommendations

1. The ICB should expand investment in targeted prevention programmes and work in collaboration with local authorities to deliver initiatives focussed on obesity; CVD; diabetes; respiratory disease; anxiety and depression.
2. The ICB and each integrator should collaborate to transform models of care to deliver proactive, integrated, and community-based care in alignment with the neighbourhood health agenda.
3. Each provider should extend CIPs across the full five-year period and identify where there is opportunity to deliver productivity improvements either individually or through system-wide collaboration.
4. The three providers and the ICB should mobilise system-wide transformation and service change in the following areas:
    - Outpatient transformation programme to design planned specialist care once and deliver it across all three organisations, leveraging the shared Epic platform and embedding standardised pathways and single points of access.
    - Elective surgical hubs to determine feasibility to concentrate activity, ring-fence capacity, and deliver productivity improvements and financial benefits for the system. This must start from development of a detailed demand and capacity modelling exercise covering all specialties and be associated with a theatres and estates review to confirm the ability for GIRFT standards to be met.
    - Breast surgery to consolidate surgical activity to strengthen service resilience and improve quality.
5. The ICB and acute providers should work to address other services identified through this review to ensure high quality care and system sustainability:
    - Oral and dental health should be explored for a smaller acute estate footprint, consolidating specialist activity where clinically appropriate and moving residual and non-specialist activity into community estate.
    - Maternity and general paediatrics should be jointly explored for transformation in South East London.
    - Non-tertiary surgery for cancer should be considered as part of the above mentioned elective surgical hubs and breast surgery consolidation.
    - Specialised services transformation, including specialised paediatrics, cancer, and cardiothoracic, should be considered as part of the London Specialised Services Review.