

Appendix H

Securing sustainable NHS Services Consultation document



**Securing
sustainable
NHS services**

Securing sustainable NHS services

Consultation on the Trust Special
Administrator's draft report for
South London Healthcare NHS Trust
and the NHS in south east London

These are our
recommendations

**Let us know
what you think**

Your comments
are important



For more information about the consultation, or to request a summary of the information provided in this document in a different format or language*, please get in touch with us.

*Requests for information in a different language will be provided in a document format where possible, and if not possible, via an interpretation service.

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*வேறொரு மொழியில் தகவல்களை பெறுவதற்கான வேண்டுகோள்கள் இயன்ற வரை ஆவண வடிவில் தரப்படும் மற்றும் இயலாத பட்சத்தில் மொழிபெயர்ப்பு சேவை வாயிலாக தரப்படும்.

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Pour plus d'informations sur la consultation, ou pour demander un résumé des informations fournies dans ce document dans un format différent ou dans une autre langue*, veuillez entrer en contact avec nous.

*Les renseignements demandés dans une autre langue seront fournis sous forme de document dans la mesure du possible, et si ce n'est pas le cas, par l'intermédiaire d'un service d'interprétation.

Puede ponerse en contacto con nosotros para obtener más información sobre la consulta o para solicitar un resumen de la información contenida en este documento en otro formato o idioma*.

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Para mais informações sobre a consulta, ou para solicitar um resumo das informações fornecidas neste documento num formato ou idioma diferente*, por favor, entre em contato conosco.

*Os pedidos de informação num idioma diferente serão atendidos em formato de documento sempre que possível. Se tal não for possível, serão atendidos através de um serviço de interpretação.

➤ **Visit our website**

www.tsa.nhs.uk

➤ **Call us (freephone)**

0800 953 0110

➤ **Write to us**

Office of the Trust Special Administrator

c/o South London Healthcare NHS Trust, Froggnal Avenue, Sidcup, Kent DA14 6LT

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What is this document for?

This document sets out the Trust Special Administrator's recommendations for securing a sustainable and long-term future for health services currently provided by South London Healthcare NHS Trust and the wider NHS in south east London. The London boroughs defined by the NHS as south east London are Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

The Trust Special Administrator has worked with GPs, hospital doctors, nurses, providers of community care and other services such as mental health services, social services as well as patients and members of the public to develop his recommendations.

This document is a consultation document and we would like to hear your views on the changes that the Trust Special Administrator is recommending.

Question

Throughout this document you will see a number of questions in boxes, looking like this. These questions relate to the response form that comes with this document, which contains the actual consultation questions we would like you to answer.

Once you have read the consultation document please give us your answers to these questions on the response form provided. We have shown which sections of the consultation document cover the issues raised by each of the questions. Please refer back to these sections as you answer the questions.

Throughout the response form there are boxes for you to explain your answers if you feel the questions have not given you the chance to give your views fully. If you think there are options that the TSA has not considered and should have done please say so in the box at the end of the response form.

If you would like to know more about the extensive work undertaken by the Trust Special Administrator that sits behind this document, please read the Trust Special Administrator's draft report which is on our website at www.tsa.nhs.uk

You can answer the questions on the printed response form and post it to our Freepost address:

► **Freepost Plus RSHB-CGKA-RYHK**

TSA Consultation
Ipsos MORI Research Services House
Elmgrove Road
Harrow HA1 2QG

Or, you can complete the response form online on our website.

► www.tsa.nhs.uk

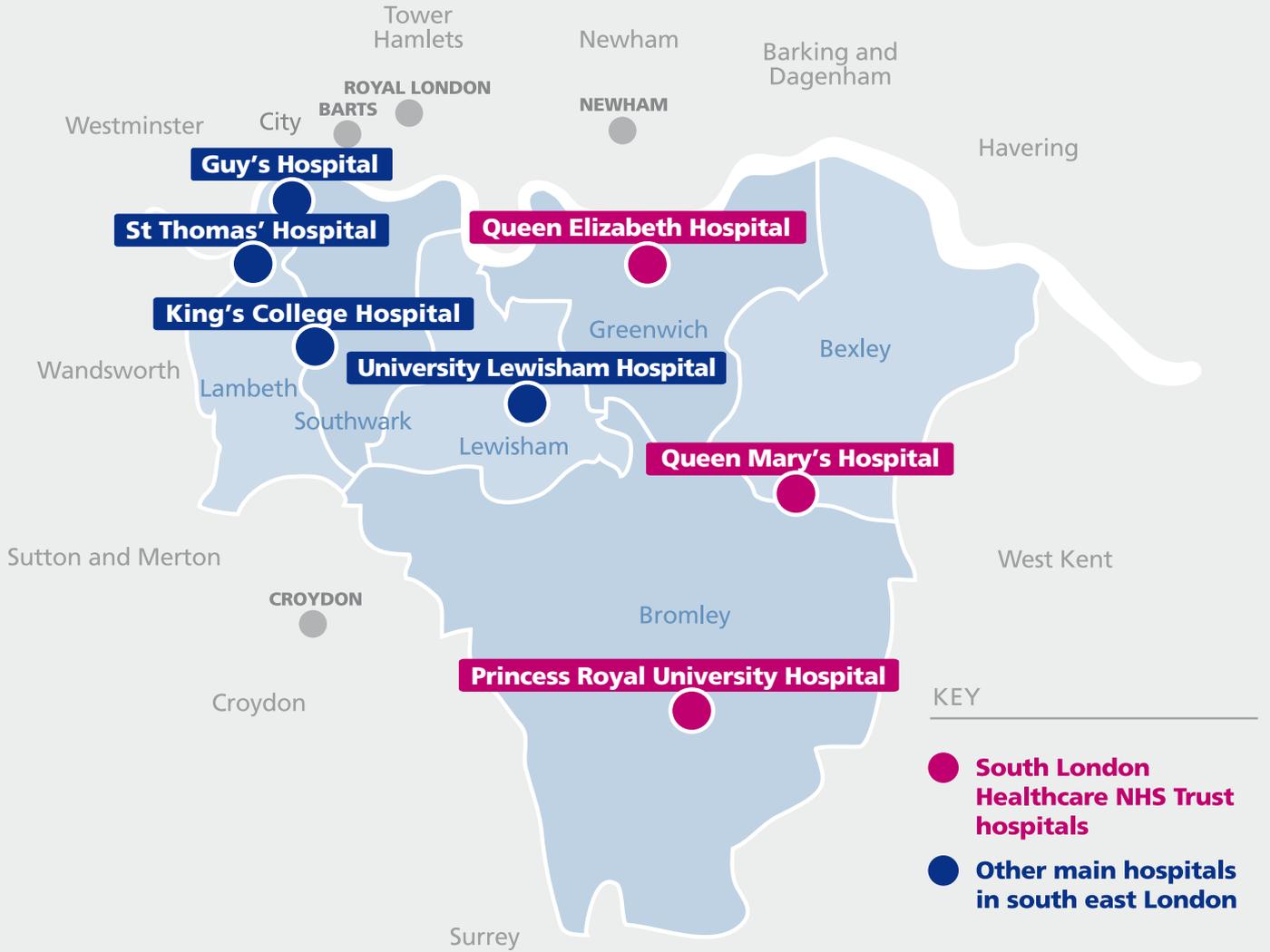
To make sure your views are considered we must receive your response form by no later than midnight on **13 December 2012**.

If you have any queries about how to complete the questionnaire, or about any of the questions themselves, please call
► **0808 129 5719** (free from landlines, mobile charges will apply).

If you have any complaints about the consultation please contact:

Amy Darlington
Associate Director of Communications,
Office of the Trust Special Administrator
c/o South London Healthcare NHS Trust
Frogna Avenue
Sidcup
Kent DA14 6LT

Main hospital sites in south east London



Foreword

Matthew Kershaw

Trust Special Administrator

You rely on the NHS being there when you need it most; to provide you and your family with high quality and safe care – looking after you when you are unwell and supporting you in staying healthy. You deserve nothing less.

Those of us working in the NHS have a responsibility to provide high quality and safe services to local patients, meeting your healthcare needs to the highest standard possible. However, we also have a responsibility to you the taxpayer; to provide these services within the money that is available; making sure that every pound of taxpayers' money given to us is spent wisely and provides the maximum benefit to patients. Any waste or inefficiencies means that money is being taken away from patient care which is not acceptable, especially in these financially challenging times.

In July 2012 I was appointed as Trust Special Administrator to South London Healthcare NHS Trust by the Secretary of State for Health. This was because the Trust was consistently failing to provide services to patients within budget and was spending around £1 million more than it had each and every week and had no long-term plan to fix this problem.

This money is being unfairly and inappropriately drawn from other areas of the NHS and therefore drastic action is needed to fix this very serious problem, the roots of which have existed for many years.

I have been tasked with developing recommendations to resolve this significant problem in a way that will make sure that high quality, safe and accessible services are available for the communities served by South London Healthcare NHS Trust as well as the wider NHS across south east London long into the future.



“...money is being unfairly and inappropriately drawn from other areas of the NHS and therefore drastic action is needed to quickly fix this very serious problem.”

I have worked closely with GPs, hospital doctors, nurses, providers of community care and other services such as mental-health services and social services as well as patients and the public, to develop the recommendations outlined in this consultation document. Lots of people have given up their time to support me in this important work and for that I would like to extend my personal thanks.

I now want to hear what you think. Please take the time to read this consultation document and share your views using the response form enclosed. I will then review this feedback. I will use it, together with the additional work my team and I do, to inform my final recommendations. I will provide these to the Secretary of State in January 2013. He will then make a decision on my final recommendations in February 2013.

A handwritten signature in black ink that reads 'Matthew Kershaw'.

Matthew Kershaw

Foreword

Dr Jane Fryer

Chief Medical Advisor to
the Trust Special Administrator

As a doctor and as a clinical leader in south east London, my passion is to make sure we deliver consistently high quality healthcare to people when they need it, whilst recognising we have to do this with a large but limited amount of money.

People nowadays have quite different healthcare needs to those of say 20 or 30 years ago. More people survive things like heart attacks, cancer and stroke, but may require ongoing care to help them in their longer-term recovery. And many more people are living with what we call 'long-term conditions' – things like asthma, diabetes and arthritis for example – conditions that can't be cured but can be managed with medicines and other therapies.

Alongside this, medicine and treatments for health conditions are also changing. This is because doctors, nurses and therapists are taking advantage of improved medicines and technology, as well as better knowledge and evidence of what works in treatment.

Because of these advances many more people's health and medical conditions are treated at home and in GP surgeries than ever before. Now only very sick people need to be treated in hospital and we therefore need to make sure that the coordination of care between different NHS organisations, and between hospitals and other community settings, is better to help patients receive the best care in the most suitable place.

At the moment South London Healthcare NHS Trust is overspending by around £1 million every week and this cannot continue.



“We want to use this opportunity to improve the quality and consistency of NHS services for all of the communities we serve across south east London, and ensure we do this in an affordable way.”

I have led a group of senior doctors and nurses from across south east London in advising Matthew Kershaw in his role as Trust Special Administrator. As a group of leading clinicians from all NHS organisations across our six boroughs we have agreed that together we should seize the opportunity of his work and design healthcare differently. We want to use this opportunity to improve the quality and consistency of NHS services for all of the communities we serve across south east London, and ensure we do this in an affordable way.

Change is challenging for everyone whether you are a patient or a member of staff. However, I believe the recommendations for the NHS in south east London that Matthew has set out in his draft report and which are described in this consultation document, will secure high quality and affordable services for the long-term for the people of south east London.

A handwritten signature in black ink that reads "Jane Fryer".

Dr Jane Fryer

1

Why is change needed?

South London Healthcare NHS Trust is the most financially challenged trust in the whole of the NHS, overspending by around £1 million each and every week.

On 16 July 2012 a Trust Special Administrator was appointed to South London Healthcare NHS Trust by the Secretary of State for Health. His task is to resolve this significant problem in a way that would mean that high quality, safe and accessible services are available for the long-term for the communities served by South London Healthcare NHS Trust as well as the wider NHS across south east London.

This chapter describes in more detail the role of a Trust Special Administrator and why one was appointed to South London Healthcare NHS Trust.

The role of a Trust Special Administrator

The NHS is guided by the principles set out in *The NHS Constitution*¹. These include an aspiration to attain the highest standards of excellence and professionalism in delivering high quality care to all and, in doing so, a commitment to provide best value for taxpayers' money. All NHS organisations have a duty to deliver these principles, however, for a variety of reasons, a small number of NHS trusts across the country fall short. This is unacceptable and action must be taken to ensure that safe and high quality services are delivered to patients within the funding available.

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Under NHS legislation, the Secretary for State for Health has powers to appoint a Trust Special Administrator (TSA) to any NHS trust he deems is failing to meet its duty to provide high quality and safe services to patients within the funding that is available. These powers are used when other solutions have been tried and not worked.

The TSA has two roles:

- 1 Ensuring the Trust he is appointed to continues to deliver safe services to patients during the period of his work
- 2 Developing recommendations for securing safe, high quality and affordable health services for the long-term.

The drive behind the work of the TSA is an absolute focus on implementing rapid, fundamental and transformational change within a highly challenged Trust to ensure long-term sustainability and to protect access to high quality services for local patients.

Therefore the timescales are short. The TSA's work has to be completed and the Secretary of State for Health decides what action to take within 150 working days of the TSA being appointed. This timescale includes a 30 working day public consultation period ahead of the TSA submitting his final recommendations to the Secretary of State.

The TSA is therefore required to work closely with GPs, hospital doctors, nurses, providers of community care and others such as mental-health services and social services as well as patients and members of the public to develop his recommendations within the set timescales.

¹ *The NHS Constitution*
www.dh.gov.uk/health/2012/03/nhs-constitution-updated/

Timeline



Trust Special Administrator (TSA) appointment takes effect on **16 July 2012**



Within 75 working days the TSA must produce and publish a draft report outlining his recommendations and a plan for how he will consult on them by **29 October 2012**



Consultation begins within five working days of publishing draft report by **2 November 2012**



Consultation ends after 30 working days on **13 December 2012**



Trust Special Administrator must submit his final report and recommendations to the Secretary of State within 15 working days of consultation ending by **7 January 2013**



Within 20 working days, the Secretary of State must make a decision on the Trust Special Administrator's recommendations by **1 February 2013**

Why has a Trust Special Administrator been appointed to South London Healthcare NHS Trust?

Despite recent improvements in the quality of services at South London Healthcare NHS Trust (SLHT), there is a long-standing history of being unable to deliver high quality services within budget meaning the Trust continues to overspend and end up in more and more debt.

A large number and wide range of solutions have been tried in an attempt to fix this deteriorating problem and make sure safe, high quality services can be provided to local patients within the funding that is available. These

include, but are not limited to, a merger of three south east London NHS trusts in 2009 to form South London Healthcare NHS Trust, changes in senior management, significant cost reduction initiatives as well as changes to some services as a result of implementing *A Picture of Health*².

Whilst these solutions have delivered some improvements, none have delivered the scale of change required to enable SLHT to deliver high quality services for patients within budget for the long-term.

In the three years since its formation, SLHT generated a total debt of £153 million by the end of March 2012. It ended the last financial year (2011/12) with a £65 million deficit (how much it overspent by). This is equivalent to the cost of 12,000 hip replacement operations. It is predicted that by the end of this financial year (so by March 2013) SLHT will have overspent in the course of its lifetime as an organisation by £207 million.

SLHT is the most financially challenged Trust in the NHS and it does not have a credible plan in place to address this serious financial problem. This is not acceptable.

Unless action is taken now to put things right, over the next three years (ending March 2016) the Trust is expected to accumulate a further debt of more than £240 million. This cannot be allowed to happen. It is important that addressing this problem happens quickly, but in a planned way so services for patients are not put at risk by short-term or quick fix decisions. Finding a planned solution for the services provided by SLHT and the wider south east London system in the long-term is the task of the Trust Special Administrator.

² *A Picture of Health*
www.apictureofhealth.nhs.uk/consultation/index.html

2

How has the Trust Special Administrator gone about developing his recommendations?

When the Trust Special Administrator (TSA) first started work with the Trust, he and his team conducted a wide ranging review of South London Healthcare NHS Trust (SLHT). They looked at how it works as part of the wider south east London healthcare system, to understand where the problems are. This included identifying why the Trust has accumulated a debt that will reach £207 million by the end of March 2013.

The analysis showed that SLHT's financial problems have a number of different parts to it. Whilst the issues start with the Trust, the TSA's analysis has shown that there is a significant future financial challenge facing other parts of the NHS in south east London as well. The TSA's role is to address the financial problems sitting within SLHT and protect the quality of care. However, it is important that on the back of this wider south east London analysis that any recommendations he makes take the wider NHS in south east London into consideration. No hospital works in isolation from the other hospitals and health services around it. This will ensure that problems are not just pushed from one part of the NHS to another and patients can access safe and high quality sustainable services in the future across the whole of south east London. Indeed, commissioners (those who plan and buy care on behalf of their local populations) in the area agree that the solution to SLHT's problems must be south east London wide for this reason.

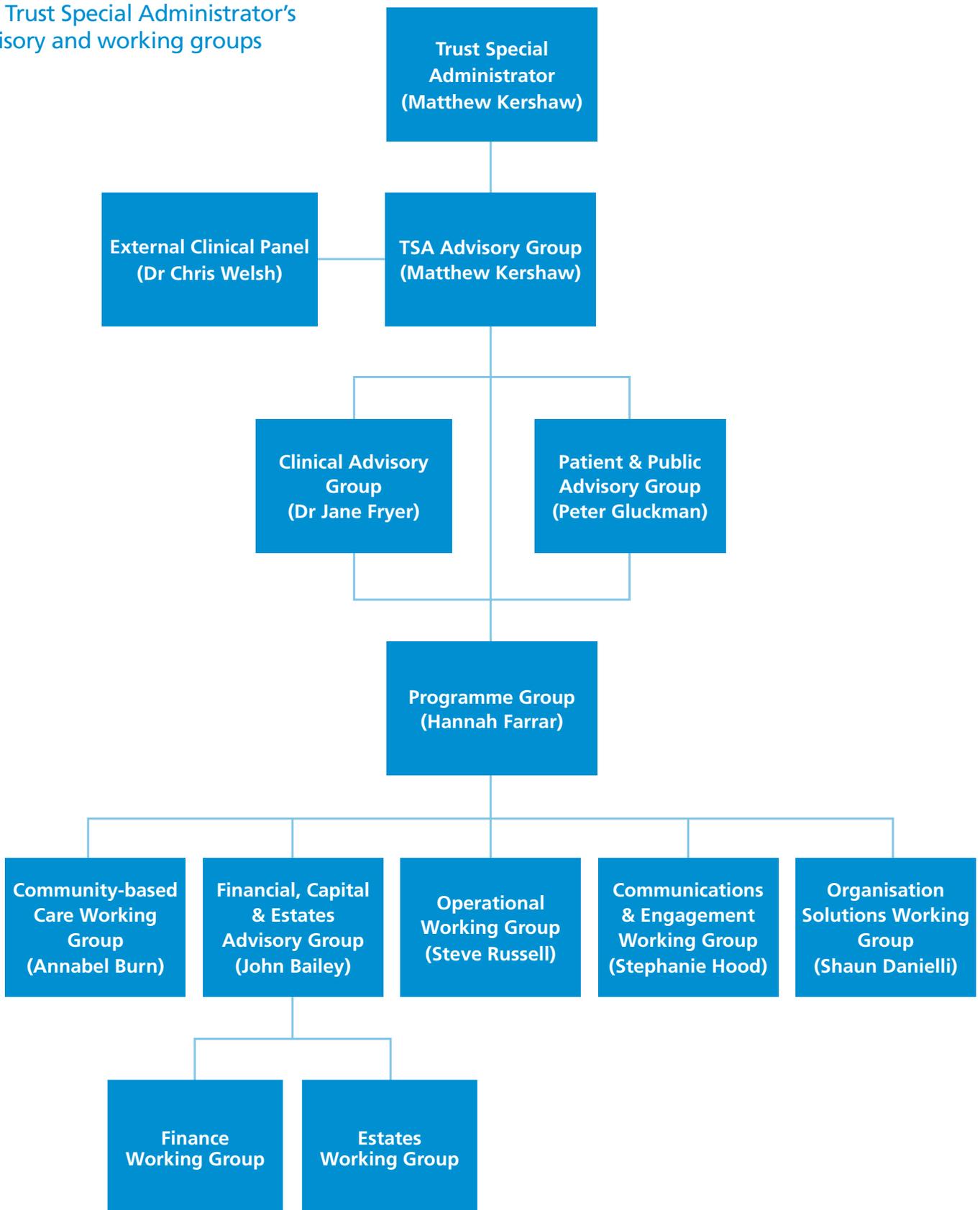
To make sure that all patients in south east London can access high quality and safe services in the future, and that all NHS organisations deliver affordable services and have a sustainable future, the TSA's recommendations cannot just be about changes to SLHT. The recommendations need to take a broader perspective and be developed with doctors, nurses, GPs, and other providers of community and social care across the whole of south east London.

A number of advisory and working groups involving doctors, nurses, community healthcare providers, ambulance staff and social care providers as well as health and other professional experts, such as accountants, were therefore set up. These groups have all helped the TSA develop the recommendations set out in this consultation document.

An additional group of nationally recognised expert doctors, drawn from across England, was set up as an External Clinical Panel to test and check the ideas of the south east London advisory groups, before the proposals were finalised.

The following chapters of this consultation document look at the different parts of the problem. They explain the Trust Special Administrator's recommendations and how these have been formed and then ask for your views on these.

The Trust Special Administrator's
advisory and working groups



3

What is the problem the Trust Special Administrator must solve?

This consultation is called *Securing sustainable NHS services* but what does that mean?

If you look up the word sustainable in the dictionary the definition reads 'able to be maintained' and this is what we mean – services that can be maintained and be successful into the future.

However, these services must be safe and of a high quality and meet the needs of patients. They must also be affordable making sure they are designed within the available funding and that taxpayers' money is spent wisely.

In the NHS we refer to this as clinically and financially sustainable services.

What are clinically sustainable services?

You expect your NHS to provide high quality care for you and your family. After all, you deserve nothing less.

To make sure that NHS organisations are providing the best possible care, new clinical standards are regularly set by doctors and nurses working at a national level. These standards push the NHS to continuously improve for the benefit of patients. They take account of changes in technology, medicine, and scientific advances. And aspiring to meet these standards keeps the NHS at the top of its game. It ensures patients receive the highest possible standards of care. These standards are explained more in Chapter 8.

NHS organisations that are able to meet these standards, and are able to continuously adapt and respond quickly to advances in care, are said to provide clinically sustainable services.

What are financially sustainable services?

The Department of Health and the regulator for NHS foundation trusts, Monitor, expect NHS organisations to make a financial surplus – this means the amount it costs to provide services to patients needs to be slightly less than what trusts are paid to provide these services. This is so NHS organisations can sensibly manage their money and make sure they have some 'spare' money that they can use to spend on improving their services and / or in the event of an unexpected situation – just like when, as individuals, we might keep some money saved in case something unexpected happens that we need to pay for.

The measure of a financially sustainable organisation, as set out by the Department of Health and foundation trust regulator, Monitor, is the delivery of a 1% surplus in its budgeting. This means that the NHS organisation's costs are 1% lower than the amount it is paid to deliver the services it provides

The task of the Trust Special Administrator

The task of the Trust Special Administrator (TSA) is to secure sustainable NHS services for those people served by South London Healthcare NHS Trust and the wider NHS in south east London.

This means making recommendations that address the challenge of delivering both clinically and financially sustainable services. If he only addresses the financial problems, quality could suffer, and if he only addresses clinical sustainability services may be unaffordable.

The Trust Special Administrator therefore needs to balance both of these components in his recommendations, therefore securing clinically and financially sustainable NHS services for the future.



4

South London Healthcare NHS Trust's financial problems

Financial problems are not new for South London Healthcare NHS Trust.

South London Healthcare NHS Trust (SLHT) was formed in 2009 following the merger of three south east London NHS hospital trusts. However, the financial problems started long before this date as the three predecessor trusts had all been overspending since 2004.

This overspend has continued, despite the merger which was an attempt to overcome the problem. Last year the Trust overspent by £65 million and it is expected that SLHT will overspend by just over £54 million in this financial year (ending March 2013).

Every year SLHT overspends it needs to receive additional financial support from the Department of Health so it can continue to pay its staff and suppliers. By the end of March 2013 the total support received from the Department of Health will have reached £207 million.



Financial problems are expected to continue, and get worse, in the future

Looking forward over the next three years analysis shows the Trust will continue to have financial troubles if a resolution is not found.

It is expected that if the Trust does nothing differently to what it is doing now, over the next three years (ending March 2016) it is expected to accumulate a further debt of more than £240 million. The predicted figures show that in the financial year 2015/16 itself (April 2015 – March 2016) it will overspend by another £74.9 million if it carries on as now. This is a worse position than this year.

The financial problem will get worse if nothing is done to fix it. Quality will be put at risk because the Trust won't be able to afford to continue providing the quality of services it does now to local patients. It may be forced into taking some 'quick fix' financially driven decisions that impact on the quality of care it can provide in an unplanned way.

What is the size of the financial problem in the future?

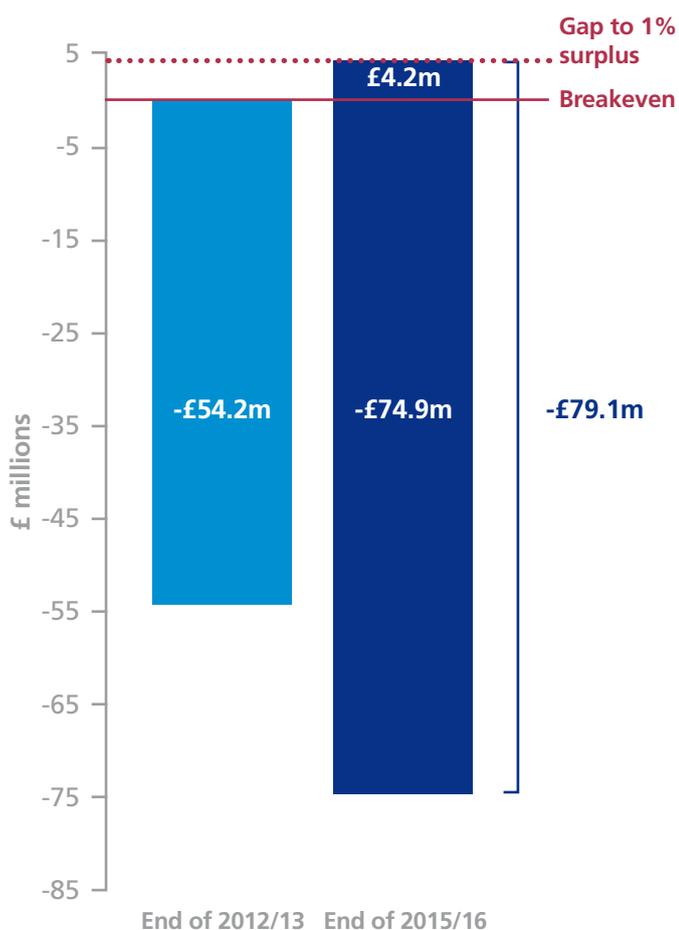
Like all NHS organisations, SLHT will be working to reduce as much of its costs over the next three years as it can. In its current form this could be £43.3 million by the end of 2015/16.

However, this is not enough to cover the expected overspend. And actually, the challenge of the Trust Special Administrator (TSA) is more than just getting SLHT to stop overspending – though this is a significant task – it is to make the services provided by SLHT sustainable for the long-term. As explained in Chapter 3, from a financial perspective this means that SLHT's income (what it gets paid to deliver services to patients) must be 1% more than the amount it costs to deliver those services – this is called a surplus.

This means that, even if SLHT makes savings of £43.3 million over the next three years, in 2015/16 the financial gap to stopping the overspend and achieving a 1% surplus will be £79.1 million pounds. This is shown in the chart below.

The task of the TSA is to develop a set of recommendations that address this gap of £79.1 million in 2015/16. This will make the Trust financially sustainable. His task is also to ensure this is done in a way that ensures services meet the required clinical standards so that they are clinically sustainable. Achieving both these will mean that sustainable NHS services will be secured for the future for the people served by SLHT and the NHS in south east London.

Forecast deficit for 2012/13 and 2015/16 for South London Healthcare NHS Trust



What is driving the financial problems at South London Healthcare NHS Trust?

The Trust has three main challenges which are driving its financial problems:

- It is not as efficient as it could be (see Chapter 5 for an explanation of what this means) and the clinical and managerial leadership has not made enough improvements
- It is not making the best use of the buildings it owns and rents, and has a number of very expensive Private Finance Initiative (PFI) buildings (see Chapter 6 for more detail about what the PFI challenges are) which has created a gap between what is owed and what is affordable
- No hospital anywhere in the country operates in isolation. Hospitals are part of a bigger NHS family, working closely with other healthcare services in a locality. Each NHS organisation's financial position is therefore affected by how it works as part of the wider healthcare system. This is true for South London Healthcare NHS Trust (SLHT), and for the wider NHS in south east London. This is explored later in this document in Chapter 8.

A financial challenge of this size cannot be dealt with easily. To ensure that high quality, safe and clinically sustainable services can be provided into the future within the funding available something radical is needed to fix the problem. The status quo simply is no longer an option as it is not in the best interest of patients.

5

Recommendations for South London Healthcare NHS Trust

There is a lot that could be done within South London Healthcare NHS Trust (SLHT) itself to improve the current position. These are described in recommendations one to three and outlined in this chapter.

Recommendation 1

Improve the efficiency of South London Healthcare NHS Trust.

When we talk about efficiency we mean the amount of resources the Trust uses, such as staff, buildings and supplies, and how they are used to treat a certain number of patients.

Hospital trusts that are more efficient will spend less on staff, buildings and equipment compared to the amount of income that they receive. The amount of income a hospital receives is related to the number of patients they treat.

One of the key challenges SLHT faces is the way it uses resources such as staff, buildings and equipment. In comparison with other NHS trusts, particularly the high performing ones across England, SLHT spends more on these things compared to the amount of income it receives.

If it was as efficient as other similar sized and structured NHS trusts, SLHT could provide the same services but save around £79 million over the next three years (ending March 2016).

This has been shown in two main pieces of analysis that were done to understand what improvements could be made in the way SLHT provides its current services.

- 1 a comparison of SLHT with 18 other NHS trusts – known as SLHT’s ‘peer’ group or ‘peer’ trusts. These NHS trusts are similar to SLHT in terms of the number and types of patients they treat, the number of hospitals they have, and the amount of funding they receive.
- 2 an internal review looking in particular at SLHT’s current finances, which included the latest data and interviews with staff.

This analysis has identified that improvements can be, and need to be, made in the following key areas.

Paying for hospital staff

SLHT spends more on doctors, nurses and other staff in relation to the amount of patients the Trust is paid to treat, compared to its peer NHS trusts.

It spends a relatively high amount on nursing staff, with more senior nurses than other similar NHS trusts in its peer group. Compared to other peer trusts, SLHT also has a high number of A&E nurses for the amount of patients it treats and does fewer operations per operating theatre nurse.

Again compared with its peers, SLHT has a higher number of staff in professions such as pharmacy, speech and language therapy, and pathology and is not using its non clinical staff as efficiently as possible.

The numbers of doctors and nurses need to be more closely matched to what SLHT delivers in terms of care. By better organising the way that doctors and nurses work and reducing the



duplication and overlap that currently exists, the same amount of patients could be treated with fewer doctors and nurses just as is the case with high performing peer NHS trusts across the country. And the number of full time equivalent Scientific, Technical and Therapeutic staff should be reduced in line with top performing peer NHS trusts. There is also real work to do to reduce the amount of money spent on using expensive agency staff in these areas.

Some may think that SLHT patients are receiving a better experience, or higher quality of care, because there is more staff. The peer trusts that SLHT was compared against have similar, or higher quality of care scores. This shows that SLHT could deliver its current services with fewer staff and could maintain or improve the quality of services provided.

Work already started on this should be accelerated and this will help reduce reliance on agency staff. Opportunities for more efficiencies in terms of the staff running SLHT's office systems such as Human Resources and IT (Information Technology) should be pursued, including outsourcing as a primary alternative.

What are the savings that could be achieved on staff pay? £36m

Operating theatres

Some of the most expensive care delivered by hospitals takes place in their operating theatres and, in the case of SLHT, these are not being run as efficiently as they could be in comparison with top performing peer NHS trusts.

In fact, SLHT is only achieving 67-76% operating theatre efficiency – this means that of the time that SLHT pays operating theatre doctors and nurses in theatre, only 67-76% of their time is spent treating patients. This is compared to 85% in peer NHS trusts. This is expensive for SLHT, and means patients are not getting as good a service as they could be.

SLHT's systems and processes need to change to improve the way it uses its operating theatres. This is particularly in planning numbers and types of patients undergoing operations, and ensuring its doctors and nurses work more efficiently. They should spend more of their time treating patients, so they can use theatre time more efficiently and operate on more patients in each theatre session, just as other peer NHS trusts do.

This would mean that either more patients could be treated or that the same number of patients could be treated as now, but with fewer operating theatre doctors and nurses.

Achieving 85% operating theatre efficiency and reducing the average time it takes to operate on a patient by 10% would reduce the number of theatre hours required by approximately 8,000 hours; saving time and improving care for patients.

The review has identified three specialties in which to begin this work. These are general surgery, gynaecology, and trauma and orthopaedics.

What are the savings that could be achieved in operating theatres? £2m

Outpatient services

SLHT could treat the same number of outpatients – patients who do not need to stay in hospital overnight – with fewer appointment slots if the number of patients seen per clinic matched the top performing peer NHS trusts.

A significant proportion of efficiencies can be achieved by better use of outpatient capacity at SLHT. For example this could be by reducing the number of changes and cancellations the hospital makes and the number of patients who do not attend their appointments – which is often because the communication with them from the hospital has not been clear.

What are the savings that could be achieved in outpatients? £4m



Length of stay in hospital

Although SLHT performs relatively well compared with peer NHS trusts when it comes to the length of time patients need to stay in the hospital – this being relatively low – it could be even better.

For example, SLHT could make a reduction of 90-100 beds if 'lengths of stay' were reduced still further in line with the best across the NHS. This doesn't affect the number of patients that can be treated, but means that the number of beds (and staff looking after patients in those beds) can be used more effectively. This would, also improve care for patients since they would be leaving hospital and getting home sooner. This is better for patients and the costs are less.

Changes need to be made to both the way patients are cared for by the hospital when they have to stay overnight, and the way they are cared for outside the hospital, such as in community facilities.

What are the savings that could be achieved in inpatients? £6m

Clinical equipment and supplies

Equipment and supplies bought by hospitals includes everything from bandages and dressings, syringes and protective gloves to surgical tools such as scalpels, drugs, and artificial prosthetics such as hip or knee replacements. SLHT currently spends £92.5 million on these kinds of items every year – which is 10% more than its peer NHS trusts.

Too many different suppliers are being used by SLHT, often to buy the same things. This makes the purchasing of simple items too complicated, and too expensive. SLHT should be buying more of its supplies in bulk, and from fewer suppliers, as well as managing its stock levels better.

What are the savings that could be achieved? £9m

Scientific, Technical and Therapeutic services

In SLHT, some of the Scientific, Technical and Therapeutic (ST&T) services are not working as efficiently as they could. In comparison with other similar NHS organisations across the country, SLHT is currently spending more on its pathology and pharmacy services.

By using better technology and increasing automation SLHT can make its pathology services more productive. For example, through the use of specialist machines more samples can be tested every hour, and need fewer staff to run them.

What are the savings that could be achieved in technical services? £5m

If SLHT were to implement all these improvements, it could potentially save £62 million over the next three years, and take its quality and efficiency to current levels seen in top performing peer NHS trusts.

However, top performing NHS trusts do not stand still and constantly work to improve how efficient they are, day by day, year on year, making best use of the resources available to them. In fact the best NHS trusts have demonstrated they can make everyday efficiencies equivalent to at least 2% of their overall costs per year.

If SLHT were to do this also, it would save a further £17 million over the next three years on top of the £62 million, taking the total potential savings from operational efficiencies to £79 million by the end of March 2016.

As explained in Chapter 4, SLHT could deliver £43.3 million savings over the next three years, however, the analysis undertaken by the Trust Special Administrator has shown that the opportunities to save money by changing how the Trust works are much larger than that - £79 million. Subtracting the £43.3 million figure from the maximum financial opportunity identified (£79 million) as this has already been accounted for, means the savings from Recommendation one total £35.4 million.

Financial impact of recommendations in 2015/16 for South London Healthcare NHS Trust



Question

To what extent do you agree or disagree that the efficiency of the hospitals that make up South London Healthcare NHS Trust needs to improve to match that of top performing NHS organisations?

Question

To what extent do you agree or disagree that the areas outlined in Chapter 5 of the consultation document for improving efficiency at the hospitals that make up South London Healthcare NHS Trust are appropriate?

Recommendation 2

Develop a Bexley Health Campus at Queen Mary's Hospital Sidcup.

The Bexley Health Campus

The future of Queen Mary's Hospital, Sidcup has been an area for discussion between the NHS and the London Borough of Bexley for the last two years – both organisations are keen to maximise Queen Mary's potential as a provider of a range of healthcare services to Bexley and neighbouring communities. Together Bexley Clinical Commissioning Group (the GP led NHS body responsible for planning and buying healthcare and services for local people) and the London Borough of Bexley have developed a vision for Queen Mary's Hospital to be transformed into a Bexley Health Campus that would provide a range of services to local communities.

Bexley Clinical Commissioning Group will need to go through a process to select an organisation to provide planned day case surgical services (ie services for those patients who have a planned operation but won't need to stay in hospital overnight). To ensure patients will continue to receive these surgical services ahead of a decision being taken, it is suggested that Dartford and Gravesham NHS Trust provide these services.

Making these changes would mean Oxleas NHS Foundation Trust would be the provider organisation delivering the largest number of services from the Queen Mary's Hospital Sidcup site, including the Urgent Care Centre, rehabilitation and mental health services. This creates an opportunity for SLHT to divest its assets here, which would help the organisation to resolve some of its financial challenges. In addition, developing Queen Mary's Hospital into a Bexley Health Campus will need a lot of investment in the buildings and equipment on the existing site. Given the financial challenges faced by South London Healthcare NHS Trust (SLHT), the Trust is not in a position to make this investment.

It is proposed that the following services would be provided from the Bexley Health Campus:

- Urgent care services that treat patients with urgent illnesses and injuries and conditions that can be seen and treated without the patient needing to stay in hospital overnight
- Rehabilitation services that allow people to recover from illnesses or treatment closer to home, often after receiving specialist treatment in a different hospital
- Community services to support those with long term conditions, such as diabetes
- A Children's Development Centre that will be at the centre of providing specialist services for children
- Outpatient services, including some diagnostic tests such as x-ray and ultrasound scans

- Radiotherapy services that allow patients to have cancer treatments closer to home rather than travel into central London
- Day case surgery for procedures that do not require a stay in hospital, such as general surgery, cataracts and endoscopy procedures
- Mental health services, including a dementia centre of excellence and possibly an inpatient mental health centre of excellence for patients in Bexley and Bromley.

These services are currently provided by a number of different NHS providers (primarily Oxleas NHS Foundation Trust and South London Healthcare NHS Trust) and will continue to be delivered to patients by a range of different providers of NHS services. For example, Oxleas are likely to continue providing the Urgent Care Centre, rehabilitation and mental health services, and it is likely that staff from Guy's and St. Thomas' NHS Foundation Trust will run the radiotherapy service.

Current and future services to be provided at Queen Mary's Hospital, Sidcup site

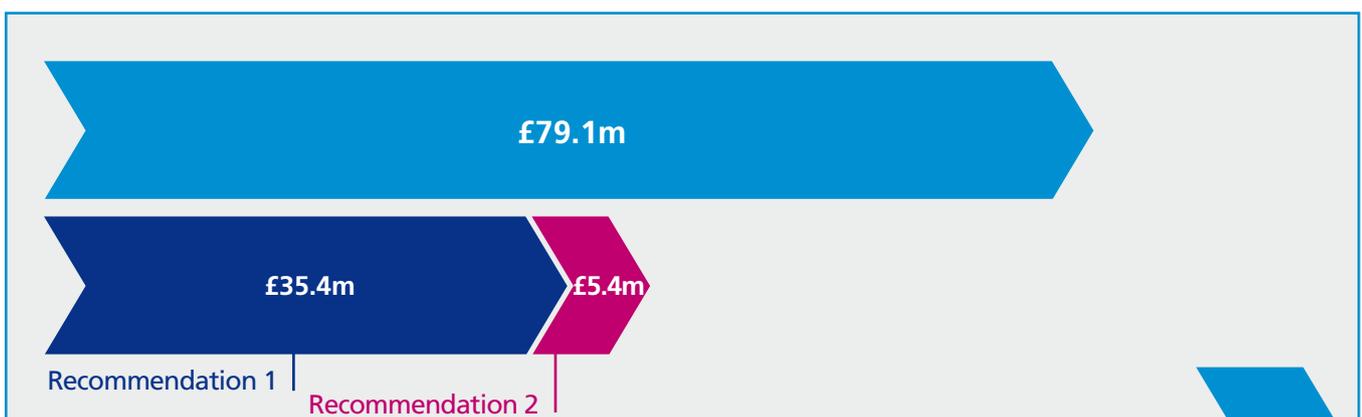
Today	In the future
Non – admitting Urgent Care Centre*	Non – admitting Urgent Care Centre
Outpatients (inc. for children)	Outpatients (inc. for children)
Diagnostic tests and screening (e.g. X-rays)	Diagnostic tests and screening (e.g. X-rays)
Antenatal and post-natal care	Antenatal and post-natal care
Renal dialysis	Renal dialysis
Intermediate care/Rehabilitation beds*	Intermediate care/Rehabilitation beds
Mental Health Services for Bexley*	Centre of excellence for mental health services
Inpatient and Day case surgery	Day Case Surgery
Endoscopy	Endoscopy
Chemotherapy	Chemotherapy
	Radiotherapy
Children's Development Centre	Children's Development Centre

*services currently provided by Oxleas NHS Foundation Trust

It is therefore recommended that the space required to develop the Health Campus be transferred or sold to Oxleas NHS Foundation Trust. Oxleas not only provides a range of services from Queen Mary's Hospital site, it is also willing to invest in the site in order to bring it up to the standard required to deliver excellent care to local communities. As part of this investment they could develop an inpatient mental health centre of excellence for patients in Bexley and Bromley. Doing this would provide patients with a better experience and free up more money to invest in community services – as they did when they created a similar centre of excellence for dementia patients.

Developing a Health Campus is great for patients as they will have improved facilities and it helps address some of the financial problems at SLHT as the Trust would no longer have the cost of running the buildings which is £5.4 million.

Financial impact of recommendations in 2015/16 for South London Healthcare NHS Trust



Question

How far do you support or oppose the proposal for Queen Mary's Hospital Sidcup to be turned into a Bexley Health Campus?

Question

How far do you support or oppose the proposal for the land and buildings required for Bexley Health Campus at Queen Mary's Sidcup site to be transferred or sold to Oxleas NHS Foundation Trust?

Recommendation 3

Making the best use of buildings owned and leased by South London Healthcare NHS Trust.

South London Healthcare NHS Trust (SLHT) has three main hospital sites, but also provides services from a number of other locations and buildings. Some of these buildings are not used as well as they could be. For example, space in some of the buildings SLHT rents is only used to treat patients for a few hours a day, and only five days a week– this is not a good use of taxpayers' money.

Addressing this issue would reduce how much SLHT spends on buildings meaning that more money could be spent on patient care.

Three opportunities have been identified within this recommendation:

- **Sale of excess land at Queen Mary's Hospital in Sidcup:** with the development of a Bexley Health Campus some of the current hospital site will no longer be needed to deliver the services proposed for the future – this excess land should be sold to save money that can be reinvested into patient services. Selling this land would mean SLHT would reduce its costs each year by £0.7 million (see diagram on page 23).
- **Sale of Orpington Hospital:** SLHT had already identified that continuing to provide services from Orpington Hospital in its current form was not a good use of taxpayers' money. The Trust has therefore given notice that they are planning to sell Orpington Hospital and will continue to work with Bromley Clinical Commissioning Group and the London Borough of Bromley to ensure local people continue to receive the care they need. This is expected to save SLHT £1.5 million a year.

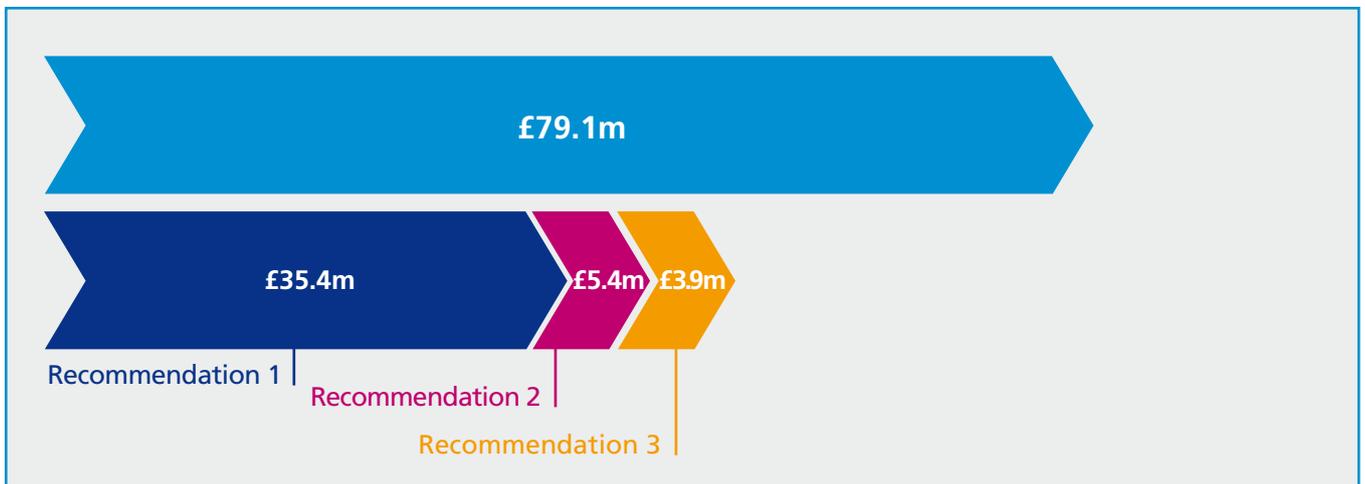
In order to make sure that healthcare services can still be provided for patients living in and around Orpington, Bromley Clinical Commissioning Group has very recently consulted on proposals for a modern health service for Orpington that puts services in the best place for patients. The consultation, which finished on 29 October 2012, is looking to determine what the right services are for the local population and is considering from where those services should be provided. Following the consultation, SLHT will continue to work with Bromley Clinical Commissioning Group and the London Borough of Bromley to ensure local communities continue to receive the care they need. This will include further discussions to agree the future of the site.

- **Ending South London Healthcare NHS Trust's lease at Beckenham Beacon:** the Trust currently rents almost half of the space at Beckenham Beacon to provide a range of outpatient and diagnostic services. This space is poorly used and is costing the Trust around £1.7 million a year. By providing these services from Princess Royal University Hospital in Bromley the Trust could save the money it spends on renting Beckenham Beacon every year. The Trust is proposing to end its lease for this site and is discussing options for this with Bromley Clinical Commissioning Group. This recommendation is not proposing services are not provided at Beckenham Beacon in the future, just that SLHT will not be the organisation delivering them. Bromley Clinical Commissioning Group will consider what primary and community care should be provided from the Beckenham Beacon site in the future to meet the needs of local communities.

Excess land at Queen Mary's Hospital, Sidcup site



Financial impact of recommendations in 2015/16 for South London Healthcare NHS Trust



Question

How far do you support or oppose the recommendation that South London Healthcare NHS Trust should sell or no longer rent poorly used or empty buildings?

6

Recommendation for national support

Recommendation 4

Department of Health provides additional annual funds to cover part of the costs of the PFIs.

What is a Private Finance Initiative (PFI)?

Private Finance Initiative is a concept that was introduced across the public sector, including the NHS, in the early 1990s. One of the concepts of PFI is that new buildings that previously would have been funded by public sector money are instead funded through private finance, which due to greater availability enables public sector organisations to invest more in improving buildings, equipment and services. In the NHS this is usually by building hospitals or other facilities - paying back the money borrowed over a period of up to 30 to 35 years.

PFI contracts can be likened to a mortgage on a house. PFI enables NHS trusts to buy or build new facilities which create huge benefits for patients when they do not have sufficient money to buy or build the facilities outright. PFI is quite commonplace within the NHS and many NHS organisations have entered into PFI contracts. The majority of these work well and provide modern and efficient (easy to heat, clean and maintain) facilities from which to provide services. In March 2012 there were 118 PFI contracts within the NHS across England, and 717 PFI contracts across the whole of the public sector.

As described in Chapter 4, one of the areas that is contributing to South London Healthcare NHS Trust's financial problems is the high cost it is paying for its Private Finance Initiative (PFI) contracts.

South London Healthcare NHS Trust (SLHT) has six PFI contracts in total across its three main hospital sites – two of these contracts are very large and were used to pay for the development of Princess Royal University Hospital in Bromley and Queen Elizabeth Hospital in Greenwich. The other four are smaller contracts are for the running of equipment and other services for the hospital buildings.

It currently costs SLHT £69 million each year to maintain its PFI contracts at Princess Royal University Hospital (£35 million) and Queen Elizabeth Hospital (£34 million).

Just like people who enter into a mortgage, SLHT has budgeted for paying its PFI repayments each year. However, in looking at the PFI contracts in more detail it has become clear that SLHT cannot afford the full amount each year, and is paying a higher proportion of its income as annual payments for its PFI contracts than some other NHS organisations across the country.

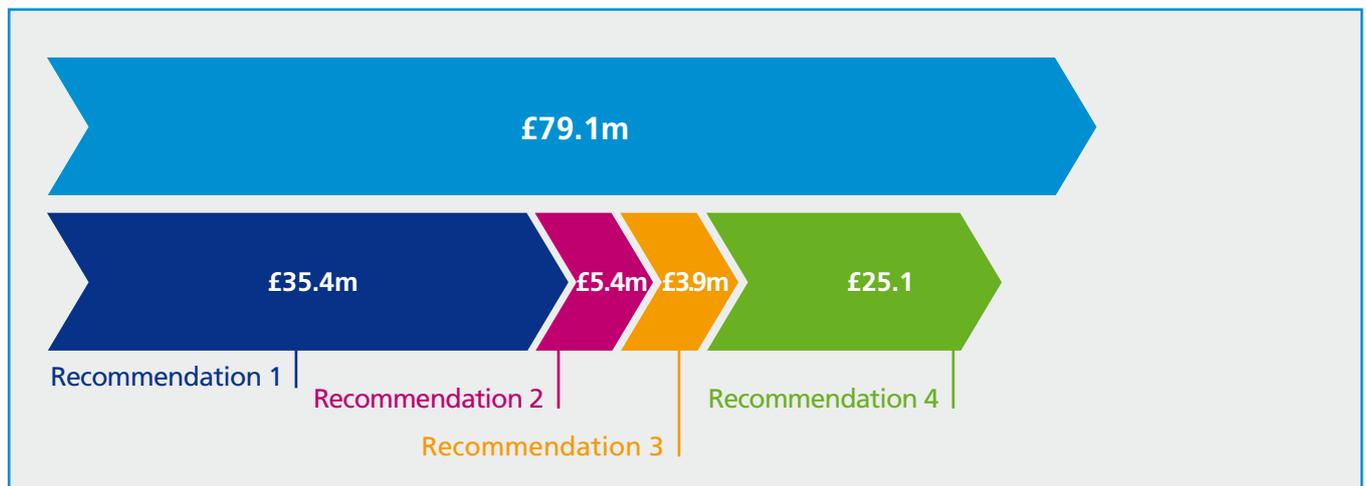
The Trust spends 16% of its turnover on its PFI contracts which is much higher than the national average of just over 10%. These higher payments cannot be easily covered by the amount of income the Trust receives each year. Analysis has shown that the two PFI contracts cost substantially more than had they been financed through traditional public finance arrangements and for this SLHT should not be penalised.



Analysis has shown that even if SLHT was as productive as the most productive hospital trusts in England, and if it earned the most money it could from filling the beds and other clinic space within these buildings, it would still not receive enough income from its activity to pay the costs associated with the particular PFI arrangements in place.

SLHT is one of seven trusts across the country that the Department of Health believe needs help with paying for their PFI contracts due to the costs incurred. It is therefore recommended that the Department of Health provides additional funds each year to the local NHS to cover part of the costs of the PFI buildings at Queen Elizabeth Hospital and Princess Royal University Hospital until the relevant contracts end. In the financial year 2015/16, this would be a payment of £25.1 million.

Financial impact of recommendations in 2015/16 for South London Healthcare NHS Trust



Question

How far do you support or oppose the recommendation that the Department of Health provides additional annual funds to cover the additional costs of the Private Finance Initiative (PFI) buildings at Queen Elizabeth Hospital and Princess Royal University Hospital until the relevant contracts end?

7

How South London Healthcare NHS Trust works as part of the NHS locally

As outlined in Chapter 4 in 2015/16 the financial gap to stopping South London Healthcare NHS Trust's (SLHT) overspend and achieving a 1% surplus is £79.1 million pounds.

The improvements outlined in the first four recommendations will significantly reduce the costs of SLHT by £69.8 million in 2015/16, but they don't address the entirety of the problem as they do not bridge the financial gap (£79.1 million) which is required to secure sustainable services (see Chapter 3) in the long-term. The remaining financial gap is still very big, and the analysis shows it is due to how the wider health system in south east London is designed and delivered and SLHT's role in this.

No hospital anywhere in the country operates in isolation. Every hospital is part of a bigger NHS family, working closely with other healthcare services such as GPs, the ambulance service, community healthcare providers and indeed other hospitals. Each NHS organisation's financial position is therefore affected by how it works as part of the wider healthcare system.

SLHT is a core part of a wider NHS health system in south east London, which includes three other large NHS hospital and foundation trusts: Lewisham Healthcare NHS Trust, King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust (see map on page 5). Alongside these there are also a wide range of other health and social care providers.

The Trust Special Administrator (TSA) has therefore explored how SLHT works as part of the wider healthcare system in south east London. Only by doing this could he develop

a set of recommendations that will ensure high quality, safe services can be provided within the funding available and last into the future across south east London.

Healthcare has changed in south east London

In looking at how South London Healthcare NHS Trust (SLHT) works as part of the wider NHS in south east London, and how this may continue in the future, it is important to understand the changing environment in which all NHS organisations are working within.

The way health services are delivered nowadays is changing: a phrase that is commonly used but what does this actually mean?

If we look at how and where healthcare is delivered to patients today compared with 20 years ago there are a number of big differences.



Due to advances in treatment as well as the growing skills of doctors, nurses and other healthcare professionals, many treatments that in the past would have had to be provided in a hospital can now be provided to patients in a community setting for example, at their local GP surgery, a local walk-in centre or even in their own home.

For example, 20 years ago patients with high blood pressure, diabetes or asthma would have been sent by their family doctor to see a specialist in a hospital in order to manage their condition. These days the treatment and monitoring of these conditions, with medicines and with lifestyle advice about diet and exercise, can easily be delivered by family doctors and specialist nurses in GP surgeries. Not only does this reduce patients going to hospitals as outpatients but it also reduces the amount of patients that are admitted to hospital with these conditions in an emergency situation – for example, good management of blood pressure significantly reduces the likelihood of patients having a stroke.

The length of time it takes to provide some treatments to patients in hospital has significantly reduced meaning patients spend less time in hospital than 20 years ago.

For example, due to advances in technology a number of operations can now be done via 'keyhole' surgery. Because the operations are 'key hole' the incisions are much smaller meaning it takes less time for the patient to heal and their recovery time is much quicker. This means for this type of operation patients only need to come into hospital for a single day – they don't even need to stay overnight – whereas 20 years ago they would have had to stay in hospital for at least a week. Removing a gall bladder or breast surgery would fall into this category.

The role of the ambulance service has changed significantly; ambulances now have a range of specialist equipment on board and ambulance staff are highly trained healthcare professionals who are able to provide life saving treatment and drugs to patients at the scene of an emergency.

For example, a person has a stroke in their home. The majority of strokes are caused by a clot on the brain and can be quickly treated by giving the patient a clot-busting drug known as a thrombolytic. The sooner this is given to the patient after the stroke the better as it increases their chance of survival as well as reduces the risk of long-term disability in the future, therefore improving their quality of life. Paramedics can now rapidly assess, treat as appropriate, stabilise and transfer patients to specialist centres across London, for example a Hyper Acute Stroke Unit where clot-busting drugs can be given quickly. Providing the right treatment immediately also means that the patient recovers more quickly, meaning less time spent in hospital. And nowadays many people who have suffered a stroke access rehabilitation services in the community. This also reduces the need for them to spend a long time in hospital away from their home.



The healthcare needs of the local population also need to be considered – these have changed and will continue to change. The NHS therefore needs to change too to be able to best meet the needs of local people. For example, more people are living with long-term conditions such as diabetes, asthma and high blood pressure.

More people are living for longer which is a good thing, but this does impact upon healthcare needs. When older people become unwell they are often taken into hospital, however, we know that this can lead to a more rapid deterioration in their health and independence. For example, older people living with dementia can be managing their condition fine at home but if they end up in hospital with an unrelated illness or condition they can get very confused and disorientated and this can lead to a deterioration in their health.

The number of births expected across south east London over the coming years is also changing. It is projected that birth numbers will increase by about 5% across south east London from 25,954 births in 2012/13 to a projected 27,351 births in 2017/18. Overall population growth during this time is expected to be about 6% (taking into account migration and other factors affecting the overall growth rate).

Ensuring patients can access the appropriate care for their needs in the community, and where possible in their homes, is vital in the future.

The fact that health services are being delivered differently now to how they were delivered in the past means that some services that could once only be delivered in a hospital setting are now being delivered more conveniently and as effectively outside of hospitals, and the time patients are spending in hospital when they do need to go there can be reduced.

This is more convenient for patients and also often a cheaper way of delivering services as they do not require all the costly infrastructure of a hospital setting. This is good for patients and good for the taxpayer.

When looking at how South London Healthcare NHS Trust works as part of the wider NHS, it is important to understand the potential impact of the changes in health need and healthcare delivery as described in this section.

Linking changing health need with the current and future financial position of the NHS in south east London

In looking at how healthcare is changing, and how it will continue to change over the coming years, we must also look at the funding available to the NHS across south east London and how this may change over time too. The two elements are inextricably linked.

The Trust Special Administrator (TSA) took a detailed look at the finances both for NHS commissioners (organisations that plan and buy NHS services on behalf of local communities) and NHS providers (organisations that provide NHS services to local communities).

All providers will face the same financial pressures in the future from an increase in inflation on costs, a reduction in the price that commissioners will pay for services (which is agreed nationally), and a drive towards reducing unnecessary admissions to hospital and delivering more care in the community, which reduces hospital income.

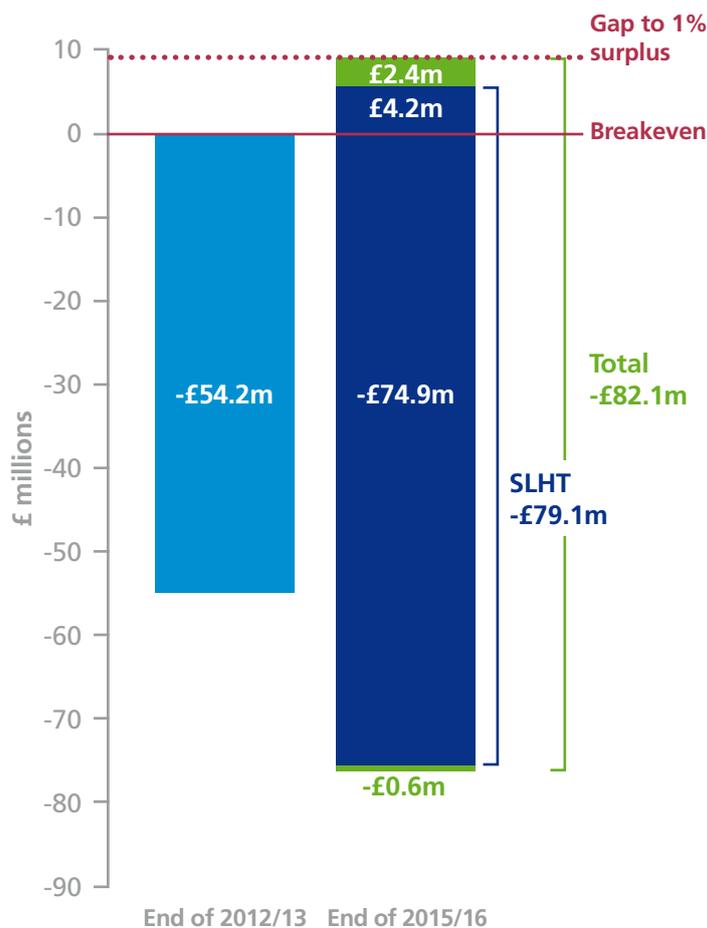
The financial position has been assessed to show income and costs today, and predicted income and costs over the next three years to 2015/16.

What the financial analysis of the wider NHS in south east London has revealed is that whilst South London Healthcare NHS Trust (SLHT) is facing significant financial challenges today making it unsustainable, those challenges will be faced by the wider NHS in south east London over the coming years.

This recent and updated analysis undertaken by the TSA based on new information from commissioners has highlighted that Lewisham Healthcare NHS Trust is expected to be making a loss from 2014/15 and by the end of March 2016 will have a £3 million gap to achieving a 1% surplus – the measure of a financially sustainable NHS organisation as outlined in Chapter 3. This figure is the total of a £0.6 million expected overspend and an additional £2.4 million gap to 1% surplus on top of that.

Taking together SLHT's financial gap to 1% surplus of £79.1 million and Lewisham Healthcare NHS Trust's gap of £3 million, creates a financial gap of £82.1 million for the NHS in south east London. The TSA's recommendations need to address this total financial gap to ensure sustainable services for the whole of south east London (this is shown in the chart to the right).

Forecast deficit for 2012/13 and 2015/16 for south east London health system



Why is the NHS in south east London facing financial problems in the future?

Just like in our own lives, the NHS has to live within its means – there is no bottomless pot of money available. The challenge for all NHS organisations across the country is to provide high quality, safe and accessible services to local communities within the money that is available. Due to a number of reasons this has become more challenging than ever for hospitals.

Hospitals are treating fewer patients than they did in the past, as a lot of care that has been historically delivered in hospitals can now be better and more conveniently delivered in the community and closer to home. And as hospitals are paid depending on the number of patients they treat, it means they are receiving less income each year.

The reduction in income goes further still as the prices set nationally that hospitals can charge for the different services they provide – known as the ‘tariff’ – is not expected to increase in line with inflation and rising costs over the coming years. This means that hospitals will not only get paid less as they are treating fewer patients, but won’t be able to compensate for this by charging more for the work they do.

And as their income is reducing the inflation-related costs associated with employing staff, buying medicines and equipment and paying for buildings are increasing.

In addition, although the amount of money available to spend on healthcare will continue to increase, the way that NHS commissioners choose to spend on behalf of their local communities may change as more care is delivered to patients in the community, supporting people to stay healthy and avoid unnecessary trips to hospital.

This means that the amount of money being spent on hospitals will not significantly increase in future years, and in some cases will decrease.

However, the costs of delivering hospital care across the area are expected to rise. This is because hospitals are very large organisations with many buildings and staff – all of these cost a considerable amount of money to run and will cost more in the future as inflation impacts them as it will for all other parts of the economy.

This is why the NHS needs to rethink how and where services are delivered as hospitals will not be able to continue to provide high quality services in the future without overspending, just like South London Healthcare NHS Trust is today and Lewisham Healthcare NHS Trust will be in the future. This makes these organisations financially unsustainable.

If changes are not made to the way services are delivered, taking into account the changes in healthcare and the increased amount of care delivered in the community, then NHS trusts will have to make unplanned cuts to make the books balance as overspending is simply not an option.

The Trust Special Administrator (TSA) does not believe that allowing unplanned cuts to services is the best way to manage the NHS either now, or in the future. It would be highly irresponsible for the NHS to foresee these problems occurring, potentially putting quality of services and patient care at risk, and not act quickly to prevent it from happening.

This is why the TSA has been supported by a wide range of doctors, nurses, other healthcare professionals and managers to redesign the NHS in south east London, so high quality services can continue to be delivered into the future within the funding that is available.





8

Recommendations for NHS services in south east London

As outlined in previous chapters, the Trust Special Administrator's (TSA) work has identified that it is not only South London Healthcare NHS Trust (SLHT) that is financially challenged and needs to work with other NHS organisations to address its issues. In the future other NHS organisations in south east London will also be challenged financially thus threatening the quality of services in the future unless changes are made to where and how care is delivered.

This chapter sets out the process for how the TSA has worked with doctors, nurses, other healthcare professionals and managers to develop his fifth recommendation for the wider NHS in south east London to ensure high quality services can continue to be delivered into the future within the funding that is available.

Redesigning clinical services with doctors, nurses and other health experts

The Trust Special Administrator (TSA) brought together a group of senior doctors and nurses from all NHS organisations in south east London into a Clinical Advisory Group. He has asked the group to work with him to look at how services can be designed for the future so that they are clinically safe, effective and high quality, but also affordable for the long-term.

The group has met regularly from July 2012 to October 2012, and will continue to meet until the Trust Special Administrator presents his final report to the Secretary of State for Health in early 2013. The group has looked at what could be the best clinically designed system for

delivering health services in south east London, within the available resources.

The Trust Special Administrator has also brought together a group of nationally recognised senior doctors to form a second group of clinical advisors. They are the Trust Special Administrator's External Clinical Panel. Their role is to provide additional assurance and challenge from an external perspective to the work and thinking of the south east London group.

Establishing some criteria to test and evaluate any proposed changes to health services

The Clinical Advisory Group recognised from early conversations and analysis of the current situation for the NHS in south east London, as outlined in Chapter 7, that there would need to be some changes to the way services are designed and delivered – to make them safe, high quality, affordable and therefore sustainable for the long-term.

Before getting into any detailed conversations about what any changes could look like, the group developed and agreed a set of 'evaluation criteria' against which suggested changes should be scored.

The 'evaluation criteria' set out what local clinicians and local people considered to be the five most important things to consider when judging any suggested changes to the way health services are designed. This list of five things was developed and discussed with the Clinical Advisory Group, but it was also discussed and tested with the Trust Special Administrator's Patient and Public Advisory Group, and separately by six independently run focus groups made up of a representative sample of residents from each of the six boroughs in South East London.

The 'evaluation criteria' set out what local clinicians and local people considered to be the five most important things to consider when judging any suggested changes to the way health services are designed.

1 Quality of care

2 Access to care

3 Affordability and value for money

4 Deliverability

5 Clinical research and education

The five overarching criteria are:

1 Quality of care: any proposed changes should be scored on the basis that they will improve quality of care and the patient experience.

2 Access to care: any proposed changes should be scored on the basis that access to care is not negatively affected, and if possible is improved. Access to care has been defined by looking at equality of access (whether care is available for all people in the community, not just some), distance from and travel time to particular services and whether patients have a choice of services available to them.

3 Affordability and value for money: any proposed changes should be scored against how affordable they are within the funding available for the NHS in south east London, and the degree to which any changes use the available resources (staff, buildings and equipment) most wisely.

4 Deliverability: how easy it would be to put any proposed change in place, including how long it would take to change from the current way of delivering services to a new way.

5 Clinical research and education: to assess any proposed changes against how supportive a differently designed system would be to levels of important clinical research and the training and education of doctors and nurses that currently goes on in south east London hospitals.



Recommendation 5

Transform the way services are provided across hospitals in south east London.

Any change proposed by the Trust Special Administrator (TSA) must ensure high quality and safe services are available to the communities across south east London, and that this is done in an affordable way.

The following section of this chapter looks at four areas of care and how standards and quality can be improved in all four across south east London, how that supports the need to create a financially sustainable solution and what changes need to be made to make this happen. This makes up the TSA's fifth recommendation.

The four areas are:

1. Care in the community and closer to home
2. Urgent and emergency care
3. Maternity services
4. Planned care

1. Care in the community and closer to home

Currently access to community care services, for example, GP services, community nurses and local clinics, is varied across south east London. The standards and quality of care also vary.

This is why the six clinical commissioning groups in south east London – the GP led organisations that are responsible for planning and buying healthcare services on behalf of the communities they serve – have produced a strategy or plan to improve community based care for south east London.

At the heart of this strategy is a set of aspirations for how care will be delivered in the future so that patients across south east London can receive the best possible care in the community, including their homes where possible. This will support people to live healthier and more independent lives and reduce unnecessary demand on hospitals. These aspirations have been grouped into three areas of care:

➤ **Primary and community care services** that will provide easy access to high quality care for all, to support people in staying healthy, are available to the whole population. Examples of what this will include are:

- Being supported to manage your own health
- Being supported to make decisions about your care
- Having access to healthcare advice 24 hours a day, 7 days a week for urgent needs (for example through a new health telephone service 111).

➤ **Integrated care services** that support high risk groups, such as those with long-term conditions like diabetes, the frail elderly and those with long-term mental health problems, to remain active and supported in their own homes wherever possible. Examples of what this will include are:

- Having a personal care plan, with a named care coordinator to help you in managing your care
- Receiving expert advice and support promptly, so any problems you have are treated early and thereby preventing unnecessary trips to hospital for treatment of a worsening condition
- If you do have to be treated in hospital, being supported to leave hospital as soon as you are fit enough to do so, knowing you will get the right ongoing support.

➤ **Planned care services** to support those with a specific healthcare need to receive consistently high quality care in the appropriate location. Examples of what this will include are:

- Having the right information to make an informed choice about the healthcare services you need
- Being confident you will receive the same high quality standard of care, wherever you receive your care in south east London
- Having pre- and post- surgery care closer to home, but receiving specialist care in specialist centres delivered by experts.

The provision of care closer to people's homes and improved care for people with long-term conditions will reduce the length of time patients need to stay in hospital if they do have to stay in hospital for treatment, as well as providing better care for patients. This approach will save the NHS money.

The TSA is therefore recommending that the community based care strategy for south east London is further developed and then implemented to deliver improved community services for patients. This will enable people to receive care in the most appropriate location, much of which will be closer to, or in, their home.

Question

How far do you support or oppose the recommendation to implement the community based care strategy as outlined in Chapter 8 of the consultation document?

The impact of improving community based care in south east London

Issue	Evidence	Impact
Ageing and growing population	The overall population of south east London is forecast to grow by 6% in the next five years ⁱ	£68m investment in community based services planned to address issues ^{iv}
Significant health inequalities in part due to a lack of good preventative and primary care access	3.5 years difference in life expectancy between Greenwich and Bromley ⁱ	37 heart attacks and strokes could be prevented each year through early detection of risk factors with improved use of NHS Health Checks ^{ix}
Increasing number of people living with long term conditions which are not managed effectively	More than 1 in 4 people aged 75+ have one or more of the major long term conditions ⁱⁱⁱ	700 lives could be saved each year through early detection and improved management of diabetes alone ^x
High rates of uncontrolled diabetes	Up to 27% of people with diabetes remain undiagnosed and 53% of those diagnosed do not have their condition controlled and therefore have a higher risk of exacerbation, amputation, stroke and other complications	The number of people with uncontrolled diabetes should be reduced by half ^{xi} Around 200 amputations a year could be avoided through improved diabetes management in the community ^{xii}
Variation in access to and quality of community based care	10% of admissions for older people could have been managed through better community based care ^v 41% of patients do not feel they are supported enough by local services to manage their long term conditions ^v	10% reduction in emergency admissions for older people with long term conditions managed effectively in community care ^v 85% of patients to feel supported to manage their long term conditions ^{xiii}
Insufficient access in primary care for urgent same-day or out-of-hours services	20% of patients do not believe that GP surgeries are open at convenient times ^v	6% reduction in A&E attendances ^{xiv}
High A&E attendance rates across hospitals	3 of the 6 boroughs are below the national average for out of hours access to primary care ^{vi}	Improvement in % of respondents to annual GP patient survey that are very or fairly satisfied with GP opening hours by 2015/16
Unnecessary admissions to hospital care	44% of all emergency activity is coded as minor and could potentially have been dealt with in the community ^{vi}	
End of life care is not always available in the patient's preferred place of death - too many people die in hospital which is not their preference	A local Coordinate My Care (CMC) pilot survey indicates that 82% of people would prefer to die at home. In 2010, just 20% of residents who died, died at home ^{viii}	A significant increase in the number of patients that will be supported to die in their preferred place of death by 2015/16 ^{iv}

2. Urgent and emergency care

A recent study³ showed that patients in London admitted to hospital as an emergency at the weekend have a significantly increased (10%) risk of dying compared with those patients admitted on a weekday. Across London this accounts for 520 adult deaths a year, and in south east London this accounts for around 100 adult deaths a year. The reasons for this are complex but reduced service provision, including fewer senior consultant doctors working at weekends, is associated with this higher death rate.

As part of an ongoing piece of work across London, clinical expert panels made up of specialist doctors and nurses have developed a set of clinical quality standards for emergency care to address the existing variations in standards of healthcare and patient outcomes across London's NHS.

In south east London there is variation in the way services are provided between weekdays and weekends, with less senior consultant doctors available to treat patients who are admitted at the weekend. Changing where and how emergency care services are delivered to enable the NHS in south east London to meet the agreed clinical standards for emergency care could save around 100 lives a year. At the moment these standards are not met all the time in any of south east London's main hospitals.

The key themes of the emergency care standards include:

- Senior consultant doctors will be available at hospitals to care for patients 24 hours a day, 7 days a week
- Senior consultant doctors' workload will be managed so they care for the most seriously sick and injured emergency patients, without being distracted by anything else
- All patients admitted to hospital as an emergency will be seen by a consultant within 12 hours of the decision to admit that patient into hospital for care, or within 14 hours of the time of their arrival at the hospital
- Patients identified by doctors as 'high risk' will be seen by a senior consultant doctor within one hour, 24 hours a day, 7 days a week

- Patients admitted in to hospital will be assessed by all relevant clinical teams (for example, nursing, physiotherapy, occupational therapy, pharmacy, and acute pain management) within 24 hours of their admission
- All patients will be seen and reviewed by a hospital consultant doctor during twice daily ward rounds
- Key diagnostic imaging and reporting (for example x-ray and ultrasound scans) will be available 24 hours a day, 7 days a week
- Patients will be asked regularly to provide feedback on their experience of their care. This information will be reported to the hospital's senior leadership team, and acted upon where necessary.

Meeting the standards for emergency care will be a significant challenge for the NHS in south east London as no NHS trust currently meets all of them.

To meet these standards, hospitals will need to increase the number of doctors and nurses they have on their rotas. This is a challenge because the cost of additional doctors is significant and currently there are not enough doctors with the skills and experience needed to meet the standards.

Simply increasing the number of doctors at every hospital is not the answer, though this may seem the most obvious solution. This is because, for example, surgeons who perform a high volume of procedures tend to have better outcomes so, even if there were the staff available to provide this increased level of cover at every hospital, doctors may not be undertaking a sufficient number of procedures to maintain their skills and expertise.

An example of this is emergency surgery. Many patients needing an operation as an emergency have a relatively straightforward problem – for example an abscess that needs draining quickly to remove the pus and fluids. But some people have more serious conditions – such as a blocked gut – something which can rapidly lead to death if not treated.

³ London Health Programmes, *Acute medicine and emergency general surgery case for change, 2012*



Surgeons need to be dealing with sufficient numbers of these more serious and complicated cases each year to maintain their surgical skills and experience – put more simply, so they don't become rusty.

If there are lots of emergency surgeons in one hospital with a small number of patients needing these operations, the surgeons rapidly lose their skills and capabilities. This is more of a problem now than in the past as surgeons have increasingly become more specialised and therefore only focus on a smaller area of surgery.

So, whereas in the past there were general surgeons who could operate on any part of the body, this is no longer the case. There are now surgeons who only do breast surgery, or only do urology (bladder and associated areas) surgery, vascular surgeons who only operate on blood vessels, and so on. This improves their skills in their specialist area but means they have less experience in general procedures.

So, the surgeons who could operate on a blocked gut, for example, are fewer in numbers and need to be based in a larger hospital which

treats more patients so they can be available 24 hours a day (on a rota) to provide emergency life saving treatment to patients whilst at the same time maintaining their skills and experience.

So, in order to improve the standards of healthcare across south east London and ensure high quality and safe care is provided long into the future the Trust Special Administrator has been working with GPs, hospital doctors, nurses, community and social care providers as well as the ambulance service to look at how, where and when care is provided across the area. They have looked at how this might need to change in the future to meet the clinical standards set out in the previous sections of this document. They have also looked at how to do this in a way that ensures all NHS organisations in south east London are financially sustainable in the future.

In just the same way that hospitals don't work in isolation from other health services and other hospitals, the different departments and services within any one hospital don't work in isolation from each other either.

So, in order for an accident and emergency department to have the backup specialist services it might need to help treat its most critically ill patients it needs to be connected to 24 hours a day, 7 days a week diagnostic services, emergency surgery services and emergency medicine services within the hospital. These are the services that take over from the 'front door' of the hospital (the accident and emergency department) once the doctors there, or paramedics arriving to help someone in their home or a public place, have assessed a patient as so ill that they need to be admitted to hospital. To meet the clinical standards for emergency care outlined here, and increase the availability of consultant doctors for seriously ill patients, that include A&E consultants, surgeons, physicians and doctors specialising in intensive care, it is recommended those who are most critically ill will be best served by four major hospitals in the future instead of five.

It is recommended that these hospitals are:

- King's College Hospital
- St Thomas' Hospital
- Queen Elizabeth Hospital
- Princess Royal University Hospital

Care for those suffering from trauma, stroke or heart attacks and emergency vascular services will be provided in the same hospitals that they are now.

There will continue to be urgent care centres at:

- Queen Mary's Hospital in Sidcup
- Guy's Hospital

And there will be a 24 hours a day, seven days a week urgent care centre at University Hospital Lewisham providing round the clock treatment for conditions such as:

- Illnesses and injuries not likely to need a stay in hospital
- X-rays and other tests
- Minor fracture (breaks)
- Stitching wounds
- Draining abscesses that do not need general anaesthetic
- Minor ear, nose, throat and eye infections.

Clearly this recommendation will see change for Lewisham, however, less than some may initially think. Based on the work done by Lewisham Hospital itself, it is expected that nearly 80% of patients who currently visit University Hospital Lewisham's A&E would be treated at the urgent care centre in the future. This recommendation is not about 'closing' an A&E department but rather making changes to it. If you can get yourself to the hospital in a car or on public transport then University Hospital Lewisham's Urgent Care Centre would be able to give you the care you need.

If you do go to an Urgent Care Centre and the doctors there decide you need more specialist care you will be quickly transferred by ambulance to ensure you see the right doctors and nurses to meet your needs. The most critically ill patients – those who we are considering being treated in future in one of the four major hospital sites – would by and large not have to take a decision about where to go because the ambulance service would take them straight to the right hospital for their condition.

We understand that people may have concerns about how long it would take to get to hospital under these new arrangements, but as stated above the vast majority of patients will still be able to be treated at Lewisham's urgent care centre.

For the small minority who may be critically ill or injured, and therefore would be taken to a major hospital by ambulance, those patients will be taken straight to a specialist unit. This is similar to what happens now for stroke, heart attack and trauma patients, adopting the same principle to take the most critically ill patients straight to a specialist team to look after them.

Detailed and validated travel analysis has shown that the average increase in blue light ambulance journey time for the population of Lewisham to reach the specialist team would be just over seven minutes. Currently all people across south east London can reach one or more accident and emergency departments within 30 minutes in a blue light ambulance. This will not change under these recommendations.

Emergency and urgent care services across south east London today

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Full admitting accident and emergency department	Full admitting accident and emergency department	Non-admitting urgent care centre	Full admitting accident and emergency department	Full admitting accident and emergency department	Urgent care centre	Full admitting accident and emergency department
24/7 surgical emergency admissions	24/7 surgical emergency admissions		24/7 surgical emergency admissions	24/7 surgical emergency admissions		24/7 surgical emergency admissions
24/7 emergency medicine	24/7 emergency medicine		24/7 emergency medicine	24/7 emergency medicine		24/7 emergency medicine
Critical care unit	Critical care unit		Critical care unit	Critical care unit	Critical care unit	Critical care unit
Hyper-acute stroke unit				Evelina children's hospital		Hyper-acute stroke unit
						Major Trauma Centre

Emergency and urgent care services across south east London in the future

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Full admitting accident and emergency department	Full admitting accident and emergency department	Non-admitting urgent care centre	Non-admitting urgent care centre (adults and children)	Full admitting accident and emergency department	Urgent care centre	Full admitting accident and emergency department
24/7 surgical emergency admissions	24/7 surgical emergency admissions			24/7 surgical emergency admissions		24/7 surgical emergency admissions
24/7 emergency medicine	24/7 emergency medicine			24/7 emergency medicine		24/7 emergency medicine
Critical care unit	Critical care unit			Critical care unit	Critical care unit	Critical care unit
Hyper-acute stroke unit				Evelina children's hospital		Hyper-acute stroke unit
						Major Trauma Centre

Question

How far do you support or oppose the proposed plans for delivering urgent and emergency care in south east London? The following shows how urgent and emergency care would be delivered:

- Emergency care for the most critically unwell – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital
- Urgent care – Guy's Hospital, Queen Mary's Hospital Sidcup, University Hospital Lewisham

3. Maternity services

A 2012 study⁴ highlighted that the maternal death rate (when a woman dies whilst giving birth or shortly afterwards) in London was twice the rate of the rest of the United Kingdom. Additionally, in terms of women's experience, London's maternity services are the least well performing nationally ie more women tell us in the NHS in London that they think the care they received could have been better, than in any other part of the country.

This is unacceptable and therefore maternity services must be improved in south east London.

Clinical expert panels made up of specialist doctors, nurses and midwives have developed a set of clinical quality standards for maternity services to address the existing variations in standards of healthcare and improve patient outcomes. These standards are not met in all hospitals all of the time in south east London at the moment.

The key themes of the clinical standards for maternity services include:

- A consultant obstetrician (senior doctor specialising in labour and birth) on the labour ward 24 hours a day, 7 days a week
- All women are provided with one-to-one care during established labour from a midwife

- New and expectant mothers will be provided with interpreting services if they need it and will be regularly asked to provide feedback on their experience of their care. This information will be regularly reported to the hospital senior leadership team and acted upon where necessary.

There are two options being considered for improving maternity services in south east London so they meet the clinical standards outlined here, these are:

- 1 Consultant obstetrician led deliveries across four major hospitals:
 - King's College Hospital
 - St Thomas' Hospital
 - Queen Elizabeth Hospital
 - Princess Royal University Hospital
- 2 Consultant obstetrician led deliveries across four major hospitals as well as a 'stand alone' consultant obstetrician led delivery unit at University Hospital Lewisham.

Ante-natal and post-natal care will continue to be delivered in a range of locations across south east London as it is today.

⁴ Bewley, S. Helleur, A., 2012. *Rising Maternal Deaths in London, UK*. The Lancet, Vol. 379



Maternity services across south east London today

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Obstetric and co-located midwife-led birthing unit	Obstetric-led birth unit		Obstetric and co-located midwife-led birthing unit	Obstetrics and co-located midwife-led birthing unit		Obstetrics and midwife-led birthing unit
Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care		Ante-natal and post-natal outpatient care

Maternity services across south east London in the future

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Obstetric and co-located midwife-led birthing unit	Obstetric-led birth unit		Potential obstetric and co-located midwife-led birthing unit	Obstetrics and co-located midwife-led birthing unit		Obstetrics and midwife-led birthing unit
Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care	Ante-natal and post-natal outpatient care		Ante-natal and post-natal outpatient care

Question

Which of the following options would you prefer, if any, for providing obstetric-led services:

- Obstetric-led services should only be provided at the four major hospitals that will offer care for those who are most critically ill (King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital)
- A stand-alone obstetric-led unit should also be provided at University Hospital Lewisham, in addition to the four above
- I do not support either of these options
- Not sure / don't know

4. Planned care

Planned care is when you know that you're having an operation or treatment and this is booked in advance.

There are three different types of planned care:

- 1 Day case surgery – when you go into hospital in the morning for an operation and go home the same day. This is between 70-80% of all planned care
- 2 Routine, non complex operations that require a stay in hospital, for example knee or hip replacements
- 3 More complex operations that it is known in advance will require intensive care support or backup.

Many people who have an operation planned find that they have their operation date changed or cancelled at the last minute, sometimes even when they are in hospital, because an emergency patient has arrived and more urgently needs the bed or the operating theatre.

We believe that the following proposals for planned care will improve patient experience, reduce cancellations and reduce waiting times to come into hospital, therefore improving care for patients.

It is recommended that day case surgery will continue to be delivered across all seven main hospitals (see map on page 5) in south east London as it is today so it is accessible to patients.

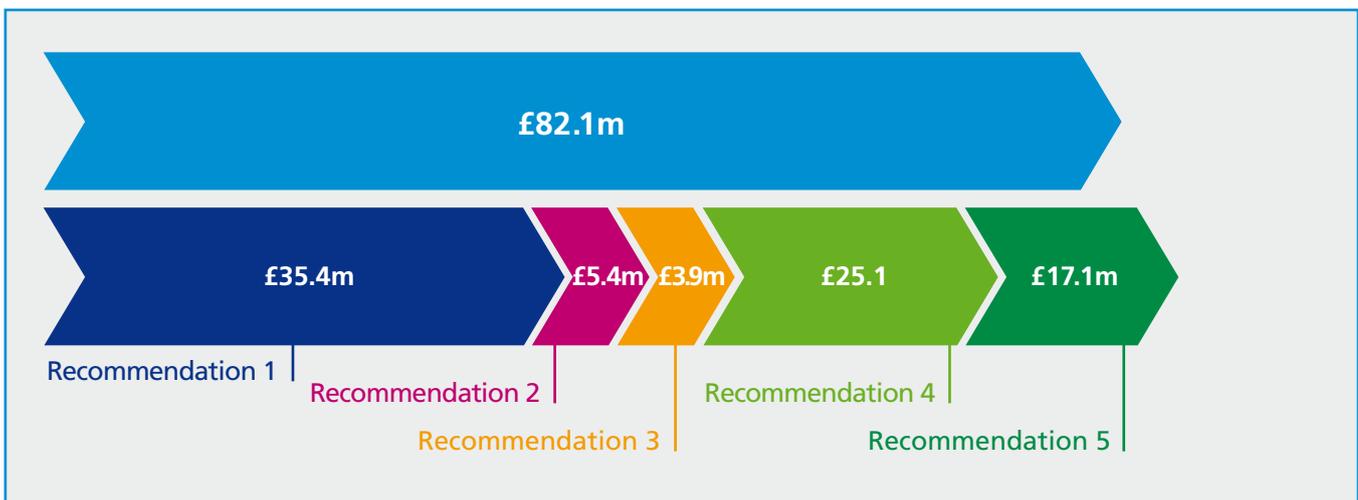
It is recommended that more complex operations will be delivered at the four major hospitals so patients have access to backup intensive care services should they be required:

- King's College Hospital
- St Thomas' Hospital
- Queen Elizabeth Hospital
- Princess Royal University Hospital

Specialist non complex elective services will be provided at Guy's Hospital, King's College Hospital and St Thomas' Hospital, as they are today.

And for routine, non complex operations that require a stay in hospital such as hip and knee replacements, some routine gynaecology, general surgery and other services, it is recommended that a new 'elective' (or planned care) centre is created at University Hospital Lewisham that will serve the whole of south east London. If this recommendation is accepted this is expected to be the largest elective centre for planned, routine operations in the country.

Financial impact of recommendations in 2015/16 for the NHS in south east London



Planned care across south east London today

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Non-complex inpatient elective care and day cases						
Complex inpatient surgery	Complex inpatient surgery		Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery
				Specialist elective care	Specialist elective care	Specialist elective care
Outpatients and diagnostics						

Planned care across south east London in the future

Princess Royal University Hospital	Queen Elizabeth Hospital	Queen Mary's Hospital, Sidcup	University Hospital Lewisham	St Thomas' Hospital	Guy's Hospital	King's College Hospital
Some non-complex inpatient elective care and day cases	Some non-complex inpatient elective care and day cases	Day case surgery	Non-complex inpatient elective care and day cases	Some non-complex inpatient elective care and day cases	Some non-complex inpatient elective care and day cases	Some non-complex inpatient elective care and day cases
Complex inpatient surgery	Complex inpatient surgery			Complex inpatient surgery	Complex inpatient surgery	Complex inpatient surgery
				Specialist elective care	Specialist elective care	Specialist elective care
Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics	Outpatients and diagnostics

Question

How far do you support or oppose the proposed plans for providing planned care services in south east London? The following shows how planned care would be delivered:

- Day case surgery – Guy's Hospital, King's College Hospital, Queen Elizabeth Hospital, Queen Mary's Hospital Sidcup, Princess Royal University Hospital, St Thomas' Hospital, University Hospital Lewisham
- Complex operations – King's College Hospital, Queen Elizabeth Hospital, Princess Royal University Hospital, St Thomas' Hospital
- Specialist non-complex operations – Guy's Hospital, King's College Hospital, St Thomas' Hospital
- Routine non-complex operations that require a stay in hospital – University Hospital Lewisham

9

What do these proposals mean for you and your family?

Use of urgent care centres



Now

Margaret has been feeling unwell for a few days – with diarrhoea and vomiting and now her two children are also unwell. She has come home from work and is worried. She calls her GP but they are closed. She calls the out of hours service but can't get through. She bundles the children in the car, travels to A&E and then waits for three hours to be seen. They are then seen by a junior doctor who suggests light fluids and sends them home.

In the future

Margaret can now call the local 111 telephone health service who can offer advice as to what to do. If they are worried, or if Margaret is worried, she can now visit the local GP, based at her nearest urgent care centre if out of hours. They can offer advice and treatment, have access to her family's health records and can update those records.

Need for emergency surgery



Now

Tom has been having severe abdominal pain for several days. He collapses in his nursing home and an ambulance is called. The ambulance takes him to the closest A&E department where he is assessed by a junior doctor. The junior doctor is worried that he has an obstructed bowel and tries to contact a more senior doctor for an opinion and to consider whether emergency surgery is necessary. There is no senior doctor available so Tom has to wait while one is found from a neighbouring hospital. The surgeon eventually arrives and decides that Tom should be operated on as an emergency the next morning.

In the future

Tom's nursing home now has a direct number to call a GP who can come and assess Tom in the nursing home. The GP is concerned about Tom and so calls an ambulance. He shares background information with the ambulance team. Tom is now taken directly to a hospital which has senior surgeons available 24 hours a day, 7 days a week. He is rapidly assessed by a senior surgeon and proceeds to surgery immediately.

Community based care



Now

John has diabetes. His care is managed by his GP. John is not always very good about going to see his GP on a regular basis – sometimes he forgets to make appointments, sometimes he forgets to turn up for them. He struggles to stick to a diabetic diet and finds it hard to exercise as he is overweight. He is now starting to get problems with high blood pressure and is at risk of suffering damage to his kidneys.

In the future

John has diabetes. His care is now managed by the local diabetes service which includes a specialist diabetes nurse and a specialist GP. John visits the local health centre for his care. The nurse called John at home, having reviewed all patients in the local area who have a diagnosis of diabetes (something she does every month). She noticed from his health records that he has not been seen on a regular basis. She spent time with him reviewing his care and agreed with him a plan for regular appointments with her. She made him an appointment to see a dietician and to visit the local gym. She will coordinate his care and call him to make sure he attends future appointments.



Planned care



Now

Mary needs a hip replacement. She is in a lot of pain and struggles to walk. She is finding it hard to look after her grandchildren – something she does twice a week so her daughter can go to work. She has had two dates for the operation cancelled due to emergencies taking precedence. She finally gets a date, has the operation which goes well, but then develops an infection in the wound site which means she has to stay in hospital for two weeks rather than the 3-4 days which she had expected.

In the future

Mary can now go to the specialist elective centre to have her hip replacement operation. The centre does a very large number of cases and has no emergency work – so staff are very skilled and do not have to cancel operations due to emergencies taking priority. Mary has her operation done on the first date scheduled and is able to go home after two days. With regular physiotherapy she is rapidly getting back to walking and is able to look after her grandchildren again just four weeks after the operation.

Maternity



Now

Joanne is having her fourth baby. She has a straightforward labour but immediately after giving birth starts to bleed heavily. The bleeding doesn't stop and staff are concerned about how much blood she is losing. There is no senior doctor available and the junior doctors are concerned about what to do. By the time a senior doctor is tracked down, Joanne has lost a lot of blood. She is rushed to theatre and the doctors manage to save her life but she suffers complications and is on the intensive care unit at the hospital for five days. Joanne went on to suffer post natal depression as a result of her traumatic experience post birth.

In the future

All obstetric units in south east London now have consultant obstetricians available 24 hours a day, seven days a week – so when Joanne suffers her post partum haemorrhage, a consultant can rapidly assess her and make a timely decision to operate. Joanne's care is straightforward post operatively and she is reunited with her new baby after a day.



10

Recommendations for organisations delivering NHS services in south east London

The staff within South London Healthcare NHS Trust (SLHT) have worked hard over the past three years to deliver high quality care to patients and this is still the case today. There have been significant improvements in the quality of care in recent years.

However, since the merger of the three predecessor trusts in 2009 to form SLHT, the clinical and managerial leadership of SLHT has not been successful in seizing the opportunity of the merger to cut out duplication and do things once instead of three times. Nor has it been able to transform enough and embed a culture capable of delivering the operational efficiency and high quality care needed. Sustainable healthcare organisations need the capacity and capability to do both of these to make sure that they are providing the best care possible to patients and spending the finite amount of money they receive as wisely as they can, for the maximum benefit of patients.

One example of this is that the Trust still has a number of disconnected and/or duplicated systems in place across each of its sites. For example there are three different IT systems for booking patient appointments; a lack of integration in some of the clinical teams offering the same services at different sites; and, a lack of standardisation for buying some equipment and appliances. This means duplication and inefficiency has not been taken out where it could have been and money isn't being spent as wisely as it could.

Recommendation 6

Delivering service improvement through organisational change.

Recommendations one to five outline an even greater challenge than the one the Trust has faced in recent years. Making such big improvements in the way the hospitals are run (recommendation one), supporting the establishment of the Bexley Health Campus (recommendation two), selling off land that is not needed (recommendation three), ensuring support from the Department of Health around the Private Finance Initiative challenges (recommendation four) and making the changes that will redesign services to within the funding available whilst improving the quality of care in south east London (recommendation five) will all require very strong leadership and significant cultural change. Strong leadership that can work with staff throughout the organisations to make the changes required must be in place.

Therefore, recommendation six is that South London Healthcare NHS Trust stops being an organisation in its own right (is legally dissolved) and the Trust's services, staff and assets (for example buildings) become part of other organisations.

Question

How far do you support or oppose the recommendation for South London Healthcare NHS Trust to be dissolved, with current NHS services managed and delivered by other organisations?



Considering options for the future

The Trust Special Administrator (TSA) has undertaken a 'market engagement' process to ask other organisations what they think could be done to ensure the sustainability of the services provided by South London Healthcare NHS Trust (SLHT).

This process asked other organisations, including those in the NHS and independent sector, what ideas they had about how they could run the Trust better. This included consideration about running the whole Trust as it currently is. It also included consideration about what they would do if the hospitals were split up.

Having looked in more detail at the Trust, none of the organisations the TSA spoke to thought it would be possible to keep the Trust going as it is currently run. They all agreed that without significant changes the services could not be made sustainable and also meet the quality standards clinicians have said should be provided in south east London.

Having ruled out the option of keeping the Trust as it is, the TSA talked to a wide range of people about options for the individual hospitals within it.

The options being considered within this recommendation are outlined below:

- **Queen Mary's Hospital**

Recommendation two outlines a proposal for the future of Queen Mary's Hospital Sidcup as a Bexley Health Campus, providing a range of services for the local population. It is proposed that Oxleas NHS Foundation Trust should own and run the site with a number of other providers also providing NHS services from the Health Campus.

- **Queen Elizabeth Hospital**

Lewisham Healthcare NHS Trust has said that it would like to run services at Queen Elizabeth Hospital in Woolwich. With this in mind this recommendation proposes that the two hospitals come together as one single organisation to deliver healthcare services for the populations in Lewisham and Greenwich from two sites.

The leadership team at Lewisham Healthcare NHS Trust have already started thinking about how they would do this. Their

proposals will need more work, but initial thinking is suggesting that the following services would be provided:

Queen Elizabeth Hospital, Woolwich	University Hospital Lewisham
24/7 emergency services	24/7 urgent care services
Complex planned surgery	Rehabilitation (including for patients recovering from strokes)
Day case surgery	Intermediate care – where patients still need intensive rehabilitation services but not 24/7 care from doctors
Maternity services (including obstetric-led and midwife-led services)	Day case surgery
Outpatient services	Outpatients
	Planned inpatient surgery for the whole of south east London
	Maternity*

* Depending on the decision around recommendation five, University Hospital Lewisham may also provide obstetric-led and midwife-led maternity services.

This new organisation would provide hospital services for Greenwich and Lewisham, and so would need to work closely with the local Clinical Commissioning Groups and other providers to help deliver better, joined up care for patients.

Setting up this new organisation and improving care for patients will be very challenging, but the strong leadership team at Lewisham Healthcare NHS Trust can draw on their experience to do this.

Question

How far do you support or oppose the plan for the Queen Elizabeth Hospital site and Lewisham Healthcare NHS Trust to come together to create a new organisation?

- **Princess Royal University Hospital**

There are two options being considered for Princess Royal University Hospital.

The first, and preferred option, is for King's College Hospital NHS Foundation Trust to run the hospital and the services it provides, and the second option is to run a procurement process to find the best organisation to run the hospital and its NHS services – which could be an NHS or an independent sector organisation or a combination of both.

Making sure the new organisations are successful

The Trust Special Administrator's role is to secure clinically and financially sustainable services in the future, and therefore his recommendations must ensure that the organisations proposed to implement these changes, as outline here, have the best possible chance of success. This is more likely if they are not saddled with the financial problem South London Healthcare NHS Trust has built up over the years. To make sure that there will be sustainable NHS services in the future this recommendation therefore includes a proposal that the Department of Health writes off the debt so that the future can focus on delivering improved patient care rather than managing the problems of the past.

Question

Which of the following options would you prefer, if any, for the running of the Princess Royal University Hospital?

- The Princess Royal University Hospital should be acquired and run by King's College Hospital NHS Foundation Trust
- A procurement process should be run allowing any provider from the NHS and/or independent sector to bid to run NHS services on the Princess Royal University Hospital site
- I do not support either of these options
- Not sure / don't know

Question

To what extent do you agree or disagree with the recommendation for the Department of Health to write off the debt accumulated by South London Healthcare NHS Trust?

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What happens if we do nothing?

Why is there the need for such significant change? Surely the money can be found from somewhere or provided by the government?

Unfortunately, the situation facing South London Healthcare Trust, and indeed soon the wider NHS in south east London is very serious and therefore needs drastic solutions to protect services for local patients into the future.

The fact is, if nothing is done to address this worsening problem, things will become even worse for patients across south east London:

- People will continue to die unnecessarily. A recent study by London Health Programmes showed patients treated at weekends and evenings in London hospitals – when fewer consultants are available – stand a greater chance of dying than if they are admitted during the week when they can be seen by a consultant quickly. We need a system that allows all of our hospitals to benefit from having senior, expert consultants on-site at all times.
- Our dependency on hospital services would continue when this is not the best use of money, buildings or indeed doctors and nurses. We need to focus more on helping people to stay well in the community and avoid having to go to hospital at all. And for those patients that do need to go to hospital, we need to make sure they have 24/7 access to the specialist care they need.
- More hospital trusts would be under severe financial pressure, not just SLHT, meaning they could be entered into NHS administration. While the NHS can cope with some financial losses, this is obviously far from ideal and the deeper in debt that NHS trusts become the more difficult it is to keep services running,

to retain doctors and nurses and to provide high-quality patient care. If hospitals get into this sort of financial trouble they will need to make ever more difficult and quick decisions and this would inevitably happen in a disorganised and unplanned way meaning a worse effect on patients and staff.

- All the time that an NHS organisation overspends means that money is being unfairly and inappropriately taken away from other parts of the NHS. The NHS as whole has a finite amount of money to spend on services each year. If one trust spends more than it should, this means another part of the NHS and its patients, has less money which is unacceptable.
- There would also be problems with the NHS workforce. As it is, some services have already had to be reduced because there are not enough clinicians to provide them safely. Recruiting and keeping clinical staff in London is always a challenge and if we do not offer the best places to work, and the best places to train, we will not attract the best staff. Equally, if there are not enough senior staff, trainee doctors can't be supervised and are withdrawn from the hospital. All this means patients will not get the best care, and services will be reduced.

While this may sound alarming, it is important that patients and local communities understand the severity of the situation and what would happen if we did nothing.

Though services are mostly providing good standards of care at the moment, they cannot do so into the future given the financial pressures all NHS organisations are facing. It will be patients, and the doctors, nurses and other health professionals who treat them and care for them, who will be the first to feel the consequences if nothing is done to address these immense financial problems.



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Having your say

Ipsos MORI, an independent research and analysis organisation, has been commissioned to collect and analyse all responses to this consultation. The findings will help the Trust Special Administrator form his final recommendations to the Secretary of State for Health.

Please read this document all the way through then give us your answers to the questions either by completing the response form inserted in this document and sending it back to Ipsos MORI using the freepost envelope provided. You can also feedback your views online by visiting www.tsa.nhs.uk and completing the online response form.

In the response form (both the hard copy and online versions) we have shown which sections of the consultation document cover the issues raised by each of the questions. Please refer back to these sections as you answer the questions.

If you want to explain any of your answers, or you feel the questions have not given you the chance to express your views fully, or if you think there are options we have not considered that we should have done, please say so in the box at the end of the form.

You have until **midnight on 13 December 2012** to get your response form back to us. The freepost envelope provided is second class, so please ensure you post your response form in plenty of time to reach us. Responses received after midnight on 13 December 2012 will not be accepted or considered.

If you have any questions about the consultation call us on (freephone) **0800 953 0110**.

If you have any queries about how to complete the response form, please email Ipsos MORI at tsaconsultation@ipsos-mori.com or call them on **0808 129 5719** (free from landlines, mobile charges will apply).

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Next steps

After the consultation on the Trust Special Administrator's recommendations closes at midnight on 13 December 2012, he has 15 working days to review the feedback and develop his final recommendations for the future of NHS services in south east London.

The recommendations will be outlined in his final report that he must submit to the Secretary of State for Health by Monday 7 January 2013.

The Secretary of State then has up to 20 working days to make a decision on the Trust Special Administrator's recommendations. A decision will be made on the future of South London Healthcare NHS Trust and health services in south east London by Friday 1 February 2013.



Glossary of terms

111	A new 24/7 telephone number that is being introduced to make it easier to access local NHS healthcare services.
24/7	Twenty four hours a day, seven days a week
A&E	Accident & Emergency is a service available 24 hours a day, seven days a week where people receive treatment for medical and surgical emergencies that are likely to need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery, and other serious illnesses.
Acute care	Acute care refers to short-term treatment, usually in a hospital, for patients with any kind of illness or injury.
Acute trust	NHS acute trusts manage hospitals. Some are regional or national centres for specialist care, others are attached to universities and help to train health professionals. Some acute trusts also provide community services.
Average Length of Stay	Average Length of Stay is an average of the length of time patients stay in a hospital when admitted.
Clinical Commissioning Groups (CCGs)	These are health commissioning organisations which will replace primary care trusts (PCTs) in April 2013. CCGs are led by GPs and represent a group of GP practices in a certain area. They are currently shadowing the PCTs and will be responsible for commissioning healthcare services in both community and hospital settings from April 2013 onwards.
Cost Improvement Plan	Plans to meet the cost savings target levied on NHS bodies by the government.
Commissioning	The planning, procurement and contract management of health and health care services for a local community or specific population.
Day case or day surgery	Patients who have a planned investigation, treatment or operation and are admitted and discharged on the same day.
Deficit	When expenditure is greater than income.
Elective centre	This is where patients go if they need an operation which is not urgent and so can be planned.
Elective surgery	Planned surgery that is not immediately necessary to save life, carried out in a hospital either as a day case or an inpatient.
Emergency admission	A patient who is admitted on the same day that admission is requested due to urgent need (also known as urgent admission and unplanned care).
Financial surplus	When income is greater than spending.
Foundation Trust	NHS foundation trusts are not-for-profit corporations. They are part of the NHS yet they have greater freedom to decide their own plans and the way services are run. Foundation trusts (FTs) have members and a council of governors. The aim is that eventually all NHS trusts will be FTs.
GP	General Practitioner
Independent sector	A range of non-public organisations involved in providing services, including private, voluntary and charitable organisations
Mortality rate	A measure of the number of deaths (in general or due to a specific cause) in a defined population, scaled to the size of that population, per unit of time.
Midwife-led unit	A unit which specialises in delivering babies by midwives.

Obstetrics	The medical specialty that deals with care for women during pregnancy, childbirth and the postnatal period.
Obstetric unit	A unit which specialises in delivering babies by obstetricians.
PFI	Private Finance Initiative: a government-led programme to enable the private sector to become involved in the provision of facilities which will then be run by the NHS.
South East London	The six London boroughs of Bromley, Bexley, Greenwich, Lambeth, Lewisham and Southwark.
SLHT	South London Healthcare NHS Trust
Specialist hospital	A hospital which provides specialist care for complex conditions.
Tariff	A set price for each type of procedure or admission type carried out in the NHS.
TSA	Trust Special Administrator: exercises the functions of the chairman and directors of the Trust and to develop recommendations for the Secretary of State that ensure all patients have access to high-quality, sustainable services
Urgent Care Centre	A centre that is open 24 hours a day, seven days a week. These centres will treat most illnesses and injuries that people have which are not likely to need treatment in a hospital. This includes chest infections, asthma attacks, simple fractures, abdominal pain and infections of the ear, nose and throat.

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