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Notes about appendices and working papers

Several appendices are referenced in the pre-consultation business case (PCBC) and are not circulated as attachments with the PCBC. Other than the detailed financial appendices, these are short summary papers. These are available on the A Picture of Health website:

www.apictureofhealth.nhs.uk

In addition to the appendices, several working papers are also referenced in the PCBC. These are also available on the A Picture of Health website. These working papers offer more lengthy and detailed analysis and description.

A list of the appendices and working papers can be found at chapter 9.
The project to redesign health services in Bexley, Bromley, Greenwich and Lewisham is known as A Picture of Health (APOH). Throughout this pre-consultation business case (PCBC) reference is made to the Outer South East London Primary Care Trusts (PCTs), Hospital Trusts and Mental Health Trusts. For the purpose of the A Picture of Health project the PCTs and Hospital and Mental Health Trusts in Bexley, Bromley, Greenwich, and Lewisham have agreed to use the collective label of Outer South East London (OSEL) to describe their grouping. The NHS organisations in OSEL are:

- **Primary Care Trusts (PCTs):** Bromley Primary Care Trust (BPCT), Greenwich Teaching Primary Care Trust (GTPCT), Lewisham Primary Care Trust (LewPCT)
- **Care Trusts:** Bexley Care Trust (BCT)
- **Hospital Trusts:** Bromley Hospitals NHS Trust (BHT), Queen Elizabeth Hospital NHS Trust (QEH), Queen Mary’s Sidcup NHS Trust (QMS), University Hospital Lewisham NHS Trust (UHL)

It should also be noted that two Mental Health Trusts provide services in OSEL, the main provider and representative on APOH being Oxleas NHS Foundation Trust (Ox).

West Kent PCT’s population will be affected by the changes proposed in this PCBC, and the PCT has therefore been involved and is a member of the key decision making body known as the Joint Committee of PCTs.

Key partners to the project:

- The London Ambulance Service (LAS) provides ambulance services in OSEL
- Dartford and Gravesham NHS Trust (Darent Valley Hospital) (D&G)
- Guy’s and St Thomas’ NHS Foundation Trust (GST)
- King’s College Hospital NHS Foundation Trust (KCH)
- South London and Maudsley NHS Foundation Trust (SLaM)

The strategic health authority for London is:

- NHS London
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Acute</td>
<td>Used to describe a disorder or symptom that comes on suddenly and needs urgent treatment. It is not necessarily severe and often lasts only a short time. Acute is also used to describe hospitals where treatment for such conditions is available. In this document, the term ‘acute’ is used interchangeably with the term ‘emergency’.</td>
</tr>
<tr>
<td>Acute hospital</td>
<td>Hospitals that provide acute (unplanned/emergency) care and elective (planned) medical treatment and surgical procedures.</td>
</tr>
<tr>
<td>Acute medicine</td>
<td>Acute medicine is concerned with treating adult patients with a wide range of medical conditions who go into hospital as emergency cases.</td>
</tr>
<tr>
<td>Acute services</td>
<td>Medical and surgical interventions provided in hospitals.</td>
</tr>
<tr>
<td>ALoS</td>
<td>Average length of stay – a measure of how long a patient spends in hospital following admission, usually expressed in days.</td>
</tr>
<tr>
<td>Ambulance trusts</td>
<td>Ambulance trusts provide emergency access to health care, paramedic services and patient transport services.</td>
</tr>
<tr>
<td>Ambulatory care</td>
<td>Medical care (including diagnosis, observation, treatment and rehabilitation) provided on an outpatient basis. Ambulatory care is given to patients who are not confined to a hospital but rather are ambulatory and are able to walk.</td>
</tr>
<tr>
<td>APOH</td>
<td>A Picture of Health.</td>
</tr>
<tr>
<td>BCT</td>
<td>Bexley Care Trust.</td>
</tr>
<tr>
<td>BHT</td>
<td>Bromley Hospitals NHS Trust.</td>
</tr>
<tr>
<td>BPCT</td>
<td>Bromley Primary Care Trust.</td>
</tr>
<tr>
<td>Care pathway</td>
<td>A pre-determined plan of care for patients with a specific condition.</td>
</tr>
<tr>
<td>Case management</td>
<td>As patients develop multiple long term conditions, their care becomes disproportionately complex and can be difficult for them and the health and social care system to manage. Evidence has shown that intensive, ongoing and personalised case management can improve the quality of life and outcomes for these patients, dramatically reducing emergency admissions and enabling patients who are admitted to return home more quickly.</td>
</tr>
<tr>
<td>Children’s centres</td>
<td>Local facilities designed to help families with young children by providing access to a range of key services under one roof such as health, social care and parenting support.</td>
</tr>
<tr>
<td>Chronic</td>
<td>An illness of condition that persists for a long period of time e.g. asthma or diabetes.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<td>-------------------------------</td>
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</tr>
<tr>
<td>Clinical governance</td>
<td>The system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care</td>
</tr>
<tr>
<td>Clinical guidelines</td>
<td>Clinical guidelines are recommendations for the care of individuals by healthcare professionals, based on the best available evidence</td>
</tr>
<tr>
<td>Clinical networks</td>
<td>Clinical networks are linked groups of health professionals and organisations from primary, secondary, and tertiary care working in a co-ordinated manner, unconstrained by existing professional and organisational boundaries to ensure equitable provision of high quality effective services</td>
</tr>
<tr>
<td>Clinician</td>
<td>Any health professional who is directly involved in the care and treatment of patients, for example, nurses, doctors, therapists, and midwives</td>
</tr>
<tr>
<td>Commissioning</td>
<td>The full set of activities that local authorities and primary care trusts (PCTs) undertake to make sure that services funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively</td>
</tr>
<tr>
<td>Community care</td>
<td>Care, often for elderly people, people with learning or physical disabilities or mental illness or those with long-term conditions, which is provided outside a hospital setting, i.e. in the community</td>
</tr>
<tr>
<td>Community matrons</td>
<td>Senior nurses with advanced level clinical skills and expertise in dealing with patients with complex long-term conditions and high intensity needs. This is a clinical role with responsibility for planning, managing, delivering and co-ordination care for patients with highly complex needs living in their own homes and communities</td>
</tr>
<tr>
<td>Community nurse</td>
<td>A broad term for health visitors, community midwives and district nurses</td>
</tr>
<tr>
<td>Consultant</td>
<td>A senior doctor who is a specialist in a particular area of medicine</td>
</tr>
<tr>
<td>Continuing care</td>
<td>The criteria for assessing long term care eligibility</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>Critical care</td>
<td>An integrated service for critically ill patients when they are in the health system</td>
</tr>
<tr>
<td>Cross-cutting initiatives</td>
<td>Cross cutting initiatives are a number of areas for savings which cut across the organisations to deliver collective reduction in costs. These have been identified by external consultants as part of the review of financially challenged trusts</td>
</tr>
<tr>
<td>D&amp;G</td>
<td>Dartford and Gravesham NHS Trust</td>
</tr>
<tr>
<td>Day case or day surgery</td>
<td>Patients who have a planned investigation, treatment or operation and are admitted and discharged on the same day</td>
</tr>
<tr>
<td><strong>DCF</strong></td>
<td>Discounted Cash Flow</td>
</tr>
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<tr>
<td><strong>Deliberative event</strong></td>
<td>When the public, patients, service users, and staff become actively involved in the shaping of DH policy through consultation events</td>
</tr>
<tr>
<td><strong>Diagnostic tests</strong></td>
<td>Procedures and tests to help identify a condition or illness, for example, blood tests and x-rays</td>
</tr>
<tr>
<td><strong>District general hospital</strong></td>
<td>A hospital which provides a range of clinical services sufficient to meet the needs of a defined population of about 150,000 or more for hospital care but not necessarily including highly specialised services</td>
</tr>
<tr>
<td><strong>Elective admission</strong></td>
<td>A patient who is admitted to hospital for planned treatment from a waiting list</td>
</tr>
<tr>
<td><strong>Elective surgery</strong></td>
<td>Non-urgent or planned surgery (i.e. not immediately necessary to save life) carried out in a hospital either as a day case or an inpatient</td>
</tr>
<tr>
<td><strong>EMDoc</strong></td>
<td>A co-operative to provide GP out of hours services to patients registered with a GP in Bromley</td>
</tr>
<tr>
<td><strong>Emergency admission</strong></td>
<td>A patient who is admitted on the same day that admission is requested (also known as urgent admission and unplanned care)</td>
</tr>
<tr>
<td><strong>Emergency planning</strong></td>
<td>The contingency plans and advice required to prepare for specific types of disasters and attacks</td>
</tr>
<tr>
<td><strong>European working time directive (EWTD)</strong></td>
<td>As part of the Working Time Regulations, the Directive states that by 2009, training doctors will by law not be expected to work more than 48 hours a week</td>
</tr>
<tr>
<td><strong>Expert patient</strong></td>
<td>Expert patients are people living with a long-term health condition, who are able to take more control over their health by understanding and managing their conditions, leading to an improved quality of life</td>
</tr>
<tr>
<td><strong>Foundation trusts</strong></td>
<td>NHS hospitals that are run as independent, public benefit corporations, which are both controlled and run locally</td>
</tr>
<tr>
<td><strong>General practitioner (GP)</strong></td>
<td>A family doctor who works from a local surgery to provide medical advice and treatment to patients registered on their list</td>
</tr>
<tr>
<td><strong>General practitioner with special interests (GPwSI)</strong></td>
<td>GPs that supplement their generalist role by delivering a clinical service beyond the normal scope of general practice. See also Practitioners with Special Interests (PwSI)</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>See Clinical governance</td>
</tr>
<tr>
<td><strong>GTPCT</strong></td>
<td>Greenwich Teaching Primary Care Trust</td>
</tr>
<tr>
<td><strong>GST</strong></td>
<td>Guy's and St Thomas' NHS Foundation Trust</td>
</tr>
<tr>
<td><strong>Healthcare commission</strong></td>
<td>The independent inspectorate in England and Wales that promotes improvement in the quality of the NHS and independent health care</td>
</tr>
<tr>
<td>Healthcare for London (HfL)</td>
<td>A review on provision of health care for patients in London</td>
</tr>
<tr>
<td>Health inequalities</td>
<td>Narrowing the health gap between disadvantaged groups, communities and the rest of the country, and on improving health overall</td>
</tr>
<tr>
<td>High dependency unit (HDU)</td>
<td>An area for patients who require more intensive observation, treatment and nursing care than are usually provided on a general ward. It is a standard of care between the general ward and a full intensive therapy unit (see later)</td>
</tr>
<tr>
<td>Hospital trust</td>
<td>The organisation which runs one or more acute hospitals. In the case of Outer South East London there are four such trusts</td>
</tr>
<tr>
<td>Independent sector</td>
<td>An umbrella term for all non NHS bodies delivering health care, which includes a range of private companies and voluntary organisations</td>
</tr>
<tr>
<td>Inpatient</td>
<td>A patient who has gone through the full admission procedure and is occupying a hospital bed</td>
</tr>
<tr>
<td>Intensive Therapy Unit (ITU)</td>
<td>A unit which caters for patients who need the most specialised observation and treatment. These patients need very close care from specially trained staff who understand the complex monitoring and other technical equipment in use. Typically it will have a higher ratio of staff to patients than a high dependency unit or general ward</td>
</tr>
<tr>
<td>Intermediate care</td>
<td>Services designed to assist the transition for a patient from medical and social dependence to day-to-day independence. A range of services can be involved as people move from hospital to home, where the objectives of care are not primarily medical</td>
</tr>
<tr>
<td>IV Therapy</td>
<td>Intravenous therapy or IV therapy is the giving of liquid substances directly into a vein. It can be intermittent or continuous</td>
</tr>
<tr>
<td>Joint Committee of PCTs (JCPCT)</td>
<td>A committee that has been set up locally comprising the three PCTs and one Care Trust that cover Outer South East London plus West Kent PCT. The committee has authority from the PCTs to take decisions on the PCTs’ collective behalf</td>
</tr>
<tr>
<td>Joint Health Overview and Scrutiny Committee (JHOSC)</td>
<td>Health Overview and Scrutiny Committees (HOSCs) are required, under direction from the Secretary of State, to set up a Joint Health Overview and Scrutiny Committee (JHOSC) to consider and respond to proposals for developments or variations in health services that affect more than one local authority area and where the changes are considered by the OSCs (see below) to be substantial</td>
</tr>
<tr>
<td>KCH</td>
<td>King’s College Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>LAS</td>
<td>London Ambulance Service</td>
</tr>
<tr>
<td>LewPCT</td>
<td>Lewisham Primary Care Trust</td>
</tr>
</tbody>
</table>
LIFT
Local Improvement Finance Trust – a local LIFT is a partnership between the NHS and the private sector to build and refurbish primary care premises which it will own. It will rent accommodation to GPs on a lease basis (as well as other parties such as chemists, opticians, dentists etc.)

Local authority
Local authorities are democratically elected bodies with responsibility for discharging a range of functions as set out in local government legislation

Long-term conditions
Those conditions (for example, diabetes, asthma and arthritis) that cannot, at present, be cured but whose progress can be managed and influenced by medication and other therapies

Medicine
A scientifically-based discipline dedicated to the prevention and treatment of disease and injury

Mental health services
A range of specialist clinical and therapeutic interventions across mental health and social care provision, integrated across organisational boundaries

Mental health trusts
Trusts that provide specialist mental health services in hospitals and local communities

Midwifery led birthing unit (MLBU)
A unit which specialises in delivering babies by midwives, without the intervention of a consultant obstetrician

Multidisciplinary team
A team involving many different professions e.g. doctors, nurses, therapists

Musculo-skeletal conditions
Musculoskeletal complaints involve the muscles or components of the skeletal system. This includes the muscles themselves, the tendons and ligaments and other soft tissues

National service frameworks (NSFs)
Long term strategies for improving specific areas of care

NCAT
National Clinical Advisory Team

NHS foundation trusts
NHS hospitals that are run as independent, public benefit corporations, controlled and run locally. Foundation Trusts have increased freedoms regarding their options for capital funding to invest in delivery of new services

NHSL
NHS London (the strategic health authority for London)

Neonatal intensive care
Specialising in the care of ill or premature newborn infants

NPV
Net Present Value

Obstetrics
Medical care of women during pregnancy and childbirth, and the period of recovery afterwards

Obstetrician
A doctor who specialises in obstetric care
Outcomes
A change in the health status of an individual, group or population, for example, improved survival and recovery rates, reducing inequalities or increasing longevity

Out-of-hours services
Services provided in the evening and nights, weekends and other times for patients needing medical care urgently

Outpatients
People who are seen in a clinic but not admitted to hospital. Outpatient appointments can take place in a community setting or a hospital

Overview and Scrutiny Committee (OSC)
A committee made up of local government councillors that offers a view on local NHS matters. It may also have representatives from voluntary organisations and patients’ forums. It is concerned with issues of health service changes, health inequalities and strategic direction rather than how hospitals have performed against targets

Paediatrics
The branch of medicine dealing with illness in children

Paediatric assessment service
A dedicated service for assessing the clinical needs of children

Patient and public involvement (PPI)
Involving the public in shaping a care system’s development, and keeping patients well informed of clinical processes and decisions

Patients’ Forums (or Patient and Public Involvement Forums)
Patient-led organisations, established by the NHS Reform and Healthcare Professions Act 2002, for every trust (including NHS Foundation Trusts) and Primary Care Trusts (PCTs). Their functions include monitoring the quality of services and seeking the views of patients and carers about those services

Payment by results (PbR)
A funding system for NHS care in England. Trusts are paid for the work they do. They are paid a price or ‘tariff’ for similar groups of patients based on the national average cost of treating patients within a group

PCBC
Pre Consultation Business Case

PFI (private finance initiative)
Initiative that provides a way of funding major capital investments, without immediate recourse to the public purse

Planned care / planned surgery
When a patient goes into hospital on a specific day for a specific purpose (for example, surgery or tests)

Portage
This is a service provided in the home to support children with special needs related to arrested motor development, and to support their families
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice-based commissioning</td>
<td>A government policy which gives a budget to groups of GP practices so that they can select and contract the most appropriate services for their patients.</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>A set of measures taken in advance of symptoms to prevent illness or injury. This type of care is best exemplified by routine physical examinations and immunisations. The emphasis is on preventing illnesses before they occur.</td>
</tr>
<tr>
<td>Primary care</td>
<td>Collective term for all services which are people’s first point of contact with the NHS. GPs, and other health-care professionals, such as opticians, dentists, and pharmacists provide primary care, as they are often the first point of contact for patients.</td>
</tr>
<tr>
<td>Primary care trust (PCT)</td>
<td>Statutory NHS bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions.</td>
</tr>
<tr>
<td>Private finance initiative (PFI)</td>
<td>See PFI</td>
</tr>
<tr>
<td>QEH</td>
<td>Queen Elizabeth Hospital NHS Trust</td>
</tr>
<tr>
<td>QMS</td>
<td>Queen Mary's Sidcup NHS Trust</td>
</tr>
<tr>
<td>Reference costs</td>
<td>Library records of unit costs for a broad range of NHS treatments and clinical procedures since 1998.</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>The maintenance and restoration of physical and psychological health necessary for independent living.</td>
</tr>
<tr>
<td>Revenue costs</td>
<td>The day to day running costs of an organisation e.g. staffing, drugs, catering, heating and lighting.</td>
</tr>
<tr>
<td>Secondary care</td>
<td>Collective term for services to which a person is referred after the first point of contact. Usually this refers to hospitals in the NHS offering specialised medical services and care (outpatient and inpatient services).</td>
</tr>
<tr>
<td>SHA</td>
<td>See strategic health authority</td>
</tr>
<tr>
<td>SRO</td>
<td>Senior Responsible Owner – the SRO is a senior individual who takes personal responsibility for delivery of a project. The SRO ensures that: there are clear objectives; focus is maintained; the project has clear authority; the context (including risks) is actively managed and that the projected benefits are delivered</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>DH has a wide range of stakeholders that all share an interest in its work, including patients and the public, local and regional NHS organisations, local authorities and social care providers, charities, and the voluntary and community sector</td>
</tr>
<tr>
<td>Step-down care</td>
<td>Part of intermediate care facilities that are outside acute hospitals, enabling people to leave acute hospital and get ready to return home.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
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</tr>
<tr>
<td>Step-up care</td>
<td>Part of intermediate care facilities that are outside acute hospitals, enabling people to receive more support than is available at home, preventing them from requiring a hospital admission</td>
</tr>
<tr>
<td>Strategic Health Authority (SHA)</td>
<td>The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans and that Primary Care Trusts are performing well. They are the link between the Department of Health and the local NHS</td>
</tr>
<tr>
<td>Surgery</td>
<td>Treatment that involves an operation</td>
</tr>
<tr>
<td>Sustainable</td>
<td>Viable in the long-term</td>
</tr>
<tr>
<td>T&amp;O</td>
<td>The clinical specialty of Trauma and Orthopaedics</td>
</tr>
<tr>
<td>Tariff</td>
<td>A set price for each type of procedure carried out in the NHS, for example a hip replacement. See also Payment by Results (PBR)</td>
</tr>
<tr>
<td>Tertiary care</td>
<td>Collective term for services to which a person is referred from secondary care services, usually from one consultant to another. Often, this refers to hospitals in the NHS offering very specialised medical services and care (e.g. neurosurgery, plastic surgery)</td>
</tr>
<tr>
<td>Trauma</td>
<td>Very serious injury, for example following a car accident</td>
</tr>
<tr>
<td>UHL</td>
<td>University Hospital Lewisham NHS Trust</td>
</tr>
<tr>
<td>Unplanned care</td>
<td>When a patient is treated urgently or at short notice</td>
</tr>
<tr>
<td>Urgent care centre</td>
<td>A centre that provides some of the facilities and services of full accident and emergency departments and can treat minor and moderate emergency cases, which include cuts and bruises, scalds and burns, broken limbs, concussion, minor head injuries and falls</td>
</tr>
<tr>
<td>UTI</td>
<td>Urinary tract infection</td>
</tr>
</tbody>
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Executive summary

Introduction

This pre-consultation business case (PCBC) sets out the collective proposals for improving the provision of health services in the four boroughs of Bexley, Bromley, Greenwich and Lewisham. This geographical area is known as Outer South East London (OSEL). The proposals focus on both the fundamental improvements to the way hospital services are organised in OSEL and the supporting development of out of hospital care.

The NHS Trusts (acute, primary care, and mental health) in the four OSEL boroughs along with partner NHS organisations have been working collectively through a project known as A Picture of Health for outer south east London (APOH) to redesign services. Patient and public involvement has been embedded throughout to ensure that the proposals, as they have been developed, meet the needs of the local community.

The purpose of APOH is to address the urgent clinical and economic issues in OSEL to secure safe and affordable acute hospital services, alongside the drive to provide more health services out of hospital and closer to patients’ homes. OSEL needs to achieve a stable position to enable it to take forward proposals outlined in ‘Healthcare for London: A Framework for Action’ (HfL) (2007) (subject to the outcomes of the current public consultation) and wider national health policy and guidance.

This document is owned by the four PCTs in OSEL, together with West Kent PCT, which form the Joint Committee of PCTs, established to take decisions on proposed changes to services. West Kent PCT has been involved, as the proposals impact on parts of their population. West Kent PCT has recently consulted their local people on the strategic vision for healthcare services, called ‘Fit for the Future’; details of which can be found on their website www.westkentpct.nhs.uk. A Picture of Health proposals are broadly consistent with the West Kent strategic vision, such as the intent to provide more services for people closer to their homes, and to ensure access to safe, high quality specialised care when it is needed.

The document concludes with a set of proposals that are recommended to be taken forward for public consultation. The PCTs will use this document to support their consultation process, drawing evidence from it. It must be stressed that this document is based on the best available information at the time of writing, December 2007. It will be updated as more up to date information becomes available, and if a new clinically viable option emerges during the consultation process.
The case for change

Local clinicians have advised the PCTs that the current pattern of service provision cannot be maintained as services will become increasingly unviable, both clinically and economically. The need for change is fuelled by the impact of initiatives such as Modernising Medical Careers (MMC) (2004) and the European Working Time Directive (EWTD), both of which will restrict the hours doctors are available for clinical work in future. Advances in clinical care and technology are also changing the art of the possible in healthcare: it is now possible to treat and care for significantly more patients in community settings. The clinical position has been endorsed recently through an independent review by the National Clinical Advisory Team, under Professor Sir George Alberti’s leadership.

There is an urgent need to address the way in which hospital services are provided, which will also require a change in out of hospital services. Some hospital services will have to be consolidated on fewer sites to ensure that patient safety and clinical outcomes can be significantly improved. However, the OSEL commissioners have given a firm commitment that none of the four major hospital sites will be closed, but the mix of services on each site will change. This needs to be supported by the development of out of hospital care, to reduce the need for patients to use hospital based services. Greater partnership and integrated working between primary, community, mental health, social and hospital (secondary) care must also be fostered locally.

Whilst there is a compelling clinical case for change, there are also strong financial reasons for change. The economic case for change centres on the importance of securing best value from the money, buildings and people available and the urgent need to restore financial balance across the local health economy. Financial analysis has shown that whilst a range of cross-cutting initiatives can take place now, they cannot yield enough savings to bring OSEL back into financial health. Measures that consolidate hospital services on to modern, high-quality facilities deliver benefits for patients, achieve better value for money and fit well with the clinical case for change.

Service Models

The consensus of opinion between clinicians, commissioners and health service leaders in OSEL is that in order to create a stable clinical and economic platform of hospital services, there needs to be a new vision for OSEL hospitals. This vision seeks to establish two types of hospital: one, which cares for the very unwell patients who need admission and those needing more specialist and complex care (an admitting hospital); and the other (a borough hospital), which provides a range of rapid assessment services, outpatient and diagnostic services and some intermediate care and rehabilitation services. As a principle, local clinicians want to separate planned elective inpatient surgical care from emergency care, to reduce the risk of infection and the risk of cancellation. As a result, the proposals co-locate the surgical inpatient and daycase units on the borough hospital sites.
There are two variants of the admitting hospital: one that takes A&E ‘blue light’ admissions and one that takes medical admissions only and therefore does not routinely offer emergency or complex surgery (a medically admitting hospital).

Out of hospital care will be developed from 2008-2010 to support the hospital services and will focus on the development of urgent care centres, moving outpatient based services into community settings and reducing both the number and length of hospital stays.

In Greenwich, there are plans for bed based facilities in the community at Eltham Community Hospital and the health centre for East Greenwich. In Lewisham there are plans for additional District Nurses, Health Visitors, Physiotherapists and other clinical staff who will work from new health centres such as the Waldron Health Centre in New Cross. These teams will help keep patients well in the community, and save them having to visit hospital. In Bexley, a team will be established to manage patients with Long Term Conditions such as asthma, diabetes and breathing problems, avoiding the need to visit or be admitted to hospital. In Bromley, the Beckenham Beacon development will provide an extensive range of services for residents in the north of the borough, in a modern state of the art healthcare facility.

Using the basic building blocks of type of hospital referred to above, local clinicians developed four models of service provision:

- Status quo – which was not favoured.
- Three admitting hospitals, although one accepting medical admissions only, and one borough hospital, plus supporting out of hospital care.
- Three admitting hospitals and one borough hospital, plus supporting out of hospital care.
- Two admitting hospitals and two borough hospitals, plus supporting out of hospital care.

**Developing the options for consultation**

Applying site-specific permutations to the service models resulted in twenty-three different options. These were then reduced to a short list of three using a set of ‘must pass’ criteria, which included clinical quality and safety, sufficient acute hospital capacity and high level financial affordability. The status quo option did not meet these criteria, but has been kept in for comparative purposes. The three options are:

**Option 1**
Two fully admitting hospitals at BHT and QEH, one medically admitting hospital at UHL and one borough hospital at QMS, plus supporting out of hospital care

**Option 2**
Three fully admitting hospitals at BHT, QEH and UHL and one borough hospital at QMS, plus supporting out of hospital care

**Option 3**
Two fully admitting hospitals at BHT and QEH, and two borough hospitals at QMS and UHL, plus supporting out of hospital care
It is proposed that more detailed analysis of the options takes place during the consultation period, using a set of weighted benefits criteria. This will be used, post-consultation, to assist the JCPCT in their decision on the option to take forward to implementation. These criteria will include accessibility for patients and visitors.

### Economic analysis of the short list options

Before making a decision on which options should be recommended for consultation, these three options were subject to detailed activity and financial modelling. This took into account the changes to clinical services on each hospital site. It also takes into account the impact of delivering significant efficiency improvements, known as cross-cutting initiatives, in the context of the existing financial deficit across the OSEL health economy.

The “do minimum” position is not financially sustainable and is only included for comparative purposes. Options 1 to 3 deliver a positive net present value based on a discounted cashflow over thirty-five years when compared with the status quo (the “do minimum” position). Only option 1 returns each of the individual organisations to in-year financial balance. However, all options return the whole OSEL health economy to in-year financial balance after including the separate cross-cutting initiatives, the financial benefits of which are included in this business case for completeness. Whilst over a ten-year period some recovery of cumulative deficits and cash debt is achieved, the problem is not solved within this timeframe.

The financial analysis takes into account both the costs of moving significant activity out of hospital into the community and the capital required to facilitate changes to hospital services both within OSEL and on other organisations impacted by activity flowing out of the local health economy, such as King’s College Hospital NHS Foundation Trust.

### Transition and implementation

Careful planning of the change is required and the earliest any of the options can be delivered is estimated to be 2010/11. All options require the development of out of hospital care in advance of significant changes to hospital services. Option 3, as the most radical of the options, will take longer to deliver and will need to be implemented in a phased way. It is quite likely that it will pass through options 1 and/or 2 in transition to two admitting and two borough hospitals. The end points, as well as being dependent upon the development of out of hospital care, are also reliant on sufficient capacity being available or developed at neighbouring hospitals beyond OSEL, where some activity is forecast to flow.

### APOH Senior Responsible Owner (SRO) recommendations

This pre-consultation business case concludes with recommendations from the APOH Senior Responsible Owner (SRO), who proposes that all three options for change are put forward for public consultation. The “do minimum” position is not viable, clinically or financially. However, it is proposed that a commentary is included in the consultation to demonstrate why
maintaining the status quo is not acceptable. An assessment of the feasibility of delivering each of the options for change is also included in this pre-consultation business case.

Based on the performance against the ‘must pass’ criteria, the financial and activity modelling and the feasibility of delivering each option, a provisional ranking of the three options has been made. Option 1 is ranked first, as it is both clinically and financially viable and delivers the greatest number of clinical benefits for patients in the shortest timescale. Option 2 is ranked second as it both clinically and financially viable, but delivers less clinical benefits. Option 3 is ranked third. It is clinically viable (for hospital services) and financially viable. The full clinical benefits will take the longest timescale to deliver. Also, the feasibility of this, particularly in relation to the ability to secure capital and to ensure the clinical viability of out of hospital care, will need further testing. This will take place during the consultation period, using feedback from key stakeholders.

This provisional ranking of options will be revisited in light of completing an assessment of the benefits of each option and in light of views raised during consultation.

Conclusion

This pre-consultation business case sets out a compelling case for change with clear options for the future. It paves the way for consultation on options for change to begin. The consultation will inform the final decision on which option will be taken forward to improve care for the local population. Speed is of the essence - patients deserve higher quality services now; financial balance needs to be restored; and local clinicians are keen to embrace the significant degree of change needed.

The pre-consultation business case is based on the best information available to the APOH Project Team at a point in time, in this case early December 2007. The financial and activity models will be updated during the consultation period. This will allow any clinically viable alternative option that emerges through consultation to be modelled. It will also mean that final decisions can be taken based on the most up-to-date information available.
1. Introduction

1.1 Foreword from Senior Responsible Owner

I am recommending this pre-consultation business case (PCBC) to the Joint Committee of Primary Care Trusts and NHS London in order to allow the proposed public consultation to proceed. It summarises proposals for the redesign of hospital services in Outer South East London (OSEL) and out of hospital care development to support the changes to hospital provision. It has the support of the Project Board for A Picture of Health (APOH).

Simon Robbins
Senior Responsible Owner (SRO) and Chief Executive of Bromley Primary Care Trust
January 2008

1.2 Purpose of the pre-consultation business case

The purpose of APOH is to address the urgent clinical and economic issues in OSEL to secure safe and affordable acute hospital services. Achieving this will facilitate the long-term developments associated with national and London health policy and guidance, to be implemented at the appropriate time in the future.

The PCBC describes proposals for improving the provision of hospital services in OSEL, supported by out of hospital care development. As part of these changes, there will also be improvements to interfaces between hospital services and mental health and social care. The PCBC describes how and where health services are proposed to be provided in the future. The time frame for implementing the first phase of the changes is 2008-2013.

Chapter 2 sets out in depth the case for change in OSEL and also the high-level vision of how services will look once they have improved. It gives a detailed rationale for the timing of the APOH PCBC and consultation, articulating the distinguishing factors and urgency for the APOH case for change in comparison to the longer term agenda of Healthcare for London: A Framework for Action’.

In summary, as an introduction to the issues and the PCBC, the headlines from Chapter 2 are:

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The overarching goal of APOH is to improve clinical quality and outcomes and patient safety for people living in OSEL.

The status quo cannot be maintained and services will become increasingly unviable.

The urgent clinical and economic issues must be tackled now, so that improvements can be made in a planned fashion and services are not put at risk of being further destabilised.

Efficiency drives are under way and making a significant contribution, but these alone cannot address the financial deficit.

PCTs in London are holding a consultation during winter 2007/08 on a ten-year plan to redesign and develop London’s healthcare services and address long-term health challenges as set out in Healthcare for London: A Framework for Action (HfL) (2007).

OSEL needs to achieve a stable position to enable it to take forward HfL, so the focus of the PCBC is on the immediate issues rather than longer-term developments.

OSEL has to find its solutions, consult the public and start implementation of proposals ahead of the implementation timeline for HfL.

The OSEL vision is grounded in partnership and integrated working between primary, community, mental health and secondary care.

Clinicians across the professional groups will provide healthcare that supports the whole OSEL population, rather than solely on an organisational basis.

The commissioners have given a firm commitment that none of the four major hospital campuses will be closed. The shape of services at the hospitals will change significantly, with a different and more diverse mix of hospital, mental health, primary, community and social care available.

Development of out of hospital and primary care is one of the key mainstays of the OSEL vision, in support of all options for changes to hospital provision proposed.
1.3 Scope

The NHS organisations in the four OSEL boroughs are working collectively through APOH to redesign services:

- **Hospital Trusts**: Bromley Hospitals NHS Trust (BHT), Queen Elizabeth Hospital NHS Trust (QEH), Queen Mary’s Sidcup NHS Trust (QMS), University Hospital Lewisham NHS Trust (UHL)

- **Primary Care Trusts (PCTs)**: Bromley Primary Care Trust (BPCT), Greenwich Teaching Primary Care Trust (GTPCT), Lewisham Primary Care Trust (LewPCT)

- **Care Trusts**: Bexley Care Trust (BCT)

- **Mental Health Foundation Trust**: Oxleas NHS Foundation Trust (Ox)

- **West Kent PCT (WKPCT)**, although not in OSEL, is a participant in the project and is a member of the Joint Committee of PCTs

*Partner organisations*: London Ambulance Service (LAS), Dartford and Gravesham NHS Trust, King’s College Hospital NHS Foundation Trust (KCH), Guy’s and St Thomas’ NHS Foundation Trust (GST) and South London and Maudsley NHS Foundation Trust (SLaM).
1.4 Organisational configuration issues

The PCBC does not make proposals for organisational reconfiguration. The philosophy of APOH is that form should follow function. It is acknowledged that a review of organisational configuration may need to take place as a consequence of service redesign, in order to help facilitate the implementation of service changes.

1.5 Overview of governance and project management

The governance and project architecture of APOH comprises the following tiers of decision-making and responsibility:

▪ One: Joint Committee of Primary Care Trusts

The Joint Committee of Primary Care Trusts (JCPCT) holds ultimate and statutory responsibility for agreeing the PCBC, consultation materials and recommending the APOH proposals go out to public consultation, on behalf of OSEL and West Kent PCTs. It will also receive the responses to consultation and make decisions in light of this. Its membership comprises OSEL PCTs and West Kent PCT Board representatives, including clinicians.

▪ Two: SRO and Project Board

The SRO is the Senior Responsible Owner who takes personal responsibility for delivery of the project. The SRO ensures that: there are clear objectives; focus is maintained; the project has clear authority; the context (including risks) is actively managed and that the projected benefits are delivered.

The Project Board’s role is advisory. It advises the SRO, who makes recommendations to the JCPCT. It supports the SRO in delivering the APOH project plan, endorses the pre-consultation business case and supports the development of consultation materials. It is chaired by the SRO. Its membership comprises the OSEL PCT and hospital Trust Chairs and CEOs, the CEO of Oxleas on behalf of mental health services in OSEL, West Kent PCT CEO, an LAS representative and the CEO/authorised deputies from NHS London.

▪ Three: Project Executive

The Project Executive is responsible for the overall programme management of APOH, implementation of the strategic project plan and its resourcing. It is chaired by the SRO. Its membership comprises: OSEL PCT CEOs, plus West Kent PCT CEO/representative, OSEL hospital Trust CEO and NHS London representatives.

▪ Four: Work Streams

Six work streams are responsible for delivering elements of the APOH project plan, developing and endorsing aspects of the pre-consultation business case, engagement and consultation materials and processes. These work streams are:
- The Clinical Reference Group (Hospital Trust and Oxleas Medical Directors and PCT PEC Chairs);
- The Out of Hospital Care Forum (PCT Directors of Commissioning and PEC Chairs) – links to Local Authority Group;
- The Provider Forum (Hospital Trust CEOs and Medical Directors);
- Finance Directors Group (PCT and Hospital Trust Finance Directors);
- Communications and Engagement Work Stream (OSEL PCT and Hospital Trust communications leads); and
- Impact Assessment Group (PCT and Hospital Trust expert representatives).

**Project Team**

A project team comprising staff seconded from the OSEL PCTs and Trusts and independent consultants supports the work of APOH. Specialist organisations have been engaged to develop specific pieces of work, such as the independent collation and analysis of engagement activities, a review of productivity measures and an analysis of estates requirements. The project team is led by the Project Director, who reports to the SRO.

**Consultation Advisory Panel**

An independent Consultation Advisory Panel, comprising national and local public and patient involvement experts, was convened in May 2007 to oversee the public consultation.
A Picture of Health Governance Model (September – December 2007)

**PCT Joint Committee**
OSEL & West Kent PCTs

**APOH Project Board**
Chair: Simon Robbins, SRO
Members: OSEL and West Kent PCT and Trust Chairs and CEOs + NHS London CEO/rep + LAS

**Project Executive**
Chair: Simon, Robbins, SRO
Members: OSEL PCT CEOs, West Kent PCT CEO, Hospital Trust CEO, Project Director, NHS London rep, others as required

**Work streams**

**Providers Forum**
Chair: Antony Sumara, BHT CEO
Members: OSEL Trust CEOs & MDs

**Clinical Reference Group**
Chair: Simon Robbins, SRO
Members: OSEL MDs and PEC Chairs

**Out of hospital care forum**
Chair: Jane Schofield, GPCT CEO
Members: OSEL & W.Kent PEC Chairs & Commissioning Directors

**Finance group**
Chair: Anthony McKeever, BCT CEO
Members: OSEL PCT and Trust FDs

**Communications & engagement**
Chair: Gill Galliano, LPCT
Members: OSEL comms leads

**Impact assessment group**
Chair: Helen Cameron, Project Director
Members: TBC

**Consultation Advisory Panel**
Chair: Michael English
1.6 Brief overview of stakeholder involvement

- Public

Public engagement commenced with a pre-consultation discussion phase in October 2006. A wide range of small and larger meetings have been held. Four large deliberative events were held in February 2007 to test the case for change and develop the ‘people’s principles for change’. A further event was held in June 2007 to discuss criteria for assessing options. Two further large deliberative events were held in November 2007 to involve members of the public in contributing to the development of the options that will be presented to the public in the formal consultation.

Chairs and representatives of the Overview and Scrutiny Committees (OSC) and Public and Patient Involvement Forums (PPIFs) have been involved in developing the discussion and consultation arrangements and have been updated regularly on the emerging proposals for redesign. MPs, councillors and the media have been briefed on a regular basis.

An independent Consultation Advisory Panel, comprising national and local public and patient involvement experts, was convened in May 2007 to oversee the consultation. Advice has been taken throughout the pre-consultation discussion phase from Capsticks Solicitors, which has given assurance that the engagement activities and approach fulfill legislative requirements.

- Professional and NHS organisations

Unions, professional bodies, the Deanery and other key stakeholders including NHS organisations in West Kent, Lambeth and Southwark PCTs, the London Ambulance Service, and social services departments have been involved. Unions, professional bodies and the Deanery have been kept informed of the process and there have been staff side meetings in the four hospitals. The Chief Executive of West Kent PCT was invited to join the Project Board and there have been update meetings with the Chief Executives of Dartford and Gravesham NHS Trust, King’s College Hospital NHS Foundation Trust and Guy’s and St Thomas’ NHS Foundation Trust. Social services departments have contributed to the work of the Out of Hospital Care Forum, through a sub group. The Director of Service Improvement at the London Ambulance Service is a member of the Project Board and with colleagues has contributed to a number of clinical meetings and groups.

- Clinical

Clinical engagement has taken place through regular meetings of the acute Trust Medical Directors, primary/community care clinical leaders, clinical networks, clinical work streams and ‘roundtables’. A Clinical Reference Group, comprising hospital Medical Directors and PCT Professional Executive Committee (PEC) Chairs, has advised the SRO and Project Board on the development of service models and the pre-consultation business case. Two major clinical plenaries, where acute clinicians gave their advice and recommendations on service models, were held in June and September 2007. Further clinical engagement has been undertaken in November and December 2007, with borough-based events for community clinicians and plenaries for allied health professionals (AHPs) and nursing staff.
Further detail about stakeholder engagement can be found at Appendix 1 and Working Papers 1a-e.

1.7 Background – current health landscape

- **Health status in outer south east London**

Almost a million people live in the four OSEL boroughs, and this is set to rise over the next ten years, due to factors including the Thames Gateway regeneration and expansion. There is an equator in OSEL between the north and south of the area in terms of the health status of residents. On the whole, the health of residents closer to the Thames - in the northern wards of Greenwich, Lewisham and Bexley - is worse than in the south of these boroughs and than in Bromley. People’s health in these areas is also generally worse than the London and national averages. In Greenwich and Lewisham people live about two years less than most Londoners (77 for men and 81 for women)\(^2\), whereas in most parts of Bromley and Bexley people have better health and live up to two years longer than people in many places in London. Although people in Bexley and Bromley are largely more affluent and in better health, there are pockets of inequality and poorer health status in these boroughs too.

<table>
<thead>
<tr>
<th></th>
<th>Current population size</th>
<th>Anticipated population over next 10 years*</th>
<th>Current level of deprivation**</th>
<th>Current diversity of ethnicity***</th>
<th>Any notable demographics ****</th>
<th>Anticipated significant changes to population in next 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>220,000</td>
<td>224,440</td>
<td>15.01</td>
<td>8.6%</td>
<td>30% of population aged over 65</td>
<td>-</td>
</tr>
<tr>
<td>Bromley</td>
<td>299,000</td>
<td>311,178</td>
<td>13.17</td>
<td>8.4%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Greenwich</td>
<td>226,000</td>
<td>272,804</td>
<td>31.47</td>
<td>22.9%</td>
<td>12% of population aged over 65</td>
<td>Growth in Thames Gateway area</td>
</tr>
<tr>
<td>Lewisham</td>
<td>247,000</td>
<td>275,555</td>
<td>24.55</td>
<td>34.1%</td>
<td>-</td>
<td>Growth in Thames Gateway area</td>
</tr>
<tr>
<td>OSEL total</td>
<td>992,000</td>
<td>1,083,977</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* Thames Gateway Report
** DETR 2004
*** ONS neighbourhood statistics (% non-white population)
**** PCT Annual Public Health Reports 2005/06

\(^2\) Life expectancy in SEL 2003-2005
**Current provision of hospital services**

The four hospitals in OSEL all provide the core clinical services associated with the traditional district general hospital, but not all provide the full range of specialties. Two of the hospitals, BHT and QEH, provide services in new PFI buildings. UHL’s estate comprises both older stock and a new PFI wing, on a single campus.

<table>
<thead>
<tr>
<th>Main location(s)</th>
<th>BHT</th>
<th>QEH</th>
<th>QMS</th>
<th>UHL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Farnborough (PFI)(1)</td>
<td>Woolwich (PFI)</td>
<td>Sidcup Erith (PCT owned)</td>
<td>Lewisham (part PFI)</td>
</tr>
<tr>
<td>No. of acute beds in March 2007</td>
<td>459</td>
<td>414</td>
<td>329</td>
<td>382</td>
</tr>
<tr>
<td>Occupancy in March 2007</td>
<td>99.5%</td>
<td>94%</td>
<td>93.1%</td>
<td>90%</td>
</tr>
<tr>
<td>A&amp;E attendances 2006/07</td>
<td>98,049</td>
<td>101,313</td>
<td>88,190</td>
<td>109,776</td>
</tr>
<tr>
<td>Non-elective inpatients 2006/07</td>
<td>24,793</td>
<td>31,000</td>
<td>19,712</td>
<td>31,647</td>
</tr>
<tr>
<td>Elective inpatients 2006/07</td>
<td>29,867</td>
<td>24,700</td>
<td>19,389</td>
<td>21,486</td>
</tr>
<tr>
<td>Outpatient attendances</td>
<td>239,361</td>
<td>186,700</td>
<td>151,010</td>
<td>182,858</td>
</tr>
</tbody>
</table>

(1) Now known as the Princess Royal University Hospital

**Distances between hospitals**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Distance: miles</th>
</tr>
</thead>
<tbody>
<tr>
<td>QEH</td>
<td>QMS</td>
<td>6</td>
</tr>
<tr>
<td>QMS</td>
<td>PRUH (1)</td>
<td>6.25</td>
</tr>
<tr>
<td>PRUH (1)</td>
<td>UHL</td>
<td>8</td>
</tr>
<tr>
<td>UHL</td>
<td>QEH</td>
<td>4.5</td>
</tr>
<tr>
<td>QEH</td>
<td>PRUH (1)</td>
<td>10.75</td>
</tr>
<tr>
<td>UHL</td>
<td>QMS</td>
<td>7</td>
</tr>
</tbody>
</table>

(1) Part of Bromley Hospitals NHS Trust

Darent Valley Hospital, in West Kent PCT, is approximately 11 miles from QMS and approximately 14 miles from PRUH.

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3 Acute beds as reported on SITREPs for mid-March 2007, including medical, surgical, gynaecological and paediatric beds; excluding maternity, high dependency, intensive care and day beds.
1.8 Project and PCBC process

The *A Picture of Health* project commenced in December 2005. In 2004/05, the leaders of the NHS Trusts recognised that changes in clinical practice, guidelines and legislation, such as the European Working Time Directive, meant that current services would be unsustainable in the next few years and collaborative solutions were needed. Locally, there was a history of clinicians and health service leaders working together to improve the quality and efficiency of services. Financial pressures were also increasing, which could no longer be handled through brokerage alone, and it was evident that the scale of the actions required would have wider implications than could be managed by separate organisations.

Originally, the fourteen NHS organisations in south east London were part of *A Picture of Health*. In 2007, it became clear - through the Department of Health-led Financially Challenged Trust programme and analysis by the project team - that the weight of the urgent clinical and financial issues rested in the OSEL hospitals and work began to focus increasingly in this area. In July 2007, a gateway review by the Office of Government Commerce (OGC) recommended streamlining and focusing on OSEL. In August 2007, the governance arrangements and project architecture for APOH were revised to support the new focus, following a review by the new SRO.

The PCBC process described below outlines the key steps and milestones achieved by the project since its initiation, enabling the production of the PCBC.

The PCBC process is underpinned by a quality assurance framework. This has four key aspects as follows:

a) **Clinical assurance**

In the first place, the SRO asked the Medical Directors and then the Clinical Reference Group to validate the clinical options that should be modelled. The National Clinical Advisory Team, under Professor Sir George Alberti’s leadership, has given an external view on the clinical models.

b) **Financial modelling assurance**

The financial modelling is being reviewed by NHS London as part of the quality assurance of the pre-consultation process.

c) **Governance and project management assurance**

The OGC reviewed the governance and project management in July and November 2007.

d) **Legal assurance**

Capsticks Solicitors will give legal assurance, including the public involvement aspects of *A Picture of Health* (both engagement already undertaken and planned for January 2008).
## Development Process

<table>
<thead>
<tr>
<th>STEP</th>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dec 2005</td>
<td><strong>PROJECT INITIATED &amp; THE CASE FOR CHANGE IDENTIFIED</strong> - Recognition of SEL clinical and financial issues – high level case for change</td>
</tr>
<tr>
<td>2</td>
<td>Jan – Oct 2006</td>
<td><strong>BASELINE ANALYSIS</strong> - Baseline analysis and modelling to substantiate case for change - Initial clinical engagement</td>
</tr>
<tr>
<td>3</td>
<td>Oct 2006 - Feb 2007</td>
<td><strong>PUBLIC INVOLVEMENT IN CASE FOR CHANGE</strong> - OSC/stakeholder briefings on case for change - Peoples ‘principles for change’ developed</td>
</tr>
<tr>
<td>4</td>
<td>Jan 2007</td>
<td><strong>COMMISSIONING CONTEXT</strong> - PCTs produce Commissioning Intentions (CIs) - Signals development of out of hospital care</td>
</tr>
<tr>
<td>5</td>
<td>Mar – Jun 2007</td>
<td><strong>DETAILED ANALYSIS, CLINICAL MODELLING &amp; OSEL FOCUS</strong> - Patient flows, PFI, and acute sector finances analysis completed - Focusing of APOH on SEL issues - Four acute clinical work streams convened, identifying clinical principles and models and clinical plenary held to share models</td>
</tr>
<tr>
<td>6</td>
<td>Jun 2007</td>
<td><strong>PUBLIC INVOLVEMENT IN CRITERIA DEVELOPMENT</strong> - People’s principles weighted</td>
</tr>
<tr>
<td>7</td>
<td>Jun 2007</td>
<td><strong>DRAFT BUSINESS CASE</strong> - First draft of PCBC completed - Further analysis and modelling continues</td>
</tr>
<tr>
<td>8</td>
<td>July - Aug 2007</td>
<td><strong>OGC and SRO REVIEWS</strong> - Quality assurance of process to date - Formal refocusing of project on OSEL issues</td>
</tr>
<tr>
<td>9</td>
<td>Sept 2007</td>
<td><strong>CLINICAL ADVICE ON SERVICE MODELS</strong> - The preferred models of care recommended at clinical plenary</td>
</tr>
<tr>
<td>10</td>
<td>Sept-Oct 2007</td>
<td><strong>DEVELOPMENT OF CRITERIA, SHORT LISTING OPTIONS</strong> - Detailed modelling and analysis of clinical recommendations - Development &amp; application of criteria to reach options for PCBC</td>
</tr>
<tr>
<td>11</td>
<td>Oct-Nov 2007</td>
<td><strong>PREPARATION OF PCBC</strong> - Validation of key aspects of PCBC by APOH governance mechanisms - Public involvement in option development</td>
</tr>
<tr>
<td>12</td>
<td>Nov-Dec 2007</td>
<td><strong>QUALITY ASSURANCE OF PCBC</strong> - Quality assurance of the clinical case for change by Professor Sir George Alberti and the PCBC by OGC, NHS London &amp; Capsticks</td>
</tr>
</tbody>
</table>
1.9 PCBC Timeline to consultation

<table>
<thead>
<tr>
<th>Time period</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 December 2007</td>
<td>Meeting to receive, consider and note draft PCBC of OSEL hospital/mental health Trust Boards, with representatives from LAS, King’s College Hospital NHS Foundation Trust, Guy’s and St Thomas’ NHS Foundation Trust and Dartford and Gravesham NHS Trust invited. Social services receive the draft PCBC for noting.</td>
</tr>
<tr>
<td>7 December 2007</td>
<td>Draft PCBC considered by the APOH Project Board and submitted for peer review to NHS London.</td>
</tr>
<tr>
<td>18 December 2007</td>
<td>JCPCT meets to review the PCBC and consultation document and potentially agree proceeding to public consultation.</td>
</tr>
<tr>
<td>19 December 2007</td>
<td>NHS London Board receives the PCBC for noting.</td>
</tr>
<tr>
<td>Throughout December 2007</td>
<td>PCT Board meetings – briefings about PCBC and consultation.</td>
</tr>
<tr>
<td>7 January 2008</td>
<td>Proposed date for commencement of public consultation</td>
</tr>
</tbody>
</table>

The consultation process timeline and decision-making timeline are described in chapter 8.

1.10 Overview of structure of pre-consultation business case

The PCBC comprises a main document and associated appendices. The structure of the main document is as follows:

- **Ch 1 Introduction**
The scope and purpose of the PCBC, governance/project management and stakeholder involvement, current health landscape, and project and business case process.

- **Ch 2 The case for change**
The clinical and economic case for change, within the context of national policy.

- **Ch 3 Objectives and measures of achievement**
The objectives and measures of achievement that the proposals aim to fulfill, both for hospital and out of hospital care.

- **Ch 4 Pre-consultation business case models: clinical recommendations**
A descriptor of the clinical recommendations about non site specific service models for hospital provision and supporting out of hospital care.

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- **Ch 5** Decision-making: option development, criteria and short listing
  The process undertaken in developing the PCBC options, criteria used and the application of criteria to arrive at a short list of options.

- **Ch 6** Detailed economic analysis of pre-consultation business case options
  The impact of the proposals in terms of activity, productivity, affordability and investment requirements. Outlines plan for specialist impact assessments and benefits realisation.

- **Ch 7** Transition and implementation
  The timeframe for change and transition issues and plans are outlined.

- **Ch 8** Results and SRO recommendations
  The results of the detailed analysis, the range of options to be recommended for public consultation by the SRO to the Joint Committee of PCTs, the process and timetable for consultation and decision-making.

- **Ch 9** Appendices

The pre-consultation business case is based on the best information available to the APOH Project Team at a point in time, in this case early December 2007. The financial and activity models will be updated during the consultation period. This will allow any clinically viable alternative option that emerges through consultation to be modelled. It will also mean that final decisions can be taken based on the most up-to-date information available.
2. The Case for Change

2.1 Introduction

This chapter of the PCBC sets out the case for change in OSEL, and also the high level vision of how services will look once change is achieved. Benefits to patients and staff are highlighted.

In section 2.2, the rationale for the timing of the APOH PCBC and consultation is argued, articulating the distinguishing factors and urgency for the APOH case for change in comparison to the longer term agenda of Healthcare for London: A Framework for Action\(^4\).

Section 2.3 describes the case for change at a high level for the sector/whole health economy.

Section 2.4 gives a brief overview of public involvement in developing the clinical case for change.

The high level vision for the sector/whole health economy is outlined in section 2.5, showing how the model for out of hospital care will be the foundation for the solutions to the immediate issues and will also enable future developments. More specific and detailed description of clinical recommendations about service models that can take forward the high level vision are given in Chapter 4.

Then in section 2.6 greater detail is described for the clinical drivers for change in the major groupings of hospital services.

Section 2.7 describes how to find out more about Professor Sir George Alberti’s review of the OSEL clinical case for change.

Finally, there is a more detailed section on the economic case for change in section 2.8.

2.2 The rationale for APOH acting now: the immediate and longer term agendas

2.2.1 The immediate agenda

The case for change for APOH is focused squarely on the urgent clinical and economic issues in OSEL. These issues must be addressed now to stop a critical situation becoming any more precarious and impacting on clinical safety – to this end, the pre-consultation business case sets out a plan for urgent service redesign. The status quo cannot be maintained and without change services will become increasingly unviable, unable to meet national evidence-based guidelines and legislative requirements. Unless a stable platform of acute hospital service provision is secured swiftly, planned improvements across the health

economy could be lost. This will pose a risk to relocating appropriate care in the primary/community setting, and will have a disproportionate impact locally on quality standards. Action must be taken now so that changes can be made in a planned fashion rather than allowing damaging unplanned change to occur.

Urgent service redesign is required because two other main routes for addressing the situation, namely efficiency drives and implementing the radical proposals for healthcare redesign and development associated with ‘Healthcare for London: A Framework for Action’ (HfL) (2007)\(^5\) either cannot go far enough or cannot happen with the necessary speed.

There is a major efficiency programme underway in OSEL, as part of the Department of Health’s Financially Challenged Trusts support process. It has already identified potentially significant savings from increasing efficiency in the hospitals. This is a valuable contribution to addressing the financial challenge, but it does not close the gap. The size of the economic problem in OSEL, where debt is increasing by c. £400,000 a week, is such that even aggressive efficiency measures cannot and have not alone secured the financial stability of the hospitals and health economy at large. Moreover, a plan based solely on recovering the situation through efficiency drives could only improve the situation so far. Any further cost reduction would result in damaging clinical implications as it would entail stripping back clinical teams and restricting services. OSEL is already struggling to provide and maintain clinical teams and services of sufficient size and expertise to meet national clinical guidelines and legislative requirements, as described in the clinical specialty section 2.6. The out of hospital care plans described below, which are fundamental to stabilising the provision of hospital services could be restricted as funding will have to be used to support services in hospitals, rather than investing it in the wider local health economy.

PCTs in London are holding a consultation during winter 2007/08 on ‘Healthcare for London: A Framework for Action’. This describes at a pan London and strategic level, a ten year plan to redesign and develop London’s healthcare services. It proposes far reaching solutions to some of the long standing health issues in London, such as health inequalities and long term public health issues such as obesity and mental well-being; potentially an overhaul of primary care services with the development of the polyclinic concept; and the possible consolidation of very specialist services for serious trauma, cardiac illness and stroke. These issues will require long term plans and solutions, and will not be solved overnight. Planning to implement the outcomes of the HfL consultation will start in spring/summer 2008, and there will be a need for further consultation on the detailed local plans that will take forward the outcomes of HfL consultation.

OSEL needs to work on these issues too, but to be able to do this requires a stable position and this means the urgent clinical and economic issues have to be addressed first. Therefore, this PCBC and case for change are focused on the immediate agenda. The situation is such that another year cannot pass, with OSEL accruing debts at the level it is currently - services cannot be sustained under such pressure. This means OSEL has to find its solutions, go out to public consultation and start implementation of proposals well ahead of the implementation timeline for HfL.

\(^5\) Ibid.

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Principally, OSEL’s proposals for APOH although they address some of the same clinical care pathways as HfL, such as maternity and emergency care, are focused on more local, immediate concerns about securing and maintaining safe, quality services than the strategic, developmental and long term aims for these care pathways as described in HfL. In a very few areas APOH will consult on/potentially implement the strategic goals of HfL early because these are such priority issues and action has to be taken now for safety reasons, and this will be subject to public consultation through the APOH consultation process. The areas of HfL where APOH is likely to consult on early are:

Staying healthy

- Reducing hospital acquired infection through moving care into community settings and by separating emergency and elective surgery.

Maternity and newborn care

- Expectant mothers to be offered:
  - early assessment by midwife
  - local one stop antenatal care
  - choice of birth venue
  - care by same team from conception through postnatal care
  - one to one midwifery care through labour
  - postnatal care at home and/or at local one stop shop
  - mental health support, where required.

- Encouraging and providing greater home birth services and information.

- Fewer, larger obstetric units but offering 98 hour consultant led service (08.00 – 22.00 seven days a week), able to deal with complications (units delivering 4,000+ births).

- Provision of midwife led birthing units.

- Provision of neonatal intensive care units and all professionals involved in birth to be competent in basic newborn life support skills.

Children and young people

- Specialist urgent care concentrated at fewer, but more specialist hospitals.

- Children’s assessment units to be located at non specialist hospitals to provide day care and review children in the A&E.

Acute care

- Telephone advice for urgent care (new number).

- Provision of more urgent care services/centres in the community and also co-located at hospitals.
2.2.2 The longer term agenda

Although OSEL faces the immediate issues described above and throughout this case for change, it also has a series of deep seated health challenges to resolve, which require longer term solutions. These generally are not only about quality and safety of hospital services, which need to be guaranteed here and now, but about the wider determinants of good health and tackling disadvantage, and need broader collaborative working with a range of statutory and voluntary bodies.

These issues will not be described, or proposals put forward, in this PCBC to address the longer term agenda. This case for change and PCBC does not discuss the detail of developments, such as polyclinics; mental health service development; and changes to the provision of specialist stroke, trauma and cardiac services which are part of Healthcare for London. Rather, the PCTs describe how they will pursue the long term agenda through the OSEL Commissioning Intentions and Commissioning Strategy Plans. In brief, these longer term plans reflect the HfL agenda and are focused on improved care from cradle to grave, looking at six patient pathways:

- **Birth**
  - Increasing home birth rates.
  - Greater emphasis on prevention of complications through improved community care.

- **Staying Healthy**
  - Maximising the opportunities presented by the 2012 Olympics in London to further develop physical activity for health schemes and linked to anti-obesity strategies which include healthy eating components.

- **Long Term Conditions (e.g. asthma, chronic obstructive pulmonary disease, diabetes, arthritis, neurological disorders such as multiple sclerosis and Parkinson’s Disease)**
  - Case managers to support people with long-term health conditions.
  - Tele-health and care schemes.
  - Plans to strengthen preventive care and early detection.
  - Proactive management of patient journey in the community.
  - Optimising coordinated use of community and hospital care.
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- Acute and Urgent Care
  - Developing primary-care led emergency centres.
  - Potentially centralising major illness/trauma services to optimise quality of care and use of resources, dependent on the outcome of HfL.

- Planned Care
  - Consolidating tertiary services.
  - Refocusing elective surgery.
  - Introducing specialist outpatient services nearer to home.
  - Introducing community hospitals.
  - Improved intermediate care.

- End of Life Care
  - Support for people who choose to die at home.
  - Respite care for patients and carers.
  - Delivering the Marie Cure Choice pilot in SEL, which aims to support patient choice and preference for place of death in a coordinated framework.

Achieving a stable clinical and financial platform will facilitate the long term developments needed to address these issues, and key policies relating to them:


- ‘Choosing Health’ (DH, 2005) identifies effective partnerships as one of the key mechanisms needed to underpin this, and outlines key priorities for health improvement: health inequalities, smoking, obesity, sexual health, alcohol and mental health.

- ‘Our health, our care, our say’ (DH, 2006) call for a shift in funding and services from hospitals and into community services.

The longer term vision for health in OSEL is that people in the area will enjoy health, well-being and independence equal to the best in London; and supported by world class services. As set out in HfL, the long term goals are to5:

- Improve health.
- Improve satisfaction with services.
- Tackle health inequalities.
- Move more care into community settings.
- Provide more specialised care.
- Ensure London is at the cutting-edge of research and clinical excellence.
- Use the workforce and buildings effectively.

6 Ibid, pp4-7.
- Make best use of taxpayers’ money.
- Build a health service that can meet the challenges of the future.

There will be a great deal of detailed work undertaken to address the longer term issues in OSEL, as part of the implementation of HfL, following consultation in late 2007/early 2008.

2.3 Whole health economy case for change

The urgent clinical and economic issues must be addressed to ensure the overarching goal of APOH – to improve safety, quality and clinical outcomes for people living in OSEL. As noted in Chapter 1, there are significant differences in the health status of people living in the OSEL boroughs, with a four year gap between the best and worst mortality rates across the area. Improving health is not only the responsibility of health services. Social, environmental, economic and lifestyle factors can all play a critical role in making the change, and many of these are greater than the NHS’ sphere of influence. However, health services must contribute to narrowing the four year gap between boroughs in OSEL.

In the immediate future, as this case for change describes, health services can make their contribution by ensuring the best outcomes through more investment in out of hospital care services; better access to specialist services and round the clock consultant-led opinion; provision of quality, safe services in the best facilities and development of integrated care pathways, for example for urgent care.

OSEL is facing a number of pressing concerns that are undermining the clinical and financial viability of the services, organisations and health economy as a whole. The clinical drivers for change in hospital services were identified at a clinical plenary in September 2007, attended by over a hundred hospital clinicians, where there was a high level of consensus that the status quo in acute hospital care cannot be sustained and major changes are required. The main focus is on clinical quality and safety which cannot be guaranteed under present organisation of services.

The priority concerns are:

- There is a strong need to provide integrated services across the whole health economy with close working between primary care, community care, social care and hospital services to give a smooth patient journey. This should aim to provide care as close to home as safely possible, with patients attending hospital when that is the only place which has the appropriate expertise and facilities to meet their needs.

- Some services must be concentrated, with fewer but larger, multidisciplinary and specialist teams to improve patient safety and clinical outcomes. Advances in clinical practice and new national guidelines on clinical quality and safety are calling for significantly increased hours of consultant cover in many key service areas, and also setting minimum caseload volumes/catchment populations. Clinical evidence is increasingly pointing to the need for more specialist interventions, whilst at the same time there is greater localisation of services into community settings, meaning there is a tension about the future direction of district general hospitals. For OSEL hospitals this
means the teams and rotas in each individual hospital are too small to provide the level of consultant and specialist cover required. Simply increasing the numbers of doctors, even if there were the doctors available to recruit and this was affordable, would not solve the problem as each of the hospitals individually would not see the level or complexity of caseload necessary to employ the full range of specialists, or for the doctors to retain their skill level.

- As district general hospitals change, there is the opportunity to provide more services locally and **closer to home**\(^7\), and people have said in national surveys and at the OSEL deliberative events (see 2.4 below) that this is what they want. Many of the advances in clinical care enable a significant move of treatment and care into community settings. This includes making a wider range of diagnostic services available in community settings. Other key services that could be more localised include urgent care services, ante and post natal services, minor procedures, outpatient appointments, and support to people to manage their long term conditions at home. Highly specialist services, where people currently have to travel into central London, could also be moved more locally with outpatients clinics provided at hospitals in OSEL.

- The impact of *Modernising Medical Careers* (MMC) (2004) and also the European Working Time Directive (EWDT), require **major changes to the hours doctors can work** from 2008/2009. Again, the clinical teams in OSEL are too small to be able to reduce the hours doctors work and still provide round the clock care. In particular for many acute conditions patients deserve and require seven days per week, round the clock service, provided by experienced doctors and other health care professionals.

- **Nursing roles need to be developed.** The Department of Health will shortly launch a consultation on *Modernising Nursing Careers*. This will focus on five post registration pathways, encompassing the whole patient pathway through secondary and primary care. Redesigning services will enable a critical mass of staff to be created, improving the ability to introduce expanded roles e.g. nurse endoscopist, surgical practitioners, anaesthetic nurse practitioners, and non-medical prescribers. These types of roles will increase OSEL’s ability to attract and retain staff and strengthen links to the higher education institutes.

- **Attracting and retaining the best staff** is a critical issue for the four hospitals in OSEL. Concerns about the clinical viability of services and lack of opportunities to specialise affect the appeal of working in OSEL. Staff want to work in organisations and a sector that have sound clinical and financial futures. There are ongoing challenges with the recruitment of a number of specialist staff groups i.e. critical care nurses, midwives, and pharmacists that can directly impact upon service delivery. There are very real concerns that with the level of uncertainty key clinical staff will seek posts elsewhere, which can only further undermine the viability of some services. If key services in OSEL were to consolidate into larger, specialist units, a much more attractive environment is created for staff. Staff will be able to work where their careers can grow through access to a wider range of experience, multi-disciplinary working and the potential to specialise. Training opportunities will be improved through an enhanced ability to support expanded roles for non medical staff and it will also be easier to attract funding. There will be greater ability

\(^7\) Department of Health, *Our health, our care, our say*, 2006.

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to attract research and development funding, creating an environment where service innovation can flourish.

- Equally, there is a need to provide and attract more GPs, primary and community staff to support out of hospital care to continue to build a vibrant and flourishing community and primary care sector.

The urgent issues is OSEL are having a deleterious effect, and solutions must be put in place without delay. Further detail on these priority issues and drivers for change, and their impact on particular clinical specialities and on the organisations is set out in section 2.6.

2.4 Public involvement in the case for change

Between January-April 2007 pre-consultation engagement took place with the public and key stakeholders through a number of briefing and discussion events, a discussion document, survey and website. There were over 180 meetings, from small groups to larger events. Results from the meetings were independently analysed by Ipsos-MORI\(^8\). Opinion Leader facilitated four deliberative events for a cross section of over 250 local people, who were recruited using a random/representative selection method. Participants were asked about their experiences of current NHS services, presented with the case for change from a clinical, policy, and economic perspective, and then asked for their comments and views on priorities for the NHS in SEL. People were generally positive about the fact that the need for change is being recognised and that they are being given insight into the clinical reasons for change. The principles and priorities articulated by local people show enthusiasm for moving health services forward (not in any order of priority)\(^9\):

- Standards of care
- Accessibility
- Patient focus
- Increasing focus on prevention & mental health
- Information & promotion


2.5 Whole health economy vision: out of hospital care as the foundation

In response to the case for change and the principles and priorities of the participants of the deliberative events, the vision presented here is grounded in partnership and integrated working between primary, community, mental health, social and secondary care. Clinicians across the professional groups, will provide healthcare that supports the whole OSEL population, rather than on a solely organisational basis.

While substantial changes are needed to secure and further improve hospital services, the commissioners have given a firm commitment that none of the four major hospital campuses will be closed. The shape of services at the hospitals will change significantly with a different and more diverse mix of hospital, primary, community and social care available - and these will be provided at all four hospitals.

In total, the changes proposed to address the urgent issues for hospital provision mean that there will need to be a significant shift of care into the community sector, particularly urgent care (see section 4.2.2) and intermediate care (see section 4.2.3). Therefore, one of the key mainstays of the OSEL vision is that alongside and in support of all options for changes to hospital provision proposed (other than the status quo) there will be significant development of out of hospital care.

As already noted, there is a wider agenda to develop out of hospital care and primary care, in response to ‘Our health, our care, our say’ and this will be more fully described following the winter 2007/08 consultation on Healthcare for London, and as part of the PCT Commissioning Strategy Plans. However, ahead of this work, there will have to be some early and substantial development of aspects of out of hospital care required to support the urgent changes in hospital provision. More detail is given in chapter 4. However, in summary OSEL PCTs are now developing and redesigning services.

Initiatives are focused on:

- Increased provision of nursing and therapy services which support people in their own homes e.g. increased numbers of community matrons, virtual ward schemes, specialist nursing teams, specialist rehabilitation schemes.
- Increased access to urgent care support locally e.g. through improved GP access and development of local 'walk in' centres.
- Enhanced levels of intermediate care, including developing pathfinder pilots of the community hospital/polyclinic concept and bridging rapid response teams.
- Urgent care centres on all four hospital sites and reviewing primary care 'out of hours' provision and medical assessment services in the context of these developments.
- Improved end of life care through the Marie Curie Delivering choice project.

For local people, putting out of hospital care at the heart of the vision for addressing the urgent issues in OSEL, will mean that as well as securing safe, quality hospital services they will also have improved access to services such as general practice, out of hours services, urgent care, intermediate care and more support to self-care, manage their long-term conditions and maintain independence (see section 4.2).
Ultimately, with the urgent issues in OSEL addressed through solutions that are grounded in developing out of hospital care and integrated working across primary and secondary care, OSEL will become a secure and strong health economy, with health services and local communities looking ahead and working together to shape services to meet future needs.

2.6 Hospital provision: clinical drivers for change

The APOH Provider Forum commissioned the four Medical Directors to lead work streams to assess the extent of the issues for priority services, identify the case for change and propose immediate solutions that will secure safe, quality provision now, as well as a sound platform for future developments.

The major groupings of priority hospital services described in this case for change are:

- Maternity, newborn and seriously ill children’s services
- Urgent and emergency care: medicine, older people and surgery
- Critical care
- Elective surgery

Work on redesigning services has spanned a number of sub specialties within the major groupings. Not all this work is described in the PCBC, as the focus here is on the major priority areas. It should be acknowledged though, that considerable work has and continues to take place across the board for all clinical specialties and sub specialties. Outputs from this work will be made available on the APOH website.

Clinical Support Services

In particular, the work of the clinical support services work stream should be mentioned here. A number of clinical support services have considered how they might best support the redesign of hospital services, with their own redesign. The configuration of these services will be dependent on service model and site specific options:

Pathology

Each hospital currently has a pathology department and there is duplication across the four sites. The pathology group has considered a range of redesign options for pathology, looking at rationalising the services across OSEL to ensure a critical mass/the best use of clinical resources, efficiency and value for money. This work is going forward under the hospital efficiency study, which is part of the Financially Challenged Trusts process.
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Pharmacy

As with pathology services, there is a level of duplication of pharmacy services across the four hospitals. The pharmacy group has worked on procurement efficiencies and external contracting benefits.

Radiology

The radiology group has examined a redesign option that would achieve a 24/7 service, as well as procurement efficiencies and external contracting benefits.

Therapies

The therapies group has looked at which specialist skills and services could be shared across sites to ensure a more comprehensive service across the sector.
2.6.1 Maternity

Case for change

The pregnant woman and her baby must be the central focus of maternity services, which should be designed to provide safe, high quality, accessible, appropriate, woman-friendly and empathetic services. For most women pregnancy is a normal physiological event and so unnecessary medicalisation should be avoided, and normality encouraged. However, for those women and babies who develop medical problems or complications there must be seamless access to high quality medical care. Women should be offered real choice in patterns of antenatal, intrapartum and postnatal care, and place of birth.

The roles of midwives and obstetricians are distinct but complementary. Midwives are the experts in normal pregnancy, normal delivery and normal postnatal care, and should be ‘champions of normality’. When pregnant women (without medical problems or complications) are cared for by midwives, their prospects for an entirely normal birth are maximised and the risk of intervention minimised. Obstetricians are doctors who have specialised in the care of women who have medical problems or complications in pregnancy, delivery or after delivery. Complicated pregnancies carry high risk and require highly skilled and experienced obstetric consultants to provide the highest quality care and to achieve the best outcomes. Such obstetric units must work hand in hand with high quality neonatal units led by consultant paediatricians.

Fertility rates in two of the OSEL boroughs (Greenwich and Lewisham) are some of the highest in England, and there is increasing pressure on women’s and maternity services. At QEH there has been a 40% increase in births since 2000, and 10-11 babies are born there every day. There is also a high level of complications in birth in SEL. Estimates suggest that circa 40% of the pregnant women might experience medical complications which require a specialist consultant led unit at the point of labour.

In order to develop midwifery practice and promote normality the OSEL obstetricians and midwives have recommended that: there should be increased provision of (predominantly) midwifery led antenatal and postnatal care in the community; there should be sufficient midwifery staffing and structure to support homebirth for those mothers who choose this option; and, there should be midwifery led birthing units (MLBUs). There has been local professional debate as to whether such MLBUs should be situated on the same site as and directly adjacent to an obstetric unit (co-located), or another site without obstetric, anaesthetic or neonatal services (isolated or ‘stand alone’). The perceived advantages of ‘stand alone units’ are that they provide a more woman friendly and less medicalised atmosphere, and that they are more effective in promoting normality. However, if complications requiring medical intervention occur (and this might be as simple as a request for an epidural) the mother will need to be transferred by ambulance to the obstetric unit on another site. Rates of transfer in

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labour from such units in the UK range from 12% to 25%.\textsuperscript{12} In a co-located unit transfer in labour would be simple and rapid, and with strong midwifery leadership and management it should be possible to create a woman-friendly environment. The balance of professional opinion amongst midwives, obstetricians and local GP’s is in favour of co-located MLBUs.

There is a growing body of circumstantial evidence from varied sources indicating that if more care were to be delivered directly by fully trained consultant obstetricians, outcomes for women and their babies would be improved, meaning less maternal morbidity, less fetal morbidity, and reduced fetal death rates. The evidence for this view is well summarised in ‘The future role of the consultant’\textsuperscript{13} and ‘Safer Childbirth’\textsuperscript{14}.

There is also increasing concern that the junior doctors in training who provide the resident ‘onsite’ medical cover to the maternity units, are progressively less experienced and skilled than they have been in the recent past. This is a direct consequence of changes in the culture and organisation of medical training (Modernising Medical Careers), and a progressive reduction in the hours which junior doctors work (the ‘New Deal’ on junior doctors hours and the EWTD. The result is that the resident obstetrician of 2007 may well have less than half the experience of his or her predecessors.

As a consequence of the above, several professional bodies have strongly recommended that there needs to be a progressive increase in the number of hours per week of ‘consultant presence’ on labour wards. The Royal College of Obstetricians and Gynaecologists (RCOG) in 2005 recommended that the goal should be consultant presence for 24 hours every day (168 hours per week), and set out a staged timetable for achieving this\textsuperscript{15}. Local clinicians believe that the third stage, of 98 hours per week, is a sensible goal in the medium term.

At present, the maternity units in OSEL have approximately 28 consultants in total, and struggle to achieve 40 (out of 168) hours of consultant labour ward presence per week. Taking into account the need to cover the gynaecology service in addition to obstetric care, local workforce calculations estimate that as a minimum an additional 25 consultants would be required to provide 98 hours per week of consultant labour ward presence across four obstetric units, 18 additional consultants across three units, and 10 across two units (assuming consultants work 10 programmed activities per week).

A majority of the consultants across the OSEL sector recommend reconfiguring to fewer and ideally two obstetric units. This would allow for the desired provision of increased ‘consultant presence’ whilst minimising the requirement for an increase in consultant numbers. Such a change would in a similar manner facilitate increased quality of care in obstetric anaesthesia and neonatal care. Such a larger critical mass would offer improved conditions for teaching, training, governance, and research.

There may be concerns that such units would be too big, but this model works well at St Thomas’ Hospital, London where delivery numbers are approaching 6500, and also at the

\textsuperscript{12} NICE, Intrapartum Care: care of health women and their babies during childbirth, 2007.
\textsuperscript{14} RCOG, RCM, RCA, RCPCH, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, Appendix 5, 2007, pp.69-73.
Liverpool Women’s Hospital with 8000 births per year. The success of these units is dependent upon having sufficient resource to achieve adequate staffing levels and physical capacity. Two obstetric units would allow ‘doubling up’ of junior doctor rotas on each site (two registrars and two senior house officers on duty at all times). Clear guidance on staffing is provided in ‘Safer Childbirth’\textsuperscript{16}.

\begin{itemize}
  \item **Vision for maternity services in OSEL**

  In response to the case for change, midwives, obstetricians and commissioners are agreed that the vision for birth and maternity services in OSEL should fulfil the ambitions of the \textit{Maternity National Service Framework (2004)} and \textit{Maternity Matters}\textsuperscript{17}, ensuring that\textsuperscript{18}:

  \begin{itemize}
    \item There are flexible individualised services designed to fit around the woman and her baby’s journey through pregnancy and motherhood, with emphasis on the needs of vulnerable and disadvantaged women.
    \item Women are supported and encouraged to have as normal a pregnancy and birth as possible, with medical interventions recommended to them only if they are of benefit to the woman or her baby.
    \item Midwifery and obstetric care is based on providing good clinical and psychological outcomes for the woman and her baby, while putting equal emphasis on helping new parents prepare for parenthood.
  \end{itemize}

  There exists a wide consensus amongst the public, midwives and obstetricians that in order to promote normality and reduce inequality of outcome maternity services should be easier to access, should be delivered closer to people’s homes, and offer choice in antenatal care, place of delivery and postnatal care\textsuperscript{19,20,21}.

  Women should be able to arrange their maternity care through their GP or directly with a midwife. The majority of antenatal care should be delivered by midwives in community settings, with obstetric antenatal care and maternity ultrasound available in a smaller number of community health centres, with access to specialist hospital services where necessary. Obstetricians and midwives in OSEL advocate promotion of home birth for low risk women and the development of ‘co-located’ Midwifery Led Birthing Units (adjacent to obstetric units), which both increase the probability of normal birth and decrease intervention rates\textsuperscript{22}. Such community and autonomous midwifery practice should exist as an integral part of a local

\textsuperscript{17} Department of Health, \textit{Maternity Matters: Choice, access and continuity of care in a safe service}, 2007.
\textsuperscript{18} South East London NHS PCTs, \textit{Commissioning Intentions}, 2007
\textsuperscript{19} Department of Health, ‘Our Health, our care, our say’, 2006.
\textsuperscript{22} NICE, \textit{Intrapartum Care: care of health women and their babies during childbirth}, 2007.
maternity network with a unified governance structure, such that all professionals act together in the best interests of women, their babies and families\textsuperscript{23}.

The overriding concern must be to improve outcomes. Larger, more specialist units should be created in OSEL, and the obstetricians have recommended that the service be reconfigured into fewer and ideally two obstetric units. This will ensure 98 hour ‘consultant presence’, including weekends (08.00 – 22.00 7 days per week), which would improve quality and safety of medical care for women in labour. There will be greater ability to provide specialist support to women, such as increased access to perinatal psychiatry services, given that suicide is a leading cause of maternal death. Continuity of care will be improved and midwifery staffing levels for women in labour improved. Reconfiguration into two obstetric units would allow the reconfiguration of neonatal services into two units resulting in better care of sick new born babies (see next section). In addition, with the consolidation of services, there should be more scope financially and in terms of the capacity of midwives, to extend choice for women and provide midwifery-led units.

\begin{itemize}
\item **The benefits**
\end{itemize}

*For patients*

- Safer obstetric services: normalisation of childbirth for low risk women; enhanced medical care (consultant obstetrician, consultant anaesthetist, consultant paediatrician) for high risk women and their babies.
- Improved access for ante natal and post natal care: provision of midwifery led services from an increased number of locations in the community.
- Increased choice: midwife or obstetrician antenatal care; homebirth, midwifery led birthing unit or consultant led delivery unit.

*For staff*

- Enhanced senior medical support for junior staff.
- Better training.
- Higher standards.
- Sub specialisation.
- Increased variety/rotation.
- Increased job satisfaction.

\textsuperscript{23} RCOG, RCM, RCA, RCPCH, *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*, 2007
2.6.2 Newborn and seriously ill children’s services

- Case for change: newborn children

The main issue for neonatal units is staffing. There is a national shortage of neonatal nurses, and in three out of four units in OSEL consultant medical staffing is also stretched with consultants covering inpatient paediatrics, accident and emergency (A&E) and the neonatal unit simultaneously. Already difficult junior medical rotas will be further threatened by full implementation of EWTD next year (2008), with a significant risk that staffing rotas will become unsustainable. The strains in the current configuration are illustrated by the fact that currently 30% of newborns requiring high dependency and intensive care are transferred out of the sector, sometimes to units many miles away. This is often because of a lack of capacity in the central most highly intensive and specialist neonatal units in south east London, where the sickest babies are transferred to from OSEL. This is neither clinically safe nor appropriate. The OSEL paediatricians have said that concentrating resources in fewer neonatal units with more expertise and equipment will enable them to meet the neonatal network target of caring for 95% of newborns locally. The UK neonatal staffing study has identified poorer outcomes when staffing is inadequate, and also suggested that larger neonatal units appear to introduce new technologies, such as surfactant, sooner. In the US there is clear evidence that outcomes for babies are better in larger units. Although this is a useful study, it should be noted that there are differences between the US and UK healthcare systems and populations.

Bearing the above issues in mind, there is a clear consensus of opinion from the paediatric consultants, neonatal nurses and paediatric nurses in the sector, that there should be separate dedicated consultant medical, junior medical and nursing staffing rotas for neonatal units, and that this would improve quality of care and probably outcomes. At present only UHL has separate and dedicated neonatal and paediatric rotas. The paediatric consultants are again very clear in their advice that the best way to achieve this is through reconfiguration to fewer but larger neonatal units. To move to separate rotas with the existing four neonatal units would require a significant expansion of consultant numbers, and the size of each unit would not be sufficient to optimise patient outcomes and productivity. A change to fewer but larger neonatal units would not require a significant increase in consultant numbers, and would result in a sufficient critical mass to optimise staffing, training, governance and outcomes. Such larger units should work within the local neonatal network with each other and also with a tertiary centre in central London which would provide the most complex care. Such integrated working would be dependent on good IT links, but should result in fewer transfers.

- Case for change: seriously ill children

Over recent years introduction of ‘Hospital at Home’ and a move towards treatment in non-inpatient settings wherever possible, combined with a reduction in prevalence of common

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24 Information supplied by South East Thames Neonatal Network.
infectious illnesses has resulted in a decline in numbers of children admitted to hospital and reduced lengths of stay. For example, hospital admission rates for childhood asthma have halved between 1990 and 2000; diabetic home care can reduce bed days by 75%; and children with cystic fibrosis receive antibiotics at home.

The local experience at QMS is that median length of stay on the paediatric ward is now just over one night, and across the sector the inpatient bed base for medical paediatrics has shrunk to only 16 to 18 beds on each site. The growth in paediatrics has been in outpatient services, and rapid access services, such as the very successful paediatric oncology shared care unit, which allows children with cancer to be treated locally in partnership with the tertiary centre without the need for admission.

The opinion of the local clinical staff is that these trends will continue and that to maintain an adequate critical mass for safe patient care, teaching and training, inpatient paediatric beds should be consolidated onto fewer sites. Simultaneously there should be development of consultant led ambulatory care on the other sites to maintain access to expert paediatric services. Ambulatory care would include a full range of outpatient services, a day hospital, and an emergency service which should be available seven days per week. The majority of children currently attending A&E departments are not seriously ill and could be safely managed by experienced staff in such a setting.

Twenty five percent of attendees at A&E departments are children, and there are clear standards for children’s services within A&E departments, focused around separate children’s facilities and dedicated staffing\(^\text{27}\). All these will be easier to achieve with a reconfigured service.

Currently there exists a high quality regional paediatric surgery unit at UHL. There are strong arguments in favour of relocating the more specialised elements of this service to a tertiary centre such as the Evelina Children’s Hospital at Guy’s and St Thomas’ Foundation NHS Trust.

There is a strong consensus amongst local clinicians that sustainable paediatric services can be delivered to a higher standard by consolidating inpatient units and neonatal units onto fewer and ideally two (acute) hospital sites, whilst extending provision of ambulatory care on the other two sites and in the community. It is imperative, however, that such units are financed to achieve recommended staffing levels.

\* Vision for newborn and seriously ill children’s services in OSEL

The vision for neonatal and seriously ill children’s services is to provide two principal acute inpatient units comprising:

- Dedicated paediatric emergency department.
- Inpatient unit.
  - In patient beds.
  - High dependency unity (HDU) beds.

\(^{27}\) RCPCH, Services for Children in Emergency Departments, 2007.
- Adolescent area.
- Level 2 neonatal unit (NNU).
- Outpatient services.
- Paediatric shared care oncology unit.
- Diagnostics.

Note: separate staffing rotas for neonatal unit and inpatient/emergency service.

Plus, paediatric ambulatory centres (PAC), on the two other hospital sites in OSEL comprising:

- Day assessment unit.
  - Urgent assessment of children.
  - Planned medical care, e.g. chemotherapy, food challenges.
  - Planned investigations.
  - Advice centre – telephone, email etc.
- Out-patient services.
- Diagnostics, phlebotomy, therapies, audiology, dietetics.
- Child development centre, where there is not already existing provision.

Supported by community children’s nursing teams:
- Outreach outpatient clinics.
- Closer working with primary care.
- Transitional care teams.
- Closer links with other children’s services.

**The benefits**

*For children and their families*

- There will be child friendly services, where children will be seen in the right setting, at the right time, by staff with the appropriate level of skills.
- Higher standards of care delivered by neonatal units, paediatric inpatient units and emergency departments.
- Children will benefit from a more flexible, streamlined service that will aim to deliver care closer to home.
- The service will aim to avoid admission wherever possible, and support the family with prompt discharge and continuing care at home.
- The overall aim will be to continually improve the health of children and reduce the number of times and the actual time they have to spend in hospital.

*For staff*

- More robust combined workforce.
- Increased opportunities for learning, e.g. sharing good practice, access to a wider range of learning.
- New career opportunities, e.g. extended roles for nurses and midwives.
- Increased job satisfaction, e.g. exposure to more clinical problems, able to provide continuing care.
2.6.3 Urgent and emergency care

- Case for change

A&E

Surveys of OSEL hospitals have found that between 40-60% of people who attend the A&E departments do not require these services\(^{28}\). Hospital and community clinicians in OSEL have advised that these people could be cared for equally well and more promptly in other, community based settings.

The OSEL hospitals have inadequate numbers of consultants, experienced doctors and nurses to cover four major A&E departments, when treating life threatening conditions. The Royal College of Surgeons’ guidance on the minimum catchment size for a safe major A&E, offering consultant–led assessment and treatment and access to a range of specialist interventions, is a population of 300,000, with a strong recommendation that major A&E services serve a population of 450,000\(^{29}\)\(^{30}\). With a population of just under a million this means maintaining the current four A&E departments in OSEL is not sustainable for reasons of future safety and quality.

Acute medicine

Moreover, providing 24 hour cover in OSEL on a daily basis for emergency on-call opinion in some areas of medical specialisation is not possible as there are not sufficient numbers of acute physicians. The OSEL hospitals rarely achieve more than three consultants per hospital in any particular area of medical specialisation, and the physicians indicate that the average is nearer two consultants per hospital. In a similar way the lack of on-call 24-hour a day consultant opinion in all medical specialities is seen as exerting an important limiting effect on the quality of the services currently available. The consensus of opinion amongst OSEL physicians is that there should be daily, on site consultant opinion available for the range of medical disciplines that are required for an acute admitting service. In common with the other specialities described in this case for change the impact of EWTD will also result in increasing difficulties in providing 24/7 medical cover, both at a junior and senior level with the present configuration of hospitals.

Clinicians have also recommended that larger teams of eight to twelve specialists working across the four hospitals in sub specialities would allow for a degree of sub-specialisation within these disciplines, which will become increasingly important in providing high-quality services given the constant expansion of scientific knowledge and medical technology.


Care of older people

Clinicians in OSEL have identified that many older people who attend A&E departments do not require admission. They advise that there is a group of older patients with acute medical problems who will need to come to an A&E and will need an acute admission, followed by post acute care in a variety of settings. However, there is also another group of patients with less acute illnesses, who will not require admission. Instead, the consensus of clinical opinion in OSEL is that these patients should receive an urgent, multidisciplinary and holistic assessment with access to immediate investigations, so that a prompt diagnosis can be made for the healthcare professionals in the community to carry out ongoing treatments. A&E is a suboptimal environment for such assessments, which do require senior geriatric input.

The impact of EWTD and MMC also causes difficulty in the provision of adequate junior and senior medical cover for prompt emergency and out of hours medical services for older people. With a rising aging population and government and national guidelines on treatments in primary and secondary care, this means that new ways of working must be developed in hospitals and primary care to ensure that safe, prompt and modern medical treatments are available to older people round the clock, 24/7.

Emergency general and trauma & orthopaedics surgery

Currently emergency and elective surgery is not separated in OSEL, with shared rotas in place. This way of organising surgery is not ideal, although standard in many district general hospitals. It has implications for:

- Lack of availability of senior surgical expertise in emergency situations.
- Potential cancellations of elective operations as clinicians are called away to emergencies.
- Potential for increased risk of infection from mixing elective and emergency patients in the same wards. There are infection control frameworks that are being rigorously enforced across the OSEL hospitals and PCTs, and are under continual development. However, not all emergency patients can be screened and treated in advance for pre-existing infections in the same way as patients admitted from the emergency assessment units, nursing home and elective patients.
- Increased lengths of stay, if patients do acquire infections.

From December 2008 hospitals must meet the government target of achieving no more than 18 week waits for referral to treatment, and although OSEL is on track to meet the target, combined emergency and elective rotas frustrate the ability to reach and sustain the target.
Vision for urgent and emergency care in OSEL

A&E and urgent care

Providing alternatives to A&E, such as urgent care services offers patients access to GPs, specialist nurses and allied health professionals who can best treat them. This is particularly pertinent for people with long term conditions. OSEL is developing its urgent care services in line with the recommendations of two key national policy documents issued by the Department of Health in 2006, Direction of Travel for Urgent Care: a discussion document and Emergency Access: a clinical case for change.

Clinicians and commissioners are designing more differentiated types of emergency services at, and potentially between, acute hospitals to ensure that patients get care based on best practice for their particular condition and needs. The clinical consensus is that patients with primary care needs who present to a hospital A&E will receive a standard of assessment that is in line with best primary care practice. Clinicians in OSEL have advised that each of the four hospitals will have an urgent care centre (UCC), irrespective of whether the hospital takes acute admissions. The UCCs will be part of an urgent care network and care will be provided by emergency nurse practitioners supported both by A&E doctors, where possible, and out of hours GP services. This element of service will be fully integrated with local primary and community care networks. Commissioners are also keen to explore the potential to integrate this element of service with GP out of hours services and potentially also services provided through Local Authority arrangements e.g. community alarms, tele health care. To support these changes emergency transport services will be developed that can offer ‘hospital on the move’ support to patients.

The mental health service professionals in OSEL have confirmed that both A&E services and urgent care centres can be redesigned in ways that ensure pathways of care for mental health service users with physical problems are safe and accessible. They will also ensure continuing access to mental health beds where required. There will be close links to crisis and home treatment services so that people can receive intensive support in the community as an alternative to admission.

Clinicians and commissioners are also developing new primary and community based services for specific groups of patients who frequently access local A&E departments, but whose needs are not best met in this setting. These include: the provision of support for parents to enable them to self care for minor illness in their children and the provision of services for people (including young people) who have alcohol problems that currently lead to frequent attendances in A&E departments.

Community clinicians have recommended that there should also be alternate care pathways that offer direct patient management through skilled practitioners (paramedics, nurses, enhanced practitioners) on first contact within patients’ homes. These pathways will be based on integrated working between emergency transport services and primary/community care e.g. falls, community matrons, GP practices, social care, intermediate care etc. This should help avoid unnecessary journeys to an A&E department.
Acute medicine

It is the consensus of clinical opinion that OSEL needs fewer but more specialist emergency and acute medicine (including A&E) services, where patients have better access to consultant opinion, enhanced nurse practitioners and specialist interventions. Better clinical outcomes could be achieved by creating larger clinical teams, treating greater numbers of patients. This would also enable the hospitals to staff rotas in line with EWTD requirements.

Care for older people

The most acutely ill group of older patients, who require emergency medical care, will continue to access A&E and will be admitted to an acute medical unit (AMU), as described in the recent Acute Medicine Taskforce Report (October 2007)\(^\text{31}\). A subgroup of these patients may need to be diverted to a regional/tertiary centre for more specialist treatments e.g. thrombolysis for stroke. Following the initial management and stabilisation on an AMU, older people requiring further inpatient care could be transferred to a specialist geriatric bed base or some other community facility appropriate for their needs.

Clinicians have recommended that other older people with less acute medical illness should receive a rapid same day assessment and diagnosis before discharge back to the community, with same day communications regarding continuing community treatment. Such patients may have an exacerbation of their chronic disease or may present with the symptoms known as the ‘geriatric giants’ i.e. falls, confusion, immobility and incontinence needing a diagnosis. Clinical opinion locally proposes that a medical assessment service (MAS) for older people will fulfil this function and should be sited in each of the four hospitals open seven days a week, providing a less acute alternative day medical assessment and treatment for older people, avoiding unnecessary admission. There would be the opportunity for daily urgent stroke assessment clinics, falls clinics etc. Rehabilitation services could also be enhanced and become more specialist, including hip fracture care (physician led), stroke rehabilitation and intermediate care provision. A larger, multidisciplinary team will consist of four to six elderly care specialists with junior doctors, nurses and other multidisciplinary staff with good links to the rest of the health and social care systems in the community. GPs and multi-professionals can also phone the MAS for senior advice preventing unnecessary hospital visits by the patient. Excellent information technology is important so that patient information and communications can be shared the same day with General Practitioners and other community healthcare professionals, who will provide ongoing care in or near the older patient’s home.

Emergency general and trauma & orthopaedics surgery

The OSEL surgeons have recommended that emergency and non complex elective surgery should be undertaken separately, with where possible non complex elective activity taking place in elective treatment centres. Senior surgeons can then be dedicated to emergency surgery and readily available. The case for change, vision and benefits for elective surgery are described below in the general surgery section.

The OSEL trauma and orthopaedic (T&O) surgeons and nursing staff have also recommended that emergency and non complex elective surgery should be undertaken separately, with where possible non complex elective activity taking place in a T&O elective treatment centre(s). There is a specific infection control issue relating to joint surgery and an absolute need to prevent infection in patients who have undergone this type of surgery.

**Benefits**

*For patients*

- With further development of local urgent care services more people can be seen nearer their homes or workplaces and more quickly than at A&Es.
- Better support for people with long term conditions or mental health conditions in relapse or crisis, enabling them to stay at home.
- Access to information and self care support.
- Increased access to consultant-led and specialist opinion in A&E, when seriously ill.
- High quality emergency care delivered by dedicated emergency surgery team with rapid access to diagnostics and theatres.
- Improved outcomes through better organisation of trauma services (daily trauma list, consultant led service, more experience).

*For staff*

- More appropriate use of specialist skills in A&E departments.
- Extended roles and opportunities to develop new skills for community and hospital staff.
- Improved ability to offer continuity of care, especially to people with long term conditions through more provision of services at home and in the community.
- Concentration of expertise to fewer sites would enable a critical mass to deal with ever more complex cases.
- Increased consultant cover for acute specialties with workable cross site rotas.
- Enhanced junior supervision and senior decision making.
- Compliance with EWTD.
2.6.4 Critical care

- **Case for change**

The Intensive Care Society (ICS) has set out standards in ‘Standards for consultant staffing of ICUs’ that should be met by 2008/09\(^2\). The aim for critical care in OSEL is that it will fulfil the standards within the ICS timeframe. This includes:

- All units must have a minimum of 15 programmed activities (Pas) of consultant time totally committed to intensive care management each week, per eight Level 3 beds (the highest level of intensity, patients requiring intubation).
- There must be twenty-four hour cover of the ICU by a named consultant with appropriate experience and competences.
- Consultants should not have any other clinical commitment when covering the ICU during daytime hours.
- During working hours the consultant in charge of the ICU should spend the majority of his or her time on the ICU and must always be immediately available on the ICU.
- All consultants providing an ‘on-call’ service to the ICU must have Pas committed to intensive care management.
- A consultant in intensive care must see all admissions to the ICU within twelve hours.

ICUs that do not have these arrangements by the end of 2008 will have recognition for training withdrawn. This has implications for QMS, as it will lose its accreditation as it does not have sufficient consultants. BHT, QEH and UHL meet the standard. ICU is core to the acute service provision. Any ICU that does not meet the standards cannot be providing a first-rate, safe, best quality modern practice. Withdrawal of training will result in failure to attract brightest and best trainees, with a view to future recruitment. Any reduction in the quality of this ‘regenerative’ service provision will lead to a lowering of quality and range in those acute services which depend on the ICU e.g. T&O, acute surgery, and acute medicine.

OSEL has four intensive care units (ICU) providing 25 Level 2 beds and 16 Level 3 beds. (Level 3 is the highest level of acuity for intensive care, where patients often require intubation). The majority of the beds for both levels are in the two northern hospitals (QEH and UHL) with 16 Level 2 beds and 12 Level 3 beds. In contrast, in the southern hospitals (BHT and QMS) there are 16 beds in total, of which a maximum of 12 can be used for Level 3 patients. This dispersal of beds across four sites, meaning some have a small number of beds, has implications for safety and quality.

The intensive care consultants in OSEL have advised the number of beds in OSEL is broadly appropriate, but they are not in the optimal configuration. As there are fewer beds in the south of the sector, some patients have to be transferred; and there is a level of inter-hospital transfer that is less than optimal, as transferring critically ill patients increases the risk of compromising outcomes. For example, the critical care consultants have indicated that this year QMS is on average transferring two patients a month.

OSEL’s ability to reach the required standards is further limited by the impact of EWTD on working patterns. All A&E departments admitting patients with life threatening conditions should be supported by a Level 3 ICU. Other services requiring the support of Level 2 and/or 3 ICU include: renal, obstetrics, complex elective surgery, and oncology (where there are pathway complications).

In addition to the above issues, evidence shows that bigger ICUs have better outcomes than smaller ones, and this then is a particular concern for BHT and QMS. In a recent large US study, ICUs were ranked according to how many ventilated patients they cared for in a year. Patients ventilated in ICUs in the top quartile (greater than 400 patients ventilated/year) had a 37% reduction in their chances of dying compared to patients ventilated in ICUs in the lowest quartile (less than 150 ventilated patients/year). The conclusion was that larger ICUs allow a concentration of expertise and are better able to apply evidence-based best practice. Further, ICUs that have a high intensity of ICU Consultant input (i.e. every patient has 24-hour access to a trained ICU Consultant) have a lower mortality than ICUs which do not have 24 hour access. In one large study patients in high intensity ICUs had a reduction in ICU mortality of 40%, a reduction in hospital mortality of 30% and a shorter length of stay compared to patients in low intensity ICUs. It should be noted that there is a range of opinion in OSEL about the applicability of this study in the UK setting.

- The vision for critical care in OSEL

The consensus of clinical opinion is that OSEL should provide Level 2 ICU services at all four hospitals, but requires fewer ICUs with the most intense level of critical care, Level 3. The Level 3 units should be optimally staffed and sized, to provide 3 care. A&E departments admitting patients with life threatening conditions will be supported by Level 3 and Level 2 critical care units. This will be underpinned by a critical care network that encompasses all sites. The network will provide a critical care outreach service to assess and support care for Level 1 patients, as well as facilitating inter-hospital transfer of patients to Level 2 or 3 units where necessary.

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2.6.5 General surgery

- Case for change

The OSEL surgeons and nurses have identified that critical mass, volume and case mix are at the centre of the case for change in general surgery. With increasing specialisation and guidelines setting standards for minimum volumes of case load, it is becoming increasingly difficult for all four hospitals in OSEL to provide the range of surgical expertise required or to see the volume and richness of case mix to enable surgeons to maintain their specialist skills. EWDT impacts on this situation, in the same way as described for other specialties in this case for change. Moreover, patients have expectations of consultant-led care.

As described in the urgent and emergency care section above, from December 2008 hospitals must meet the government target of achieving no more than 18 week waits for referral to treatment, and although OSEL is on track to meet the target, combined emergency and elective rotas frustrate the ability to reach and sustain the target.

- Vision for general surgery in OSEL

The aim is to improve outcomes by consolidating across the four hospitals to create larger teams, offering the opportunities for greater specialisation and also increased multi-disciplinary working. The surgeons have recommended that ideally there should be two elective inpatient units.
The OSEL surgeons have recommended that emergency and non complex elective surgery should be undertaken separately, and where possible, non complex elective activity taking place in elective treatment centres. There are clinical benefits to this approach 35. Clinical outcomes should be better both for emergency surgery and elective care. At elective only centres there would be greater capacity for non complex elective surgery to take place uninterrupted by emergences, meaning patients are more likely to be treated by a specialist/consultant.

Local people have said consistently that one of their top priorities for change in the NHS in OSEL is the reduction of hospital-acquired infections. With a separation of activity, there should be reduced hospital acquired infection rates, particularly for patients requiring non-complex elective surgery as elective treatment centres should be much less vulnerable environments. This is because risk is reduced as elective and emergency patients are not sharing the same wards, and elective patients can be screened and treated in advance for any infections.

Efficiency of services should also be improved by a separation of activity. In elective treatment centres, where theatre lists do not include complex elective or emergency work more non complex elective patients can be seen on each list. This means shorter waiting lists, addressing another important concern of local people. Cancellations are also reduced as the risk is eliminated of lists being affected by operations on complex or emergency patients who develop complications or take longer than scheduled. There is also an enhanced ability to support admission on the day of planned surgery through streamlined admission pathways.

Traditionally surgery was followed by an inpatient stay in hospital. Increasingly with new, less invasive surgical techniques this work can be done as a day case or with a short stay. The OSEL surgeons have recommended that by expanding the provision of 23 hour units many more patients can be scheduled for a short stay, reducing the pressure on in-patient beds substantially.

In addition, the OSEL surgical nurses have recommended that there should be an expansion of existing nurse led outreach services, where early discharge is supported with patients being discharged with drains in situ and being cared for within their own home. Opportunities include the ability to provide multi-professional teams providing physiotherapy and pharmacy support in the home.

Some patients will still require complex and lengthy planned surgery, and will require the full back up of Level 3 intensive care. These patients should have their operations at the emergency centres where all the necessary back up is available.

35 Consensus statement Association of Surgeons Great Britain and Ireland.
2.6.6 Trauma and orthopaedics

- Case for change

Demographics are a key concern for the trauma and orthopaedics (T&O) case for change. The population is aging, and already almost one fifth of the local population in the southern boroughs is over the age of 65. There is a need for increased investment particularly in treating fractured neck of femur, providing dedicated wards for these patients. OSEL is already struggling to afford to provide a full, quality service across four small T&O services.

Evidence demonstrates that with specialist nurse orthopaedic practitioners, specialist allied health professional support i.e. physiotherapy, occupational therapy and a robust orthogeriatric model of care outcomes are improved, and length of stay reduced\(^{36}\).

Clinical evidence shows that providing services in larger centres with appropriate ICU/HDU support can improve survival rates.

Changes in clinical practice are having an impact. There is a higher volume of day surgery, requiring fewer inpatient beds. Working patterns have also changed in response, with the work being more intense but less frequent. T&O will also be impacted by EWTD, which will reduce training time.

At present, because each of the four T&O departments is relatively small, there is limited ability to sub specialise and patients have to go out of sector sometimes as comprehensive, round the clock expertise cannot be offered.

Services for patients following trauma, and care for those needing orthopaedic investigation and surgery, are provided by the same group of consultants and their teams. The OSEL T&O

surgical staff have recommended that in future there should be enough surgeons concentrated on each emergency site to ensure that specialist/consultant opinion is more widely available following traumatic injury, with dedicated rotas. This should improve the quality of care for example for older people with hip fractures. As with general surgery more can be done as a day or 23 hour case reducing the hospital stay for patients, cutting the risk of hospital acquired infection or cancellation. In some places, even patients needing hip replacements are able to go home after just one day in hospital. However, where the planned surgery is particularly complex and patients require Level 3 intensive care afterwards, this should be done on the emergency site with full back up readily available.

- **The vision for trauma and orthopaedics in OSEL**

In line with general surgery, the goal for T&O is to improve outcomes by consolidating across the four hospitals to create larger teams, offering the opportunities for greater specialisation and also increased multi-disciplinary working. The T&O surgeons have recommended that ideally there would be two elective orthopaedic units.

The clinical consensus is that there should be an increased ability to support dedicated wards for people with fractured neck of femur with the provision of specialist nursing and allied health professional (AHP) skills as outlined above. This will be linked with acute medicine services and the provision of ortho-geriatric models of care for this cohort of patients.

- **The benefits**

  **For patients**
  - High quality local care with specialist units such as physician-led hip fracture units, supported by care of the elderly teams.
  - Less time in hospital.
  - Super-specialisation available locally.
  - Access to rapid elective surgery.
  - Access to Consultant-led opinion.
  - Access to specialist nursing and AHP staff.
  - Early discharge supported by specialist nursing teams.
  - Fewer cancellations.
  - Opportunities for a critical mass in sub-specialties.
  - Reductions in hospital acquired infection, as part of wider infection control initiatives.

  **For staff/sector**
  - Better organisation of trauma (daily trauma list, Consultant led service, more experience).
  - Improved productivity, increased throughput and less cancellations.
  - Trainees will get more intensive experience.
  - EWTD compliance.
  - Ability to further expand skills for Nursing and AHP staff.
  - Nursing/support staff better organised, with more manageable hours.
  - Reduced hospital stay and reduced inpatients beds.
  - Better work-life balance in larger units.
  - Repatriation of work from out of sector for sub-specialties.
2.7 **External assessment of the case for change and clinical vision: Professor Sir George Alberti’s findings**

Professor Sir George Alberti and the National Clinical Advisory team (NCAT) team reviewed the APOH clinical case for change in October 2007. The full findings of this review were published on 5 December 2007, see [www.apictureofhealth.nhs.uk](http://www.apictureofhealth.nhs.uk).

2.8 **Economic case for change**

2.8.1 **Links between the clinical case for change and the economic case**

The earlier part of this chapter has set out the issues supporting the clinical case for change. These clinical issues impact directly on the current economic position of the local health economy and, as a consequence, there is recognition that the clinical case for change has a correlation with the financial case for change. As has been emphasised even the provision of additional financial resources at all of the existing four hospitals would not address many of the issues highlighted in delivering clinical improvements.

The following clinical issues – highlighted earlier - have particular financial consequences for the hospitals:

- Development of health care as close to a patient’s home as possible, with patients attending hospital only when that is the place which has the appropriate expertise and facilities to meet patients needs, impacting on the income received by acute hospitals.

- The implementation of new national guidance on clinical quality and safety, across a range of services, requires increased consultant cover, which is facilitated with the creation of larger groupings of patients and range of complexity of caseload both in terms of clinical effectiveness, but also for greater cost efficiency in its implementation.

- *Modernising Medical Careers* is more effectively achieved with larger groupings of patients which contributes to the delivery of the MMC agenda, which would otherwise add more significantly to costs.

- Increasing evidence is showing that many of those attending hospital for urgent and emergency treatment do not require hospital based services and could be more effectively treated in the community closer to the patients home, which leads to resources going to the community rather than hospitals\(^37\).

- Developments in trauma and orthopaedics are beneficially provided in larger centres, impacting on those hospitals acting as the centres, but offset by those no longer providing those services.

- Clinical support services are more effectively provided in larger units.

Patients benefit when health services are delivered in modern buildings rather than out-of-date facilities.

Without reconfiguration of service provision across the four hospitals and developments in out of hospital services, the implementation of these beneficial clinical changes will continue to place further pressure on the financial position of the local health economy for OSEL.

NHS Trusts and PCTs are legally required to spend within their means. The majority in OSEL are currently failing to do so, and the situation is getting worse.

### 2.8.2 Current position

**Primary Care Trusts**

The biggest area of PCT expenditure is on referrals to acute hospital providers. Under the Payment by Results (PbR) rules, PCTs must pay for most acute referrals at a centrally-determined price laid down in the national tariff. Other acute referrals, particularly to providers of tertiary care, are paid for at negotiated prices where no tariff price exists. But under the ‘lead commissioner’ arrangements these prices are negotiated by the provider’s local PCT, not the patient’s PCT.

Once a patient is in bed in an acute hospital, the fixed price tariff only lasts for a certain number of days. Beyond this period the hospital attracts further payments for what are known as ‘excess bed days’ – but at a lower level of income. If for any reason the hospital does not discharge patients as quickly as possible, these excess bed days mount up, increasing income for the hospital and raising expenditure for the PCT. There is some scope for PCTs to limit these excess bed day payments, but only by agreeing suitable arrangements in advance with the providers involved.

The rapid increase in acute sector expenditure has squeezed expenditure in high-priority services such as mental health, primary and community care. If acute expenditure can be brought under control then these sectors will absorb the funding released.

In summary, although PCTs are able to show leadership and enact change with the cooperation of willing partners, the only certain controls on acute expenditure lie on the supply side.

These intrinsic difficulties have contributed to the problems that the local health economy is now facing. Bexley CT and Lewisham PCT have historically been in deficit; Lewisham PCT has turned its finances around and Bexley Care Trust is working towards this and plans to have repaid all its debt by 2010/11. All PCTs entered 2007/08 with plans to achieve financial balance. But, as the next section shows, these plans are under pressure.

**Deficits Brought Forward to 2007/08**

The OSEL health economy entered 2007/08 with significant cumulative deficits, despite numerous and sustained attempts to control expenditure in recent years and realisation of
cost improvement programmes. The following table sets out the Income and Expenditure deficits brought forward and the more significant cash debts which under current NHS rules are subject to interest and future repayment.

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<th>Acute Hospital NHS Trust / Primary Care Trust</th>
<th>Income and Expenditure Deficit Brought Forward to 2007/08 (£ million)</th>
<th>Cash Shortfall Brought Forward to 2007/08 (£ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHT (32)</td>
<td>(87)</td>
<td></td>
</tr>
<tr>
<td>QEH (40)</td>
<td>(65)</td>
<td></td>
</tr>
<tr>
<td>QMS (28)</td>
<td>(15)</td>
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</tr>
<tr>
<td>UHL (6)</td>
<td>(13)</td>
<td></td>
</tr>
<tr>
<td>Bexley CT (13)</td>
<td></td>
<td>(13)</td>
</tr>
<tr>
<td>Bromley PCT -</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Greenwich tPCT -</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Lewisham PCT -</td>
<td>(3)</td>
<td>(3)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>(122)</strong></td>
<td><strong>(196)</strong></td>
</tr>
</tbody>
</table>

Without significant changes from existing plans, these debts will grow rapidly with no opportunity to finance or repay cash borrowing:

**Carried Forward Deficits**

<table>
<thead>
<tr>
<th>Acute Hospital NHS Trusts &amp; Primary Care Trusts (£ million)</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-year net Income and Expenditure</td>
<td>(21)</td>
<td>(38)</td>
<td>(42)</td>
<td>(57)</td>
<td>(57)</td>
<td>(57)</td>
<td>(57)</td>
</tr>
<tr>
<td>Cumulative Income and Expenditure</td>
<td>(143)</td>
<td>(180)</td>
<td>(222)</td>
<td>(279)</td>
<td>(336)</td>
<td>(393)</td>
<td>(449)</td>
</tr>
<tr>
<td>In-year cash deficits</td>
<td>(21)</td>
<td>(38)</td>
<td>(42)</td>
<td>(57)</td>
<td>(57)</td>
<td>(57)</td>
<td>(57)</td>
</tr>
<tr>
<td>Cumulative cash debt</td>
<td>(218)</td>
<td>(255)</td>
<td>(297)</td>
<td>(354)</td>
<td>(411)</td>
<td>(468)</td>
<td>(525)</td>
</tr>
</tbody>
</table>

**Cross-cutting financial initiatives**

All four acute Trusts are part of the Department of Health’s Financially Challenged Trusts programme. The Department has required the development of a range of initiatives to address the significant financial issues faced by the Trusts. Working with NHS London’s Provider Agency, the Trusts have taken forward this work over the last few months to identify the cross-cutting initiatives that reduce overheads and clinical support costs.

At the same time, the four PCTs are to agree a range of cross-cutting initiatives that, as with the Trusts, are designed to reduce their overheads.

For the four Trusts, preliminary indications demonstrate recurrent savings in the range of £10 to £15 million per annum, plus separate one-off capital proceeds of £50 million in the year 2008/09. These savings are still the subject of evaluation and assessment of implementation costs.

It is important to stress that these cross-cutting initiatives are distinct from the programme of service reconfiguration described in this document. The savings identified at the most significant level are, in any case, not sufficient to address the overall deficit and, at least in the initial period, projected savings will be offset by the costs of implementation. The continuation of a deficit, even with such efficiency savings, are demonstrated in the following tables:
Carried Forward Deficits, including benefit of cross cutting initiatives at £10m p.a. commencing in year 2008/09

<table>
<thead>
<tr>
<th>Acute Hospital NHS Trusts &amp; Primary Care Trusts (£ million)</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-year net Income and Expenditure</td>
<td>(21)</td>
<td>(28)</td>
<td>(32)</td>
<td>(47)</td>
<td>(47)</td>
<td>(47)</td>
<td>(47)</td>
</tr>
<tr>
<td>Cumulative Income and Expenditure</td>
<td>(143)</td>
<td>(170)</td>
<td>(202)</td>
<td>(249)</td>
<td>(296)</td>
<td>(343)</td>
<td>(389)</td>
</tr>
<tr>
<td>In-year cash deficits</td>
<td>(21)</td>
<td>(28)</td>
<td>(32)</td>
<td>(47)</td>
<td>(47)</td>
<td>(47)</td>
<td>(47)</td>
</tr>
<tr>
<td>Cumulative cash debt</td>
<td>(218)</td>
<td>(245)</td>
<td>(277)</td>
<td>(324)</td>
<td>(371)</td>
<td>(418)</td>
<td>(465)</td>
</tr>
</tbody>
</table>

Carried Forward Deficits, including benefit of cross cutting initiatives at £15m p.a. commencing in year 2008/09

<table>
<thead>
<tr>
<th>Acute Hospital NHS Trusts &amp; Primary Care Trusts (£ million)</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-year net Income and Expenditure</td>
<td>(21)</td>
<td>(23)</td>
<td>(27)</td>
<td>(42)</td>
<td>(42)</td>
<td>(42)</td>
<td>(42)</td>
</tr>
<tr>
<td>Cumulative Income and Expenditure</td>
<td>(143)</td>
<td>(165)</td>
<td>(192)</td>
<td>(234)</td>
<td>(276)</td>
<td>(318)</td>
<td>(359)</td>
</tr>
<tr>
<td>In-year cash deficits</td>
<td>(21)</td>
<td>(23)</td>
<td>(27)</td>
<td>(42)</td>
<td>(42)</td>
<td>(42)</td>
<td>(42)</td>
</tr>
<tr>
<td>Cumulative cash debt</td>
<td>(218)</td>
<td>(240)</td>
<td>(267)</td>
<td>(309)</td>
<td>(351)</td>
<td>(393)</td>
<td>(435)</td>
</tr>
</tbody>
</table>

Note
The above figures have been rounded to the nearest £ million.

2.8.3 Possibilities for achieving financial balance

These are the possible actions that would contribute to lasting financial balance:

- **Achieving the PCTs’ plans**

Delivering their Commissioning Strategy Plans in 2007/08 will enable PCTs to achieve financial balance. This involves getting more patients treated closer to their home. As seen above, this can only be secured by reducing acute hospital capacity and thereby capping supply.

- **Reducing overhead costs**

The tables in 2.8.2 demonstrate that even with cross-cutting efficiencies identified already, this would be insufficient to return the OSEL health economy to in-year balance. The projected downturn in the OSEL health economy’s finances reflects the consequences of developments, where services are provided that result in reduced income for hospitals that are faced with having to address high fixed costs, especially for the PFI sites. Every action that PCTs take to control their expenditure, from reducing acute referrals to eliminating excess bed days, will produce a corresponding reduction in the incomes of the hospitals.

Many of the hospitals’ costs are fixed. New and modern facilities have been provided through PFI developments. Some 78% of existing acute beds are in new purpose-built buildings, whose capital and servicing costs cannot be avoided because of contractual obligations. Capital and overhead costs are high because services are spread across four hospital sites, each trying to maintain the critical mass and comprehensive service levels expected from an acute admitting hospital.
There are other cost pressures in the hospitals too. Both the financial consequence of clinical developments and the standards and requirements to reduce working hours are placing enormous pressure on cost of providing acute services.

No money can be saved by simply treating patients in one place instead of another. If it is possible to find better and more efficient ways of caring for people, parts of a hospital’s buildings may no longer be needed and could be disposed of, so that all the costs of operating them are eliminated, thus addressing the high fixed costs issue highlighted earlier.

It cannot be concluded that non-PFI beds can simply be eliminated, because there are clinical safety considerations which affect the size of each hospital site and it is important to preserve local access to services where that is appropriate. But it can be concluded that there is in principle scope for reducing the number of beds provided in OSEL.

- Improving productivity

There is scope for improving productivity in all areas of healthcare, but reliable performance indicators only exist for bed usage. The figures available for the average length of stay in acute beds show that OSEL hospitals do not perform particularly well. Reducing the length of hospital stays would reduce expenditure significantly, but would further emphasise the scale of high fixed cost capacity that did not have income to support such costs and therefore needs to be part of a more fundamental restructuring of capacity. To achieve major reduction in the average length of stay in hospital also requires services and facilities out of hospital to facilitate such improvements.

2.8.4 Conclusion

The economic case for change centres on the importance of securing best value from the money, buildings and people available and the urgent need to restore financial balance in the health economy. This can only be achieved through measures that eliminate significant amounts of physical estate and the associated running costs, as well as ensuring the consolidation of services to achieve better value for money and addressing issues on clinical standards. Whilst continued efficiency programmes are being addressed, the scale of the improvement required to return the health economy into balance will not be solved by such efficiency programmes alone. This will require more fundamental consideration of options to address the declining financial position, which maintains the clinical priorities and also utilises most effectively the modern buildings that have been provided through PFI developments that are otherwise at risk of being underutilised. At the same time, the development of efficient out of hospital services and facilities needs to be established as part of any change programme. Further action will be required to reduce the cost of back office and support functions and drive up productivity, in order to achieve financial balance.
This chapter of the PCBC sets out both high level objectives and measures of achievement and then more specific ones for out of hospital care supporting the hospital changes, and hospital services.

### 3.1 APOH strategic objectives and measures of achievement

**High level objectives**

Responding to the case for change and what local people have said they want from services, strategically and at a whole economy level, A Picture of Health will:

- Ensure the safety and viability of hospital services in outer south east London by 2013 at the latest:
  - Clinical standards and outcomes will be improved to match the best in London and nationally.
  - Service shortfalls or gaps will be addressed, including increased provision of Consultant led and specialist services.
  - National guidelines and legislative requirements will be fully implemented.
  - A focused range of out of hospital care schemes will be developed to support the flow of activity from hospitals into the community.
  - Care pathways will be designed that address APOH’s clinical priorities.

- Guarantee financially affordable and sustainable hospital and primary/community services, resulting in a sound health economy.

**High level measure of achievement**

APOH will have:

- Built a clinically and financially stable foundation for hospital services in outer south east London, enabling innovation and investment to deliver the wider goals of national and London health policy across the health economy by 2013.
3.2 Specific objectives and measures of achievement

Chapter 2 sets out in detail a clinical case for change which focuses on the urgent clinical and economic issues within OSEL.

This chapter of the PCBC sets out some of the associated objectives that OSEL will be seeking to deliver, and confirms the measurements that will show whether these have been achieved or not.

The clinical case for change described how out of hospital care will be the foundation and will support the hospital changes. This chapter begins with the same starting point, and outlines objectives and measures of achievement for out of hospital care.

Then follow tables that identify some of the objectives which the reconfiguration is expected to achieve or maintain for each of the acute clinical areas referenced in the case for change:-

- Maternity newborn and seriously ill children’s services
- Urgent and emergency care : medicine, older people and surgery
- Critical care
- Elective surgery

The tables outline the target achievement proposed and identify ways of measuring that target. This is not, however, intended to be a definitive list of all potential benefits with associated measurements. It does not replace the more in depth monitoring and audit of clinical outcomes and mortality rates, and the benchmarking against national best practice that takes place as a matter of routine within healthcare providers. Equally, it is not possible to track all possible areas of improvement e.g. the monitoring of improved access to consultant assessment following emergency admission would be costly to track and monitor on a routine basis.

It is proposed that objectives such as this should be measured by annual audit for at least the first two years post reconfiguration.
### 3.2.1 Out of hospital care

<table>
<thead>
<tr>
<th>Objective</th>
<th>Target</th>
<th>Measurement</th>
</tr>
</thead>
</table>
| **Urgent care:** To respond to people with urgent care needs providing them with a timely and locally accessible service provided by clinicians with the appropriate skills to deal with their health problem. | - Increase in the number of people who access urgent care services through their local pharmacy, local GP, local ‘walk in’ service or local urgent care centre (UCC).  
- Decrease in the number of people accessing care through A and E.  
- Increase in the number of services supporting specific client groups who currently frequently access A and E e.g. substance abuse services. | - Walk in centres, A&E and UCCs to report quarterly GP access survey  
- Uptake of alternative forms of support |

- To ensure that patients who no longer need full emergency care receive care locally, making it easier for family and friends to visit.  
  Monitor number of patients admitted as emergencies from out of borough and number transferred to intermediate care post acute phase.  
  Admitting hospitals to report quarterly. |

| **Long term conditions:** To systematically support people with long term conditions, enabling them to manage their condition such that they have the optimal health status possible. | Reduction in emergency admissions to acute hospitals for people with Long Term Conditions | - Monitor number of emergency admissions for diabetes, asthma, COPD, heart failure six monthly.  
- Monitor Community matron caseload annually.  
- Monitor caseload of specialised LTC community teams. |

- **Intermediate care:** To support people with illness, frailty or rehabilitation needs (where they do not need the acute specialist care and equipment found in acute hospitals) in their own homes or in intermediate care beds.  
  Increase in the number of people cared for in their own homes and in intermediate care.  
  Monitor numbers cared for in Intermediate Care beds and by Intermediate Care Teams. |

- **Maternity:** To increase the number of normal births experienced by women in the four boroughs.  
  Aim to enable at least 1,000 women to deliver in each Midwifery-led Birthing Unit and for 7% of all women to be able to choose to give birth at home  
  % of all births in midwifery led units  
  % of all births at home. |

- **Planned care and outpatients:** To provide planned care and outpatients in a primary and community setting (where they do not need the acute specialist care and equipment found in acute hospitals) as close to home as possible.  
  Increase in the number of people seen for planned care and outpatients in local venues.  
  Monitor rates of minor surgery undertaken in and outside hospital six monthly  
  Monitor rates of diagnostic tests provided in and outside hospital. |
### 3.2.2 Maternity, newborn and seriously ill children’s services

<table>
<thead>
<tr>
<th>Objective</th>
<th>Target</th>
<th>Measurement</th>
</tr>
</thead>
</table>
| To ensure that there are sustainable staffing levels in all specialties   | All specialties are compliant with the European Working Time Directive | • Identify specialities at risk of non-compliance by Trust  
• Identify how compliance will be achieved (reconfiguring service or more staff)  
• Agree date for achieving compliance by specialty |
| To improve the outcome for women giving birth on obstetric units through an increased level of senior presence and leadership | All labour wards have 98 hour consultant cover | Timetable for each consultant obstetric unit |
| To improve continuity of care and the experience for women giving birth. | All women have a designated midwife to provide care for them when in established labour for 100% of the time. | Percentage of women who have a designated midwife to provide care for them when in established labour for 100% of the time. |
| To increase the number of very sick babies safely cared for within the sector i.e. not having to transfer to a more remote hospital | % of neonatal patients cared for within network | Neonatal network to report 6 monthly using SEND data |

### 3.2.3 Urgent and Emergency care: medicine, older people and surgery

<table>
<thead>
<tr>
<th>Objective</th>
<th>Target</th>
<th>Measurement</th>
</tr>
</thead>
</table>
| To ensure that there are sustainable staffing levels in all specialties   | All specialties are compliant with the European Working Time Directive | • Identify specialities at risk of non-compliance by Trust  
• Identify how compliance will be achieved (reconfiguring service or more staff)  
• Agree date for achieving compliance by specialty |
| To ensure rapid access to appropriate care for people after a heart attack | Patients requiring PCPI arrive at the specialist centre within 3 hours | LAS to collect and report 6 monthly. |
| To improve the outcome for patients with hip fractures                    | 95% Fractured Neck of Femur (NOF) operated on within 48 hours           | Percentage of Fractured NOF operated on within 48 hours |
| To increase the level of expert assessment urgently available to people (often the older person) and their primary care clinicians without the patient having to move through sub optimal settings e.g. A and E | Increase use of the rapid medical assessment service | Monitor number of referrals for each element of service. |
### 3.2.4 Critical Care

<table>
<thead>
<tr>
<th>Objective</th>
<th>Target</th>
<th>Measurement</th>
</tr>
</thead>
</table>
| To ensure that there are sustainable staffing levels in all specialties   | All specialties are compliant with the European Working Time Directive | - Identify specialities at risk of non-compliance by Trust  
- Identify how compliance will be achieved (reconfiguring service or more staff)  
- Agree date for achieving compliance by specialty |
| To reduce mortality in critical care units                                | 400 plus patients treated in each level 3 ICU annually                  | Each Level 3 unit to report throughput and mortality using ICNARC            |
| To ensure appropriate capacity for Level 3 critical care                  | - Increase the number of patients cared for within the network  
- Monitor the number of transfers from elective centres to Level 3 ITU   | Critical care network to report 6 monthly.                                  |

### 3.2.5 Elective Surgery

<table>
<thead>
<tr>
<th>Objective</th>
<th>Target</th>
<th>Measurement</th>
</tr>
</thead>
</table>
| To ensure that there are sustainable staffing levels in all specialties   | All specialties are compliant with the European Working Time Directive | - Identify specialities at risk of non-compliance by Trust  
- Identify how compliance will be achieved (reconfiguring service or more staff)  
- Agree date for achieving compliance by specialty |
| To ensure that planned care is not disrupted by emergency work            | To reduce the number of cancelled elective episodes                     | To monitor the number of cancelled episodes                                  |
| To ensure that patients undergoing elective care Do not acquire infection | To reduce the number of elective patients with hospital acquired infections | To monitor hospital acquired infection rates.                                |
| To provide planned care in a primary and community setting (where they do  | Increase in the number of people seen for planned care in local venues  | Monitor rates of minor surgery undertaken in and outside hospital six monthly  
need the acute specialist care and equipment found in acute hospitals) as close to home as possible. |
| To speed up the patient’s journey from point of referral by the GP to point | All elective patients seen within 18 weeks for referral                | Via 18 week Referral to Treatment programme                                  |

If patients are to have confidence in their redesigned local health service these measurements must be made available to the public with explanatory information and an action plan if the objective is not being met.
This chapter describes, for the purpose of modelling, the advice and recommendations of the primary/community and hospital clinicians in OSEL about potential service models. Four models have been identified; however, only three of these are recommended. Model 1, the status quo, is included but it is the strong advice of the clinicians that this model is not viable and will severely compromise services in the future. The recommendations form the basis of the PCBC models.

The models have been developed in response to the clinical case for change given in chapter 2 and to enable the objectives and measures of achievement to be met, as set out in chapter 3.

The models are not site specific as this would pre-empt the modelling and financial analysis, plus the application of criteria to these models. The results of the modelling, analysis and application are described in chapters 5, 6, 7 and 8.

- Section 4.1 draws out the vision for three major groupings of healthcare activities and the types of places where these activities will take place.

- Section 4.2 sets out the whole health community/sector level model for out of hospital care, which as described in Chapter 2 is the foundation and support to the proposed changes to hospital provision.

- Section 4.3 then describes the models for hospital provision.

- Section 4.4 describes specific borough based proposals for the development of OHC/primary care to support the hospital services redesign. The OHC/primary care support is described in a stand alone section, rather than under each model. This is because the model of OHC/primary care that support the models for change (2, 3 and 4) will be the same under each model. However, the quantum and time frames for development will vary, and this is indicated in section 4.2. It should be noted that under the status quo model there will only be continued incremental development of OHC. This is because the hospitals will still receive the lion’s share of funding as they are not reconfigured, thereby constraining investment in OHC.
WORK IN PROGRESS

4.1 OSEL vision for organisation and location of health care services

In Chapter 2, the clinical case for change described the high level vision for health care provision:

- A foundation of out of hospital care (including care at home).
- Many standard hospital services that should be provided on a local basis and offering, in addition, a range of community, primary, social and mental health care services.
- Hospital services that need to provided in more concentrated, acute and specialist environments.
- Clinicians across the professional groups, will provide healthcare that supports the whole OSEL population, rather than on a solely organisational basis.

This means there are different models of care that need to be provided in OSEL. At present both standard and more acute/specialist care is provided by the four hospitals, organised as traditional district general hospitals. However, as the case for change demonstrates that district general hospitals are struggling to provide this range of care, and in light of national evidence based guidelines and legislative requirements are too small and generalist to continue to offer specialist and complex care at all four locations.

The consensus of opinion between clinicians, commissioners and health service leaders in OSEL is that in order to create the stable clinical and economic platform of hospital services there needs to be a new vision for its hospitals. This vision seeks to establish two types of hospital, one which will deals with specialist and complex care and the other which will offer standard hospital services and will expand its range of services to offer a richer mix, integrated care pathways and stronger links to community, primary, social and mental health care.

In this PCBC the hospital offering standard services is called a ‘borough’ hospital and the hospital with complex and specialist services is called an ‘admitting’ hospital. Two variants on an admitting hospital are outlined in models 2 and 3. The variants are:

- A fully admitting hospital which takes A&E blue light admissions, and offers a major A&E, emergency and complex surgery, medical admissions, Level 3 critical care, consultant-led obstetrics unit and children’s inpatient services.

- A medical admitting hospital which has an A&E and takes medical admissions, but does not routinely offer emergency and complex surgery, consultant-led obstetrics and children’s inpatient services.

*Healthcare for London* also sets out a vision for developing new and different types of healthcare provision and hospitals, for example the polyclinic, major and local hospital. The HfL model represents a longer term vision and introduces a more radical reorganisation of healthcare, and the types of location where different types and complexity of care could be sited. The APOH vision is consistent with and works toward this vision, but as yet is not
proposing the exact same models or as radical reorganisation for two reasons. Firstly, APOH is proposing a model which will enable OSEL to have a stable clinical and financial platform for hospital provision, addressing the urgent issues and not the longer term vision. The APOH proposed models of borough and admitting hospitals, supported by out of hospital care should achieve the secure platform. Secondly, the models proposed in HfL will be subject to public consultation in winter 2007/08 and the APOH PCBC does not wish to set out models that pre-empt this consultation. As APOH secures a stable platform and in due course, and subject to consultation, OSEL will continue to evolve its models in line with HfL. However, its models are broadly in line with the HfL models, with the major hospital and admitting hospital both seeking to offer more complex, specialist and concentrated services. The local hospital and borough hospital both offer most standard services locally, and may incorporate either elements of a polyclinic, or an actual polyclinic co-located on site.

The following diagrams illustrate the models for:

- Out of hospital care that will support the hospital changes
- A borough hospital
- An admitting hospital

Tertiary level care is not described, as it is not subject to redesign as part of the APOH urgent and immediate agenda, although there are discussions underway with tertiary providers in central London about providing more tertiary outpatient services including chemotherapy, renal care, cardiac care and neurology.
4.1.1 Model for out of hospital care that will support the hospital changes

Out of hospital care will support the changes to hospital provision by ensuring, that where possible, unnecessary admissions to hospital are prevented and supporting people to come home from hospital in a timely way. This will mean more care in the patient’s home or in community settings, such as urgent care centres. Expert community and primary care staff will deliver this care, and people will also be supported to better manage their conditions at home. The detail of this model is described in 4.2 and 4.4.

NB: The diagram above only features elements of out of hospital care that will be further developed to support the changes to hospital provision. There is already a wide range of primary and community care services, and others in development as part of the pre-existing and on-going plans for the expansion of primary and community care. This includes developments such as end of life care, a children's hospice, mental health services, social care and healthy living schemes. More services will be developed potentially following the Healthcare for London consultation.
4.1.2 Model for a borough hospital

A borough hospital will offer many of the standard services that district general hospitals have traditionally provided, but the emphasis will be on ambulatory care and providing integrated care with a richer and expanded range of community, primary, intermediate, social and mental health services. The detail of this model is described in 4.3.
4.1.3 Model for a fully admitting hospital

A fully admitting hospital will focus in the main on providing treatment and care to people who have more complex and specialist needs, including life threatening conditions. It will offer more specialist, concentrated and larger units to improve safety and quality for services such as maternity and neonatal care. There will be some ambulatory services, such as urgent care and medical assessment services at an admitting hospital, as well as a borough hospital. The detail of this model is described in 4.3.

Services marked with * will be offered by a medical admitting hospital, see model 2, section 4.3
4.2 Out of hospital care model to support changes to hospital provision

General Practice and the individualised care offered within the wider community healthcare setting will remain the cornerstone of NHS patient care. As now dentists, pharmacists, optometrists (opticians) and other practitioners will offer a service from many local venues within each borough.

PCTs will be commissioning General Practice teams to build on their strengths, offering longer opening hours and better access in a local venue.

Schemes will be developed to ensure that people who have factors making them particularly at risk of serious disease are pro-actively identified and supported with interventions that help them maintain a healthy lifestyle.

People with long-term conditions (e.g. chronic lung disease, diabetes) will receive increasing amounts of care in a community setting, either from their own General Practice or from a General Practitioner specialising in that condition on behalf of a network of local practices, or from specialised community nursing and therapy teams. There will be an emphasis on informing and supporting patients so that they can best manage their own conditions through ‘expert patient’ programmes and similar initiatives.

There will be increased integration of primary and community care with social care services including the provision of telemedicine and other technology that allows people to retain their independence and be safely cared for in their own homes.

The framework within which broader changes anticipated in out of hospital care (OHC) will be progressed forms part of the separate Healthcare for London consultation. The following section seeks, however, to bring forward and identify elements of change and improvement which will underpin the proposed hospital service changes in OSEL.

4.2.2 Urgent Care

Patients will receive urgent care through the urgent care centres (UCC) that will be based on each current hospital site in every borough. BCT, BPCT, GTPCT and LewPCT have confirmed through the Out of Hospital Care Forum their intention to have designated centres, in addition to their local urgent care centre at the hospital site. At this stage three PCTs have confirmed plans for this i.e. Bromley at the Beckenham Beacon, Greenwich at the new Eltham Community Hospital and Lewisham at New Cross.

These borough based facilities will cater for all but the very major health emergencies (this means about 70% or more of existing A&E activity). UCCs will bring together a range of clinical skills required to meet a wide spectrum of urgent care needs of patients and will be securely linked into wider health and social care networks. Their focus will not just be on ensuring that the patient’s immediate needs are met. They will also ensure that, where necessary, appropriate self care advice is offered and that follow up packages of care and support are developed in discussion with the individual patient. A core specification for these
four centres that will bring together and integrate the very best of existing hospital A&E and primary care skills can be found in Working Paper 2.

Patients, in particular older patients, whose GP feels they would benefit from an urgent assessment, could receive this from medical consultants and other specialist staff from the medical assessment service (MASs), and where appropriate in conjunction with the urgent care centres. The MASs are based in each borough on all four existing hospital sites. This assessment service will provide a level of expertise not found within every GP team and will be able to complete the assessment, which has already commenced in the community, without unnecessarily admitting patients to a hospital bed or requiring the patient to attend A&E. The assessment service will provide advice to the GP team on the most appropriate interventions and packages of care, strengthening the ability for the patient’s health needs to be managed in the familiar surroundings of their own home. A core specification for the four borough medical assessment service can be found in Working Paper 3.

Patients who contact the London Ambulance Service (LAS) usually get conveyed to an acute hospital setting, via A&E, regardless of whether their needs are best met in this setting. In future patients will continue to be able to telephone the London Ambulance service when they believe that they need to, but will receive a service that is increasingly tailor made to their needs following assessment by trained ambulance service practitioners. Patients for example, could be conveyed by ambulance directly to an intermediate care centre thus avoiding the patient waiting in A&E or being unnecessarily admitted to an acute hospital bed.

4.2.3 Enhanced and intermediate care in home and community settings

Patients who need extensive care and support, but who do not need either the on site specialist expertise or the technology found within an acute hospital setting, will be cared for either in an increased number of beds in locally based intermediate care centres or in their own homes with the support of enhanced community based clinical support teams.

Patients with rehabilitation needs will have their needs met in an intermediate care setting, e.g. following a stroke.

Patients whose health status is vulnerable or deteriorating will be systematically identified and, in discussion with them and their carers, be pro-actively supported by General Practice and expanded community based nursing and therapy teams.

Patients reaching the end of their lives will be provided with services and support to enable them to have a real choice about where they die. All four boroughs are participating in the SEL Marie Curie ‘Delivering Choice’ Project which is summarised in Working Paper 4 and which should have identified and specified the most appropriate service models for investment by the end of phase two scheduled to be completed in mid 2008.
4.2.4 Management of increased elements of elective care pathways in a community setting

Patients will increasingly be able to be referred for specialist advice provided by GPs, nurses or therapists with a special interest in an out of hospital setting.

4.2.5 Management of increased elements of maternal and child care in primary and community settings.

Pregnant women will increasingly have the majority of their antenatal and postnatal care appointments in local community settings, e.g. at their General Practice, community clinic or in a local children’s centre. Provision will increasingly be made for scans and other obstetric assessments to be made within these local settings. Should concerns arise during the course of the pregnancy women will only need to be transferred to an acute obstetric led unit if their needs indicate the requirement for this.

Increasing primary and community based support will be provided for mothers with uncomplicated pregnancies, enabling higher numbers of women to choose to have their baby in their own homes. Alternatively, they could choose to have them in a local midwifery led birthing unit of their choice.

Breast feeding will be supported not only through expert advice for mothers, but also through wider initiatives associated with the UNICEF baby friendly accreditation.

Children’s care will increasingly be managed in venues outside hospital, which will increasingly be co-located with other children’s services e.g. children’s centres and schools.

Children with life limiting conditions in all four boroughs will have access to the new children’s hospice currently being built by Demelza House in Eltham.

4.2.6 How the out of hospital care model supports the hospital models

Section 4.3 below describes the four models for hospital provision:

- Model 1: The status quo (four district general hospitals and elective inpatient surgical unit at Orpington).

- Model 2: Two fully admitting hospitals, one medical admissions hospital and one borough hospital.

- Model 3: Three full admitting hospitals and one borough hospital.

- Model 4: Two fully admitting hospitals and two borough hospitals.
This section sets the scene for considering the hospital models, by highlighting how the out of hospital care model can support the hospital models, plus any constraints:

- Under the status quo model there will be continued incremental development of OHC/primary care, but as the funding will continue to flow predominantly into the acute hospitals investment in OHC/primary will be severely constrained. This means that preventative services and primary and community support services will remain limited and people will continue to be admitted unnecessarily to hospital, and will stay in hospital longer than necessary.

- The OHC model of care that supports hospital provision will be the same for models 2, 3 and 4, although the quantum and time frames for development will vary.

- Models 2 and 3: There will be the opportunity to develop OHC/primary care much faster, as this class of models is reliant upon investment in major OHC development schemes that will prevent ill health and support people better in their own homes and other community settings.

- Model 4: As with models 2 and 3, but with opportunity and requirement to invest in schemes that move OSEL towards international best practice in the prevention of ill health and support of people in their own homes and in community settings.

### 4.3 The hospital models

Hospital clinicians have identified that there are four models for hospital provision, however only three models are recommended as viable:

**Model 1:**

- District general hospital
- District general hospital
- District general hospital
- District general hospital
- Limited OHC & ambulance services

**Model 2:**

- Fully admitting hospital
- Fully admitting hospital
- Medical admitting hospital
- Borough hospital
- OHC and ambulance services

**Model 3:**

- Fully admitting hospital
- Fully admitting hospital
- Fully admitting hospital
- Borough hospital
- OHC and ambulance services

**Model 4:**

- Fully admitting hospital
- Fully admitting hospital
- Borough hospital
- Borough hospital
- OHC and ambulance services

Models 2, 3 and 4 will require the provision of additional emergency ambulances.
Model 1 – the status quo

Patients will continue to have the option of four district general hospitals with specialist care being provided in central London (BHT, QEH, QMS and UHL). All existing services remain on the sites; however for the reasons described in chapter 2, the clinical case for change, it cannot be guaranteed that clinical safety, affordability and environmental suitability are sustainable.

Hospital services currently available

- As currently, emergency care will continue to be provided from all four existing hospitals. These hospitals provide care for people taken to hospital by blue light ambulance, following GP urgent referral and for people who ‘walk-in’ to A&E. Each provides level 3 critical care (the highest level), medical in-patients and emergency surgery, consultant led obstetrics and in-patient paediatrics. There is also planned surgery, both in-patient and day case offered from all hospitals together with the existing range of outpatient and diagnostic services.

- It should be noted that under model 1 there is an existing elective surgical inpatient unit based in Orpington, part of BHT, and this will stay at this location (there is no intensive care service at present at this location, so only non complex surgery can be undertaken). This unit is open 7 days a week and provides elective care for patients requiring planned surgery. It has 41 beds and 3 theatres. At the Orpington site, BHT also offers, and will continue to offer, a full range of out patient services including hydrotherapy. BPCT also provides an intermediate care facility at the Orpington site for patients requiring an extended period of rehabilitation (40 beds).
Model 2: Two fully admitting hospitals, one medical admitting hospital and one borough hospital

Patients will receive full emergency care from two admitting hospitals, with a third admitting hospital taking urgent medical admissions. All three will have A&E services. Planned, non complex elective care will be provided at two hospitals. Outpatients and diagnostics will be provided at all four hospitals. Two additional emergency ambulances will be required.

Maternity, newborn and seriously ill children’s services

- Women having babies will receive their ante and post natal care at their choice of the four hospitals or in the community. For the actual birth they will be cared for in consultant led obstetric services or midwifery led birthing units at the two full admitting hospitals, with full neonatal backup, or they might choose to have their baby at home. The third medical admitting hospital will not have a consultant led obstetric service.
- Most children needing urgent care will receive this at any of the four hospitals, using the urgent care centre. New paediatric ambulatory centres *(PACs)* will be developed at the third medical admitting hospital and borough hospital and would mean that all but the very sickest children receive services locally. Children requiring in-patient treatment would be admitted to the either of the two fully admitting hospitals.
- * The PAC will provide unscheduled care (but not blue light ambulance cases), consultant led assessment, diagnostic testing, care management plans for all common problems, out-patient and day case procedures, joint working with social care and children’s centres. Ideally PACs will include staff with paediatric mental health skills or at least clear protocols for liaison with psychiatric services.

Urgent and emergency care: medicine, older people and surgery

- Patients who ‘walk-in’ for emergency treatment will receive urgent assessment and care from each of the four existing hospitals in an urgent care centre. Any patient whose condition was found to be more serious will be transferred by ambulance to a hospital with the right skills/equipment.
- Trained paramedics within the LAS blue light service will assess a patient’s needs and take them to the most appropriate facility. This will be a major A&E department when the patient has serious illness or trauma but in some cases they will take the patient to other, more suitable, venues e.g. hospice, intermediate care centre, urgent care centre.
- Patients taken to hospital by blue light ambulance will be taken to the admitting hospitals within the area and will have the back up of level 3 critical care, emergency medicine and emergency surgery.
- Patients who need urgent medical admission will also be able to receive this at any of the three admitting hospitals and will receive intermediate care (step up and step down) there too. Patients needing intermediate care after their hospital stay, from the area without a medical admissions service, will receive this at their borough hospital. There will be elderly day care assessment units at all four hospitals.

Critical care

- Level 2 and 3 critical care will be provided at all three admitting hospitals. Level 2 will provided at the borough hospital.

Elective surgery

- Patients needing elective surgery will be able to choose any hospital in the country from April 2008. Locally, the two fully admitting hospitals will provide complex surgery with the back up of Level 3 Intensive Care. People will have a choice of two elective centres for non complex inpatient general surgery and orthopaedic surgery (plus Level 2 ICU), based at the medically admitting and borough hospitals. These hospitals will also offer 23 hour day case surgery units, with Level 2 ICU back up.

Diagnostics

- Patients requiring diagnostic investigations such as X-ray, CT or MRI scans will receive this at their borough hospital site.
Model 3: Three fully admitting hospitals and one borough hospital

Patients will receive full emergency care from three fully admitting hospitals. Out patients and diagnostics will be provided at all four hospitals. Inpatient and day case elective care would be provided from two separate elective centres. Two additional emergency ambulances will be required.

Maternity, newborn and seriously ill children’s services

- Women having babies will receive their ante and post natal care at their choice of the four hospitals. For the actual birth they will be cared for in consultant led obstetric services or midwifery led birthing units at one of three fully admitting hospitals with full neonatal backup or they might choose to have their baby at home.
- Most children needing urgent care will receive this at any of the four hospitals, using the urgent care centre. Children requiring in-patient treatment will be admitted to one of three admitting hospitals. A new paediatric ambulatory centre *(PAC)* at the borough hospital will mean that all but the very sickest children receive services locally.
- * The PAC will provide unscheduled care (but not blue light ambulance cases), consultant led assessment, diagnostic testing, care management plans for all common problems, out-patient and day case procedures, joint working with social care and children’s centres. Ideally the PAC will include staff with paediatric mental health skills or at least clear protocols for liaison with psychiatric services.

Urgent and emergency care: medicine, older people and surgery

- Patients who ‘walk-in’ for emergency treatment will receive urgent assessment and care from each of the four existing hospitals in an urgent care centre. Any patient attending the hospital without emergency inpatients whose condition was found to be more serious will be transferred by ambulance to a hospital with the right skills and equipment to provide the necessary treatment.
- Trained paramedics within the LAS blue light service will assess a patient’s needs and take them to the most appropriate facility. This will be a major A&E department when the patient has serious illness or trauma but in some cases they will take the patient to other, more suitable, venues e.g. hospice, intermediate care centre, urgent care centre.
- Patients taken to hospital by blue light ambulance will be admitted to one of three fully admitting hospitals (or to the nearest emergency hospital outside the area) and there will be the back up of level 3 critical care, emergency medicine and emergency surgery.
- Patients from the remaining area who need intermediate care will receive this at their borough hospital and will be able to be transferred to the intermediate care service locally following admission at one of the admitting hospitals. There will be elderly day assessment units at all four hospitals.

Critical care

- Level 2 and 3 critical care will be provided at the three fully admitting hospitals. Level 2 will provided at the borough hospital.

Elective surgery

- Patients needing elective surgery will be able to choose any hospital in the country from April 2008. Locally, the three fully admitting hospitals will provide complex surgery with the back up of Level 3 Intensive Care. People will have a choice of two elective centres for non complex inpatient general surgery and orthopaedic surgery (plus Level 2 ICU). One at a fully admitting hospital and one at a borough hospital. These hospitals will also offer 23 hour day case surgery units, with Level 2 ICU back up.

Diagnostics

- Patients requiring diagnostic investigations such as X-ray, CT or MRI scans will receive this at their borough hospital site.
Model 4:  Two fully admitting hospitals and two borough hospitals

Patients would receive full emergency care from two fully admitting hospitals. The other two ‘borough’ hospitals would provide a wide range of services: elective inpatient and day case surgery, outpatients, paediatric assessment centres, and diagnostics. Two additional emergency ambulances will be required.

Maternity, new born and seriously ill children’s services

- Women having babies would receive their ante and postnatal care at any of the four hospitals or in the community. For the actual birth they would be cared for in consultant led obstetric services or midwifery led birthing units one of two admitting hospitals with full neonatal backup, or they might choose to have their baby at home.
- Most children needing urgent care would receive this at any of the four hospitals, using the urgent care centre. Children requiring in-patient treatment would be admitted to one of two admitting hospitals. Two new paediatric ambulatory centres* (PACs) at the borough hospitals would mean that all but the very sickest children would receive services locally.
- * The PACs would provide unscheduled care (but not blue light ambulance cases), consultant led assessment, diagnostic testing, care management plans for all common problems, out-patient and day case procedures, joint working with social care and children’s centres. Ideally the PACs will include staff with paediatric mental health skills or at least clear protocols for liaison with psychiatric services.

Urgent and emergency care: medicine, older people and surgery

- ‘Walk-in’ emergency patients would receive urgent assessment and care from each of the four existing hospitals at urgent care centres. Any patient attending the centres at the non-acute hospitals whose condition was found to be more serious would be transferred by ambulance to a hospital with the right skills and equipment to provide the necessary treatment.
- Trained paramedics within the LAS blue light service will assess a patient’s needs and take them to the most appropriate facility. This will be a major A&E department when the patient has serious illness or trauma but in some cases they will take the patient to other, more suitable, venues e.g. hospice, intermediate care centre, urgent care centre.
- Patients taken to hospital by blue light ambulance would be admitted to one of two fully admitting hospitals where there would be the back up of level 3 intensive care, emergency medicine and emergency surgery.
- Patients from the other areas who need intermediate care would receive this at their borough hospital and could be transferred back to the intermediate care service locally following admission to one of the emergency hospitals. There will be elderly day assessment units at all four hospitals.

Critical care

- Level 2 ICU back up would be available on all four sites. Some complex cases would need to be carried out at the sites with emergency services to have the back up of Level 3 intensive care.

Elective surgery

- Patients needing elective surgery will be able to choose any hospital in the country from April 2008. Locally, the admitting hospitals will provide complex surgery with the back up of Level 3 intensive care. People will have a choice of two elective centres for non complex inpatient surgery and orthopaedic surgery (plus Level 2 ICU) and 23 hour day surgery units, collocated with inpatient surgical units at the borough hospitals. Level 2 ITU back up will be available on both sites.

Diagnostics

- Patients requiring diagnostic investigations such as X-ray, CT or MRI scans would receive this at their borough hospital site.
### 4.3.1 Summary of hospital models (2,3,4)

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<th>Model</th>
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4.4 Borough based proposals: out of hospital care

The model for out of hospital care to support the changes to provision of hospital services has been described above in section 4.2. This section describes in greater detail more specific and borough based proposals for out of hospital care that could support the changes to hospital provision.

The four boroughs in OSEL have very differing populations and differing existing patterns of service provision.

The following borough specific sections signal future developments that are firmly planned, together with new developments that have recently been established. All of these developments will support more people in their own homes and communities, and will therefore facilitate the proposed models for acute hospital change.

4.4.1 Specific developments planned for Bexley residents

- Supporting patients in their own homes

Out of hospital care is taking place with the local GPs working with district nurses, practice nurses and social workers as they develop a plan to support local patients with poor health and in need of home support. This plan addresses the current needs of the patient and anticipates what help the patient might need in the future. BCT is creating ‘Virtual Wards’ (a caseload management system for nurses, GPs, allied professional and social workers to manage people at home) the first of these commenced in North Bexley in November 2007. Each practice in North Bexley will identify, on a weekly basis, high risk patients that should be monitored and receive care regularly. Each ward will consist of about 28 patients and will be managed by one of the following members of the ward team: an advanced primary nurse, a GP, a practice nurse or a senior district nurse. Patients will be supported by other members of the local team, including social worker or care manager, occupational therapist, physiotherapist, pharmacist or specialist nurse.

This will ensure a planned programme of intensive patient care to avoid admission on a seven day basis from 8am-8pm. This maximises the use of the advanced primary nurses. Additional virtual wards covering the whole of Bexley will be introduced by April 2008.

There are times when patients’ needs become very complex and more intensive care is required in patients’ homes. The virtual ward staff will be able to access additional nursing support when dealing with chronic obstructive pulmonary disease (COPD), stroke and palliative care. This will be available seven days a week. They will also have the facility to purchase additional home care and spot purchase residential respite or intermediate care on a short term basis. The virtual ward staff will access either existing residential beds in Bexley Care homes or will make use of intermediate care beds in neighbouring boroughs. They can also access both day and residential service provided by the local hospice.
Supporting patients in an emergency

Bexley’s existing primary care urgent care unit sees and triages, assesses and manages patients at the front of the A&E Department at QMS building upon an established site. Patients have instant access to GPs and the primary care emergency nurse practitioner team in A&E. The patients are ‘seen and sorted’ at a single point. The patient is directed either to alternative services in the community, to services of the urgent care centre or directly into A&E streams of major, complex minor or complex paediatrics. This service commenced in October 2007 and is available from 8am to 11pm seven days a week with proposals to extend opening hours. The service currently sees and treats 100 patients a day and potentially as much as 75% of current A&E attendances could be seen in an integrated UCC. Patients never wait more than 4 hours and are usually seen within 90 minutes.

Following some early analysis of the patient demand managed by the urgent care centre, there may be scope in the future for patients using the urgent care centre to access additional care, such as night sitting, which will be provided in the patient's own home.

Supporting patients to return home after a hospital admission

In June 2007 BCT established its first Bridging Team consisting of nurses, therapists and the hospital social work team in QMS to work between hospital and community in supporting patients for six weeks at home after a hospital discharge. The current team supports on average 100 patients a month to return safely to the community. It re-establishes contact with the virtual ward team or the patient's primary care team. BCT will extend the Bridging Team to all local hospitals by April 2008.

Supporting children out of hospital

Children who have a range of complex needs require local services to be joined up. A child development centre is being proposed in Bexley which is expected to be located at QMS and will work in close collaboration with the paediatric ambulatory care service. The child development centre will include health, social care and education services, specifically: community paediatrics, a full range of children’s therapy services, audiology and a new born hearing screening service, an orthoptic service, parenting support, the children’s community nursing team, the child health and school health record service, the disabled children’s social work team, portage and specialist advisory services. The child development centre will offer a range of diagnostic services as treatments or other interventions for children with developmental needs or long term conditions.

The child development centre will enable the extension of joint clinics supported by colleagues from specialist tertiary centres and as a result ensure that care is delivered closer to children’s homes. There is also the potential to support clinic arrangements with other local health providers, particularly the child and adolescent mental health service.

Supporting people in a residential environment

In addition to the eight existing intermediate care beds BCT will extend its intermediate care beds by using spare capacity that currently exists in Bexley care homes or in neighbouring
boroughs to provide **step up/step down facilities**. Clinical management of these beds will be secured by awarding explicit contracts to a consultant (with an interest in elderly care) or, a GP (with an interest in intermediate care) or an appropriately qualified nurse consultant. BCT’s *Commissioning Strategy Plan* sets out its intention to increase **intermediate care bed** numbers from eight to up to fifty beds. This will be a joint provision with Bexley Council.

Patients will receive active rehabilitation during their stay, to facilitate skills required for independent living. It is anticipated that the majority of patients will return to their own homes following 6-12 weeks of residential intermediate care.

### Other specific developments

All the following services are currently either being implemented, or are actively in development:

- **A community based anticoagulation monitoring & management service** for suitable stable patients is being implemented. This will provide improved access to services in the community setting, along with domiciliary support for patients who are unable to attend a clinic.

- **A new diabetes model of care** is being introduced to transfer Type 1 & 2 diabetics who are stable to be monitored and managed in local GP practices.

- **Orthopaedics and physiotherapy services within the community setting** are currently being introduced, in conjunction with GPs and the community rehabilitation team.

- **A single provider for non-invasive cardiology diagnostics** for ECGs, 24 hour ECGs, 24 hour BP and Echo’s is being established.

- **A community stroke rehabilitation facility** is under development, with local primary and secondary care clinicians.

4.4.2 Specific developments planned for Bromley residents

### The development of Beckenham Beacon

This large, modern, purpose-built facility is unique in the area. It serves a population of about 100,000. Plans are already established that enable services such as general practice, diagnostics, outpatient clinics and minor surgery to be undertaken in this community setting. This facility will provide a ‘hub’ and a focus for many practices in the area and the facilities will serve to improve health and reduce inequalities in a deprived area. An already existing minor injuries unit is to be further developed to provide a focus for residents in the area who need urgent care.
The PCT expects that two local GP practices will take up occupation under leases in May 2009 (covering a population of around 23,000).

Currently Beckenham Beacon provides:

- Minor injuries unit (to be redesigned as an urgent care service)
- Radiology
- BHT outpatient clinics (including pain, orthopaedics, surgery, medicine, endocrinology, children, ENT, gynaecology, chest, dermatology, rheumatology)
- Ante natal outpatient clinics
- Physiotherapy
- Contraception and reproductive services
- Genitourinary medicine
- Speech and language therapy
- Health improvement service
- Sickle cell and thalassaemia service (working in conjunction with ante natal services)
- Audiology service
- Phlebotomy
- Minor treatments
- Pharmacy dispensing services for outpatient clinics
- Primary Care Refugee Project Team
- Surgical appliances
- Primary care mental health service

The only diagnostics currently on site are X-ray, ultrasound and phlebotomy. It is possible that additional diagnostic services will be included in phase 2.

Bromley PCT (BPCT) will refine plans for the development of Beckenham Beacon, including taking into account the outcomes of the APOH and HfL consultations. BPCT will use these consultations, together with the development of Bromley’s primary care strategy and the estates strategy to improve services for out of hospital care. BPCT will need to consider whether further, similar facilities are needed and appropriate for the population of Bromley and, if so, how they will be developed. These types of developments have the potential to result in significant numbers of patients being seen closer to their homes and treated away from secondary care settings.

Services planned for inclusion in phase 2 of the Beckenham Beacon:

- Diabetic retinal screening to support PCT to offer 100% access for eligible patients in line with national target of March 2008
- Children’s speech and language therapy
- COPD group sessions
- Podiatry (Chiropody)
- District nurse base and clinics for Beckenham and Penge
- Health visitor base and clinics for Beckenham and Penge
- 2 GP Practices including 9.WTE principals, 3WTE salaried - (List size currently 22k population)
- Dental services
- Cardiac rehabilitation service
- GP shared care for substance misuse
- Domestic violence unit

Development of planned care through practice based commissioning (PbC)

It is anticipated that referral management will be maximised in order to reduce unnecessary referrals and, in addition, some community and primary care outpatient/surgical services will be developed as alternatives to traditional secondary care clinics. This has already started in a limited way in 2007/08 with the development of minor surgery capacity within practices, but is anticipated to grow together with the development of further community based surgical, endoscopy, outpatient and diagnostic services.

By the end of 2007/08 it is anticipated that 3,000 outpatient attendances and 500 minor surgical cases will be moved from hospital to the community, as a result of the PbC initiative. This figure will increase from 2008/09 onwards. The PCT anticipates that the pace of change will accelerate and learning from the success of plans in other parts of the country will inform BPCT’s plans. It is anticipated that circa 30% of outpatients and 10% of minor surgery will transfer from acute hospitals into primary care facilities. These figures are part of BPCT’s Commissioning Strategy Plan and are based on plans to expand capacity in primary care. Beckenham Beacon will provide a significant facility to enable this transfer to take place. In addition, the investment in, and expansion of, community teams will provide increasingly specialised care in people’s homes.

The investment in, and expansion of, community teams providing increasingly specialised care in people’s homes

Plans are in place for nine community matrons and 13 case managers to start work by March 2008. Community Matrons will plan, manage and co-ordinate the care of people with complex long term conditions and high intensity needs within the community to reduce the need for full secondary care involvement. Case management techniques will also be used to reduce some unplanned admissions which are caused by poor disease control and lack of effective prevention and support. Each practitioner will have a caseload of around 50 patients, many of whom will have multiple diagnoses.

A rapid response team has been initiated to ensure that patients requiring urgent support can be referred to them for assessment, support and case management rather than go to A&E. The rapid response team is staffed during daytime hours by three trained nurses/emergency care practitioners with advanced assessment skills, and during the out of hours period with one nurse. The team is developing its caseload, which is planned to increase to a maximum capacity of 100 patients per week.

The nurses are based within the community assessment and rehabilitation teams (CART) during the day time (8am to 4pm) and with EMdoc out of normal working hours (from 6pm to 10pm), and provide assessment and short term case management and signposting for patients who would otherwise have been referred to hospital. Unlike the rest of the CARTs team they do not undertake long term management of patients.
Eltham ‘community’ hospital

Greenwich Teaching PCT (GTPCT) is developing a new ‘community hospital’ with forty intermediate care beds in Passey Place in the heart of Eltham.

This requires a capital development; the outline business case is already approved by NHS London and the project now commenced. The proposed development includes:

- **Forty intermediate care beds:** providing intermediate care for patients e.g. those needing rehabilitation following a stroke, re-hydration, blood transfusions or antibiotics for exacerbations of long term conditions or prompt management of urinary tract infections and cellulitis.

- **24 hour, 7 day a week primary care ‘walk-in’ service.**

- **Four partner GP practice (option to extend to a further four partner practice)** as a relocation of existing practices into improved premises.

- **Clinical space for a range of clinical interventions** currently provided on an outpatient basis in hospital e.g. complex wound management and leg ulcer clubs, back and neck pain, sports injury, phlebotomy, & anti coagulation clinics and sessional work to support self care e.g. expert patient programme, health promotion, good neighbour scheme, carer support, and psychological support services.

- **Provision of a range of diagnostic tests:**
  - Non Obstetric Ultrasound
  - Echocardiogram
  - ECG
  - Exercise / Stress Test

- **Provision of a range of outpatient consultations.**

The intention is that this development at Eltham Community Hospital substitutes for the intermediate care capacity of 26 beds currently at the Bevan unit in a building owned by BUPA and located in Thamesmead. This will mean that the Bevan unit closes. Whilst patients will have a choice of the venue they are cared in GTPCT envisages that residents in the north of the borough will then predominantly choose to access the other existing intermediate care beds in the north i.e. ‘Time Court’ in Woolwich and ‘Ash Green’ in Charlton and residents in the south of the borough will predominantly choose to access this new community hospital in Eltham. This plan will provide an overall increase of 14 beds across the borough and will improve services to the older population in the south of the borough. However, a variant of the plan is that there could be a period of double running with the Bevan (i.e. with an addition of 40 beds in total) whilst GTPCT builds up intermediate care in the home setting. The final plan
will be influenced by the outcome of the APOH consultation and may be subject to further public consultation.

- **The development of a new expanded health centre for East Greenwich**

This scheme requires capital development and an outline business case has been written and is currently being actively considered by NHS London. It is envisaged that this will form part of a much wider public sector development on the old Greenwich District Hospital site.

  - The east Greenwich development provides a unique opportunity to re-house several existing **general practices** whose current premises are inadequate within a much wider development that affords opportunities for the expansion of healthcare services in a way which integrates them with other services that local people might use e.g. swimming pool, spa and libraries.

  - The intention is to provide clinical space for a range of clinical interventions currently provided on an **outpatient** basis in hospital e.g. complex wound management and leg ulcer clubs, back and neck pain, sports injury, phlebotomy, & anti coagulation clinics and also to use the shared space available in the wider scheme to offer sessional work to support self care e.g. expert patient programme, health promotion, good neighbour scheme, carer support, and psychological support services.

In addition to the above two centres, which already have business cases developed and where building is planned to commence in 2008-2010, a similar strengthening and consolidation of primary and community based services are being considered for populations in the Plumstead, Woolwich and Thamesmead areas. This will include the development of venues for additional **planned care and walk in services**. As with the existing plans these will take into account existing strengths in provision and gaps in services, as well as the specific needs and aspirations of the local populations. The intention is to bring forward business plans for these three areas by 2008.

- **Development of planned care through practice based commissioning**

In 2007/08 over a 1000 individual **patient pathways** were systematically audited against evidence based good practice guidelines in Greenwich as part of a cycle of audit undertaken by practice based commissioners. This has already resulted in a reduction in unnecessary referrals to acute outpatient clinics. In 2008/09 it will provide practice based commissioners with a rich evidence base for the development of additional services and associated investment that will increasingly offer patients outpatient services in a local primary care setting, further reducing the need to attend an acute hospital unless the expertise or equipment based within it is required to meet the patient’s needs.

- **The investment in, and expansion of, community teams providing increasingly specialised care in people’s homes**

GTPCT has a wide range of existing community based services including three inpatient intermediate care units comprising a total of 46 beds, an existing rapid response team, a falls team, a community rehabilitation team, and 15 community matrons in line with the DH target.
In 2006/7 additional services were established in Greenwich by investments in clinical staff supporting people with neurological needs, with tissue viability needs, with upper urinary tract infections, with chronic lung disease.

In 2007/8 further expansion of clinical services is agreed and underway in Greenwich with investments in clinical staff supporting people needing IV therapy, people who have suffered a stroke, people with cellulitis and leg ulcers, people with diabetes, people with heart problems, adults with asthma, children with asthma and people with tuberculosis.

### 4.4.4 Specific developments planned for Lewisham residents

- **Expansion of primary and community based facilities**

  During 2006-2007 Lewisham has seen some significant new centres open their doors:

  The **Waldron Health Centre** in the north of the borough was opened in July 2007 and provides high quality accommodation for four GP practices. It also provides a range of community services e.g. sexual health and family planning, podiatry, leg ulcer, heart failure and diabetes clinics, phlebotomy etc. During the next year the range of services offered there will be expanded to include facilities for minor surgery and dentistry, a community gynaecology service and health improvement courses. It will also be a resource for the local community with a café and resource rooms.

  The **Downham Healthy Living Centre** opened in May 2007 and is a joint venture with the London Borough of Lewisham. It provides a library, pool, fitness centre, community health services such as immunisation, child health and enuresis, GP practices and specialist dentistry. Additional services are planned for 2007-2008 to offer community gynaecology, paediatric dermatology and a range of services monitoring and treating other long term conditions.

  **Kaleidoscope**, in the centre of the borough, opened in October 2006 and offers a ‘one stop shop’ for children with disabilities, where families can access services from community health, mental health, education, social care and health and voluntary organisations under one roof.

  All of these new facilities support the aim of delivering high quality services nearer to people’s homes, promoting access to care and making the very best use of the skills of LewPCT primary care staff. They offer further capacity for future service developments during 2007-2008 and beyond.

- **The New Cross Walk-in Centre**

  From January 2008 the existing Lewisham Walk-in-Centre will be expanded and enhanced to deliver a co-located service with the McFarlane GP practice in New Cross. This will maintain...
the provision of extended surgery hours within an area of high deprivation, but will integrate
the service with the existing network of primary and community health services.

- **The investment in, and expansion of, community teams providing increasingly
specialised care in people’s homes**

Lewisham PCT has invested to the DH recommended level of specialist community
practitioners such as community matrons and specialist nurses, actively identifying those
patients at greatest risk and working with other primary care providers to manage their needs
in the community long term. A number of specific services are being developed or are
already in operation e.g. urinary tract infection project with care homes to reduce hospital
admission and A&E attendances, intravenous antibiotic therapy at home, LSL Sickle Cell
project to reduce admissions and attendances, with enhanced and integrated community
based services.

Lewisham PCT is strengthening and developing its Intermediate Care Service to support
patients in their own homes and avoid hospital admissions where appropriate, and to expedite
safe and timely hospital discharge and patient rehabilitation.

The Lewisham service is integrated across health and social care and provides two teams,
one to facilitate rapid safe discharge and a second to provide rapid response to avoid
hospital admission and provide care out of hospital. This home based service is in addition to
the 22 bed based service that provides intensive intermediate care within a nursing home
setting.

Developing alternative community services for the management of long term conditions e.g.
community pharmacy is providing an extended and enhanced range of clinical services.
These services, with appropriate dedicated clinical space where necessary are provided in a
wide range of sites across the borough to ensure easy access close to home including, for
example, follow-up out patient anticoagulation blood testing.
This chapter describes the decision-making processes that have supported the development of the PCBC and the options that will be subject to formal public consultation. From this chapter forward the non site specific service models discussed in chapter 4 are translated into feasible site specific options, and the terminology changes from the use of ‘models’ to ‘options’.

5.1 Design principles

The following high level principles have underpinned the development of the APOH health service redesign proposals:

- Proposals for change should be clinically-led.
- NHS services should be provided at all the current OSEL hospital sites to ensure choice and access for patients, although the configuration of these services may change substantially.
- More care should be moved out of hospital to community settings.
- Care should be provided in the highest quality buildings, maximising the use of the existing NHS estate and minimising any investment needed in buildings to bring about the clinical changes needed. This means focusing services on the PFI estate first and avoiding new build on hospital sites.
- Proposals must ensure financial stability for both the hospital and primary/community sectors, deficits cannot be shifted and a whole economy solution is required.
- Any new configuration of services should continue to offer staff flexible and sustainable roles, in order to appropriately rotate staff to maintain training requirements and avoid burnout.
- Opportunities to create larger, specialist teams so that tertiary services can be provided locally should be pursued.

5.2 Overview of process to develop options

There has been a two phase process to develop options and criteria for assessing these.

- Phase One

The first phase was exploratory, and helped to develop a baseline. It saw the evolution of the analysis and thinking about focusing the decision-making on OSEL. This phase ran from December 2005 to July 2007. A summary of this phase is given in Working Paper 6.
Phase Two

The second phase saw APOH focus formally on urgent clinical and financial issues in OSEL, identifying potential service models and options, following clinical advice and recommendations.

APOH completed a stage ‘0’ Office of Government Commerce Review in the first week of July 2007, which recommended formally refocusing APOH on the urgent clinical and financial issues in OSEL. The SRO Review Report addressed the OGC recommendations in August 2007. The new approach was endorsed by NHS London. New governance and project architecture was put in place by September 2007. This included a reformed Project Board, a new Project Executive, a revived Clinical Reference Group, an Out of Hospital Care Forum, Provider Forum, Finance Group and Communications and Engagement group.

The new approach meant that the development of options and criteria needed to be refreshed and reworked to reflect the focus on OSEL. The former options, which had included the Trusts and PCTs in Lambeth and Southwark, were no longer relevant.

Phases One and Two have been underpinned by public involvement

During the pre-consultation engagement, which took place in phase 1, four large deliberative events were held, independently facilitated by Opinion Leader. Over 250 local people (representatively recruited) attended these events and helped develop the ‘people’s principles for change’ (see Chapter 2). The report by Opinion Leader is available on the APOH website. There were also circa 180 small and big meetings with the public and a survey, The Big Ask. Notes from meetings, written responses and the survey responses were analysed by Ipsos-MORI. This report is available on the APOH website.

In June 2007 a further deliberative event was held to develop criteria arising from the ‘people’s principles for change’, independently facilitated by Ipsos-MORI and Finnamore Management Consultants. Again, about 50 local people were representatively recruited to the event. The key findings from this event are available in the report by Finnamore Management Consultants, available on the APOH website and a summary may be found in Appendix 2.

Two more large deliberative events, facilitated by Opinion Leader and also involving Imperial College, were held in late November/early December (a report will be published on the APOH website in due course). Local people were representatively recruited. The purpose of these events was to review the final criteria, as developed by the Directors of Commissioning, used for the short-listing process. Then the public was asked to consider the service models and

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options, taking account of the criteria. An independent report on these events will be available, to supplement the PCBC and consultation process.

Evidence from all of these events has been used to influence: the service models; the options; the criteria used to assess options against; and the more rigorous tests that each of the short listed options will be subject to.

- **Overview of the steps taken in Phase Two**

The following bullet points give an overview of the key steps that were taken in Phase Two to arrive at a short list of options for further consideration.

- **Confirm the clinical advice and recommendations**

In May 2007 the four hospital Medical Directors each led a work stream to start to identify the principles, interdependencies, and benefits to patients of potential service models. An initial clinical plenary was held in June 2007, enabling the work streams to start to share their thinking. The debate continued to grow in its richness over the summer and planning began for a major clinical plenary in September 2007, which would put forward the findings of the work streams as a set of advice and recommendations to the PCTs. At the same time the PCTs developed a programme of work to develop out of hospital care schemes that could support the potential changes to hospital provision.

As part of the new governance arrangements agreements were put in place that ensured the clinical advice and recommendations and work to develop both hospital and out of hospital care options would be reviewed by the Clinical Reference Group (CRG).

The clinical plenary was attended by over a hundred hospital clinicians and a panel of hospital CEOs and the SRO, on behalf of the PCTs. A high level of consensus was reached that the status quo was unsustainable. A series of recommendations for service models was given. This advice is described in Chapter 4. Staff briefings and press statements were put out immediately following the clinical plenary to keep staff, stakeholders and the public informed of the process to develop options.

- **Identify criteria**

Whilst the clinicians developed the service models, the PCT Directors of Commissioning on the Out of Hospital Care Forum, developed criteria for assessing the options. The criteria development took account of the outcomes of the event to develop criteria and weight the ‘people’s principles for change’ that was held in June 2007. The criteria development also involved the Medical Directors, PEC Chairs, Provider Forum and the CRG, who were asked to review the criteria and ensure that the clinical elements of the criteria were appropriate and robust. The clinical criteria were cross referenced and drawn from national standard frameworks and clinical guidelines. The criteria are described in section 5.4.
Review and validate the service models

The service models were taken to the Clinical Reference Group in October 2007 for validation, to enable modelling for the PCBC. The CRG also ensured that there were robust out of hospital care developments planned to support the models for hospital models, receiving briefings about plans for each borough and at a sector level.

Professor Sir George Alberti and NCAT began to review the case for change, recommendations and service models in October 2007.

Draw up a long list of options

The four service models produced a long list of twenty-three site specific options, described in section 5.3.

This initial set of twenty-three options were not specific with regard to the location of:

- Inpatient elective centres.
- Inpatient elective orthopaedic centre(s).
- Daycase facilities.

Adding these variables into the twenty-three options would have created hundreds more options, and so clinical guidance, along with advice from NHS Elect, was sought on the appropriate clinical configuration for the above elective services. The advice from the clinicians and NHS Elect is included in section 5.5.

Apply criteria to the long list to reach a shorter list of feasible options

The application of criteria to the long list, including process and outcome, is described in section 5.4. The application of criteria formed a shorter list of feasible options for the PCBC, which could be put to the public in formal consultation, as outlined in section 5.5. The long list process, application of criteria and confirming the shorter list of options was endorsed by the CRG in November 2007.

Quality assure the process of developing the PCBC

A quality assurance framework was put in place by the SRO to underpin the decision-making and development of the project and PCBC (see chapter 1). As part of this legal advice has been taken throughout the project to ensure that the decision-making processes fulfill legislative and policy requirements. The Office of Government Commerce Reviews in July and November 2007 has also reviewed the governance and decision-making processes.
### 5.3 Long list options

The service models developed resulted in twenty-three site specific options, as set out in the table below:

<table>
<thead>
<tr>
<th>Long List Option</th>
<th>Model</th>
<th>Description</th>
<th>Type of hospital by site</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>BHT</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Status quo, four district general hospitals</td>
<td>A</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>A</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>A</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>M</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>A</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>A</td>
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<tr>
<td>7</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>M</td>
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<tr>
<td>8</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>A</td>
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<tr>
<td>9</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>A</td>
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<td>10</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>A</td>
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<tr>
<td>11</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>B</td>
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<tr>
<td>12</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>B</td>
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<tr>
<td>13</td>
<td>2</td>
<td>2 fully admitting hospitals, 1 medically admitting hospital, and 1 borough hospital</td>
<td>B</td>
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<tr>
<td>14</td>
<td>3</td>
<td>3 fully admitting hospitals and 1 borough hospital</td>
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<td>15</td>
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<td>3 fully admitting hospitals and 1 borough hospital</td>
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<td>16</td>
<td>3</td>
<td>3 fully admitting hospitals and 1 borough hospital</td>
<td>A</td>
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<tr>
<td>17</td>
<td>3</td>
<td>3 fully admitting hospitals and 1 borough hospital</td>
<td>B</td>
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<tr>
<td>18</td>
<td>4</td>
<td>2 fully admitting hospitals and 2 borough hospitals</td>
<td>A</td>
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<tr>
<td>19</td>
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<td>2 fully admitting hospitals and 2 borough hospitals</td>
<td>A</td>
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<tr>
<td>20</td>
<td>4</td>
<td>2 fully admitting hospitals and 2 borough hospitals</td>
<td>B</td>
</tr>
<tr>
<td>21</td>
<td>4</td>
<td>2 fully admitting hospitals and 2 borough hospitals</td>
<td>B</td>
</tr>
<tr>
<td>22</td>
<td>4</td>
<td>2 fully admitting hospitals and 2 borough hospitals</td>
<td>A</td>
</tr>
<tr>
<td>23</td>
<td>4</td>
<td>2 fully admitting hospitals and 2 borough hospitals</td>
<td>B</td>
</tr>
</tbody>
</table>

**Note:**

- **A** = Fully admitting hospital
- **M** = Medically admitting hospital
- **B** = Borough hospital

A full description of each of these types of hospital is set out in Chapter 4.
5.4 Application of criteria to long list

The initial plan was to have a two stage process to reduce the long-list to a manageable short-list:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assess each option against a set of mandatory criteria that each option must meet in order to be included on the short-list.</td>
</tr>
<tr>
<td>2</td>
<td>Assess remaining options against a supplementary set of criteria, referred to as the 'weighted benefits criteria', in order to come up with a ranked list of options. This second set of criteria more directly encompass the people’s principles, as referred to in Section 5.2 above.</td>
</tr>
</tbody>
</table>

In practice, this second stage was not necessary as the first stage reduced the twenty-three options down to three options. It is proposed that these weighted benefits criteria will be used, post consultation, to inform the decision on the preferred option. For reference these weighted criteria are set out in Appendix 3.

- Mandatory criteria that each option must meet

A summary of the criteria used to assess the options is set out in the table below.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Assessment/evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSOLUTE MINIMUM STANDARDS – If any option fails on any constraint then it is discounted and does not proceed further</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Quality and Safety</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to meet guidance &amp; regulation requirements.</td>
<td>Ability to meet relevant national clinical guidelines – demonstrated in the working papers prepared for clinical consensus conferences.</td>
</tr>
<tr>
<td>Critical mass of work to ensure skills of workforce are maintained and developed.</td>
<td>Ability to achieve Royal College Accreditation – demonstrated in the working papers prepared for clinical consensus conferences.</td>
</tr>
<tr>
<td>Travel times for blue light ambulances maintaining safe emergency care.</td>
<td>LAS confirm ability to reach patients within target times &amp; time to hospital.</td>
</tr>
<tr>
<td>Clinical support from primary &amp; secondary care.</td>
<td>Options need clinical support – demonstrated from the clinical consensus conferences.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Assessment/evidence</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Staffing &amp; employment</td>
<td>Able to operate safe clinical rotas and meet the European Working Time Directive (EWTD). Workforce planning needs to demonstrate the ability to operate safe clinical rotas and the ability to achieve EWTD compliance – demonstrated in the working papers prepared for the clinical consensus conference.</td>
</tr>
<tr>
<td>Capacity</td>
<td>Able to care for the predicted number of future patients within the current acute hospital physical capacity (also maximising the use of the best quality estate), without the need for significant additional capital investment in the acute hospital estate. Capacity planning needs to demonstrate space requirements for reconfigured services are able to be met – i.e. number of beds, theatres, clinics required to deliver the activity. Key community schemes need to be operational ahead of hospital reconfiguration – Out of Hospital Care Forum assessment.</td>
</tr>
<tr>
<td>Finance – revenue</td>
<td>Each statutory body must achieve at least financial balance (or in the case of a Foundation Trust a 3% surplus) in each financial year. Trusts where there are high fixed costs (due to estates overheads) must maximize the levels of clinical activity in order to cover these fixed costs and break even. Options in which Trusts have high fixed estates costs, but where the level of clinical activity is significantly reduced from the status quo, will be discounted.</td>
</tr>
<tr>
<td>Finance – capital</td>
<td>Capital expenditure must not exceed the capital funding available in any financial year, and acute hospital capital expenditure needs to be kept to a minimum in order to reduce any further revenue burden. Any option that needs additional acute hospital physical capacity (see above capacity criteria) will require additional capital, and will therefore be discounted.</td>
</tr>
<tr>
<td>Policy</td>
<td>The mandatory policy requirements of the Secretary of State must be delivered. Options need to demonstrate compliance with the Healthcare Commission Standards – as demonstrated by Directors of Commissioning assessment.</td>
</tr>
<tr>
<td>Other law</td>
<td>Compliance with other law, including accessibility of buildings, must be achieved. Buildings need to meet the regulations required e.g. Disability Discrimination Act – Directors of Commissioning assessment. Health &amp; Safety standards also need to be met – Directors of Commissioning assessment.</td>
</tr>
</tbody>
</table>
Criteria | Assessment/evidence
--- | ---
**Deliverability**<br>Must be able to deliver urgent elements of reconfiguration within three years, and all Trusts affected beyond those in OSEL must also be able to deliver their part of the change required within the timescales. | Organisations within OSEL must be able to deliver the urgent elements of reconfiguration within three years – assessment based on degree of service change required.<br><br>Organisations beyond OSEL that are also affected must be able to deliver their part of the reconfiguration required – formal responses from affected trusts.

**Unforeseen circumstances**<br>Ability to respond effectively to a major incident (providers and emergency planning leads). | OSEL needs to be able to respond effectively to a major incident – review of ability to respond.

A summary of the reasons for discounting options is set out in [Appendix 4](#) and a fuller description is available in [Working Paper 6](#). The criteria that were most influential in discounting options were:

- **Capacity** – in many circumstances hospitals did not have the physical capacity to be able to accommodate the planned numbers of patients needing care in future.

- **Finance (capital)** – options that required additional hospital capacity to meet the predicted clinical flows of patients also would require significant capital investment (particularly to convert non-clinical to clinical space), and therefore failed on this criteria too.

- **Finance (revenue)** – in many of the options the use of the existing PFI estate, which carries high fixed costs, was not maximised, thereby creating an imbalance between income and expenditure.

A number of the options were not discounted, but marked as amber, in that one or more of criteria were assessed to be challenging to achieve. However, given the balance of evidence it was not felt strong enough to discount the options altogether at this stage. They should therefore proceed to the next stage for more detailed evaluation, as set out in Section 5.6.
5.5 Short list options

As a result of the process set out in section 5.4, there were three options going forward as the short list for detailed financial analysis and modelling. The short list options were not ranked and no preference has been expressed at this stage. Although discounted, the status quo “do minimum” position was kept in for comparative purposes only. These short listed options have been numbered from one to three:

The “do minimum” position The status quo – do minimum position: four district general hospitals at BHT, QEH, QMS and QEH and limited out of hospital care

Option 1 Two fully admitting hospitals at BHT and QEH, one medically admitting hospital at UHL and one borough hospital at QMS, plus supporting out of hospital care

Option 2 Three fully admitting hospitals at BHT, QEH and UHL and one borough hospital at QMS, plus supporting out of hospital care

Option 3 Two fully admitting hospitals at BHT and QEH, and two borough hospitals at QMS and UHL, plus supporting out of hospital care

Options 1, 2 and 3 will require the provision of additional emergency ambulances: one in option 2 and two in options 1 and 3.

Note
“Do minimum” – is long list option number 1
Option 1 – is long list option number 8
Option 2 – is long list option number 16
Option 3 - is long list option number 22
Configuration of surgical services

Whilst the above options largely focus around the configuration of emergency services, along with obstetrics and paediatrics, the location of elective surgical services needs to be identified. Essentially the configuration of these surgical services is set for each service model and therefore each option, based on the key clinical principle that elective and emergency surgery should take place on separate sites, because:

- this reduces the risk of hospital acquired infection.
- this reduces the likelihood of elective patients having their operations cancelled (either through lack of beds or lack of theatre time) due to a sudden influx of emergency patients.

The Clinical Reference Group also agreed the number and location of elective centres as follows:

- 2 elective inpatient centres.
- 2 orthopaedic centres (co-located with the elective inpatient centres).
- 2 daycase units (co-located with the elective inpatient centres).

For each of the options, excluding the “do minimum” position, the configuration of elective surgical services is set out below, based on the clinical principles outlined above.

<table>
<thead>
<tr>
<th>Option</th>
<th>Location of elective surgical services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medically Admitting Hospital - UHL</td>
</tr>
<tr>
<td>2</td>
<td>Admitting Hospital[1] – UHL</td>
</tr>
<tr>
<td>3</td>
<td>Borough Hospital – UHL</td>
</tr>
</tbody>
</table>

Note (1) For Option 2 there are three possible configurations for the location of elective surgical services as one elective surgical centre needs to be on an admitting hospital site (and there are three such sites). The options are: UHL & QMS, QEH & QMS and BHT & QMS. It was decided that the admitting hospital site should be UHL to ensure that the capacity on this site was best utilised and support to safe medical admissions.

Implications of options for Orpington elective surgery inpatient unit

It should be noted that under the “do minimum” position the existing elective surgical inpatient unit based in Orpington will stay at this location (there is no intensive care service at present at this location, so only non complex surgery can be undertaken). Under options 1, 2 and 3 this unit will move as the elective surgical inpatient units will be based at QMS and UHL, where they will have level 2 ICU support, meaning more complex surgery can be undertaken. BHT will continue to offer a full range of out patient services including hydrotherapy at Orpington. BPCT will also continue to provide an intermediate care facility at the Orpington site. Under these options, the NHS will take the opportunity to ensure the best disposition of services on the Orpington site.
Out of hospital care implications

All options will be supported by the provision of out of hospital care packages (e.g. home care, intermediate care). PCTs are planning to:

- improve the efficiency of existing services.
- expand the current level of service provision.
- or develop new facilities.

The level of additional out of hospital care that is needed to support the delivery of the options differs between PCTs:

<table>
<thead>
<tr>
<th>PCT</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>43</td>
<td>26</td>
<td>99</td>
</tr>
<tr>
<td>Bromley</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Greenwich</td>
<td>45</td>
<td>27</td>
<td>103</td>
</tr>
<tr>
<td>Lewisham</td>
<td>22</td>
<td>13</td>
<td>50</td>
</tr>
<tr>
<td>TOTAL</td>
<td>111</td>
<td>66</td>
<td>254</td>
</tr>
</tbody>
</table>

Currently additional out of hospital care has been identified in bed equivalents, however services will not necessarily be bed based. Examples of the types of developments planned have been outlined in Chapter 4.
6. Detailed Economic Analysis of Pre-Consultation Business Case Options

6.1 Introduction

This chapter of the PCBC provides the analysis of the options set out in earlier chapters. This analysis comprises a full financial evaluation of the short-listed options, and the “do minimum” position which is based on:

- The service dispositions derived from the short-listed options and the clinical propositions resulting from those options.
- The activity consequences resulting from those service dispositions in terms of both out of hospital care and the location for the provision of emergency and elective services within the acute hospital sector.
- The income consequences based on Payment by Results (PBR) tariff or underlying contractual costing for non-PBR services for the respective acute hospitals.
- The application of funding for out of hospital services based on existing commissioning plans and their further development derived from the options and developing healthcare strategies.
- The analysis also sets out the flow of activity between organisations and external to the OSEL health economy.
- The application of improved efficiencies for service provision in acute hospitals, in particular moving to the current top decile of length of stay and options for reducing both variable and fixed costs.
- Demonstrating the impact on the health economy of the separate cross-cutting savings initiatives and capital realisation proceeds related to the acute hospital trusts.
- The financial analysis derives in-year financial performance for each OSEL organisation, including PCTs and respective acute hospital Trusts and also for the OSEL health economy collectively.
- The financial analysis exposes whether the options return the OSEL health economy back into in-year financial balance and the extent to which the options contribute to addressing the brought-forward historic deficits.
- A comparison of the options is presented by demonstrating the net present value (NPV) of the respective discounted cash flows (DCF) of all organisations over a 35 year period, based on the three options for change compared with the status quo (the “do minimum”
position). This analysis has included an assessment of transitional costs and indicative capital requirements.

The analysis comprises eight separate organisations:

- Bexley Care Trust
- Bromley PCT
- Greenwich TPCT
- Lewisham PCT
- Bromley Hospitals NHS Trust
- Queen Elizabeth Hospital NHS Trust
- Queen Mary’s Sidcup NHS Trust
- University Hospital Lewisham NHS Trust.

As the PCBC is focused on OSEL, West Kent PCT has not been involved in the detailed financial analysis.

Whilst the individual PCTs and acute hospital Trusts are currently separate financial entities, this business case sets out to focus on the financial impact of service reconfiguration on the OSEL health economy as a whole, rather than necessarily returning each entity back to financial balance. No assumptions have been made about organisational reconfigurations which, should they develop, could enable further reductions in cost to be realised.

6.2 Current Financial Position

In section 2.8.2, the financial case for change exposed the cumulative financial deficits that the OSEL health economy brought into 2007/08 both in income and expenditure terms and in relation to cash deficits and the implications of extrapolating those positions forward in the absence of fundamental change.

6.3 PFI capacity and costs

Modern hospital facilities have been provided across most of the OSEL health economy through PFI developments. Patients benefit when health services are delivered in modern buildings rather than out-of-date facilities. It is also important to preserve local access to services where that is appropriate.

A significant fixed cost issue for the OSEL health economy is the existence of PFI developments on three of the four acute hospital sites. Such costs are embedded in the cost structures of the individual organisations. No account has been taken of the potential impact of the implementation of International Financial Reporting Standards on reporting PFI projects in the NHS.

The continuing development of out of hospital initiatives, consistent with clinical priorities, together with associated reductions in emergency attendances and ongoing reductions in length of stay, reduces the capacity requirements within acute hospitals. Given the long-term
nature of PFI contractual commitments, it is important to achieve service dispositions that achieve optimum use of PFI capacity to enable cost reductions on sites with greater cost reduction flexibility.

6.4 Process followed and analysis

6.4.1 Process

The APOH review has been conducted with the close involvement of the individual organisations and between professional groups within those organisations. The diagram below shows an overview of the process followed in developing the analysis included in this chapter. The particular features of this process are:

- The development of activity dispositions for each option and agreement of targeted improvements to average length of stay (ALoS) with the involvement of Medical Directors and clinicians and financial management of each organisation.

- The development of income templates based on service dispositions which were reconciled centrally with local Finance Director involvement from each organisation both PCTs and hospital Trusts.

- The evaluation of out of hospital impact and assessment of deliverability by PCT commissioners and Finance Directors.

- The development of out of area impact and sharing of that information with the organisations affected, primarily KCH and D&G.

- Assessment of the impact on the London Ambulance Service.

See section 1.5 for the full APOH governance structure.
6.5 Elements of financial change

6.5.1 Service and activity disposition

As highlighted in the process described above, the service disposition for each short listed option was agreed with the Clinical Reference Group. The PBR activity consequence of this service disposition was analysed for each hospital location. The financial summary of this activity, based on PBR tariff by location of delivery for each option, is summarised in Appendix 5.

6.5.2 Improvements to Average Length of Stay

A review was conducted of existing average length of stay within individual hospitals and comparing this to available data of the top decile nationally. The following comparison was then undertaken to identify improvements within individual hospitals to achieve current national top decile performance.

- Identification of hospital (current) ALoS values for each specialty.

- Reduction of those ALoS values by the percentage improvement in ALoS required to move each hospital into the top decile of current national performance. No assumptions have been made on further improvements in the top decile nationally in the future. The percentage improvements are shown below:
  - reduce BHT ALoS values by 34% across both non-elective and elective specialties. This particularly high impact is influenced heavily by a small number of specialties where peer review across the health economy is being undertaken to achieve improvement.
  - reduce QEH ALoS values by 5% across both non-elective and elective specialties.
  - reduce QMS ALoS values by 15% across both non-elective and elective specialties.
  - reduce UHL ALoS values by 10% across both non-elective and elective specialties.

- These revised ALoS formed the foundation of bed capacity requirements to deliver the activity based upon agreed service configurations for the respective options. Costings took account of this reduced capacity requirement recognising the associated loss of income for excess bed days and the reduced costs implications associated with these performance improvements. In reducing ALoS in hospitals it is essential that out of hospital services and facilities are established and this is an important feature of changes proposed under all options.

- Top decile ALoS performance has been modelled for all change options and has been agreed by acute and non acute clinicians as an appropriate current benchmark to use to develop change proposals. The achievement of this benchmark by all four hospitals is vital to ensure that the activity modelling and financial affordability assumptions are met.

6.5.3 Fixed cost reduction

In developing costings resulting from the service and activity dispositions, the hospitals examined all costs. To the extent that whole services were moved from individual locations,
the aim was to reduce 100% of costs including fixed costs where this was feasible. As has been highlighted previously, this is more limited on those sites with PFI developments in view of the long-term fixed cost implications of contractual commitments.

6.5.4 Cross-cutting initiatives

As highlighted in section 2.8.2, a range of cross-cutting initiatives is being developed, across the Trusts and PCTs. Whilst this programme of work is separate from the service reconfiguration proposals, it has been agreed with NHS London that the financial benefits should be taken into account in the presentation of this document. However, the financial benefits of both programmes of work are presented separately, in order to demonstrate the economic impact of APOH on its own.

The indicative benefits shown in the financial summaries and within the discounted cashflow from the cross-cutting initiatives are the realisation of £10 to £15 million per annum revenue cost savings and a capital realisation of £50 million in the year 2008/09. These savings are still the subject of evaluation and assessment of implementation costs. These savings are presented in subsequent schedules at the OSEL summarised level.

6.6 Options

6.6.1 Description

Chapter 5 describes the options which can be summarised as:

- Option 1: Two fully admitting hospitals, one medical admissions hospital and one borough hospital.
- Option 2: Three fully admitting hospitals and one borough hospital.
- Option 3: Two fully admitting hospitals and two borough hospitals.

The “do minimum” position, the status quo of four district general hospitals, is also included for comparative purposes.

This chapter has applied these definitions related to costings for the four acute hospital Trusts.

6.6.2 Timing

To provide a basis for financial modelling assumptions needed to be made on the pace that the various options could be achieved. In making these assumptions, the views of Professor Sir George Alberti have been considered and, as a consequence, the following assumptions have been made and applied in the modelling:
<table>
<thead>
<tr>
<th>Description</th>
<th>Year of Transition</th>
<th>Preceding years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>2010/11</td>
<td>The “do minimum” position</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for earlier years</td>
</tr>
<tr>
<td>Option 2</td>
<td>2010/11</td>
<td>The “do minimum” position</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for earlier years</td>
</tr>
<tr>
<td>Option 3</td>
<td>2013/14</td>
<td>Option 1 for earlier years</td>
</tr>
</tbody>
</table>

### 6.6.3 Presentation of financial analysis

For each option, individual organisations have prepared financial costings based on their income and expenditure. For income, this was based on the service dispositions and associated activity priced at tariff rates for PBR services. For all other income, this was derived by individual organisations taking account of the impact of service dispositions and also known changes to other income including Research & Development (R&D) funding and support for teaching. Costings of expenditure were derived by the individual organisations which involved a challenge process from the central project team and external support to ensure consistency of costing principles. All costings are based on 2007/08 values. The following sections summarise that information for each of the options. This summarised information is analysed in greater detail in the Appendices as follows:

- **Appendix 6** Summary Income and Expenditure Statements (as summarised in the following text).
- **Appendix 7** PCT Income and Expenditure Statements.
- **Appendix 8** Acute Hospital Trusts Income and Expenditure Statements.

In presenting the financial analysis for each option, the following text includes only summarised information. However, the individual income and expenditure analysis for each organisation can be examined in the respective Appendices as detailed above. At the summary level the following have been identified separately:

- Capital.
- Interest on cash deficit.
- Transitional Costs.
- Recurrent savings from cross-cutting initiatives in the range of £10 - £15 million per annum described earlier.

### 6.7 Capital

As part of this analysis, consideration was given by each acute hospital Trust of the capital consequences resulting from each of the options. This was conducted with external support visiting each Trust in dialogue with both estate and financial management. The two issues evaluated were:
- The requirement for additional specific capital to enable individual options to be implemented (excluding capital requirements that would be proposed by the Trust as part of ongoing investment).
- The potential for capital proceeds as a result of implementing individual options.

As a result of this process, very limited specific capital was identified as being required to achieve the implementation of the options. However it was emphasised that enabling works may be necessary for reconfiguration of wards for specific specialties. The only identified specific capital requirement was at QEH where capacity could be constrained under options 2 and 3. To create some additional capacity, it is proposed to convert existing day bed facilities into acute beds at a cost of £500,000 providing some 20 additional beds.

Consideration was given to the availability of facilities for Out of Hospital services. Earlier sections have identified specific existing facilities and additionally there would be spare capacity released by individual hospitals which would be capable of use for such services. A large number of out of hospital services are provided through LIFT schemes which will not require capital to be provided. However, the revenue cost consequences have been taken into account. As a consequence, no capital has been included for out of hospital provision.

In addition to the specific capital, an overall provisional figure of £10 million has been included centrally as a provision for a range of small-scale works across the health economy to support service reconfiguration.

Under Option 3, there is a significant flow of activity out of the OSEL area, particularly to King’s College Hospital. To enable robust comparison between options, a broad assessment has been made of the cost of providing additional beds to accommodate this transfer of activity, which has been assessed as requiring new build facilities. This has been included within the comparative discounted cash flow for Option 3. The feasibility of such additional capacity will be the subject of more detailed evaluation during the course of consultation. In discussions, King’s College Hospital NHS Foundation Trust has indicated a willingness to work with the APOH Project Team to review the feasibility of this option from their perspective.

As highlighted earlier, the separate cross-cutting initiatives programme has identified potential capital realisation proceeds at an indicative value of £50 million. As a result of this, individual Trusts did not consider that there would be additional proceeds as a result of implementing any of the options.

6.8 Interest on cash debt

As highlighted previously, the OSEL health economy has brought forward deficits both in terms of income and expenditure and cash debt. As a result of changes in the Trust financial regime, to be more compatible with Foundation Trusts, the policy has been adopted of charging interest on cash deficits. In the first year of the adoption of this new policy, some charges were waived. In addition, there is not consistency on the financial funding between individual Trusts.
As a consequence, to simplify the comparison the current forecast charges included in individual Trust financial figures have been extracted and shown at summary level. The current provision amounts to £5.4 million. To the extent that interest at the current NHS rate (4.95%) is charged on the full cash debts, this figure would increase significantly. Should full interest at National Loan Funds rates be charged, this figure could increase under each option and would reach a peak of an additional £7.9 million in the year 2010/11 prior to the impact of future debt reduction. It is understood that continuing consideration is being given centrally to the position of Trusts with large cash deficits and as a consequence no assumptions have been made to alter the current figure in the financial modelling.

6.9 Transitional costs

Within the summary tables, assumptions have been included for both the impact of additional requirements for London Ambulance Service and for workforce consequences. A section is included later in the chapter on the impact on the LAS and the derivation of associated costs. In addition, a preliminary assessment has been undertaken on the workforce implications of the changes under each option. At this stage, these figures should be considered indicative only and will need to be the subject of detailed evaluation as part of the ongoing development of the business case. The figures included under each option are based on the following elements:

<table>
<thead>
<tr>
<th>Transition costs</th>
<th>Option 1 £000s</th>
<th>Option 2 £000s</th>
<th>Option 3 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff restructuring</td>
<td>3,200</td>
<td>2,700</td>
<td>4,400</td>
</tr>
<tr>
<td>Retraining</td>
<td>50</td>
<td>40</td>
<td>68</td>
</tr>
<tr>
<td>Pay Protection</td>
<td>720</td>
<td>603</td>
<td>999</td>
</tr>
<tr>
<td>Double Running</td>
<td>5,627</td>
<td>4,335</td>
<td>13,277</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9,597</td>
<td>7,678</td>
<td>18,744</td>
</tr>
</tbody>
</table>

The amount for double running has included a small provision in hospitals but with three months double running for Out of Hospital changes under option 1 and 2 which has been increased to 6 months for the further growth under option 3 in view of the significant level of change involved. Pay protection has been included in the modelling for a period of three years. In view of the fact that option 3, for the purposes of financial modelling, is achieved via option 1 in its transition, this has been recognised in the modelling of the above costs and only the difference between option 3 and 1 has been added in the year in which option 3 is assumed to be achieved, based on the planning timetable identified earlier in this chapter.

6.10 Financial Comparison of Options

The Appendices detail Income and Expenditure statements at summary, PCT and hospital Trust level and are extrapolated through to the year 2017/18. This detail is not replicated in this text. Although the “do minimum” position is not acceptable either clinically or financially, it is included as a comparative for the three options.
To enable comparison between the options, the following table demonstrates the impact on the in-year financial performance of each option taken one year after implementation of the option. This comparison is used to assess the extent to which the in-year performance is improved following the period in which transition costs are incurred. Whilst the comparison will therefore be the year 2011/12 for options 1 and 2 and the year 2014/15 for option 3, because the modelling is at constant price levels you can make a comparison.

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bexley Funding</td>
<td>£357,306</td>
<td>£357,306</td>
<td>£357,306</td>
</tr>
<tr>
<td>Bexley Commissioned services &amp; costs</td>
<td>(£357,306)</td>
<td>(£357,306)</td>
<td>(£357,306)</td>
</tr>
<tr>
<td>Bexley NET POSITION</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bromley Funding</td>
<td>£427,273</td>
<td>£427,273</td>
<td>£427,273</td>
</tr>
<tr>
<td>Bromley Commissioned services &amp; costs</td>
<td>(£427,273)</td>
<td>(£427,273)</td>
<td>(£427,273)</td>
</tr>
<tr>
<td>Bromley NET POSITION</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Greenwich Funding</td>
<td>£403,879</td>
<td>£403,879</td>
<td>£403,879</td>
</tr>
<tr>
<td>Greenwich Commissioned services &amp; costs</td>
<td>(£403,879)</td>
<td>(£403,879)</td>
<td>(£403,879)</td>
</tr>
<tr>
<td>Greenwich NET POSITION</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lewisham Funding</td>
<td>£451,198</td>
<td>£451,198</td>
<td>£451,198</td>
</tr>
<tr>
<td>Lewisham Commissioned services &amp; costs</td>
<td>(£451,198)</td>
<td>(£451,198)</td>
<td>(£451,198)</td>
</tr>
<tr>
<td>Lewisham NET POSITION</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TRUST</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHT Income</td>
<td>£136,022</td>
<td>£130,859</td>
<td>£140,331</td>
</tr>
<tr>
<td>BHT Expenditure</td>
<td>(£134,922)</td>
<td>(£129,759)</td>
<td>(£139,231)</td>
</tr>
<tr>
<td>BHT NET POSITION</td>
<td>£1,100</td>
<td>£1,100</td>
<td>£1,100</td>
</tr>
<tr>
<td>QEH Income</td>
<td>£146,826</td>
<td>£141,467</td>
<td>£146,756</td>
</tr>
<tr>
<td>QEH Expenditure</td>
<td>(£141,716)</td>
<td>(£145,034)</td>
<td>(£145,494)</td>
</tr>
<tr>
<td>QEH NET POSITION</td>
<td>£5,111</td>
<td>£6,433</td>
<td>£5,263</td>
</tr>
<tr>
<td>QMS Income</td>
<td>£78,348</td>
<td>£78,348</td>
<td>£78,348</td>
</tr>
<tr>
<td>QMS Expenditure</td>
<td>(£75,255)</td>
<td>(£75,255)</td>
<td>(£75,255)</td>
</tr>
<tr>
<td>QMS NET POSITION</td>
<td>£2,421</td>
<td>£1,114</td>
<td>£1,479</td>
</tr>
<tr>
<td>UHL Income</td>
<td>£158,534</td>
<td>£180,442</td>
<td>£132,794</td>
</tr>
<tr>
<td>UHL Expenditure</td>
<td>(£157,649)</td>
<td>(£172,045)</td>
<td>(£137,377)</td>
</tr>
<tr>
<td>UHL NET POSITION</td>
<td>£884</td>
<td>£8,397</td>
<td>(6,583)</td>
</tr>
<tr>
<td><strong>SUMMARY TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSEL POSITION</td>
<td>£9,516</td>
<td>£7,043</td>
<td>£3,259</td>
</tr>
<tr>
<td>Transition costs (LAS and workforce)</td>
<td>(£1,488)</td>
<td>(£825)</td>
<td>(£1,341)</td>
</tr>
<tr>
<td>Interest on cash deficit</td>
<td>(£5,350)</td>
<td>(£5,350)</td>
<td>(£5,350)</td>
</tr>
<tr>
<td>OSEL NET POSITION</td>
<td>£2,678</td>
<td>£868</td>
<td>(3,432)</td>
</tr>
</tbody>
</table>

This demonstrates that all options return the health economy to in-year balance after inclusion of cross-cutting initiatives. However, only option 1 returns each of the individual organisations back to in-year balance and only options 1 and 2 return the health economy to in-year balance without including the cross-cutting initiatives.
6.11 Impact analysis

6.11.1 Out of hospital care

Out of hospital service provision is reflected within the individual Commissioning Strategy Plans of each PCT. These options will require the following financial changes:

- Reduction to the ALOS within hospitals and the reduction of payment for excess bed days. To the extent that this reduces income to acute hospitals, this saving will be reinvested in initiatives out of hospital.

- Based on achieving the existing top decile of ALoS, there are calculated to be capacity constraints at QEH primarily in relation to option 3. At this stage, it has not been considered appropriate to consider building additional capacity. As a consequence, consideration is being given to the feasibility of providing additional care out of hospital to avoid capacity constraints at QEH.

The following table demonstrates at a summarised level the financial impact of the above.

<table>
<thead>
<tr>
<th></th>
<th>Option 1 £000s</th>
<th>Option 2 £000s</th>
<th>Option 3 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>OOH Budget - Excess Bed Day savings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bexley CT</td>
<td>1,342</td>
<td>1,342</td>
<td>1,342</td>
</tr>
<tr>
<td>Bromley PCT</td>
<td>2,925</td>
<td>2,925</td>
<td>2,925</td>
</tr>
<tr>
<td>Greenwich PCT</td>
<td>3,075</td>
<td>3,075</td>
<td>3,075</td>
</tr>
<tr>
<td>Lewisham PCT</td>
<td>1,527</td>
<td>1,629</td>
<td>1,311</td>
</tr>
<tr>
<td><strong>Total Excess Bed Day Savings</strong></td>
<td><strong>8,869</strong></td>
<td><strong>8,971</strong></td>
<td><strong>8,653</strong></td>
</tr>
<tr>
<td>Savings from acute commissioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General medicine</td>
<td>7,685</td>
<td>4,888</td>
<td>19,151</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>1,532</td>
<td>970</td>
<td>2,629</td>
</tr>
<tr>
<td>T&amp;O</td>
<td>3,424</td>
<td>1,515</td>
<td>5,877</td>
</tr>
<tr>
<td><strong>Total acute saving</strong></td>
<td><strong>12,641</strong></td>
<td><strong>7,372</strong></td>
<td><strong>27,657</strong></td>
</tr>
<tr>
<td>Total OOH budget</td>
<td>21,510</td>
<td>16,343</td>
<td>36,309</td>
</tr>
</tbody>
</table>

The delivery of these additional out of hospital services are described in earlier chapters. Financial recognition has been given to financial resources during the period of transition and recognised in the financial modelling.

6.11.2 Out of area impact

As a consequence of the service reconfigurations under the individual options, assessments have been made on the extent to which patients would attend hospitals out of area rather than attending one of the four acute hospital Trusts within OSEL. The results of this flow of activity are shown in financial terms in Appendix 9 by activity and by location. In summary, the flows out of area financially under each option are as follows.
### Income (£000s)

<table>
<thead>
<tr>
<th>Description</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non elective</td>
<td>10,690</td>
<td>8,315</td>
<td>17,875</td>
</tr>
<tr>
<td>Elective inpatient</td>
<td>1,751</td>
<td>1,715</td>
<td>1,820</td>
</tr>
<tr>
<td>Elective daycase</td>
<td>2,675</td>
<td>2,572</td>
<td>2,034</td>
</tr>
<tr>
<td>Outpatient</td>
<td>46</td>
<td>444</td>
<td>444</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>1,387</td>
<td>299</td>
<td>1,512</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>16,549</strong></td>
<td><strong>13,345</strong></td>
<td><strong>23,685</strong></td>
</tr>
</tbody>
</table>

The potential impact of these flows has been discussed with the respective out-of-area acute hospital Trusts. However, the extent to which patients are anticipated to travel out of area and the associated income flowing out of area has impact on overall financial performance, as illustrated particularly under option 3. Recognition has been given in this business case to the possible capital consequences of these transfers.

### 6.11.3 Impact on London Ambulance Service

As part of this analysis, a separate study has been undertaken by ORH Ltd to model the consequences to patient flows and access impacts of the various options. In addition, an assessment was made of the impact on the London Ambulance Service. Separately, LAS costing were established to reflect the implications of additional ambulances and crews. These figures have been included in the costings as follows.

<table>
<thead>
<tr>
<th>Description</th>
<th>Additional Ambulances (Nos)</th>
<th>Annual Cost (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The “do minimum” position</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Option 1</td>
<td>2</td>
<td>1,248</td>
</tr>
<tr>
<td>Option 2</td>
<td>1</td>
<td>624</td>
</tr>
<tr>
<td>Option 3</td>
<td>2</td>
<td>1,248</td>
</tr>
</tbody>
</table>

### 6.12 Summary financial analysis

The financial analysis is set out in the appendices (Appendices 7 and 8), which demonstrate the in-year position of individual organisations and the overall OSEL health economy. In addition to considering the in-year position, further consideration is given to the relative comparison of the different options as a discounted cash-flow model. In addition, further analysis is provided on the impact of the individual options on the cumulative deficits both cash and income and expenditure.

#### 6.12.1 Net present value comparison

A full Discounted Cash Flow analysis has been undertaken for each of the options over a 35 year period compared to the “do minimum” position. This is consistent with NHS guidance for the development of business cases. This PCBC is not primarily concerned with capital investment, which as described earlier only amounts to some £0.5 million for bed reconfiguration at Queen Elizabeth Hospital and an overall provisional figure of £10 million as
provision for a range of small-scale works across the health economy to support service reconfiguration. The summary level NPV is included in Appendix 11 with detailed analysis of the options available. Appendix 11 examines solely the financial details of the individual options reflected in this PCBC. In addition a calculation has been derived of the net present value of the benefits that arise from achieving the cross cutting initiatives described earlier at both £10 million savings per annum and at £15 million per annum and additionally the benefit of £50 million of capital proceeds in the year 2008/09. The overall impact is summarised below.

<table>
<thead>
<tr>
<th>Description (£m)</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 year NPV</td>
<td>1,024.0</td>
<td>999.5</td>
<td>859.2</td>
</tr>
<tr>
<td>1. NPV of cross cutting initiatives at £10m per annum</td>
<td>241.9</td>
<td>241.9</td>
<td>241.9</td>
</tr>
<tr>
<td>2. NPV of cross cutting initiatives at £15m per annum</td>
<td>338.7</td>
<td>338.7</td>
<td>338.7</td>
</tr>
<tr>
<td>Net NPV with 1 above</td>
<td>1,265.9</td>
<td>1,241.4</td>
<td>1,101.1</td>
</tr>
<tr>
<td>Net NPV with 2 above</td>
<td>1,362.7</td>
<td>1,338.2</td>
<td>1,197.9</td>
</tr>
</tbody>
</table>

As demonstrated above all options produce a positive net present value prior to taking the benefits of the cross cutting initiatives and potential capital proceeds which further improve the NPV values.

6.12.2 Impact on carry forward deficits

Earlier sections of this chapter have concentrated on returning the OSEL health economy to in-year break-even. Under the NHS Act 2006, Trusts are required to live within their means and break even over a period of 3 years (in special circumstances extended to 5 years). As has been highlighted, the OSEL health economy entered 2007/08 with a cumulative shortfall which, under the financial regime described, it should recover. In addition, the recently changed cash regime requires cash deficits to be repaid. Whilst the earlier analysis has demonstrated the ability to return the health economy to in-year balance, it has not addressed the ability to recover historic operating and cash deficits. The following table exposes the projected position under each option, extrapolated to the year 2017/18, in recovering cumulative income and expenditure deficits and cash debt. Whilst significant improvements are demonstrated against the status quo (the “do minimum” position), there continue to be cumulative income and expenditure and cash debts which have not been recovered.
The above table is analysed by year at Appendix 10 and reflects the Income and Expenditure impact only and excludes capital items.

In addition to the Income and Expenditure impact on the carried forward cash position reflected in the above table, there is a further in-flow of cash resulting from capital proceeds less capital spend which would improve the cash position under the “do minimum” and all options by a further £39.5 million.
6.13 Sensitivity Analysis

A full sensitivity analysis has not been undertaken at this stage. It is considered that sensitivities would generally impact consistently across the various options and therefore their relative comparison would be consistent. However, there are some factors which impact differently across options. The main general sensitivities are:

- The impact on interest on cash debt and its imposition – this has been assessed earlier in this chapter.
- The potential change in accounting for PFI projects.
- The extent to which tariffs will be unbundled and the implications for services both in and out of hospital.
- The extent to which the assumptions for loss of income for R&D and training which has been recognised in the projected income assumed is ameliorated.
- The full implications of the cost of implementation of the European Working Time Directive and the implications for establishments and consequential staff costs Some account has been taken of this impact at hospital level but these need refining and indications are that there could be a risk of £3 to £4 million.
- The ability to realise change within the short timescales assumed under each of the options.
- The achievement of reduced lengths of stay within the acute hospitals to achieve top decile nationally.
- The assumptions made in relation to transitional costs concerned with workforce issues – these will be refined prior to final consideration of the options.
- The impact of general efficiency savings beyond those to return the OSEL health economy to in-year break-even.

This final sensitivity presents the greatest financial risk to the financial modelling in this PCBC. The issue is a consistent risk against all the options and does not remove or change the requirement for urgent action. The cost reductions required under these options are significant. However, the NHS has a further requirement to deliver annual savings of 3%. The ability to deliver such savings, in addition to those in the business case, is inevitably a major risk, especially in the years of transition. This saving is largely driven through the lower level of inflation applied to tariff income relative to the general level of inflation for acute trust income. To the extent that this poses a risk for acute hospital trusts, this would need to be managed across the OSEL health economy.

6.14 Refining analysis and other issues

The analysis undertaken is robust to enable conclusions to be reached and evaluated on direction of travel and the financial issues in relative comparison between the options. Further refinement will be necessary prior to developing any final decisions on implementation of any option. This will be both in terms of activity flows and associated income, but also relative to the fundamental change in cost structures at individual Trusts. In addition the assessment of transitional costs for workforce is based on broadly based assumptions without the detailed evaluation of workforce consequences.
6.15 Conclusion

This section has demonstrated the extent to which the various options return the OSEL health economy into financial balance and the implications for individual Trusts, both financially and in associated delivery of activity, together with a range of implications for these changes.

6.16 Impact assessments

APOH seeks to improve the quality and accessibility of care and to make a significant contribution to ensuring financial sustainability in the OSEL health economy. APOH must also ensure that inequalities in health are not increased. The re-design of services must deliver a reduction in inequalities and improvements to health.

There is a statutory requirement to undertake an equality impact assessment on reconfiguration proposals. However, as APOH is likely to result in fundamental changes in the way services will be provided in the future, there are other important potential impacts that which need to be considered, such as the impact on the environment.

It is proposed to take an integrated approach and assess the impact of the proposals more widely, to include equality, health inequalities, the environment, transport and access. A specialist provider will be commissioned to undertake integrated impact assessments on the options that are put forward for consultation during the consultation period. A steering group is being established to guide the process of the impact assessment. Impact assessment is also built into the project’s engagement strategy.

6.17 Benefits realisation

Relating to the case change as set out in chapter 2, the expected benefits of APOH are:

- A benefits realisation framework will be designed to support the delivery of the agreed objectives for APOH. This will ensure that the benefits intended are realised.

- Metrics will be defined against each objective of the project, so that progress towards delivering the benefits is tracked and monitored. These metrics will relate to the planned activity needed to implement the eventual chosen option and will include, for example, clear measures for clinical, quality, staff and financial benefits.

- Even before an option is agreed, it will still be possible to determine early benefits from the project, such as increased public and clinical engagement.
7. Transition and implementation

Once consultation is finished and a decision is reached by the Joint Committee of PCTs about the future shape of services in OSEL, there will be a period of transition when changes to services will be planned in detail, in readiness for full implementation. Some preparatory planning can take place early for example identification of the increases in out of hospital care.

PCTs, NHS Trusts (acute and mental health), social care, and ambulance services will need to work closely together to ensure that plans are drawn up and implemented to achieve the aim that patients receive their care at the most appropriate and clinically effective place, in line with the finally agreed option. Clinicians from all professional backgrounds and organisations will need to be intrinsically involved and in many cases leading the change planning process.

Patients and members of the public will be invited to participate in the transition and implementation planning.

A detailed governance and programme plan will be established which will ensure that the transition from the current configuration to the final configuration of services is planned and managed effectively.

7.1 Sequencing and timetable for clinical change

As a principle, out of hospital services and ambulance services will be developed first prior to changes to hospital services. The working assumption is that these services will be developed between 2008 and 2010.

The endpoints for implementation of the changes to hospital services, by option are:

<table>
<thead>
<tr>
<th>Option</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>2010/11</td>
</tr>
<tr>
<td>Option 2</td>
<td>2010/11</td>
</tr>
<tr>
<td>Option 3</td>
<td>2013/14*</td>
</tr>
</tbody>
</table>

*At the earliest – it should be noted that the greatest level of uncertainty concerning implementation accompanies option 3, as the timeline extends over the longest time period

The endpoints, as well as being dependent upon the development of out of hospital care, are also reliant on sufficient capacity being available or developed at neighbouring hospitals, where some activity will flow. This includes King’s College Hospital NHS Foundation Trust and Darent Valley Hospital (Dartford and Gravesham NHS Trust). Detailed transition and implementation planning will be undertaken for whichever option is chosen, following consultation.
7.2 Transition planning

If services are transferring between hospitals, receiving hospitals will need to be ready, in terms of having the physical facilities available (e.g. beds, theatres); having staff available, either existing or transferring with the clinical service; and having sufficient clinical support services (e.g. pharmacy, diagnostics). As it is proposed that three options will be put forward for public consultation, along with the “do minimum” position for comparative purposes, there are a number of transition scenarios to be planned.

- **The “do minimum” position**

Under the “do minimum” position, there will be no transition plan as such but there will be increasing pressure on services as they become less and less viable, clinically and financially. Out of hospital services will developed very slowly, if at all. Contingency plans will need to be drawn up in the event that services can no longer be staffed or financially supported.

- **Options 1 and 2**

Under options 1 and 2, detailed transition and implementation plans will need to be developed depending which option is agreed, after the consultation has completed and the results have been considered.

There will be, however, certain aspects of preparatory planning, which can usefully happen whichever option is eventually chosen, ahead of the close of consultation as described in the programme management section in chapter 8:

- Setting up the clinically led working groups to consider care pathways and clinical networks, as described below.

- Determining common themes to all option scenarios, excluding the baseline, such as out of hospital care, urgent care centres, paediatric assessment, elective centres.

- Beginning to establish how these could operate most effectively: building on best practice and service transformation evidence; identifying how they could be staffed; assessing lead in times for setting them up; and identifying clinical dependencies.

- Determining what cannot be resolved until the final option is decided.

- Once the final option is agreed, planning the detail of the implementation.

- **Option 3**

Similarly, under option 3 detailed transition and implementation plans will need to be developed, after the consultation has completed and the results have been considered. Option 3 will have a longer timeframe for transition and implementation, and in reaching towards its endpoint it will pass through options 1 and/or 2 as a transition point.
7.3 Developing care pathways and networks

The programme plan will need to consider how the necessary changes will be made to care pathways and clinical networks, such as:

- Urgent and emergency care including trauma and emergency surgery.
- Elective surgery.
- Children’s services.
- Maternity.
- Musculo-skeletal conditions.
- Services for older people.
- Long term conditions.

Supporting clinical services, for example:

- Diagnostics and theatres.

It is envisaged that clinically led working groups or networks will be established, if not already in place, to lead the planning and implementation of the agreed change. This will need careful consideration with clinicians to ensure that the potentially complex sequencing of moves of services is done in a way which is clinically safe.

7.4 Operational support work streams

The clinical work streams and networks will be supported operationally by detailed planning for workforce, organisational development, transport/access, estates, supplies, market development of out of hospital services, and business case development.

Planning for changes to the workforce will be a particularly important work stream. It will consider crucial issues such as sustaining services while change takes place, the impact of any necessary ‘double running’, maximising existing skills, and meeting any training requirements. Robust human resources and change management arrangements will need to be secured to support the transition and implementation phases. Cost estimates of staffing changes have been included in the financial schedules of this PCBC.
8. Results and SRO Recommendations

8.1 Options going forward to public consultation

8.1.1 Public involvement in the development of options

The options presented in this PCBC have been subjected to a number of criteria, in order to be selected as clinically and financially feasible and deliverable.

The development of options has been accompanied by a programme of engagement with clinicians and members of the public and patients. A further two events were held at the end of November/early December 2007 to gain input from local people into the options. These deliberative style events focused on gathering reactions from a representative cross section of the public to the options and assessed how they are seen to fit with the case for change, in order to help shape the final options for the formal consultation.

A separate and independent report about the outcomes of these events is being produced by the facilitators, Opinion Leader Research.

8.1.2 The options

Four service models, responding to the case for change, were described in chapter 4. These formed the basis for identifying the site specific long list of clinically viable options in chapter 5. Criteria were applied to derive a shorter list of feasible site specific options; and in chapter 6 the shorter list was subject to financial analysis and modeling to ensure that as well as being clinically viable and practically deliverable, they were also affordable and financially sustainable.

The result of the assessment and analysis undertaken in chapters 5 and 6 is that it is proposed that there is a range of three options to put forward to formal public consultation, and the “do minimum” position will be included only for comparative purposes.
The “do minimum” position: four district general hospitals at BHT, QEH, QMS and QEH and limited out of hospital care

<table>
<thead>
<tr>
<th>BHT</th>
<th>QEH</th>
<th>QMS</th>
<th>UHL</th>
<th>Limited out of hospital care</th>
</tr>
</thead>
<tbody>
<tr>
<td>District general hospital</td>
<td>District general hospital</td>
<td>District general hospital</td>
<td>District general hospital</td>
<td>Ambulance services</td>
</tr>
</tbody>
</table>

**Option 1**
Two fully admitting hospitals at BHT and QEH, one medically admitting hospital at UHL and one borough hospital at QMS, plus supporting out of hospital care

<table>
<thead>
<tr>
<th>BHT</th>
<th>QEH</th>
<th>UHL</th>
<th>QMS</th>
<th>Out of hospital care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully admitting hospital</td>
<td>Fully admitting hospital</td>
<td>Medically admitting hospital</td>
<td>Borough hospital</td>
<td>Ambulance services</td>
</tr>
</tbody>
</table>

**Option 2**
Three fully admitting hospitals at BHT, QEH and UHL and one borough hospital at QMS, plus supporting out of hospital care

<table>
<thead>
<tr>
<th>BHT</th>
<th>QEH</th>
<th>UHL</th>
<th>QMS</th>
<th>Out of hospital care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully admitting hospital</td>
<td>Fully admitting hospital</td>
<td>Fully admitting hospital</td>
<td>Borough hospital</td>
<td>Ambulance services</td>
</tr>
</tbody>
</table>

**Option 3**
Two fully admitting hospitals at BHT and QEH, and two borough hospitals at QMS and UHL, plus supporting out of hospital care

<table>
<thead>
<tr>
<th>BHT</th>
<th>QEH</th>
<th>UHL</th>
<th>QMS</th>
<th>Out of hospital care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully admitting hospital</td>
<td>Fully admitting hospital</td>
<td>Borough hospital</td>
<td>Borough hospital</td>
<td>Ambulance services</td>
</tr>
</tbody>
</table>

Options 1, 2 and 3 will require the provision of additional emergency ambulances: one in option 2 and two in options 1 and 3.
Implications of options for Orpington elective surgery inpatient unit

It should be noted that under the “do minimum” position the existing elective surgical inpatient unit based in Orpington will stay at this location (there is no intensive care service at present at this location, so only non complex surgery can be undertaken). Under options 1, 2 and 3 this unit will move as the elective surgical inpatient units will be based at QMS and UHL, where there will be level 2 ICU support, meaning more complex surgery can be undertaken. BHT will continue to offer a full range of out patient services including hydrotherapy at Orpington. BPCT will also continue to provide an intermediate care facility at the Orpington site. Under these options, the NHS will take the opportunity to ensure the best disposition of services on the Orpington site.
8.1.3 The hospital service disposition for the options and the “do minimum” position is as follows:

The “do minimum” position: The status quo – do minimum position: four district general hospitals at BHT, QEH, QMS and QEH and limited out of hospital care

<table>
<thead>
<tr>
<th>BHT</th>
<th>QEH</th>
<th>UHL</th>
<th>QMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>District general hospital</strong></td>
<td><strong>District general hospital</strong></td>
<td><strong>District general hospital</strong></td>
<td><strong>District general hospital</strong></td>
</tr>
<tr>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
</tr>
<tr>
<td>Level 3 critical care</td>
<td>Level 3 critical care</td>
<td>Level 3 critical care</td>
<td>Level 3 critical care</td>
</tr>
<tr>
<td>Acute medicine</td>
<td>Acute medicine</td>
<td>Acute medicine</td>
<td>Acute medicine</td>
</tr>
<tr>
<td>Obstetrics including level 2 neonatal intensive care</td>
<td>Obstetrics including level 2 neonatal intensive care</td>
<td>Obstetrics including level 2 neonatal intensive care</td>
<td>Obstetrics including level 2 neonatal intensive care</td>
</tr>
<tr>
<td>Inpatient paediatric service</td>
<td>Inpatient paediatric service</td>
<td>Inpatient paediatric service</td>
<td>Inpatient paediatric service</td>
</tr>
<tr>
<td>Complex inpatient surgery</td>
<td>Complex inpatient surgery</td>
<td>Complex inpatient surgery</td>
<td>Complex inpatient surgery</td>
</tr>
<tr>
<td>Inpatient Elective Surgery</td>
<td>Inpatient Elective Surgery</td>
<td>Inpatient Elective Surgery</td>
<td>Inpatient Elective Surgery</td>
</tr>
<tr>
<td>T&amp;O surgery</td>
<td>T&amp;O surgery</td>
<td>T&amp;O surgery</td>
<td>T&amp;O surgery</td>
</tr>
<tr>
<td>Day case surgery</td>
<td>Day case surgery</td>
<td>Day case surgery</td>
<td>Day case surgery</td>
</tr>
<tr>
<td>Outpatients and diagnostics</td>
<td>Outpatients and diagnostics</td>
<td>Outpatients and diagnostics</td>
<td>Outpatients and diagnostics</td>
</tr>
</tbody>
</table>
### Option 1
Two fully admitting hospitals at BHT and QEH, one medically admitting hospital at UHL and one borough hospital at QMS, plus supporting out of hospital care (by 2010/11)

<table>
<thead>
<tr>
<th></th>
<th>QEH</th>
<th>BHT</th>
<th>UHL</th>
<th>QMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admitting</strong></td>
<td>Admitting</td>
<td>Medically Admitting</td>
<td>Borough</td>
<td></td>
</tr>
<tr>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
<td>A&amp;E – receiving medical emergencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care centre</td>
<td>Urgent Care Centre</td>
<td>Urgent Care Centre</td>
<td>Urgent Care Centre</td>
<td>Urgent Care Centre</td>
</tr>
<tr>
<td>Emergency surgery – admission and treatment</td>
<td>Emergency surgery – admission and treatment</td>
<td>Emergency surgery – admission and treatment only by exception in life threatening circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3 critical care</td>
<td>Level 3 critical care</td>
<td>Level 3 critical care</td>
<td>Level 2 critical care</td>
<td></td>
</tr>
<tr>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td></td>
</tr>
<tr>
<td>Inpatient paediatric service</td>
<td>Inpatient paediatric service</td>
<td>Paediatric Ambulatory Centre</td>
<td>Paediatric Ambulatory Centre</td>
<td></td>
</tr>
<tr>
<td>Complex IP surgery</td>
<td>Complex IP surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatients and diagnostics</td>
<td>Outpatients and diagnostics</td>
<td>Outpatients and diagnostics</td>
<td>Outpatients and diagnostics</td>
<td>Intermediate care (step up and step down) &amp; rehabilitation beds</td>
</tr>
</tbody>
</table>
Option 2  Three fully admitting hospitals at BHT, QEH and UHL and one borough hospital at QMS, plus supporting out of hospital care (by 2010/11)

<table>
<thead>
<tr>
<th>BHT</th>
<th>QEH</th>
<th>UHL</th>
<th>QMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fully Admitting</strong></td>
<td><strong>Fully Admitting</strong></td>
<td><strong>Fully Admitting</strong></td>
<td><strong>Borough</strong></td>
</tr>
<tr>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
<td></td>
</tr>
<tr>
<td>Urgent care centre</td>
<td>Urgent Care Centre</td>
<td>Urgent Care Centre</td>
<td>Urgent Care Centre</td>
</tr>
<tr>
<td>Level 3 critical care</td>
<td>Level 3 critical care</td>
<td>Level 3 critical care</td>
<td>Level 2 critical care</td>
</tr>
<tr>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
</tr>
<tr>
<td>Inpatient paediatric service</td>
<td>Inpatient paediatric service</td>
<td>Inpatient paediatric service</td>
<td>Paediatric Ambulatory Centre</td>
</tr>
<tr>
<td>Complex inpatient surgery</td>
<td>Complex inpatient surgery</td>
<td>Complex inpatient surgery</td>
<td></td>
</tr>
<tr>
<td>23 hour day case surgery</td>
<td>23 hour day case surgery</td>
<td>23 hour day case surgery</td>
<td></td>
</tr>
<tr>
<td>Outpatients and diagnostics</td>
<td>Outpatients and diagnostics</td>
<td>Outpatients and diagnostics</td>
<td>Outpatients and diagnostics</td>
</tr>
<tr>
<td>Intermediate care (step up and step down) &amp; rehabilitation beds</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Option 3  Two fully admitting hospitals at BHT and QEH, and two borough hospitals at QMS and UHL, plus supporting out of hospital care (2013/14 at earliest)

<table>
<thead>
<tr>
<th></th>
<th>QEH</th>
<th>BHT</th>
<th>UHL</th>
<th>QMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Admitting</td>
<td>Fully Admitting</td>
<td>Borough</td>
<td>Borough</td>
<td></td>
</tr>
<tr>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
<td>A&amp;E – receiving trauma (level 2), medical, surgical and paediatric emergencies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care centre</td>
<td>Urgent Care Centre</td>
<td>Urgent Care Centre</td>
<td>Urgent Care Centre</td>
<td></td>
</tr>
<tr>
<td>Emergency surgery – admission and treatment</td>
<td>Emergency surgery – admission and treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3 critical care</td>
<td>Level 3 critical care</td>
<td>Level 2 critical care</td>
<td>Level 2 critical care</td>
<td></td>
</tr>
<tr>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td>Medical Assessment Service – including Older Person’s Assessment Unit</td>
<td></td>
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<tr>
<td>Inpatient paediatric service</td>
<td>Inpatient paediatric service</td>
<td>Paediatric Ambulatory Centre</td>
<td>Paediatric Ambulatory Centre</td>
<td></td>
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<tr>
<td>Complex Inpatient surgery</td>
<td>Complex Inpatient surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inpatient Elective Surgery</td>
<td>Inpatient Elective Surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elective Orthopaedic Centre</td>
<td>Elective Orthopaedic Centre</td>
<td></td>
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<td></td>
<td></td>
<td>23 hour day case surgery</td>
<td>23 hour day case surgery</td>
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<tr>
<td>Outpatients and diagnostics</td>
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<td>Outpatients and diagnostics</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intermediate care (step up and step down) &amp; rehabilitation beds</td>
<td></td>
</tr>
</tbody>
</table>
8.1.4 Out of hospital care

For options 1, 2 and 3 out of hospital care will be developed from 2008-2010 to support the hospital provision as described in chapter 4. In summary, by borough developments include the following (please note under some categories there are already existing services and these are not included here, only recent or planned developments are highlighted):

<table>
<thead>
<tr>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lewisham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care</td>
<td>Urgent care centre at QMS</td>
<td>Urgent care centre at QEH</td>
<td>Urgent care centre at UHL</td>
</tr>
<tr>
<td></td>
<td>Beckenham Beacon inc minor injuries</td>
<td>24/7 walk in service at Eltham community hospital</td>
<td>New Cross Walk in Centre</td>
</tr>
<tr>
<td></td>
<td>unit/urgent care centre – see section 4.4.2</td>
<td>Plans for walk in services in Plumstead, Woolwich, Thamesmead</td>
<td></td>
</tr>
<tr>
<td>Community hospital/facility</td>
<td>Beckenham Beacon</td>
<td>Eltham community hospital</td>
<td>Waldron Health Centre</td>
</tr>
<tr>
<td>offering GP services, outpatients, diagnostics, minor surgery etc</td>
<td></td>
<td>New expanded health centre for East Greenwich</td>
<td>Downham Healthy Living Centre</td>
</tr>
<tr>
<td>Increased GP/community care for specific pathways/services</td>
<td>Anticoagulation service</td>
<td>Development of planned care in primary care settings</td>
<td>Alternative services for management of long term conditions including community pharmacy</td>
</tr>
<tr>
<td></td>
<td>GP based diabetes service</td>
<td></td>
<td>Anticoagulation service</td>
</tr>
<tr>
<td></td>
<td>Orthopaedics &amp; physiotherapy service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-invasive cardiology diagnostics</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stroke rehab facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP services</td>
<td>2 GP practices at Beckenham Beacon</td>
<td>Four partner practice relocation to Eltham community hospital</td>
<td>Four partner practice relocation to Waldron Health Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New expanded health centre for East Greenwich</td>
<td>GP services at Downham Healthy Living Centre</td>
</tr>
<tr>
<td>Home care and community matrons/case management</td>
<td>Virtual wards</td>
<td>Increase to 9 community matrons and 13 case managers</td>
<td>Specialist home care for IV therapy, stroke care, cellulitis/leg ulcer care, diabetes care, asthma care, cardiac care, TB care</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------</td>
<td>----------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Intermediate care:</td>
<td>Bridging team Consultant or nurse consultant clinical management Increase to 50 IC beds</td>
<td>Increased case management</td>
<td>40 new beds at Eltham community hospital</td>
</tr>
<tr>
<td>Children’s services</td>
<td>Child development centre at QMS</td>
<td>Beckenham Beacon</td>
<td>Home care for asthma</td>
</tr>
</tbody>
</table>
8.2 SRO recommendation

<table>
<thead>
<tr>
<th>Option</th>
<th>Achievable</th>
<th>Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8.2.1 Rationale for recommendation

Following the identification of the case for change, development of service models, application of criteria and detailed analysis outlined in this PCBC, the rationale for the recommendation is:

- **Clinical viability**
  
  Options 1 and 2 and 3 are clinically viable.
  
  The “do minimum” position is not clinically viable.

- **Financial viability**
  
  Options 1, 2 and 3 are financially viable.
  
  The “do minimum” position is not financially viable.

- **Capacity considerations**
  
  The capacity required from neighbouring hospitals and in terms of out of hospital care is achievable for options 1 and 2.

**Options 1 and 2 require (using the modelling assumptions):**

- 83 beds capacity at Darent Valley Hospital (Dartford and Gravesham NHS Trust) in both options.
- 55 beds capacity at King’s College Hospital NHS Trust in option 1 and 23 beds capacity in option 2.

Option 1 requires provision of out of hospital care packages (e.g. home care, intermediate care), equating to 111 beds.

Option 2 requires provision of out of hospital care packages (e.g. home care, intermediate care), equating to 66 beds.
Option 3 requires (using the modelling assumptions):

83 beds capacity at Darent Valley Hospital (Dartford and Gravesham NHS Trust).
138 beds capacity (probably some new build) at King’s College Hospital NHS Foundation Trust.

Option 3 requires provision of out of hospital care packages (e.g. home care, intermediate care), equating to 254 beds.

For option 3, the increased activity at neighbouring hospitals is likely to require major capital investment by King’s College Hospital NHS Foundation Trust and the additional out of hospital activity will require higher levels of spending by the PCTs over and above that required for options 1 and 2. Achieving option 3 will therefore require a longer timeline and will be reached via options 1 and/or 2 as a transition point. Reaching the transition point is attainable; however, moving to the endpoint of option 3 will require further detailed implementation planning over and above that required for options 1 and 2. This will be explored further with the NHS organisations affected during consultation.

A robust assessment of option deliverability will be completed and made available to assist the JCPCT in its decision making, post-consultation, on which option to take forward for implementation.

8.2.2 Rationale for ranking

Based on the performance against the ‘must pass’ criteria, the financial and activity modelling and the feasibility of delivering each option, a provisional ranking of the three options has been made.

Option 3 is ranked third. It is clinically viable (for hospital services) and financially viable. However, whilst it may deliver the greatest clinical benefit, it takes a much longer timescale to deliver these. Also, the ability to secure capital, and to ensure the clinical viability of out of hospital care, will need further testing once the transition point (option 1 and/or 2) is achieved.

Option 2 is ranked second. It is clinically and financially viable. However, it does not optimise the clinical recommendations on maternity, neonatal and seriously ill children’s services made by hospital clinicians.

Option 1 is ranked first. It is clinically and financially viable and meets the greatest number of clinical benefits for hospital care in the shortest timescale.

This provisional ranking of options will be revisited in light of completing an assessment of the benefits of each option and in light of views raised during consultation.
8.3 Moving forward

8.3.1 Overview of consultation process and timetable

The table below represents an initial plan for the consultation. The three PCTs and one Care Trust have undertaken detailed work on local communications and engagement plans. These have been developed with the input of local PPI Forums and Health Overview and Scrutiny Committees. Plans are not set in stone, but may be amended and revised as a consequence of consultation. If local groups request a consultation event APOH will respond to this, and will also further target specific seldom heard groups if it is established that they are not represented in consultation responses being received.

Imperial College London’s Centre for Health Management has been commissioned to receive and independently analyse all responses to the consultation. They have reviewed the draft consultation document and options, using this to write the consultation questions to ensure there is no bias, and that APOH is eliciting people’s genuine views. The testing of draft questions was done as a part of the deliberative events which took place in late November/early December. Following the final analysis of consultation responses, Professor Rifat Atun who heads the Centre, will present the findings to the Joint Committee of PCTs.

There will be two core consultation documents, one will be the full consultation document and one will be the summary consultation document. The summary consultation document will be distributed to every home within the boroughs of Lewisham, Greenwich, Bexley, Bromley and on a postcode basis to homes in West Kent who use services in OSEL. Newspaper advertisements will be placed in the boroughs of Lambeth, Southwark and in West Kent which will direct patients who may be affected by the proposals to a freephone number or the project website to obtain further copies of the summary or the full consultation document.

Consultation events will be held in early 2008. They will be held at different times to ensure that people who work are able to respond, as well as people who do not wish to come out when it is dark. There is a firm commitment to listening, and reviewing the approach as consultation progresses, and advice will be taken from the Consultation Advisory Panel in planning the style of events.

Consultation events will also incorporate the Healthcare for London consultation, with discrete branding, presentation sections and response forms to make it clear to which consultation people are being asked to give a response.
**Consultation timetable**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Dec 2007</td>
<td>Joint Committee of PCTs considers proposals for A Picture of Health full public consultation and associated documentation.</td>
</tr>
<tr>
<td>Days 1-5 of consultation</td>
<td>Consultation documents are delivered to every home in Outer South East London, and are available at NHS outlets. Formal consultees will be sent letter inviting a response and documents.</td>
</tr>
<tr>
<td>4 weeks after date of launch</td>
<td>Receive interim report from Imperial College on consultation responses to date, and plan remedial action as necessary.</td>
</tr>
<tr>
<td>January –March 2008</td>
<td>Re-visit those community groups, attended during pre consultation phase, who ask or require a further visit, and enact communications and engagement plans for each borough.</td>
</tr>
<tr>
<td>April</td>
<td>Consultation ends.</td>
</tr>
<tr>
<td>Early May 2008</td>
<td>Imperial College to send final consultation report to the SRO.</td>
</tr>
<tr>
<td>Late May 2008</td>
<td>Feedback event* (see note below).</td>
</tr>
<tr>
<td>Late May 2008</td>
<td>Imperial College report Executive Summary and full research study is published on the A Picture of Health website.</td>
</tr>
<tr>
<td>End June 2008</td>
<td>All respondents and organisations involved in the consultation will be written to explaining the decision taken and a summary of the implementation plan.</td>
</tr>
</tbody>
</table>

* Feedback Event Outline

A public event will be held to feedback following the consultation. This will be prior to the Joint PCT Committee meeting. The event will have presentations from Prof Rifat Atun, Imperial College on the consultation findings, Professor Sir George Alberti on the clinical models, the Joint Health Overview and Scrutiny Committee on their view of the consultation, and a question and answer session with the PEC chairs and Medical Directors.

The meeting will be a public meeting (demand will need to be assessed and tickets issued if appropriate). Invitees will include Health Overview and Scrutiny Committee members, members of the project work streams, Local MPs, MEPs and GLA members, Leaders of local Councils, Lewisham’s Mayor, all Board members from the four PCTs and Care Trust, and the four hospital trusts, London Ambulance Service representative, South London and the Maudsley NHS Foundation Trust and Oxleas Mental Health NHS Foundation Trust representatives, King’s College Hospital NHS Foundation Trust and Dartford and Gravesham NHS Trust representatives and LINKs.
### 8.3.2 Overview of decision-making process/timetable

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 December 2007</td>
<td>JCPCT committee will consider the business case, National Clinical Access Team report and consultation documents. If agreement is reached, a date for formal consultation will be announced.</td>
</tr>
<tr>
<td>19 December 2007</td>
<td>NHS London will note the JCPCT’s plans for consultation and satisfy itself that the PCBC is sound.</td>
</tr>
<tr>
<td>January 2008</td>
<td>Formal Consultation starts.</td>
</tr>
<tr>
<td>April 2008</td>
<td>Formal Consultation ends.</td>
</tr>
<tr>
<td>Early May 2008</td>
<td>Imperial College will issue report to SRO.</td>
</tr>
<tr>
<td>End May 2008</td>
<td>Joint Overview and Scrutiny Committee will meet to consider the consultation process.</td>
</tr>
<tr>
<td>End May 2008</td>
<td>Feedback Event.</td>
</tr>
<tr>
<td>June 2008</td>
<td>Joint PCT Committee meeting to consider the findings from Imperial College report and the feedback event discussion. The decision will then be taken on how to best configure services.</td>
</tr>
</tbody>
</table>
8.3.3 APOH management arrangements going forward

To date APOH has been managed as a project, but moving forwards needs to be managed as a programme, comprising multiple projects. The management arrangements will be refreshed at appropriate intervals as the programme moves to different phases of its life. Once the pre-consultation business case is agreed, the programme will move into the consultation phase, whilst needing to prepare for decision making post consultation. Preparation will begin for implementation planning.

An overview of the phases of work, as currently envisaged, is shown in the diagram that follows:

The high level activities as shown in the diagram above, together with the responsibilities for delivery, are:

- The development of the PCBC and the consultation document. This is being delivered by the SRO, central programme team, with support from work stream leads.

- Programme design, management and monitoring. This will be delivered by the programme management office.

- The work associated with the consultation phase will be led by the consultation work stream with delivery support from local teams in the PCTs and Trusts. Each PCT and Trust will have their own plan, which will be overseen by the consultation work stream manager.

- Updating the PCBC/full business case and monitoring implementation against the PCBC/full business case. This will be delivered by a business case team.

- Implementation planning will need to be delivered by joint teams from the PCTs and Trusts, with support from the programme management office.
WORK IN PROGRESS

- Transition management will need to be delivered by joint teams from the PCTs and Trusts, with support from the programme management office.

- Implementation will be delivered by the PCTs and Trusts.

NHS London will play a quality assurance and performance management role throughout the process.

Each phase of work will be coordinated by a programme management office, reporting through the Programme Director to the SRO. There will be a number of work streams for each phase, which will change in line with the requirements of the phase. Each work stream will have an accountable lead, who will be held accountable for delivery against their work stream plan.

There is a detailed programme initiation document (PID) which describes in detail how the programme is to be managed in the future. It also guides the work of the programme team. The PID is available as a working paper, and also includes full information on the programme management office and governance arrangements.
9. Appendices

Ch 1

1. Outline of APOH Communications and Engagement

Ch 5

2. Key findings from the criteria development event, June 2007
3. Draft weighted benefits criteria
4. Summary of evidence used to produce the APOH short list (table)

Ch 6

5. Activity summary
6. Summary income and expenditure statements
7. PCT income and expenditure statements
8. Acute trust income and expenditure statements
9. Out of area flows
10. Summary carry forward income and expenditure and cash
11. Discounted cash flow

Working papers – available at www.apictureofhealth.nhs.uk

Ch 1

1. Borough communications and engagement plans
   - Bexley communications and engagement plan (1a)
   - Bromley communications and engagement plan (1b)
   - Greenwich communications and engagement plan (1c)
   - Lewisham communications and engagement plan (1d)
WORK IN PROGRESS

- Staff briefing about September 2007 Acute Clinical Plenary (1e)

**Ch 4**

2. OSEL approach to urgent care (2a) and UC processes (2b and 2c)

3. Improving access and quality: medical assessment service

4. Delivering choice at the end of life

**Ch 5**

5. Overview of the process to develop options

6. Summary of evidence used to produce the APOH short list