Better Services, Better Value

Summary of draft pre-consultation business case

3 May 2013

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This document is set out as follows:

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SECTION 1 – WHY ARE CHANGES BEING PROPOSED?

The NHS cannot stay the way it is – we need to change

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- Our communities, the way we live and the type of healthcare we all want are **constantly changing**, yet the way we provide health services has largely stayed the same for 30-40 years
- The **safety and clinical quality** of services at your local hospital depends on what day of the week it is, what time of day or night it is, and which hospital you go to
- When we are very sick or need emergency care, it is important that the **most senior, experienced and specialist staff** are on hand **at the hospital 24 hours a day, seven days a week**
- To achieve this we need to **concentrate teams of highly trained professionals at fewer hospitals** to make services safer and better
- We need to provide **more services in the community**. In particular, provide preventative and supportive care to people with long term conditions so they are healthier and less likely to be admitted to hospital

A recent report from NHS London showed that patients have a much higher chance of dying if they go into hospital at the weekend, compared to a weekday. Across London hospitals, this could mean 520 lives are needlessly lost each year; locally, it means we could save around 80 more lives by doing things differently.

We want to save more lives and deliver better services

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- We are **failing to meet London Quality Standards** and Royal College guidelines
- **London Quality Standards** are clear that the **most senior, experienced and specialist doctors and nurses should be available at weekends** as well as during the week. This is not the case in all our hospitals at the moment
- **Maternity units** should have the **most senior, experienced and specialist staff** available on labour wards **24 hours a day, during the week and at weekends**, in case mothers or babies get into difficulties during the birth and need emergency medical help
- We can provide better quality care by carrying out **routine operations in separate dedicated facilities.** We want to do this for all, except the most complex, inpatient surgery and plan to establish a state of the art facility in south west London and Surrey for inpatient planned surgery

We need to change the way we provide health services to respond to this and improve the quality and safety of care. We do not believe we can guarantee the highest quality of care with the way our services are currently organised.

There are opportunities to respond to continuing improvements in healthcare to save people's lives

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- **Advances in technology and treatments** continue to revolutionise healthcare. **A knock-on effect of these advances is the increasing need for specialist staff**
- It is becoming difficult for every hospital to have every type of specialist staff, and even if they did, there **would not be enough patients at each hospital** to treat to maintain their expertise
- To ensure specialist staff treat enough patients to maintain their skills, we need to **centralise services**
- We have **already done this in London** for the treatment of heart attacks, stroke, cancer and major trauma with designated centres for each of these. Survival rates are now much higher as a result

To respond to improvements in healthcare, we need to deliver services differently. We have already done this successfully for a number of conditions.

Better financial outcomes can be delivered by reorganising healthcare services

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- **Value for money** plays a part in Better Services, Better Value, **but firstly it is about saving lives**
- **Funding has not been cut**, we just need to **spend it differently to cope with rising demand**. The demand for services is rising because the population is growing and many people are living longer, often with long-term conditions
- 50% of people who use our A&E departments could be **treated better, more quickly and at lower cost to the NHS in an urgent care centre**
- People with **long-term conditions** could be **treated in the community and in their own homes**. This should stop them from becoming sicker and needing to be admitted to hospital. This is good for patients who are more likely to be kept well and at home, and it saves the NHS the cost of emergency hospital admissions and long stays in hospital wards

We want to deliver a fundamental shift in the way health services are delivered – meaning more care is delivered in the community, by GPs and in people's homes, with hospitals becoming specialist centres of excellence for those who really need them because this is how we make better use of what we have got.

No change is not an option

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- There are **not enough qualified, senior people in training**, so we would not be able to recruit additional senior staff required across the five sites to meet the recommended clinical standards
- If these trainees did exist, we could **not afford the extra staff required**
- We would **not be able to meet the standards of care and safety** that are being introduced in other London hospitals (London Quality Standards), meaning our patients would receive a service that was not as good as those being developed elsewhere in London hospitals
- We would **overspend our budget** to the point where our services would reach crisis point in the next few years as we would not be able to deliver services cost-effectively
- We would **not be able to invest** as much money **in services outside hospital** to support people with long term conditions and deliver better care in GP surgeries, community settings and in people's homes

We have considered not moving services and working to deliver the recommended improved services at all five sites. However, we do not believe this is a viable option clinically and financially.

The benefits of reconfiguration

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- More patients would receive **improved quality of care** and get the best health outcomes first time around, therefore reducing the need for further treatment or hospital readmission
- There would be more **investment in GP and community services** to deliver out of hospital care
- We would have the required number of **experienced and specialist staff** on hand at the hospitals and provide the necessary training to ensure skills are maintained – the financial savings from reconfiguration would help us to meet the London Quality Standards for best practice clinical care
- The reconfiguration would **improve the finances of local hospitals**, making them financially viable for the future
- The four hospital trusts as a whole, and the NHS community service providers, would be able to **afford to provide the necessary health services** for the population within the available NHS budget
- Reconfiguration would improve hospital infrastructure, with between £200-£300 million being invested in existing hospital facilities

These proposals would be better value primarily because they would ensure the best possible NHS services for all local people.

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SECTION 2 – WHAT ARE THE PROPOSED CHANGES?

Patients and clinicians have influenced and developed these proposals

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- The review has been **clinically led** by over **100 doctors, nurses, midwives and other clinicians** from south west London and Epsom and surrounding areas, organised into six clinical working groups

- A **Patient and Public Advisory Group** was set up with members from all geographical areas impacted by BSBV. Patient representatives and the group have met throughout the review, helping us to steer the programme in the right direction and ensuring we engaged properly with local people

- We have talked to **local people, communities, staff and others with an interest**, including local authorities and the voluntary sector. We have attended over 100 meetings with local people

- Following the widening of the scope of the review to include Epsom Hospital, there has been involvement of **Surrey Downs and Epsom Hospital clinicians.** We agreed that the clinical working groups should meet again and include extra members from Epsom Hospital and GPs from Surrey Downs Clinical Commissioning Group

Patients and clinicians have been involved in influencing and developing the proposals through clinical working groups, the Patient and Public Advisory Group and meetings with local people and online surveys

The process of agreeing on the options for consultation

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We had a carefully structured, five-stage process for doing this:

1. **Development of non-financial criteria and options**

   Online survey and three large events held in January 2012 to get public input. Clinicians and patient representatives were brought together to decide how each factor should be weighted. When Epsom Hospital was included, a **large-scale event was organised at Epsom** racecourse

2. **Financial 'hurdle' to rule out options that would not work financially**

   Financial assessment of all available options was carried out by a **specialist team of financial experts and agreed by the directors of finance** from each trust

3. **Non-financial assessment**

   Remaining options were assessed by **an expert NHS panel**, who worked with a data pack containing information relevant to the assessment of each of the options against the non-financial criteria

4. **Financial assessment**

   Remaining options were assessed financially by our **specialist team of financial experts and accountants and agreed by the hospital directors of finance**

5. **Recommendation by the Better Services, Better Value Programme Board**

   Our **Clinical Strategy Group and Programme Board** looked at the outcomes and held further discussions about the best way to shape services in the future

The local doctors and nurses' recommendations

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Local doctors and nurses support the need for change and recommend the following by 2017:

- More and better **services outside hospital**, including in GP surgeries, community health settings and at home
- Three expanded **emergency departments**. Two hospitals would no longer provide emergency care. All five hospitals to continue to provide urgent care
- Three expanded **maternity units** led by consultant obstetricians with co-located **midwifery led** units. Two hospitals would no longer provide obstetric-led maternity units
- A separate, **stand-alone, midwife-led birthing unit** for women with low risk pregnancies, at a hospital that no longer provides obstetric-led maternity services, if public support and affordable for the local NHS
- A **network of children's services** with St George's Hospital at its centre. This would include inpatient beds, children's A&E and children's short stay units at the three hospitals with emergency services. Two hospitals would no longer have an A&E or inpatient beds for children
- A **planned care centre** for all inpatient surgery, except the most complex, on a separate site from emergency care, meaning that planned operations are not disrupted or delayed by emergencies

Over 100 local doctors, nurses, midwives, health professionals and patient representatives have met in different clinical groups. They strongly believe the NHS must change.

The types of hospitals and services offered (1 of 2)

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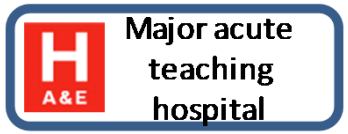
Type of Hospital	Types of services offered
Major acute teaching hospital 	• Major Trauma Centre • Hyper Acute Stroke Unit • Heart attack centre • A range of tertiary services • Consultant-led 24/7 A&E department, plus a co-located urgent care centre • Obstetric-led maternity services with co-located midwife-led unit • Acute inpatient medicine, including care of the elderly • Emergency inpatient surgery • Intensive therapy unit, high dependency unit • Hub for children's specialist and tertiary care • Children's A&E, Children's Short Stay Unit and Children's ward • Level 3 Neonatal Intensive Care Unit • Paediatric Intensive Care Unit • Full range of diagnostic and therapeutic services (including magnetic resonance imaging, computerised tomography, ultrasound scan, X-Ray, interventional radiology, therapies, pharmacy, dietetics) • Day surgery, outpatient (including antenatal, sexual health, pain clinic, paediatrics, mental health) and ambulatory services
Major acute hospital 	• Consultant-led 24/7 A&E department, plus a co-located urgent care centre • Obstetric-led maternity services with co-located midwife-led unit • Acute inpatient medicine, including care of the elderly • Emergency non-complex inpatient surgery • Intensive therapy unit, high dependency unit • Children's A&E, Children's Short Stay Unit and Children's ward • Level 2 Neonatal Intensive Care Unit or Local Neonatal Unit • Full range of diagnostic and therapeutic services (including magnetic resonance imaging, computerised tomography, ultrasound scan, X-Ray, interventional radiology, therapies, pharmacy, dietetics) • Day surgery, outpatient and ambulatory services

The types of hospitals and services offered (2 of 2)

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Type of Hospital	Types of services offered
Local hospital with elective centre 	• Elective medical procedures, including endoscopy and lithotripsy • Stand alone Urgent Care Centre • Level 2 Intensive Care Unit • Diagnostics (including plain X-ray, ultrasound scan, computerised tomography, magnetic resonance imaging) • Therapies • Outpatients, including antenatal, sexual health, pain clinic, paediatrics, mental health • Daycase surgery including ophthalmology (for adults, not children) • Primary care health centre + out of hours GP service • Rehabilitation beds • *May include a stand-alone midwife-led unit* • *May include step up beds dependent on further discussions on beds requirement across the Area*
Local hospital 	• Stand alone Urgent Care Centre • Diagnostics (including plain X-ray, ultrasound scan) • Therapies • Outpatients • Daycase surgery (for adults not children) • Primary care health centre + out of hours GP service • *May include a stand-alone midwife-led unit* • *May include rehabilitation and/or step up beds dependent on further discussions on beds requirement across the Area*

80% of footfall currently attending each Local Hospital would continue to get there treatment there

The recommended options for reconfiguration

- One major acute teaching hospital, at **St George's**, providing stroke, heart attack and major trauma services. It would also have a A&E, obstetric-led maternity unit, specialist children's inpatient unit and a children's ward

- Two major acute hospitals, at **Kingston** and either **Croydon** or **St Helier**, providing emergency and urgent care and obstetric-led maternity services with an attached midwife-led unit. These hospitals would also have children's inpatient wards

- One local hospital, at either **Epsom** or **St Helier**, with a planned care centre, diagnostics, outpatients and day surgery

- One local hospital, at either **St Helier**, **Epsom** or **Croydon**, with diagnostics, outpatients and day surgery

The Programme Board has **recommended 3 options** that have been ranked in order of preference:

Rank	Croydon	Epsom	Kingston	St George's	St Helier
Preferred	Major acute hospital	Local hospital with elective centre	Major acute hospital	Major acute teaching hospital	Local hospital
Alternative	Major acute hospital	Local hospital	Major acute hospital	Major acute teaching hospital	Local hospital with elective centre
Least preferred	Local hospital	Local hospital with elective centre	Major acute hospital	Major acute teaching hospital	Major acute hospital

The preferred option

Rank	Croydon	Epsom	Kingston	St George's	St Helier
Preferred	Major acute hospital	Local hospital with elective centre	Major acute hospital	Major acute teaching hospital	Local hospital

Configuration of the preferred option

- **St George's** is a major acute teaching hospital
- **Kingston and Croydon** are major acute hospital
- **Epsom** is a local hospital with a planned care centre
- **St Helier** is a local hospital

Rationale

- **This option scored highest** on the overall financial and non-financial appraisal
- This configuration where the local hospital with elective centre would be located on the Epsom site **plays to the strengths of Epsom's existing estate and capability** by locating the elective centre there, and has a relatively **low capital cost** which is reflected in the high financial appraisal score

The alternative option

Rank	Croydon	Epsom	Kingston	St George's	St Helier
Alternative	Major acute hospital	Local hospital	Major acute hospital	Major acute teaching hospital	Local hospital with elective centre

Configuration of the alternative option

- **St George's** is a major acute teaching hospital
- **Kingston and Croydon** are major acute hospitals
- **St Helier** is a local hospital with a planned care centre
- **Epsom** is a local hospital

Rationale

- **This option scored lower than the preferred option** and slightly higher than the least preferred option in the overall financial and non-financial appraisal
- Scores lower in the financial appraisal than the preferred option, as it would require a **significant additional in-area capital investment** of approximately £100m. This is broadly a consequence of building a new elective centre at St Helier rather than expanding the existing one at Epsom
- However, this option faces **considerably fewer delivery challenges than the least preferred option** (see pg 19) and, as a consequence, is assessed as the next preferred option

The least preferred option

Rank	Croydon	Epsom	Kingston	St George's	St Helier
Least preferred	Local hospital	Local hospital with elective centre	Major acute hospital	Major acute teaching hospital	Major acute hospital

Configuration of the least preferred option

- **St George's** is a major acute teaching hospital
- **Kingston and St Helier** are major acute hospitals
- **Epsom** is a local hospital with a planned care centre
- **Croydon** is a local hospital

Rationale

- **This option scored lower than the preferred option** and slightly higher than the alternative option in the overall financial and non-financial appraisal
- However this option would be least preferable because it would have a **high level of associated delivery risks**
- The delivery risks are primarily due to the loss of emergency and maternity services in Croydon resulting in a **considerable flow of activity to King's College Hospital's** ability to accommodate projected activity in maternity and emergency care
- The least preferred option has the **highest estimated out of area capital costs** which raises the total capital requirement to the highest by far of all options. This was not reflected in the score in the financial evaluation.

Potential development of a stand-alone midwife-led unit

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- Local doctors and midwives believe that a **stand-alone midwife-led unit** (**SAMLU)** at one of the two local hospitals would be a **clinically safe option** that would provide additional choice for some women. They believe this unit **could support at least 1000 women to give birth**, depending on where it is located

- This unit would be **open to women who are considered to be suitable for a home birth and who are at low risk of having complications** during childbirth. If complications do arise, women and babies would be transferred by blue light ambulance to the nearest hospital with consultant obstetricians available

- Such a unit may be **potentially expensive to run if not enough women were to give birth there**. We would need to first work out whether it was something local women would want to use and to ensure we had enough demand for the service, but it is something we would actively like to consider

- We have started to have **conversations with local women** about their views on a standalone midwife-led unit, both through an online questionnaire and going to speak with local mothers groups. We have found that many local mums are supportive of the idea, especially if they have previously had midwifery-led care. Common anxieties we heard were around the safety of such a unit given there would be no doctors on site

- During the consultation we would like to **explore how local people feel about the development of a stand-alone midwife-led unit**

The financial outcomes of reconfiguration

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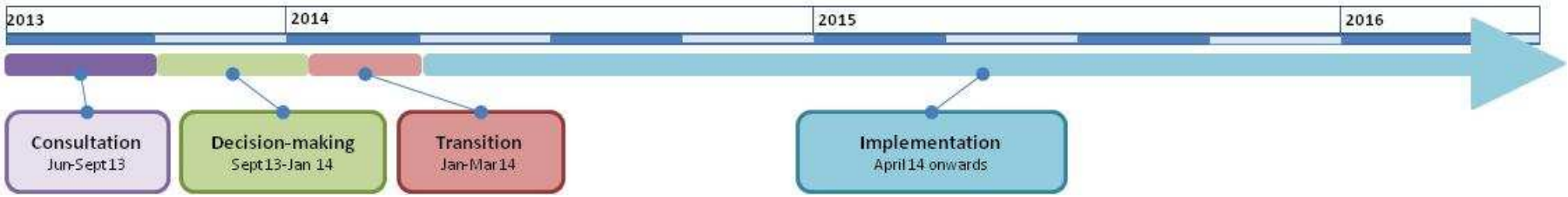
- The budget for the local NHS has not been cut, however our **costs are going up**. Our calculations have shown that **by not making changes to services we would put our financial viability at risk**
- More and better clinical and financial outcomes would be delivered by **organising the healthcare services differently.** This would **require capital investment**
- Depending on the option selected after consultation, **capital investments of £197-£305m will be required** at the five hospital sites and there will also be capital investment needed to accommodate the limited activity that would be served by hospitals outside the area
- Post consultation we would need to apply for capital funding for reconfiguration

Rank	Croydon	Epsom	Kingston	St George's	St Helier	In area capital requirement (£m)	Estimated out of area capital requirement (£m)	2017/18 improvement on baseline (£m)
Most preferred	Major acute hospital	Local hospital with elective centre	Major acute hospital	Major acute teaching hospital	Local hospital	197	51	40
Alternative	Major acute hospital	Local hospital	Major acute hospital	Major acute teaching hospital	Local hospital with elective centre	298	51	32
Least preferred	Local hospital	Local hospital with elective centre	Major acute hospital	Major acute teaching hospital	Major acute hospital	305	137	36

- We have worked out that our **preferred option would save nearly £40m a year** to invest in more and better health services for the NHS by 2017/18, while the next best financial option would save £36m more than the 'no change' option

The timeline of the changes

- **Improvements in out of hospital and community services** have **already begun** and these alternatives need to be in place and working well before any hospital-based services are closed
- If the proposals are agreed following public consultation, the **A&E and maternity units would not close until the other three hospitals have expanded** to cope with more patients
- We are not proposing to implement the changes immediately – it would take **four to five years** to develop out of hospital services and create the capacity in the three major acute hospitals to accommodate projected activity



- In implementing any reconfiguration option the **risks for delivery need to be managed carefully.**
- Experience of other similar programmes has informed us that we need to focus on:
  - Delivery of Out of Hospital initiatives
  - Availability of capital
  - Tracking of implementation
  - Monitoring changes in other NHS providers

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SECTION 3 – WHAT WILL THESE PROPOSALS MEAN TO SERVICES FOR PATIENTS?

The impact of the changes

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- In order to deliver the recommended improved standards **for quality and safety** we believe we would need to **make changes** to the way the services are provided

- Changes have been recommended for the following services:
  - **Community** and **GP** practices
  - **Urgent** and **emergency** services
  - **Maternity** services
  - **Children's** services
  - **Planned care** services

- This section outlines what the recommended **changes to the services could mean to the local area**

Recommended changes to community and GP practices

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What are the current problems?

- There is **not enough support in the community** to keep people well and out of hospital
- People do **not always find it easy to access support in the community**, especially out of hours
- We need an approach to 'end of life' services that **better addresses patients' needs**
- Many patients with **long term conditions** go undiagnosed and poorly managed and the total number is expected to rise

What are the recommended changes to the services?

- **More support** for patients to self manage their long term conditions
- Much **more care would be delivered in GP surgeries, community settings and at home**
- We would **deliver Out of Hospital care** and a commit to working together with neighbouring CCGs to develop initiatives that are aligned and to share best practice
- **NHS 111 services** to provide signposting to the most appropriate local services
- **Improved proactive identification and intervention** for patients at **high risk** of needing hospital admission, including patients with long term conditions
- **Roll out of 'coordinate my care' to support** everyone in having a **dignified end to their life in a location of their choice**
- Major and sustained **investment and improvement in community-based services**
- More **joined up services** with health and social care working more closely together
- **Hospitals would become specialist centres of excellence** and people would only go to hospital if they really needed to

Recommended changes to urgent and emergency services

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What are the current problems?

- Your chances of **a good outcome depend on when** you are admitted as an emergency
- We do **not meet best practice standards** of emergency care
- **A&E and urgent care** services are **not organised as well** as they could be
- We need to **improve community-based services**
- Providing extra doctors is **not as simple as just recruiting** them
- Hospital care is expensive, meaning **preventable visits to A&E cost the NHS money** that it could be spent better elsewhere

What are the recommended changes to the services?

- **Better information** for patients about how to access emergency and urgent services because we know we could do this better. The Department of Health is working with the wider NHS to be clearer about what urgent care services are and how they are described
- All **five hospitals to have urgent care centres** available 24 hours to be able to see patients with minor injuries or illnesses
- Concentrate emergency care in **expanded units in three hospitals**, rather than the current five, to ensure senior doctors and highly experienced emergency and critical care teams are on hand to treat patients swiftly and safely.
- **Better access** to GPs out of hours for urgent conditions, as well as better support in the community for people with long term conditions and end of life care

Recommended changes to maternity services

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What are the current problems?

- Our maternity services do **not meet best practice clinical safety standards**
- We **cannot achieve senior doctor cover 24 hours a day**, seven days a week for all five maternity units in south west London by 2017/18
- There have been **too many maternal deaths** in London hospitals that could have been avoided
- We need to **balance safety, capacity and patient choice**

What are the recommended changes to the services?

- Every woman in labour should have at **least one-to-one midwife care**
- Women and their babies would continue to receive the majority of their **antenatal and postnatal care close to their homes** with their GP practice or local midwife teams
- Concentrate obstetric-led services in **three expanded units** rather than the current five, bringing together a highly trained workforce in three hospitals. These will be co-located with **midwifery led** units
- One the local hospitals may have a **stand-alone midwife-led unit** if there is enough demand and support for this
- Women would have **a choice about whether to give birth in a midwife-led unit or at home** if they wanted to

Recommended changes to children's services

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What are the current problems?

- Children often end up **in hospital when they do not need to**
- Children's services are **not meeting best practice clinical standards**

What are the recommended changes to the services?

- **St George's Hospital at the centre of a new network** of children's services to ensure high quality of care across the area and provide world class standard of specialist care to the sickest children
- Investment in **better services for children in the community** to provide more care closer to home and reduce the need for admission to hospital. This will include **urgent care centres** at the five hospital sites that will be open 24 hours a day, 7 days a week
- Each hospital with an A&E should have a **dedicated children's A&E open 24 hours a day, seven days a week** led by consultants to provide the children needing emergency care fast access to experienced paediatricians
- Each A&E should also have **a short stay unit for children** where they can be monitored for up to 36 hours without requiring admission to hospital
- An **inpatient children's ward** at each major acute hospital for children needing a longer stay in hospital

Recommended changes to planned care services

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What are the current problems?

- **Too many operations get cancelled** due to emergencies elsewhere in hospital
- Surgeons do **not always get enough practice** to develop their expertise

What are the recommended changes to the services?

- **Separate planned and emergency care** by creating a specialist planned care centre. This would mean that patients could benefit from improved care, shorter waiting time and a much lower chance that their operations would be cancelled at the last minute

SECTION 4 – WHAT IS THE CONSULTATION PLAN?

Consultation plan

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- Our Consultation Plan has been approved by the Joint Health Overview and Scrutiny Committee (JHOSC) subject to some minor comments and amendments
- Detailed **individual plans** for each borough/area have been developed and will be shared with the Clinical Commissioning Groups (CCGs) and JHOSC councillors from each borough for their input
- Our **consultation approach** will aim to focus more activity in the areas most impacted by the changes
- This is likely to mean fewer public meetings in areas such as Wandsworth and Kingston if the current proposals in the pre-consultation business case are put forward, with **more in the areas most impacted**, though we will hold **at least one public event** in each borough
- We will also hold **roadshows** across the whole patch, encouraging people to respond to the consultation
- Our approach is based on best practice advice from the **Consultation Institute**

Our consultation approach

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We aim to begin a 12-14 week consultation in spring or early summer 2013. We want as many people as possible to be aware of the consultation and to respond

In addition to a number of engagement events, the consultation document and summary version will be made available at:

- Hospitals (A&E departments and Urgent Care Centres)
- GP surgeries
- Pharmacies
- Opticians
- Community based primary care services (walk-in centres, primary care centres)
- Sports centres/football and rugby clubs
- Voluntary organisations
- Local Authority customer service areas
- Libraries
- Citizens Advice Bureaux
- Job Centres
- Schools via Local Authorities
- Colleges/Universities
- Faith organisations and centres
- Local businesses

How will we be consult with patients and the public?

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We plan to actively consult with communities using the following general methods:

- Roadshow events in each borough
- Public meetings and events
- Supplying consultation materials to patients using primary, secondary and community care services
- Website and social media activity
- News media

And also a targeted approach for hard to reach communities and to address gaps in responses:

- Community outreach work to target seldom heard groups and those most likely to be affected by change; working with a network of **Health Guides** who have local insight and connections
- Close liaison with **Community Development Workers**
- Focus groups

How GPs could be involved with the consultation

CCGs will be the local leaders of the public consultation. Current proposals needing **GP support** include:

- **14 public events** – 2 each in Croydon, Sutton, Merton, Epsom & Ewell. 1 each in Elmbridge, Reigate and Banstead, Mole Valley, Kingston, Richmond and Wandsworth – independently facilitated

- **1 GP/practice staff event** in each CCG – independently facilitated

- **10 events for provider trusts** – independently facilitated

- **Roadshow events** (approx. 4 per borough) to raise awareness of the consultation across the patch, e.g. in areas of high footfall such shopping centres and train stations - GP support is desirable for 2 to 3 events per borough

- **Meetings to which we are invited** by MPs, residents groups, etc – as an example, NWL participated in or organised **200 meetings** in total