

**Save Lewisham Hospital Campaign
Lambeth Keep Our NHS Public**

Our response to

**South East London:
Sustainability and Transformation Plan**

Footprint: South East London, No.30

OHSEL's Final draft submitted to NHS England October 21st 2016

20 November 2016

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South East London: Sustainability and Transformation Plan

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Executive summary of SLHC & LKONP's response to OHSEL's Sustainability and Transformation Plan (STP)

	Page
1.1: Our concerns about the SE London STP	3
1.2: What we positively want from Health and Social Care in SE London	3
1.3: NHS England and consultancy methodology is misleading and potentially dangerous	4
1.4: Clinical engagement	4
1.5: The importance of the national environment, 'Footprints' and STPs	5
1.6: Concerns over OHSEL's proposals Proposal for centralised elective (planned) orthopaedic care centres Models of care based on de-skilling and de-professionalising the workforce NHS England's has demonstrated a commitment to widen privatisation	5
1.7: Save Lewisham Hospital Campaign's recommendations	7
2: Footprints, STPs and the myths that give cover to what local commissioners and NHS providers are expected to deliver	8
2.1: 'We can't afford the NHS' – NHS is being de-funded at the worst level ever	
2.2: Key national figures express their concern about NHS funding	9
2.3: The reality behind NHS funding Waste; de-funding	10
2.4: NHS does not have enough hospital beds	11
2.5: NHS needs more doctors, nurses – the STP replaces them with 'physician assistants'	12
2.6: Community-based care (CBC), whilst desirable, does not replace hospital capacity	13
3: What is the main purpose of OHSEL's STP and Footprint?	14
3.1: New models of care	
3.2: Lack of evidence to support NHS England's Five Year Forward View (FYFV) 'new models'	
4: The wider risks that STPs bring	16
5: What others say about the STP process	17
6: OHSEL's Financial modelling	17
7: Planned/Elective Care	20
8: Summarising our concerns	22
9: Save Lewisham Hospital Campaign's recommendations	25
APPENDIX A: NHS Sustainability and Transformation Plans (STPs) Don't Slash, Trash and Privatise our NHS!	26
APPENDIX B: Evidence on Community-Based Care and admission avoidance, and Integrated care/Out of Hospital Care <i>October 2015</i>	29
APPENDIX C: Elective care in South East London – unaddressed risks	33
APPENDIX D: Analysis of Advice on Proposal for elective orthopaedic care in South East London <i>London Clinical Senate Review June 2016</i>	35

1: Executive summary on OHSEL's Sustainability and Transformation Plan (STP) ¹

1.1: Our concerns about the SE London STP

The financial context: austerity

- For our STP, OHSEL have taken nationally imposed pressures and translated them through the *Five Year Forward View* and the STPs into a local financial 'challenge' of £1billion savings from annual budgets by 2020/21
- To be specific: in the four years from 2016/17, the **NHS in SE London** is predicted to need £934m more funding to meet health needs annually than it will receive. SE London **will suffer an imposed deficit in annual health funding rising to £934m** by 2020/21.
- Add to this the **underfunding of adult social care annual budget by £242m** by the same year, 2020/21.
- The SE London STP has been published by the ***Our Healthier South East London*** team (OHSEL). This **title disguises the reality** that it is truly **impossible to build a healthier community under such austerity conditions**.
- ***We acknowledge OHSEL's assurances that they intend to maintain the current full range of urgent and emergency services in the hospitals of SE London, including Lewisham Hospital.***
- **But:** OHSEL's STP just **does not add up financially** – a financially driven plan cannot succeed in delivering as good or better health services, in partnership with social care and other agencies who are also facing greatly reduced funding.
- **Year on year worsening of budget deficit** results in annual budgets by 2020 that are nearly £1b less than needed to deliver health services and £242m less than needed for adult social care.
- **What will the consequences be if the financial plan fails?** NHS England and NHS Improvement threaten to impose special measures on those Footprint areas, CCGs and trusts who fail to 'balance their books' faced with such unreal expectations.
- **Explicit threats of sanctions – worst case scenario** could see our area placed under a 'success regime' **losing autonomy of decisions**, with previous reassurances swept away, financial sanctions such as the withholding of transformation funding and imposed financially driven service cuts.
- And that is why **our campaign is so concerned about the OHSEL STP**. It does not add up: the STP is based on the flawed premise that our NHS services can be better even after such massive cuts.

1.2: What we positively want from Health and Social Care in SE London

- The Save Lewisham Hospital Campaign believes strongly in the provision of **high quality community based health and social care where our local district general hospitals are part of the network of community provision**
- Some of us have been advocates professionally for **integrated delivery of health and social care**, along with other agencies (eg Education, Third Sector) to those that need it.
- Well-coordinated delivery of services by cooperative work – across teams and agencies, hospital and community – is **essential for people and families with complex and/or long-term needs**

¹ <http://moderngov.southwark.gov.uk/documents/s61328/OHSEL%20-%20Sustainability%20and%20Transformation%20Plan.pdf>

- A **high-quality, easily accessed, district general hospital, close to the community** it serves, is an **essential part of safe community-based care** – where the teams can share skills and knowledge in *established local networks* with quick and safe access to hospital when needed.
- This **work is labour intensive, skilled**, personalised and sensitive **and does not come cheap**. The work was going forwards in Lewisham and SE London before **major financial austerity** first halted it and now **is sending it backwards**.
- Successful community services should include **real participation of the families, community and organisations** they serve

1.3: NHS England and consultancy methodology is misleading and potentially dangerous

- The **NHS is a complex, highly regarded nexus of services** within healthcare and reaching out to other services. Across the country there are **inevitable variations in practice**.
- **Professional and managerial mechanisms to share new ideas** clinically and in terms of efficiency were **dealt mortal blows** by the fragmentation of a previously national service **under the Health & Social Care Act 2012**.
- The consultancy **McKinsey has developed dangerous myths** relied upon by successive governments to provide a justification, in particular, for their plans to close NHS hospitals:
 1. **That one third of hospital beds could be replaced by community based care** (on request no evidence is produced – see our evidence shared with OHSEL Appendix B)]
 2. That **every trust** providing healthcare **should be able to achieve ‘upper quartile’ performance** in all areas (a new form of maths where we can all be above average)
- When translated into such massive projects as the Footprint/STP programme, the health service is now expected to achieve upper quartile performance **in all areas at once**. This is not only impossible, but to try to achieve it is **so disruptive as to be dangerous**.
- When Simon Stevens and NHS England demand **‘upper quartile’ transformation within 4 years**, they demand the impossible. The King’s Fund, Nuffield Trust and NHS Employers have all said that this is impossible.
- But this is the **smokescreen used as the justification for over 30% underfunding of the NHS 2010 to 2020** (underfunded by an average of 3% per year for 10 years). **The NHS is underfunded greatly in comparison with similar European countries** (see full document).
- **These myths underpin the South East London STP**

1.4: Clinical engagement

- **Responsible clinicians** when asked to **attend OHSEL workstreams to plan better services willingly** give up their time to do so, at some cost to their Trusts and their clinical time
- **Dozens of clinicians have attended numerous meetings** within six workstreams in SE London – Urgent & Emergency Care, Planned Care, Cancer, Maternity, Children, Community Based Care. They have shared their experience – of course they have. But there is little evidence that their views have been taken into account in final decisions!
- When you read or hear that clinicians have been fully engaged, **just remember** that this was **the message used by Jeremy Hunt, Sir Bruce Keogh** (Medical Director of NHSE) and the ‘Trust Special Administrator’ regime (Matthew Kershaw) as added justification for deciding **to close Lewisham Hospital’s A&E, acute and maternity services in 2013** – a decision which, were it to have been allowed to happen, would mean that our local SE London health service, on the edge permanently these last two years, would be 400 beds the poorer – and the more dangerous.

- When the **financial driver for systemic change** has so obviously **replaced the clinical driver for better services**, please know that **NHS services are in mortal danger**.

1.5: The importance of the national environment, 'Footprints' and STPs

- **The national context** is one of **severe de-funding²** of the **NHS and the Public Health and social care budgets**. (See King's Fund et al 2016, *The Autumn Statement* ³ The NHS is tasked by 2020/21 to have absorbed an *annual equivalent of £22b* of health service cost pressures.
- The **NHS is not 'in debt'**: – it has been **de-funded** and **it cannot provide safe care without 'overspending'**.
- Nationally, **Sustainability & Transformation Plans (STPs)** have been **created to implement these cuts**, and to impose new cheaper models of practice in a fractured, weakened health service.
- **England has been divided into 44 Footprint areas** – an STP for each. Under great pressure and secrecy, each area has been ordered **to create an STP with the financial driver centre stage to 'balance the books' by 2020**.
- **Simon Stevens** put forward the *Five Year Forward View* as the template for realising this impossible ask. But he **highlighted specific caveats** which if ignored would prevent his deliverance of *FYFV* and £22b savings. **Most important was the requirement that adequate funding of social care be maintained**.
- However, **severe cuts in local authority funding** have resulted in **over 30% reduction in adult social care budgets** with more to come. There is a national crisis. **One million elderly people nationally⁴ no longer receive the personal care they need from social services**.

1.6: Concerns over OHSEL's proposals

Proposal for centralised elective (planned) orthopaedic care centres

- **OHSEL's flagship proposal** is to centralise all inpatient elective orthopaedic surgery on to **two elective orthopaedic centres (EOC)**, with their **preference being Guys (Guys & St Thomas') and Orpington (King's)**. **Lewisham & Greenwich NHS Trust would no longer do inpatient elective orthopaedic surgery in their hospitals**;
- Specialist centres for stroke, major trauma, heart attack and vascular emergencies have evidence for regional centres providing better outcomes
- There is also evidence that protected elective operating systems provide better outcomes when linked to good joined-up pre- and post-operative multi-disciplinary teams.
- There is **no evidence** that says **standalone specialist centres** would be **better than** for example, **three centres one each in the three main trusts**, with investment to provide better more ring-fenced elective pathways (protected from disruption by emergency work). **This is the 'enhanced status quo' option. OHSEL has refused to work up this proposal** and it has **NOT been evaluated**, and was **not part of the option appraisal**
- **Planned care** (including orthopaedic surgery) has **£36m savings** badged against it. The elective centres are the only proposal worked up, and savings are clearly prioritised here – a worry when pre- and post-operative care involve staff-intensive input.

² De-funding: prolonged underfunding in the knowledge that the quality of NHS services will start to fail

³ <https://www.kingsfund.org.uk/publications/autumn-statement-2016>

⁴ <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/communities-and-local-government-committee/social-care/written/36776.html>

- The Government has placed an embargo on central capital funding for NHS projects for three years 2015/16-2018/19. **The capital funding required to provide the EOCs will be at least £10.2m and will have to be raised from the private finance market.**
- Lewisham and Greenwich residents will lose their local provision linked to local community networks directly.
- **We insist on seeing the ‘enhanced status quo’ option and that it is appraised fairly.**

Models of care based on de-skilling and de-professionalising the workforce

- The UK does not have enough doctors or nurses or therapists, nor sufficient in-house expertise to manage the NHS
- Instead of training sufficient people with the right clinical and service management skills, it relies on overstretching staff, using a lower banded skill-mix in staff teams, using agencies for gaps, outsourcing cherry-picked services and paying consultancies huge amounts.
- **Example: Physicians associates** – Our STP outlines a projected shortfall of 134 GPs and 82 practice nurses by 2021. **To fill these gaps not with GPs or nurses but with less skilled physician associates or nurse/care assistants is to paper over the dangers of these vacancies.** Such posts should aid GPs, hospital doctors and nurses to deliver better care not to replace the need for them.

NHS England has demonstrated a commitment to widen privatisation

- This is no idle threat: from hiring consultancies to subcontracting commissioning to full takeover of NHS services
- Contracts or specialised services worth £billions have just been put into the category of services that are open to competitive tender releasing £billions for potential cherry picking by private companies⁵
- Virgin Care has just been awarded a £700m contract over 7 years for over 200 types of NHS and social care services including diabetes, stroke and dementia to over 200,000 people in Bath and NE Somerset.⁶
- Local examples:
 - OHSEL has spent £5.3m on consultancies since December 2013 – mainly PwC
 - Greenwich CCG has decided to appoint Circle Health as Prime Contractor holding the £73m 5-year MSK services contract

⁵ Example: Specialised prescribing <https://www.contractsfinder.service.gov.uk/Notice/449190bf-e5fc-474d-b99d-ea26f5ec41d9>

⁶ <https://www.theguardian.com/society/2016/nov/11/virgin-care-700m-contract-200-nhs-social-care-services-bath-somerset>

1.7: Save Lewisham Hospital Campaign & Lambeth KONP's recommendations

- 1: That individual CCGs and Local Authorities in SE London do not give their approval to the OHSEL STP**
- 2: That the six CCGs and six LAs inform NHS England that good and safe care cannot continue without adequate funding – failure to provide this is seriously undermining health and social care**
- 3: That elected representatives, councillors, the Mayor and MPs, write to the Local Government Association, the Prime Minister and explain why the NHS and social care must be funded properly urgently**
- 4: That the cooperative work to improve health systems in the community continue but in the realistic context explained above.**
- 5: That the proposal to centralise care in two inpatient Elective Orthopaedic Centres in SE London is abandoned because:**
 - (a) it is expensive and too risky to the overall health economy;**
 - (b) care can be improved by each of the three main elective surgery providers retaining a centre in each trust, but with additional funding to ensure a streamlined elective surgery service available to the residents of each of the six OHSEL boroughs.**
- 6: That workforce plans should prioritise the training and recruitment of more nurses in community and hospital, more GPs to fill the existing vacancies and to meet the predicted shortfall, and more hospital doctors.**
 - (a) These measures would ensure vacancies are reduced and reliance on agency cover is minimised;**
 - (b) OHSEL, the six CCGs and six LAs need to make clear to national bodies and government that workforce plans need to be overhauled rapidly.**

The role of scrutiny *now* is of critical importance

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And material from Carol Ackroyd

www.hackneykeepournhpublic.org

Page by page annotated comments are also available

Fuller narrative report to follow

Part 2: A fuller explanations of the key areas contingent on the STP

STPs, Footprints and the myths that give cover to what local commissioners and NHS providers are expected to deliver

The national context is one of **severe de-funding⁷** of the **NHS and the Public Health and social care budgets**. (See King's Fund et al 2016, *The Autumn Statement*⁸). The NHS is tasked by 2020/21 to have absorbed an *annual equivalent of £22b* of health service cost pressures. The **NHS is not 'in debt'** from poor management: – it has been deliberately **de-funded**. The **NHS cannot provide safe care without 'overspending'**.

Government policy has been to underfund the public health service, to open up NHS services to the private sector and to pursue the break-up of a previously national health service into a **deregulated, regionalised set of units**. Accompanying policy proposals explore introduction of **more charges for some services at the point of use**. In more areas, some **aspects of health care** that are currently part of comprehensive healthcare are **being rationed**. And the principle of universal access to healthcare is in danger with proposals to exclude some parts of the population from universal healthcare at the point of use ie to people who are classified as obese.

Sustainability & Transformation Plans (STPs) have been **created to implement these policy changes and financial cuts of a further £22b**. They are the work of **Simon Stevens** and are the vehicle created from his *Five Year Forward View* – the template for realising this impossible ask. But Simon Stevens **highlighted specific caveats** which, if ignored, would prevent his deliverance of *FYFV* and £22b savings. **Most important was the requirement that adequate funding of social care be maintained. This has been quietly dropped by NHS England from frontline messaging.**

Severe cuts in local authority funding have resulted in well **over 30% reduction in adult social care budgets** with more to come. There is a national crisis. **One million elderly people nationally⁹ no longer receive the personal care** they need from social services.

2.1: 'We can't afford the NHS' – NHS is being de-funded at the worst level ever

UK spending on healthcare is significantly below the average of major European economies.¹⁰ If the UK were to increase its spend to 10.7% of GDP, this would equate to an extra £15bn pa.

£22bn cuts in annual budgets will be imposed through 44 STPs across England by 2020-21

No growth in services – despite sharply rising costs, population numbers and rising health needs – means a **devastating decline in what's available** to individuals. **These are CUTS**, masked by deliberately ambiguous and vacuous language designed to mislead and manipulate the public.

⁷ De-funding: prolonged underfunding in the knowledge that the quality of NHS services will start to fail

⁸ <https://www.kingsfund.org.uk/publications/autumn-statement-2016>

⁹ <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/communities-and-local-government-committee/social-care/written/36776.html>

¹⁰ <https://chpi.org.uk/wp/wp-content/uploads/2014/11/CHPI-Long-term-sustainability-NHS-submission-to-House-of-Lords.pdf>

	% GDP spent on health (new definitions)	\$ per head on healthcare
France	11.1	4,367
Germany	11.0	5,119
The Netherlands	10.9	5,277
Norway	9.3	6,081
Sweden	11.2	5,065
Switzerland	11.4	6,787
United Kingdom	9.9	3,971
Average (excl. UK)	10.7	5,264

Spending on **health has a 4.3 times positive impact on the general economy** (the *'fiscal multiplier'* effect ¹¹) and is a necessary and valuable investment.

By 2010, the NHS had record lows in waiting times and A&E waits. It was a high performing and cost effective service compared internationally. **A well-known US think tank** ¹² on comparative healthcare systems internationally **scored the NHS as number one amongst health services** in comparable economies. The report published in June 2014 used **data up to financial year 2012/13.**

The **Health & Social Care Act** was **implemented in April 2013.** Since then **performance has steadily declined** under the dual blows of de-funding and enforced competitive tendering of health contracts with steadily rising numbers of contracts going to the private sector.

Academic research on health economics (including work from the IMF) is referred to above. It shows that investment in the population's health has a positive return to the economy. **A well-funded NHS is cost-effective and a valuable investment.**

We cannot afford *not* to invest in good health care

2.2: Key national figures express their concern about NHS funding, challenging the validity of Government statements and its aim to save £22b annually by 2020/21 through STPs

Increasingly key figures are being more public in stating the obvious: the NHS is being disabled by de-funding.

Dr Sarah Wollaston MP, on behalf of HSC on Government funding for the NHS ¹³

"The continued use of the figure of £10bn for the additional health spending up to 2020-21 is not only incorrect but risks giving a false impression that the NHS is awash with cash," Wollaston and four fellow committee members said in a letter to the chancellor.

"This figure is often combined with a claim that the government 'has given the NHS what it asked for'. Again, this claim does not stand up to scrutiny as NHS England spending cannot be seen in isolation from other areas of health spending."

Dr Wollaston, Conservative MP is chair of the Commons Health Select Committee (HSC)

¹¹ <https://www.ncbi.nlm.nih.gov/pubmed/24059873>

¹² <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>

¹³ <https://www.theguardian.com/society/2016/oct/31/theresa-may-denies-that-10bn-nhs-funding-pledge-is-misleading>

Chris Hopson, chief executive of NHS Providers¹⁴

NHS underfunding means: *“It is being asked to deliver an impossible task. Put simply, the gap between what the NHS is being asked to deliver and the funding it has available is too big and is growing rapidly”.*

Prof John Appleby, the chief economist at the Nuffield Trust health think tank¹⁵

The Health Select Committee MPs were right to claim that cutting the amount of per capita funding for healthcare could mean major restrictions to NHS services being needed in the later years of this parliament, too:

“It is hard to see how this can be reconciled with providing high-quality healthcare that meets the needs of a growing and ageing population,” Appleby said. “Something will have to give – whether that’s an explosion in waiting lists, patients not being able to access new drugs coming on-stream or another record set of hospital deficits.”

2.3: The reality behind NHS funding

- The **Health & Social Care Act reorganisation cost at least £3b**
- **PFI repayments cost £2b annually** – a high proportion of that is exaggerated interest payments.
- **£3b was spent last year on agency staff** because insufficient nurses and doctors are being trained.
- Between **£5b - £10b is wasted annually on the market system in the NHS**
- **£640m was spent on external management consultants in the NHS in 2013/14** – this has risen since then
- Locally, **OHSEL** revealed (Freedom of Information request) that **it has cost £11.65m over three years, more than £5.3m going to consultancies** on strategy development.

Waste

De-funding – Government policy

Funding for the **NHS has virtually flat-lined for 6 years** since 2010 and is continuing to do so if nothing changes, until 2020/21: a period of **ten years**.

On the Government claim to have given **£10b extra to the NHS 2016/17 -2020/21:**

- Firstly they arbitrarily included a sixth year backdated (2015/16). The true figure equates to **£7.6b** from 2016/17.

¹⁴ <https://www.theguardian.com/society/2016/oct/31/theresa-may-denies-that-10bn-nhs-funding-pledge-is-misleading>

¹⁵ <https://www.theguardian.com/society/2016/oct/31/theresa-may-denies-that-10bn-nhs-funding-pledge-is-misleading>

- In fact just over £4b of this remains as a net increase after other Dept of Healths cuts in public health and training (see Table 1 below).
- There is acknowledged inbuilt inflation costs for the NHS (3.5-4% per annum) to maintain expected standards for a population rising in number and greater need.
- This £4b now equates to only £800m over inflation.¹⁶
- In any case that funding is being used to offset unavoidable NHS overspends because the budget is insufficient for safe delivery of the NHS.¹⁷

Table 1 Health spending in real terms to 2020/21

	£ million in 2016/17 prices						
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Change 2015/16 - 2020/21
NHS England	£102,008	£106,800	£108,251	£108,430	£109,335	£110,987	£8,979
Other Department of Health	£16,999	£13,811	£13,250	£13,126	£12,598	£12,173	−£4,826
Department of Health total DEL	£119,007	£120,611	£121,501	£121,556	£121,934	£123,160	£4,153

Note: All figures are expressed in real terms using 2016/17 prices. These are taken from the Department of Health annual accounts 2015/16. The figures in line one are calculated using the Department of Health annual accounts and Spending Review 2015. Unusually, the Spending Review used 2020/21 prices to estimate real spending, which results in higher forecasted spending in future years.

The OHSEL team declined to discuss NHS funding with campaigners and programme director, Mark Easton gave the following reason:

“Clearly resources for the NHS in total are subject to parliamentary scrutiny and approval, and while we as individuals might agree that the NHS would benefit from additional resources, our role as public servants is to make the best use of the resources made available to us.”

2.4: ‘Too many beds’? – the NHS does not have enough hospital beds!

England has fewer doctors, nurses and beds per 1000 population than our key European comparator nations eg France, The Netherlands, Germany, Sweden.¹⁸ Department of Health officials briefed internally that the 7-day NHS of Jeremy Hunt was not achievable on current funding, with simply not enough staff.¹⁹

Nationally, STP plans seek to cut thousands of hospital beds yet beds have been cut by over 50% during the last 25 years to the point where we do not have enough.

¹⁶ <http://www.nuffieldtrust.org.uk/blog/behind-numbers-nhs-finances>

¹⁷ King’s Fund, Nuffield, Health Foundation, Table 1 above. Full publication at:

https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Autumn_Statement_Kings_Fund_Nov_2016_3.pdf

¹⁸ http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT

¹⁹ <https://www.theguardian.com/society/2016/aug/22/secret-documents-reveal-official-concerns-over-seven-day-nhs-plans>

Local history is important:

A Picture of Health (APOH) in 2007/8 proposed the closure of *both* A&Es at Queen Mary's Hospital Sidcup (QMS) *and* University Hospital Lewisham (UHL). QMS closed as an acute hospital with the loss of hundreds of beds.

The South London Healthcare Trust Special Administrator regime (TSA – directly responsible to Jeremy Hunt) proposed *again* in **2012/13** the closure of University Hospital Lewisham's A&E and all acute inpatient and maternity services. This decision was overturned in the High Court at judicial review. Without that decision, a further 350-450 beds would have been lost.

OHSEL say that predicted need requires all the current acute capacity in A&E and acute services and that its STP is designed to avoid the need for *an additional 700 hospital beds*.

Our conclusion is clear: there were *not too many beds in 2007/8 nor in 2012/13*. Those plans were wrong. **SE London does not have enough beds now**. We need every facility we have, facing as we do increasing population and need. **Hospital staff are under daily pressure** to get patients out of hospital, to find beds and **have increasing difficulty** in doing so **safely and with patient dignity**, especially with loss of intermediate care beds (such as at Eltham Community Hospital, Greenwich).

Resourcing of the UK NHS against comparable nations' health systems

- **Health expenditure in UK was 9.8% of GDP in 2015**

This compares to 16.9% USA, 11.1% Germany, 11% France, 10.8% Netherlands, 10.6% Denmark

- **Expenditure per capita (using purchasing power parity) for UK \$4,015 in 2015.**

Compare \$9,451 USA, \$5,343 Netherlands, \$5,267 Germany, \$4,943 Denmark, \$4,614 Canada, \$4,415 France

- **UK had 2.8 physicians per 1,000 people in 2015**

Compare 4.1 Germany (2014), 3.9 Italy (2014), 3.8 Spain (2014), 3.5 Australia (2014), 3.4 France

- **UK had 2.7 hospital beds per 1,000 people in 2014**

Compare to 8.2 Germany, 6.2 France, 3.0 Spain

2.5: The NHS needs more doctors, nurses – the STP seeks to replace this shortfall with 'skill-mix', 'reprofiling' and 'physician associates'

We need the doctors and nurses trained to staff the hospital services with sufficient ratio of staff to patients and with sufficient skills. *We also need now* far better community care, with skills and confidence to match the challenge of working, often alone without direct supervision as a single professional in a patient's home.

With the expectation of a huge increase in workload (equivalent to 700 hospital beds but looked after in the community) and with increasing levels of acuity of illness managed in the community, this will require high levels of skill and confidence.

OHSEL's plans to skill mix and cheapen the community care workforce are therefore worrying.

Impact and risks of downgrading professional staffing (STP plans nationally – Appendix A)

- Development of **new roles such as Physician Assistant/ Associate (PA)** (just 2-years' training) are part of a general move to reduce costs while de-professionalising the NHS and tightening management control over professional decision making.
- These changes have a poor evidence base, often reporting 'acceptability' rather than outcomes. Evidence for success is often anecdotal and **much of the 'research' would not meet professional standards or peer-review requirements.**
- Proposals to engage Physician Associates rather than experienced (yet cheaper) nurses have been justified by 'too many professional limits' placed by professional bodies on nurses!
- **There is no mandatory registration for PAs, raising major concerns about regulation.**
- There is robust (and unsurprising) evidence that PAs are less effective than doctors at diagnosis
- BMA warnings that PAs are not a substitute for fully trained doctors are likely to be ignored
- Concerns that PAs will not recognize important signs that a fully trained doctor would spot
- Pressure to grant PAs independent prescribing powers will lead to enhanced risk to patient safety and increased risk that PAs will be used to substitute for, rather than support, doctors.
- Concerns that **GP receptionists may in future be triaging patients** and directing them to PAs who will miss more subtle indications
- Concerns that patients directed to PAs are more likely to be **elderly, vulnerable, speakers with poor English** etc – while articulate middle class patients will be able to get GP appointments
- **Similar concerns apply to other proposed new roles**, substituting minimally trained staff for professional clinicians, nurses, pharmacy and professions allied to medicine throughout the NHS.
- **As the Nuffield Trust puts it:** *'... In the future, care will be supplied predominantly by non-medical staff, with patients playing a much more active role in their own care. Medical staff will act as master diagnosticians and clinical decision-makers'.¹*

2.6: Community-based care (CBC), whilst desirable, does not replace hospital capacity

There is a myth central to the *FYFV* and Sustainability and Transformation Plans that good CBC could replace 30% of hospital capacity. It is one of the main tenets of McKinsey, the global consultancy which ran the TSA regime in SE London in 2012/13. **This assertion was the McKinsey 'clinical' justification for the proposal, adopted by Jeremy Hunt, to close Lewisham Hospital as an acute district general. Believe it or not, closing Lewisham was going to save 100 lives a year and deliver better community care.**

The consultancies were unable to offer evidence then to support their argument when challenged by roomfuls of clinicians. Evidence still does not exist. See our paper evidencing that lack of evidence. (Appendix B) We have shared this with OHSEL.

The Save Lewisham Hospital Campaign believes strongly in the need for **high quality community-based health and social care**. Some of us have been career-long advocates professionally for **integrated delivery of health with social care** and other agencies (eg Education, Third Sector) available for those families and individuals that need it.

Well-coordinated delivery of services by cooperative work – across teams and agencies, hospital and community – is **essential for people and families with complex and/or long-term needs**

A **high-quality, easily accessed, district general hospital, close to the community** it serves, is an **essential part of safe community-based care** – where the teams can share skills and knowledge in *established local networks* with quick and safe access to hospital when needed.

This **work is labour intensive, skilled**, personalised and sensitive **and does not come cheap**. The work was going forwards in Lewisham and SE London before **major financial austerity** first halted it and now **is sending it backwards**.

We argue for excellent community-based care with the essential lynch-pin of excellent local hospital care at the centre of that community. Although OHSEL argue that some of the huge savings planned will be reinvested in community services, as above, it doesn't add up to a financially sound or clinically robust plan to avoid the need for hospital care equivalent to 700 beds.

3: What is the main purpose of NHSE's STPs and Footprints?

3.1: New models of care

- **Fewer sites for NHS services** – people will have to travel further for healthcare. We can't assume a reduction in locations is acceptable without full analysis of travel implications for local patients and visitors - especially the impact on elderly or disabled relatives and families with children
- **Specialist hubs:** some specialist focus is needed for complex and rare conditions – **but not for routine health issues where local services and accessibility / travel are more important**. Local clinicians could access specialist advice if needed via good NHS networks.
- **Selling off the NHS family silver/estate.** A one-off boost for treasury finance, with few or no guarantees for local funding. When it's gone -much of it handed over to private housing - it's gone forever
- **No new capital money – so rely on new private finance (PF2)** – Many of the new models of care require different, potentially larger premises than currently available. We fear a repeat of disastrous consequences of PFI.
- **Reliance on enhanced self-care, Skype, apps and unproven technology** to avoid hospital admission and clinical care amounts to magical thinking! And relies heavily on unpaid family carers (mainly women). **These proposals do not explore sufficiently issues of poor connectivity generally in the UK, even within major cities, and lack of access to broadband, particularly among the economically and socially disadvantaged.**
- **The most vulnerable and socially excluded patients and families & women** will be hardest hit.
- **Restructuring of the NHS** involves less clinical, more corporate management. Ripe for privatisation.
- **Data-sharing.** We are very concerned about proposals to share confidential medical data across a range of health and social care providers, leading to major potential for confidentiality breaches.

3.2: Lack of evidence to support NHS England's Five Year Forward View (FYFV) 'new models'

- The NHS has a proud track record of evidence-based practice. This is all but abandoned in the FYFV.
- The 'new models of care' are cost-driven. We campaigners don't oppose changes to services – but changes need to be driven by combination of clinical need & requirement for good patient access. Service changes need to be rigorously assessed against these criteria.
- STP changes are being imposed with no such assessment, and lack of valid, peer-reviewed research evidence-base. Anecdotes claiming success are routinely substituted for valid evidence that also takes account of a wider picture. Examples include:
 - decisions to focus services on specific outcomes often take no account of the impact on patients with multiple conditions who may lose coordinated care.
- Arguments about the need to centralize highly complex specialized care are misused to justify closure of units offering excellent care for routine conditions. *Often no account has been taken of increased risks of extended blue-light journeys to A&E or difficulties for patients and visitors facing of longer journeys.*

Please bear that in mind when considering the elective care centres proposal.

Finance, not clinical care, is the main intent behind NHS England's STPs and Footprints. The STPs are a process not specifically governed by statute by which NHSE is attempting to create a set of plans, financially driven, with approval not only of local CCGs and, where possible, local providers too, but also the local authorities.

In SE London's STP, the language of cooperation and innovation across health and social care blinds us to the reality that **there is no real money for these schemes**. Although a proportion of the largely mythical savings is ear-marked for reinvestment, in the very first year – 2015/16 – reliance on 'business as usual' savings slipped by £80m and will be increasingly impossible year on year.

Nationally, STPs contain - within their as yet largely undisclosed appendices – plans that are truly shocking: eg – 31% of plans include a downgrading or closure of a major A&E, and 20% include a plan to end medical input to the local maternity unit – see Appendix A.

The quadruple financial 'challenge' in South East London:

- **Health budget deficit:**
SEL is facing a **financial [health] challenge** annually of **£934m** by 2020 [OHSEL STP p4,41²⁰]
- **Adult social care budget deficit:**
The **financial challenge to Local Authorities'** spending on adult social care is a deficit in annual funding of **£242m by 2020** [p4]
- **No capital funds until 2019/20 earliest:**
Of £1.137b of **capital expenditure** planned over 5 years, **£169m** of capital connected with transformation projects **has not been secured** [STP p42] – **must be met by local budgets**
- **STP capital schemes using private finance**
OHSEL has stated that **capital expenditure for the elective orthopaedic centres**, if they go ahead, will be funded locally and this **will involve private finance**

²⁰ <http://moderngov.southwark.gov.uk/documents/s61328/OHSEL%20-%20Sustainability%20and%20Transformation%20Plan.pdf>

4: The wider risks that STPs bring

Destabilisation of NHS provider trusts

- The **commitment from OHSEL that no NHS provider would be destabilised** by the planned care recommendations (written into the elective orthopaedic care project) **did not survive into the STP**. The STP now records:

“a shift away from a focus on individual organisational achievement and towards shared ownership and accountability for improved health and social care outcomes for the populations of SE London” [pp38-39].

The proposal for two elective orthopaedic centres and a favouring of the option that would end this inpatient elective work at Lewisham, brings real risks of reducing the orthopaedic staffing on site and a damage done to the trauma capacity essential for Lewisham’s major A&E role. Training would also be affected, with the potential loss of training posts.

Drawing up of plans by management consultants – unintended consequences

- We have severe doubt about the depth of local knowledge, loyalties, NHS health experience and commitment of the consultancy advisers employed in our South East London STP, which might enable them to seek out the unintended consequence of changes in one sphere (eg altering orthopaedic care resource balance in elective care) and the impact on a vital service in another part of the economy (eg orthopaedic support for trauma in the A&E pathway). The impact of adult social care cuts has not been analysed.

A new organisation created without public consultation

- And OHSEL has plans for an ongoing project management team within an ongoing OHSEL-type organisation. Plans include a Strategic planning group led by ‘The Quartet’ of leaders giving executive oversight. They are assuming huge powers centralised through this and expect the CEOs and Chief Officers of local organisations to meet monthly. They will continue with five project boards for their productivity workstreams and subgroups, finance department, directors of finance, strategy technical (IT) and engagement.
- Some talk of this being a return to a strategic health authority, but the SHAs were part of a national health service governed by statute.
- **The speed of these fragmentary changes, without discussion of risk, consequences, future direction of travel and public consultation is breathtaking.**

The role of scrutiny now is of critical importance

5: What others say about the STP process

Julia Simon was until September **head of NHS England's commissioning policy unit** and its co-commissioning of primary care programme director. She has been **at the centre of NHSE's policy making on STPs**. She was interviewed by *Gponline* ²¹ in September and had worrying insights to share:

Julia Simon on the whole STP process and financial reliability:

Interviewed about STPs by *Gponline* said that *forcing health and care organisations to come together so quickly to draw up the complex plans was likely to backfire.*

Ms Simon said *the timescale imposed on health and care organisations to draw up STPs was 'unrealistic' and 'an unfair ask'.*

'Everyone will submit a plan, because they have to. But it means there is a lot of blue sky thinking and then you have a lot of lies in the system about the financial position, benefits that will be delivered – it's just a construct, not a reality.'

'The speed that NHS England has imposed on this process ... is, frankly, kind of mad.' It was 'actually shameful, the way we have done it'.

6: OHSEL's Financial modelling – the risk of double counting

OHSEL plans huge savings from different approaches to the SE London health economy. But the sums are eye-watering and seem to come from sources that have overlap with each other.

OHSEL's calculations to bridge the financial gap (STP October 2016)

All of this is a paper exercise:

- Start of year April 2016 – 'challenge of £854m
- Include £80m slippage in economic performance from original estimates for 2015/16
£854m becomes £854+£80m = (£934m **(A1)**)
- Baseline overall affordability gap – 'do nothing' **(A)** **£854m (over four years from 2016/17)**

Before slippage of £80m added

- Within organisation efficiencies **(B)** **£262m** – "BAU: business as usual savings"
- Remaining Status quo challenge **(C)** **£592m** - [A – B]

ACTIONS asserted to be BEYOND 'Business as usual'

- Collaborative productivity **(D):** **£225m** [£232m]
- CBC care, standardising better care **(E):** **£116m**
- Specialised commissioning + LAS **(F):** **£202m** [£190m]
- STP funding **(G):** **£134m**** £ hoped for by OHSEL from NHSE

To meet the Status Quo Challenge **(C)** of £592m, OHSEL calculate savings or revenue from the measures **D + E + F + G = £677m**, but finances have slipped £80m, so that makes **£597m** which is in theory £5m ahead of their target.

'Productivity' targets required by trusts has increased to 5.5% per year for 4 years! – an unprecedented expectation

²¹ <http://www.gponline.com/shameful-pace-stp-rollout-risks-financial-meltdown-warns-former-nhs-commissioning-chief/article/1410546>

'Business as usual' assumes 1.6% savings per annum from the provider trusts amounting to **£262m**. However, trusts have been trying to make such savings for 10 years and so there is very little left without cutting clinical areas. **Predicted savings** in 2015/16 **have already slipped** £80m on the plan – **this is likely to be repeated year on year**.

Appendix 3(a) South East London STP Briefing Note on Financial Submission, 21 October, has a Risk section on p4. This states that the **annualised productivity improvement required over the next four years has risen to 5.5%**. This is a huge ask, **unprecedented and unrealistic**.

Providers look everywhere for savings: what costs can they legitimately pass back to other trusts? Can collaboration between trusts or sharing a resource save money? This 'business as usual' is a constant, desperate search for savings going into a second decade of efficiencies, including 'QIPP' and 'CIP' schemes²², and imposed lower tariffs year on year, paying trusts less for the same work done. **The 'fat' has gone. Further cuts will be to life and limb.**

Estimated savings in the OHSEL STP are top-down, paper guesswork and undoubtedly include double counting.

6.1 Collaborative productivity

This assumes £245m through workforce changes, purchasing collectively, 'capitalising on the collective estate' and merging pharmacy, pathology and radiology services. And a further £116m savings from clinical pathway efficiencies.

6.2 Specialised commissioning and London Ambulance Service (LAS)

This also supposed to find £190m annually by 2020 (plus £12m from LAS) - £202m in total

- **All of these areas have a high risk of overlap and double or treble-counting**
- **For example:** Specialist pathways include specialist centres AND district general hospitals AND community health services AND adult social care.
- Workforce changes are looked for in business as usual savings as well.
- And savings from reduction in hospital based care are dependent on cooperation also with adult social care, where further huge cuts are imminent.

6.3 Estimated clinical savings in different areas are derivatives from benchmarking

An example in point from personal experience

In the June 2016 version there were savings put down from Children & Young People's (CYP) services of £13million to be achieved annually by 2020 (STP June 2016 p17). Where did this come from?

In the CYP workstream we were asked to develop positive models for children's services, involving enhanced teamwork and interdisciplinary working. The author of this critique helped significantly to develop the models – he was chair first of the Children & Young People's Workgroup and later of the CYP Community Based Care work group. **We had very positive discussions on how to improved care for children.** However, from the outset, Spring 2014, the OHSEL team pressed us for 20% savings: they wanted us to highlight aspects of good practice we were developing that would save 20% of funding.

²² QIPP: quality, innovation, productivity and performance. CIP: cost improvement programme

The clinicians unanimously refused to do this, arguing that the models had to be clinically worked up, based on evidence and costed, before any such claims could be made. I was alarmed to see £13m being put down as projected annual savings when I know for a fact that no such savings were discussed with clinicians. **We warned constantly that excellent community-based care was extremely unlikely to be a cost-saving option.**

Recently the OHSEL team pressed for greater savings and allocated £6m annual savings from their assumed changes at the Queen Elizabeth Hospital Woolwich children's department. L&G Trust had to point out that the entire budget for the department was only £5m.

OHSEL confirmed that this was an error and they amended the target. However, the STP finally submitted to NHS England 21 October asserts in the plan that they will save £7.6m from children's services (£6.8m net). (Although the original figures remain in the appendices on the CYP delivery plan). We would like to see the evidence for these new figures.

We believe the methodology is a top-down one of imposing national benchmarking data on our South East London area. By asserting that the providers will achieve upper quartile – or even 'best in class' – productivity in various clinical areas they create and then seek to impose a financial figure of savings. Has evidence been sought that clinical quality or patient experience has been evaluated?

This is neither based on evidence from local reality, nor is it clinically outcome-focused.

6.4 Capital funding

We remain concerned that where **capital resources** are required for transformation, the Government and NHSE have confirmed that this **funding is no longer available. Capital costs** involved in implementing the STP **will come from within existing local funding streams, private finance or the sale of NHS estate.** Health services in SE London already carry a heavy financial burden of PFI debt and the lack of any capital resources is bound to increase the reliance on private finance.

6.5 Evidence on community based care, admission avoidance and integrated care /out of hospital care

OHSEL shared our concern regarding change that, whereas you should invest to transform services first in order to be clinically and financially sustainable, NHS England has got the process back to front. By insisting that providers cope with swingeing reductions in core funding (in social care too), NHSE undermines any chance of clinically safe and sustainable transformation.

We have asked the OHSEL team for evidence to support their thesis that community based care can increase productivity to the extent that the predicted huge increase in demand on hospital care by 2020 will be managed safely in the community setting. We have shared evidence to the contrary with OHSEL (Appendix B). We presented the **evidence from the Southwark and Lambeth Integrated Care (SLIC)** research which **demonstrated that community based care (CBC) did not make the planned cost savings or achieve the planned reduction in hospital admissions in the short term.** OHSEL says that "the evidence is mixed".

However, the evidence from the SLIC project is highly relevant and undermines confidence in reliance on the central tenet that CBC will realise such huge savings. Here are some extracts.

'Integrating care in Southwark and Lambeth'²³ is an 'end of grant' report by the Guy's & St Thomas' Charity on the impact of its grant of several millions to SLIC. The charity 'supports projects that intend to build an evidence base by testing hypotheses' (p42).

The project has just ended its first phase after 4 years and **nearly £40m spent** and these are some important findings:

- 'The envisaged **cost savings in wasted/duplicated effort were not met**' (p3)
- 'what was also **ambitious** in the business case was the **trajectory of change and the financial targets: the stakeholder consensus now is that these were unrealistic**' (p7)
- A local McKinsey report recommended an 18% shift in resources from hospital to community and primary care - this was not realised in the project.
- here were only some signs of a slowing down of increase in service demands.
- The changes in culture and relationships required to get inter-professional cooperation inherent in service integration was harder and slower to achieve than estimated.
- the longer periods needed to produce lasting and beneficial change are an anathema in the 'pull towards priorities that reduce costs in the short term' (p41)
- 'There is a **pervasive culture** in health and social services that **almost overstates the potential benefits subconsciously** and this **should be guarded against**' (p43)
- There was **no evidence that integration works where individual services are struggling** – district nursing was a specific example.

We wonder if any lessons have been learned by SELSTP from this highly relevant local project.

We highlight as a major risk that clinical staff under intense pressure will not be capable of drastic system change and innovatory ways of working. We remain unconvinced that CBC can be improved to the expected extent **in the context of the severe current nursing and GP shortage.**

One unintended consequence it that hospital nurses simply moving from hospital into community nursing leaving difficulties of recruitment to essential posts in the acute hospital setting (as has happened in Lewisham & Greenwich).

7: Planned/Elective Care

Our critique of OHSEL's proposal for centralised inpatient elective orthopaedic centres (EOCs) – for planned (ie not emergency) orthopaedic surgery)

OHSEL's flagship proposal is to centralise all inpatient elective orthopaedic surgery on to two elective orthopaedic centres (EOC). Their strongly preferred sites are Guys (Guys & St Thomas' FT) and Orpington (King's FT). Lewisham & Greenwich NHS Trust would no longer do the tranche of non-complex inpatient elective orthopaedic surgery in their hospitals. There are financial risks when, despite reassurances, Lewisham could lose an important part of their income. But there are yet more serious potential risks if reduced orthopaedic staffing on site resulted in an undermining of the trauma input to Lewisham A&E and the training of junior doctors and nurses.

Our campaign has consistently asked, along with others, through attendance at OHSEL engagement meetings, that **a fully worked out consideration for an 'enhanced status quo option' based at the three main trusts, should be presented.** This demand has also been made by the Joint Health Overview and Scrutiny Committee of the six boroughs involved in OHSEL. So far **this option has not been presented.**

²³ <https://www.gsttcharity.org.uk/sites/default/files/FINAL%20Full%20End%20of%20SLIC%20Report.pdf>

Wider planned care strategy – does this pose a danger for Lewisham & Greenwich Trust?

The proposal to centralise elective orthopaedic surgery is to be followed by later work envisaged to centralise other specialties (ophthalmology, urology, neurosurgery, nephrology, gynaecology, dermatology are mentioned OHSEL Consolidated Strategy June 2015).

If pursued, without clear clinical evidence to justify it, this strategy would gradually and incrementally undermine the district general hospital at Lewisham.

- **Specialist centres for stroke, major trauma, heart attack and vascular emergencies** have evidence for regional centres providing **better outcomes**
- There is also evidence that protected elective operating systems provide better outcomes when linked to good joined-up pre- and post-operative multi-disciplinary teams. There is more than one way of delivering these outcomes.
- **OHSEL claims** that a report by **Professor Tim Briggs supports their two model proposal**. This is **not accurate**. What Briggs actually says is that organised, but not necessarily locational, changes need to be made:
“If orthopaedic services, within a certain geographical area and with an appropriate critical mass were brought together, either onto one site or within a network ... and worked within agreed quality assurance standards, not only would patient care improve but billions of pounds could be saved.” (Tim Briggs, *Getting It Right First Time: Improving the Quality of Orthopaedic Care within the National Health Service in England* - GIRFT)
- **OHSEL has failed to evaluate the impact of investment to improve current provision** – ie to *enhance* the status quo and to ensure a ringfenced elective surgical pathway in each of the three provider NHS trusts. It has failed therefore to evaluate a **potentially cheaper and less disruptive option** alongside OHSEL's preferred model – two specialist centres.
- OHSEL has dismissed this as the ‘status quo’ option. **The ‘enhanced status quo’ proposal has NOT been evaluated, and was not part of the option appraisal.**

BUT:

- There is **no evidence** that says **that two standalone specialist centres** would be **better than three centres one each in the three main trusts**, with investment to provide better and more ring-fenced elective pathways (protected from disruption by emergency work).
- OHSEL say that any organisation which suffers from loss of income via their proposed two-site model would be compensated.
 - **However for Lewisham and Greenwich Trust loss of income is only one factor;**
 - **Loss of inpatient elective orthopaedic surgery would impact on their ability to retain sufficient orthopaedic surgeons; and**
 - **staff needed to fully staff their trauma work in A&E, thus potentially affecting their existence as a trauma centre and a full A&E.**
- **Planned care** (including orthopaedic surgery) has **£36m savings** badged against it. The elective centres are the only proposal worked up, and savings are clearly prioritised here – a worry when pre- and post-operative care vital to the pathway require investment in staff-intensive input.
- **Capital costs:** The Government has placed an embargo on central capital funding for NHS projects for three years 2015/16-2018/19. **The capital funding required to provide the EOCs will be at least £10.2m and funding will have to be raised from the private finance market.**
- **Reduced access:** Lewisham and Greenwich residents will lose their local provision linked to local community networks directly. Lewisham has very good transport links with south east London and average travel times are reduced in options that include Lewisham.

We insist on seeing the 'enhanced status quo' option *BEFORE* public consultation and insist that it is appraised fairly

Additionally:

- **Is elective surgery really the clinical priority anyway?**
Given the relatively high performing current **elective surgery** services in SE London (not far short of the London average), this is simply **not the priority** given the financial and clinical risk, the disruption to current services and extra travel involved for patients.
- **Are capital-build elective surgery centres the financial priority?**
Higher priorities include the **emergency pathway and A&E, care of the elderly, primary care and mental health**. This is where £10.2million capital funding should go rather than into private financing schemes to fund the elective centres.
- **Improvements to care – more to it than centralised surgery?**
Clinical improvements, according to the Briggs Report (*Getting it right first time – GIRFT*), are not just about actual times spent in hospital but about improving pre- and post-operative pathways – multi-disciplinary and inter-agency teamwork is needed. These are relatively ignored aspects of care, separate from the proposed new centres, but essential to the success of the pathway.

The London Clinical Senate review raised these points and the report contained **no fewer than 30 requests** to OHSEL that it address these aspects of the pathway without which the proposals cannot be safely evaluated. Many remain unanswered. (See Appendix D – Analysis of Advice on Proposal for

We say that:

(a) the option to improve (enhance) current Trust provision has *not* been examined or taken seriously in any way; and

(b) no impact assessment has been completed on the consequences of moving inpatient elective surgery away from Lewisham Hospital.

We ask the Joint Health Overview Scrutiny Panel to insist that the 'enhanced status quo' option be fully developed before consultation starts and compared with other options on an equal basis, looking at:

(a) clinical impact;

(b) patient experience – including travel times;

(c) potential negative impact on the stability of the L&G NHS Trust; and finally

(d) on the financial model including the impact of capital costs and risk of private finance

elective orthopaedic care in South East London, London Clinical Senate Review June 2016).

8: Summarising our concerns

8.1 The need for consultation on the whole STP

OHSEL's '*Communications and engagement forward plan*' (supporting paper for the April 2016 JHOSC meeting) outlines OHSEL's communication and engagement plan. The paper **states that the elective orthopaedic centres plan is the only one likely to require public consultation.**

We are concerned that we do not know **what criteria are being used to decide** whether proposed changes are 'significant', 'substantial' or 'having an impact' (hence requiring formal consultation). **We ask who will make those judgments.**

We are concerned that other aspects of the plan will not be formally consulted on and that the tone of the Guidance suggests that consultation will be about how rather than whether to implement changes in the STP.

NHS England's guidance on consultation (NHSE Sept 2016: *Engaging local people*) states:

- (a) The STP footprint itself is not a statutory body and
- (b) That CCGs, local authorities and hospital NHS trusts all have a 'variety of legal duties including to involve the public in the exercise of their statutory functions'.
- (c) Formal consultations with the public and local authorities are likely to be needed in the case of proposed 'substantial changes in the configuration of health services'.

Change that involves meeting the unprecedented challenges of £1b in health funding ad £242m of adult social care funding is in any sense of the word 'substantial'.

OHSEL may be within statutory regulations but they are avoiding public scrutiny of work that could have systemic implications in SE London for a generation when the financial case crashes.

Scrutiny Committees can request improvements to process, more evidence or may refer matters to the Secretary of State if processes, including consultation, have been inadequate.

Please consider this option very carefully.

8.2 Double and Treble counting

- We have pointed to the poverty of real data on how to save *annually* £1b
- We have commented on our concerns about the main financial methodology which is top-down and dislocated from the reality of SE London – and the danger of asserting that the health network will achieve top quartile or 'best in class' performance in a very wide range of clinical areas concurrently – something that has ***never been done before.***
- We have pointed to the revised upwards frankly incredible productivity challenge modelled by OHSEL for local providers: they will be expected to achieve 5.5% annual productivity challenge for four years (SELondon STP Appendix 3a: STP October Submissions - Finance Covering Paper FINAL). Ten years of 3% efficiencies annually have exhausted easy options. The next stage is damaging cuts.
- We have pointed to the risks of double or even treble counting of savings. 'Central programmes' are projected to make huge savings but the assumption is that they are not overlapping with savings from 'provider efficiencies', and specialist commissioning savings. (pathways of course involve *all* the providers).

- The main areas of savings – business as usual, clinical pathway efficiencies, inter-provider collaboration, specialist commissioning – are all part of the same complex organism and there is a high risk of double and treble counting cost savings.

We would like to hear a serious response on these risks.

8.3 Estimated savings in risky clinical areas

- We have already stated that in the Children’s and Young People’s work groups OHSEL were repeatedly warned that good CYP community-based care (CBC) would be labour-intensive and may well not save money; and that, while there is evidence of good services in the community delivering good outcomes, there is scant evidence that those services significantly reduce the need for hospital-based care. ***There is no clear evidence to support the revised proposed net savings of £7m in children’s services funding.***
- It is also surprising that £15m Cancer Services savings are identified, since the NHS is judged to be performing badly in comparison with health services in similar countries and currently Trusts are failing to meet the NHS Constitution target for cancer.

These look like examples of top-down financial guess work rather than locally informed evidenced-based projections.

8.4 Adult social care funding

- There is a worrying assumption that adult *social* care funding cuts will not be a problem: *‘There is considerable scope for achieving a substantial quantum of these savings through collaborative work across the OHSEL partnership.’* (STP p4)
- This is dangerously optimistic and is a denial of the overlap in impact between health and social care in joined-up care pathways. The expected South East London funding reduction in annual adult social care budgets of £242m (30%) by 2020/21 has a massive impact. ***We would like to hear a serious response to this.***

8.5 Community-Based and Primary Care

- The Save Lewisham Hospital Campaign reaffirms our strong desire to see **high quality community based health and social care** alongside **our local district general hospitals** as part of the **network of community provision**
- OHSEL estimates that the STP will lead to net savings of £116m from Local Care Networks and linked efficiencies in physical and mental health.
- We repeat that there is no evidence that CBC will *replace* significant quantity of hospital care. We would like to see OHSEL’s evidence for its stated aim of saving 700 additional hospital beds via a new model of workforce providing ‘lower cost, higher value care’.

8.6 Consequences

The consequences of these plans, however well-intentioned (eg improving community-based care), are that the strategy for the SE London health economy is built on false premises. And the threat from NHS England is that areas who fail to ‘balance their budgets’ by 2020 will be put into special measures – or given a ‘success regime’. At that point the destiny of services in SE London, including the future of Lewisham Hospital and its A&E, will be out of local hands.

That is a fear that will not go away and should not be set aside.

9: Save Lewisham Hospital Campaign and Lambeth KONP's recommendations

1: That individual CCGs and Local Authorities in SE London do not give their approval to the OHSEL STP

2: That the six CCGs and six LAs inform NHS England that good and safe care cannot continue without adequate funding – failure to provide this is seriously undermining health and social care

3: That elected representatives, councillors, the Mayor and MPs, write to the Local Government Association, the Prime Minister and explain why the NHS and social care must be funded properly urgently

4: That the cooperative work to improve health systems in the community continue but in the realistic context explained above.

5: That the proposal to centralise care in two inpatient Elective Orthopaedic Centres in SE London is abandoned because:

(a) it is expensive and too risky to the overall health economy;

(b) care can be improved by each of the three main elective surgery providers retaining a centre in each trust, but with additional funding to ensure a streamlined inpatient elective surgery service available to the residents of each of the six OHSEL boroughs.

6: That workforce plans should prioritise the training and recruitment of more nurses in community and hospital, more GPs to fill the existing vacancies and to meet the predicted shortfall, and more hospital doctors.

(a) These measures would ensure vacancies are reduced and reliance on agency cover is minimised;

(b) OHSEL, the six CCGs and six LAs need to make clear to national bodies and government that workforce plans need to be overhauled rapidly.

The role of scrutiny *now* is of critical importance

The time for clinicians to speak out is *now*

***Now* is the time for elected representatives to speak out**

**APPENDIX A: NHS Sustainability and Transformation Plans (STPs)
Don't Slash, Trash and Privatise our NHS!**

A Briefing prepared by campaigners from NE London STP area – November 2016

Introduction

STPs are driven by a combination of NHS underfunding, new budget cuts, and the Government's determination to shift the NHS from a clinically-driven service towards US-style models that fit more readily with private insurance-based and corporate-managed healthcare. These changes will have a devastating impact on the NHS and on services and healthcare for local people.

'Everyone will submit an STP because they have to, but it means there is a lot of blue sky thinking, and then a lot of lies in the system about the financial position, benefits that will be delivered - it is just a construct, not a reality.' Julia Simon, until Sept 2016, Head of NHSE Commissioning Policy Unit.

How STPs will affect the NHS

An HSJ poll ²⁴ of leaders of England's 209 Clinical Commissioning Groups has revealed the extent of "service changes likely or planned" over the next 18 months:

- **52% would be closing or downgrading community hospitals**
- **46% were planning an overall reduction in in-patient beds**
- **44% intend to centralise elective services**
- **31% would be closing or downgrading A and E**
- **30% intend to close an urgent care centre or similar provision**
- **23% are planning an overall reduction in acute services staff**
- **23% intend to stop in-patient paediatrics in one or more hospitals**
- **21% would be reducing consultant-led maternity provision**

Funding

- £22bn cuts to be imposed through 44 STPs across England by 2020-21
- No growth in services despite sharply rising costs, population numbers and rising health needs – means a devastating decline in what's available to individuals. These are CUTS, masked by deliberately ambiguous and vacuous language designed to mislead and manipulate the public.

	% GDP spent on health (new definitions)	\$ per head on healthcare
France	11.1	4,367
Germany	11.0	5,119
The Netherlands	10.9	5,277
Norway	9.3	6,081
Sweden	11.2	5,065
Switzerland	11.4	6,787
United Kingdom	9.9	3,971
Average (excl. UK)	10.7	5,264

- **UK spending on healthcare is significantly below the average of major European economiesⁱⁱ**. If the UK were to increase its spend to 10.7% of GDP, this would equate to an extra £15bn pa.

Lack of evidence to support NHS England's Five Year Forward View (5-YFV) 'new models'

²⁴ <http://www.telegraph.co.uk/news/2016/10/30/almost-half-of-nhs-authorities-to-cut-hospital-beds-and-third-to/>

- The **NHS has a proud track record of evidence-based practice**. This is all but abandoned in the 5-YFV.
- **The ‘new models of care’ are cost-driven**. We campaigners don’t oppose changes to services – but changes need to be driven by combination of clinical need & requirement for good patient access. Service changes need to be rigorously assessed against these criteria.
- **STP changes are being imposed with no such assessment, and lack of valid, peer-reviewed research evidence-base**. Anecdotes claiming success are routinely substituted for valid evidence that also takes account of a wider picture. Examples include:
 - **decisions to focus services on specific outcomes** often take no account of the impact on patients with multiple conditions who may lose coordinated care.
 - **Arguments about the need to centralize highly complex specialized care are misused** to justify closure of units offering excellent care for routine conditions. Often no account has been taken of increased risks of extended blue-light journeys to A&E or difficulties for patients and visitors facing of longer journeys.

The New Models of Care for the NHS mean:

- **Fewer sites for NHS services** – people will have to travel further for healthcare. We can’t assume a reduction in locations is acceptable without full analysis of travel implications for local patients and visitors - especially the impact on elderly or disabled relatives and families with children
- **Specialist hubs**: some specialist focus is needed for complex and rare conditions – but not for routine health issues where local services and accessibility / travel are more important. Local clinicians could access specialist advice if needed via good NHS networks.
- **Selling off the NHS family silver/estate**. A one-off boost for treasury finance, with few or no guarantees for local funding. When it’s gone -much of it handed over to private housing - it’s gone forever
- **No new capital money – so rely on PF2** - Many of the new models of care require different, potentially larger premises than currently available. We fear a repeat of disastrous consequences of PFI.
- **Reliance on enhanced self-care, Skype apps and unproven technology** to avoid hospital admission and clinical care amounts to magical thinking! And relies heavily on unpaid family carers (mainly women).
- **The most vulnerable and socially excluded patients and families & women** will be hardest hit.
- **Restructuring of the NHS** involves less clinical, more corporate management. Ripe for privatisation.
- **Data-sharing**. We are very concerned about proposals to share confidential medical data across a range of health and social care providers, leading to major potential for confidentiality breaches.

Downgrading professional staffing

- Development of **new roles such as Physician Assistant/ Associate (PA)** (just 2-years’ training) are part of a general move to reduce costs while de-professionalising (dumbing down) the NHS and heightening management control.
- These changes have a poor evidence base, often reporting ‘acceptability’ rather than outcomes. Evidence for success is often anecdotal and much of the ‘research’ would not meet professional standards or peer-review requirements.
- Proposals to engage PAs rather than experienced (yet cheaper) nurses have been justified by ‘too many professional limits’ placed by professional bodies on nurses!
- There is no mandatory registration for PAs, raising major concerns about regulation.
- There is robust (and unsurprising) evidence that PAs are less effective than doctors at diagnosis
- BMA warnings that PAs are not a substitute for fully trained doctors are likely to be ignored
- Concerns that PAs will not recognize important signs that a fully trained doctor would spot
- Pressure to grant PAs independent prescribing powers will lead to enhanced risk to patient safety and increased risk that PAs will be used to substitute for, rather than support, doctors.
- Concerns that **GP receptionists** may in future be triaging patients and directing them to PAs who will miss more subtle indications
- Concerns that patients directed to PAs are more likely to be **elderly, vulnerable, speakers with poor English** etc – while articulate middle class patients will be able to get GP appointments

- **Similar concerns apply to other proposed new roles**, substituting minimally trained staff for professional clinicians, nurses, pharmacy and professions allied to medicine throughout the NHS.
- As the Nuffield Trust puts it: *‘..... In the future, care will be supplied predominantly by nonmedical staff, with patients playing a much more active role in their own care. Medical staff will act as master diagnosticians and clinical decision-makers’.*ⁱⁱⁱ

Implications for community care services

- **Local Councils have already presided over 30% cuts in adult social care**, with over 400,000 fewer people receiving social care services since 2010, and those in receipt getting fewer hours^{iv}. We have not heard councils explaining these cuts and protesting loudly and very publicly about them.
- **Local councils have outsourced the future of the social care sector to large financialised businesses** which want to be paid more for doing the same (with no questions asked about their accounting and finance decisions). These businesses manoeuvre politically to reduce risk and avoid consequences, while threatening to hand back vulnerable residents when they go bust^v.
- **We are concerned** that Councils will preside over a similar demise of our NHS.
- **Fewer hospital beds, and early discharge mean more pressure on GPs, primary care and community care services.** The changes will mean repeated tightening of eligibility criteria and more people excluded.
- **Social care staff** increasingly required to take on tasks previously done by NHS professional staff. Safety risks and extra burden on family carers – predominantly women - and vulnerable patients have not been evaluated.
- **“There is a myth that providing more and better care for frail older people in the community, increasing integration between health and social care services and pooling health and social care budgets will lead to significant, cashable financial savings in the acute hospital sector and across health economies. The commission found no evidence that these assumptions are true.”**^{vi}

A better future for the NHS: the risks and The NHS Bill

- Our health service is being re-modelled in a way that will be ripe for wholesale privatization and insurance-based care, leaving a low-quality rump NHS for those who cannot afford private insurance.
- We are very concerned that this is the Government’s plan for future healthcare.
- **At least £4.5bn per year is wasted on simply managing the NHS market**, and more on private profit
- Procurement Rules mean that any marketized service is prey to international healthcare corporates.
- **There IS an alternative to this wholesale devastation. We want out Councils to support the NHS Bill^{vii} that will reinstate a publicly funded, publicly provided, accountable NHS.** This Labour private members’ Bill, drafted by Professor Allyson Pollock and barrister Peter Roderick, is supported by Labour, the Greens and the SNP, and will receive a second reading in Parliament on 24th February 2017.

What we want from CCGs and councils

We understand and accept that CCGs and Councils are required to manage sharply diminishing resources – but we ALSO expect our political representatives, together with other councils, to explain and shout from the rooftops to protest the devastating impact of these cuts and service changes to local people, and campaign forcefully for the NHS Bill.

Carol Ackroyd, Hackney KONP

References on page 39

<p>Overview on proposition that there are alternatives that can replace hospital care</p> <p>Review at</p> <p>2 October 2015</p> <p>NHS For Sale: Myths, Lies & Deception. Jacky Davis, John Lister, David Wrigley. 2015 pp 44-47- Are alternatives any cheaper? Do they even work? [references in book] http://keepournhspublic.com/</p> <p>Monitor. Moving healthcare closer to home: a summary</p> <p>It is difficult to cut costs across a local health economy in the short run</p> <p>Although schemes can help hospitals avoid future capital spending, it is difficult for local health economies to save costs in the short run through community-based schemes. Three of the four schemes we modelled did not break even within five years. This is because:</p> <ul style="list-style-type: none"> • Schemes can take up to three years to set up, recruit and become sufficiently credible to attract referrals. So providers and commissioners should not expect immediate impacts. • Even when schemes are cheaper per patient, it may be difficult for the local health economy to realise any savings. A local scheme (or schemes) will only lead to health economy-wide savings if it consistently diverts enough patients from local acute hospitals to allow them to close bed bays or wards. The cost saving is then only realised if providers and commissioners have the will to close down capacity that is freed up. In the context of rising demand for acute care, commissioners and providers will need to be entirely confident that community-based schemes can safely absorb expected extra demand before they will feel justified in closing acute capacity. However, community-based schemes will help commissioners and providers to avoid or delay future capital spending whether acute capacity is closed or not. <p>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459400/moving_healthcare_closer_to_home_summary.pdf</p>
<p>Is there evidence for community based care reducing hospital admissions safely?</p> <p>David Oliver. Preventing hospital admission: we need evidence based policy rather than “policy based evidence”. BMJ September 2014; http://www.bmj.com/content/349/bmj.g5538</p> <p><i>“In July 2014 commissioners throughout England published projections for reductions in urgent admissions to their local hospitals.1 But the size and speed of these reductions were not informed by any credible peer reviewed evidence—they rarely are.</i></p> <p><i>Recent reviews by the Universities of Cardiff and Bristol on admission prevention and by the health think tank the Nuffield Trust on new models of service in the community, found that the big and rapid reductions were illusory, once the findings had been peer reviewed and control data taken into account.” [other references in article]</i></p>
<p>Roland M, Abel G 2012. Reducing emergency admissions: are we on the right track? BMJ 2012;345:e6017, 16 September 2012 http://www.bmj.com/content/345/bmj.e6017 - [further 22 references in article]</p> <p><i>“Most admissions come from low risk patients, and the greatest effect on admissions will be made by reducing risk factors in the whole population... even with the high risk group, the numbers start to cause a</i></p>

problem for any form of case management intervention - 5 percent of an average general practitioners list is 85 patients. To manage this caseload would require 1 to 1.5 case managers per GP. This would require a huge investment of NHS resources in an intervention for which there is no strong evidence that it reduces emergency admissions.” [thanks for finding, Greg Dropkin]

<http://www.biomedcentral.com/content/pdf/1744-8603-9-43.pdf> Does investment in the health sector promote or inhibit economic growth?

http://www.hsj.co.uk/Journals/2014/11/18//q/r/HSJ141121_FRAILOLDERPEOPLE_LO-RES.pdf
Commission on hospital Care for Frail Older People HSJ and Serco

S Purdy. Interventions to reduce unplanned hospital admissions. 2012. A series of systematic reviews of 18000 studies and includes a very handy two page summary of evidence.

<http://www.bristol.ac.uk/primaryhealthcare/researchpublications/researchreports/>

“Background: The overall aim of this series of systematic reviews was to evaluate the effectiveness and cost-effectiveness of interventions to reduce UHA [unplanned hospital admission]. Our primary outcome measures of interest were reduction in risk of unplanned admission or readmission to a secondary care acute hospital, for any speciality or condition. We planned to look at all controlled studies namely randomised trials (RCTs), controlled clinical trials, controlled before and after studies and interrupted time series. If applicable, we planned to look at the cost effectiveness of these interventions.”

“Conclusions: This review represents one of the most comprehensive sources of evidence on interventions for unplanned hospital admissions. There was evidence that education/self-management, exercise/rehabilitation and telemedicine in selected patient populations, and specialist heart failure interventions can help reduce unplanned admissions. However, the evidence to date suggests that majority of the remaining interventions included in these reviews do not help reduce unplanned admissions in a wide range of patients. There was insufficient evidence to determine whether home visits, pay by performance schemes, A & E services and continuity of care reduce unplanned admissions.”

[See below for further extracts on individual areas reported on]

Effect of targeted intervention to population ‘at risk’ of admissions

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/red_cross_research_report_final.pdf The effect of the British Red Cross 'Support at home service' on hospital utilisation. Nuffield Trust

“We analysed data on hospital use in the six months after referral to Support at Home. The Red Cross group had a 19% higher rate of emergency admissions than the control group. Accident and emergency visits were also similarly higher. Nonemergency admissions, however, were 15% lower in the Red Cross group than in the matched control group. There was no significant difference between the two groups in terms of outpatient attendances.” [extract from executive summary]

On Integrated care

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf The reconfiguration of clinical services: what is the evidence? Kings Fund. Candace Imison

<http://www.nuffieldtrust.org.uk/sites/files/nuffield/evidence-base-for-integrated-care-251011.pdf>

http://www.nets.nihr.ac.uk/data/assets/pdf_file/0005/81266/BP-08-1210-035.pdf

On impact of social care

David Oliver president, British Geriatrics Society, and visiting fellow, King's Fund.
We cannot keep ignoring the crisis in social care. BMJ May 2015;
<http://www.bmj.com/content/350/bmj.h2684>

S Purdy (2012) **Interventions to reduce unplanned hospital admissions** which is a series of systematic reviews of 18000 studies and includes a very handy two page summary of evidence.

<http://www.bristol.ac.uk/primaryhealthcare/researchpublications/researchreports/>

Executive summary:

***“Background:** The overall aim of this series of systematic reviews was to evaluate the effectiveness and cost-effectiveness of interventions to reduce UHA [unplanned hospital admission]. Our primary outcome measures of interest were reduction in risk of unplanned admission or readmission to a secondary care acute hospital, for any speciality or condition. We planned to look at all controlled studies namely randomised trials (RCTs), controlled clinical trials, controlled before and after studies and interrupted time series. If applicable, we planned to look at the cost effectiveness of these interventions.”*

***“Conclusions:** This review represents one of the most comprehensive sources of evidence on interventions for unplanned hospital admissions. There was evidence that education/self-management, exercise/rehabilitation and telemedicine in selected patient populations, and specialist heart failure interventions can help reduce unplanned admissions. However, the evidence to date suggests that majority of the remaining interventions included in these reviews do not help reduce unplanned admissions in a wide range of patients. There was insufficient evidence to determine whether home visits, pay by performance schemes, A & E services and continuity of care reduce unplanned admissions.”*

Executive summary of findings under individual categories

Overall **case management** did not have any effect on UHA although we did find three positive heart failure studies in which the interventions involved specialist care from a cardiologist”

“specialist clinics for heart failure patients, which included clinic appointments and monitoring over a 12 month period reduced UHA. ... There was no evidence to suggest that specialist clinics reduced UHA in asthma patients or in older people.”

Community interventions: Overall, the evidence is too limited to make definitive conclusions. However, there is a suggestion that visiting acutely at risk populations may result in less UHA e.g. failure to thrive infants, heart failure patients.

Care pathways and guidelines: There is no convincing evidence to make any firm conclusions regarding the effect of these approaches on UHA, although it is important to point out that data are limited for most conditions.

Medication review: no evidence of an effect ... in older people, and on those with heart failure or asthma carried out by clinical, community or research pharmacists ... the evidence was limited to two studies for asthma patients.

Education & self-management: Cochrane reviews concluded that education with self-management reduced UHA in adults with asthma, and in COPD patients but not in children with asthma. There is weak evidence for the role of education in reducing UHA in heart failure patients.

Exercise & rehabilitation: Cochrane reviews conclude that pulmonary rehabilitation is a highly effective and safe intervention to reduce UHA in patients who have recently suffered an exacerbation of COPD, exercise based cardiac rehabilitation for coronary heart disease is effective in reducing UHA in shorter term studies, therapy based rehabilitation targeted towards stroke patients living at home did not appear to improve UHA and there were limited data on the effect of fall prevention interventions

Telemedicine is implicated in reduced UHA for heart disease, diabetes, hypertension and the older people.

Vaccine programs: ... the effect of influenza vaccinations on a variety of vulnerable patients. A review on asthma patients reported both asthma-related and all cause hospital admissions. No effects on admissions were reported. A review on seasonal influenza vaccination in people aged over 65 years old looked at non-RCTs. The authors concluded that the available evidence is of poor quality and provides no guidance for outcomes including UHA. A review on health workers who work with the elderly showed no effect on UHA.

Hospital at home: This was a topic covered by a recent Cochrane review of hospital at home following early discharge. Readmission rates were significantly increased for older people with a mixture of conditions allocated to hospital at home services.

We found insufficient evidence (a lack of studies) to make any conclusions on the role of finance schemes, emergency department interventions and continuity of care for the reduction of UHA.

APPENDIX C: ELECTIVE CARE in SOUTH EAST LONDON – unaddressed risks

'The review team felt very strongly that the case for change should be developed further to explicitly consider the whole elective orthopaedic care pathway. We also noted the case for change currently lacked evidence of being informed by an equalities impact assessment.'

London Clinical Senate Review June 2016

Introduction

- This document represents the views of local campaigners from the Save Lewisham Hospital campaign and Lambeth Keep Our NHS Public.
- The Joint Health Overview & Scrutiny Committee is being consulted by OHSEL about its public consultation on plans for two Elective Orthopaedic Centres in SE London.

Elective care

- Elective care – or planned care – is non-emergency health care.
- Planned care is one of the 6 main strands of the work undertaken by the OHSEL programme.
- OHSEL's work commenced December 2013 and work on elective orthopaedic surgery commenced Spring 2014.
- OHSEL has settled on the consolidation of planned orthopaedic surgery in two centres rather than continuing to provide it across all the hospitals in SE London.
- The cost of this is two-fold: capital expenditure is in the 10s of £millions. There is no capital funding available *other than private finance*. **This is extremely costly for the next generation.**
- The Foundation Trusts are wealthier than Lewisham and Greenwich Trust and at an unfair advantage in raising capital.
- In reaching this decision, **OHSEL has failed so far to evaluate the very realistic option of investing to improve the current provision.** After 2½ years of work on planned care, **this omission is not acceptable.**
- The London Clinical Senate report strongly recommends that the enhanced status quo option be evaluated fully, and points to numerous concerns about the consequences of pursuing the two elective centres option, with relative lack of regard to the rest of the pathway, before and most importantly after surgery after discharge.
- Enhancing the status quo could realistically raise standards to the required level (see Briggs Report) whilst avoiding both the financial risks and the risks of destabilisation of local health providers, whose integrated service and 'business plan' would be jeopardised.
- OHSEL's justification for centralising surgery in order to guarantee that surgeons have enough experience with procedures is unjustified and not backed up by any figures. There is a sufficiently high volume of work for the majority of elective orthopaedic procedures in South East London in local hospitals.
- Centralisation of low volume specialist procedures is already supported.

The points we raise here are, in our opinion, endorsed by the London Clinical Senate Review, June 2016.

OHSEL's own clear hurdle criteria *failed*

We have major concerns about the elective care proposals. In our view they significantly fail to meet two of OHSEL's own criteria (which, if not met, would theoretically rule out the option):

- **Firstly:** that the proposals do not undermine the stability (financial or clinical) of local NHS providers.

Financial Criteria

The option maintains or improves all organisational positions. Any option which could destabilise the ongoing financial and organisational viability of individual providers or commissioners without a compensating strategy will be ruled out.'

OHSEL document Planned Care reference group 29.09.16: Improving elective orthopaedics

There is an undeniable risk to the providers where the centres are not based.

- Tariff-based funding of the NHS leads to penalising of hospitals who lose activity to a specialist centre.
 - Staff recruitment will be affected if there is a loss of activity in essential surgical experience required for training and job satisfaction
- **Secondly:** that there should be sound clinical and financial evidence supporting the proposed change. The soundness of the evidence must be in context: ie in comparison to the clinical and financial evidence of other options – notably the 'enhanced status quo'.
There are other clinical consequences, both direct and indirect, of reconfiguring this high volume area of surgical activity away from the local hospitals, such as Lewisham and QE Woolwich.
 - Disruption to local care pathways already established around the district's hospital, multidisciplinary teams including social services – the Clinical Senate states that insufficient attention has been given to this significant part of the pathway (pre- and post-surgery).
 - Impact on **the training of staff** (medical, nursing in particular) if high volume activity important to training is diverted from the local hospital teaching and training environment and trainees cannot easily leave that hospital to experience the surgery at the centres.

OHSEL has failed to evaluate the enhanced status quo option and this is not acceptable

The process has completely failed to seriously evaluate the most obvious option: that of building on the already good performance and outcomes in the SE London health economy to enhance current provision. That option was highlighted **repeatedly** by the Clinical Senate Report and **MUST** be taken up (see appendix).

Why? Because current clinical performance is not far short of the Briggs national standards and London average, and relatively much more affordable investment in current services could attain those standards. **At least that option must be fully evaluated.**

OHSEL's failure to evaluate the 'status quo' option to date necessarily means that the evaluation of site options for the proposed centres has been biased, incomplete and fatally flawed. OHSEL belatedly plans to cover this failing, but too late to correct a flawed process.

This consultation must be halted, the enhanced status quo option fully explored, and then the full set of options subjected to a new option appraisal.

**APPENDIX D Analysis of Advice on Proposal for elective orthopaedic care in South East London
London Clinical Senate Review June 2016**

		<u>30 requests for greater development of the whole pathway</u>
1	page 5- paragraph 7	The review team felt very strongly that the case for change should be developed further to explicitly consider the whole elective orthopaedic care pathway. We also noted the case for change currently lacked evidence of being informed by an equalities impact assessment.
2	page 6- paragraph 1	Clinical engagement to date has mainly involved orthopaedic surgeons from the acute providers and now needs to be broadened to involve clinicians across the pathway, including interdependent services and primary care.
3	page 6- paragraph 3	As with the case for change the model of care needs to cover the whole pathway, including community services and primary care. Achieving the full range of benefits envisaged will require this approach. For example, variation in availability and provision of community services' is a concern, which risks inequalities in pathways to and from proposed elective orthopaedic centres.
4	page 10- paragraph 2	The review team believes however that in seeking to make these improvements, the whole planned care pathway needs to be considered
5	page 10- paragraph 2	For people on a surgical pathway, what happens before and after surgery can be equally important in achieving the best possible outcome. This view has underpinned our consideration of the case for change and the proposed model of care and our advice.
6	page 11- paragraph 4	It is also relevant that the data is more focused on secondary care with a relative paucity of community and primary care information. Analysis of referral variation would be interesting (at a practice and even GP level) and may result in a different emphasis to provision going forward.
7	page 13- paragraph 3	As noted earlier, the overarching case for change focuses on improving quality by consolidating elective orthopaedic surgery and, whilst the case for change acknowledges that this cannot happen in isolation ¹³ it does not currently address these wider pathways issues. Some stakeholders felt this to be a significant gap and the review team shares this view.
8	page 14 - whole page	Differences and variability.....ongoing medical problems exist
9	page15- third bullet point	· Changes impacting on primary care (and their feasibility) were not specified, for example any changes in volume of post-operative wound care or dressings that might arise from the fact that post discharge travel arrangements could make this more attractive.
10	page 15- paragraph 2	Other clinicians we met have had very little involvement in the work so far and whilst agreeing with the case for addressing current pressures, and the principles of consolidation, they felt there were other areas of the pathway (noted above) that would need to be addressed alongside any changes to inpatient care in order to achieve the full range of benefits envisaged
11	page 15- paragraph 3	Particular concerns related to the lack of reference to local services in the community including links to social care and primary care.

12	page 17- paragraph 6	Although there clearly are challenges within the pathway in addition to those identified in the peri-operative stage, the case for change has not yet considered them. Tackling the current variation in approaches, protocols and processes for elective orthopaedic care, particularly within community services across south east London, is a key area. The case for change does acknowledge this ¹⁶ , although it is not clear how it will be taken forward. Failure to do this risks limiting benefits realised from improvements to the inpatient part of the pathway, or creating greater inequality in access and provision of care. Increasing standardisation will need a collaborative approach and should seek to maximise benefit from the many examples of good practice that already exist.
13	page18- paragraph 3	As with the case for change, the model does not currently cover the whole pathway of care. The majority of stakeholders felt it was essential that it does in order to address current challenges in community provision noted earlier
14	page18 bullet points 7 and 8	· A lack of standardisation would be likely to create inefficiencies and inequalities, as patients admitted to the same centre for the same procedure could be following different protocols and/or have different levels and types of community support. This would impede the “pull” approach; · If constraints elsewhere in the pathway are not addressed, improvements in the effectiveness and efficiency of inpatient care (increasing the flow of patients through proposed centres and reducing length of stay) may not be achieved.
15	page 21- paragraph 22	Achieving greater consistency in community services across the six CCGs and boroughs seems critical to such a model working effectively and is likely to be challenging, however limiting these to this specific patient group may prove helpful in the long-term development of these issues. Developing the model further to encompass the whole pathway of care would help to address this, including the model of rehabilitation.
16	page22- bullet points 1 and 2	· Improvements to the inpatient part of the pathway creates new pressures and challenges elsewhere in the pathway, including the risk that inequalities could increase · The benefits envisaged are not achieved because the wider pathway changes needed to support them do not take place
17	page22- paragraph 2	Particular issues include the need for greater standardisation; difficulties in repatriating patients to local hospitals and discharge into community services; provision of timely, proactive rehabilitation, including specialist rehabilitation in the community and ensuring effective integration with primary care and social care.
18	page 28- paragraph 5	The proposed model of care for elective orthopaedic inpatient services would have implications for other areas of orthopaedic care and for other services with which orthopaedics has an interdependence or an interface. Some of these implications have the potential to increase risk
19	page 29- paragraph 6	However, we reiterate again the importance of considering the whole elective care pathway; the peri-operative stage of the pathway cannot be considered in isolation. For example, the model of care does have the potential to reduce length of stay for an elective admission, however the quality and effectiveness of pre and post-operative care are as important in achieving the best overall experience and outcome for patients. The full benefits that the case for change is seeking may not be achieved without taking this approach.
20	page 30- paragraph 5	Work to deliver some of the improvement opportunities identified in GIRFT are not necessarily dependent on the establishment of an EOC and could begin now. For example, networking across current services to begin introducing greater standardisation across the pathway. Making progress in advance, especially in achieving greater consistency within community services and strengthening education programmes for GPs, could facilitate transition to the proposed model of care if established and deliver earlier gains.

21	page 31- bullet point 1	· Addressing current differences in processes, approaches and services available within community services is a key area. If not tackled, this could contribute to inequalities.
22	page 31- bullet point 5	A sector wide opportunity for a collaborative approach to improvement and education should be jointly developed integrating both primary and secondary care. This is essential, as demand management is mostly within the gift of primary care.
23	page 32- bullet point 2	· Outcomes could be improved by increasing standardisation/reducing variation; introducing greater consistency in processes and approaches based on agreement about best practice and by addressing ALL aspects of the pathway including pre and post-operative care
24	page 34 -point 9	The case for change should now be extended to encompass the pre-referral, preoperative and post-operative phases so that it covers the whole end to end pathway from home to home. Some of the benefits which the current case for change aims to deliver will not be achieved without doing this. It would also ensure that proposals for the model of care take account of all key issues. There would need to be collective ownership of this approach.
25	page 36 - 18 a	a. The need to define a proposed model of care for the end to end pathway, including consideration of the implications for primary care and general practice;
26	page 36 18d	d. A model of care which consolidates planned inpatient orthopaedic care would increase the number of interfaces across different services and organisational boundaries. Standardisation of processes and protocols and greater consistency across all services, including community services across the six CCGs and boroughs, would be essential in ensuring such a model worked effectively;
27	page 37-point 21	Robust networking and collaboration would be essential to build the relationships and trust required for the proposed model to operate effectively, in particular standardising clinical approaches and processes. There are examples to learn from and draw on where this has been achieved in south east London. Currently, however, the model of care has little detail on the proposed networking approach.
28	page 37-point 23	As with the case for change, the model of care should be further developed and defined to encompass the whole pathway of care. Particular attention needs to be given to the pre-referral, pre-operative and post-operative phases including readmissions. Key interfaces and requirements to ensure a robust and effective model overall should be reflected in specifications developed e.g. for all parts of the pathway including community based musculoskeletal treatment and care.
29	page 40- point 45	40. Work should begin to identify where standardisation offers the greatest opportunities to deliver improvements (quality and cost). Given its importance to the overall model of care proposed, and because of wider benefits and learning that would accrue, we would recommend an early focus on community services, including pre-referral and preoperative assessment and post-operative care which could be for a defined group of patients initially e.g. older people with comorbidities.
30	page 41- point 49	49. Patients and carers and staff should be involved in identifying and agreeing measures of success. Goals and measures covering the whole pathway should be articulated as clearly as possible and be widely shared. They need to be owned by the whole system

<u>8 Requests for the consideration of the Enhanced Status Quo</u>		
1	page 18 paragraph 3	The review team felt that the rationale for including or discounting options was not explicit in the information we received
2	page 20 paragraph 2	Some stakeholders also felt the opportunity to look innovatively at an improved model for rehabilitation within the overall model of care was not being taken.
3	page 20 paragraph 4	Whilst many stakeholders indicated support for a two-centre model for elective orthopaedic inpatients, patients and carers representatives have mixed views and would like to see stronger evidence, including the potential to deliver benefits through the current model or an enhancement of it.
4	page 20 paragraph 5	The rationale for continuing to explore or discount specific options was not explicit in the documentation we received.
5	Page 34 Bullet point 4	Due to variations in community and secondary care, there was not unanimity within the review team that the centralisation approach was necessary to yield the opportunities outlined. Some members felt a comparison with the option of no site change but improved joint working alone still needed to be made both financially and from the impact on staff and patients' equalities.
6	page 35 bullet point13	A comparison with the option of no site change but improved joint working alone needs to be made both financially and from the impact on staff and patients' equalities.
7	page 36 bullet point17	We felt that the assumptions behind the two-centre model, for example relating to critical mass, could be explained in more detail and the rationale for continuing to explore or discount specific options was not explicit in the documentation we received. These issues were of particular concern to some PCRG members, who also felt the potential to achieve benefits within the current model, or an enhancement of it, had not been explored enough
8	page 37 bullet point 26	The option identification and appraisal process should be as explicit and transparent as possible in setting out the rationale for inclusion or exclusion of specific options.
<u>5 Requests for more consideration of the Equalities impact</u>		
1	page5 paragraph 6	We also noted the case for change currently lacked evidence of being informed by an equalities impact assessment.
2	page 6 paragraph 4	Travel and transport implications for patients, carers and families and the impact on equalities are important factors in considering how the model could be delivered and options for doing so; we identified several areas where there could be a risk of inequalities increasing.
3	page12 paragraph 3	We did not see any evidence that an equalities assessment has informed the case for change, including through the modelling of demographic growth and forecasts of future demand. Overall, we felt that equalities information provided for this review was weak.

4	page 17 paragraph 1	Based on the evidence we saw, equalities issues have not been sufficiently explored in the case for change. These include general issues such as travel times and costs (and any socioeconomic impact for specific population groups), disease specific issues such as complex medical care, readmissions etc and patient population issues such as such as mental health, learning disabilities, vulnerable groups and age. There is limited information about any current inequalities in relation to elective orthopaedic care or the implications of future demographic changes, particularly at a borough level where there is likely to be greater variance than for south east London as a whole.
5	Page 18 paragraph 3 bullet point 3	A lack of standardisation would be likely to create inefficiencies and inequalities, as patients admitted to the same centre for the same procedure could be following different protocols and/or have different levels and types of community support. This would impede the “pull” approach;

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ⁱ <http://www.nuffieldtrust.org.uk/publications/reshaping-the-workforce>

ⁱⁱ <https://chpi.org.uk/wp/wp-content/uploads/2014/11/CHPI-Long-term-sustainability-NHS-submission-to-House-of-Lords.pdf>

ⁱⁱⁱ <http://www.nuffieldtrust.org.uk/publications/reshaping-the-workforce>

^{iv} <https://www.adass.org.uk/media/4345/key-messages-final.pdf>

^v <http://www.cresc.ac.uk/medialibrary/research/WDTMG%20FINAL%2001-3-2016.pdf>

^{vi} <https://www.theguardian.com/society/2014/nov/19/parties-plans-nhs-future-wishful-thinking-experts>

^{vii} www.nhsbill2015.org/