Open Agenda

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

Wednesday 4 September 2013
7.00 pm
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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5.	**Acquisition of Princess Royal University Hospital by King's College Hospital NHS Foundation Trust** A paper from King's College Trust on the acquisition of Princess Royal University Hospital is attached . Background papers on the implications of the recent Judicial Review of Lewisham Hospital on the Trust Special Administrator are also attached as background information.	1 - 12
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Date: 30 August 2013

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Agenda Item 5

Acquisition of Princess Royal University Hospital by King's College Hospital NHS Foundation Trust

Update Briefing to the Southwark Health and Adult Social Care Scrutiny Sub-Committee

1. Background

1.1 In 2012, due to the South London Healthcare Trust's (SLHT) deteriorating financial performance and quality issues, the Secretary of State for Health instructed the Trust Special Administrator (TSA) to review and put forward proposals regarding the future of the failing Trust. As part of this process the proposals went out to public consultation. The TSA's overall recommendation was to dissolve SLHT, a component of which was that King's College Hospital acquire the Princess Royal University Hospital (PRUH).

1.2 In January 2013 King's College Hospital submitted an outline business case to the Secretary of State, and in February he approved the recommendation that King's acquire the PRUH.

1.3 King's full business case (FBC) has now been submitted to Monitor, the Foundation Trust regulator who will rigorously scrutinise the plan and the opinions of NHS partners. The FBC has also been sent to local commissioners.

2. The vision

2.1 'King's will become *one hospital across multiple sites*, with a single ethos and uniformly high quality of service which permeates all activities. All sites will develop clear areas of expertise.

2.2 Our key principles will be:

- One hospital, multiple sites
- High quality
- Maintain essential local health services
- Greater concentration of services to improve quality and efficiency

3. Summary of King's acquisition plans

- All services, assets and staff from the PRUH will transfer to King's
- Orpington Hospital will be run by King's on an interim basis and this will be reviewed after three years
- SLHT's services and space on the Beckenham Beacon site will transfer to King's
- Ophthalmology and Dental Services and Maternity at Queen Mary's Hospital will stay on site under a lease arrangement with Oxleas Trust.

- King's plans to take over accountability for the PRUH and Orpington on 1 October 2013

4. Benefits of the PRUH acquisition

4.1 Overall benefits

4.1.1 The acquisition will benefit patients, staff and the local health economy. The overall benefits fall into three key areas, quality, financial stability and achieving positive change in the healthcare system.

- **Quality:** Patients in Bromley and Kent will benefit from the development of specialist services. King's patients will benefit from some activity being moved from the Denmark Hill site which will reduce waiting times.
- **Supporting financial sustainability:** The PRUH will provide additional capacity and also the opportunity to restructure services which will assist in dealing with future financial challenges. King's will also put in place more rigorous performance management at the PRUH
- **Leading change:** The acquisition supports King's Health Partners' aim to lead positive change across the healthcare system by using the wider geographical area to extend its specialist networks of care.

5. Planned Service Delivery Summary

<table>
<tr><th colspan="2">SERVICE DELIVERY</th></tr>
<tr><td>Denmark Hill
High quality and efficient local acute services

Expansion of world recognised specialist services

A hospital for the seriously ill and a centre for specialist care</td><td>PRUH
High quality and efficient local acute services

Specialist services in selected clinical areas

A focus on patients who do not need complex, specialist care</td></tr>
<tr><td colspan="2">Focus on quality and systems that make the two hospitals into one</td></tr>
<tr><td colspan="2">Research and education
Expansion of King's Health Partners* vision for on-going education and development

Growth in different areas of research allowing for more innovation</td></tr>
<tr><td colspan="2">Staff</td></tr>
</table>

High performing, highly skilled, staff sharing vision and values Clinical managers working across two sites
Service innovation Physical and mental health Integrated care programme

6. Benefits to standards of care

- Improved leadership and governance will improve standards of care at the PRUH;
- Waiting times at Denmark Hill will improve as care will be shared over other sites;
- Strong clinical management will improve efficiency at the PRUH;
- Specialist services such as Ophthalmology will expanded ;
- Physical and mental health will be more joined-up;
- Wider opportunities for patients to be involved in new research and clinical trials;
- Opportunities for PRUH staff to access more education, training and development opportunities, and

7. Orpington Hospital

7.1 The TSA proposal for Orpington Hospital originally recommended that King's take over for a period of 12 months, but this has now been extended to three years, after which ongoing use will be discussed with Bromley Clinical Commissioning Group (CCG).

7.2 King's proposals for Orpington Hospital include:

- 2nd floor – Creation of a specialist orthopaedic centre for elective care (non-emergency) on the second floor to accommodate:
    - All elective inpatient activity currently undertaken by the PRUH consultants at the PRUH and Queen Mary Hospital
    - Some of King's elective inpatient activity
- 1st floor - Creation of a step-down facility for neuro patients who still need on-going specialist care
- Ground floor - Potential to provide additional services such as: out-patients, day treatment, medical records store and office space

7.3 The creation of an elective orthopaedic centre at Orpington Hospital will enable the Trust to reduce waiting times for elective treatment at both PRUH and Denmark Hill.All King's orthopaedic patients will have the choice as to where they receive their care, the Denmark Hill site or Orpington.

8. Timescales

8.1 There are still several approval processes to go through over the coming weeks, however, if these go smoothly then we expect a transfer date of 30 September 2013 and for the PRUH to be run by King's from 2 October 2013.

8.2 Plans for day one are that services and clinics on both sites will be delivered as usual. The longer term planning for the addition of more specialist services on the PRUH site is ongoing with key stakeholders and we will of course keep the HOSC updated and engaged in this planning process.

Briefing note for Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

4 September 2013

Outcome of the legal challenge to the decisions of the Trust Special Administrator for the South London Healthcare NHS Trust and the Secretary of State for Health in respect of Lewisham Hospital

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1. Background

In July 2012 the Secretary of State for Health, exercising his powers under Chapter 5A National Health Service Act 2006, appointed Matthew Kershaw as "Trust Special Administrator" ("TSA") for the South London Healthcare NHS Trust ("SLHT").

The TSA was appointed by the Secretary of State under the "Unsustainable Providers Regime" to deal with failing NHS organisations. SHLT was described as the "most financially challenged" NHS Trust in the country, with a deficit of £65 million per annum.

The TSA's task was, in effect, to run the Trust (the Trust chair and board of directors having been suspended) and then make recommendations to the Secretary of State as to what actions were needed in relation to the Trust.

The TSA published his report in January 2013. He recommended the dissolution of SLHT and the transfer of the management and delivery of NHS services to other organisations. In the view of the TSA, this also entailed a reconfiguration of NHS services in the wider south east London area, beyond the area served by SLHT. In particular:

- A reduction of the number of A&E departments in the area from five to four, necessitating the replacement of the A&E department at University Hospital Lewisham ("UHL") with a non-admitting urgent care centre.

- A reduction of the number of obstetrician-led maternity units in the area from five to four, necessitating the downgrade of the maternity unit at UHL to a stand-alone midwife-led birthing centre.

UHL is part of the Lewisham Healthcare NHS Trust, a separate entity to SLHT that was not subject to the TSA arrangements put in place in 2012.

On receiving the TSA's report and recommendations, the Secretary of State for Health asked NHS Medical Director Sir Bruce Keogh to review the recommendations with regard to whether there had been sufficient clinical input into the development of the recommendations; whether they were underpinned by clear clinical evidence; and whether a strong case had been made that the recommendations would lead to improved patient care. While

Sir Bruce accepted that while there was sufficient clinical input and a clear evidence base, he made a different recommendation with regard to the downgrading of the UHL A&E department, recommending instead that UHL retain a smaller A&E service, with 24/7 senior emergency medical cover. The rational for retaining A&E at UHL was that it would help reduce increased demand on other hospitals. An additional £37 million investment to expand services at other hospitals was also recommended.

The Secretary of State published his decision accepting the TSA's recommendations, subject to Sir Bruce Keogh's comments, on 31 January 2013. He announced that SLHT would be dissolved by 1 October 2013.

2. The Secretary of State and TSA's powers

The power of the Secretary of State to appoint a TSA is contained in the National Health Service Act 2006 ("the Act"). The power is exceptional by nature, intended to deal with Trusts which are unsustainable on financial or clinical performance grounds. In a Written Statement to Parliament in July 2012, the Secretary of State explained that:

> *"The [TSA's] Regime is not a day-to-day performance management tool for the NHS or a back-door approach to reconfiguration. The purpose is to deliver a rapid and robust process when the widest range of other solutions to improve and maintain sustainability have been tried. Implemented and not delivered the results required"*

The Act also grants the Secretary of State the power to direct NHS bodies with regard to the exercise of any functions – a more general power enabling the Secretary of State to require a reconfiguration of NHS services, including the dissolution of an NHS body and redistribution of Trust property and liabilities to other NHS bodies. This power is however subject to more rigorous scrutiny and consultation requirements than the TSA regime. In particular, any proposals for the reconfiguration of the health service would need to be mindful of:

- The requirement to consult a Local Authority on any substantial development or variation in the health service in the LA's area (Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013). The 2013 Regulations exempt a TSA from the duty to consult a LA.

- The principles set out in the NHS London Reconfiguration Guide (2011)

- The four "reconfiguration tests" set out by Sir David Nicholson, Chief Executive of NHS England, in May 2010, namely that:

    - Support from GP Commissioners will be essential;
    - Arrangements for public and patient engagement should be strengthened;

- The need for greater clarity about the clinical evidence underpinning the proposals; and
- Proposals should take into account the need to develop and support patient choice.

3. Legal challenge

The proposals concerning UHL provoked a significant outcry and protest. A Save Lewisham Hospital campaign was formed. Both the Campaign and Lewisham Council issued separate applications in the High Court for a Judicial Review of the TSA recommendations and the decision of the Secretary of State. The applications were heard together by Mr Justice Silber and judgement was handed down on 31 July.

The grounds for challenge put forward by the Campaign and Lewisham Council were that the Secretary of State and the TSA had no powers to make the recommendations and decisions that they did in respect of UHL (i.e. they had acted *ultra vires*); alternatively that the Secretary of State was wrong in finding that his tests for reconfiguring health services in south east London were met.

The vires argument

The *vires* argument centred on whether the TSA and the Secretary of State had the power to make recommendations and take decisions in relation to an NHS organisation which did not form part of SLHT. The wording of the Act suggested that the TSA and the Secretary of State's powers could only be exercised "in relation to the Trust" to which the TSA had been appointed.

The Secretary of State's case was that the words "in relation to the Trust" had to be interpreted more widely when considering the Act as a whole and that it was not Parliament's intention to give the words the narrow meaning put forward by the Applicants. The Court rejected this view, and held that as a matter of interpretation the words "in relation to the Trust" had to be specific to the Trust over which the TSA had been appointed.

Other arguments

Although the *vires* argument was sufficient on its own to defeat the TSA's recommendations and the Secretary of State's decision, the Court went on to consider other issues raised by the parties. Though largely academic, these are arguments that may fall to be considered on appeal.

The Applicants also succeeded in persuading the Court that the TSA's recommendations did not meet the four "reconfiguration tests" outlined above. The Court accepted that they did not fall to be considered under the TSA regime, but analysed the four tests in the event that its decision on *vires* was wrong. The Court held that the first requirement – namely that the support of GP Commissioners was "essential" to any reconfiguration – meant that the support of *Lewisham* GPs, as the group most affected by the changes to UHL,

had to be obtained. As Lewisham GPs had voiced strong opposition to the changes, the proposals failed this test. The Court held that the other three tests had been satisfied.

The Secretary of State sought to argue that even if he did not have the powers under the TSA regime to make the decision that he did, he could still rely on his other powers to direct NHS organisations as to the exercise of their functions, and he would have reached the same decision if he followed this route. The Court rejected this claim.

4. Conclusion and next steps

As such, the recommendations of the TSA and the final decision of the Secretary of State, but only to the extent that they related to UHL, were quashed.

The Department of Health has announced that it intends to appeal against the decision to the Court of Appeal.

Tom Crisp
Assistant Lawyer - Governance

JUDICIARY OF ENGLAND AND WALES

R (on the application of the London Borough of Lewisham and Save Lewisham Hospital Campaign Limited) v Secretary of State for Health and the TSA for South London Hospitals NHS Trust

High Court (Administrative Court)

31 July 2013

SUMMARY TO ASSIST THE MEDIA- THIS IS NOT THE JUDGMENT

The High Court (Mr Justice Silber) has today quashed recommendations made by a Trust Special Administrator and a subsequent decision by the Health Secretary to reduce services offered at University Hospital in Lewisham.

1. There are few issues, which prompt as much vociferous protest as attempts to reduce the services at a hospital, which is highly regarded and which is much used by those who live in its neighbourhood. One such hospital is University Hospital in Lewisham. This case arises because the Secretary of State for Health has decided to reduce the services provided at that hospital.

2. In these applications, Lewisham Council and an organisation entitled Save Lewisham Hospital Campaign Limited are seeking to quash the recommendation of the Trust Special Administrator ("TSA") that the services offered at University Hospital Lewisham should be substantially reduced and a subsequent decision of the Secretary of State also to reduce those services offered at that hospital.

3. This case concerns what happened on the first occasion on which a totally new special procedure entitled "The Unsustainable Providers Regime" has been used. As its name shows, it was intended to deal with failing NHS organisations, was used. South London Healthcare Trust was a very badly performing trust. In the 12 months to March 2012, it reported a deficit of £65 million making it the most financially challenged Trust in the NHS and it was forecast to have an accumulated deficit of £196 million for the five years from 2012/2013 to 2016/2017. The Secretary of State appointed a TSA to the South London Healthcare Trust which meant that the Chair and its directors of the South London Healthcare Trust board were then suspended from office and the TSA then took control.

4. The South London Healthcare Trust had three main hospitals, which were the Queen Elizabeth Hospital in Woolwich, Princess Royal University Hospital and Queen Mary's Hospital in Sidcup. It is important to emphasise that the University Hospital at Lewisham was not in the area of South London Healthcare Trust. Instead it was in a completely different healthcare trust which was the Lewisham Healthcare NHS Trust which, unlike the South London Healthcare Trust was not a failing NHS entity and no TSA had been, or indeed has been, appointed in relation to it. So the TSA for the South London Healthcare Trust was not

concerned with the affairs of the University Hospital at Lewisham or indeed the Lewisham Healthcare NHS Trust.

5. Under the "The Unsustainable Providers Regime" the TSA is required to provide to the Secretary of State and to publish a draft report stating the action which the TSA recommended the Secretary of State should take, and these are important words, "*in relation to the trust*".

6. The TSA for the South London Healthcare Trust made recommendations in his draft report of 24 October 2012. Those which are being challenged on the present application are first, that the Lewisham University Hospital should no longer provide emergency care for critically ill patients who did not need to be admitted to hospital, second, that it should lose its obstetrician-led maternity unit, and third, it should acquire an elective centre for non-complex inpatient procedures such as hip implants.

7. There was then further consultation and in his final report produced on 8 January 2013, the TSA recommended that the South London Healthcare Trust should be dissolved and that Queen Mary's Hospital should become part of Lewisham Healthcare Trust. Those decisions, which were also in the draft report, have not been challenged as there were clear statutory provisions supporting and underpinning the right of the Secretary of State to make those decisions.

8. There were also recommendations of the TSA in his final report which relate to the reduction of the services to be provided at Lewisham Hospital and it is those which are being challenged on these applications.

9. The Secretary of State then had to decide what action to take in relation to these recommendations and he observed that he was aware of the sense of unfairness in Lewisham where people felt that their much respected and admired hospital had been caught up in the financial problems of its neighbours. The Secretary of State therefore asked the NHS Medical Director Sir Bruce Keogh to review the TSA's recommendations. As a result of Sir Bruce's recommendations, the Secretary of State changed the recommendations in some respects in his Decision which is the main subject of the challenge on these applications.

10. I must stress that the issues raised on these applications do not relate in any way to the merits of arguments for and against the reduction of the services at Lewisham Hospital. Instead, my tasks are to decide first whether the TSA had the legal authority to make the recommendations which he did reducing the services at Lewisham Hospital, which was not in the area of the South London Healthcare Trust; and second whether the Secretary of State had legal authority to make the Decision which he did reducing the services offered at Lewisham Hospital.

11. Many arguments were put forward by counsel for the parties explaining why the TSA and the Secretary of State had or did not have legal authority to make respectively their recommendations and decision.

12. The main challenge was that the TSA and the Secretary of State were only entitled to make recommendations and a decision in the words of Chapter 5 A of Part 2 of the National Health Services Act 2006 "*in relation to the Trust*". Lewisham Council and the Campaign Group contended that this meant that the services offered by Lewisham Hospital could not be the

subject of the TSA's recommendations or a decision of the Secretary of State bearing in mind that Lewisham Hospital was not in the NHS Trust over which the TSA had been appointed, but instead it was in a completely different NHS Trust. In other words, the case of Lewisham Council and the Campaign Group was that the TSA and the Secretary of State could only make recommendations and decisions in relation to hospitals in South London Healthcare Trust, but not in relation to hospitals outside that Trust's area.

13. The TSA and the Secretary of State disagreed and their case was that they were respectively entitled to make recommendations and a decision which were consequences of their decision to dissolve the South London Healthcare Trust and to move Queen Mary's Hospital in Woolwich to the Lewisham Trust. So the case of the TSA and the Secretary of State is that they had authority to make recommendations and a Decision relating to the services at Lewisham Hospital including reducing them.

14. The answer to this dispute depended on an analysis of the provisions in the statute and the statutory guidance. I concluded that the case for the Claimants was correct and so the TSA and the Secretary of State were not respectively entitled to make recommendations and a decision reducing services at Lewisham Hospital because it was not a hospital over which a TSA had been appointed but in a totally different trust. In the words of the statute, the recommendations of the TSA and the decision of the Secretary of State reducing services at Lewisham Hospital were not made in the words of the Act "*in relation to the Trust*", which was the South London Healthcare Trust. My reasons are set out in more detail in paragraphs 76 to 94 of my judgment. So the effect of my decision is that the recommendations and the decision of TSA and the Secretary of State respectively relating to the services to be offered at Lewisham Hospital must be quashed.

15. There is an additional reason why the recommendations and a decision of TSA and the Secretary of State relating to the services to be offered at Lewisham Hospital must be quashed. The recommendations and a decision of the TSA and the Secretary of State had to have regard to or to ensure "*support from GP Commissioners*". There was much documentation issued by the Department of Health which indicated that it was important that "*local commissioners*" should give their views and that the lead commissioners should be GP Consortia where the majority of the patients would be most affected by the proposed service changes.

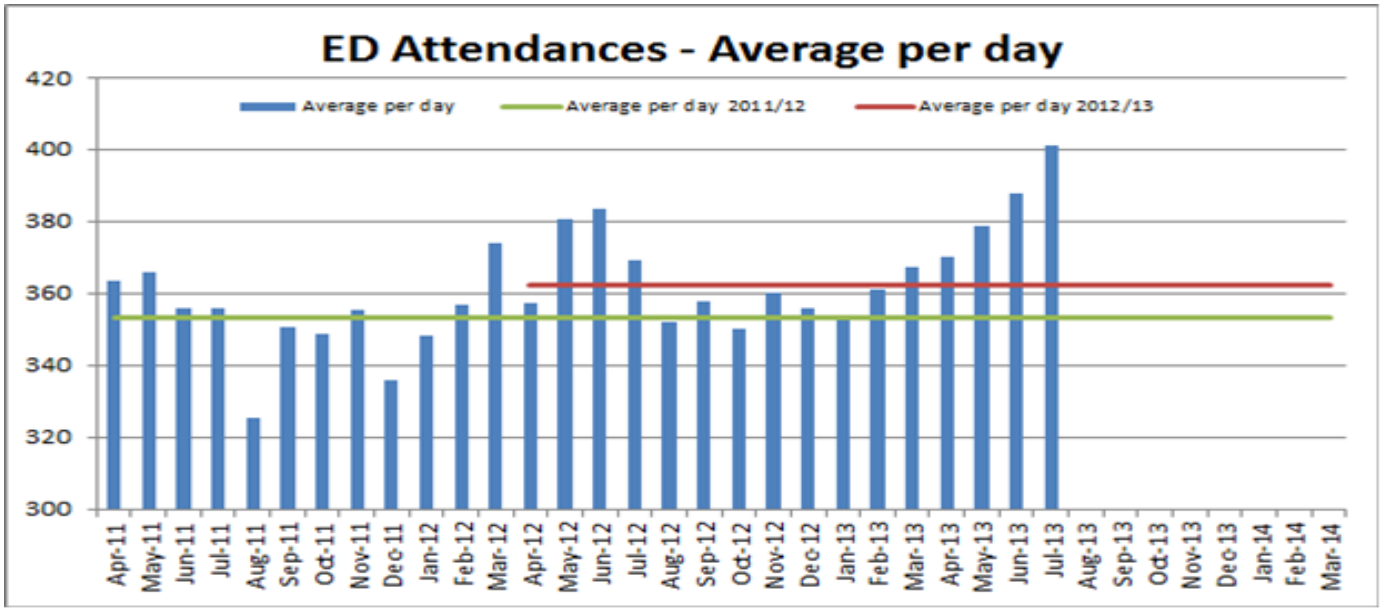
16. So far as Lewisham Hospital is concerned, there is no doubt that the majority of the patients who would be most affected by the proposed service changes would have been in Lewisham, because that is where the vast majority of the patients came from who went to the University Hospital in Lewisham. It was quite clear that the Lewisham GP Commissioners did not give support to the proposals; on the contrary, they strongly opposed them although those GP Commissioners in a number of surrounding but different areas were happy with them. I considered that it was the absence of support from the local GP Commissioners which constituted an additional reason why the decision of the Secretary of State cannot stand.

17. I should finally mention an additional point made by the Secretary of State which was even if the decision which he made under the regime with the TSA was unlawful as beyond his powers, he can still justify the decision by relying on his other powers. In the judgment I considered, but rejected, that argument. In consequence, the recommendations of the TSA have to be quashed, as has the decision of the Secretary of State.

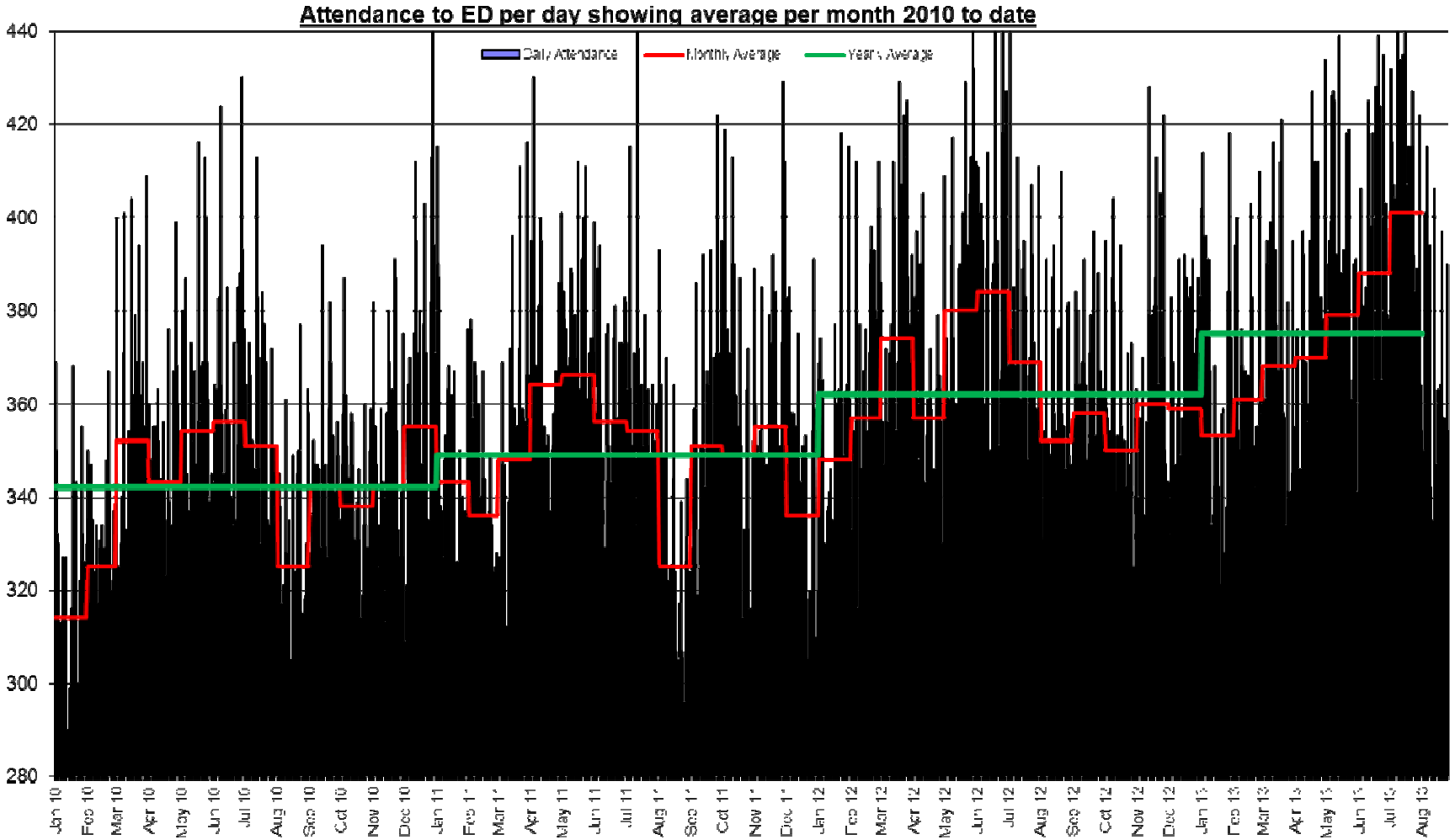
18. Bearing in mind that this was the first occasion in which the TSA regime has been considered by the Courts, I granted the Secretary of State and the TSA permission to appeal.

Report to the Southwark Health and Adult Social Care Scrutiny Sub-Committee on Emergency Care

1. Overview



	A&E attendances	Average Daily
Jan-13	10944	353
Feb-13	10106	361
Mar-13	11400	368
April-13	11112	370
May-13	11747	379
Jun-13	11651	388
Jul-13	12443	401


Attendance to ED per day showing average per month 2010 to date
Daily Attendance
Month's Average
Year's Average
440
420
400
380
360
340
320
300
280
Jan 10
Feb 10
Mar 10
Apr 10
May 10
Jun 10
Jul 10
Aug 10
Sep 10
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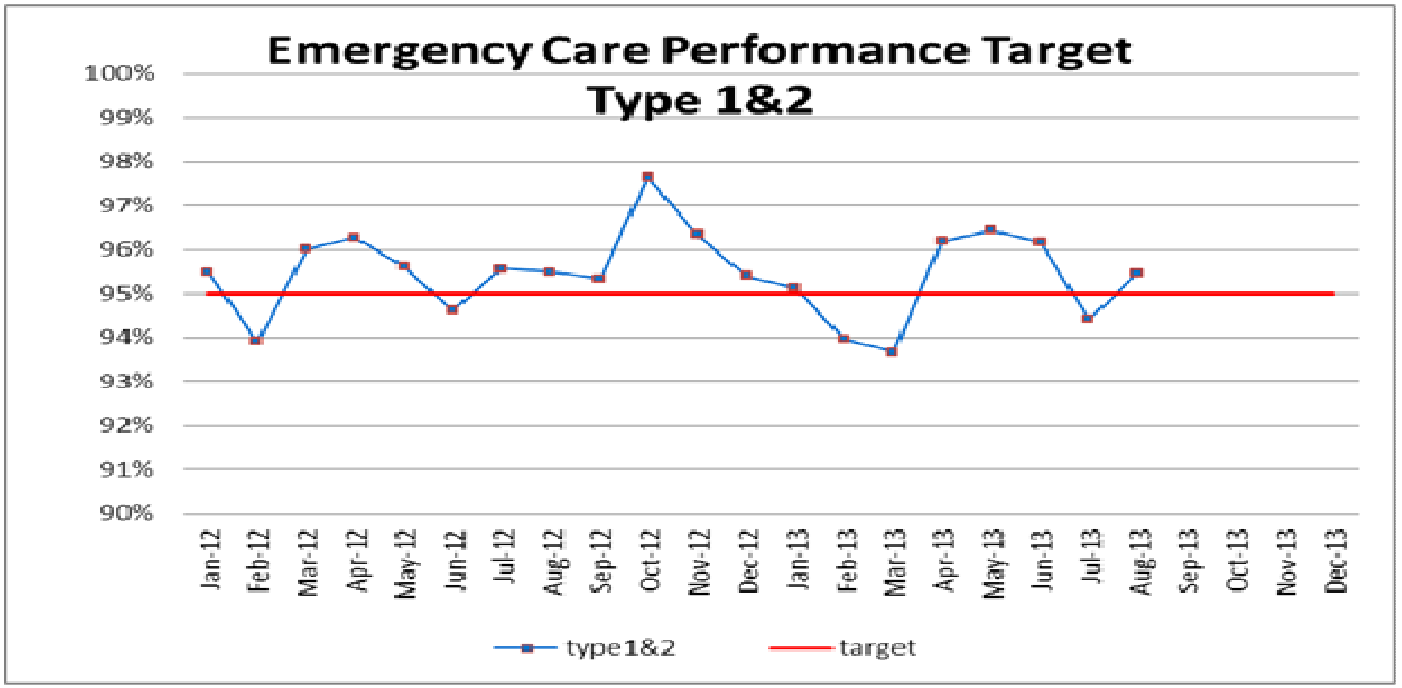
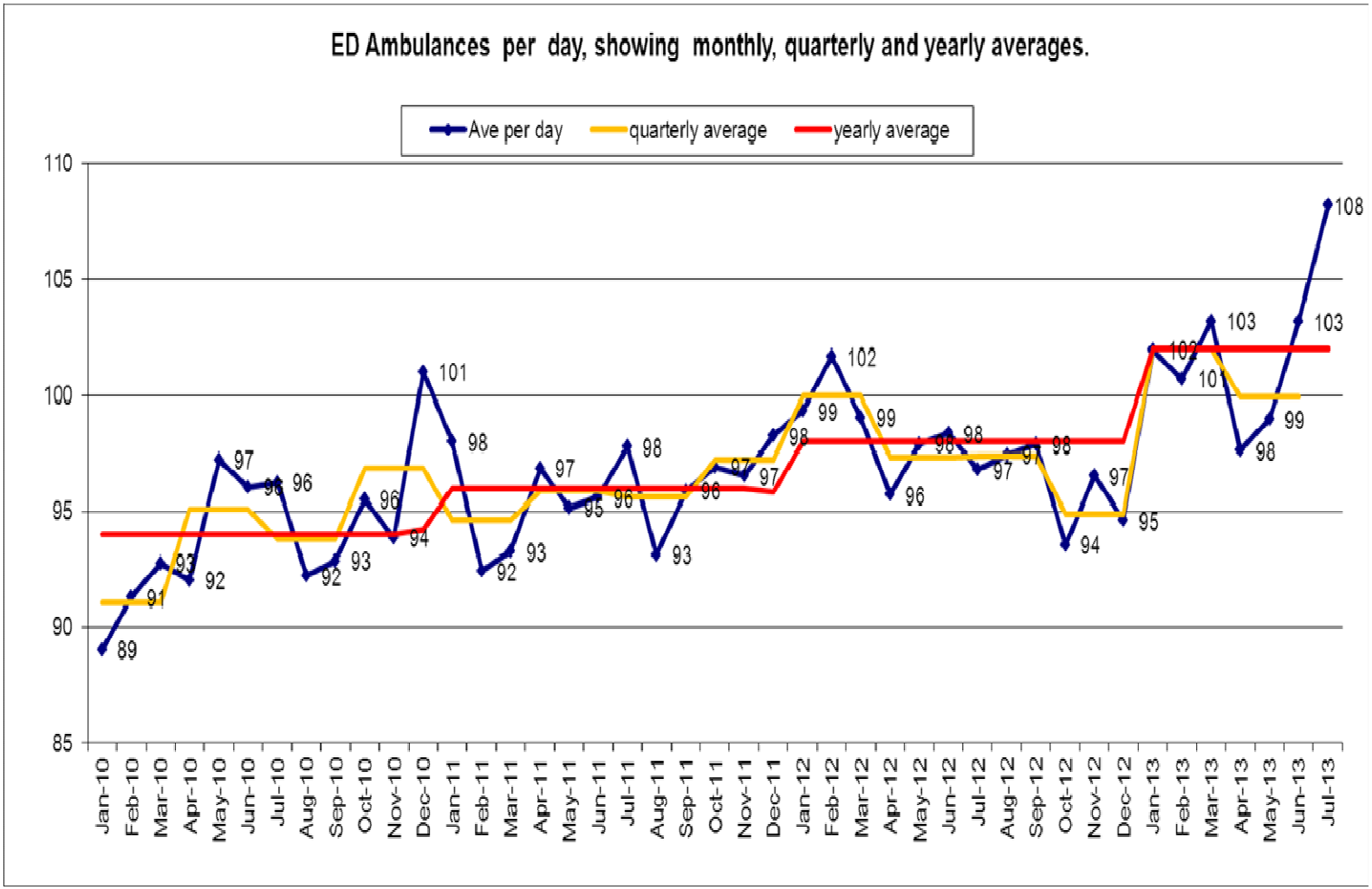
2. Emergency Care Performance



Month	Type 1& 2
Jan-13	96.13%
Feb-13	93.96%
Mar-13	93.67%
Apr-13	96.19%
May-13	96.45%
Jun-13	96.18%
Jul-13	94.42%
Aug-13	96.46%

3. Acuity


ED Ambulances per day, showing monthly, quarterly and yearly averages.
Ave per day
quarterly average
yearly average
110
105
100
95
90
85
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
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Oct-10
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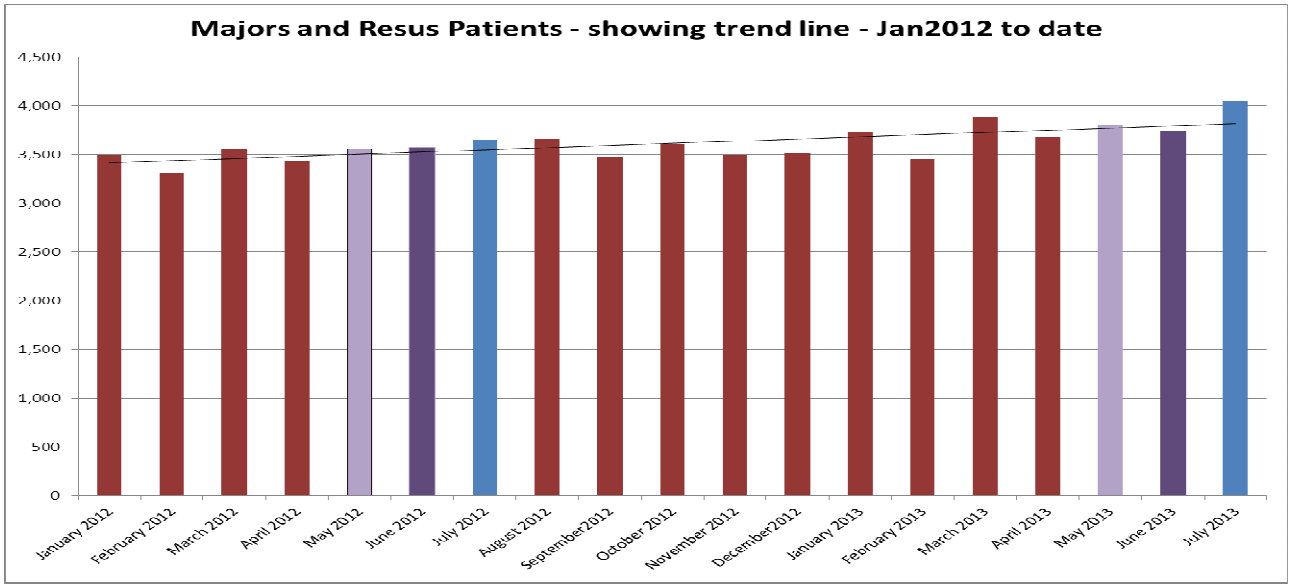
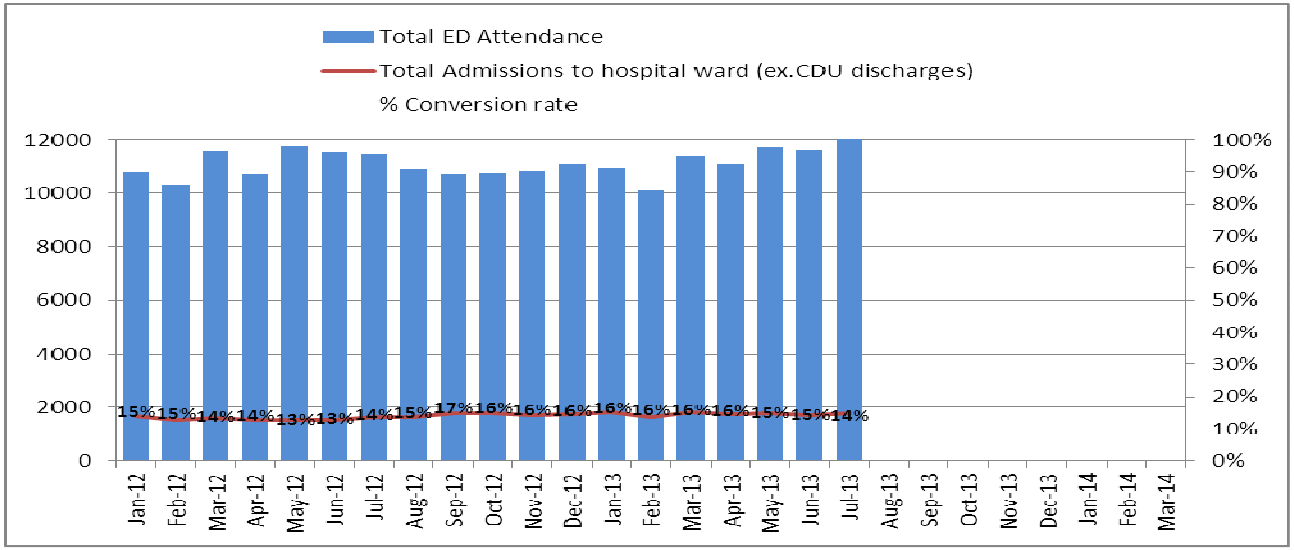
Jul-13


Majors and Resus Patients - showing trend line - Jan2012 to date
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
January 2012
February 2012
March 2012
April 2012
May 2012
June 2012
July 2012
August 2012
September2012
October 2012
November 2012
December2012
January 2013
February 2013
March 2013
April 2013
May 2013
June 2013
July 2013


Total ED Attendance
Total Admissions to hospital ward (ex.CDU discharges)
% Conversion rate
12000
10000
8000
6000
4000
2000
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
15% 15% 14% 14% 13% 13% 14% 15% 17% 16% 16% 16% 16% 16% 16% 16% 15% 15% 14%
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
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Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14

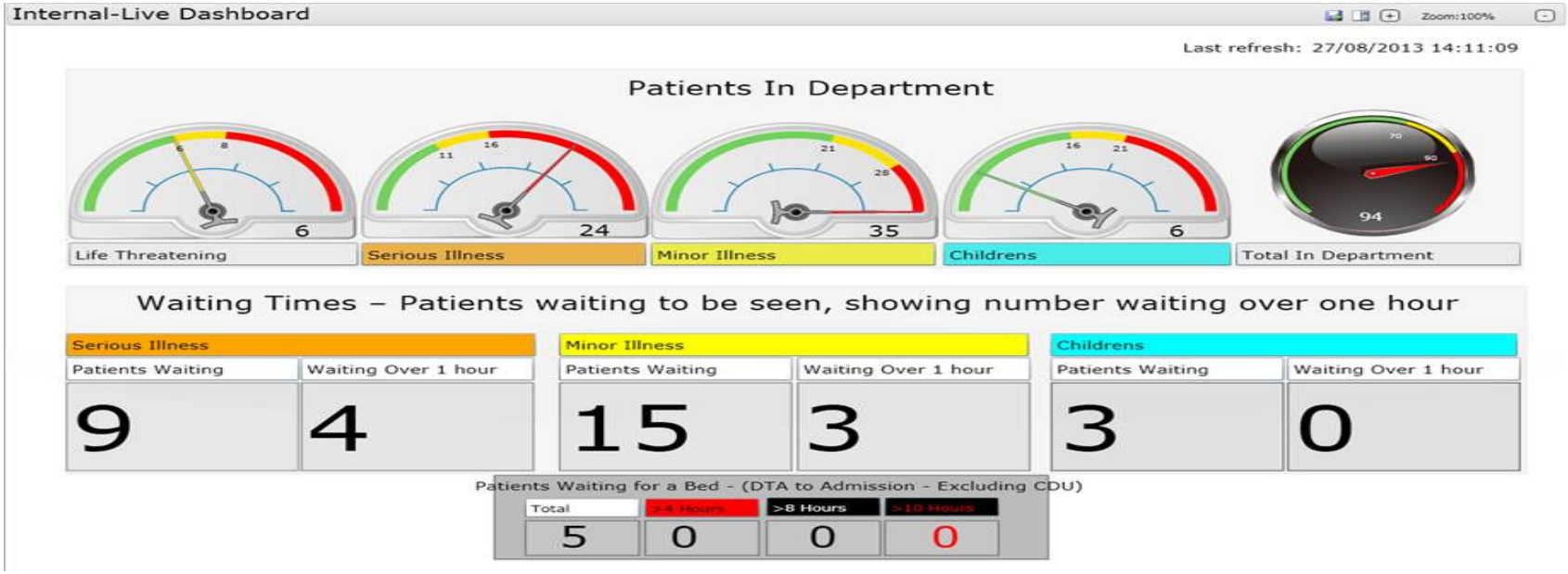
4. Work plan to help manage emergency flows and the emergency care target

4.1 The Trust has an Emergency Care Board (ECB) witha detailed recovery and improvement plan to support emergency care performance and winter planning.

4.2 The ECB has executive ownership; there is a weekly work-plan review and clear lines of accountability across all Divisional teams.Activity data is closely scrutinised and copies of performance packs and our full winter plan are available should the committee wish to review them.

4.3 The key areas of focus are:

- Pre-hospital pathways
    - London Ambulance Service (LAS) Out Of Area (OOA) analysis and clustering
    - Older persons assessment and rapid access
- Journey through the Emergency Department (ED)



    - Capacity – increased numbers of majors assessment cubicles
    - Extended ED consultant presence in the evenings and weekends
    - Urgent Care Service – primary care partner appointed, GP open evenings planned
    - Point of care testing for diagnosis and rapid decision making
- Flow within the Hospital
    - Capacity – infill wards, paediatric short stay unit and critical care capacity all coming on line. Orpington sitewill be used for elective surgery
    - Quality of care e.g. alcohol and substance misuse nurse appointment and 7/7 Registered Mental Nurses (RMNs)
    - Speed of decision making – access to diagnostics
    - Ambulatory care pathways
- Discharge planning and out of hospital
    - Discharge suite, 'home for lunch' initiative
    - Medihome
    - Red Cross
- MH pathways–Education and training, staffing, Approved Mental Health Professional's (AMHPs) in and Out Of Hours (OOH), triage wards
    - 3370 assessments in 2011-12
    - 3717 assessments in 2012-13
    - **10.2% increase**
    - 88 MHA admissions in 2011-12
    - 117 MHA admissions in 2012-13
    - **32% increase**

5. <u>Areas for improvement system wide</u>

- LAS & patient choice
- MH pathways- community care, access to approved social workers, bed availability
- Public health - awareness and expectations of urgent care options
- Integration – cross agency and cross borough

6. HOSC questions

6.1 The impact of the TSA on provision and access to Emergency & Urgent care and Maternity

Current position maintains full services at University Hospital Lewisham (UHL). KCH continues to plan forany future alternative outcome with the main pressures anticipated to be relating to capacity, specifically ED, Acute medicine, paediatrics and maternity.

6.2 The reasons for increased use of A & Es over winter and how this could be reduced - where appropriate

Access, both perceived and actual, to community services and primary care has a direct impact on attendance patterns to the Emergency Department. Supportive measures include public health messaging, increased OOH appointment availability, 7/7 community team working.

Infections outbreaks, such as norovirus,result in attendancespikes, creating capacity concerns particularly in relation to side room and isolation facilities. Extended periods of cold weather result in increased attendances specifically for the elderly. Public health messaging and close partnership working with primary care is extremely important. Campaigns giving advice and support to the elderly in relation to keeping warm have proven to be successful locally and should be repeated this winter.

Alcohol, substance misuse and homelessness continue to represent causality for a significant proportion of attendances. In reach programmes and access to rapid alcohol assessment units are beneficial. We are participating in a cross borough Big Lottery programme looking at creating packages of care for complex patients who frequently use services from acute health care, homeless teams, addictions, mental health and the judicial system.

Mental health attendances continue to increase and will be expected to rise again across the winter months.

6.3 Comment on how effective do you think Urgent / Emergency care pathways are ? What could be improved.

Effective partnership working is essential with greater integration of services. Whole system review of pressures with shared ownership and accountability for actions managed through an Urgent Care Board have been shown to be effective if managed correctly. Shared commissioning models and priorities across borough boundaries. Clear and effective signposting for the public

Briony SloperDeputy Divisional Manager, Trauma, Emergency and Urgent Care, KCH

Guy's and St Thomas' NHS
NHS Foundation Trust

Emergency Department Performance

Performance against the A&E 4 hour wait target has been achieved in Q1 (95.9%). Q2 is proving challenging and the target was failed in July (94.5%) with August presenting very similar challenges to the winter (96.4% so far). The effect of the heat wave on the Emergency pathway presented similar acuity patterns that were experienced in winter and has resulted in unusual dependency and occupancy on the wards for summer months.

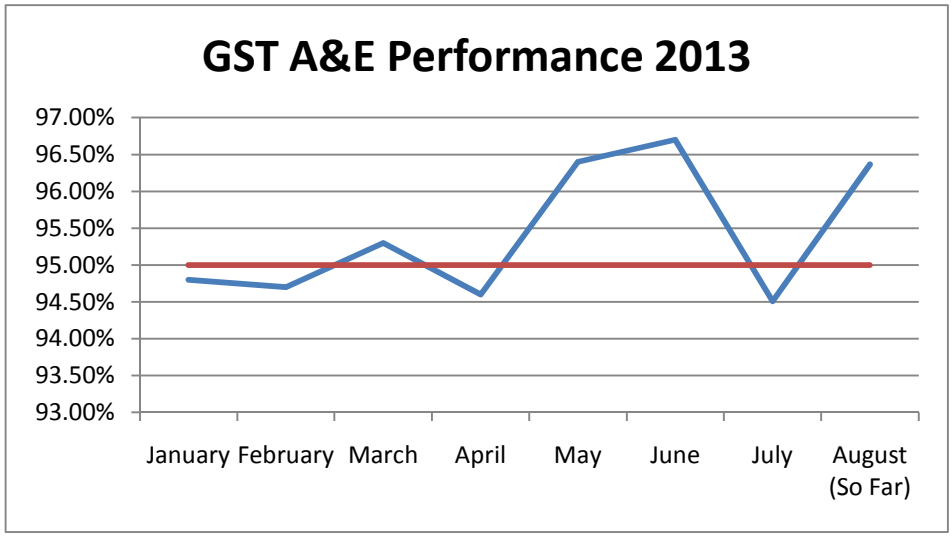
An action plan is being implemented to improve performance. Analysis indicates that there is no relationship between the number of breaches of the 4 hour wait and the total number of patients attending A&E. Staff consider that performance is determined by the combination of a number of factors, including:

- Bed availability at St Thomas' Hospital and in the Emergency Medical Unit in particular;
- The "clustering" of attendances at A&E, especially ambulance arrivals which have often occurred in clusters of more than 20 in an hour;
- The acuity of attendances, particularly the effect of "resus" cases diverting senior staff;
- The time of day, as the deployment of staff is lower at nights.

Guys and St Thomas' Foundation Trust A&E performance 2013

All types of A&E Attendances; proportion waiting less than 4 hours

January	February	March	April	May	June	July	August (So Far)
94.80%	94.70%	95.30%	94.60%	96.40%	96.70%	94.5%	96.4%



Reducing Unplanned Admissions to A&E

Guy's and St Thomas have a range of services and initiatives within the hospital setting and also as the boroughs Lambeth and Southwark as the local provider of community services. The overall aim is to reduce unplanned admissions where possible, manage length of stay and ensure that discharge arrangements are as effective as possible to avoid unnecessary re-admissions

a) Prior to arrival in A&E

- Lambeth & Southwark CCGS have commissioned a package of community based admission avoidance schemes, which form part of the broader Southwark and Lambeth Integrated Care (SLIC) Programme's frail elderly pathway. Interventions that have been successfully implemented include the Home ward, Enhanced Rapid Response team, establishment of geriatrician-led hot clinics, Community Multi-Disciplinary Teams (MDTs) within each locality and the re-ablement programme.

- A number of initiatives delivered through the GSTT Charity funded End of Life Care Modernisation Initiative, including Amber Care bundle, have resulted in better management of symptoms and end of life care in the community and nursing homes.

b) Discharge and out of hospital care

- Bed management: Bed management models (compliant with ECIST – Emergency Care Intensive Support Team) are used by GSTT to monitor occupancy and capacity, with escalation processes in place to implement changes as required. GSTT have reviewed elective bed requirements and have plans in place to reduce Length of Stay (LoS) and internal delays via the Patients Waiting project.

- Use of Expected Date of Discharge (EDD): GSTT have systems for setting consultant-led EDD which are audited regularly. There are multi-disciplinary services in place to assess and support discharge of frail elderly patients e.g. Enhanced Rapid Response, Kings Older People Liaison team. GSTT have plans to improve discharge planning. GSTT is launching a LoS work stream focussing on management of complex discharges as part of the Fit for the Future transformation program.

- Flexing community capacity to accept discharges: Step down facilities are available for very dependent patients needing rehabilitation and restorative care, however this is limited in terms of capacity and covering housing &

social care needs. Community teams are able flex capacity to accept some patients who may otherwise need step down beds. Redesign projects underway which aim to improve capacity and effectiveness of community health and social are provision, with expected outcomes to include reduced readmissions and referral times, for example the mobilisation of the Home Ward – which focuses on the three components of admission avoidance, early discharge and Case Management by Clinical MDTs - and Enhanced Rapid Response with Supported Discharge Team (SDT), which responds same/ next day when needed rather than 48 hr standard referral to start up time.

- GSTT Community Health Service also provides homeless intermediate care at Bondway which supports admission avoidance.

- Re - ablement - capacity has been increased.

Key patient groups

- Mental Health: At GSTT an integrated care pathway for mental health patients has been introduced to speed up transfers from Emergency Department (ED) to the Emergency Medical Unit (EMU).

- Alcohol: An Alcohol Recovery Centre was piloted at the St Thomas site in February using winter funding, which provided alternative care for this cohort of patients, releasing medical time - future commissioning arrangements are being agreed. Kings Health Partners have recently launched a combined Alcohol Strategy in response to increasing attendances in ED.

- Homeless patients: KHP have fully scoped the impact across KCH, SLaM and GSTT in conjunction with the Pathway charity. A business case is currently being finalised with a view to implementation of a dedicated Homeless Liaison Team across the two acute hospitals from this autumn.

- Children: There is a dedicated 24/7 paediatric ED, supported by the Evelina Children's' Hospital at the S Thomas'.

GSTT has already highlighted some areas for improvement and further work, some of which are already in progress and documented in Trust recovery plans. These include:

- Physical space –GSTT are implementing large scale ED redevelopment over the next two years and in the interim a number of short-term actions are being taken to improve the patient flows within the department.

- Enhanced seven day working arrangements

- Improve urgent paediatric care across the health system

- Ensure bottlenecks to flow out of the department/EMU are identified and processes put in place to remedy.

- Improving redirection to more appropriate services (GP slots etc)
- Improved IT infrastructure within the Emergency Department
- Continued pathway work for challenging patient groups (Mental health, alcohol)
- Reducing Length of Stay
- Improving internal waits and external delays
- Improving day case rates and reducing preoperative nights
- Managing the flow of tertiary semi-elective pathways
- Southwark & Lambeth Integrated Care (SLIC). Over the coming year, we will continue to support the ongoing implementation and review of the Integrated Care Pilot (ICP) for frail elderly pathway. The next phase of work will focus on simplified discharge process, enhanced seven day working arrangements; redesign of the falls pathway, Community Multi-Disciplinary Team registers holistic health checks and case management. In addition the programme will address Integrated Care against a wide range of Long Term Conditions.

Actions identified within GSTT ED Recovery Plans include:-

- Bed capacity: detailed review of general medical and respiratory bed usage over a 24 month period undertaken to plan a flexible bed base for winter 2013-14
- Increased clinical capacity: appointment of four consultants & nurse recruitment completed, in addition to a review of junior doctor pool to explore increasing cover at peak times
- Hourly monitoring of occupancy leading to early identification of problems and development of actions/trigger points
- Working with LAS to improve pathways and utilisation of HAS data to proactively respond to activity surges
- Working with SLaM to improve patient pathway and discharge process
- Paediatrics: review of paediatric ED processes, joint Paed & Adult ED medical post to be advertised and use of occupancy tool to manage surges in pressure

Naveed Mirza General Manager, Adult Community Services
Victoria Hastings Deputy General Manager, Acute Medicine

NHS
Southwark
Clinical Commissioning Group

Update for Southwark Council's Health, Adult Social Care, Communities and Citizenship Overview and Scrutiny sub-committee (HOSC)

South east London NHS 111 service update

July 2013

1. Performance of the NHS 111 service in south east London

1.1. The NHS 111 service was launched in Bexley, Bromley and Greenwich on 12 March 2013. Following the launch, there were a number of teething issues that led to variable performance against Key Performance Indicators (KPIs).

1.2. The most recent performance data (for June 2013) however, shows that the service has subsequently gone on to meet its access KPIs: with over 95% of calls answered within 60 seconds and 0% of calls abandoned - both of these meet KPIs based on national quality standards for the service. The rate of triaged calls resulting in an ambulance dispatch reduced to 8% during June 2013 (from 10-12% in previous months), which is a welcome development. Of these dispatches the rate at which the London Ambulance Service conveyed the dispatch remained over 75%.

1.3. Performance continues to be below national standards for clinician referrals and call-backs, however, NHS Direct are working with Commissioners to identify and resolve pinch points to improve performance. In June 2013, around 29% of triaged calls were referred to a nurse clinician for further assessment. 34.2% of the calls directed to a clinician were offered a call-back, and 63% of clinician call-backs were undertaken within 10 minutes. The average time for a call-back over this period was 12.5 minutes. Commissioners have put in place a safe and sustainable plan with NHS Direct to monitor these service levels. Furthermore, NHS Direct have established processes for managing clinical call backs, including queue prioritisation.

2. Sustainability of NHS Direct

2.1. Commissioners are aware that NHS Direct is seeking to withdraw from NHS 111 contracts across England. We are currently reviewing future delivery plans for the service and working with NHS Direct and NHS England to assess potential solutions including contingency arrangements. No final decision on a preferred option has yet been made, but we will be able to provide an update to the HOSC Chair as soon as decisions are made.

2.2. A National NHS Direct Liaison Group has been established to assist with this process and Dr. Angela Bhan (South east London NHS 111 Senior

Responsible Officer) is representing London commissioners on this Group. Our priority is as always to ensure the continuation of a stable, efficient and high quality 111 service for patients in South East London. We have assured ourselves that NHS Direct is safe to keep functioning at this point in time and we are closely monitoring the situation to ensure patients continue to get a quality and safe service, while planning ahead for any necessary contingencies.

2.3. NHS 111 services are operating as normal in south east London and patients should continue to contact 111 for help and advice.

3. Roll out of south east London NHS 111 to Southwark, Lambeth and Lewisham

3.1. As a result of the initial performance and capacity issues, a decision was made by south east London Commissioners to delay roll out to Southwark, Lambeth and Lewisham.

3.2. In light of the matters raised above, south east London commissioners have taken the decision to suspend plans to roll out NHS 111 in the boroughs of Southwark, Lambeth and Lewisham. A stable, high standard of service is what we wish to be available for our patients across the whole area. It would not be appropriate to implement the service fully in Southwark, Lambeth and Lewisham while future arrangements are likely to be subject to change.

4. Practical information for patients accessing urgent and OOH care in Southwark, Lambeth and Lewisham

4.1. The telephone advice aspect of NHS Direct has been decommissioned and replaced by NHS 111. The NHS Direct 0845 4647 number was switched off on 21 March 2013.

4.2. Patients who call NHS Direct since 21 March 2013 are asked to state their location via an automated message. Callers from a location in Southwark, Lambeth or Lewisham are advised that the 0845 service is no longer available in these areas. The caller is advised that, if they need to access non-emergency healthcare they must hang up and call 111 and the call is then ended.

4.3. As NHS 111 is a national service, patients in Southwark, Lambeth and Lewisham who choose to call 111 will get through to the service and their call will be handled within the 111 system.

4.4. This situation is clinically safe for patients - all healthcare services accessible from the NHS 111 service in Southwark, Lambeth or Lewisham are on the local Directory of Services (DoS), which provides the 111 call handler with real time information about services locally available. The patients' GP will receive a notification that the patient has contacted 111 and what the outcome of the call was (patients will be given the choice to opt out of this).

4.5. During the out of hours period, calls from Southwark, Lambeth or Lewisham that are connected to 111 and require GP out of hours service will be

transferred electronically to SELDOC (the local out of hours provider). This link has been in place since 28 March 2013.

4.6. Patients are still able to contact SELDOC directly for out of hours GP services, or they will be directed to SELDOC should they call their GP practices (either by direct divert or answer phone message).

4.7. The in hours automated message given by SELDOC advises patients to call their practice (or if they are not registered with a practice to go to www.nhs.uk to find the nearest one to them).

5. Quality assurance of the SEL NHS 111 service

5.1. The quality assurance of the south east London NHS 111 service is overseen by a dedicated clinical lead, Dr Patrick Harborow. Dr Harborow chairs the south east London NHS 111 Clinical Governance Group which has representatives from NHS Direct, GP out of hours (OOH) providers, acute sector, clinical commissioners and patient representatives.

5.2. Feedback from Health and Social Care Staff and of patients is vital to help us learn and continually improve the south east London NHS 111 service. A feedback form is available for both healthcare professionals and patients, which asks the respondent to provide information on the call so that the feedback can be applied as call specific. The form for healthcare professionals has been issued by CCGs (and previously by NHS South East London Cluster). The patient version of the form has been distributed via local Healthwatch groups.

5.3. The clinical lead receives daily and weekly updates on all feedback, incidents and complaints, and NHS Direct present a monthly report to the Clinical Governance Group with key trends to help shape service improvement.

healthwatch Southwark

NHS 111 feedback report

Audience: Health, Adult Social Care Communities and Citizenship Scrutiny Sub-Committee

30th August 2013

Below provides a brief summary of our feedback received based on the NHS 111 service and our involvement in current local NHS 111 developments.

1. Public feedback.

We have only received a couple of feedback responses relating to NHS 111. The experiences have been described below, which seems to highlight wider key issues. This was received in May 2013. Our response to the experiences is also included.

- Individual required health advice and information relating to her condition. She called her GP practice, where the voice message told her to call NHS Direct. She called NHS Direct answering a long list of automated questions, before being advised to call NHS 111. (She was incensed at this point!)
- She called NHS 111, again followed the list of automated questions before speaking to a call handler and being advised to go to A&E which she did after spending time in the waiting room.
- She felt that her query was only seeking assurance and could have been dealt with over the phone. She did not feel it was appropriate for an elderly lady to travel during the evening and wait at the A&E department, nor did she feel that it was the best use of A&E resources and waiting time.
- She was very angry with the service and wanted to know how to complain.
- Other feedback from the public also agreed that the NHS 111 process to get to speak to someone is quite long

Key issues highlighted:

- process of service
- Access and awareness of GP out of hours service (SELDOC), and GP practice role in this.
- Long automated of list of questions before speaking to NHS 111
- No clear way to complain or feedback about NHS 111
- NHS 111 signposting to local services
- Quality of NHS 111 advice, including the option to speak to a health care professional

Our response:

- We passed these issues to NHS CCCG commissioner overseeing urgent care, who informed us of the complaints process to South London CSU or completing the NHS 111 feedback form

- We sent the patient the feedback form, the e-mail address she was to send it to and outlined the process to her. She said she did not complain not as felt it was quite 'fiddly' and came in a PDF format.
- Forwarded her comments to the Public Rep at the Urgent Care Board

2. Current involvement in the NHS

Healthwatch Southwark produced a **Signposting document** on how to access important local health and social care services in Southwark. Following discussion with Southwark CCG, we followed their advice and did not publicise the NHS 111 service in Southwark. This is because NHS 111 is not fully rolled out in Southwark, Lambeth and Lewisham.

We are involved in two groups:

a) Patient Involvement Sub-group of the SEL Clinical Governance Group

In South East London, NHS 111 is currently being developed and led by the South East London Clinical Governance Group(CGG). It was acknowledged that there was a lack of patient engagement on local NHS 111 developments. A **Patient Involvement Sub-Group of** the SEL Clinical Governance Group was created with all six SEL Healthwatch organisation's involved, chaired by the CGG Lead. The Group are focusing on:

- Equality and Diversity issues and data with a view to monitor and shape future actions and development to ensure the NHS 111 service is accessible to the local population and is represented in the caller demographics.
- Community engagement and publicity, especially on the protected characteristics and borough specific groups with Bromley, Bexley and Greenwich (BBG) boroughs taking the lead where 111 is fully rolled out. Learning from the BBG will inform future Lambeth, Southwark and Lewisham developments.

b) **Lambeth and Southwark Urgent Care Network**

Cross section of commissioners, providers and London Ambulance Service, focusing on emergency attendance and admission pressures on the acute hospitals, in the current climate and with incoming winter pressures.

Health scrutiny overview 13/14 work-plan

Tuesday 15 October	Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee (3)
	Take evidence on reviews: **Review : Access to Health Services in Southwark** **Review : Prevalence of Psychosis and access to mental health services for the BME Community in Southwark** **Drug Joint Strategic Needs Assessment** **Consider Frances report:** - Committee prepare draft response - Hospital present response - Healthwatch present response - CCG present response
Monday 9 December	Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee (4)
	Cabinet member interview Take evidence on reviews: **Review : Access to Health Services in Southwark** **Review : Prevalence of Psychosis and access to mental health services for the BME Community in Southwark**

Monday 27 January	Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee (5)
	Annual Safeguarding **Update on Health and Wellbeing** **Drug Joint Strategic Needs Assessment & Alcohol Strategy** Agree reports on : **Review : Access to Health Services in Southwark** **Review : Prevalence of Psychosis and access to mental health services for the BME Community in Southwark**
Wednesday 5 March	Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee (6)
Monday 24 March	Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee (7)
	DRAFT Quality Accounts

	Items to be slotted in as appropriate
	1. JOSC on KHP consultation – if deemed substantial – on publication of Full Business Case 2. Adult Mental Health review (part of Psychosis CAG – so linked to review) 3. Possibilities: Integrated Care – Frail & elderly and new long term conditions

Agenda Item 12

Tony Griffiths
Regional Director London
NHS Property Services London
London Office
1 Lower Marsh
London SE1 7NT

Scrutiny Team
Direct dial: 020 7525 0514

12 August 2013

Dear Tony Griffiths

Dulwich Hospital

Southwark Council's Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee met on 15 July 2013 and discussed Southwark CCG's consultation on 'Health Services in Dulwich'.

The committee discussed planned and current arrangements for the procurement and leasing of buildings on the present Dulwich Hospital site. As a result of this discussion the committee resolved to write to NHS Property Services to determine current leasing arrangements.

Could you please clarify the following:

- What parties are currently involved in leasing land and buildings on the Dulwich Hospital site?
- What are the terms of any current leases?

Please can you provide a response by 23 August. If you have any queries please contact Julie Timbrell, scrutiny project manager, in the first instance via email on julie.timbrell@southwark.gov.uk or by telephone on 02075250514.

Yours Sincerely

Cllr Rebecca Lury

Chair, Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee.

Cc Andrew Bland CEO SCCG

Agenda Annex

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HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE **MUNICIPAL YEAR 2013-14**

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