Epsom and St. Helier NHS
University Hospitals
NHS Trust

Reply to:

St. Helier Hospital
Wrythe Lane
Carshalton
Surrey SM5 1AA

Tel. 020 8296 2000
Direct Line: 020 8296 2267
Direct Fax: 020 8296 3462
Email: matthew.hopkins@esth.nhs.uk

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Rachel Tyndall
Programme SRO
Better Services Better Value Team
Wimbledon Bridge House
1 Hartfield Road
Wimbledon
SW19 3RU

Dear Rachel

As I am not able to attend the next *Better Services Better Value* (BSBV) Programme Board meeting, I thought it might be helpful to summarise a number of outstanding issues and concerns, along with some suggestions about how we might move forward in addressing them. This letter also seeks to reflect the concerns raised by some of the Epsom and St Helier University Hospitals NHS Trust (ESTH) clinicians in a recent letter sent to me about their experiences of being involved in the BSBV Clinical Working Groups (CWGs) and their concerns about the emerging clinical models.

The contents of this letter are intended to be constructive, and are set against the backdrop of an organisation that understands that change is necessary in order to secure long term clinically and financially sustainable services at our hospitals, and in the health economies for the populations we serve. There is a clear understanding within our Trust Board and across our organisation that BSBV is the definitive commissioner–led vehicle for identifying the solution for the health economies of South West London and North Surrey, and we remain committed to working with the programme to the benefit of the people we serve and the staff we employ.

Many of the material outstanding issues of note have been rehearsed before, but the reason for summarising them here is to ensure that we can move forward to resolve them in a coherent, comprehensive and constructive manner.

1. Clinical Quality and Safety

As a clinically led process, there will inevitably be components of the clinical models which emerge from the CWGs that are contentious and where consensus is difficult to achieve. However, in order to secure a clinically coherent narrative, which addresses the case for change, it is enormously important that clinicians of all hues are satisfied that their views have been heard and properly considered, and that the models have been rigorously evidenced and tested. I believe we still have some way to go to be confident that we have a strong, clinically coherent platform to build upon. For example, at a recent meeting regarding the Urgent Care model, our clinicians learnt that the proposed Urgent Care Centre (UCC) model will accept ambulances and will not have a 'list' of clinical exclusions to use to triage patients into other care settings. It appears that the UCC model being proposed would be staffed by a combination of GPs and Emergency Care Physicians, and a wide range of nursing staff including 24/7

paediatric nurses. Even if this model were affordable, it lacks clinical coherence and clinicians are concerned about whether it would be a safe model in practice.

A second example relates to the cross-cutting issues emerging from the Urgent Care and the Children's CWGs, where I understand that the decision about the preferred number of Accident & Emergency Departments (A&Es) across the geographical area has been made in the absence of paediatric emergency clinicians, thereby missing the expert view from clinicians dealing with a large population of the current users of A&E departments on a daily basis.

I understand that it is planned to work through these issues at a later stage. However, I would counsel against waiting; rather, a rich clinical debate should be encouraged now to see how these models might work and, in particular, what infrastructure beyond a UCC would be required. Then the clinical models would be well placed to stand up to rigorous scrutiny and the financial consequences could be properly calculated.

2. Workforce

It was helpful that Charlotte Joll, BSBV Programme Director, attended our recent Trust Executive Committee to provide an update on progress. In her presentation, the future workforce constraints were noted as a key driver for change. However, given that a coherent workforce transformation programme must be an essential 'golden thread' through the BSBV narrative, it is a concern that so little actual work has been done, and what has been done has raised a number of significant questions. For example, I understand that to date the Maternity and Newborn CWG has concentrated on the consultant obstetrician manpower needed to deliver 168 hours of consultant presence on labour ward, without any firm consideration of the numbers of midwives needed to run the services in the three larger labour wards, or any consideration of how community midwifery services would feature in this large scale change.

To strengthen confidence levels amongst clinicians that the case for change can be addressed, and the strategic vision realised, it would seem prudent at this stage to ask the Workforce Group to meet urgently to interrogate some of the workforce details below the consultant level, i.e. a detailed analysis of the nursing and allied health professional workforce requirements for both the transformed acute sector and the transformed community sector. The group could also then consider the implications for the NHS workforce arising from the Francis Report on the Mid Staffordshire NHS Foundation Trust.

3. Out of Hospital Care

As you know, I have for some time had serious concerns about the risks to patients should the out of hospital health and social care provision be inadequate to enable 17.5% fewer emergency admissions across the geography we serve (In addition to the reduction in A&E attendances). This transformational change programme has and continues to be an essential antecedent to a credible plan to reduce the number of A&E departments from five to three, and to realise the BSBV strategic vision (as was previously raised by the National Clinical Advisory Team (NCAT)).

I know we all agree that our oldest and most frail patients in our geographical patch require well co-ordinated care, with all partners coalescing their efforts and resources around an efficient, transformed, patient-centred pathway of care. While it is acknowledged that what might work in one locality might need to be adjusted in another (i.e. co-location of social workers, therapists and community nurses, initiatives like the virtual ward), there are some common themes to all areas that might enable transformational change at scale. And the role of the ambulance services in London and Surrey will be mission critical in avoiding attendances to the proposed smaller number of emergency departments.

Therefore, I would recommend a further urgent debate about the benefits of developing a multi-agency transformation programme to oversee the necessary out of hospital care change. My clinical colleagues believe that to do otherwise would be irresponsible and place our frail, elderly populations at significant risk.

In addition, NCAT should be commissioned to review progress at regular intervals to provide external assurance to clinicians and stakeholders that strong progress is being made. NCAT could also provide assurance for the clinical commissioning groups on whether progress is being made with quality improvements in the hospitals, to the expected common high standards the case for change requires.

4. Consistency in Approach

We have spoken before about the apparent correlation between consistent approaches to financial and non-financial components of the programme, and confidence levels amongst clinicians and subject matter experts in the transparency of the programme. As you know, our finance team has raised some concerns about apparent inconsistencies between the application of commissioning intentions and estate redevelopment requirements between acute trusts, and these are being discussed with the team assigned to the modelling activities.

However, there have also been other issues. For example, there appears to be a difference between views within the BSBV team about whether the financial and workforce implications have been compared in detail between three and four acute site scenarios. I am sure this issue can be resolved on receipt and subsequent scrutiny of the comparative modelling data as promised by Marilyn Plant and Gavin Marsh. This is in addition to the data that Charlotte Joll agreed to provide relating to the paediatric model; modelling the increased consultant presence of 14 hours on the children's short stay units comparing the single and multi-site scenarios.

In order to reduce the risk of any inconsistencies emerging later, it might be helpful to outline the process whereby external assurance on the data assumptions will be provided. I am sure this will help both to show alignment with the case for change, but also secure confidence in the outputs, which will emerge in the next few weeks.

It might also be a sensible decision at this juncture to increase the number of ESTH representatives on the non-financial 'scoring panel', thereby ensuring that both hospital sites are represented.

In summary, ESTH is firmly committed to securing long term clinically and financially sustainable services at our hospitals, and in the health economies for the populations we serve. We will continue to engage fully in the BSBV process. This letter has intended to highlight some of the current concerns and to offer some solutions to them, and I hope that the contents of this letter are taken in the spirit in which they are offered.

I look forward to receiving your response.

Yours sincerely,

Matthew Hopkins
Chief Executive