BHT Acute Service Configuration Topic Paper (Sept 2013)

Purpose

- Refresh HASC member understanding of the evidence base behind the current configuration of acute hospital services across the Stoke Mandeville (SMH) and Wycombe Hospital sites, drawing on evidence previously submitted to the HOSC/HASC and new evidence.
- Inform future HASC Scrutiny of Buckinghamshire Healthcare Trust (BHT).

Following recent calls for an investigation by the County Council into the provision of urgent healthcare services for Wycombe residents, this paper outlines the evidence for the current location of services, and should assist with isolating issues over the accessibility of services, from issues over the quality of services which was the focus of the work on the Keogh Report by the HASC Working Group. Mindful of this evidence and the Keogh Report issues and associated action plan, the HASC can reach agreement on what further work is required on the urgent care pathway in Buckinghamshire.

2012 Configuration (Better Healthcare in Bucks) Summary

The preferred option which was implemented in Autumn 2012 following the Better Healthcare in Buckinghamshire (BHiB) consultation was to "organise acute services in one network, between two Buckinghamshire acute hospitals (with links to Wexham Park and for vascular services to Oxford University Hospitals)", meaning effectively we have one acute hospital split across two sites 15 miles apart (Stoke Mandeville and Wycombe).

Under the BHiB proposals the vast majority of people would continue to go the same hospital as they did before. The proposals would affect 3% of those patients who use Wycombe Hospital (approx. 7,600 patients out of a total of 225,000 people who came for outpatient, day case emergency or inpatient treatment in 2010/11). With patients requiring specialist urgent care treatment or medical admission for conditions other than stroke and cardiology treated at an alternative hospital. 0.5% of Stoke Mandeville Hospital patients (approx. 1,700 out of over 330,000 people who came to Stoke Mandeville Hospital for outpatient, day case, emergency or inpatient treatment in 2010/11) would be affected comprising those requiring initial assessment or outpatient appointments related to breast care that would be treated at Wycombe Hospital instead.

Justification

The following reasons were summarised by the HOSC in their response to the BHiB consultation, to explain why the changes were necessary:

- Maintaining and improving safety, clinical quality and patient outcomes
- Rising demand for services, particularly as a result of our growing ageing population and new, more complex treatments that are now available;
- The existing duplication of specialist services across two hospitals – Wycombe Hospital (WH) and Stoke Mandeville Hospital (SMH) – is not sustainable over the longer term from a safety and financial viewpoint;
- The European Working Time Directive (WTD) which requires more doctors than previously to be employed to ensure safe 24/7 cover;
- Financial constraints and the need to do more for less[1].

Other evidence provided includes that for a population of Buckinghamshire's size the College of Emergency Medicine recommends that the urgent care department needs a minimum of 10 consultants to meet national requirements. Wycombe and SMH only had 6 between them in 2012, and this number has remained unchanged in 2013 on the SMH site. There is a recruitment issue, and the WTD may be a contributory factor in this.

The Royal College of Surgeons[2] state that "the preferred catchment population size for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency medical and surgical care would be 450,000 – 500,000". It is estimated that hospitals of this size account for less than 10% of acute hospitals in England so the RCS concedes as a first step smaller hospitals should have a catchment of at least 300,000. Given the Bucks population, of which not all use BHT, this would preclude a duplication of acute services across SMH and Wycombe.

Coupled with the above, under the previous configuration consultants at the two centres did not see a sufficient number of patients to maintain their skills, putting services and patients at risk.

New evidence: Keogh on the configuration of services

The Keogh report into BHT was critical in a number of areas, and certainly felt with regard to the recent reconfiguration of services that there was a need for greater board oversight and real time evaluation, and that some elements such as patient transfers between sites needed attention. However there was no criticism of the configuration changes made,

[1] The Care for the Future programme that reviewed the clinical and financial challenges across Berkshire and Buckinghamshire ran from 2009-2011 identified that Buckinghamshire Healthcare faced a deficit of between £36.5-43.8 m by 2013/14, with a deficit of up to £350m across the two counties. Coupled with issues around clinical sustainability and service quality this programme concluded the three acute sites should be at Aylesbury (SMH), Reading (Royal Berks) and Slough (Wexham Park).

[2] RCS Delivering Services for the Future (2006)

which were considered positive developments. The following quotes from the Keogh Panel at the Buckinghamshire Risk Summit evidence this:

"*I think it's quite important to say that there was nothing that the panel found that said that the changes were the wrong changes to have been made for patient safety or experience*" (Andrea Young)

"*I just want to reiterate that I don't think we have a problem with the fundamental model in that the centralisation of stroke and cardiac reception being on this site, and the centralisation of unselected emergency care being on the Stoke Mandeville site. It's about the implementation and the quality and patient experience assurance in the delivery of that process*" (Chris Gordon)

These conclusions were reinforced by Chris Gordon when he attended the HASC Keogh Working Group meeting on 14 August 2013.

New Evidence: House of Commons Health Select Committee Report on Urgent and Emergency Services 2013

Whilst generally supportive of centralisation, drawing on evidence cited and provided by the Department of Health (DoH), the report does cite evidence from the College of Emergency Medicine that the benefits may be diminished in rural areas due to the distance patients must travel.

It is worth emphasising that there are different levels of rurality, and the distances involved in reaching a regional centre in a more rural county than Buckinghamshire, will be greater than those between the south of the county and SMH. Overall however this evidence emphasises the need to monitor patient outcomes post configuration, to provide assurance that patients travelling further are not experiencing significantly worse results. The following are extracts from the report:

"*The bulk of the evidence we received made a strong case for centralisation of treatment for patients with certain conditions such as stroke care, cardiac care and major trauma. When implemented successfully, the creation of specialist centres enhances clinical skills and concentrates resources, with demonstrably improved outcomes for patients.*

Centralisation, however, is by no means a universal remedy for the ills of emergency care. Service redesign must account for local considerations and be evidence based. Some rural areas would not realise the benefits from centralising services that London has, therefore the process must only proceed on the basis of firm evidence. The goal is to improve patient outcomes – centralisation should not become the end in itself." (4). The College of Emergency Medicine argued in their written evidence that the benefits of regional centres for patients in rural areas could be entirely negated by increased transport times. These observations merely reinforce the requirement for local commissioners to develop a fully integrated service which responds quickly and effectively to patient need."(23).

DoH evidence to the Health Select Committee:
The Department of Health has defined the various types of A&E facility[3]*. If a unit is to receive unfiltered 999 blue light ambulances it must be capable of the resuscitation, diagnosis and immediate treatment of all acute illnesses and injuries in all ages. This will range from major haemorrhage from a stomach ulcer to an overdose in a patient with depression to a finger burn in a child*. (EV 69)

The King's Fund (2011) Reconfiguring hospital services document states that there are good evidence based reasons why, in some services, larger units serving a wider catchment area produce better patient outcomes and are more cost-effective. It discusses the good reasons why consolidation of those services onto fewer hospital sites can be expected to drive up quality and drive down costs. The King's Fund cites examples including A&E, maternity and neonatal services, hyper-acute stroke units and heart attack centres. (EV 73)

There is clear evidence of the benefit of centralising services and treatment for a number of defined urgent conditions: major trauma; brain injury; chest injury; heart and lung injury; and major abdominal, pelvic, spine and limb injuries; Stroke; heart attack; major vascular (blood vessel) rupture or blockage; severe neurological disorders; and severely ill children.

It is possible that smaller A&E departments would become less clinically sustainable. Hospital trusts have important interdependencies of services for critical care, radiology, pathology and acute bed numbers. Removing certain groups of patients can therefore reduce the need for these interdependent services. Given the current shortage of medical staff in acute and emergency care, recruitment and retention may also become difficult for smaller units, as staff move towards the larger centres where better care can be delivered. Therefore, any decision to centralise services needs to take into account issues of equality and health inequalities, so that no individuals or groups are disproportionately disadvantaged by the relocation of service and that the benefits of any service change are experienced by whole populations. .. The emergence of networks (hub and spoke) with larger A&E departments working with local urgent care centres is one of the emerging solutions. (EV 75).

College of Emergency Medicine evidence to the Health Select Committee:
Urban areas are most suitable for centralisation of services. Clinicians can work in more than one unit thus retaining skills, patients are not geographically or psychosocially disadvantaged and economies of scale are maximised. In rural areas significant clinical benefit is lost as a result of increased transport times and none of the advantages stated for urban areas pertain. (EV 95).

[3] [1] Type 1—A consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.
Type 2—A consultant led single specialty accident and emergency service (e.g. ophthalmology, dental, children's A&Es) with designated accommodation for the reception of patients.
Type 3—Other type of A&E/minor injury units (MIUs)/Walk-in Centres with designated accommodation for the reception of accident and emergency patients. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community. A defining characteristic of a service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP practice or outpatient clinic) or one mainly or entirely accessed via telephone or other referral (for example most out of hours and primary care services) is not a type 3 A&E service even though it may treat a number of patients with minor illness or injury.

New Evidence: Emergency College of Medicine *The Drive for Quality 2013*

Among other things this report clarifies what services are required on an emergency medical site, demonstrating what would be required on the Wycombe Hospital site for a safe A&E / Emergency Department (ED) to be reinstated. *"The College view is that an ED must have 24/7 support services from Acute Medicine, Intensive Care/Anaesthesia, diagnostic imaging and laboratory services, including blood bank. It also remains the view of the College that the required support for an ED is provided by the 'seven key specialties'- Critical Care, Acute Medicine, Imaging, Laboratory Services, Paediatrics, Orthopaedics and General Surgery". (16)*

The relevant extract from this report and associated table are included in the appendices.

Future Hospital Commission: Caring for Medical Patients, Sept 2013

Outlines a way forward in response to the major challenges facing acute hospital services, centred around the needs of patients. Explains what hospitals must deliver and how they move towards this. Includes 7 day working, seamless integration with primary, secondary, tertiary and social care, measuring patient experience, staff training/education, avoiding unnecessary bed moves, reducing hospital lengths of stay. Provides a useful summary of how demographic changes and advances in medicine now required the NHS to deliver its services differently, moving away from the model of district general hospitals in every town. Encourages a move away from specialist care being limited to specific wards, and instead having specialist medical teams providing expert management of chronic disease in the community.

On the configuration of services it states: *The Commission recognises that its findings imply that tough decisions lie ahead. Reconfiguration will almost certainly be needed. No hospital can provide the range of services and expert staff needed to treat patients across the spectrum of all clinical conditions on a 7-day a week basis. We need to develop a new model of 'hub and spoke' hospital care, coordinated across health economies, centred on the needs of patients and communities and based on the principle of collaboration, not just across health services but also with social care, transport planning etc. It is likely that in many areas, large health economies will be served, not by a number of district general or teaching hospitals, but by a smaller number of acute general hospitals hosting EDs (emergency departments) and trauma services, acute medicine and acute surgery. These hospitals will be surrounded by intermediate 'local general hospitals' which, while not directly operating their own ED and acute admitting services on site, will contribute to step-down inpatient and outpatient care, diagnostic services and increasingly close integration with the community.* (para 1.27, page 9).

Appendices

- **NCAT Report on BHiB Proposals 2011 –** Worth reading for a comprehensive summary of the service configuration rationale, and for a clinical assessment and endorsement of this: http://www.buckspct.nhs.uk/bhib/wp-content/uploads/2012/02/National-Clinical-Advisory-Team-NCAT-report.pdf

- **HOSC response to BHiB Consultation 2012 Exec Summary –** A recap of the 2012 HOSC view of the proposals, with recommendations highlight areas of concern (many of which are still to be adequately resolved): http://democracy.buckscc.gov.uk/documents/s24062/Response%20to%20Consultation%20Proposals.pdf

- **Extract (pp 16-17) Emergency College of Medicine *The Drive for Quality 2013:*** http://www.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Quality%20in%20the%20Emergency%20Department/default.asp