Buckinghamshire County Council

Health and Adult Social Care Select Committee

Urgent Care

An inquiry into the design of the local urgent care pathway, and public understanding of it in Buckinghamshire

Published April 2014

Executive Summary

This report by the HASC looks at the overall design of the urgent care pathway in Buckinghamshire, and follows up the work we conducted in the Autumn 2013 in response to the concerns raised over the quality of care and treatment at Buckinghamshire Healthcare NHS Trust.

The Keogh Review into the Quality of Care and Treatment at the Trust published in July 2013, and our own response to this, was largely concerned with the quality of care and treatment. We were keen not to conflate the issue of service quality with issue of service provision/location. However in our report in response to Keogh we acknowledged there were continuing concerns over the lack of an A&E in High Wycombe, and a general lack of understanding of the reasons for the shape of service provision and the services provided.

This report focusses on the design of the urgent care pathway (i.e. the services in place and access to them) and the public understanding and awareness of this.

The report draws on national and local urgent care evidence, and includes contributions from the local Clinical Commissioning Groups, Buckinghamshire Healthcare NHS Trust and South Central Ambulance Service. Questions submitted by the public were put to representatives from these agencies at our evidence session on 28th January 2014.

The report concludes that there is a compelling clinical evidence base behind the local urgent care pathway design, and this aligns with the shape of provision advocated nationally. However, more needs to be done to explain both the shape of urgent care provision locally, and the evidence behind the shape of provision. This would encourage the public to use the services more appropriately and reduce demand on the system, and enable greater and more informed public scrutiny of the services provided and any future changes to these.

List of Recommendations

1) **That this report, and particularly paragraphs 7-21 is circulated to all local MP's, County and District Councillors, so they can understand why the local Health Scrutiny Committee considers the local A&E provision in place to be in the best interests of all residents, based on it supporting better clinical outcomes and aligning with national recommended practice. (paras 7-21)**

2) **An updated web and leaflet based summary should be produced by the Clinical Commissioning Groups explaining the reasons for the shape of existing urgent care provision in the county, particularly with regard to A&E provision. The webpage should link to original reports and evidence provided at the time of any reconfigurations, and should feature prominently on the websites of Buckinghamshire Healthcare NHS Trust, both local CCG's, and Healthwatch Bucks. The leaflet should feature at A&E, MIIU and GP surgeries. (para 22)**

3) **Video and website communications should be developed by the Clinical Commissioning Groups which inform the public on the urgent care pathways available locally regardless of whether such services are outside the county. These should then feature on CCG, Buckinghamshire Healthcare NHS Trust and Healthwatch websites, with videos used in GP and Hospital waiting rooms where this is an option. (paras 24-29)**

4) **The web based Urgent Care summary explanation should be accompanied by a guide explaining how the services which comprise the pathway are commissioned and monitored, and signpost to published data on performance and cost. (para 30)**

Background

1. In October 2013 the Buckinghamshire Health and Adult Social Care Select Committee published its report in response to the Keogh Review of the Quality of Care and Treatment at Buckinghamshire Healthcare NHS Trust. The Keogh review identified a number of shortcomings in the quality of service at the Trust, and in response an action plan was agreed for the Trust to address these. Our own report recommended a number of additional actions to improve the quality of care at the Trust covering areas such as discharge process and service accessibility.

2. Whilst the focus of both the Keogh report and our own report was in relation to the quality of service provided by the Trust, and despite the fact that the Keogh review raised no concerns about the reconfiguration of services at the Trust (see appendix 2 page 3) we acknowledged in our report (paragraph 2) that there were strong feelings around the urgent care services available. This was particularly evident in the High Wycombe area where concerns at the lack of A&E or Emergency Medical Centre (EMC) provision in the town has continued since these were replaced by a Minor Injuries and Illness Unit in 2012. As such the committee resolved in their Keogh response report (paragraph 47) to investigate the urgent care pathway in Buckinghamshire.

Inquiry Scope

3. With previous reports by Keogh and the HASC in 2013 looking at the quality of services, the committee agreed that the scope (Appendix 1) for this investigation should be limited to the location of services and the public awareness and understanding of these, and how to navigate the urgent care pathway. The inquiry was limited to services used by Buckinghamshire residents up to the point at which they either receive the urgent care advice or treatment required, or are admitted as a hospital inpatient. The quality of services was considered only in so far as this was undermined by the pathway design, and it was not within the scope of this inquiry to assess the quality of every service comprising the pathway (e.g. GP out of hours, 111, A&E, MIIU etc). The aims of this inquiry were to determine:

    - The acceptability of the current urgent care pathway design in the county, and its likely future direction in view of the recent NHS England report on transforming urgent and emergency care services.
    - Improvements required to the urgent care pathway.
    - Improvements required to how the public are informed about the urgent care services available, and the rationale underpinning the design of the local pathway.

Evidence

4. Evidence behind the current configuration of the local acute healthcare services had previously been presented to the local health scrutiny committee at the time of the

Better Healthcare in Buckinghamshire reconfiguration in 2012[1], and had been reiterated at subsequent committee meetings. To refresh the committee's understanding of this evidence, and update this with relevant new evidence we compiled a Service Configuration Topic Paper (Appendix 2). In addition to this the inquiry also draws on two recent national reports on urgent care services:

- Transforming Urgent and Emergency Care Services in England: Urgent and Emergency Care Review End of Phase 1 Report (NHS England, Nov 2013): http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

- Emergency Admissions to Hospital: Managing the Demand (National Audit Office, Oct 2013): http://www.nao.org.uk/wp-content/uploads/2013/10/10288-001-Emergency-admissions.pdf .

5. The inquiry group met on 28th October 2013 and agreed a number of questions to submit to the local Clinical Commissioning Groups for reply. Having received this reply (Appendix 3) the working group met again on 28th January 2014[2] and questioned representatives from the two local CCG's, Buckinghamshire Healthcare NHS Trust (BHT) and South Central Ambulance Service (SCAS). In addition to these meetings and the desktop research, some members of the committee also visited Stoke Mandeville Hospital in early 2014 to view improvements made to the urgent care areas. The inquiry group comprised Brian Adams, Shade Adoh, Margaret Aston, David Carroll, Tony Green, Lin Hazell (chairman), Andy Huxley, David Martin, Wendy Matthews, Mark Shaw, Jean Teesdale and Julia Wassell.

6. The majority of the inquiry group were satisfied that the inquiry had gathered sufficient evidence to deliver its scope and that the final report came to the correct conclusions and recommendations. The report was agreed by the full committee at their meeting on 15th April 2014. Four of the inquiry group members (Cllr David Carroll, Cllr Tony Green, Cllr Jean Teesdale, Cllr Julia Wassell) did not agree with the final report's completion because they felt further evidence was required. This further evidence included:
   - A public listening event in Wycombe District to hear from the general public, stakeholders and users of the A&E and Minor Injuries and Illness Unit.
   - More evidence on the Emergency Medical Centre at High Wycombe, Transportation between Wycombe district and Stoke Mandeville, and the situation of the frail elderly and hard to reach groups.

   The rest of the inquiry group and wider committee agreed these concerns did not change their view that the inquiry had achieved its scope and come to the correct conclusions. The committee noted the concerns of these four members and will keep these in mind in its future scrutiny of the local healthcare system.

[1] Health Scrutiny Committee meetings held 9.9.2011, 14.10.2011, 9.12.2011, 1.1.2012 and 13.4.2012 on Better Healthcare in Bucks proposals. Minutes available via the BCC online calendar of meetings: http://democracy.buckscc.gov.uk/mgCalendarMonthView.aspx?GL=1&bcr=1

[2] Minutes from the 28.1.14: http://democracy.buckscc.gov.uk/ieListDocuments.aspx?CId=832&MId=6099

Findings and Recommendations

Urgent Care Pathway Design: Wycombe Hospital Services and Public Understanding

7. There is a view amongst residents that it does not make sense to have removed established services from High Wycombe's hospital in recent years, when the town is only going to increase in population in future. There is also a view that patients will suffer if they have to travel further to access urgent healthcare, and this was encapsulated when in October 2013 a road traffic accident happened outside Wycombe General which received local and national press attention (patients had to be taken to Stoke Mandeville and Wexham Park Hospitals for treatment). Coupled with these concerns regarding patient safety and outcomes, are issues concerning the quality of the roads between the Wycombe area and Stoke Mandeville, the quality of public transport, and the inconvenience for people wishing to visit patients transported for treatment outside of High Wycombe. The strength of feeling among residents and concerns voiced, are evident in feedback members of our committee have received, local media coverage, and petitions (including a 16,000 name petition submitted to the July 2013 HASC meeting on behalf of Wycombe residents calling for an inquiry) which have circulated.

8. Appendix 2 details some of the evidence behind the configuration of hospital services in Buckinghamshire. The lack of an A&E at Wycombe General goes back to 2005 when the hospital's trauma services were removed. There is a lot of evidence behind the need to centralise trauma care (helpfully summarised in the 2010 National Audit Office report on Major Trauma Care in England[3]) and this underpins the national network of major and local trauma centres. Centralisation and the creation of such a national network ensures patients can access hospitals with the right expertise, experience and equipment. Such trauma specialisation cannot be provided at every hospital and an ambulance will sometimes need to drive past the nearest hospital to ensure the patient is taken to the best place to meet their medical needs.

9. Despite losing its trauma services, Wycombe General retained its A&E designation. In 2007 this designation was replaced by the Emergency Medical Centre (EMC) term when a strategic review found that the lack of trauma services meant the A&E title was no longer appropriate. The EMC subsequently was replaced with the MIIU (Minor Injuries & Illness Unit) when further acute services were removed from the Wycombe site as part of BHiB (Better Healthcare in Bucks) reconfiguration.

10. To understand the national context for urgent and emergency care service provision and its current trajectory, the 2013 NHS England report on *Transforming Urgent and Emergency Care Services in England*[4] is essential reading. Two core principles underpin the proposed future shape of urgent care services, these being:
    - For people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital.

[3] http://www.nao.org.uk/wp-content/uploads/2010/02/0910213.pdf
[4] http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

- For people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery.

Most people would agree with these principles, and would hope to receive these services in the event they need urgent health care.

11. The report articulates that to deliver the above vision, we need to move away from the outdated 1970's model of provision where most A&Es and their hospitals could offer the best treatment of the day for most conditions. Due to advancements in clinical practice this is no longer the case. Many people have gained a false assurance that all A&Es are equally effective and able to deal with anything that comes through their door, which is not true. The advancements in clinical practice which have delivered better healthcare outcomes mean not every town with a district general hospital can retain an A&E. With this context in mind it is worth considering the evidence we have heard supporting the configuration of urgent care services in Buckinghamshire:

Key facts concerning A&E provision in Buckinghamshire

- A&E can no longer be considered a general service able to be delivered safely at every district general hospital. It is a specialism.
- The minimum catchment 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 is 450,000 to 500,0000 people. This is the approximate population of Buckinghamshire and hence the county can only support the provision of a single hospital and set of acute services including A&E.
- To satisfy this provision, Buckinghamshire Healthcare NHS Trust operates essentially a single acute general hospital, but across two sites (Stoke Mandeville and Wycombe Hospitals). Cardiac and Stroke services are one site, A&E, Trauma and other acute services are on the other site.
- The College of Emergency Medicine recommends that an urgent care department serving a population the size of Buckinghamshire requires a minimum of 10 consultants to meet national requirements. In 2012 there were only 6 working across both the Wycombe and Stoke Mandeville sites.
- Nationally there is a shortage of A&E consultants, and the local Trust has found it difficult to recruit these. Pressure on workforce supply, has not been helped by the European Working Time Directive which limits the length of shifts doctors can work, and hence increases demand for doctors.
- The centralisation of most acute services onto the Stoke Mandeville Hospital site as part of recent reconfigurations, is not driven by the need to cut costs, but instead were cost neutral and were required to improve patient safety and outcomes.

- Even if money was no object and the NHS could afford to duplicate acute services across the Stoke Mandeville and Wycombe Hospital sites, and there were no constraints on consultant availability, the consultants working at each hospital would then not see a sufficient number of patients to maintain their skills and this would put services and patients at risk.
- Were the population of the county to increase in future years, for example to 600,000, there would still not be a need for additional A&E sites in the county, and instead the single A&E we have would be enlarged.
- A&E's are not standalone facilities, and require an array of 24/7 co-located support services. These include Acute Medicine, Intensive Care/Anaesthesia, diagnostic imaging and laboratory services, including blood bank. The Emergency College of Medicine considers that an emergency department also requires the seven key specialities of Critical Care, Acute Medicine, Imaging, Laboratory Services, Paediatrics, Orthopaedics and General Surgery (see Appendix 2, page 5).
- Two of the reasons why Stoke Mandeville was chosen over Wycombe to host the A&E is that firstly there was adequate space on the site to accommodate the A&E, Trauma and other required co-located acute services and any future expansion of these. Secondly, the proximity of Wycombe Hospital to Wexham Park Hospital A&E limited the population catchment size it could serve.

12. In our ongoing scrutiny of the 2012 Better Healthcare in Bucks reconfiguration, the HASC will be seeking evidence and assurances that patient outcomes have been improved by the centralisation of acute services. We are next due to do this at the April 2014 committee meeting. There are indications that benefits are already being realised, with the most recent set of mortality indicators for Buckinghamshire Healthcare NHS Trust returning to the expected range (Summary Hospital Level Mortality Indicator April 2012-2013). Mortality rates in the last few years before this had been higher than expected, and this is what triggered the 2013 Keogh inspection/review of the Trust.

13. Some concerns have been raised nationally (House of Commons Health Select Committee Report on Urgent and Emergency Services 2013, see Appendix 2 page3) that in some rural areas, the benefits of centralising services could be diminished by the additional travel times involved. We put this to NHS representatives at our evidence session and were given reassurance that the benefits were not diminished in Bucks. Ambulance journey times for Wycombe district residents to A&E are only five minutes longer on average than before the 2012 reconfiguration, the Ambulance service are not aware of people dying on route to the hospital because of the journey time, and this is not perceived as a major risk by them.

14. The Better Healthcare in Bucks consultation document explained how of the approximately 225,000 people using Wycombe Hospital each year (as outpatients, day cases, emergency or inpatients) some 7,600 (3%) would in future receive treatment at an alternative hospital. In most cases when emergency urgent care was required, ambulances would be available to ensure there was no problem with accessing the A&E. The bulk of the patients previously using the EMC would be treatable at the MIIU. Wycombe MIIU is operating 24/7 and currently serving some

32,000 people per annum. We asked the NHS commissioners to confirm it would remain a 24/7 facility, given we are aware it is being used very little during the night (on average 4 people come to the MIIU between 10pm-6am). The commissioners explained that a 24/7 service would remain, but the overnight cover may need to be via the GP out of hours service in future, which is now co-located in the MIIU. People would then be urged to phone 111 to arrange an appointment first rather than arrive at the MIIU unannounced. Phoning 111 is in any case recommended before travelling at any time of day to ensure a person goes to the most appropriate service in the first instance.

15. Concerns have been raised in the past that the loss of A&E, followed by the loss of EMC at Wycombe Hospital, along with other acute services and the consultant led maternity unit, is part of a gradual chipping away at the services provided on this site which could lead to its eventual closure. The BHT Clinical Strategy ratified at their Board meeting on 29th January 2014 would suggest this is not the intention, as this strategy outlines the trust's intent to "continue to develop Stoke Mandeville and Wycombe Hospitals as vibrant acute hospitals".

Urgent Care Pathway Design: Local Alignment to National Vision

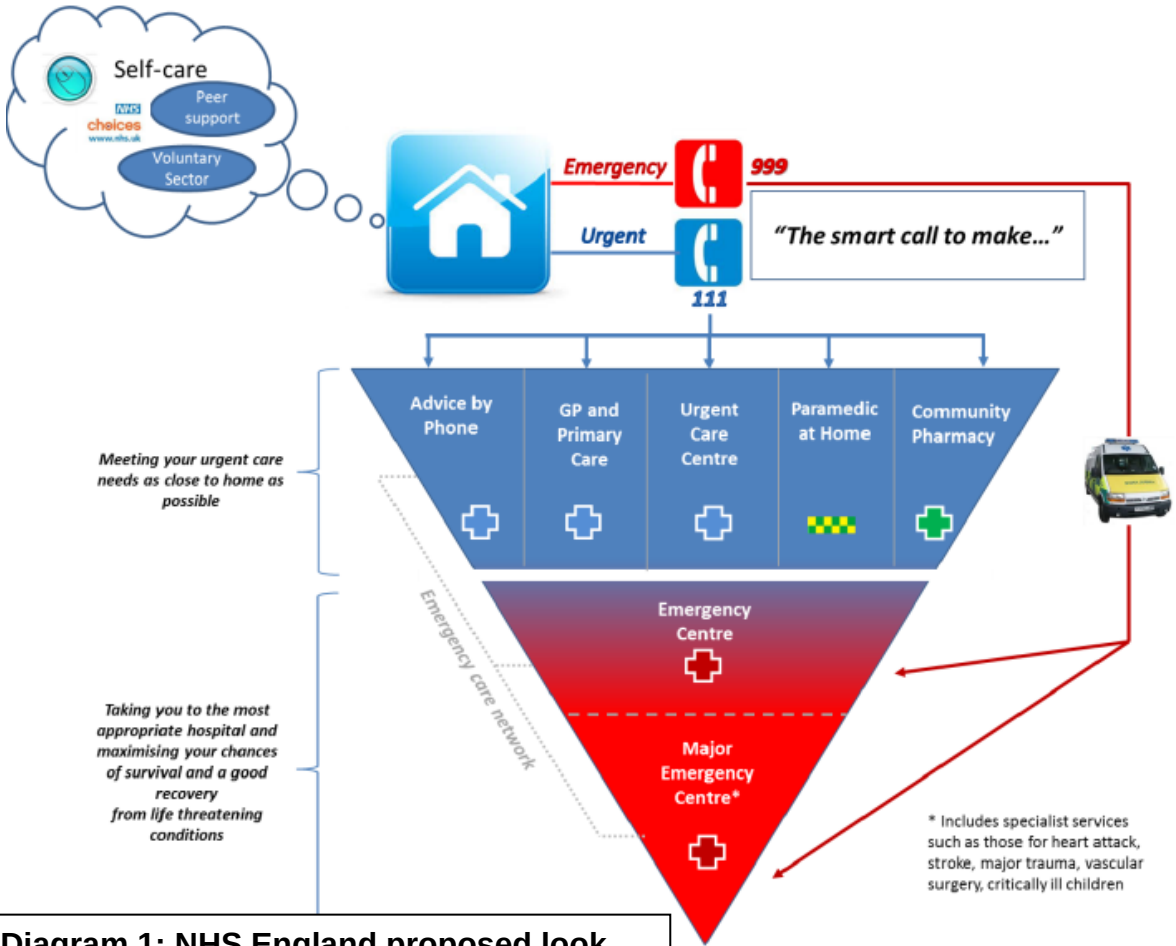

Diagram 1: NHS England proposed look and design of the new urgent care system

16. The NHS England report on *Transforming Urgent and Emergency Care Services in England* proposes a new system to be implemented across England, in which care is delivered as close to home as possible by alternatives to the acute hospital setting, with only the most serious and emergency conditions requiring people to attend an acute hospital via A&E. In between the two ends of the scale (with self - care at home at one end and a major emergency centre at the other end) there is a range of alternative urgent care options. These are illustrated in Diagram 1.

17. The model shown in the diagram is largely in place in Buckinghamshire following recent reconfigurations. The John Radcliffe Hospital in Oxford is our local Major Trauma Centre and would equate to a 'Major Emergency Centre' on the diagram, Stoke Mandeville Hospital A&E equates to an Emergency Centre, and the Minor Injuries and Illness Unit at Wycombe Hospital equates to an 'Urgent Care Centre'. The NHS England report recommends greater consistency on the naming of emergency centres, with the current A&E label deemed to mislead people on the varying services provided at different A&Es, and the term countering efforts to encourage fewer inappropriate attendances for non-emergency conditions. Nationally there is an array of titles for Urgent Care Centres (such as Minor Injuries or Minor Injuries and Illness). We can therefore expect some changes to the names of the services, however the services on offer are unlikely to need changing significantly to align with the NHS England vision.

18. At our evidence session the local Clinical Commissioning Groups provided Diagram 2 to illustrate the local urgent care pathway, which includes any constraints on where the service must be located.

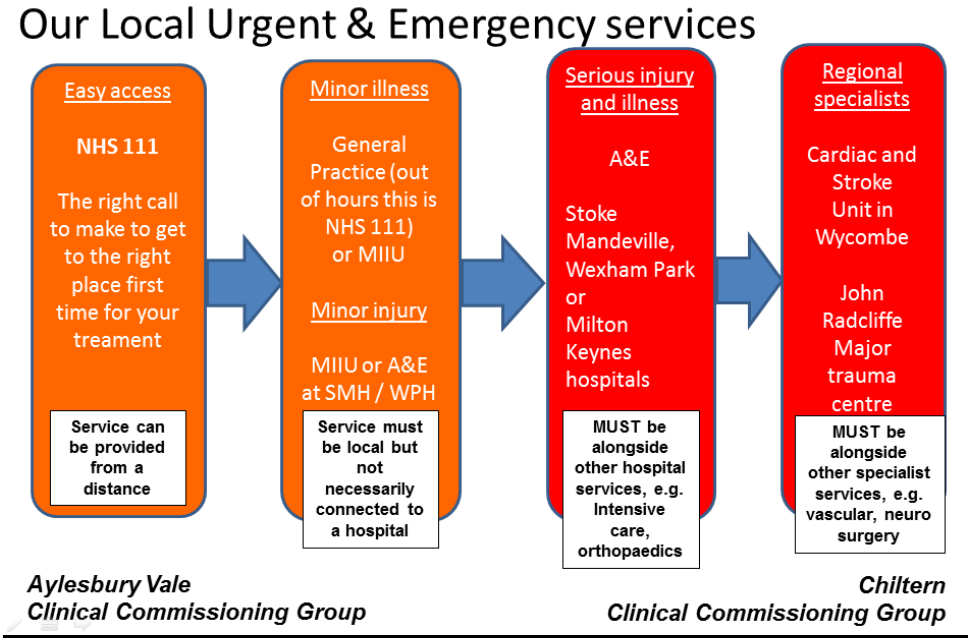

Diagram 2: Buckinghamshire Urgent Care Pathway including location constraints

19. Urgent care provision is in a period of transition nationally as we move to the model outlined in the NHS England report. Locally this is evident from the service reconfigurations than have taken place, the introduction of the 111 service and efforts being made to take pressure off A&E units which have been creaking under the pressure of growing demand for their services (nationally emergency admissions to hospital have increased 47% in the last 15 years[5]). At the HASC meeting in November 2013 we heard about efforts being made to encourage greater use of the 111 service to avoid unnecessary A&E attendance and promote alternatives such as the MIIU. On our visits to Stoke Mandeville Hospital in January we saw the improvements that have been made, which include new Clinical Decisions Units and a minor injuries unit adjoin the A&E, which assists with the filtering out of patients at A&E to avoid the build-up of queues.

Urgent Care Pathway Design: Conclusion

20. The committee considers the evidence justifying the provision of a single A&E in the county based at Stoke Mandeville, and an MIIU/Urgent Care Centre at Wycombe Hospital in the best interests of the county's residents and their health outcomes to be unarguable. The case was strong at the time of the BHiB reconfiguration, and has only got stronger since with the evidence available locally and nationally. The HASC will continue to monitor evidence to ensure the service configuration and any further changes are in the best interests of all residents, and these interests must always supersede any local attachment to established services.

21. Elected representatives at all levels have a responsibility to not only voice the concerns and dissatisfaction of their constituents, but also play a role in explaining and clarifying why some services must change to better meet the needs of constituents and the wider population. In the case of urgent health care services this is so we can all benefit from safe services and better health outcomes. The preceding section has attempted to summarise as far as possible the information all local elected officials should be familiar with when dealing with any concerns raised by their electorate. We recommend all local MPs, County and District Councillors are sent this report.

Recommendation 1: That this report, and particularly paragraphs 7-21 is circulated to all local MP's, County and District Councillors, so they can understand why the local Health Scrutiny Committee considers the local A&E provision in place to be in the best interests of all residents, based on it supporting better clinical outcomes and aligning with national recommended practice.

22. To improve public understanding on why services are configured how they are, and why services that have been removed in the recent past should not be reinstated,

[5] Emergency admissions to hospital: managing the demand, National Audit Office, 2013 :4

there needs to be much better, and easily understood information published and readily accessible. The last significant reconfiguration (BHiB) in 2012 was led by the now defunct Buckinghamshire Primary Care Trust. Evidence and consultation materials produced at this time are now difficult to obtain (via the national web archive). Even if these documents were readily accessible they would not provide adequate explanation of the service configuration in place as they are not up to date, comprehensive in terms of covering all the reconfigurations proceeding 2012 that have a bearing on the shape of current service provision, and easily understood. We feel an updated web based and leaflet summary of the reasons behind the current configuration of urgent care services in the county is required, with links to reports/evidence from the time included. As well as aiding public understanding, this would provide a useful reference in response to any public feedback on the shape of current service provision. It would also be valuable background information to any future reconfiguration and service proposals.

Recommendation 2: An updated web and leaflet based summary should be produced by the Clinical Commissioning Groups explaining the reasons for the shape of existing urgent care provision in the county, particularly with regard to A&E provision. The webpage should link to original reports and evidence provided at the time of any reconfigurations, and should feature prominently on the websites of Buckinghamshire Healthcare NHS Trust, both local CCG's, and Healthwatch Bucks. The leaflet should feature at A&E, MIIU and GP surgeries.

23. It is important that this summary also sets some context concerning the factors outside the control of local agencies that could lead to future changes in how services are delivered, such as changing national specifications, national policy changes, the design of specialist service provision, or actions by neighbouring acute NHS Trusts.

Public Understanding of Local Urgent Care Pathways

24. As previously mentioned we are in a period of transition where we are moving away from the concept of an A&E being the one stop shop or funnel which everyone descends on for any urgent care needs. With more specialist treatment necessitating fewer A&E's, and an aging population with more complex health needs increasing healthcare demand, this model of provision is no longer sustainable. Instead more thought is required as to the where to go for the most appropriate urgent care service. Diagram 1 illustrates the range of options and the key role the 999 and 111 phone services perform in advising and helping people navigate the system and access the services.

25. The NHS is keen to promote the 111 service as the default option whenever you need urgent care (and it is not felt life threatening in which case 999 would be appropriate). SCAS operate both the 111 and 999 services in Buckinghamshire, and explained that that a patient could phone either number and receive whichever service was appropriate for their needs. At our evidence session we heard positive information on how the 111 service was being used locally[6], having been rolled out in 2013.

26. We feel that for the public to have confidence in the system and for there to be adequate public scrutiny of it, the public must have a better understanding of urgent care pathways and the options available locally. Telephone signposting is not adequate on its own. NHS England acknowledge that people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E[7]. Some of the public questions we received for our evidence session on 28th January illustrated uncertainty over the services which remain at Wycombe Hospital, the services the MIIU provides and why there is a Minor Injuries unit alongside the A&E at Stoke Mandeville. There is also uncertainty concerning the services provided, and any limits on access, to various walk in centres located outside the Buckinghamshire boundary.

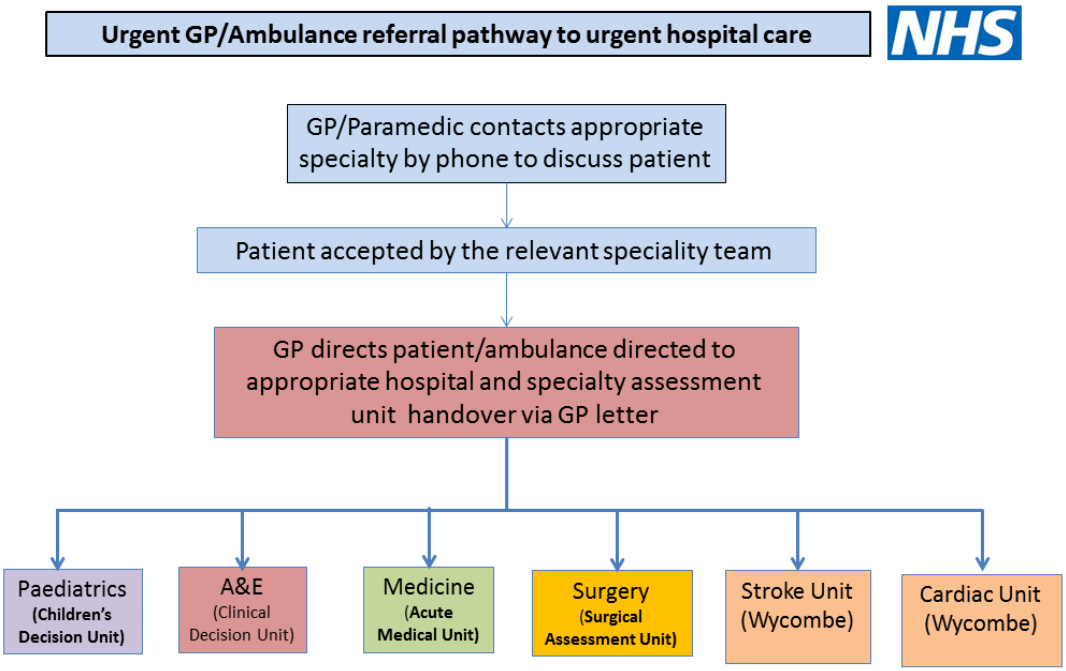

Diagram 3: Urgent Care Pathway via GP/Ambulance referral

[6] Lower transfers of 111 calls to 999 locally compared to nationally (7% of calls vs 10% call nationally), 111 calls requiring A&E direction total around 5% (which is below national average), 40% of 111 users are using it for out of hours services, and there is a 0.7% abandonment rate which is also very low (calls hung up after waiting for handler). See minutes of evidence session for more details.

[7] Transforming urgent and emergency care services in England, End of Phase 1 Report, NHS England, page 5

27. Overall we feel the local CCG's must take ownership of ensuring the public have access to a summary guide (online to keep it up to date) explaining pathways, service options and any constraints on services provided, regardless of whether these are in the county or not. We have been encouraged by the video[8] that has been produced to explain the MIIU service based at Wycombe Hospital, and associated leaflets. We have also heard about some of the more targeted campaign work (see the response to question 2 in Appendix 3) that has been conducted to inform population groups known to be using A&E services rather than more appropriate alternatives. However we have concerns that in South Bucks they are receiving messages promoting the Wycombe MIIU, but not other urgent care centres in Berkshire that might be more convenient. This may also be an issue in other parts of the county such as those on the edge of Milton Keynes.

28. At our evidence session the CCGs provided two local urgent care pathways (Diagrams 3 and 4), one based on GP or Ambulance referral, and one based on a patient self- presenting. They are based on the pathway for people using Buckinghamshire Healthcare NHS Trust services (at Stoke Mandeville and Wycombe Hospital). For patients using other hospitals such as Wexham Park the hospital based services could be slightly different.

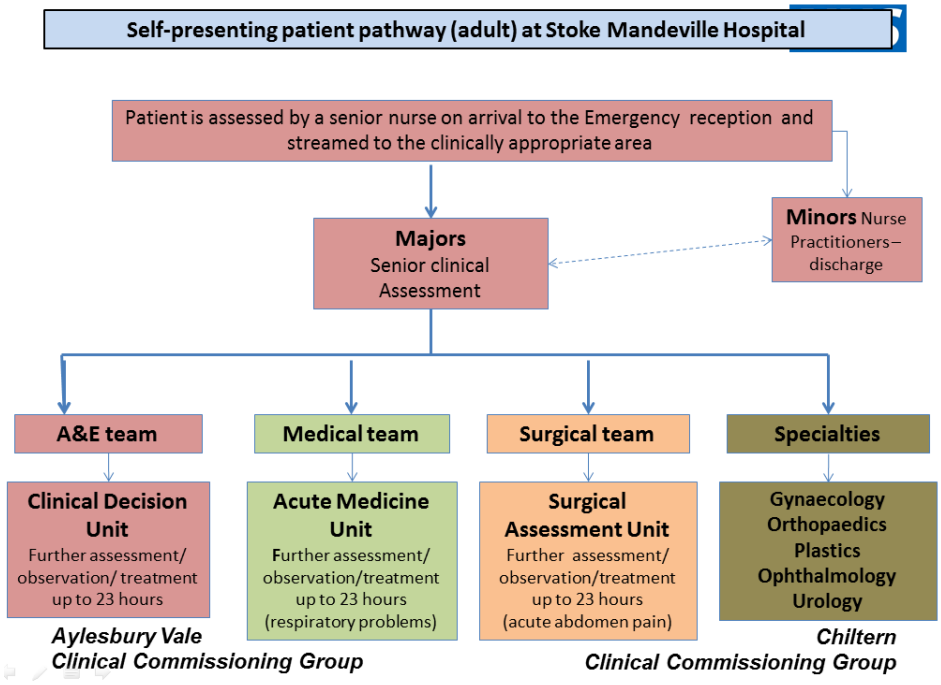

Diagram 4: Urgent Care Pathway via self-presentation at A&E

29. Alongside these pathways, a local version of Diagram 1 covering the patient experience before GP or ambulance contact would be helpful to explain the local options and service locations. A similar style of video to the MIIU version produced

8 http://www.chilternccg.nhs.uk/your_minor_injuries_and_illness_unit_at_wycombe_hospital_p8743.html?a=0

would be very effective at informing the public about local urgent care service provision, and could be shown in GP and hospital waiting areas, as well as being accessible on local NHS and Healthwatch websites. Importantly this should make people aware of services located outside Buckinghamshire (such as other acute hospitals and urgent care centres), which are likely to be used by some residents. Details on the service provided, how they are accessed (e.g. referral only or self-present) and hours of operation should be clear.

Recommendation 3: Video and website communications should be developed by the Clinical Commissioning Groups which inform the public on the urgent care pathways available locally regardless of whether such services are outside the county. These should then feature on CCG, Buckinghamshire Healthcare NHS Trust and Healthwatch websites, with videos used in GP and Hospital waiting rooms where this is an option.

30. Coupled with the above recommendation, we feel that a guide would be of value which could sit alongside the pathways described, and explain further detail on how services are managed and signpost to relevant performance data. To improve public understanding and permit greater public scrutiny it would be helpful for such a guide to explain who commissions a specific service in the pathway and who monitors the service delivery. Other data on service cost and performance should also be signposted. Such a guide should feature on the CCG, hospital trust and Buckinghamshire Healthwatch websites, alongside the overall Urgent Care guide recommended above.

Recommendation 4: The web based Urgent Care summary explanation should be accompanied by a guide explaining how the services which comprise the pathway are commissioned and monitored, and signpost to published data on performance and cost.

Conclusion

31. The urgent care pathway design in place locally appears from the evidence base available to be the right one, and in alignment with that outlined by NHS England. In future years there may be some relabeling of A&E, MIIU and other urgent care services, as well as refinement and enhancement of the pathway elements in place. In their report NHS England recommends:
    - Better information on self-care treatment options
    - An enhanced NHS 111 service
    - More responsive urgent care services outside hospital (GP's, community teams, pharmacists)
    - Dissolve traditional boundaries between hospital and community based services to better share information and expertise.

Elected representatives and the NHS generally have a role in ensuring the pathways and evidence underpinning them are clear and understood.

32. The HASC will continue to monitor the realisation of the benefits which were forecast from the 2012 reconfiguration to ensure the changes implemented have demonstrably been in the interests of service users. The committee will carefully examine any future proposals to how urgent care services are provided, and also keep abreast of any new evidence that emerges on how urgent care should be provided. Investigating the quality of elements of the urgent care pathway has not been part of this inquiry scope, but is something the committee will maintain oversight of and any areas of concern or poor performance will be looked at in more detail by the committee in future.

33. The 111 service should be the first port of call if someone has any doubt where they should go for urgent care, and whether there is an alternative to A&E which can sometimes require a lengthy journey and wait to be seen. However in the interests of public understanding and scrutiny of the services they receive there needs to be adequate explanation of the pathway published. The public have a responsibility to use Urgent Care Services properly, and a better appreciation of the pathway and alternative options to A&E that comprise it can only aid them in doing so.

Appendix 1: Inquiry Scope

Background papers

- Clinical Commissioning Group (CCG) Response to HASC urgent care questions (Nov 2013).
- Transforming urgent and emergency care services in England: Urgent and emergency care review end of phase 1 report (NHS England, Nov 2013): http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf
- Emergency admissions to hospital: managing the demand (National Audit Office, Oct 2013): http://www.nao.org.uk/wp-content/uploads/2013/10/10288-001-Emergency-admissions.pdf .
- HASC service configuration topic paper.

Scope and Aims

The urgent care pathway design used by Buckinghamshire residents up to the point at which they either receive the advice or treatment required outside of hospital or are admitted as an inpatient. The quality of services will be considered only in so far as this is undermined by the pathway design, and it is not within the scope of this inquiry to assess the quality of every service comprising the pathway (e.g. GP out of hours, 111, A&E, MIIU etc).

By considering up to date evidence published and additional explanations provided by local healthcare commissioners, the working group will aim to arrive at a consensus upon the following:

- The acceptability of the current urgent care pathway design in the county, and its likely future direction in view of the recent NHS England report on transforming urgent and emergency care services.
- Improvements required to the urgent care pathway.
- Improvements required to how the public are informed about the urgent care services available, and the rationale underpinning the design of the local pathway.

Method

The working group will meet on the 28th January in public to discuss the background papers and question local healthcare commissioners. Questions will be invited from the public in advance of the meeting, for the committee members to put to the NHS representatives.

Appendix 2: HASC Buckinghamshire Healthcare NHS Trust 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[9].

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[10] 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, 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.

[9] 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).

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

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[11]*. 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)

[11] 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.

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).

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).

Additional reports to note

- **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

- **Buckinghamshire Health Overview and Scrutiny Ccommittee 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