durrow

a better future for wycombe hospital

a proposal for a long term & successful future

2015-2040

2014
info@durrow.org.uk

When it comes to our town's hospital, the electors of Wycombe have left me in no doubt of two things. They demand gold-standard emergency care back in Wycombe and they expect me to provide leadership towards that goal from outside the NHS.

Over the past four years in Parliament, including a year chairing the Conservative back-bench policy committee on health and education, I have searched for solutions. It is clear that there is no going back to the provision of emergency surgery in England's small hospitals like ours. Over 20 hospitals across the country face the same problem.

This report sets out how a new kind of casualty unit could deliver 24/7 gold-standard emergency care in Wycombe for a clear majority of patients. It is an innovative yet realistic proposal which the NHS could deliver within current resources.

Wycombe hospital must have a bright future. That future must include serving any emergency patient who comes through the door. This proposal from Durrow should be the basis for a new and more hopeful conversation about the future of our hospital.

Steve Baker MP

"We look ahead to a Wycombe hospital run by the NHS that will accept any emergency patient any time. Most patients will be treated on site but whenever it is in their best interests, they would be quickly transferred for advanced specialist treatment."

- ***create a new generation of casualty unit as part of the main hospital, open all hours for everyone***
- ***let the hospital provide primary care and out of hours "GP" cover***
- ***move the ambulance station and crews to the hospital***
- ***reorganise and upgrade the site and buildings***

This is a proposal to change and develop services at Wycombe Hospital. A long period of centralising NHS hospital services seems to be running out of steam and the value of successful local hospitals is again being recognised. About time.

People always wanted a local service and they want clarity about who to ring and where to go. Decades of attempts to move services to distant specialist hospitals have met with popular resistance. Repeated attempts to move services out of the hospital and into 'the community' have mostly failed.

The hospital is part of the 'local community'. In fact, we see it as the centrepiece of the local health system rather than a place patients should be diverted away from. To us, it makes no economic sense to keep taking services out of it to save money - those that remain merely have to carry more and more overheads.

We do not want a thinned down semi-acute hospital in constant financial difficulty. We want gold-standard medicine in a successful modern acute hospital open round the clock.

1 introduction

Most people think of Wycombe Hospital as a single institution run by the NHS. In fact there are different organisations operating on the site:

- Buckinghamshire Healthcare NHS Trust (NHS hospital and community services)
- BMI Healthcare (private hospital care)
- Care UK (walk-in & minor injuries services)
- United Healthcare South Bucks Ltd (PFI contract for buildings and services)
- South Central Ambulance NHS Foundation Trust (ambulance services to Oxfordshire, Berkshire, Buckinghamshire, Hampshire and the Isle of Wight)
- Chiltern CCG (commission and fund NHS services for the citizens of Wycombe)

No doubt each organisation has made a plan - but for each of them Wycombe forms only a part of a jigsaw that they must balance with their other commitments. Bucks Healthcare has Stoke Mandeville, Amersham and the community hospitals to consider. BMI (which operates the Shelburne at Wycombe hospital) has 66 centres. The ambulance trust covers 3,554 sq. miles including the Isle of Wight. Care UK operates across the UK covering GP services, acute care, community services and eldercare.

The simple truth is that it is not any one organisation's job to produce a composite plan for the future of the hospital. Each organisation must balance its own books and can only plan within its own services.

As we have no vested interest, we have tried to stand back and make some common sense suggestions from a perspective of considerable experience. Our (Durrow) work over 20yrs has covered both private and public healthcare in many different countries.

You will see our proposals summarised overleaf with the main points further explained in the pages following.

We have no authority to implement these proposals. Only through discussion could a plan be adopted; one that would suit all the involved organisations and one that would attract genuine public support.

2 the proposals summarised

MIIU
Emergency Dept.
Casualty
Accident & Emergency
Walk-in Centre
GP out-of-hours
Dial 999
Dial 111

It is not easy for the public to know who to call or where to go. The hospital is always open and the staff there know what to do.

1

The hospital is, and would be, open for 24 hours 365 days per year. Anyone with urgent need or uncertain what to do can go there at any time - the staff there would know what needs to be done.

Wycombe is already set up to treat injuries and has a strong acute medical team. However, it might be that patients would be quickly transferred to another hospital that has specialist skills and equipment (just as stroke cases are transferred into Wycombe now from other places.) This is normal across the country.

As the hospital is open at all hours, it makes sense for the Minor Injuries & Illness Unit and the GP out-of-hours service to be combined with the hospital service so that a single organisation can deal with all out of hours needs of local citizens.

The existing third party contract for the MIIU expires in 2015 and this offers an opportunity to commission a single organisation to run all services for the next five years.

2

Acute ambulance crews have paramedical skills similar to those of emergency nurse practitioners and are now an important and active part of the clinical response to emergencies. Ambulance organisations have become much bigger. The local ambulance service used to cover Buckinghamshire - now after a series of reorganisations it covers Buckinghamshire, Berkshire, Oxfordshire, Hampshire and the Isle of Wight. But of course, such a large area has to be divided back into manageable patches and local stations. Our first priority is for there always to be a crewed ambulance on site at Wycombe Hospital. This will ensure that the hospital can make immediate urgent transfers without coordination at any time.

When the hospital site is redeveloped, the Ambulance Station would become part of the hospital and over time the ambulance crews and the hospital staff would become more closely integrated.

3

The hospital site is in urgent need of a makeover. The old tower is in poor condition and is nearing the end of its life. Services need to be in modern accommodation. Entrances, roadways, parking, and the staff accommodation all need to be upgraded. The roundabouts at the foot of the hill and pedestrian access to the hospital could be much improved.

Buckinghamshire Hospitals NHS Trust, Wycombe District Council, and Buckinghamshire New University share a common interest in the renewal of this part of the town. The Council could take the lead in bringing together these bodies to publish a proposed redevelopment for consultation.

This renewal is crucial in meeting the expectations of patients. It is essential to ensure that Wycombe Hospital has an attractive offering to the public and staff over the next 20- 30 years' time.

4

Integrated care is on everyone's agenda. How to simplify the who-does-what and where-do-you go of health and social care. Progress has been slow as separate budgets and professional demarcation get in the way. We see the possibility that Wycombe hospital and others like it could become registered providers of primary care. Whilst no-one would be forced to change, some might want to register with the hospital for all their care. This could be more convenient for those with complicated medical histories and needs. Over time, the old separation of hospital doctors and GPs would be blurred and there would be a clinical faculty on the new hospital site that includes both specialists and family doctors.

When the site is modernised, these possibilities would be taken very much into account as would providing good quality and affordable accommodation for young professionals in training. These are important ways to ensure that Wycombe Hospital is successful in 20 years time and has a good supply of talent wanting to come and train and work in the town.

3 the hospital is open 24hrs, seven days a week

The hospital has to be open 24hrs seven days a week. Given the high overhead costs of any hospital, it makes sense to bring the three 24hours services together at one location (the hospital) to improve coordination and spread overhead costs:

- the 24 hour hospital casualty service
- the ambulance station and crews
- the 'out of hours' GP service

It is not easy, especially in an emergency, to remember which telephone number to ring or which part of the NHS to go to. We look ahead here to a time when the hospital has taken responsibility for all 'out of hours' demands - both GP and conventional hospital attendances. There has always been significant overlap in these two groups of cases and these days it will not be your own GP who responds but a third party company contracted to do so. This contract could be awarded to Wycombe Hospital and merged with the job of running the night casualty department.

It is the norm across the NHS for certain hospitals to take lead responsibility for specialist cases. Wycombe is a centre for stroke and heart attack patients and is performing very well (see Page 10). Stoke Mandeville Hospital is a centre for major injuries, emergency surgery, respiratory attacks, diabetes and for infectious diseases. Of course, rare and specialist cases have always been taken to a regional centre such as Oxford or London: severe head injuries or very sick children, would be examples.

In theory, the public would know (and remember) where to go with what case and direct themselves. In practice, it is the attending ambulance that knows where to take the patient. However, some patients do not realise that they are having an acute emergency, others think they are but are not. Inevitably, some patients will go directly to the hospital casualty dept. because they know where it is and they know it is open.

Bringing the three services above together simplifies things. Go to the hospital after hours or call the out of hours service - it's the same team. Similarly, ring an ambulance or go to the hospital and again the same team will respond in the same way. If your condition is appropriate for direct treatment at Wycombe, you will already be there. If you need specialist acute treatment, the ambulance will be waiting there to transfer you.

“Casualty”

Go to the hospital after hours or call the out of hours service - it’s the same team. Similarly, ring an ambulance or go to the hospital and again the same team would respond in the same way.

If your condition is appropriate for direct treatment at Wycombe, you would already be there. If you need specialist acute treatment, the ambulance would be waiting there to transfer you.

WELCOME TO WYCOMBE HOSPITAL

Casualty Unit

the “emergency” patient

Wycombe Hospital’s stroke unit (HASU) serves Bucks & E. Berks - one of four centres in the region to offer life saving thrombolysis and intensive care of all stroke pts for 72hrs after admission. Wycombe is ranked third in the country for its efficiency in treating stroke-related blood clots & was also the fastest outside London for access to thrombolysis – the time from door to needle taking 38mins, against a national median of 59 minutes.

An early supported discharge team which brings together different clinical disciplines including therapists and nurses, to enable patients to receive rehabilitation in their own home as soon as possible.

A new cardiac rehabilitation unit at Wycombe Hospital. It was officially opened in March - developed in partnership with Janssen Healthcare Innovation, and builds on a successful existing programme.

The public need and seek emergency care from widely different causes. Some dramatic emergencies - like major head injuries, or attempted suicide are relatively rare and need care by specialist staff to get the best results. It makes sense to channel these patients to regional centres where they will be well practised in dealing with them and where the appropriate specialist equipment and facilities exist.

Wycombe Hospital is already such a centre for the treatment of heart attack and stroke cases - there were 2,116 emergency cardiology admissions last year (year ended 31.3.14) of which only half were from the Chiltern CCG area. (See the comments of the NHS in the margin left.)

One of the most important groups to respond to are citizens with long term chronic problems who are having an acute eruption of their existing conditions or a new problem layered on top. A minor infection or illness can become serious for a patient who is already frail.

Some patients who think they are seriously ill are not and some who think their problem is minor are in fact seriously ill.

In an ideal world, the advice issued by the NHS to the public on where to go and when to ring 999 or 111 would be understood by everyone and they would be able to match their symptoms or their circumstances to that advice. In the real world, we know that some people ring 999 when it is not needed and other people make their way to the local hospital when they should ring 999. In the evening and night (“out of hours”) it can be more difficult to know who to ring or where to go.

A central point of this proposal is to bring three elements of the local service together under one clinical team, one budget and one provider - at Wycombe Hospital:

- the hospital casualty dept.
- the local GP “out-of-hours” service
- the local ambulance service

The existing NHS advice to citizens to ring 999 for serious emergencies remains - the responding ambulance crew will know where the patient should be taken based on their assessment of the symptoms. This may well not be the nearest hospital.

There are practical advantages in having one provider responsible for all out of hours services. The hospital has to be open 24hrs so why not base things in one place? It would share overhead and management costs. For the public, it means that however they contact the NHS, they will get the right response.

The simple reality is that some citizens will attend the local hospital when they 'should' have rung 999. The co-location of the Ambulance Station on the hospital site and the coordination of local ambulance crews is intended to ensure that there is always an ambulance ready to transfer a sick patient to another more appropriate hospital - of course if it is a stroke or heart attack, they will already be at the 'correct' hospital (Wycombe.)

In the longer term, local hospitals may become registered providers of GP services - allowing citizens to elect to register for their primary care service to be provided by the hospital. This would lead to NHS hospitals that employed both hospital specialists and GPs in a unified clinical faculty. For citizens who have complicated healthcare needs and for residents of nursing homes, this might be very convenient as all of their care and their medical records would be together in one place available if they have problems out of hours.

The existing contract for the Wycombe Hospital Minor Injuries Unit and GP out of hours service ends in 2015 and we would like to see that as an opportunity to integrate these services with the running of the main hospital.

Please note. These proposals do not imply that people will be encouraged to go direct to Wycombe Hospital when it would have been better to call 999. Nor do they imply that the range of patients treated at Wycombe will be expanded. It is not the case that the hospital will have to expand its services to cope with every eventuality - patients will be transferred just as they are now when that is in their best interests. What the hospital will be able to do, is to organise immediate ambulance transfer and where it is needed and to accompany the patient to the destination hospital to speed up handover if that is needed.

NICE = National Institute for Clinical Excellence.

Intrapartum care: care of healthy women and their babies (May 2014)

Advise low-risk multiparous women to plan to give birth at home or in a midwifery-led unit (freestanding or alongside). Explain that this is because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.

Advise low-risk nulliparous women to plan to give birth in a midwifery-led unit (freestanding or alongside). Explain that this is because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit, but if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby.

Birth at home or in a freestanding midwifery unit is associated with a higher rate of normal vaginal birth.

Birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with birth in other settings.

The pattern of UK maternity and paediatric services is quite different from some of our nearest northern European neighbours. In Holland, a third of births would be at home (here it is 2%.) In Germany and France a town like High Wycombe would have a full obstetric department. These countries have clinical outcomes as good as ours.

However, things look set to change here in the UK as our birth rate is increasing and enthusiasm for ever larger obstetric units is declining as they fail to show hard evidence of better outcomes or lower costs.

NHS professional practice is guided by NICE and new draft guidance on maternity practice has just been published. This latest advice makes clear that there is no difference in the outcome for babies born in midwifery or obstetric units. 9 out of 10 women would be expected to have a normal birth in a freestanding midwifery unit with one in ten being transferred to an obstetric unit.

Our proposals for the short term (the next 5 years) look to promote and strengthen the existing midwifery unit at Wycombe and to increase the numbers of local mothers choosing it for their births.

In the longer term, UK maternity policies may change as the pendulum swings back from large high-intervention obstetric units. Midwifery units may become more and more the mainstream choice for normal births, in which scenario, Wycombe will be well placed as a sustainable local maternity unit.

planned care - routine operations and procedures

The existing hospital provides a full repertoire of elective surgery and diagnostic procedures for both NHS and private patients. (With the colocation of the BMI Shelburne Hospital, there is a better array of operating rooms than would be expected in a smaller NHS District General Hospital.)

The continued effect of increased numbers of elderly citizens will boost demand for such procedures. If the redevelopment plans can be effected, all of these services can be located in the modern buildings and the numbers of patients treated can be increased by attracting patients from further afield.

The traditional fields of surgery and their common operations such as orthopaedics (hips/knees) general surgery (gall bladder) and urology (prostate) are well understood by the public. Whilst these remain, there is also a growing repertoire in imaging and 'keyhole' procedures - it is important for Wycombe hospital to build on its strong existing skills in these disciplines.

Wycombe is well placed as its designation as a cardiac intervention centre provides a strong logistic foundation. Where opportunities occur, capacity in imaging and image guided interventions should be developed.

Expansion of the volume of elective cases from further afield will help to strengthen the financial position of the hospital and share overhead costs to the benefit of local commissioners and citizens.

care of the elderly

Elderly citizens quite rightly use the health service more than younger people. The frail elderly even more so. This is a group that values a local service and finds it most difficult to have to travel to distant hospitals.

The proposal is to widen the existing hospital role to make it a registered provider of primary care.

For patients with long term illnesses and for the frail, there would be practical advantages in having one team looking after all their health care. Such patients inevitably have to move between primary (GP) and secondary (hospital) appointments and services. Registration would be voluntary, although in some circumstances it might make sense to register groups (say, the residents of a nursing home.)

The addition of General Practitioners to the clinical faculty of what is now a conventional hospital would round out the existing strengths in acute medicine and elective surgery.

MUDAS is a multi disciplinary unit where the complex problems of the older patient can be assessed and a plan of care can be sorted out. GPs and the ambulance service can refer direct to the unit.

There is an existing multidisciplinary assessment service for elderly patients (MUDAS) at Wycombe which has spare capacity. This excellent unit provides a strong foundation on which to expand future services for the local elderly. Obviously, services would be open to all patients regardless of their GP registration.

The assessment and treatment of elderly patients with complex morbidity and polypharmacy is a very skilled field of healthcare and one that can deliver real gains to local citizens. The preservation and prolonging of independent living is a great prize and requires good teamworking across many roles in social and medical care.

This is a proposal that seeks to make sure Wycombe Hospital will be a vital element of the local public services in 20-30years. It is a look beyond the short term at what directions our hospital should be travelling in.

At worst, Wycombe hospital could become a surviving relic of 1980s healthcare but we strive to make it an example of the best of public health services in 2040.

Breaking down the historic division between primary care and hospital care is one of the big advances we can anticipate in this timescale. It is not too soon to anticipate it and for Wycombe to position as an early adopter.

Conversely, existing practitioners should not see this as an immediate threat to current professional boundaries. It would be more likely to be a shift that could occur by evolution over one or two decades as new generations of professionals with different training and expectations join the workforce.

the buildings and the site

Most people would agree that the existing site is in a mess.

Piecemeal development has left services spread across a collection of old and new buildings that stand in awkward relationship to each other. The sloping site and the difficulties presented by the main road on the hospital boundary make organising entrances, circulation and parking a challenge.

The square Tower Block is at the end of its useful life. It would be irrational to invest large sums in keeping it going. At the opposite end of the scale, the new PFI buildings have 21 years of repayments ahead of them and should be used to maximum effect.

Hospitals are an important element in the life of any town. Wycombe hospital is in a good central location but is cut off by the road system. It also presents a rather bleak concrete wall to the town. Much could be done (and needs to be done) to improve these weaknesses.

We look ahead to the transformation of the town centre, the university and the hospital through a shared plan that encompasses the roads and pedestrian routes as well as the principal buildings.

At the top of the hospital site, the staff residences could also be transformed and would be a major factor in attracting new staff to want to work and live in Wycombe.

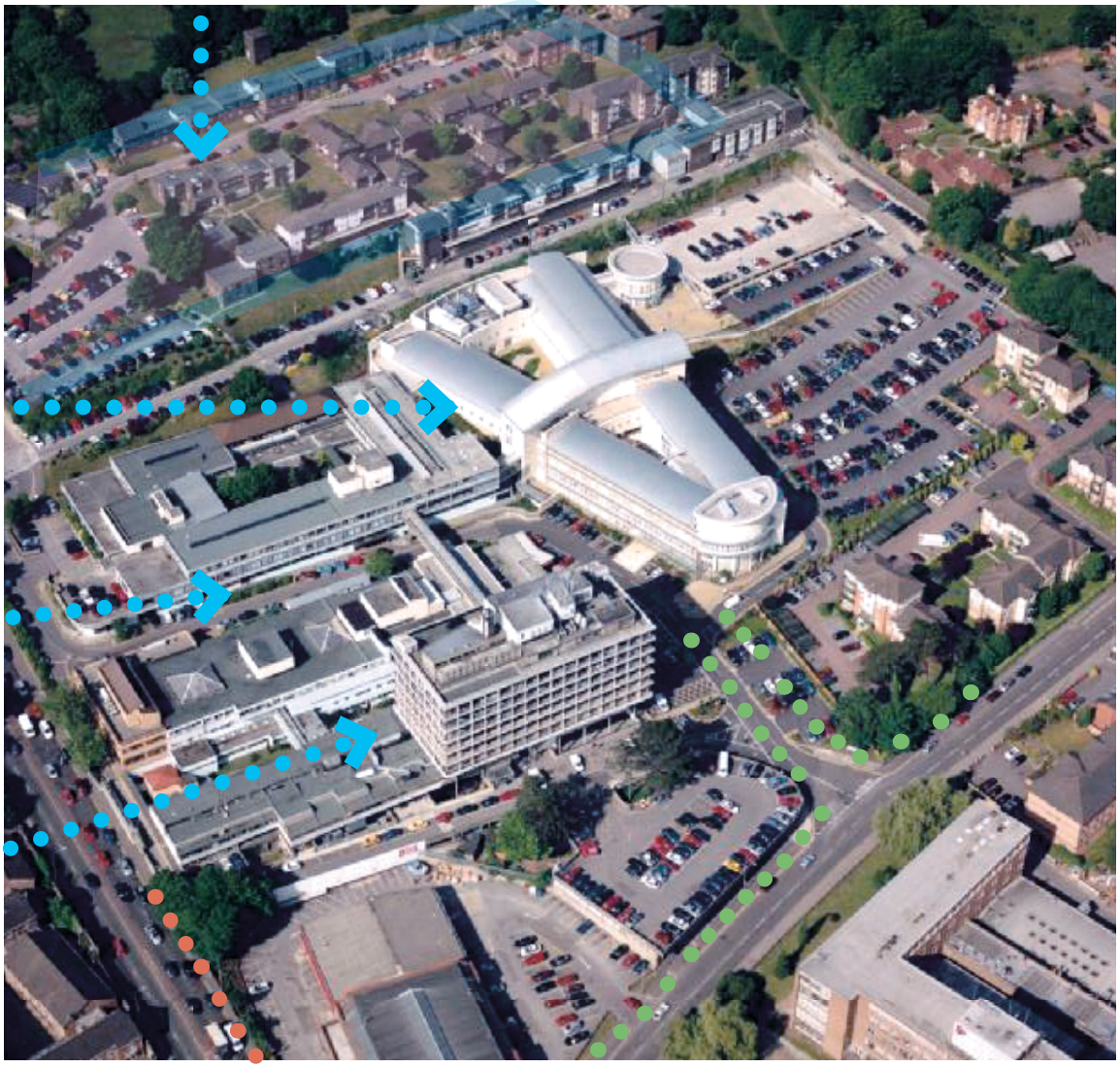
The PFI Block is the nucleus of tomorrow's hospital with 21 years still left on the contract. Using this block to the greatest advantage of NHS services is a key objective

These buildings are on different levels and of different vintages. The way they relate to each other and to the new PFI building could be revisited to see if the traditional link corridors could be improved with more imaginative design. We think it could.

The Tower Block is at or near the end of its useful life and it would be better to spend money on new accommodation. The position it occupies opens up some exciting possibilities to reorganise the way the whole site is organised.

The residences at the top of the site are an important social asset for keyworkers and those in training.

The houses will be due a makeover and the road access and surroundings could be improved to make them very desirable.



This corner at the foot of Marlow Hill is complex and tends to separate the hospital from the town. For pedestrians it is a barrier.

The entrance and circulation can be greatly improved for both cars and pedestrians.

A new and distinctive point of arrival can be made that is clearly legible to everyone and one which conveys the message that the hospital is open and welcoming