4th September 2006

towards a sustainable future for acute services in and for north devon

final report

NORTH DEVON

durrow
po box 22
machynlleth, sy20 9at

01654 761753

info@durrow.org.uk

Foreword

In Spring 2006 the three main NHS Bodies responsible for North Devon hospital services asked Durrow Ltd to submit independent advice concerning the future pattern of acute services that could be provided in and to North Devon. The commission arose from the shared need of these three NHS organisatons for clarity about the strategic direction for developing North Devon's acute services beyond the immediate imperative of bringing income and expenditure into balance. The Terms of Reference for the work are attached in the appendices - this document is the outcome.

The exercise was not one of drawing together local comments: it was, as requested, external and independent advice. As such it is important to emphasise that the views expressed in this document are those of Durrow Ltd alone and do not represent local NHS policy. We hope that they will make a contribution to the debate and will help the responsible NHS Bodies to clarify their plans and take the necessary decisions through formal channels.

Although it was not a democratic exercise, a great many people in North Devon have taken an interest in our work and made many valuable contributions and criticisms which have had a considerable influence on the result. I should thank all of them for sparing their time in what is a hectic period and for their patience in dealing with yet another outside intrusion in their affairs by our team.

Finally, can I emphasise the optimism of our conclusions. Whilst the report has had to draw attention to the risks and difficulties, the prevailing conclusion is that, with commitment and good leadership, North Devon NHS can offer its citizens a gold standard local acute service for the foreseeable future.

Andy Black
Durrow
PO Box 22, Machynlleth SY20 8WQ

info@durrow.org.uk

Summary

1 **Structure of the report**

The report is structured thus:

Profile of current services > Discussion > Recommendations > What a sustainable service might look like > Worked example.

In the discussion section (para 10) we have laboured the issue of future senior medical staffing as we believe this is the most frequent cause of loss of viability. We have particularly raised the issue of future staffing for a consultant led emergency service which we see as the absolute foundation for future success. There are no risk-free strategies – our recommendation to embrace the “emergency physician” role as an early adopter has clear risks. We also recommend preparation for an experiment in vertically integrating primary and secondary care in Barnstaple as a tactic to leverage the advantages of a manageable and stable population: again relatively untried ground (in Britain.)

We flag up the importance of energetic and purposeful networking within the region as a key job for local NHS leaders and a strategy for underwriting the future of a local acute service for ND: an agenda for this networking is given (para 20.) We also suggest it would be opportune to review the roles of each of the community hospitals.

There is a chart on page 24 that summarises the components of a future acute service for ND: notes are on following pages.

We think that the existing hospital and health centre in Barnstaple are future liabilities rather than assets and that work should begin on replacing them with a single smaller hypermodern centre that will take North Devon to the state of the art in the provision of modern acute services. The worked example section suggests that such a new centre could reduce the operating costs of the Trust whilst retaining the current level of income/workload. Perhaps most important of all, it provides an opportunity to completely recreate the service in a forward looking way comparable to the vision of the original DGH in the 1960s and 1970s. Why shouldn’t North Devon have one of the finest rural acute hospitals in Europe? – An exciting civic building, exciting to work in, ecologically sound and infection free.

The existing acute service

2 **The area.**

The combined resident population of North Devon and Torridge DCs is approximately 150,000 and projected to increase, by inward migration, to 161,555 by 2021. This resident population is significantly augmented by approximately 250,000 visitors per year. The district is a popular retirement destination and has a third more older people than the national average. Average earnings are 15% below the UK average and there are significant housing problems for local working families due to the affordability gap created by inward migration of relatively affluent retirees and second home ownership. All of these sociological factors have an influence on the base demand for acute health care.

The area is rural / semi-rural and, apart from the main towns, most settlements are of less than 5,000 persons. The road system is almost wholly single carriageway and there are major problems of congestion particularly at peak holiday times. At all times there are issues with getting around the district whether by car or public transport. The main acute hospital in Barnstaple is particularly isolated from other major centres of acute hospital care - RD&E Hospital, Exeter 50 miles; Derriford, Plymouth 60 miles. This puts Barnstaple Hospital in a very small group[1] of acute hospitals operating at great distance from the nearest main university hospital campus. This is a fundamental issue for the design of future acute services.

3 **Existing use of hospital services.**

The residents of N.Devon PCT occupied a total of [180,226] hospital bed days in 2004/5[2] which implies a rate of 1,155 bed days per 1,000 population for all causes and might equate to 550 beds[3] across all hospitals used by N.Devon citizens. There will also be a cohort of patients from outside N.Devon admitted to local hospitals, typically when on holiday as well as N.Devon citizens admitted to distant hospitals out of area. It is probable that future health commissioners will devote their attention to ways in which this level of hospitalisation can be reduced.

---

[1] *Carlisle – Newcastle 50miles; Aberystwyth – Swansea 54miles.*
[2] *HES 2004/5*
[3] *Precise number varies according to occupancy levels assumed etc. – we count 519 beds in N.Devon itself?*

There were approximately 1,500 births of which 92% born in hospital and about 7% of babies had a low birth weight (below 2,500 grms) which is normal.

4 **North Devon District Hospital. (NDDH)**

NDDH lies on the northern edge of Barnstaple and is a product of the 1962 District General Hospital strategy of the NHS. The greater part of the hospital was developed in the late 1970s although there are surviving buildings from the mid 1960s. The site covers about 34 acres and the hospital buildings comprise 47,000m^2. The Trust's Estate Strategy[4] lists 42% of the currently used space as in condition C or D (mostly C) which are the two worst conditions of the A-D classification and imply the need for reinvestment.

The hospital site is the centre of the North Devon acute service and also the location for North Devon Partnership mental health facilities which are in the process of being recreated in new accommodation on the hospital site.

The hospital has about 250 beds (see table below,) 10 operating theatres including 2 endoscopy rooms, and full-service imaging and pathology departments.

Ward	2003[5]	2005	2006	Plan[6]	Use (in 2003)
Alex	22	22	28	22	Elderly medicine
Budd	22	22	22	16	Elderly medicine
Capener	22	28	28	22	Surgery
Fortescue	34	14			Surgery
Glossop	30	30	30	30	Medicine
HDU/ICU	5				Intensive care
KGV	30	34	34		Surgery
Lundy	15	15	15	15	Surgery
Petter	22	16	22		Gynaecology
Roborough	10	10	10	10	Private patients
Staples	30	30	30	30	Medicine

[4] *North Devon Healthcare NHS Trust Estate Strategy 2003/2004*
[5] *Pg10 NDHT Estates Strategy 2003/4*
[6] *2006 Bed Reconfiguration Project Presentation NDHT*

Ward	2003[5]	2005	2006	Plan[6]	Use (in 2003)
Trinity	30	16			Medicine
Caroline Thorpe	22				Paediatrics
MAU	6	13	13	24	Medical assessment
SAU	5				Surgical assessment unit
CCU	7	10	10	10	Coronary Care
Exmoor	5				Day Surgery
Basset	22				Maternity
Delivery Suite	8				Maternity
SCBU	8				Neonatal care
FAU		20	20		
Victoria		9			
Elective surgery				34	
Women/General				34	
DSU	16				
Total	**371**	**289**	**262**	**247**	
	[All]		[Adult acute beds]		

5 **Community hospital beds**

Since the inception of this review, a proposal has been formed to (re)integrate the community hospitals and NDDH. There are 5 community hospitals with approximately 135 beds – the following details are from the ND PCT Estates Strategy (Jan 2006):

Hospital	Bideford	Holsworth	South Molton	Torrington	Tyrrell
Gross m^2	4,982	2,134	2,311	1,016	1,769
Acute beds	36	4	11	12	
Other beds	15	24	17	2	14
Services	Medical inpatients EMI inpatients Outpatients X-ray Physio & Rehab	Medical inpatients Care of the Elderly EMI Outpatients Day Unit	Medical inpatients Care of the elderly Outpatients Day Unit Renal Dialysis (8)	Medical inpatients Care of the elderly	Inpatients Outpatients X-ray Rehabilitation

6 **Consultant staff.**

The hospital has a current (July 2006) establishment of 178 full-time-equivalent medical staff with about half of these (47%) being doctors in training.

FTE medical staff	Cons	AS	CA	SPR	SG	SHO	HO	Totals
Dental			0.5		0.5			**1.0**
Accident & Emergency	1.0				5.3	7.0		**13.3**
Anaesthetics	14.0	1.8			1.3	8.0		**25.1**
Care of the Elderly	2.0			1.0	1.0	2.0		**6.0**
ENT	2.0	1.0						**3.0**
General Medicine	7.0			1.0		13.0	5.0	**26.0**
General Surgery	7.0			3.5		8.0	9.0	**27.5**
GUM	1.0				0.3			**1.3**
Obstetrics	4.9	1.0			2.0	6.0		**13.9**
Oncology	1.0				1.0			**2.0**
Ophthalmology	3.0	1.0	0.4		1.0	3.0		**8.4**
Other Medical	0.8							**0.8**
Paediatrics	5.0		0.1	1.0	1.0	6.0		**13.1**
Rheumatolgoy	1.0				0.1			**1.1**
Orthopaedics	7.0	2.0		1.0	1.4	8.0		**19.4**
Urology	2.0				1.0	2.0		**5.0**
Occ Health	0.3							**0.3**
Heamatology	2.0							**2.0**
Histopathology	3.0							**3.0**
Microbiology	2.0							**2.0**
Radiology	4.0							**4.0**
Grand Total	**67.9**	**6.8**	**0.9**	**7.5**	**15.8**	**63.0**	**14.0**	**178.0**

Caseload

HES statistics for North Devon Healthcare NHS Trust show the following pattern - note there will have been changes in the structure of the Trust:

	98/99	99/00	00/01	01/02	02/03	03/04	04/05
FCEs	35,347	36,031	37,157	36,317	38,557	39,597	41,512
Admissions	31,696	32,166	33,222	32,442	33,537	34,129	35,601
Emergencies	10,870	11,207	11,641	10,796	11,586	12,108	12,328
W.List	13,160	12,787	12,909	11,954	11,456	12,983	14,040
Daycases	10,403	11,493	11,752	12,733	12,848	13,084	13,961
Bed days	167,845	155,914	163,369	95,305	101,441	103,187	102,567

The contract between N.Devon PCT and NDH NHST closely approximates to the total projected workload for the Trust for 06/07.

Projected 06/07 activity (ND PCT)	Total	Exc Maternity
New Outpatient attendances	34,611	33,184
Follow up outpatient attendances	59,688	56,251
Elective inpatients	4,606	4,591
Elective daycases	12,745	12,745
Emergency cases	14,105	11,866
Total A/E attendances	35,170	

The composition of emergency arrivals (ND PCT cases estimated 06/07)

Gen surgery	2,343	22%
Orthopaedics	1,159	11%
Gynaecology	320	3%
Urology	156	1%
ENT	131	1%
Eyes	17	0%
Oral surgery	9	0%
Plastic surg	0	0%

General medicine	5,125	48%
Elderly medicine	1,274	12%
Cardiology	212	2%
Total adults	10,746	100%
Paediatrics	1,068	
Mat. - midwifery	1,276	
Mat. - obstetrics	963	
Total Mat & Paeds	3,307	

About two thirds of adult emergency cases will be medical and one third surgical. About 60% of emergency surgical cases will have a surgical procedure performed.

Discussion

8 **Future sustainability depends upon long term excellence in emergency services?**

The terms of reference for this report could be simplified in the question, "what acute services for North Devon can be sustained, and how?" The answer comes in two parts – elective and emergency care.

Elective services are relatively secure. Apart from a very small group of patients who will need access to the sort of high end equipment and skills only provided on a regional basis, there are not very many logistic constraints upon providing a full range of local elective care. The current menu of services could be sustained and even enhanced. This is not to say that all such elective services would always be provided by locally employed NHS specialists: visiting NHS faculty from other centres and independent sector providers could well become involved. Future commissioners of healthcare should be able to secure local service delivery of the full range of elective services at a frequency that will be appropriate to demand and at costs that are comparable with other localities. A service that is available on a daily basis in a metropolitan centre can also be provided once a week (or month) to an exactly equivalent standard in a locality such as ND. – Thus rural citizens do not necessarily face any disadvantage.

The position for emergency services is very different. The requirement to provide a constant service profile to an immutable standard puts the smaller service provider at a significant logistic disadvantage. However, the fact that the next available centre of emergency care is 50 miles away makes it essential that there is such a local service. The introduction of the NHS tariff has highlighted the financial significance of the emergency service - 48% of the NDHT income from FCE activity comes directly from emergency cases[7] but if the associated imaging, pathology, A/E, intensive care and overhead charges are included, the contribution of the emergency service to financial critical mass is decisive.

For this reason, the later sections of this report dwell at some length on the issues around securing the future of the local emergency service and to a lesser degree on the specification of future elective services. The terms of reference ask that any potential "show stoppers" be highlighted.

[7] *06/07 ND PCT contract with NDHT - £24,233,689 emergencies, £50,783,994 total fce activity.*

The loss of the ability to assess undifferentiated emergency arrivals in ND would probably represent a decisive undermining of any hope of retaining a sustainable acute service. If this is a “key risk” it should be carefully monitored and managed. The number and type of any direct emergency admissions of ND residents to out-of-area hospitals should be routinely reviewed with the cooperation of commissioners and fellow hospital providers.

9 **The current emergency service is viable – this viability window should be exploited**

NDH emergency services are currently viable and can continue so into the medium term (5yrs+.) The Trust should consider carefully how to use this “window of viability.” If changes are necessary to secure the longer term security of the local emergency service, long lead times may be needed. Longer term security can only really come from equivalence in service quality with RD&E and other acute centres: whilst ND will not be able to reproduce all of the treatment options of RD&E, it can provide an equivalent emergency assessment service. Any form of service offering that is “nearer but not quite as good” will be less stable in the face of increasing levels of quality monitoring by citizens and commissioners.

10 **The future senior clinical staffing plan for the emergency services is a key issue for today**

NDH is currently providing a conventional emergency assessment service with doctors-in-training on the front line, supported by specialist consultants. There is an emerging voice within the NHS advocating a change to a consultant led service based upon the presumption that if a senior clinician conducts the primary assessment and makes the treatment plan, then the appropriate actions will start more often and more quickly (including the decision that the patient can be discharged.) Such a change requires consultants to work a shift pattern and to take a primary interest in managing emergency arrivals.

Why is this a key issue for today’s Trust? Two reasons. Firstly, future health commissioners will be bound to take a view on the way that the emergency service is provided as it represents one of their biggest areas of expenditure. Secondly, the Trust needs to ensure that its future clinical positions are attractive to high grade young doctors coming out of training. What the future medical staffing structure should be is not clear but perhaps some of the issues are?

- There should be an overt and transparent plan.
- The (new) commissioning PCT should be in on it.

- Local GPs and citizens should be supportive.

Whilst the experience of the existing senior medical faculty makes a valuable contribution, it is the future experience and opinions o of doctors who would currently be in training that will be deterministic.

The Royal College of Physicians of London has mooted[8] the future development of the specialist "Emergency Physician" – a consultant in acute medicine with no, or a reduced level of, additional specialty interest. This new direction for consultant physicians is an alternative to the linking of higher specialist training to a narrower field of clinical skills. Such specialists would work across the emergency assessment/treatment unit and intensive care. The college report offers two model job plans for such posts:

Programmed Activities	Consultant physician with no additional specialty interest	Consultant physician with an additional specialty interest	Programmed Activities
5	Acute medicine	Acute medicine	4
1.5	HDU & ICU	Specialty of interest	3.5
1	Acute medicine unit management		
2.5	Governance, research & training etc.	Governance, research & training etc.	2.5

A number of NHS Trusts are exploring the potential of such future cadres, possibly including the RD&E with its plans to develop an "emergency hub" with consultant level staff conducting emergency assessments. Such a development (or any development) at RD&E will have an impact on NDDH as it is the only realistic alternative choice for citizens and the closest point of comparison.

Are there three directions NDDH could take?

- Continue with the existing staffing model.

[8] *Acute Medicine – making it work for patients. A blueprint for organisation and training. RCP 2004*

- Provide front-line senior presence by reorganising the job plans of existing posts.

- Adopt the emergency physician role as the basis post for emergencies.

11 **Continue the existing staffing model?**

This appears the line of lowest risk. In fact it involves a latent risk that the current arrangements will continue to find support among the health commissioners, local GPs, the public, and the nexus of training and regulatory inspectorates whose approval is a necessary condition of operating an emergency service.

12 **Reorganise the job plans of the existing specialists?**

The degree of presence of senior clinicians in the emergency arrivals areas could be strengthened by altering the job plans of existing and future specialist clinicians. It is beyond the remit of this report to give a detailed specification, however, the RCP has set out three stages for the future development of emergency physician cover which can serve as a useful indicator of how future standards and expectations might evolve.

- Immediate standard. The normative level of cover should be a specialist registrar (SpR) or equivalent with the MRCP(UK) Diploma and two years experience in managing patients presenting as acute medical emergencies available 24hours per day and without other commitments. A consultant physician who has no other scheduled commitments should support this doctor. For an average unit[9] this latter requirement implies 56 hours of rostered consultant activity; equivalent to 16 PAs[10]. Junior medical staff should have on hour allowed for the assessment, documentation, investigation and treatment for each new emergency medical patient, not including time which should be separately provided for attendance at senior ward rounds and handover at the beginning and end of shifts.

- Medium term standard. As above but with senior cover over a 14 hour daily window which would imply 98 hours or 28 PAs. of consultant rostered time per week.

[9] *25-30 emergency patients per day.*
[10] *"Programmed Activities" are elements in a consultant's job plan: cf a teacher's timetable.*

- Long term standard. Direct consultant involvement over the 24 hour period. 168 hours of consultant time or 51 PAs.

The fundamental problem of this model is that it produces a double bind - one in which consultant specialists are routinely managing patients who are outside their sphere of specialist interest, secondly, as general emergency commitments increase, there is a reduced amount of time for consultants to pursue their "main" interests. These were the driving reasons for the move to develop the emergency physician – things were not working properly. For example, a famous metropolitan hospital with 37 consultant physicians concluded in a recent internal assessment that only between 5-7 of these specialists excelled in the ability to manage the general medicine on-take.

13 **Adopt the "emergency physician" model?**

This is also risky because the role has not been properly developed, there is not a supply of properly trained candidates and there is no indication that it will prove popular with the next generation of doctors. However, the concept is particularly useful in providing an additional type of post that might be very helpful for the smaller, rural acute hospital. If we return to the basic logistic disadvantage that absolute parity of emergency assessment has to be provided but against lower par numbers, there is an inherent difficulty in creating more "specialist" posts to serve a population that will not produce a corresponding increased number of specialist cases. This disadvantage is compounded if those future specialists see the management of routine emergencies as a secondary aspect of their role.

NDDH should share the consideration of this issue with the (new) PCT and RD&E leaders. The prospect of a combined approach to training in emergency medicine with RD&E should be explored. There is a potential mutual advantage for both hospitals (and populations) in operating a similar model of emergency care in a coordinated way and with integrated training programmes.

14 **Emergency surgery and surgical assessment.**

Similar careful consideration should be given to the way in which emergency surgical cases are assessed and those requiring emergency surgery are managed. This is the aspect of the acute service where the logistic penalty is highest for small centres because the costs of maintaining service are the same as for larger centres but these must be carried across a reduced number of tariff bearing patients.

We have drawn a distinction (as in medicine) between assessment and treatment. NDDH is probably facing a level of about 4,250-4,500 emergency admissions to surgical specialties per year (see paragraph 9 this document.)

There were [287] emergency surgery procedures performed at NDDH in 2005/6 between the hours of 9pm and 7am: about half (55%) were classified as general surgery, a third (32%) were caesarian sections, and the remainder (11%) being orthopaedic cases. The 7 other cases were 2 endoscopies, 4 ENT cases, and 1 ophthalmology case.

As with medicine, a clear framework needs to be commonly understood within NDDH, with its acute provider neighbours and have the informed support of the new Commissioners. As a contribution to this agreed framework we suggest the matrix below which is intended to ensure that there is 24hr local access to secure emergency surgery for those conditions which will account for the majority of cases with shared responsibility for cases that will be uncommon or require highly specialised skills and equipment.

i	ii	iii	iv	v	vi
No surgery	Surgery indicated and scheduled: not urgent Local service Given elective appointment through usual channels	Surgery indicated and scheduled: urgent Local service Booked to next available slot in appropriate list	Emergency surgery indicated : common procedure Local service 24/7 capacity for the most common procedures: Hernia Caesarian Appendicectomy Laparotomy etc. Surgeons may need to be cross trained.	Emergency surgery indicated : difficult procedure Network service If ND is an accredited network centre and “on take” then procedure is performed locally. Eg Vascular network 1 in 6.	Emergency surgery indicated : difficult procedure Network service Urgent transfer to appropriate network centre.

15 **Maternity and paediatric staffing may need strengthening?**

There have been recent set-piece reviews[11] of maternity and neonatal services in both England and Scotland. Both had to address the issue of falling birth rates, shorter lengths of stay in hospital and the practice of later first pregnancies. In both countries there are concerns that the number of existing birthing units will be unsustainable in the longer term as clinical staff employment regulations require bigger teams to treat smaller numbers of women. These logistic difficulties collide directly with public expectations of a local birthing unit.

In England there are approximately 200 birthing units[12] and ND would be classified as a "Level 1 Small DGH Unit." There are 75 such units in England each of which has an (2001) average number of 6 consultant obstetricians and 8 paediatricians: ND has 5.9 and 5 respectively. Professional bodies recommend that consultant numbers should be increased to 8 and 10 respectively but also note that current numbers of trained candidates would not be sufficient to provide for these numbers. The table below is based upon the Scottish review and shows that ND would be at the sixth of seven levels of intrapartum care in Scotland:

Level	i	ii	iii	iv	v	vi	vii
No of births pa	<1,000	<1,000	<1,000	<1,000	<1,000	1,000 - 3,000	>3,000
Location	Home (planned)	Stand alone community unit	Community unit adjacent to acute hospital	Consultant led unit with no neonatal facility	Consultant led unit with neonatal facility on site	Consultant led unit with neonatal facility on site	Consultant led specialist unit
Lead carer	Midwife/GP	Midwife/GP	Midwife/GP	Consultant + MW	Consultant + MW	Consultant + MW	Cons Fetal Med.
Risk	Normal pregnancy and labour	Normal pregnancy and labour	Normal pregnancy and labour	Low risk pregnancy and labour	Low to medium risk pregnancy and labour	Low and most high risk pregnancies and labour	Complex and high risk cases
Facilities	Suitable home and backup from ambulance and local maternity unit	Appropriately equipped unit with agreed transfer guidelines	As ii but with capacity to perform emergency caesarian	Maternity unit with monitoring facilities and anaesthetic cover	As before but with access to paediatric cover. Transfer out to SCBU on NICU as needed	Access to SCBU/NICU and adult high dependency / intensive care	On site NICU, access to neonatal surgery and adult intensive care

[11] *Maternity and Neonatal Workforce Group: Dr S Adam DoH May 2002. Implementing a framework for Maternity Depts in Scotland*
[12] *72 Small units @ <2,500 births pa, 95 medium sized @ 2,500-4,000 and 31 large units @ >4,000. Total = 198.*

We have not checked the detail but it is likely that NDDH is the Level 1 DGH Unit in England with the greatest distance to the next available hospital maternity unit. In an employment market with potential undersupply, ND needs an active strategy to persuade the new PCT of the strategic importance of defending the existing service. This commitment should extend to support for the creation of such additional posts as will be necessary to maintain full accreditation. 1 of the existing consultant paediatricians and three of the obstetricians are listed as aged over 55, if so, the years before their retirement would be a good time to revalidate the staffing plan for both obstetrics and paediatrics so that measures can be taken proactively rather than in response to a crisis situation. If vertical integration forms part of the Trust's future strategy, the debate about future staffing should be extended to include the local GP community.

16 **The commissioning function of the NHS is likely to become stronger**

The new SHA and PCT structure has been created to strengthen the commissioning role within the NHS. The larger PCT will be somewhat more remote from the problems of ND and will have a wider range of preoccupations. This will require more effort to ensure that the particular challenges of operating an acute service to a small and remote population are understood.

Already there are signs that the government's intention to bring in new skills to strengthen the commissioning arm of the NHS is being implemented. The recent controversial OJEU advertisement[13] for expressions of interest for the provision of management services to the new PCTs casts its net very wide and, technically, will provide a mechanism for many of the internally provided functions of the PCT to be outsourced from specialist independent providers. Demand assessment, demand management, data analysis, claims settlement, service design and patient/public engagement are all referenced. There is a strong and international response expected to the invitation.

If the experience of other health systems with a strong commissioner presence is reflected in the new PCTs, one can anticipate a number of consequences for acute providers; among many would be :

- challenges to the relatively high bed-day usage in ND

[13] *OJEU 2006/S 135-145353 PCT Management Services 17th July 2006*

- pressure to publish and adhere to model pathways for common conditions
- the need for processes and systems that demonstrate clinical quality to commissioners.

17 **ND has an advantage in establishing and following patient pathways for common conditions?**

The core role of the acute provider will always be to treat individual patients who are ill. However, the quality of an individual's experience and outcome is now heavily influenced by the quality of the coordination between different parts of the health system as well as by the skill and judgement of the individual clinician(s). Here the smaller and more settled population of ND is a distinct operating advantage: the main elements of any pathway are stable and well known to each other – self-care, social care, primary care, community or homecare, community hospital care, acute hospital care. A significant proportion of the emergency acute service is directed to the acute treatment of patients with long term chronic conditions who can benefit the most from effective and widely followed patient pathways.

18 **This advantage could be further levered through vertical integration?**

ND has stable and well-found primary care services across about 21 GP practices. Relatively few patients flow out of, or into, the district giving about a 95% correspondence between local and total cases treated. This is a good background against which to exploit the potential health gain from longitudinally coordinated healthcare (contrast this scene with London W2 with up to 50% turnover on GP lists year to year.) The recent proposal to amalgamate the community hospitals with NDDH offers an opportunity to revisit and confirm the roles and purposes of each and its relationship to the main acute site. Further scope exists to explore the amalgamation of primary and secondary care – particularly in Barnstaple. This would open up further possibilities for future senior medical staffing by blurring the distinctions say between the GP with special interest and consultant specialists in fields that have a high quotient of patients that can be treated in a primary care setting (eg diabetes.)

There is strong current interest in the possibility in vertical integration among NHS policymakers. If tangible therapeutic flow from it, commissioners will be favourably disposed towards contracting (and employment) frameworks that encourage and support integration. This commissioner support to create constructive financial incentives is important. A contrasting scenario would be one in which the financial interests of primary care commissioners and the acute hospital were in opposition.

19 **Networking and modern hospital operation**

The decision to remain an independent smaller NHS Trust brings a number of benefits in terms of self-determination but a counterbalancing effort must be made to avoid isolation. The future of hospital inpatient care will be highly networked. The old concept of a managing clinician in a single hospital determining the treatment pathway from start to finish is giving way to much more complex and mandated pathways, often with fixed time standards and important tariff linked considerations. It is becoming virtually impossible for any NHS Hospital to practice high quality medicine without complicated links with other parts of the health system. There are those[14] who are arguing that the quality of care and health outcomes is as much determined by the quality of the coordination of the different contributors as by the quality of their individual technical contributions. We suggest that there is considerable scope (and need) to improve the networking of clinical services.

There are three interfaces that will require highly skilled management and constant review to ensure that they are mutually positive, transparent, work to underpin clinical quality and outcomes, and financially grounded. Not simple and not the product of a few management meetings.

- The complex relationship(s) with distant AMC(s) needs to be secure at an over-arching level Board to Board but also consolidated in each service area between specialty colleagues at ND and counterparts in neighbouring hospitals.

- The way that assessment, acute treatment, and continuing care to individuals is divided between Barnstaple and the 5 ND Community Hospitals needs to be overtly agreed in a way that makes best sense for the patient and will be endorsed by the PCT as consistent with their payment frameworks.

- The 21 or so local GP practices and their needs and views need to be managed as a vital constituency – some would see them collectively as the main “customers” of NDDH. Customer relations have to be worked at and formally monitored.

[14] *Eg Ed Wagner, Director of the MacColl Institute for Healthcare Innovation at the Center for Health Studies, Group Health Cooperative in Seattle*

20 **Links with AMCs**

There are 3 AMCs, Plymouth, Exeter, and Bristol, within the practical orbit of Barnstaple but Exeter RD&E is the closest historically and geographically. We suggest that N.Devon leaders should promote an overt and mutually understood structured relationship and we suggest the following agenda.

- To understand the strategy of each AMC and to work to ensure that ND's strategy was reciprocally understood and non-conflicting.
- To build and maintain in N.Devon a strong senior clinical faculty as a combination of local and shared appointments, with (funded) arrangements for periodic rotations of N.Devon staff to neighbouring AMCs for continuing development and accreditation. These rotations would also have the specific objective of cementing strong clinical relationships and ensuring that the AMC was aware of the clinical competencies of N.Devon players.
- To take an extremely active part in all service networks (eg cancer, coronary, vascular etc) with a view to securing favourable dispositions for ND.
- To maintain and develop ND's role in education and research, particularly by developing and emphasising ND's (future) role as a centre offering excellent experience in vertically integrated care and chronic disease management.
- To involve as many as possible of the senior clinical and management faculty of the neighbouring AMCs in opportunities to visit ND, review the services and offer suggestions for development (also to take back to the AMC campus a positive mindset about ND.)
- To promote the new Conferencing Centre at Barnstaple as a preferred venue for regional professional meetings and conferences.

21 **Future links with Community Hospitals (CHs)**

The PCT has made a firm commitment to the continued upkeep of the 5 community hospitals and it would be a good conjuncture to reassess and reaffirm the role of each. Community hospitals are actually very difficult to run well within a dynamic network – the fierce localism that they inspire and a received culture of distrust of distant headquarters can sometimes lead to stasis. Although the main acute centre will be in Barnstaple, a considerable proportion of the beds-in-use lie in the community hospitals and their role cannot be ambiguous. The main categories of chronic disease would provide a useful framework to review pathways to clarify the roles of the community hospitals in the network of services from self-care at home through to emergency acute treatment.

22 **Links with GPs**

Beyond the obvious imperative to have constructive relationships with one of the most important constituencies for any acute hospital, there will be added complications if vertical integration is introduced. A clear principle should be that all GPs will have equality of price and access for all services offered by N.Devon whichever of three categories they might fall under.

- Unaffiliated. As at present all GPs are.
- Affiliated. Co-located and with high levels of co-operation but operating as separate businesses.
- Integrated. Merged businesses with assets in common and a unified clinical faculty spanning both general and specialist practice.

Recommendations

23 **Use the current insolvency crisis to sort things out properly**

The recent Grant Thornton report has restated the deficit position of NDDH and reinforced the conclusion that longer term financial stability will not easily be established by traditional "cost improvement programmes" run against the existing framework of the NDDH – important as these programmes are in contributing to short term balance.

This might be a good time to give deep thought to the future design of the acute service and to link the energy required to solve the short term financial crisis with movement towards an affordable service set-up that will meet North Devon's requirement for local excellence for the coming decades.

Of course it is risky to reach for a model that is untried and proven (if it was tried and proven, it would be "conventional") but it is also risky to press on regardless with the current services. North Devon is perhaps in a group of three[15] UK communities with a population of >150,000 and 50 miles from the adjacent acute hospital centres (at least one of the others is also in serious planning and operational difficulty.) The conventional professional, planning and finance frameworks are simply not going to deliver a context that suits these three communities. They will have to do it themselves.

24 **Sell the existing hospital and build a smaller better one**

We see the current hospital buildings as a major liability for the Trust.

The current NDDH occupies 47,000m^2 of intermediate to poor physical accommodation with generally poor functional relationships. The most recent Estates Strategy which defines 50% of the current buildings as in condition[16] C (46%) or D (4%). The Barnstaple Health Centre and Ambulance Station bring the total to about 50,000m^2.

We suggest that there will be major advantages in reorganising these assets to achieve the following objectives.

---

[15] *Carlisle, Aberystwyth, North Devon*

[16] *Condition C – major repair/replacement needed 1-3yrs; Condition D – imminent risk of breakdown: these are national reporting conventions within NHS.*

- To focus future capital investment on direct care spaces of much higher quality, that are more intensively used and cheaper to operate. This investment should move ND to “state-of-the-art” and provide a therapeutic environment that is infection free and one that can be kept that way.

- Make the new building beautiful a civic asset and a strong attraction to work in Barnstaple.

- Make a platform for integrating primary and secondary care (and the ambulance service.)

- Review the placement of the new centre against the revised road layout for Barnstaple.

The second part of this report sets out as a “worked example” what such a centre might look like, what accommodation it might comprise and how much it would take to build and operate.

25 **Prepare the ground for vertical integration in Barnstaple**

The NDHT and interested local GP Practices should consider setting up a joint working group to explore the potential for various levels of integration from simple co-location to a completely integrated partnership. This should be a precursor to a careful and informed debate that should also involve the new PCT and the registered patients concerned, if it becomes an active proposal.

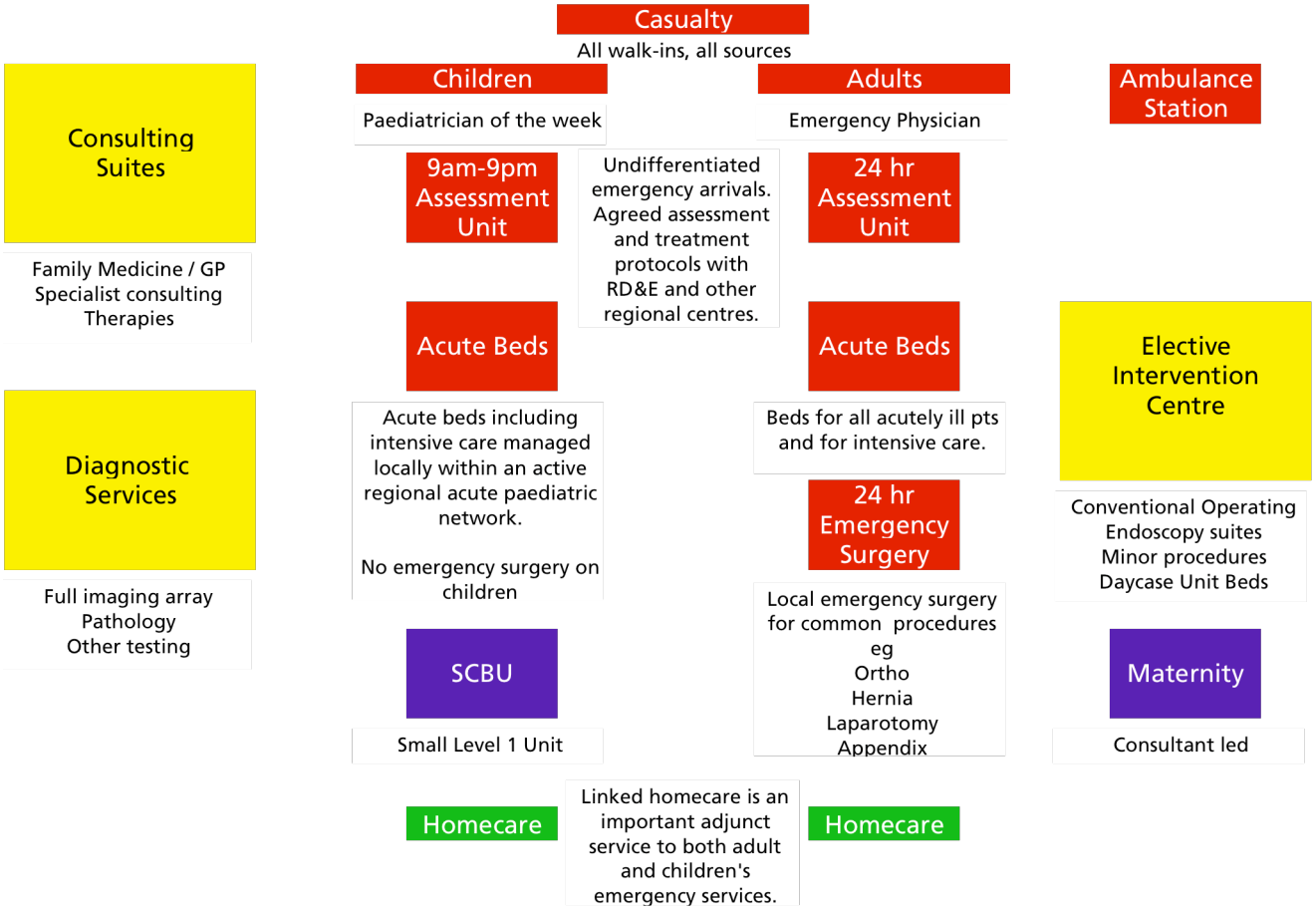
26 **Get behind the “Emergency Physician” concept and make it work**

This initiative of the RCP is a possible ticket to the provision of high calibre consultant team that would be the bed-rock group that guaranteed the long term viability of the emergency service. The issues are discussed in para 10 and following. Yes it is a risk. So are the alternatives. The risks could be significantly reduced if there was a coalition with RD&E to jointly develop this new specialist role – Exeter would have the academic and training muscle to accredit the appropriate training schemes: a second centre at Barnstaple (particularly if it incorporated vertical integration with primary care) would offer candidates an enriched experience. If the prospect is not attractive to the RD&E, it would also be possible to link to Truro/Peninsula Medical School.

27 **Become the best networkers in the region**

Because it is isolated and because it is one of the smallest acute hospitals in the region, NDDH needs to compensate with highly active and strategically managed networking. The agenda is set out in para 20. To be successful in the future, NDDH must have strong supportive relations with neighbouring hospitals and active training and staff-exchange programmes.

What will the future service look like?



28 **The future range of acute services can be very similar to today's – but somewhat modernised.**

The diagram above summarises, with modern labels, the range of services that should be sustainable in ND for the foreseeable future. This is a deliberate counterpoint to the post-1960 DGH concept which, today, somewhat over-emphasises the inpatient bed array.

29 **Core and Non-core services**

A list of core and non-core services was identified by NDHT (November 2005) and was included in the terms of reference with an invitation to comment. For completeness, that table is given below with notes.

Core Services	
Accident & Emergency	The A/E Dept., the Ambulance Station, the Walk-in Centre (TarkaDoc,) the Paediatric Assessment Unit, the Emergency Assessment Unit cluster in a common space and linked functions behind one very visible and prominent entrance marked "All Emergencies." In time, one sees the opportunity for a Director of Emergency Services to emerge as a key role in coordinating this complex set of functions as will as securing the clinical governance and professional development programmes that will be essential to maintain absolute parity with neighbouring larger acute providers. Undifferentiated emergencies are received at Barnstaple with the overwhelming majority being retained for treatment on site. A small number of cases will be urgently escalated to regional centre(s) in accordance with protocols of the day.
General Medicine	The discussion section deals at some length with the organisation of the emergency dimension of general medicine to secure this central plank in the acute service platform. If the Emergency Physician concept is embraced, sub-specialist medicine moves increasingly towards the elective and outpatient environment. If vertical integration with

	local GPs is implemented, some specialist consultants could contemplate a largely "office based" practice similar to their colleagues in some other countries?
General Surgery	A full general surgery service can be maintained including most urgent and emergency surgery as at present. Careful thought needs to be given to the way that the 250 or so out of hours surgical procedures (9pm-7am) are conducted in the future. A panel of future surgeons in different specialties should be trained to retain competence across a range of the most common emergency procedures, perhaps including caesarian sections so that a manageable rota for out of hours can be maintained.
Intensive Care / Coronary Care	Local ICU service as at present. Coronary care presents particular difficulties at this time as new protocols recommend immediate transfer to a centre with cardiac intervention facilities for some patients with one type of myocardial infarction (about 150 pts pa in ND.) A proposed pathway involving a combination of local emergency treatment and transfer to RD&E has been drawn up within the cardiac network - these pathways need to be kept under active review as services evolve.
Obstetrics & Gynaecology	Local service
Paediatrics (inc SCBU)	Local service
Pathology	Local service: with the proviso that there are national moves to review and restructure pathology services. It would be a possible candidate for a private sector carve out. (Please note: we are not recommending this but pointing it out.)
Radiology	Local service
Trauma & Orthopaedics	Local service
Non-core Services	The non core services listed below are mainly provided to elective patients on a

	scheduled basis. This gives greater flexibility about how they are provided. All could be provided locally to a high standard but not necessarily by in-house full time NHS consultants. Visiting-in consultants, independent sector providers and local GPs could all play a part. It is not appropriate to attempt to predict the detail for each.
ENT	If vertical integration is pursued, there should be ample scope to provide a local ENT service for children and the elderly. Head and neck surgery regionalised.
GUM	Demand related: no information at present.
Maxillo-facial surgery	Regionalised service?
Neurology	Provided within a regional network (cf cancer, cardiac, vascular etc) important to retain/develop local stroke services that are at national standards.
Ophthalmology	Mainly elective, surgery locally: wide choice of options who does it.
Orthodontics	As ophthalmology
Plastic surgery	As ophthalmology
Rheumatology	The standard of excellence achieved in rehabilitating mainly elderly patients is highly deterministic of the performance of any acute hospital and health outcomes in general. Leadership in rehabilitation can come from a number of sources, sometimes rheumatology. Given the nature of ND and the links to Community Hospitals, this leadership is an essential requirement for the future.
Urology	Given the elderly bias in the local population, important to retain a local service – perhaps within a vertically integrated context “office urology” would be the main role. Routine

prostate diagnostics and surgery care can be managed locally but major surgery likely to be regionalised.

30 **An alternative description**

The list given above, taken from the terms of reference, approaches future acute services very much from a medical specialty. The paragraphs below attempt a description of a future acute service based on its main elements. It is the basis for the "worked example" of a modern centre that is attached. The term LAH – Local Acute Hospital is used to describe the future hospital.

Emergency cases	A complete and modern 24hr emergency assessment service for undifferentiated emergencies will be provided for children and adults. The emergency assessment services will be provided in accordance with, and monitored against, approved protocols that match AMC standards at RD&E. Most sick adults will be treated in the new Barnstaple Local Acute Hospital by resident clinical faculty. Some sick adults will be treated in Barnstaple but under co-management with external AMC clinical advisor(s).[17] Volumes will be the same as present, subject to demographic push slightly upwards and counterbalanced by improved proactive Chronic Disease Programme activity. Some patients will be escalated to the AMC (RD&E) for emergency treatment either because of clear protocol indication or by agreement, many of these cases are likely to return for local management later. There are separately grouped beds for assessment, acute care, intensive care, patients transfer to separate rehabilitation/care beds when their immediate acute treatment phase is completed.

[17] *The local clinician is managing, the external clinician is advising – clinical responsibility is retained locally*

The LAH has open channel tele-link to an AMC advisory / co-consult service 24/7 and pays for this and maintains its effectivity at all times (this is not like having some “telemedicine” kit lying about in the corner not being used much.)

The LAH has a full roster of accredited Consultant Emergency Physicians (CEPs) and the emergency assessment service is directly provided by them and not by junior doctors in training. The LAH CEPs are tightly networked with a partner-AMC; they rotate occasionally to that AMC for a period to refresh experience of AMC working and to reinforce professional relationships/friendships. AMC CEPs periodically rotate to the LAH to gain reciprocal experience.

The responsibility for surgical assessment in the emergency unit has been separated from the responsibility to perform the procedure. The emergency unit has an assessing surgeon present without other commitments. Most surgical procedures will be scheduled-urgent and can be merged into the scheduled surgery lists of LAH surgical colleagues. There is 24/7 capacity to perform (only) the most common emergency procedures out of hours where the case meets the agreed protocol for local emergency out of hours surgery (likely to be laparoscopy/laparotomy, caesarian, hernia, appendicectomy) otherwise the cases will be rapidly escalated to RD&E.

There is a further array of Emergency Nurse Practitioners (including longer term the Ambulance staff EPs) who have similar reciprocal rotation and development arrangements.

There will be parallel and separate facilities for children also with 24/7 linkage to a partner-AMC department of paediatrics.

The Barnstaple Ambulance Station and crew will be integrated and co-located with the LAH and there will be a clear standing capacity 24/7 for emergency escalation to RD&E.

Elective cases	There is a modern Ambulatory Care Centre that has the capacity to perform the full repertoire of elective cases in conventional and endoscopic surgery. There is a full service imaging centre providing for all but the most esoteric procedures. Inpatients use the main array of acute beds (which are not dedicated to specialties.) There are opportunities to bid to colleague providers and commissioners for specialist elective services that do not require close AMC linkage to be placed at Barnstaple. We see the new LAH as a potentially very attractive venue for small specialist stand-alone units (eg ?Bareatric Surgery / Max fax & Plastics) We would expect the local caseload to support permanent faculty in: Orthopaedics General Surgery Urology Gynaecology
Births	There is a small but very modern maternity centre based on an assumption of around 1,500 births. The service is co-provided by a team of midwives and local Consultant Obstetricians with rotational training and professional development arrangements with neighbouring larger centres. There is a Level 1 SCBU
Children's centre	There is a small but modern children's centre that exploits the full potential of vertical integration with primary care and also links the home nursing service to the emergency service so that from the parents' viewpoint it becomes an intelligent whole.
Consulting centre	A modern and uplifting alternative to the traditional misery of hospital outpatients. The

	consulting centre will allow for the full range of GP and clinical specialist consulting as well for all of the other health professionals who operate on the consulting model of service.
Diagnostics	Imaging and other testing (eg cardiac) are state of the art and all modalities to AMC standards with the exception of exotic regional services. Hot pathology is on site, batch pathology is for discussion depending on the value proposition that specialist pathology providers can offer – it might be a suitable candidate for a "carve-out.[18]"
Homecare	Homecare, particularly proactive visiting and monitoring of selected chronic disease patients is an important facet of the acute service. Planned comprehensive assessment and treatment planning has important overlaps with the skill-set of the emergency assessment unit and there are opportunities to switch patients from unscheduled to scheduled appearances.

[18] *Carve-out – typically the existing staff set up a separate business with and contract to provide a specified service volume/price.*