NHS

South East Midlands Acute Services Review
The Case for Change

15th November 2011

Case for change

The NHS faces the most challenging period in its history, but also one where there are opportunities to improve care. The NHS in Bedfordshire, Luton, Milton Keynes and Northamptonshire - the South East Midlands - is working together to plan how health services need to change over the next few years to respond to this. In this document we set out our ambition to improve the quality of care for the public and be better placed to face the significant challenges ahead as finances tighten and demand increases. Many of the very challenging issues facing hospitals in the region cannot be solved if hospitals and other services work in isolation from each other. Furthermore, without the right sort of change, the local NHS is likely to fall behind in its ability to maintain the current level of quality delivered as well as miss the opportunity to improve outcomes for the population.

There are five district general hospitals in the South East Midlands area in Bedford, Kettering, Luton, Milton Keynes and Northampton. When people need more specialist treatment, typically they are referred to centres in Oxford, Cambridge, Leicester, Nottingham and London. Until recently the hospitals worked largely independently of each other partly due to administrative regional boundaries but, following the recent administrative changes within the NHS, there is now a greater opportunity for the five hospitals to work more closely together in a number of areas. If services share their resources and expertise it should be possible to sustain services locally that might otherwise have to move to specialist centres. It may also be possible to provide more specialist care, currently provided outside the area, more locally reducing the need for people to travel long distances. This means we can be more ambitious about the way that care is provided, its quality and how we improve the experience of patients. But, there is also an urgent need to look at how services are organised to ensure that they can meet the standards of safety and quality we will expect in the future and to adapt to the demands of an increasing and ageing population and the challenging economic climate.

Our ambitions

In the last two decades not only has medical care improved enormously but we also know much more about what is needed to ensure we offer the highest quality and safety of care. We want to set ambitious goals for what the health care system should achieve and how it operates, for example:

- The way that emergency care is organised can be a matter of life or death. For a number of conditions it is vital that we can provide access to a specialist opinion 24 hours a day, 7 days a week. Up to now this has not been the case locally or across most of the UK. There is strong evidence that this needs to change. By working together hospitals could ensure that this level of expertise is available to patients that need it. Similarly, well organised specialist teams for heart attacks and strokes, special units for people with multiple injuries and ensuring that there is a high quality surgical service at nights make a big difference to patients' survival and longer term health. We want to make improvements in these areas and our intention is to save 1000 lives over the next five years, 400 of these lives would be saved by changes to stroke services [1]
- We want to reduce the number of people who have to travel to hospital for tests, treatments and appointments that could be carried out in a GP surgery or a more convenient local location
- We want to improve the quality of life of people with long term conditions, particularly frail older people and reduce the risk that they will need emergency admission to hospital by making sure that services are properly coordinated and that they provide easy access to specialist advice
- Using health services in an emergency and out of hours is often confusing. We want to make sure that using the NHS is as simple and straightforward as possible for patients, their carers and families, particularly at times of crisis
- There is a need to improve the care of pregnant women, particularly those who are at higher risk of a complication, so that the number of normal births is increased. Elsewhere 'high risk' obstetric units have reduced artificial inductions of labour by up to 33%. If a similar reduction was achieved in South East Midlands about 400 fewer women would experience an artificially induced labour each year [2]
- People who are nearing the end of their lives would generally prefer to be at home; too often they receive their final care in hospital when this is neither necessary nor what they and their families want. Better planning of services at the end of life would allow more than 2000 people a year across the South East Midlands to die at home rather than hospital [3]
- The number of people aged 0-74 years whose death is potentially preventable with timely and effective healthcare has improved in the UK but could still be better in comparison to other countries such as France. Comparative to other parts of the UK, in parts of the South East Midlands area death rates from conditions regarded as amenable to health care are relatively high. As the following graph shows, none of the five local hospitals have lower than expected standardised mortality rates for death in and within 30 days of admission. We believe that the reorganisation of services can have a significant impact on potentially preventable deaths and that this review offers the opportunity to improve these outcomes for our population

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1. Figure derived from utilising London's Stroke Network figures. NHS London has a population of 7.6m and the Stroke Network saved 400 lives. SEM has a population of 1.6m thus 84 lives would be saved each year or 420 lives over five years

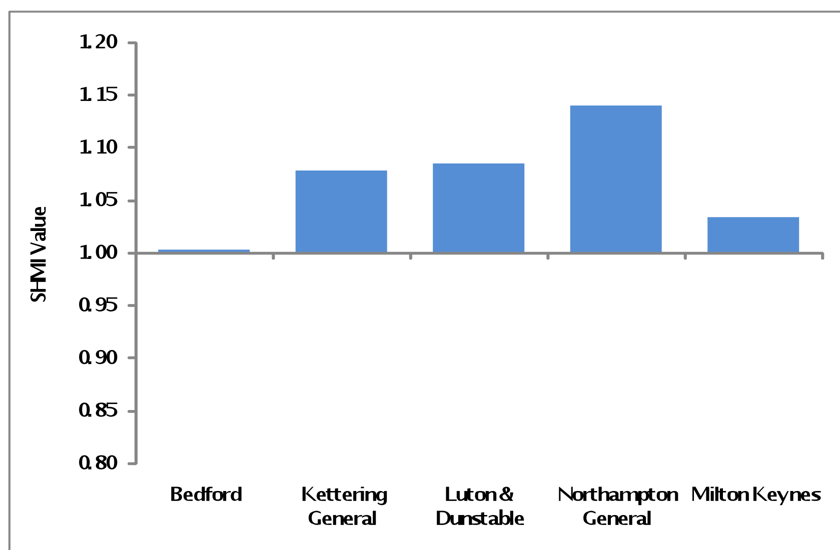
2. Figure derived from using BirthChoiceUK's statistics on numbers of birth and percentages of induced deliveries, and national statistics on high-risk births. According to BirthChoiceUK's figures the regions trusts had 20200 births in 2010. 6% of births are high risk meaning that 1212 births would be high risk within the region. This figure would thus be reduced by 33% meaning 404 fewer induced births.

3. Figure of 2000 derived from calculating mortality rate for a population of 1.6million from National Office of Statistics, forecasting the number of people who would die in hospital, and applying a 30% reduction.

In-Hospital Mortality

All the SEM acute hospital trusts had higher SHMI scores than the national index (1).

Summary Hospital Mortality Indicator (SHMI), for acute hospital trusts in 2010/11



Source: Information Centre for Health and Social Care 2011

Challenges

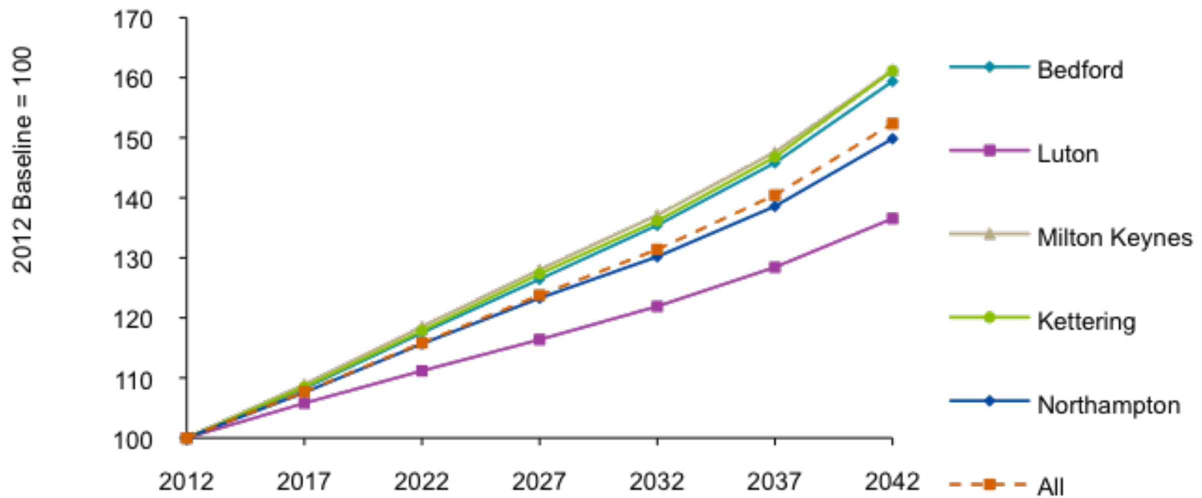
The ambition to improve and achieve excellence for the public is set against a context of significant challenges currently facing the NHS. These challenges give urgency to the need to work differently to achieve better organised healthcare and better health outcomes for the population. The NHS has to change radically over the next few years if it is to continue to improve and meet the expectations of patients, carers and families.

Three of the biggest challenges both locally and nationally are:

1. A growing and ageing population with rising levels of long term conditions
2. Sustaining the current quality and safety of services as well as improving services and optimising patient volumes for best outcomes in complex services
3. The most difficult financial situation ever faced by the NHS

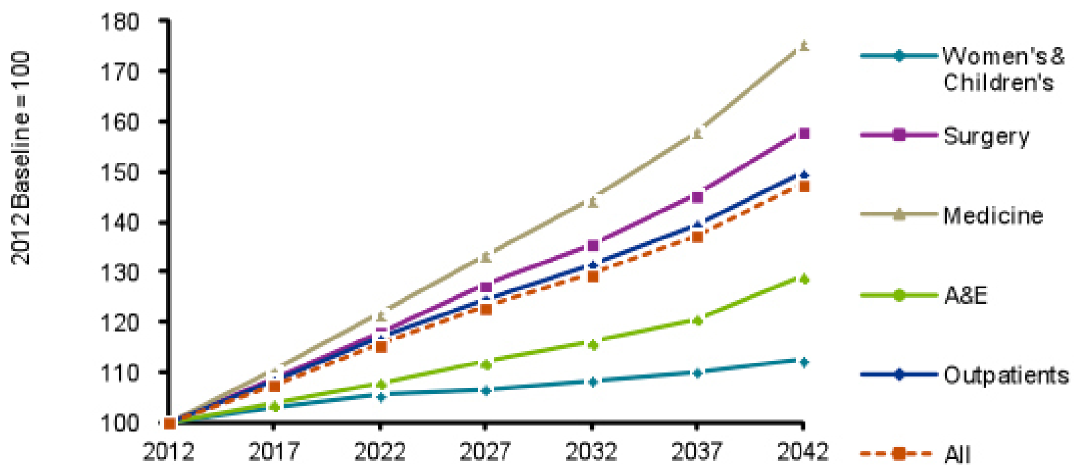
1. A growing and ageing population

As the population rises, if we remain with the current model of care we can expect to see the amount of hospital activity rise by 50% over the next 30 years. This increase in demand would be felt across the whole area but particularly in Bedford, Kettering and Milton Keynes.



Source: KPMG analysis based upon demographic and activity data provided by the five acute trusts 2011

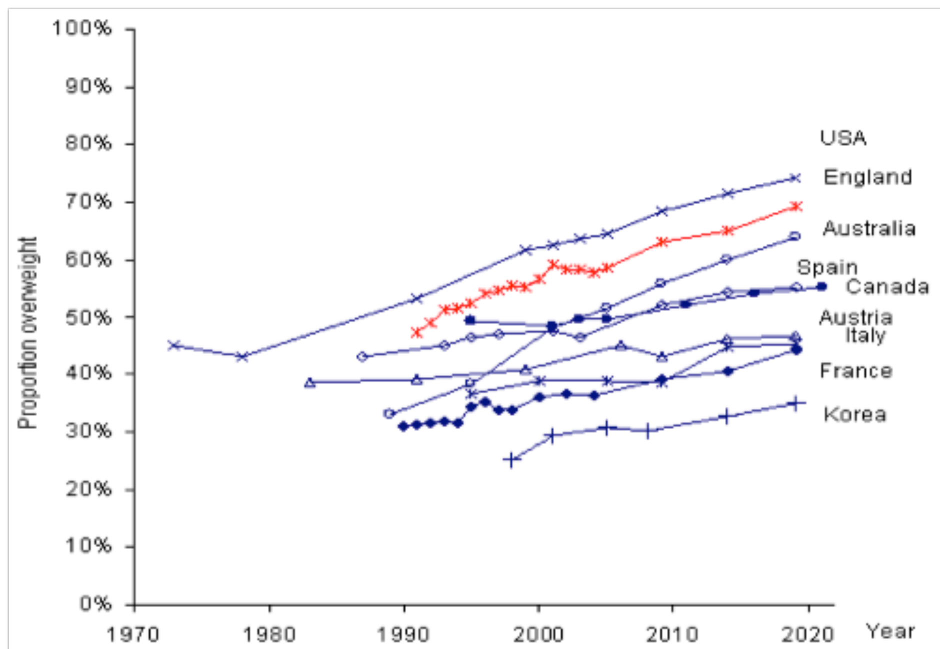
The graph below shows the forecast inpatient activity by speciality.



Source: KPMG analysis based upon demographic and activity data provided by the five acute trusts 2011

Not only is the population growing but it is also ageing and unfortunately risk factors like diabetes and obesity are increasing. Obesity is a problem facing countries around the world and, as the graph below shows, England faces a greater challenge than many others. This rise in obesity will lead to a significant rise in the numbers of people needing joint replacements. We can also expect to see more people who have more than one chronic condition whereas, in the past, hospitals were generally organised to support people who have a single problem. We need to ensure that all our services are able to support people with the complex demands that changes in the pattern of disease are going to produce. Increasingly this will mean that general practice, community services, social services and hospital care will need to work together much more closely to deliver coherent care for patients.

Past and projected future overweight rates in selected OECD countries

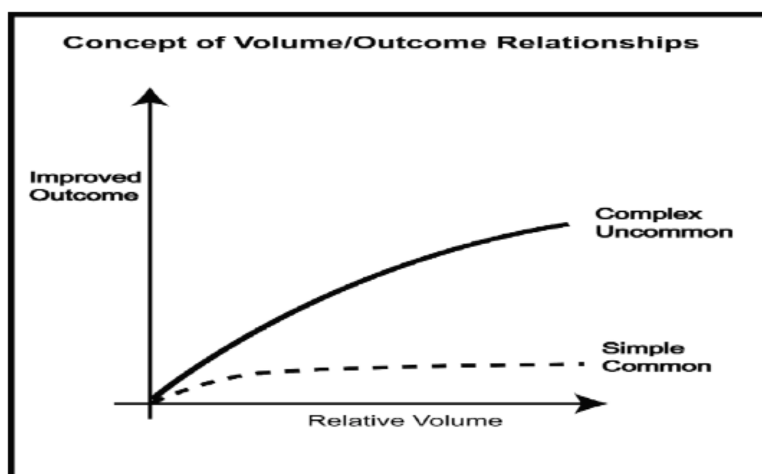


Source: Organisation for Economic Cooperation and Development

2. Sustaining and improving services

Some services need to change to ensure that they can continue to deliver safe high-quality care and meet the standards that are expected of them.

For a number of conditions it is clear that larger units that treat a high volume of patients produce significantly better outcomes than smaller units that treat fewer patients. This is because larger units can bring the right combination of multi-disciplinary expertise together. For some services it is also true that individuals and teams of clinicians who see higher volumes of particular problems often become very good at treating specific and complex conditions in a way that is not possible for individuals and teams with smaller case loads who invariably see the condition less often. This has already happened in cancer care both nationally and internationally with specialist surgery for certain types of cancer now concentrated in a smaller number of hospitals. The diagram below shows the realtionship between volume and outcome. [4]



Source: Report from the Volume/ Outcome Subgroup to NHS Scotland [4]

Changes to stroke and some specialist heart surgery have taken place already in Northamptonshire and other areas such as London, Manchester and Buckinghamshire have introduced similar changes across a range of areas including complex surgery, intensive care for children and new born babies, life-threatening multiple injuries, stroke and some types of heart attack. In all of these areas, where services have been concentrated in specialist units, there have been improvements in the outcomes for patients. This does mean that these services now cover much larger areas than a traditional hospital and for a small number of patients there is a need to travel further.

Across the South East Midlands there are a number of other areas where change is needed to take full advantage of these opportunities to improve outcomes. These include emergency surgery out of hours, vascular surgery, paediatric surgery, high risk maternity care and major trauma.

4. Report from the Volume/ Outcome Subgroup to the Advisory Group to the National Framework of Service Change for NHS Scotland, 2005

Improved infection control rates

When patients have surgery such as joint replacements, there can sometimes be complications such as an infection in the wound. Nationally the infection rate for joint replacements (knee, hip and ankle) is 1-4%.

In hospitals that serve a large population, such as 1.5m people and undertake a very high volume of joint replacements, infection rates have been seen to fall to levels as low as 0.2%.
In the South East Midlands, across the five hospitals in 2010 there were 2,440 joint replacements undertaken and registered with the National Joint Registry. If the infection rate were to fall from a supposed average of 2.5% to 0.5% this would improve the outcomes for approximately 50 patients a year.

There are also practical difficulties in keeping some smaller services working in a way that is safe and sustainable. Across the country hospitals providing care for rarer conditions or smaller specialties can struggle to find enough specialist staff to provide a reliable service with the full range of care 24 hours a day. Simply employing more specialists – even if they were available - would not be the ideal option either because there is not enough work to ensure they will be busy enough to maintain and develop their skills. Some of the services in the South East Midlands are vulnerable to individual doctors leaving, going on holiday or being off sick. This risk could be reduced if hospitals worked together more closely, a national example of this is the Primary Percutaneous Coronary Intervention (PPCI) in Greater Manchester (see box below). [5]

Hospitals working together

Services need to have a certain number of consultants in order to be able to support access to the service in the night time as well as in the day time. Some services are only able to run within the working day or in the week days as there are not enough doctors to cover the services safely overnight or at weekends and therefore patients may need to travel to a different hospital to get the right care out of hours. These arrangements can be confusing and are not the optimum way to deliver care. If hospitals are able to work together to share their resources both their clinical teams and consultants as well as their beds, equipment and finances then they are able to deliver care to patients in a safer and more convenient way both in and out of hours.

This has been successfully achieved in Greater Manchester with the Primary Percutaneous Coronary Intervention rota which covers the fourteen hospitals across the Greater Manchester area. The service is delivered from two sites, Central Manchester Foundation Trust and University Hospitals South Manchester, but the rota is staffed by consultants from across the other hospitals. This is a 24 hours a day, 7 days a week service. There is a sharing of tariff across the organisations to enable the service to operate across all areas.

5. Greater Manchester and Cheshire Cardiac and Stroke Network PPCI factsheet http://www.gmccsn.nhs.uk/cmsupload/E2_Articles-_PPCI.pdf

There are some services that hospitals may want to consider delivering in an alternative model to the traditional inpatient hospital setting. A good example of this is inpatient children's services, which are proving difficult to sustain in many parts of the country. Where new services which are more flexible and adaptable have been introduced they have been a great success with both the public and professions and the learning from these new services could be considered in the South East Midlands.

Innovative models for paediatric care

In Somerset an Integrated Therapy Service for Children and Young People brings together a range of services and creates an easy route for children and their parents to gain access to the services they need whilst keeping children out of hospital. [6]

Another example of innovation is a range of five projects undertaken in the East of England, one of which resulted in a 45% reduction in paediatric attendance at the West Suffolk Hospital, following GP consultation by phone with a paediatrician prior to making a decision regarding attendance at hospital. [7]

Applying these sorts of approaches locally could mean that in some cases specialists and their teams could work on several different sites or that some people would need to travel further to be treated by a specialist team. However, in the main this would be for complex cases allowing the patients the best chance of a good outcomes. The aim is to design services which improve care locally and keep the numbers of people needing to travel further to a minimum. In children's services, for example, elsewhere it has proved possible to provide a wide range of treatments for children locally with only very specialist care brought together in fewer sites.

Ambulance services have an increasingly important role to play. Ambulance services in the UK now have a very advanced ability to identify which patients need specialist units and who can be treated by more general services. This means that even where specialist centres have been established many patients can continue to be treated locally without having to be taken longer distances.

New technology and ways of working also offer the opportunity to provide many hospital services in local settings. Services such as outpatients, ultrasound, blood tests and a wide range of treatments that used to require a trip to hospital can be provided in a range of local settings – particularly if GP surgeries work together to support this approach. In cases where patients need a long convalescence or rehabilitation it will be important to ensure that patients can be cared for nearer to their homes so that their relatives are able to visit them – technology and skilled nurses based in the community can help with this. Although there are examples of good practice in parts of the South East Midlands we believe there is more to be done to gain the full benefits of new technologies.

We know that there is much more we can do to improve the management of many long term conditions and the quality of people's lives. For example, at the moment too few people receive all the elements of care that are known to reduce life changing complications and premature death. The following graph shows that, along with the rest of the country, only half of our population with diabetes receive all nine of the key criteria for the best practice management of their condition.

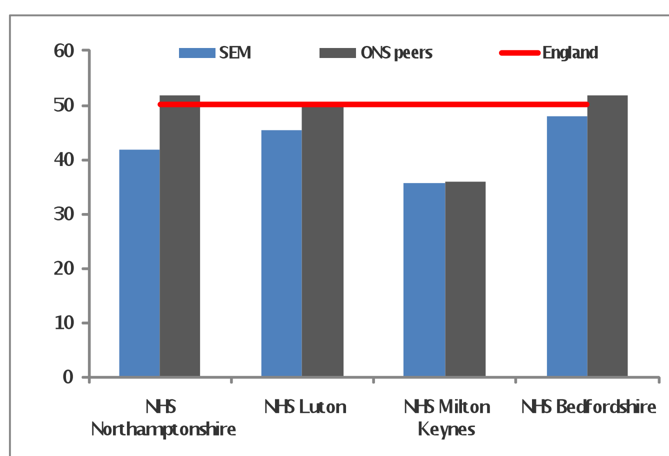
6. Somerset Partnership NHS Foundation Trust http://www.somerset.nhs.uk/integratedtherapies/Professionals.htm

7. Strategic Network for Child Health and Well-Being - regional network for paediatric ambulatory Care/Maynard Debbie. 2011

Evidence shows that our population does less well in this than other parts of the country with similar demographic characteristics.

Diabetes care

Percentage of diabetics receiving all 9 key care processes for the management of diabetes



[8]

Source: NDA Diabetes audit and intergrated performancne Monitoring Return Q1 2011/12

The way that diabetic care has changed over the years demonstrates how services can be more convenient, patients can be more in control of their condition and outcomes can be improved. Much of this necessary care can now be managed by people themselves with help from their GP and specialist staff closer to where they live and outside of hospital. Again technology, some of it quite simple, can make a big difference and reduce the need for patients to be admitted to hospital as an emergency. Our aim is a more joined up model of care that brings specialists, general practitioners, specialist nurses and other clinical experts together into an integrated service, puts new technologies in local clinics and people's homes and gives them access to specialist advice at the end of telephone.

People admitted to hospital usually want to return home at the first opportunity. Hospitals are well designed for managing the care of people who are acutely ill but are much less suitable for rehabilitation or convalescence. Better integration between the hospital, community services and social care will offer the chance to provide a more appropriate service by providing more care locally or in people's own homes. Elsewhere simple things, such as better planning of care prior to admission and the introduction of the enhanced recovery programme for surgery, has significantly reduced the length of stay and allowed people to make proper plans for coming home.

8. NDA Diabetes audit and intergrated performancne Monitoring Return Q1 2011/12

Enhanced recovery [9]

The national enhanced recovery programme is focused on improving patient outcomes and speeding up people's recovery after surgery. This results in people being actively involved in their care from before admission to hospital all the way through their hospital stay allowing everyone to plan better discharge and the post discharge care enhanced recovery.

Outcomes of the enhanced recovery programme:

- better outcomes and patients can return home more quickly
- greatly reduced lengths of hospital stay
- increased numbers of patients being treated or reduced levels of resources required
- better staffing environment (multi-professional approach)

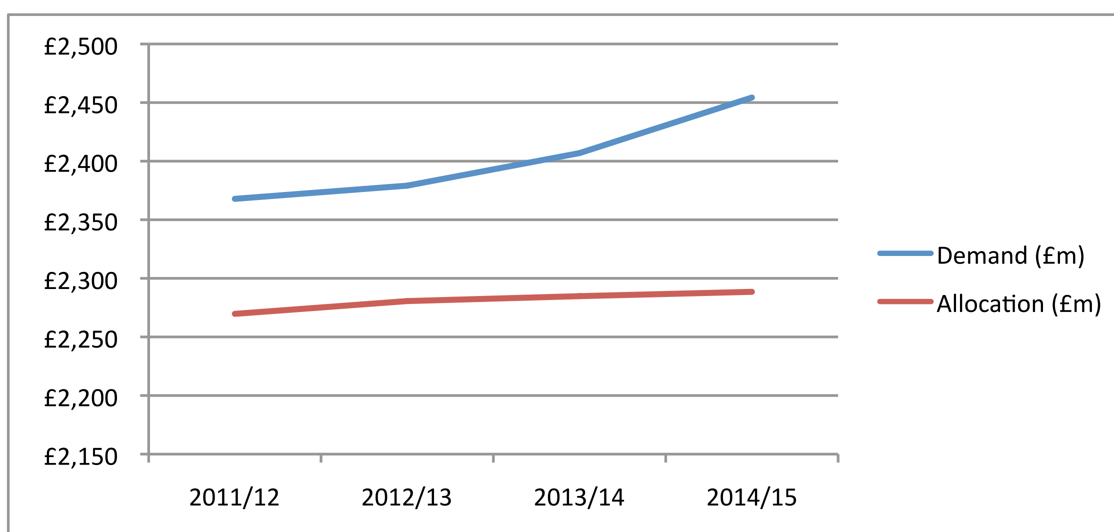
Torbay Hospital built on their existing integrated care service and introduced enhanced recovery for bowel surgery. This involved a strong partnership between the Consultant, Named Nurse, the patient and their family.   More time was spent preparing patients for surgery and planning for their discharge at the beginning of the process. In addition improving the post operative care patients received led to patients being able to go home more quickly.

9. Enhanced Recovery Programme, Quality and Service Improvement Tools, NHS Institute for Improvement and Innovation 2008 http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/enhanced_recovery_programme.html

3. Growing financial pressures

Although the finances of the NHS are under major pressure, improving the quality of care delivered remains the prime reason behind our ambition to change services. However, it is essential to address the reality of the economic and financial challenges that the health service faces now and in the future. This will require us to work more efficiently. Although the government has promised to protect the health budget in real terms, it will not rise at a rate that matches the rising demands that demographic and other changes will place on the service. The status quo for service delivery will not be an option as the increasing pressure of the growing and ageing population and technological advances means that current service configurations will become unaffordable. The Department of Health has set the NHS a national challenge to improve its efficiency by up to 20% by 2014/15. It would be prudent to plan as though continued significant improvements in efficiency and productivity will be required year on year for a decade or more.

Size of the financial gap in the South East Midlands between 2011/12 to 2014/15



source: local PCT QIPP plans 2012

Conclusion

It is very clear that the pressures of increasing demand on health services as a result of a growing and ageing population, the ever higher expectations of our patients and the scarcity of resources means that we need to change and improve across all our services. Without change we will be unable to continue to deliver healthcare at the current level of quality and outcome. In order to grasp the many opportunities that exist to improve health services and provide better outcomes and improved experience for patients we must work together across the health economy to organise services in different and more innovative ways. In many cases, these new approaches will not only improve quality and bring services closer to people's homes, but also make services more efficient, so we can do more with the money we have and build the basis for a sustainable health care system for our population in the future.

This is a very demanding task. Simply reinvesting in doing more of the same will not work. Increasing quality, ensuring our hospitals are fit to face a challenging future and making big efficiency gains will require significant change. The challenge is to make those changes in a way that improves outcomes for patients and the local population. We believe that we can do this if we work together.