“SEIZING THE FUTURE”

County Durham and Darlington NHS Foundation Trust

Report by Professor KGMM Alberti on behalf of the National Clinical Advisory Team (NCAT)

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1.0 Preamble

Seizing the Future is a 5 year strategy being developed by County Durham and Darlington NHS Foundation Trust in response to perceived needs of the population, advances in healthcare and the Next Stage Review. It encompasses the three main hospitals: Bishop Auckland General Hospital, Darlington Memorial Hospital and University Hospital of North Durham as well as Shotley Bridge Community Hospital and Chester-le-Street Community Hospital. The Trust serves a widely dispersed population of approximately 500,000 people over an area of 3000 sq km. Each acute hospital serves a relatively small population. The population includes both urban centres and sparsely populated relatively remote rural areas as well as pockets of intense deprivation.

In 2002 Lord Darzi reported on acute services in County Durham and suggested a series of changes which allowed most services to continue in all three main hospitals, although acute surgery was withdrawn from Bishop Auckland and some other services were curtailed. A single acute trust was formed which helped coordination. He suggested that acute medicine should remain but should link with the other sites. There should also be a new elective centre for surgery, a midwifery-led maternity unit and a 9 am to 9 pm children's assessment unit. He stated that the main challenges were to: maintain access to services for all its communities, improve patient choice, and to make sure that services are sustainable and will thrive in the long term.

These challenges remain but the context has changed. Since the changes were implemented following the 2002 report there have been major changes in policy as well as in medical care. These include the two major white papers: *Our Health, Our Care, Our Say* in 2006 and *High Quality Care for All*. In the former the general principles of more care in the community and care as close to home as *safely* possible were established. In *High Quality Care for All* there was particular emphasis on safe, high quality 24/7 emergency care with patients travelling further if this was required- at the same time as improving local care wherever possible. There was also major emphasis on both clinical leadership and local ownership. There was in addition commitment that changes would be for the benefit of patients, would be clinically led and would involve patients, carers and the public. There has also been

the recognition that for some conditions, such as stroke, myocardial infarction, major trauma and specialist surgery it will no longer be possible to provide up to date optimal care in every hospital and that networks of care with specialist services will be required.

In the light of this the Trust has re-examined services across its 3 major sites. It was obvious that all services could not safely be provided everywhere and that resources and senior staff were spread too thinly. A range of options were developed by the Trust under the banner of *Seizing the Future*. The Northeast SHA then requested clinical review by NCAT to provide clinical quality assurance of the suggested reconfiguration of hospital services, particularly those provided at Bishop Auckland. Professor KGMM Alberti , supported by Mr Patrick Garner, visited the Trust at the Darlington and Bishop Auckland sites on the 31st July and 1st August. They met a range of senior staff and clinicians (see Appendix 1) to discuss the clinical aspects of the plans. They also met members of the Gateway team. Professor Alberti was familiar with all 3 sites having visited them in the past. The following report is based on the discussions and written material provided by the Trust.

2.0 The Current Situation

At present Darlington Memorial Hospital (DMH) and the University Hospital of North Durham (UHND) provide most acute and elective secondary care services. Both have full A & E services, acute medicine, acute surgery, paediatrics, obstetrics and support services. Some tertiary speciality services are provided elsewhere i.e. South Tees and Newcastle. Vascular surgery functions as a clinical network with Gateshead. Bishop Auckland (BAGH) takes acute medicine but not acute surgery and provides limited paediatric services during the day with occasional paediatric cases resident overnight. There is a critical care unit but functioning at best at level 2 primarily because of staffing difficulties. 24/7 diagnostic services are patchy. Consultant cover for A & E is provided from Darlington with day to day cover provided by an experienced Associate Specialist. There are 4 A & E Consultants in DMH. At present there is a primary care led urgent care centre in addition to A & E. BAGH sees about 30000 patients a year of whom about 15% are admitted (10-15 per day). There is a 21 bed medical assessment unit but this regularly overflows.

DMH sees 51000 patients in A & E and there are about 25-30 admissions per day. UHND has similar total attendances at A & E but more admissions.

A major problem is that with no specialty in Bishop Auckland can a 24/7 service provided by an experienced clinician be guaranteed? There are 6 physicians on the acute rota and inadequate numbers of SpRs. The latter situation will get worse with the implementation of the EWTD in 2009. Consultant cover for acute specialties is also thin at DMH with 9 physicians taking part in the acute medicine rota, and it is only due to the commitment of staff at both sites that reasonable services are being maintained. Staffing is better at UHND although they are still short of the 8 Emergency Physicians (4 currently in post) to staff A &E which is recommended by the College of Emergency Medicine. There is only one committed acute physician at BAGH and 2 at DMH. Throughout the Trust there are still too many single handed consultants in subspecialties.

The main problems are therefore Acute Medicine, Paediatrics, A & E and Critical Care. The Academy of Medical Royal Colleges has stated that unselected acute medicine admissions should not occur in the absence of acute surgery and a fully functioning level 3 critical care unit. On the other hand selected medical admissions could take place but this still requires a full rota of consultant physicians, a reliable level 2 critical care unit, 24/7 diagnostic services and a senior surgical opinion immediately accessible.

In paediatrics there are currently about 1500 admissions a year at BAGH, 3000 at DMH and 4000 at UHND. There are 4 consultants at BAGH and 5 at each of the other two acute hospitals. One consultant has recently retired at BAGH and another will go in the near future. They have been unable to recruit replacements. There is no middle grade out of hours cover.

Critical care is in an even worse state. The Trust has had difficulty recruiting anaesthetists to provide out of hours cover at BAGH. The most ill patients are now being transferred to the other two sites, which is obviously unsatisfactory.

This should also be put in the context of High Quality Care for All and current trends in specialist care. It is more and more being accepted- and expected by the public- that if they are acutely ill with a serious condition that they will be seen quickly by an

experienced clinician. For some conditions such as stroke, heart attacks and major trauma highly skilled teams with appropriate support are needed to provide round the clock immediate care- and it is suggested that these services should be concentrated on a smaller number of sites. Acute myocardial infarctions are already tending to go to South Tees for primary angioplasty. Surgery is also becoming more specialised and properly staffed sub-specialty teams are needed. All of this means that we cannot continue to provide all services everywhere and that thinly staffed hospitals will have to restrict activities to those which can be done safely. This does NOT mean hospital closure but means focusing on more outpatient and planned care. In the meantime more and better care is required in the community.

Obviously the current situation in the Trust cannot continue. Acute services are unsustainable and can no longer continue meet modern needs in terms of safety and quality. No change is not an option.

3.0 Seizing the Future proposals

The Trust has gone through an extensive process of discussion and consultation including close working with the two PCTs. A wide range of stakeholders were involved as well as clinicians and members of the Trust board.

Forty nine options were produced. These were subjected to “hurdle” criteria which included: clinical safety and standards, efficiency/affordability, do-ability. Benefit criteria were also used which included: integrated models of care and patient focus, access, workforce/staffing, and sustainability.

In the end 3 options have been proposed. The first of these is “no change” and for the reasons enumerated above is not a realistic option and would not provide safe high quality care for the population served. The second and third options both envisaged 2 acute sites with the third site being a “plus” site. In option B this would involve a minor injuries unit (8am-8pm), primary care led out of hours and urgent care centre, step-down and intermediate care for local residents, all day-case surgical activity, a midwife-led maternity unit, a cataract centre, primary lower limb arthroplasty, a colorectal screening centre & a full range of outpatient services and diagnostics. Option C would have the same together with additional capacity for

assessing and managing urgent medical and paediatric patients, and step-down and rehabilitation facilities. This is the preferred option.

Modelling of costs, capacity and transport have been performed. The least costly is option B which is slightly less expensive than option C. Capital investment will be required whichever option is chosen.

4.0 Critique of the proposals

The options have been examined with particular attention to access and convenience, and clinical criteria: safety, quality, timeliness and sustainability.

Overall option C is favoured. This provides the better service for local residents, good use of existing real estate and least disturbance of services. It seems sensible for BAGH to become the “plus” site. It has the least number of emergency admissions, already does not have emergency surgery, cannot sustain critical care and paediatric services are fragile. However much can be done on the Bishop Auckland site and in the end more local people will receive care closer to home than at present.

4.1 Urgent and emergency care

Currently all 3 sites have moderately busy A & E departments. Obvious surgical cases and major trauma are diverted away from BAGH. BAGH depends on an experienced Associate Specialist with consultant support from DMH where there 4 consultants. Overall consultant numbers in Emergency Medicine are low compared with national recommendations & a long term plan to increase numbers is required so that in the medium term there are at least 6 consultants on each of the two acute sites. The plan to direct all major emergencies likely to require admission to the 2 acute sites is sensible. Two groups of patients will be affected particularly: those with strokes & the elderly patients with multiple co-morbidities. BAGH has run an excellent stroke service since the last reorganisation with a highly committed multidisciplinary team. However with the recent emphasis on stroke with national guidelines and NICE recommendations the service will not be sustainable in isolation for the hyper-acute phase due to lack of support services, critical care and 24/7

access to other specialists. Second phase care, i.e. rehabilitation, will be feasible and indeed desirable for local inhabitants. Not all elderly people will have to travel to the other acute hospitals. This is discussed further below.

As proposed in both option B & option C services for less serious illness and injury should continue to be provided at BAGH. On current numbers this would mean 22000 of the 30000 present attendees at BAGH would continue to be seen there. At present the A & E department and the urgent care centre are separate entities. It is strongly recommended that these should be merged incorporating Out of Hours GP services and employing people with the right skills and competence to deal with all less serious illness and injuries. This would then allow an appropriate service 24/7 on 7 days per week. Some diagnostic facilities such as x-rays would also be required also on a 24/7 basis. Furthermore a strategy should be developed for the whole area to ensure that local services are available to deal with so-called minor emergencies. This should incorporate the front door of the two acute sites as well as Shotley Bridge, Chester-le-Street, and the other community hospitals where appropriate. This should function as a network with a consistent approach to patients and appropriate provision of diagnostics. This together with improved care in the community and extended access to GPs should lessen the numbers of people requiring care at the main sites.

4.2 Acute medicine

At present acute medicine depends on a small number of physicians at both BAGH and DMH with the prospect of progressively less specialist registrar support. As stated above the service at BAGH is not sustainable as it stands. Both options B and C are feasible solutions. It will be important that capacity is increased at both UHND and DMH to account for the extra diverted workload. In particular a doubling of the size of the Medical assessment unit (MAU) at DMH should be anticipated. There are also only 2 acute physicians at DMH, employed as such, a third should be appointed as a matter of urgency. The physicians at BAGH currently participating in the take rota should join the acute rota at DMH which would provide a sustainable critical mass of experienced physicians.

We also support the proposal in option C that there should be a daytime urgent care assessment service for medical patients after major acute services are withdrawn -

but with some modifications. This is currently proposed as a 5 day service staffed by SpRs. It would have more impact and be safer and of higher quality if staffed by Consultants or at the very least final year SpRs. It should also focus particularly on older people. These form on average two thirds of major medical emergency cases. Many require assessment and implementation of a treatment plan rather than admission. An experienced consultant is more likely than a less experienced junior doctor not to admit such patients. It would particularly useful if most of this service could be provided by care of the elderly consultants. This service should prevent many older people from travelling longer distances with the attendant difficulties for families.

4.3 Critical care

The current position is unsustainable with one consultant and trust grades running the service at BAGH. We support the proposal in option C to remove critical care services from BAGH, but would add the caveat that workload and staffing should be carefully examined, and expanded if necessary, if the two site acute model is implemented.

4.4 Paediatrics

The preferred option C recommends that inpatient paediatrics be removed from the BAGH site. At the moment BAGH sees acutely ill children during the day and those who are stable remain overnight. However more children now go to the other sites and the BAGH facility is underused. Junior doctor cover is problematic. There are also likely to be consultant retirements in the near future. The proposal to have admitting units only at UHND and DMH is sensible. A facility will be retained at BAGH for GP referred consultant delivered urgent outpatient appointments. We would support these proposals, although we would add that the staff of the Urgent Care Centre should be trained to assess paediatric cases. The change in the service must also be indicated very clearly to the public with appropriate instructions given to the ambulance service.

4.5 Other services at BAGH

he preferred option C envisages a range of other services continuing or being introduced at BAGH. We feel it is vital that these are highlighted in any consultation

document, emphasizing the viability and continued provision of a wide range of services for the local population- with the reassurance that these will be safe and of high quality.

1. Outpatients and diagnostics. The range of outpatient services should be spelled out. If possible these should be based on a Trust wide and PCT assessment of the needs of the local population and would represent if anything an expansion of current services. This would be in line with *High Quality Care for All* and the intent to bring services closer to people's homes.

2. Rehabilitation. The Trust proposes to establish BAGH as a trust-wide centre of excellence for rehabilitation. Many skills are already there from the stroke team and other services. We support this but have some concerns about travel times from other parts of the area & thought should be given to peripatetic services being available following an intensive period at BAGH.

3. Step down services. This is also an important proposal for those local inhabitants who have received intensive or specialist treatment elsewhere & is fully supported.

4. Intermediate care. Again this will provide an important resource for local people. It should be allied with GP beds which will prevent particularly older people being admitted to remote sites. We are less certain about using this for intermediate care on a trust-wide basis as this could be highly inconvenient for people from more remote parts of the district. We suggest careful examination of other sites such as Shotley Bridge and Chester-le-Street although cost-effectiveness could be a problem.

5. Day case surgery. The Trust suggests that all day case surgery for the Trust be carried out at BAGH. We support this but careful consideration will have to be given to the increased transport required.

6. Other services. We see no objections to the proposals.

7. Overall the proposed uses of BAGH under option C look acceptable.

5.0 General Comments

5.1 Travel

Information from the Trust suggests that the maximum impact on private travel time would be 30 minutes if the proposed changes go ahead. The Trust acknowledges that further detailed analysis will be required to support the consultation. The impact of the changes on the ambulance service will also need to be explored further with patients travelling further for specialist services. We discussed this with representatives of NEAS who are aware of the changes but detailed modelling and costing will need to be carried out. Discussions with local transport companies will also be necessary.

5.2 Communication

More and better interaction and communication with the public is vital. Members of the publicly elected Governing council participated fully in developing the plans. However, it is not certain how much other members of the general public have been involved so far. A detailed plan should be developed to accompany the consultation.

5.3 Investment at DMH

If DMH is to become one of the two acute sites, which is likely due both to its surrounding catchment area and for the other reasons stated above, then significant investment will be required. This applies both to the physical infrastructure and to staffing. It is assumed that consultants from BAGH will work closely with those of DMH but there will still be a significant shortfall in consultant numbers to provide the sort of consultant delivered services anticipated in *High Quality Care for All.* The same applies to nurses and other health care professionals. Information on both physical changes at DMH and workforce plans should be contained in the consultation documents.

5.4 Consultant workforce

Considerable strides have been made in the Trust having a unified consultant workforce since the Trust was formed 6 years ago. If the proposed plans are accepted then it will be even more important for the medical workforce to have a Trust-wide approach & to be prepared to play a much more peripatetic role. Without

this the new plans and the developments expected from *High Quality Care for All* will be much more difficult to implement.

6.0 Conclusion and recommendations

The following section summarises the recommendations of the NCAT review of the *Seizing the Future* proposals:

1. The NCAT review team agrees that NO CHANGE is not an option.
2. The team broadly agrees with the recommendations being proposed under option C, i.e. that there should be two full acute sites and a "plus" site. It seems inevitable and sensible that BAGH should be the "plus" site.
3. Some modifications and refinements of the plans for the BAGH site are suggested. These are:
    a) The Urgent Care Centre at BAGH should be a fully integrated primary/secondary care service incorporating the GP Out of Hours service. It should be open 7 days a week.
    b) The proposed Medical Assessment Centre should focus on the needs of older people; be available for GP referrals; be open 7 days a week for 10 hours per day on weekdays and at least 6 hours/day at week-ends; and be staffed by experienced clinicians i.e. consultants or final year Specialist registrars.
    c) There should be an appointment based urgent paediatric service.
    d) Outpatient services should be expanded to meet the needs of the local population and follow-up appointments for local people after admission to the acute sites be organised at BAGH wherever possible.
    e) Plans should include a GP ward.

Other suggestions and recommendations include:

4) The numbers of local people to be seen at BAGH in the future compared with now should be estimated as well as the numbers who will have to travel to one of the other sites allowing for the fact that some major emergencies will be assessed at BAGH and returned to the community without needing admission.

5) The use of community hospitals should be reviewed by the Trust and the 2 PCTs with a view to expanding local services. In particular better use for consultant delivered outpatient clinics should be considered as well as forming a network of Urgent Care Centres together with the three main hospitals. A detailed analysis of how they will be used for intermediate care and step down care should also be performed.

6) An urgent care advisory board should be established to ensure smooth pathways of care and to plan optimal services. This should include social services, the ambulance service, pharmacies, other providers of services as well as the PCTs and the hospital Trust. Similarly and older people's board could usefully be established to plan for older people's care and needs across the whole system.

7) More detailed analysis of transport needs should be carried out & further discussions held with NEAS and local transport companies.

8) A detailed workforce plan should be included in the consultation document including short, intermediate and long-term needs.

9) A clear account of how the extra emergency workload will be coped with at UHND and DMH should be included, together with the extra investment required, particularly at DMH.

10) The communication strategy for consultation should include clear plans on greater public involvement.

Appendix 1. NCAT Visit Timetable

Thursday 31 July 08

Time	Venue	Attending	Role/Responsibility
10:30 - 12:00	Woodlands Meeting Room,	Stephen Eames	Chief Executive
	Darlington Memorial Hospital	Bob Aitken	Medical Director
		Laura Robson	Director of Nursing
12:00 - 13:00	"	Bob Aitken	Medical Director
	Working lunch with Bob Aitken		
13:30 - 14:00	(drive to BAGH - Patrick Garner)		
14:00 - 15:00	Tour of BAGH site	Glenis Curry	Associate Director of Nursing
15:00 - 15:30	Interview Room 1, Education	Neil Munro	Divisional Clinical Director, Medicine
	Centre, BAGH		
15:30 - 16:00			
16:00 - 16:30	"	Andrew Cottrell	Consultant Paediatrician
16:30 - 17:00	"	Ola Afolabi	Lead A&E Consultant
17:00 - 17:30	"	Richard Prescott	Lead Geriatrician
17:30 - 18:00	"	Stuart Findlay	Lead GP responsible for out of hours services (Chair of Practice-based
			Commissioning Cluster Group)

Friday 01 August 08

Time	Venue	Attending	Role/Responsibility
10:30 - 11:00	Woodlands Meeting Room,	Pat Taylor	Deputy Chief Executive, County Durham PCT
	Darlington Memorial Hospital		
11:00 - 11:30	"	Dr Katherine Noble	Clinical Champion for Acute Care (= local PEC Chair), County Durham PCT
11:30 - 12:00	"	Les Mathias	Ops Manager (Durham Division) North East Ambulance Service
		Elaine Bennington	Ops Manager (Tees Division) North East Ambulance Service
12:00 - 12:30	"	Gateway Review Team	to give feedback further to their interviews with OSC reps
12:30 - 13:00	"	Kath Toward	Local patient group representative
13:00 - 13:30	" Lunch		
13:30 - 14:00	"	John Preston	PBC Chair for Durham and Chester-le-Street
14:00 - 14:30	"	Bob Aitken	*Feedback*