ITEM NO. 3

Northumberland, Tyne and Wear NHS
Strategic Health Authority

County Durham and Darlington Acute Hospitals NHS Trust

Haematology and Chemotherapy Services Review (update) 2006

A report
by
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Summary

In January 2005 the directorate of medicine and elderly care for Durham Memorial Hospital and Bishop Auckland General Hospital produced a strategic review of haematology and chemotherapy services in south Durham, concluding that a centralised in-patient service was urgent, and furthermore a single centralised trust wide centralisation (to incorporate Durham) should be considered. A consensus on the way forward was not agreed.

After preliminary discussions in late 2005, at the beginning of 2006, as an independent process, I was asked by the Trust's medical director to update the review with terms of reference that included making clear recommendations to the board for the future development of:

- A single trust wide haematology service
- The future of inpatient haematology & chemotherapy services.

I have taken into account all of the preceding work, including the Darzi review and two cancer networks' "improving outcomes guidance" for haematology, the views of patients and local public representatives, trust staff, local commissioners, 'visiting' staff (specifically consultant oncologists from South Tees Trust cancer services) and County Durham and Tees Valley SHA. I have visited all three sites and considered very carefully all of the (conflicting) views expressed to me.

I conclude that:

1. There should be a single haematology service for the trust
2. There should be a centralisation of inpatient services, immediately incorporating the Darlington and Bishop Auckland services at Bishop Aukland, and designed to extend to include Durham services.

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Introduction

1. In January 2005 the directorate of medicine and elderly care for Durham Memorial Hospital (DMH) and Bishop Auckland General Hospital (BAGH) produced a strategic review of haematology and chemotherapy services in south Durham. It represented a follow-up to a previous review by the former South Durham NHS Health Care Trust in 2001 – itself following a recommendation made in a 1999 review of clinical services that suggested the possible centralisation of haematology services.[2]

2. Professor Darzi's review "Access, Choice and Sustainability" noted the option of centralisation at BAGH but speculated that a standards driven approach may make DMH a better option – because of the potential difficulties in meeting all modern standards and the complex clinical inter-dependencies potentially desirable for sick cancer patients not being all available at BAGH (but actually not all necessarily available at DMH either[3])

3. The local cancer network (the Cancer Care Alliance) had in 2002 thought centralisation at DMH the right approach but their own plans were later overtaken by newer requirements of the haematological malignancies "improving outcomes guidance" which would mean some of the anticipated caseload being treated in South Tees Hospital in any event. It is also worth noting that this long period of discussion about specific haematology inpatient treatment (from 1999 – 2005) coincided with a period of significant growth in out-patient and in-patient chemotherapy for many non-haematology cancers re-locating from the cancer centre in Middlesbrough to DMH and BAGH.

4. In 2001 there was agreement that inpatient services in south Durham should centralise and day case treatment should continue at both sites. It is beyond this review to speculate why this never happened except to note that it appears neither the two single-handed consultant haematologists working at the two sites respectively at that time nor the management could agree where to base the new unit. The 2005 review again concluded that a centralised in-patient service was urgent, and furthermore a single trust wide centralisation (to incorporate Durham) should be considered. A consensus on the way forward has again not been agreed – or where it has been agreed, has not been implemented.

The case for change

5. Listening to patients who have benefited from and show great loyalty to both DMH and BAGH inpatient services over this period – and of course are not aware that they have suffered any disadvantage from the lack of

[2] Royal College of Physicians review suggested centralisation at Bishop Auckland

[3] This is a small hospital/large hospital 'boundary' issue. If every possible standard was always required for treating all patients then all complex medical technology would have to be centralised in huge regional hospitals. The majority of patients can, in fact, be safely treated in smaller well organised units.

implementation of the recommendations over the years - it is worth asking again why centralisation is repeatedly suggested and even considered urgent.

6. There are a number of key so caller "drivers" for change:
    a. The need to meet national standards, based on evidence that meeting those standards improves outcomes for patients
    b. One of those standards is that an inpatient unit requires a minimum of 3 consultants providing 24 hour cover[4]
    c. There are obvious potential and very practical problems with the current service where a single-handed consultant is responsible at both DMH and BAGH (although it is the nature of the services provided that the highly expert nursing staff provide much of what is required over any 24 hour period, supported by local consultants "in-hours" and site specific resident medical staff and a trust wide rota of the four available haematologists "out-of-hours".)
    d. The Trust is in a national competition to recruit new consultant staff and cannot and will not attract to vacancy posts (or replacements when they are required – as they inevitably will be) in the current configuration.[5]
    e. The Trust is increasingly vulnerable – should there be any accident or untoward incident – to criticism and litigation as it has not implemented any of the "long-standing and often" recommended changes in line with modern practice and standards.

7. Many if not all of the consultant staff and nursing staff involved with providing services (as well as many supporting services, particularly pharmacy) are suffering from "planning blight". Uncertainty has become potentially worse than the changes previously disagreed with or even resisted and clear direction for the future is now urgently sought.

The case against change

8. Both the DMH and BAGH units (wards 42 and 3 respectively) attract huge support from their staff and patients. Listening very carefully to the discussions and comments, it seems to be a case where the need for change is understood, but it is preferred that it should be the "other unit" that changes (i.e. "closes") and "not our ward".

9. Of particular concern to patients is the "double whammy" of possibly having to travel further when sick and in need of admission, together with the possibility of being admitted to a ward in a different location to the place where regular day-case treatment has been received and the "staff know me".

[4] Improving Outcomes Guidance for Haematological Cancers
[5] New consultants will opt for working in bigger teams with less onerous out-of-hours duties and more focussed opportunities to pursue special interests and sub-specialty expertise.

Durham services and Trust wide considerations

10. The haematology services in the University Hospital of North Durham (UHND) have only relatively recently been drawn into the on-going review of what should happen in the south of the county. Partly this is historical (previously part of a different trust), partly it is because of different wider networks (part of the Northern Cancer Network relating to colleagues in Newcastle, not the Cancer Care Alliance and James Cook hospital) and partly it is because the partnership of two consultants at the unit meant there was not the pressing "single-handed consultant" issue.

11. Nonetheless the issues and drivers for change are very much the same. The outcomes guidance and standards apply. A vacant third post has not been successfully filled – for the very reasons discussed above (see footnote 5). Patients are not looked after on a dedicated unit (as indeed they are not at BAGH at present) and the current network plans foresee complex cases being managed in Newcastle or Sunderland, not UHND.

12. The 2005 review concluded that centralisation at BAGH included the possibility (a business case based on available space and cost) of incorporating the Durham based inpatient cases – if that was considered desirable – and thus this previously unasked question drew the UHND services into the longstanding unresolved south Durham controversy. Whilst DMH (Ward 42) was large enough to accommodate the BAGH cases, only BAGH (in a new dedicated unit adjacent to the planned new day-case unit) was thought large enough to centralise all three inpatient services.

13. The 4 consultant haematologists across the trust (two in Durham and one each in DMH and BAGH) have relatively recently started cooperating more closely in a shared "out-of-hours" rota to support all three inpatient units.

Terms of Reference and process

14. To start in early 2006 and conclude in May, I agreed with the Trust Medical director to bring to the Trust Board clear recommendations for the future development of:
    a) a single trust wide haematology service, serving all three sites, integrated with all other pathology services (and taking into account any planned developments of pathology) and capable of meeting the needs of all clinical services;
    b) the future of inpatient haematology services (and by implication inpatient chemotherapy and treatment/support services for other cancers), including recommending either:
        - the centralisation of southern services at DMH or BAGH; or
        - further work to establish a single inpatient service for the whole trust

        Furthermore, the recommendation should address the key issues of:

- keeping the 'spirit of Darzi' i.e. the long term viability of all three sites;
- making haematology in the Trust as attractive as possible to assist future key staff recruitment and retention;
- meeting the requirements of the Improving Outcomes Guidance for haematology from both relevant cancer networks;
- services should be delivered within the projected financial envelope.

15. A considerable number of documents were studied and taken into account in this review update, including:
    a) The January 2005 Strategic Review. This work, by the directorate of medicine at DMH and BAGH, has not been repeated. The options reviewed were based on current services and activity, costs and risks.
    b) The September 2001 Strategic Review by South Durham Healthcare NHS Trust
    c) Improving Outcomes Guidance for Haematological Malignancies, and the accompanying standards, and the current plans to meet that guidance for both cancer networks.
    d) Relevant board papers, briefings, meetings minutes and email correspondence
    e) Written submissions from patients and consultant staff
    f) A patient survey (65% response rate from 632 questionnaires)

16. Two round table discussions took place with representatives of staff from all three units, at the start of the review and after the public meetings.

17. A site visit to all three units was conducted.

18. A "listening" event – an opportunity to hear the views of patients, the public and local GPs, unit staff and Primary Care Trust (the service commissioners) representatives – also was conducted at all three sites.

19. I have reached my conclusions as described below and the recommendations are made personally to the board.

A single trust wide haematology service

20. A single trust wide haematology service, serving all three sites and integrated with all other pathology services is clearly necessary. Haematology is a very wide discipline with extensive laboratory services as well as the more visible clinical services.

21. The historical development of the clinical services in three different sites (and the delivery on four - the UHND service includes day-case chemotherapy at Shotley Bridge) with the north/south divide between cancer networks, together with the geographical challenge of "single-service / multiple sites" that faces all services in the Trust, all contribute to

the difficulties of feeling like and operating as a single service. However, the workforce, safety, business continuity and – ultimately – quality agendas all suggest forcibly that haematology in the Trust should be designed and configured as one service.

22. The laboratory services are closely integrated with other pathology services (like biochemistry) and the multiple site working is a challenge under constant review. The quality and efficiency drivers for these services are part of a wider multiple trust challenge to "modernise" pathology services across north east England. The Trust needs a strong haematology voice as part of that process.

23. The consultants are already cooperating with an "on-call" rota across the trust and clearly could together develop all the services further. They are trying to attract new colleagues to the team and should be able to further develop their complementary special interests.

One service, more than one site

24. Being "one service" categorically does not mean that everything needs to be on only one site. The laboratory services are supporting all of the main hospital sites (and local GPs and other community services) and the haematology consultants work in partnership with all the specialties to look after patients (from providing transfusion services to support surgery and obstetrics to giving expert opinion on all blood conditions to all other consultants).

25. Day-case administration of chemotherapy (together with out-patient consultations, other day-case investigations and non-cancer blood treatments) is an essential component of all the local hospital services. Likely increased demand for these services – both numbers of patients and types of available treatments – mean that day-case units for chemotherapy should thrive and be continually developed in all the hospital sites.

26. The single service concept refers rather to the staff. The consultants, nurses, scientists, technicians and partnership colleagues like the pharmacists need to work as one. Learning and training together, developing services and standards compliance together, continuously improving the patient experience and so on. Whilst some aspects of this philosophy are already in place, I found that there is a more decisive vision for haematology in the Trust to be pursued and the management and consultants, senior nurses and laboratory chiefs must lead this. It is possible that the controversy over inpatient beds has held this team development back.

The future of inpatient haematology services

27. Taking the patient experience, safety and long term access to good services into account as the top priority, there should be a centralisation of inpatient services, immediately incorporating the Darlington and Bishop Auckland services. This is the overriding clinical need.

28. The site for the service development should be Bishop Auckland.

29. I have decided on this option (as against centralisation at DMH) based on a number of considerations, namely:
    a. The quality of the available space and the environment of both the potential new unit and of the hospital as a whole.
    b. The opportunity – at relatively low cost – to offer the Trust a dedicated single site configuration for all inpatients
    c. The need to support the strategic development of BAGH – haematology and chemotherapy have a good alignment with the general medicine and older peoples' services expertise that already exists there

30. I listened very carefully to the views of the visiting consultant oncologists who would have preferred the services to centralise at DMH. The majority of their arguments are about geography and patient choice, however, and I am not persuaded that they out-weigh other considerations.

31. They also, amongst others, made the important point that as there are more linked specialties based at DMH then there are clinical reasons why it should be preferred. Again I am not persuaded:
    a. If it were an absolute consideration, taken to its logical conclusion this argument would mean inpatients should actually centralise at South Tees and no-one believes this is appropriate.
    b. The vast majority of support needs that the inpatients may have beyond the specialist haematology/chemotherapy nursing and consultant haematologist services are available (and/or can be developed) at BAGH. (For example, general medicine and intensive care)

32. The DMH unit (Ward 42) has a very special place in the community because of the major local fund-raising that has gone into its development. Again I listened very carefully to the views of the fund raising committee, local Darlington patients and friends of the unit. DMH will of course continue to develop a day-case unit and if it stays in the same location the environment for delivering chemotherapy (which will be an increasing work-load in future years) can be hugely enhanced once the in-patient work is moved.

33. The question of how soon the UHND inpatients should also join the centralised south of county services at BAGH is less definite and I recommend that the new BAGH unit is nonetheless designed with this in mind. There are very good reasons:

a. Service resilience and standards: the new BAGH unit may mean the Trust can attract a third consultant to the team for the south of the county – but actually a service based on 4 consultants growing to six will be much more attractive
b. Safety: for many reasons including staff training & competency achievements, out of hours cover and consolidation of risk, a single unit in the Trust is a better option
c. Profile: the Trust is in an increasingly competitive and scrutinised climate and part of the objective of my recommendation is that the BAGH unit becomes an acknowledged regional centre of outstanding excellence – not just in clinical service provision, safety and outcomes – but in patient experience, reputation and the quality of the environment. The scope for everything from dedicated parking to world-class facilities is available at BAGH and no-where else in the Trust at a comparable cost.

34. There are risks with these recommendations and I have very carefully considered the following:
    a. Staff may not wish to transfer with the service and particularly expertise amongst specialist nurses is lost. The quality of the environment for the new unit may counter this, but the key issue is ensuring all haematology and chemotherapy staff – for both inpatients and day-case treatment (at whichever site) - feel part of the same team. Indeed, regular rotation around the sites for at least part of the work of all staff would have learning, quality and safety benefits.
    b. Patients may choose alternatives to the trust as a whole rather than potentially have to travel to BAGH. This risk is easily mitigated by the support of consultants and nursing staff to the vision of the "single service – multiple sites". A positive attitude and good information from the very first consultation (wherever it is in the trust) combined with the spreading reputation and experience of the new unit will ensure the extra distances are seen as a reasonable price to pay for the quality of the care and the experience, should inpatient care ever be required[6].
    c. Oncologists visiting either the DMH site or the UHND site for out-patients / day cases may feel "disconnected" from their inpatients and possibly that their patients are disadvantaged from the lack of access. I think this is a relatively weak concern as the inpatient care is inevitably a team delivered service wherever the beds are located and furthermore – in particular cases where one consultant can make a significant difference – can be overcome by both technology (video links etc.) and a bit of intermittent extra travel for the doctors.
    d. The pharmacy based service for making up chemotherapy regimes for inpatients is based in DMH and new costs and risks

[6] Many patients will never require inpatient care as part of their chemotherapy or other treatment regime and receive all they need at their local day-case unit

are introduced by the need for more drugs transfers. This is a logistics problem that might have a business case for change, however, assuming the main pharmacy capacity is at DMH then the risks are relatively easy to manage. The potential risk for drug errors or the need for on-site pharmacist input can both be managed.

e. Some sick patients will have to travel further or be admitted in one hospital only to then have to be transferred to BAGH. This is a potential objection to any service rationalisation. However, two key issues mitigate the risks. Firstly, the long term viability on any service at all depends upon safety and quality and ability to retain consultant staff now. The cost of smaller increased journeys now may be much further journeys to different trusts in the future. Secondly, the issue is a short term one as discussed in section 34(b) above. Good information, good staff training and well designed internal systems will stop delays, avoid any confusion and allow full support of all patients. A 'single team' and good communications also avoids the "but they don't know me in Bishop" fear.

f. A single centralised service may have to respond to two sets of expectations and/or treatment plans (for the same kind of cancer in two different patients) from the two cancer networks. This potential confusion for the staff is and must only be very short term. If there are significant differences between the networks they should be immediately addressed and resolved. Irrespective of where they are treated, similar patients should not have different care because of where they live[7].

35. There may be some concern that I give any weight at all to the strategic question of a whole-hospital development plan for BAGH. Surely this review is just about haematology? I am very minded however of one of the key conclusions of Darzi, repeated in his more recent review of North Tees and Hartlepool Trust, that the viability of all hospital sites is of paramount concern. Without a plan for BAGH then local access to much more than haematology is compromised.

36. A similar issue affects the haematology review as a whole. Many people, patients and staff, will be disappointed that I have not chosen their preferred option. However, I have kept as my primary concern the long term viability of haematology services collectively. Without clarity on the inpatient issue then the continued uncertainty affects future consultant recruitment and retention. Without consultants there is no trust based service. Without trust ownership and control of such a service, the ability to maintain day-cases at all sites, comprehensive laboratory services and so on all is put into question.

[7] The two cancer networks in North East England are, in any event, planning to combine as one and this theoretical risk will cease

Conclusion

37. The inpatient issue is very important, highly emotive and controversial and has been subject to debate for seven years or more. Actually it may have been a distraction to the pursuit of a clear vision for haematology services in the Trust which have the potential to be the best available anywhere. The excellent and committed staff, the enthusiastic and sincere support of local communities and the leadership of the Trust can all support a brilliant service. In response to the questions posed to me in updating previous work my main conclusion is to centralise the existing inpatient services at BAGH and thereby release everyone from the 'planning blight' currently affecting the service as a whole and allow forward progress to gather momentum.

Dr Stephen Singleton
Medical Director
May 2006

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