Appendix

HEALTHIER TOGETHER PROGRAMME (SOUTH EAST MIDLANDS ACUTE SERVICES REVIEW)
PROGRESS REPORT FOR CENTRAL BEDFORDSHIRE SOCIAL CARE, HEALTH & HOUSING OVERVIEW AND SCRUTINY COMMITTEE

22 August 2012

1. Purpose

The purpose of this paper is to provide the Central Bedfordshire Social Care, Health and Housing Overview and Scrutiny Committee with an update on progress against all aspects of the programme.

2. Background

Healthier Together is a review of the way hospital services are delivered in Bedford, Kettering, Luton and Dunstable, Milton Keynes and Northampton. Our vision is to:

- **Provide the best care, in the right place, at the right time for patients** - increasing the provision of services in local or community settings, while establishing specialist centres to meet complex and intensive health needs where this will improve patient outcomes
- **Make the South East Midlands an area of healthcare excellence** – improving quality and consolidating expertise across our five main hospitals to ensure patients have access to the appropriate level of care 24/7, and reducing the need for patients to travel outside the area for care
- **Properly coordinate services** - especially for the frail elderly and those with long-term conditions and make the most of the facilities available in local community settings
- **Ensure the delivery of high quality, sustainable services** - for the next 10 years and more

The programme is commissioner-led but all proposal for new ways of working are being developed by local clinicians working together with senior leaders in the NHS, patients and local residents.

Since January, six clinical working groups of local hospital consultants, nurses, GPs, commissioners and other health professionals have been working alongside patient representatives to consider how to set health services on a sustainable path.

Clinical Working Groups:

- Services for people with long-term conditions
- Maternity services
- Children's services
- Planned care (including general surgery)
- Cancer services
- Emergency and urgent care

3. Summary of the Case for Change

In Phase One of the programme, the twelve NHS partners leading the review developed a Case for Change that all Boards signed up to in December 2011. Given a range of challenges facing all five hospitals and the wider health system there was an acknowledgement that the status quo was not an option either clinically or financially. Challenges included:

- The need to keep up with advances in healthcare in order to provide better outcomes for patients
- Increasing demand at a time of limited financial growth as people live longer and our population grows significantly:
    - Today the SEM population is 1.6m. By 2031 it is expected to be 2.2m
    - In 1948, average male life expectancy was 66. It is now 80 years of age
    - If we stay the same, hospital workloads will rise by 50% over the next 30 years
    - In 2010 84,000 people had diabetes in the South East Midlands. In 2020, this is predicted to rise to 112,400, requiring an annual spend of £130m on the condition
- The need to collaborate to make the best use of staff and resources. In many areas there are shortages of consultants, for example in urgent care where there is a national shortage of trainees. Working in isolation many services cannot always provide the level of consultant cover required by RoyalCollege guidelines

4. Emerging Clinical Headlines

Below is a summary of the emerging themes for each Clinical Working Group area:

Planned Care

The main challenges include increasing specialisation of surgeons set alongside strong evidence that outcomes can be improved by those performing greater numbers of procedures. In addition, in some areas there are developing manpower issues in terms of availability of both senior and junior clinicians. Compliance with national targets and standards is thus increasingly difficult for smaller hospitals.

The working group has therefore focused on consolidating clinical resources and appropriately skilled multi-disciplinary teams where this can provide a sustainable improvement in patient outcomes. Focus also has to be on providing the best care in the right place and the right time, streamlining services so that the patient doesn't have to travel any more than necessary. Their broad model is that whilst some services, including all outpatients, will be available locally (potentially in the community, rather than the hospital in some cases) patients may have to travel to a centre of excellence within the region for some specialised or inpatient services.

Maternity Services

The main challenges include growing demands on women's services both in relation to the number and the complexity of cases. The growth in annual delivery rates is projected to rise from 20,000 in 2011 to 22,000 in 2020. As birth rates rise, there are increasingly stringent national standards to meet in delivering obstetric and maternity care. Clinicians believe the current configuration will not be sustainable to cope with this increase. There is also a need to improve consultant cover on labour wards, which currently falls short of the required standards by the Royal College of Obstetricians and Gynaecologists (only Luton and Dunstable Hospital currently has 98hr consultant obstetrician presence on the labour ward).

The focus of the group's proposal is to normalise low risk births as much as possible by offering choice through the further development of high quality midwifery-led units on all five acute hospital sites and home birth pathways, whilst ensuring equitable access to a largely consultant delivered service for those with higher risk pregnancies who require more intensive labour ward care. This more specialised care is likely to be centralised on fewer than five sites.

Children's Care

The main driver for changing the way we deliver children's care in hospital is to ensure the South East Midlands area reaches the recommended standards on quality and safety as laid out by the Royal College of Paediatrics and Child Health (RCPCH) 2008. Clinicians recognise the need to use the limited available medical workforce in the best way to achieve the highest standards.

The focus of the group's proposal is to ensure that, wherever appropriate, children will be cared for in the community rather than in hospital, which is better for children and their families. The emphasis will also be on providing earlier access to more senior assessment of sick children, ensuring hospitals have the skills and capacity to deliver complex specialist treatment, and latest training for all those seeing children in A&E, community and paediatric units. When it comes to critical and less common paediatric care, this is likely to be provided in fewer centres and we will also continue to work collaboratively with surrounding specialist centres.

Long-Term Conditions

There is a national imperative to improve the way we care for people with long-term conditions. Long-term conditions can have a significant impact on a person's ability to work and live a full life. People with at least one long-term condition are about 10% less likely to be in employment than people with none. People with physical long-term conditions are up to three or four times more likely to experience depression and anxiety disorders.

The recommendations of the group are to improve significantly the management of patients with long terms conditions by implementing common treatment pathways, supported by proactive improvements in self-help and community "hubs". In addition there would be greater specialist working in the community and closer working arrangements with colleagues in Social Care to

reduce unnecessary hospital care, and support significant bed reductions and A&E attendances across the South East Midlands.

Cancer Care

Good quality cancer surgery in particular is affected by the numbers of some procedures performed by both individual surgeons and within units. The planned care group's recommendations will therefore support some improvements in cancer services. In addition, the development of uniform protocols and, greater access to treatment facilities such as radiotherapy and local chemotherapy will improve access and outcomes for many people. Finally by working together we can develop high quality acute cancer services for those with complications of either their disease or their treatment. In addition, improved coordination of pathways for the increasing number of people who will have to live with cancer as well as those who require palliative and end of life care, will reduce unplanned hospital admissions and improve patients choice of their preferred place of care.

Emergency and Urgent Care

The biggest challenge facing our A&E departments is resourcing levels. The College of Emergency Medicine guidelines say an emergency department should be staffed by a minimum of 10 A&E consultants with clearly defined services supporting them. On the other hand there are clear models of different levels of emergency care that can be delivered using highly trained specialist nurses and GPs.

In order to maximise the quality of A&E provision for all we intend to ensure that all A&E departments, however staffed, work to the same clear clinical protocols as a network, working for our patients. However, Accident & Emergency is only part of urgent care. The work of the other working groups will reduce the reliance on hospital care, but we will continue to provide immediate access in an emergency to both surgeons and physicians, working in conjunction with our partners in the Ambulance Trusts.

5. Programme Progress

The six Clinical Working Groups (CWGs) continue to finalise their reports, each of which sets out the process followed, evidence base used, draft clinical models and key inter-dependencies for their areas. The Clinical Senate plans to receive and sign off final CWG reports in October. In the meantime work continues to ensure alignment between the recommendations emerging from all the CWGs, the clinical models and emerging strategic models.

The Healthier Together Programme Board met on 24th July and, having considered seven strategic models, agreed to explore in more detail two strategic models of care which are described below. Work is now underway to assess the two draft models using a rigorous business modelling process and by ongoing clinical, patient and public engagement. The draft models are being shared with staff at the five hospitals to gain their views and they were also shared at a stakeholder engagement event on 27th July.

Model 3 (also known as Model A)
Three hospital sites would provide 24/7 emergency services including A&E and emergency surgery as well as the full range of maternity obstetric services and in-patient paediatrics. In addition, acute medicine, outpatient appointments and day case procedures would be provided at these sites.

Two hospital sites would have a networked A&E department working to shared protocols with the A&E departments at the other three sites. Acute medicine would continue to be provided and the sites would also offer planned surgery in an elective surgery centre. Midwife-led units would provide maternity care; these units would be networked with the three obstetric units. There will be short-stay paediatric assessment units and out-patient appointments would also be available. However, emergency surgery would not be provided at these sites.

Model 6 (also known as Model B)
As in model 3, three hospital sites would provide 24/7 emergency services including A&E and emergency surgery as well as the full range of maternity obstetric services and in-patient paediatrics. In addition acute medicine and outpatient appointments and day case procedures would be provided at these sites.

Two hospital sites would have a networked A&E department working to shared protocols with the A&E departments at the other three sites. The sites would offer planned surgery in an elective surgery centre. Midwife-led units would provide maternity care; these units would be networked with the three obstetric units. There will be short-stay paediatric assessment units and out-patient appointments would also be available. However, emergency surgery and acute medicine would not be provided at these sites.

A second meeting of the Travel and Transport Group took place on 31st July, chaired by Dr Fiona Sim, Cluster Medical Director, NHS Bedfordshire & Luton. Travel time analysis from the business modelling has been discussed by the group and priorities for further analysis agreed. An update on travel and transport will be presented to the Joint Health Overview and Scrutiny Committee in September.

6. Communications and Engagement

Since February, there has been on-going extensive patient and public engagement to raise awareness of the Case for Change and to encourage as wide a cross section of the local community as possible to get involved.

This has involved:

- Asking people what they like and dislike about current services
- Testing views and understanding of the Case for Change
- Seeking views on the principles that should underpin the programme
- Shaping the evaluation criteria that will be used to assess potential options for new models of care

The programme's engagement plans and processes are shaped by the programme's Patient and Public Advisory Group which has an independent chair, Dr Steven Lowden and a membership of 30 local residents including LINk members, hospital governors, third sector groups, minority group representatives and members of the public.

6.1 Shaping the programme's principles

A set of principles which will underpin the programme and be used to shape the overall models of care has been developed. These have been shaped and tested by the Patient and Public Advisory Group (PPAG) and the Commissioner Group and approved by the Programme Board. The principles are:

1. We will provide high quality care that is safe, effective and delivers measurable improvement in health outcomes throughout South East Midlands
2. We will improve patient experience and maintain patient choice
3. We will ensure services are delivered by the most appropriate person in the most appropriate place
4. We will provide care more locally wherever possible
5. Where there is good evidence to show that centralised clinical services could save lives or improve the quality of care we will do so
6. We are committed to providing best value for tax payers money and the most effective, fair and sustainable use of available resources
7. We will identify and work to reduce health inequalities
8. We will ensure that all options are generated by and discussed widely with local clinical leaders
9. We will address the need for clinical pathways that cover early identification of health needs, self-management and timely and appropriate interventions
10. We will be transparent and clear with public, patients and staff and engage them throughout the process
11. We will ensure that proposals for change have the support of Commissioners
12. We will ensure that services are provided by a flexible, skilled and motivated workforce

6.2 Shaping the programme's evaluation criteria

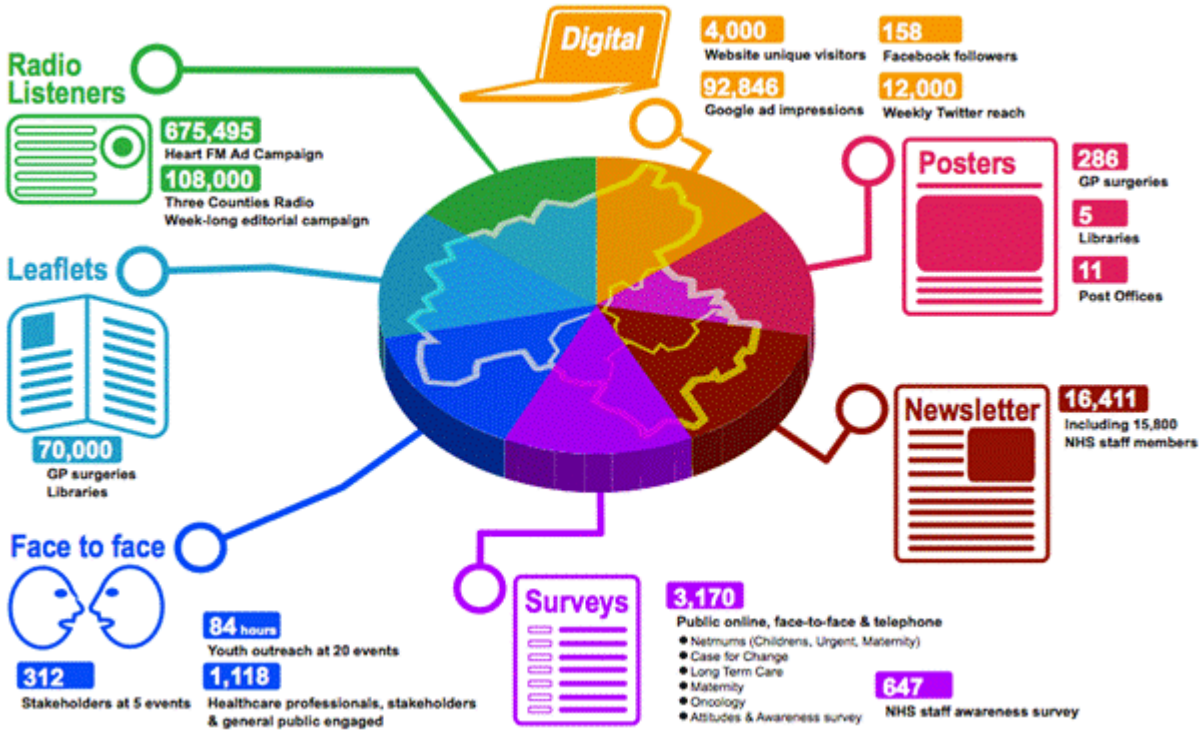
Evaluation criteria will be used by the programme to assess the individual options ahead of a public consultation. Draft evaluation criteria have been developed as a result of significant clinical, patient and public engagement and were considered by the Programme Board in July. Attendees at public deliberative events and members of the Patient and Public Advisory Group reviewed the initial draft evaluation criteria that were produced at the end of Phase One of the programme and subsequently the programme's governance groups have been involved in ranking and weighting the criteria.

The draft evaluation criteria have been changed significantly as a result of this engagement and the proposed evaluation criteria are set out below:

Quality/Safety	Does the service model improve the clinical standards for quality and safety? Does the service model sustain or enhance the patient experience? Does the service model improve clinical outcomes? Does the service model meet national best practice guidelines? Does this service model enable patients to be transported safely by emergency vehicles?
Affordability	Is the service model achievable within current and future financial resources? Does it provide best value for taxpayer's money across the health and social care economy? Is the capital expenditure affordable (including its revenue consequences)?
Deliverability	Will the proposed model receive support from NHS staff/clinicians as well as from local stakeholders? Does it meet clinical commissioners' strategies for the future shape of health services for their population? Can the model be supported by a workforce/staffing model which is realistic? Can the model be effectively supported by education and training arrangements in the future? Are assumptions about transitional funding and capital funding realistic?
Sustainability	Does the service model address the increased demands that will result from a growing and ageing population over the next two decades? Will it help organisations deliver their environmental sustainability responsibilities? Is it clinically sustainable over the foreseeable future? Are the medium term workforce implications sustainable?
Equity of Access	Does the model allow for equity of access for all sections of our diverse population including vulnerable people and those with specific needs? Does the model enable patients to exercise their right to Choice when considering treatment options?
Travel Access	Are there sufficient transport options to allow all patients and their families to travel to access relocated services within a reasonable time?

6.3 Communications and engagement methods

A wide range of communications and engagement methods have been used to give people different opportunities to find out more about, and become involved in, the Healthier Together programme. The programme has had direct involvement with approximately 9,000 people and the reach of some of our communications is more extensive still as the infographic overleaf illustrates:



Specific examples of engagement activity include:

- 5 deliberative events – one for stakeholders and four public events held with a representative sample of local residents in each area
- 9 open public events across the area
- Surveys on maternity services, cancer care, long term conditions, children's services and our case for change
- 70,000 Case for Change leaflets delivered via hospitals, GP surgeries and direct mail
- A road show in busy public areas to encourage responses to the Case for Change survey
- A radio campaign on local Heart FM with an audience reach of 160,000
- A telephone survey of 1,600 local residents
- Individual engagement plans with each areas' third sector umbrella group (CIO) to ensure vulnerable communities and traditionally 'harder to reach' groups are informed and engaged in the programme
- On-going presentations and discussions with LINk and other community group meetings
- Monthly newsletter for staff and stakeholders
- Email newsletter and links from Netmums
- Social media, including Twitter, Facebook, Flickr, Audioboo and Tumblr and keyword search advertising on Google
- Public website with extensive information and downloadable resources
- Week long editorial feature on BBC 3 Counties Radio
- Posters in GP surgeries, libraries and post offices

6.4 Using the feedback we receive

All feedback received from the different methods of patient and public engagement outlined above is being fed back into the six Clinical Working groups and Clinical Senate so that the views of local residents can help shape and refine the development of possible options for new models of care. A follow up stakeholder deliberative event on 27th July gave participants an opportunity to discuss and debate the emerging themes from the Clinical Working Groups and discuss the two draft strategic models of care selected for further exploration. Reports summarising feedback from the Case for Change survey, the deliberative and stakeholder events are available on the Healthier Together website.

Key findings from the Case for Change survey include:

- A wish to see improvements around weekends, 24/7
- The importance of caring, qualified staff
- People want to access to expertise and the best possible treatment
- There is support for centres of expertise but people do have concerns about travel
- 63% were supportive or very supportive of the Case for Change

Transport is an issue that people have concerns about however when asked as part of a survey or a deliberative event to rank the above criteria in order of importance, both patients, public and clinicians consistently rank transport access as the least important. Quality and Safety is consistently ranked the most important criterion by all groups.

Participants at the stakeholder event on 27th July were given an overview of the Healthier Together programme, including the case for change, vision, programme activity to date and a review of the evaluation criteria and the core principles. The key challenges and themes emerging from the clinical working groups were shared with participants, together with the seven draft strategic models.

Key findings from the stakeholder workshop on 27th July in Milton Keynes were: When asked if they agreed that the case for change had been made, 91% agreed.

29% strongly supported and 55% supported the overall direction of travel.

Participants were presented with the emerging findings and models of care for each of the six clinical working groups. When asked if they supported the direction of travel for each CWG the response was:

- Planned care — 36% strongly support, 56% support
- Cancer care — 44% strongly support, 51% support
- Long term conditions — 30% strongly support, 53% support
- Emergency/urgent care — 18% strongly support, 45% support, 23% neither for nor against
- Maternity services — 35% strongly support, 20% strongly support, 20% neither for not against

- Children's services — 31% strongly support, 36% support, 26% neither for nor against

When asked to vote on the two models to be taken forward for more detailed consideration and analysis the feedback from participants was:

- Model 3 — 27% support, 54% neither for nor against
- Model 6 — 31% strongly support, 44% neither for nor against

Participants were also asked to vote on their preferred model. The results were:

- Model 6 — 54% — (Model 6 is described earlier in this report)
- Model 3 — 19% — (Model 3 is described earlier in this report)
- Model 1A — 15% — (Model 1A has five sites providing a range of networked emergency and elective services, three of which also provide obstetric and inpatient paediatric services, and two of which have midwifery-led units and short-stay paediatric assessment units)
- Model 2 — 8% — (Model 2 has four sites focussing on emergency services, three of which also provide obstetric and inpatient paediatric services, and one site focussing on elective services. There are midwifery-led units and short-stay paediatric assessment units on two sites)
- Model 5 — 4% — (Model 5 is a hybrid of models 3 &6 with one of the sites focussing on elective services also providing acute medicine)
- Models 1 & 4 — 0% — (Model 1 is the status quo, model 4 is a variant on model 3 where one of the sites providing obstetric and inpatient paediatric services is a site focussing on elective services rather than a site focussing on emergency services)

Delegates at the event included Clinical Commissioning Group chief executives, chairs of Health &Well-being Boards, members of the Joint Health Overview and Scrutiny Committee, LINKs representatives, local councillors, NHS trust chairs, directors and governors, local charity representatives and members of Healthier Together's own Patient and Public Advisory Group (PPAG).

Participants commended the clinical leadership of the programme and joint working across organisations and different clinical specialities.

More detailed work on transport and travel implications was identified as being of prime importance, together with more information about how services would

be maintained during any future reconfiguration and on how conceptual models could be turned into working practice.

Acute trust chief executives are leading on engaging with their staff and seeking their views on the emerging themes and draft strategic models, assisted by materials based on those used at the stakeholder event.

Arrangements are in hand to hold workshops with Clinical Commissioning Groups during September to raise awareness and seek views on the emerging themes and draft strategic models.

A further briefing with local MPs has been arranged for 13th September. We will also be providing an update to the JHOSC on 10th September.

Targeted engagement with ethnically diverse, younger audiences and those with disabilities and long term conditions continues. We have run a focus group with Bedford Youth Cabinet to obtain their views on the draft strategic models of care, with particular reference to what this could mean for children's services. Discussions are currently underway with Milton Keynes Youth Cabinet to arrange a similar event. Voluntary Action Luton has arranged focus groups with both younger and older people that will take place during September. Engagement with communities in the Fishermead and Beanhill areas of Milton Keynes is taking place during August led by community mobilisers. There has been targeted engagement with those with sensory impairment and disabilities in Northamptonshire, Milton Keynes and Bedfordshire. Additionally, we are in discussion with the lesbian, gay, bisexual and transgender community in Milton Keynes.

To date, the Healthier Together website has received 7,083 visits and 4,618 unique visitors. There have been 21,764 page views. On average, visitors stay on the site for 3.16 minutes and view 3.07 pages.

The @HealthTogether twitter account reached a weekly average of 6,386 twitter accounts during the last month. Additionally, posts on the Healthier Together Facebook page received 454 views during the last month.

6.5 Evaluating the Healthier Together patient and public engagement processes

An independent report has been commissioned by the Healthier Together programme to assess the robustness of its patient and public engagement processes. This will involve reviewing the engagement processes and an analysis of how far the process meets the principles outlined in The Consultation Institute's charter. It will include a review of stakeholder satisfaction and involvement and a decision audit to assess how far the views of patients and the public have been incorporated into the final decision making process of the programme. An interim report will be published ahead of a formal consultation and the final report will be published following the outcome of the public consultation.

7. Next steps

- The draft strategic models will be subject to rigorous business modelling and analysis to review the likely impact of a range of clinical and locality options on income, expenditure, bed numbers, resources and patient experience.
- A further series of events will take place over coming months with clinicians and stakeholders to raise awareness of the draft models and test views.
- Once the models have been tested, subsequent location options will be shared/tested
- A final set of proposals will be developed to go forward to public consultation later this year.
- Decisions will be taken on the consultation proposals, taking into account all the consultation responses
- Based on the outcome of the consultation we will begin work on implementation. We expect this to take 3-5 years to complete.

7. Recommendations

The Social Care, Health and Housing Overview and Scrutiny Committee is asked to note progress to date.