Healthier Together
South East Midlands
Better care in the right place

Clinical Senate Report

Final Version for Publication

1. Introduction

Healthier Together's aim is to meet the health challenges of the 21st century and improve health services in the South East Midlands (SEM) to deliver improved patient outcomes in a safe, sustainable and affordable way. Led by GPs and hospital clinicians, the programme is a collaboration of twelve NHS partners across Bedfordshire, Luton, Milton Keynes and Northamptonshire.

Healthier Together partners have a shared understanding that the current pattern of hospital provision is not sustainable. With a growing and ageing population, expected to rise from 1.6m to 1.8m by 2022, and finances becoming more constrained, commissioners and the five hospitals have agreed to work together with key stakeholders to improve quality of care, clinical outcomes for patients, efficiency and effectiveness.

2. Summary of case for change for services in the South East Midlands

There is a strong case for change for services in SEM. This case is similar to those facing many other English health care systems and is based on the following key factors:

- The health care demands of a growing population (from 1.6 million now to 1.8 million in 2022) and an ageing population (over 65s to increase by one third over the same period)
- The increasing complexity of healthcare needs as the population ages
- The current and inevitable future financial constraints brought about by the global economic recession
- Increasing standards for service specifications and technological reliance, creating inefficiencies within smaller units
- Shortages of qualified, experienced clinicians in key clinical specialties including A&E, paediatrics and maternity services
- Increasing difficulty in meeting national best practice standards in particular around senior consultant cover
- Increasing evidence of the variability of care and, in specialist areas, of the volume – outcome relationship.

Analysis of current patient pathways shows significant variation for some conditions across SEM. There is good national and international evidence that reducing variation improves outcomes and increases patient satisfaction.

Service reconfiguration is therefore required to secure the clinical and financial viability of the five main hospitals serving SEM namely Bedford Hospital, Kettering General Hospital, Luton & Dunstable Hospital, Milton Keynes Hospital and Northampton General Hospital.

3. Scope, structure and work of the programme

The Healthier Together programme includes all clinical services currently delivered on an acute hospital site. Mental health and dental services are outside the scope of the programme.

The cornerstone of the programme is the Clinical Senate. The Clinical Senate's remit was to develop clinically viable models for the population, based on the continued presence of five hospitals each continuing to deliver A&E and maternity care. Reporting in to the Clinical Senate are six Clinical Working Groups (CWGs) made up of almost 200 clinicians from all specialties and partner organisations. The six CWGs are:

- Maternity
- Children
- Planned Care
- Cancer
- Emergency Care
- Long Term Conditions.

The Clinical Senate is chaired by an acute Trust Medical Director and is made up of clinical representatives from all stakeholder organisations, the chairs of the six CWGs and patient and public representatives. The Clinical Senate met regularly, to ensure all members of the programme were kept abreast of developing ideas and to consider key interdependencies for each speciality and service.

The Long Term Conditions CWG was chaired by a practising local GP and the other five CWGs by hospital consultants from within SEM. Each CWG met at least five times in 2012. In addition a series of joint meetings were held and, where needed, sub groups set up.

The CWGs took account of national and international clinical evidence and best practice and local volume and outcome data in developing potential models of care to recommend to the Clinical Senate. Each report was then checked externally to ensure all the latest evidence had been taken into account.

The task of the Clinical Senate was then to make recommendations on strategic clinical *models* for five acute sites to serve a population of 1.6 – 1.8 million people, irrespective of current service provision.

Thereafter it was the task of the Clinical Implementation Group (CIG) to identify how those strategic clinical models could be delivered within the existing five hospitals to create *options* for clinical reconfiguration.

4. CWG case for change and proposals

The case for change and proposals from each CWG are summarised in the sections below.

4.1 Maternity

Case for change

The National Service Framework (NSF) for Children, Young People and Maternity Services 2004 required Trusts to ensure the availability of midwife-led care including midwife led units in the community or on a hospital site. SEM has not to date fully delivered this requirement.

Obstetrics and gynaecology services are facing many challenges such as an increase in older mothers with higher complication rates, increasingly complex cases, increased fertility treatment resulting in more multiple births, maternal obesity, rising intervention in labour and an increasing social and ethnic diversity within SEM. The ratio of live births to women is higher than the England average particularly in Corby, Luton and Milton Keynes. This is an important factor when considering any proposed changes and geographical location of future obstetric units.

The Royal College of Obstetricians and Gynaecologists has recommended that maternity units should have onsite labour ward cover by a specialist consultant for a designated number of hours each week depending on the number of births. At present not all units in SEM meet those standards. The ultimate aim will be to provide consultant presence in the labour ward 24 hours every day.

Midwife led care should be the norm rather than the exception. Concerns over intervention and caesarean section rates have been highlighted by commissioners.

There is an inequity of critical care services. Luton and Dunstable Hospital, the largest obstetric unit in SEM, does not currently have a High Dependency Obstetric Unit although this facility is available in the four smaller obstetric units.

Proposals

The proposed model is supported by national guidance on clinical standards and workforce issues and allows for the provision of care in the community by midwives and obstetricians including home visits, early pregnancy assessment units, antenatal clinics and late pregnancy assessment units. The model also increases choice by introducing the concept of stand-alone and adjacent midwifery units.

The proposed model is as follows:

- The option of home births for low risk women
- Outpatient and day case (<23 hour) gynaecological services on all five sites supported by obstetricians and gynaecologists based in the obstetric units. The proposed model assumes that inpatient gynaecological services would be co-located with a consultant obstetric unit
- Three obstetric consultant-led units developing specialist services and increased consultant presence supported by acute and inpatient gynaecological services
- Three adjacent midwifery-led units and two stand alone midwifery-led units to increase choice and reduce medical interventions for low risk women. Each midwife led unit would share an overarching management and governance process with an obstetric unit.

Critical interdependencies for obstetric units include neonatal intensive care facilities, imaging, pathology services and critical care.

The proposed model would be supported by one level 3 neonatal unit (providing higher level intensive care in keeping with neonatal network requirements) and two level 2 neonatal units for SEM, following consultation with neonatology leads and existing neonatal networks.

Benefits

The proposed model will deliver the following benefits:

- Normalisation of antenatal, birth and postnatal care through separate midwifery-led care, promoting home births and births in midwifery led units
- Promotion of care close to home – development of early pregnancy assessment units, antenatal clinics, antenatal assessment units
- Improvements in patient choice
- Equity of obstetric services across SEM
- Immediate provision of 98 hours obstetric consultant labour ward presence in the three obstetric units, moving towards 24/7 presence
- Consolidation of emergency and elective gynaecological practice linked with service provision and a consultant-led service
- Provision of equity in obstetric critical care services
- Potential for future separation of obstetric and gynaecology on call rotas in response to specialty trends indicative of a potential future shift (but not achievable under current budgetary limitations)

- Development of neonatal services in cooperation with, and the support of, the neonatal networks
- Centralised inpatient facilities for perinatal mental health services where none currently exist within SEM
- Development of specialist services – twins, chorion villus sampling and obstetric haematology, cardiac, endocrine and mental health care, leading to improved outcomes.

Freestanding midwifery led units are associated with significantly reduced incidences of maternal morbidity, birth interventions including caesarean section, and increased likelihood of spontaneous vaginal birth and no increase in perinatal mortality.

4.2 Children

Case for change

For children's services there are four key drivers of change:

- Safe care at home
- Medical advances
- Service quality
- Workforce challenges.

Safe care at home. Many children who previously required care in hospital can now be assessed and treated by specialist clinicians in and outside hospital and then safely and appropriately cared for at home. As care shifts into the community, fewer inpatient beds are required and smaller units become less viable. In addition, up to 25 per cent of patients presenting in A&E are children. Many of these attendances would be avoidable if better pathways could be established.

Medical advances. There will always be a small number of children who have sudden, unexpected severe illness. There are also more children with complex conditions who now survive and require long term access to expert paediatric care with short periods of treatment in hospital. Critical and less common inpatient paediatric care would be more sustainable by consolidating expertise and resources across fewer hospital sites.

Service quality. Quality and safety standards published by the Royal College of Paediatrics and Child Health (RCPCH) include a requirement that all inpatient children are seen early by a senior clinician and recommendations for increased consultant presence in the evenings and at weekends. Units within SEM currently struggle to achieve these standards consistently. There is also a need for all A&Es and Urgent Care Centres to reach recommended Urgent Care Standards for the care of children including; appropriate separate areas, children's trained / skilled staff available at all times, the ability to initiate resuscitation for a sick child with appropriate resuscitation skills / anaesthetic support and robust safeguarding systems and processes.

Workforce challenges. SEM does not have enough specialist clinicians to continue to meet the RCPCH standards across five hospitals in the long term, nor are there sufficient trainees to provide the necessary numbers to recruit. Demands on paediatric services are increasing as a result of increasing case complexity. There is a need for earlier senior review and decision making, more consultant delivered care and consultant on site presence in the evenings and at weekends.

Proposals

Two broad models were proposed:

- Three 24/7 sites with A&E, outpatients and inpatient beds, with three alternatives for the other two sites:
    - A&E and outpatients on the other two sites
    - A&E, outpatients and a short stay paediatric assessment unit on one other site and A&E and outpatients only on one other site
    - A&E, outpatients and a short stay paediatric assessment unit on the other two sites
- Four 24/7 sites with A&E, outpatients and inpatient beds, with A&E and outpatients on the other site.

The three 24/7 site proposal offers the biggest opportunity for quality improvements and addresses workforce challenges and is therefore the likely best option. However, the four 24/7 site proposal may provide a useful 'stepped' approach to implementation of full reconfiguration.

Collaboration and clear clinical protocols between sites is necessary to run short stay paediatric assessment units safely, with support from receiving 24/7 paediatric inpatient units. The short stay paediatric assessment unit model could be medical or nurse led and less than 24/7. To reduce reliance on inpatient care community services must be provided 7/7, with extended evening hours to cover periods of peak demand and rapid reaction teams to avert avoidable admissions and readmissions. Clear 'treat and transfer' policies will need to be designed to minimise the number of transfers of children.

When benchmarked against all criteria, models with three 24/7 units best met the requirements. Retaining short stay paediatric assessment units (SSPAU) on sites without inpatient beds would preserve access to paediatric expertise (beyond outpatient services) at each location, but models would need to be carefully developed to address safety, sustainability, safeguarding and medical workforce issues of SSPAUs.

Currently there are three level 2 neonatal units and one level 3 unit within SEM. The proposals envisage obstetric units as proposed will be supported by a level 2 or level 3 neonatal unit.

High volume, planned surgery for children (e.g. ENT) and emergency orthopaedics needs to be easily accessible. There are opportunities to consider whether more specialist children's surgery (but non- tertiary) could be provided on one or two sites.

Access to emergency surgical assessment for children and appropriate emergency children's surgery on site is essential for 24/7 inpatient paediatric units.

A theme throughout the Children's CWG discussions was the interdependency between urgent care / A&E provision and paediatric care and crucially the need for recognised standards with demonstrable competency in initial assessment and treatment to be met at any location offering emergency assessment for children, with or without a 24/7 paediatric facility.

Children's cancer services are currently provided via managed networks with tertiary providers. It is anticipated that existing arrangements will continue. The location and level of children's local cancer care will continue to be determined by POSCU accreditation.

Benefits

The concentration of inpatient care on three sites, whilst retaining outpatient and assessment services on the two other sites, would allow the redeployment of skilled workforce from inpatient services to support more care in the community, in line with the national strategic direction.

The redeployment of consultant medical staff across three inpatient sites would increase frontline consultant presence whilst also still providing outpatient services and access to an opinion close to home on the other two sites. This would improve outcomes, training and patient experience.

Rotational working is recommended between and across hospital sites and community services as an opportunity to ensure that skills and knowledge are maintained and developed across the workforce. This should improve the experience of patients and their families.

There are opportunities to provide some sub specialist services currently not easily accessible in SEM on one or two sites only e.g. Child Sexual Abuse Referral Centre (SARC) and paediatric orthopaedics. Any redesign of services must demonstrably strengthen the quality of safeguarding, requiring effective clinical communication with robust IT systems to access and share information.

4.3 Planned Care

Case for change

In some areas of SEM, primary outcomes such as mortality and complications are higher than expected. Concentrating some specialist services on fewer than five sites will improve overall outcomes. There is an increasing body of evidence to support improved outcomes for patients in specialist centres cared for by specialists. For example:

- Centralisation of gynaecological cancer shows an improvement in survival rates in the region of 10%, particularly for ovarian cancer
- In vascular surgery, there are clearly improved outcomes from aortic surgery in busy vascular centres, with a strong relationship between volume and outcome for each institution
- In urology, there are improved outcomes from major cancer surgery in centres performing a larger number of cases.

Some services have recently been centralised in line with guidance from the Royal Colleges, NICE and Cancer Service Reviews but variability in access to specialist care shows that there is scope for further centralisation within SEM.

It is currently difficult to provide 24/7 cover in a number of specialties in SEM including interventional radiology and specialist gastro-intestinal surgical cover for patients undergoing major colorectal surgery. The increasingly stringent requirements for a consultant delivered service, with recommendations about the minimum number of surgeons needed in order to deliver a sustainable on call rota, make this increasingly difficult. Concentrating some specialist services on fewer than five sites will ensure sustainable staffing. It could also enable SEM to develop services for which patients currently have to travel outside SEM.

Each of the five hospitals in SEM provides elective surgical services alongside emergency care. Increasingly there is evidence to support the separation of emergency and elective work streams. In 2007 the Royal College of Surgeons of England demonstrated that if well planned, resourced and managed, this way of working can achieve a more predictable workflow, provide excellent training opportunities, increased senior supervision of complex/emergency cases, and improved quality of care delivered to patients.

Overall, day surgery rates are variable across SEM. Day surgery should be performed in dedicated units on as many sites as possible, to retain services close to home, including in elective centres, day units, 23 hour units or short stay units.

Proposals

Across SEM core elective surgery would continue to be delivered on all five sites (except ophthalmology where fewer sites could be considered). Day case and short stay surgery would be provided in dedicated short stay units, which offer the greatest flexibility in terms of case mix.

Complex surgery would be delivered on fewer sites as follows:

- One site for complex orthopaedic surgery
- One or two sites for complex breast, head and neck, gynaecology, plastics, colorectal and ophthalmology surgery
- Two sites for complex vascular surgery.

Outpatient and general diagnostic services would continue to be provided on all five sites or in the community where appropriate. Responsibility for some follow ups would be devolved to primary or community providers, with enhanced protocols, to minimise the disruption to patients.

Benefits

The main benefit is to improve the quality and efficiency of planned care services and to improve outcomes and patient satisfaction.

Through collaborative working there is an opportunity to concentrate resource, manpower, expertise and equipment. With seamless pathways between the community and the hospital, there is an opportunity to create a network of services that will serve the demands of an increasing and ageing population, make best use of available resources and retain and develop services within the region. A seamless standard pathway for patients will also reduce variation and improve outcomes.

Another benefit is the opportunity to develop clinical expertise by delivering services differently, for example by centralising specialist services. This could also lead to increased access to high quality training for our consultants of the future.

4.4 Cancer

Case for change

The incidence of most cancers increases with age. Due to an ageing population, the national incidence of cancer is projected to increase by 55% for men and 37% for women by 2030.

Cancer services are amongst the best established network services in the UK, with a system of cancer centres, cancer units and multi-disciplinary management. However, patients from SEM are currently managed within four surrounding networks and reducing variation within SEM should lead to improved diagnoses, better local initial (often surgical) treatment and hence better outcomes for patients.

Improving outcomes guidance on minimum caseload or catchment population exists for head and neck, urological, gynaecological and haematological cancers. Currently, the configuration of specialist cancer services within SEM struggles to meet this guidance. It is unlikely that specialist commissioners will continue to commission services that do not meet the minimum population requirements. This means that, unless we work together, there is a risk that SEM will lose more of the specialist cancer services.

Some services within SEM may not be able to sustain compliance with peer review, as their low volume of activity makes it difficult to justify investment in all the areas of expertise involved in managing the patient pathway. Also, cancer waiting time performance across the five Trusts is variable and very difficult to maintain.

There is a national shortage of oncology consultants, chemotherapy nurses and radiotherapy staff (physicists and radiographers) and hospitals within SEM find it difficult to appoint to these posts. The size and number of hospitals in SEM make it less attractive for the recruitment of specialised staff who may prefer a post in a larger centre with more opportunities for research, technical innovation and career development.

There are a number of small services within SEM, which are based on two or three consultants and one or two Clinical Nurse Specialists. This makes services fragile and potentially unsustainable during periods of holiday or sickness which may result in delayed treatments and poor patient experience.

Some patients have to travel long distances outside SEM to access services not currently available within SEM. For example, it is estimated that about 40 – 50 patients a year travel out of SEM for complex breast reconstruction surgery. Patient feedback has also highlighted concerns about current travel times for radiotherapy, particularly in the south, where patients from Luton and South Bedfordshire have to travel to Mount Vernon for their radiotherapy treatment.

Proposals

A separate model of care has been developed for each tumour site. A summary of the themes of the potential models is as follows:

- Consolidation of some elective surgical specialties to improve outcomes
- Development of some specialist diagnostics
- Uniform co-ordination of screening services
- Provision of satellite radiotherapy to offer patients this service closer to home
- Ensuring reconfigured services continue to link with existing Cancer Networks
- Consideration of joint working for specialist cancer services across SEM to create volume and share expertise between sites

- Elective surgery of low complexity cancer could be on a non acute site but specialised high complexity cancer work eg head and neck should be on an acute site
- All hospitals with an A& E require an acute oncology service on site to meet cancer peer review.

The requirements of each tumour site, including co-dependencies will be different, but the CWG initially looked at the medical and surgical aspects of care for seven specific groups:

- Breast – complex breast surgery on one or two sites to improve local access
- Urology – specialist cancer surgery on one site
- Gynaecology – specialist cancer surgery on one or two sites
- Head and neck – specialist cancer surgery on one or two sites
- Lung – local thoracic opinion on one or two sites
- Haematology – inpatients on one or two sites. Care of acutely unwell haematology and oncology patients should be on an acute site. Specialised commissioning standards require a population of 4 million to undertake stem cell transplants but support a model of shared care with some elements of care undertaken locally
- Colorectal – specialist cancer surgery on two or three sites.

Overall there was a view that it would be better if all the very specialist cancer surgery were done in one or two centres. Further work would be required to look at the detail of this, which would also depend in part on the final configuration of inpatient elective services.

Specialist cancer consultants should work across SEM, for example by taking responsibility for one area with shared rotas to cover on-call. Specialist nurses and rehabilitation specialists would support this work.

Pathways for non-surgical oncology will depend on the final configuration of other services and pathways for each tumour site will need to be developed. Consultant oncologists will continue to be an integral part of the MDT directing patients' treatment by working with radiotherapy and chemotherapy services.

Benefits

With seamless pathways between primary and secondary care, between the community and the hospitals, there is an opportunity to strengthen the local networking of services so they better serve the demands of an increasing and ageing population. This also provides an opportunity to improve efficiency through shared cancer management functions.

The biggest opportunity is to combine specialist surgical services where appropriate for rarer tumours across SEM, leading to a sustainable local service. There is also an opportunity to develop our own specialist services, for example local PET, breast cancer reconstruction and specialist lung cancer diagnostics.

A joined up approach to commissioning radiotherapy across the area would enhance existing radiotherapy services and improve access for patients. Improved access could also be delivered through new models of chemotherapy delivery closer to home and local screening hubs with travelling facilities.

4.5 Emergency Care

Case for change

There are significant pressures on hospitals to cope with A&E attendances and emergency admissions. Nationally there has been a 46% rise in emergency admissions in England between 2004 and 2009. With an increasing and ageing population, rates will continue to rise across all age groups, but more so in older patients.

There is variation in the rate of emergency admission and readmission across SEM. Positively reducing this variation will improve outcomes.

There is significant variation in systems and services in place to reduce inappropriate admission and facilitate timely discharge from hospital. A number of admissions avoidance and demand management strategies have been implemented across SEM. Despite this, overall emergency admission rates and complexity of patients' conditions continue to rise.

The risk of death for emergency admissions is 10% higher in patients admitted at the weekend compared with patients admitted on a weekday. Research also suggests an association between reduced numbers of senior staff at weekends and increased mortality. Evidence shows that the earlier consultants are involved in making decisions in the care of patients, the better the outcomes for the patient.

Current A&E staffing levels do not meet national guidance, which recommends a minimum of ten consultants for a medium-sized A&E department. There is likely to be a national shortage of trained A&E consultants for the next 5-10 years. The staffing of emergency general surgical rotas has also become challenging as surgical training has become more specialised.

Proposals

The CWG's preferred model was the retention of full A&E services on all five hospital sites. A list of specialties required to support an A&E department was also defined. However, further consideration needs to be given to whether all these services need to be on site or can be accessed easily from another site using clear, agreed protocols.

The CWG also recognised the concerns over the long-term viability of retaining five acute surgical rotas. Concentrating A&E and general surgeons onto fewer sites could improve sustainability, but there would still be a need to recruit further A&E consultants to provide consultant presence.

The CWG therefore proposed an alternative model of four fully supported A&E sites with the fifth site being a 'warm' site managing and transferring some patients under clear protocols. Consolidating emergency surgery onto four sites would improve the viability of the acute surgical rota.

Strong commissioning of emergency and network services is also required. National evidence suggests that 10-30% of cases that attend A&E could be classed as primary care. To meet future acute healthcare needs, community and social services need to extend operational hours to incorporate nights and weekends. There is also a requirement for greater standardisation of service provision, skills and expertise to avoid varying responses.

In addition to A&E services, the CWG considered the number of sites for specialty service provision and proposed the following:

- Two sites for urology, acute stroke, ophthalmology, ENT, maxillofacial, complex gastroenterology and complex respiratory cases
- One or two sites for neurology
- One site for complex cardiology and specialist inpatient endocrinology.

Benefits

The main benefits of the proposals are:

- Improved patient pathways involving specialist hospitals, District General Hospitals and primary care providers. There is evidence that outcomes for patients can be improved if reconfiguration is combined with new clinical pathways
- The opportunity to improve healthcare through consolidation of specialist services
- Reduced variation in services through the standardisation of clinical pathways and improved integration between health and social care
- The opportunity to improve consultant cover, particularly at weekends, to improve quality and safety of care
- Less reliance on hospitals for acute care, treating patients within their home environment for longer.

4.6 Long Term Conditions

Case for change

People with long term conditions are significant users of NHS services. Patients with long term conditions currently account for 50% of all GP appointments, 64% of outpatient attendances and 70% of inpatient bed days. Around 70% of the total health and care spend in England is attributed to caring for people with long term conditions.

There is an increasing prevalence of long term conditions in England, in particular people having two or more conditions. The predicted rise in population will only increase this. We also know that early diagnosis and proactive management can affect outcomes for people with long term conditions.

The proactive management of people with long term conditions, including the promotion of self-care by patients, is a key priority for the NHS and is supported by clinical quality (NICE) guidance. Better long term condition management can also make a real difference to narrowing the health inequalities gap.

In SEM there are a number of local initiatives and services in place that fit within a generic framework for people with long term conditions. However, there is significant variation in both provision and outcomes.

Proposals

The first part of the proposals is to adopt the national generic, integrated framework for long term conditions, which is based on implementing three key service components:

- Risk profiling
- Patient self-management
- Shared decision making.

The CWG also proposes a model for complex long term conditions which describes what should be provided at every GP practice and the support available from acute and community services, including social care.

In this model, groups of practices would work together to share expertise and resources in community multi-disciplinary teams covering a population of 50,000 to 100,000. Each community multi-disciplinary team would sit within an integrated care system and be supported by access to specialist services: consultant led community clinics, specialist telephone advice for GPs or input during an acute episode of care. Acute and community based health and social care services would support early discharge and community care.

In addition, seamless pathways of care should be adopted for diabetes, chronic obstructive airways disease and heart failure with much of this pathway being provided in the community. Common aspects of care that could be managed in the community are: support for chronic conditions, improving access to psychological therapies (IAPT), mental health support, patient education and end of life care where appropriate. In acute care, the specialties of care of the elderly, imaging, pathology and ITU/HDU are

identified as close or critical interdependencies for all three diseases.With medical advancement there are growing numbers of adolescents living with long term conditions and disability. Planning future services across SEM must include planning for their transition from paediatric to adult services.

Benefits

Implementation of the generic framework will have a positive impact not only on people's lives but on reducing health and social care costs. It will ensure equity of provision, improve efficiency and provide better value for money.

Risk profiling will help the local health service plan and focus on prevention for many patient groups. At an individual level, risk profiling will ensure that patients and key workers know what to do to manage an exacerbation. This will help avoid unnecessary admission to hospital.

Increasing the number of patients cared for in the community and avoiding unnecessary hospital admissions will free capacity for specialist consultants to focus on newly diagnosed, unstable or acutely ill patients and to provide outreach specialist support for primary care.

Using an integrated model of care for people with complex long term conditions will provide better continuity of care and ensure access to specialist advice when required.

5. Clinical Senate review

The Clinical Senate has reviewed the emerging and final proposals from each CWG and considered the implications for an overarching strategic clinical model for SEM. The Clinical Senate undertook a 'challenge and confirm' process with each of the CWGs to review their evidence base and proposals. The proposals were then discussed and debated.

In considering the CWG proposals the Clinical Senate took three clear starting points:

- The vast majority of outpatient services would remain either on the current hospital sites or, where appropriate, would be moved into community facilities even closer to the patient's home
- There should be uniform access to the majority of diagnostic services across SEM, perhaps ensuring a more central location for those more specialised diagnostic services that will not be required in every area of SEM
- With an increasing and ageing population, changes in acute medical provision will only be feasible when out of hospital care has been significantly strengthened. The implementation of the long term conditions CWG proposals will be critical in reducing reliance on hospital care. In addition, the Clinical Commissioning Groups covering SEM are developing out of hospital strategies to support this.

In considering the individual CWG proposals, the following observations were made:

- It was recognised that reconfiguration of A&E services may not be deliverable without significant change in the provision of out of hospital care services, particularly if significant changes in the provision of acute medical care are to take place
- It was considered very unlikely that the health economy would be able to recruit sufficient emergency department consultants and junior staff to fully meet national recommendations and CWG requirements for all five A&E departments. It was therefore considered that continuing with five A&E departments operating as per existing arrangements will become increasingly unsustainable
- The Clinical Senate coined the term "networked A&E" to describe a 24/7 A&E which works closely with those A&E departments on the more acute sites, sees and manages the majority of patients locally, but has clear protocols in place to manage and transfer patients between sites if necessary. It is envisaged that staff would rotate between departments to maintain and improve skills. The details of the clinical pathway are still to be determined, but this is line with the national direction of travel and reflected in recent changes in London
- It was recognised that resolving the issue of how to provide emergency surgical support to A&E and emergency medicine would be critical
- The interdependence of the maternity and children CWGs proposals was recognised and supported
- The maternity recommendations give a strategic direction which needs to be developed in the context of more detailed local implementation planning, to ensure deliverability
- The maternity proposals envisaging three larger obstetric units supported by a level 2 or level 3 neonatal unit fit with the proposals from the Children's CWG providing that they are co-located with 24/7 inpatient units
- The emphasis on increased provision of children's services in the community was welcomed and the implications for hospital services supported
- The desirability of the separation of the planned and emergency patient pathways in order to deliver improved efficiency and a better outcome and experience for the patient was recognised. It was agreed that this will require clinical staff, and particularly consultants, to work in teams across more than one site
- It was felt that all sites should continue to undertake day surgery, but dedicated elective inpatient units should be developed where necessary for specific specialist services. Whether or not these are co-located with emergency services will depend on the size and nature of the specialty

- The importance of continuing to work closely with the existing cancer networks was stressed. However, it was also recognised that there were opportunities to work more closely together to ensure sustainable and seamless high quality services in SEM that deliver improved outcomes and a better patient experience. To achieve this, mechanisms may need to be developed for patients to have some aspects of their pathway delivered by different cancer networks
- The centralisation of more specialist services was supported
- Improved, proactive and anticipatory care for patients with long term conditions, including cancer, particularly towards the end of life is key to reducing unnecessary hospital admissions and improving patient experience
- The greater the number of variations in service delivery, the greater the risk that the ambulance service might take a patient to a less appropriate facility.

The Clinical Senate is clear that there is no single overarching strategic clinical model that would incorporate all of the CWG proposals. It therefore developed seven strategic clinical models (see Appendix), each of which incorporate differing aspects of the CWG proposals:

- Model 1 represents the status quo. It was agreed that the status quo was not a sustainable position and that this should only be used as a baseline against which to test the other options
- Model 2 retains five sites delivering a combination of emergency and elective care but centralised specialist care. This reflects the views of the emergency care CWG but not the views of the planned care, maternity and children CWGs
- Model 3 has four sites focusing more on emergency care and one site focusing more on elective care, together with the centralisation of more specialist care. This site also has a 'networked' A&E which would provide emergency and urgent care for the majority of patients and manage and transfer small numbers of more specialist patients. This reflects the alternate views of the emergency care CWG but not the views of the planned care, maternity and children CWGs
- Models 4 – 7 have three sites focusing more on emergency care and two sites focusing more on elective care, together with the centralisation of more specialist care. The two sites focusing more on elective care would also provide emergency and urgent care through a 'networked' A&E. These reflect the views of the planned care, maternity and children CWGs but not the views of the emergency care CWG who were of the opinion that such a change should only be delivered when out of hospital care strategies have delivered significant reductions in secondary care emergency activity.

Models 4 – 7 differ in the extent to which general acute medicine is provided on the sites focusing more on elective care and on whether or not obstetric and inpatient paediatric services are provided on the sites focusing more on emergency care or the sites focusing more on elective care.

It was agreed that the views of the cancer CWG could work with any of the models other than Model 1, but that they best supported Models 4 – 7. The views of the long term conditions CWG could work with any of the models other than Model 1 and the successful implementation of their proposals would be critical for Models 4 – 7.

There was considerable discussion and debate over the proposals from the emergency care CWG and those from the planned care CWG. The two key concerns from the emergency care CWG with regards to Models 4 – 7 were the inexorable rise in A&E and emergency activity (particularly in acute medicine) combined with a lack of confidence in out of hospital care strategies delivering significant reductions in activity and the importance of retaining emergency surgery presence 24/7 on any site providing A&E and emergency medicine services. The key concern from the planned care CWG with regards to Models 2 – 3 was the difficulty and inadvisability in retaining complex and emergency surgery on more than three sites.

As a result of these discussions, three conclusions emerged:

- It was important that there was evidence that CCG out of hospital strategies were reducing significantly demand on A&E and emergency medicine services before any changes were made to A&E and emergency medicine services
- Model 3 could be seen as a potential transitional stage to one of Models 4 – 7
- It was suggested that a satisfactory model of access to surgical opinion 24/7 and significant surgical presence could be developed to support A&E and emergency medicine, in the context of single integrated surgical teams working across two hospital sites.

On this basis, the Clinical Senate supports the strategic direction of a minimum of three hospital sites where the focus is more on urgent and emergency care with up to two remaining sites developing a focus on planned care.

Local delivery of these changes will rely on the successful implementation of CCG out of hospital care strategies moving more care into the community. The Clinical Senate believes that these recommendations would enhance the safety, quality, clinical outcomes, sustainability and patient experience for the population of the South East Midlands.

6. Specialist Services

Whichever strategic clinical model is adopted, it is clear from the work of the CWGs that there are a number of specific services that should only be provided on one or two sites across SEM. This will enable them to deliver improved outcomes through increased volumes and better value for money from the required facilities and resources. A summary of these services is shown below and it should be noted that some of these services are already provided from the number of sites indicated.

1 site	1 or 2 sites	2 sites
Complex cardiology (Primary PCI)	Complex plastic surgery	Acute stroke
Complex orthopaedics	Complex ophthalmology	Vascular surgery
Spinal surgery	Neurology	Specialist feto-maternal medicine
Bariatric surgery	Complex colorectal	
Level 3 neonatal unit	Complex gynaecology*	
Complex urological cancer	Complex head and neck*	
Anal cancer	Complex breast surgery*	
	Complex Haematology*	
	Lung cancer assessment	

** Including cancer*

A number of these services relate to specialist cancer services and, as stated above, careful consideration will need to be given to ensure we work with existing cancer networks to deliver robust safe pathways for patients. Accessibility to related diagnostics, treatment facilities and inpatient services will be key to the delivery of these specialist units.

Other interdependencies within the list include breast reconstruction and plastic surgery. It should be noted, however, that the development of a separate burns unit in SEM is not envisaged.

In addition to the above services, the development of one or two specialist elective orthopaedic centres serving a wider population should also be considered. Elsewhere, these have been shown to provide high quality and efficient care. The long term need to develop specialist elective surgery centres for other services should be determined by each individual specialty.

The location of these specialist services will either need to be considered alongside the strategic clinical model or, potentially, once the strategic clinical model has been determined. Either way, it will be important that they are considered across the whole of SEM and that decisions on location take into account the potential impact on any wider populations that may be affected by any proposed service changes.

Finally, there are a range of other specialist services which will continue to be provided on more than two sites and which would benefit from a continuation of the networking

opportunities that have been provided by the Clinical Senate and the CWGs. Consideration should be given as to how that might best be achieved.

7. Benefits and Outcomes

The Clinical Senate believes that the above changes will lead to a high quality safer system of health and social care provision for SEM that is clinically sustainable for at least the next ten years. The key benefits of the proposed changes for patients are that:

- Services would be more focussed on the needs of the individual patient so the overall patient experience will increase
- There would be earlier access to specialist opinion for both emergency and elective services
- The move towards 24/7 provision of high quality consultant delivered emergency services, the creation of centres of excellence, improvements to cancer care and improvements to long term condition management would see mortality rates decline as a result of more than 100 lives a year being saved and more than 500 premature deaths a year avoided
- Wherever possible, services would be delivered close to, or in, the patient's home
- The greater separation of elective care from emergency care would result in fewer cancelled operations, the development of more highly skilled and specialised nursing and medical teams, and hence a better, more predictable outcome for patients.

8. Further areas to consider

The Clinical Senate recognises there are a number of further issues that will need to be addressed as this work is taken forward:

- A considerable amount of work is still required to deliver the proposed changes
- Appropriate governance arrangements need to be put in place to ensure that a cohesive view is taken of all services which may need to be delivered on one or two sites only across the South East Midlands
- There will need to be continued strengthening of Long Term Condition management and a focus on the development of out of hospital care strategies with appropriate alternatives to acute hospital admission
- There may be increased travel for clinicians and patients so the implications of proposed service change will need to be considered as part of implementation planning
- SEM is covered by three ambulance trusts. Further modeling is required to assess the impact of possible increased numbers of transfers and longer journey times

- SEM covers a large geographical area. The impact of potential change on public and private transport use and availability, particularly in terms of social-deprivation, will need to be considered
- The development of uniform clear clinical pathways and transfer protocols are essential across SEM
- Improvements to the current hospital infrastructure will be required but, through collaborative working, any building programme should now be planned strategically, to support the delivery of these proposals
- Capital and transitional funding will need to be identified
- A robust IT system is essential to underpin all of these proposals
- The recruitment of consultant and middle grade doctors should continue, to ensure the same high quality service seven days a week
- Easy access to a high quality in hours and out of hours urgent primary care service, including admission avoidance, is essential
- A detailed assessment of the workforce impact and the identification of staffing and training requirements will be needed
- Current patient flows and pathways will need to change, so further discussion and engagement with tertiary providers is required
- Careful consideration must be given to the impact on patients in the areas surrounding SEM who currently access our services
- Strong governance and contractual arrangements will need to be in place so that services can work seamlessly across multiple sites
- Higher quality services should give better educational opportunities for trainees, and further work will be needed with clinical deans and LETBs to ensure equitable access to these
- Public engagement will need to be maintained going forward
- It is recommended that a proactive approach be taken to dissemination of CWG reports and the Clinical Senate report to clinicians and the public.

9. Conclusions

These strategic clinical models are the end result of 12 months of hard focussed work by almost 200 clinicians to recommend models of care for their population that are sustainable and meet 21st century standards and expectations. The Clinical Senate believes the case for change is incontrovertible and maintaining the status quo unsustainable both clinically and financially.

The Clinical Senate supports the strategic direction of a minimum of three hospital sites where the focus is more on urgent and emergency care with up to two remaining sites developing a focus on planned care in order to enhance quality, sustainability and

patient experience. Wherever possible care should remain as close, or even closer, to the patient's home as it currently is. However, a small proportion of patients may be required to travel slightly further in order to access higher quality elective inpatient services, and, depending on the final model adopted, whilst more patients with urgent needs may be treated in their own home or in their local communities others may need to travel slightly further to access emergency inpatient care of a higher quality.

The Clinical Senate also recognises that it will take some time to implement any agreed changes and that key changes in emergency care provision are dependent upon significant change in out of hospital care provision. This will provide the opportunity for transitional stages, which can be used to test and potentially modify any previously agreed assumptions.

There are a number of services still to be reviewed such as critical care, pathology and radiology but the requirements of these services will be determined by the final configuration of the frontline clinical services that they support. It is anticipated that work will continue when the final configuration has been agreed in order to ensure these services undergo a similarly robust review.

Appendix

Strategic Clinical Models

Model 1 (Status Quo)

Site 1	Site 2	Site 3	Site 4	Site 5
A&E	A&E	A&E	A&E	A&E
Trauma Unit	Trauma Unit	Trauma Unit	Trauma Unit	Trauma Unit
Emerg Surgery	Emerg Surgery	Emerg Surgery	Emerg Surgery	Emerg Surgery
Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	Complex & elective surgery
Acute medicine	Acute medicine	Acute medicine	Acute medicine	Acute medicine
ITU and HDU	ITU and HDU	ITU and HDU	ITU and HDU	ITU and HDU
Inpatient paeds	Inpatient paeds	Inpatient paeds	Inpatient paeds	Inpatient paeds
Obstetrics	Obstetrics	Obstetrics	Obstetrics	Obstetrics
Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement

And .. specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.

Model 2

Site 1	Site 2	Site 3	Site 4	Site 5
Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre
A&E	A&E	A&E	A&E	A&E
Trauma Unit	Trauma Unit	Trauma Unit	Trauma Unit	Trauma Unit
Emerg Surgery	Emerg Surgery	Emerg Surgery	Emerg Surgery	Emerg Surgery
Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	Complex & elective surgery
Acute medicine	Acute medicine	Acute medicine	Acute medicine	Acute medicine
ITU and HDU	ITU and HDU	ITU and HDU	ITU and HDU	ITU and HDU
Inpatient paeds	Inpatient paeds	Inpatient paeds	SSPAU*	SSPAU*
Obstetrics	Obstetrics	Obstetrics	Midwifery-led unit	Midwifery-led unit
Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement

And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
***SSPAU long term sustainability will need to be determined.**

Supported by strengthened Long Term Condition management and out of hospital care strategy

Model 3

Site 1	Site 2	Site 3	Site 4	Site 5
Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre
A&E	A&E	A&E	A&E	Networked A&E
Trauma Unit	Trauma Unit	Trauma Unit	Trauma Unit	
Emerg Surgery	Emerg Surgery	Emerg Surgery	Emerg Surgery	Day case and inpatient elective surgery centre
Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	Complex & elective surgery	
Acute medicine	Acute medicine	Acute medicine	Acute medicine	Acute medicine
ITU and HDU	ITU and HDU	ITU and HDU	ITU and HDU	ITU / HDU
Inpatient paeds	Inpatient paeds	Inpatient paeds	SSPAU*	SSPAU*
Obstetrics	Obstetrics	Obstetrics	Midwifery-led unit	Midwifery-led unit
Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics Inpatient reablement

And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
***SSPAU long term sustainability will need to be determined.**

Supported by strengthened Long Term Condition management and out of hospital care strategy

Model 4

Site 1	Site 2	Site 3	Site 4	Site 5
Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre
A&E	A&E	A&E	Networked A&E	Networked A&E
Trauma Unit	Trauma Unit	Trauma Unit		
Emerg Surgery	Emerg Surgery	Emerg Surgery	Day case and inpatient elective surgery centre	Day case and inpatient elective surgery centre
Complex & elective surgery	Complex & elective surgery	Complex & elective surgery		
Acute medicine	Acute medicine	Acute medicine	Acute medicine	Acute medicine
ITU and HDU	ITU and HDU	ITU and HDU	ITU / HDU	ITU / HDU
Inpatient paeds	Inpatient paeds	Inpatient paeds	SSPAU*	SSPAU*
Obstetrics	Obstetrics	Obstetrics	Midwifery-led unit	Midwifery-led unit
Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement

And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
***SSPAU long term sustainability will need to be determined.**

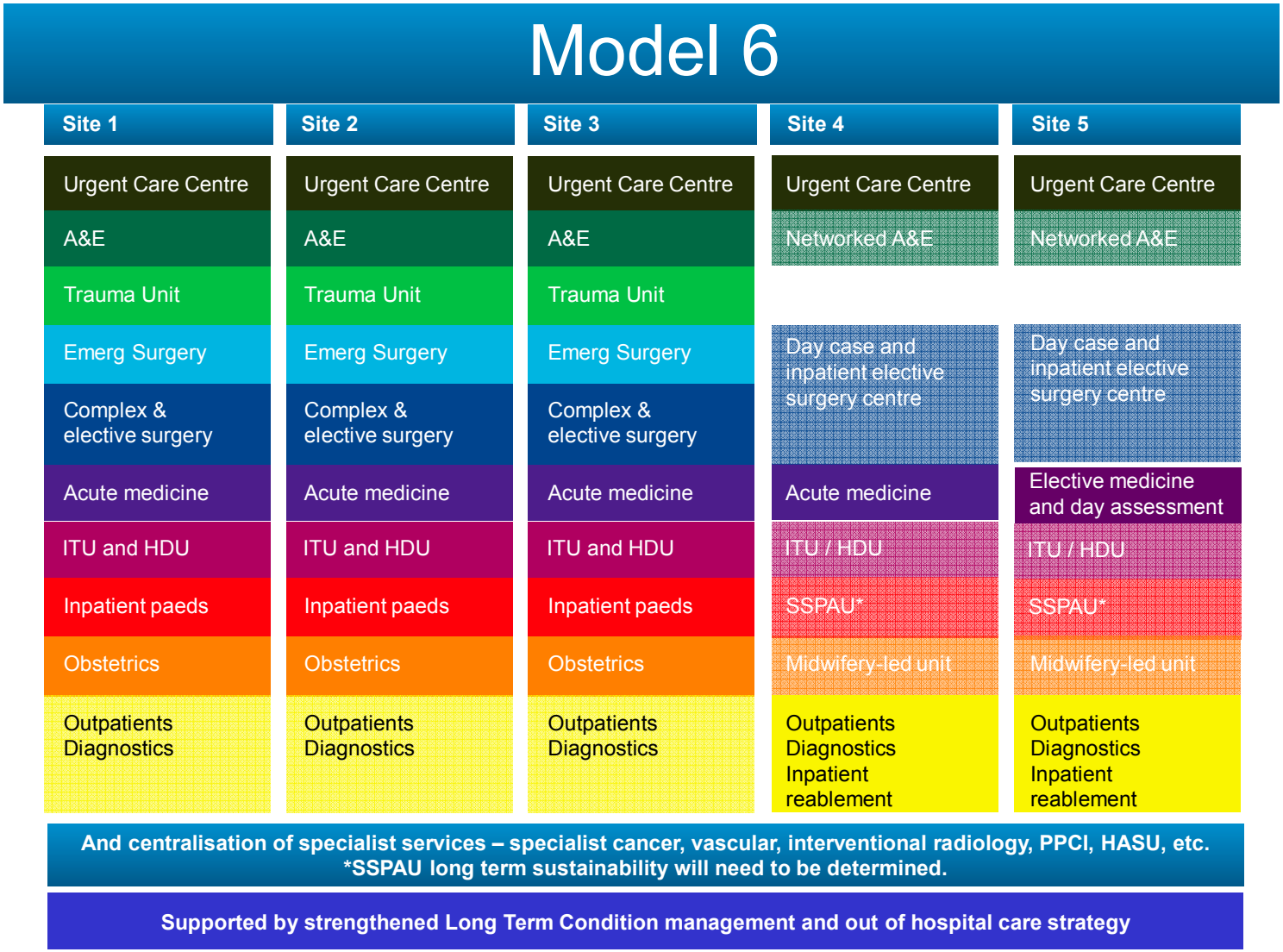
Supported by strengthened Long Term Condition management and out of hospital care strategy

Model 5

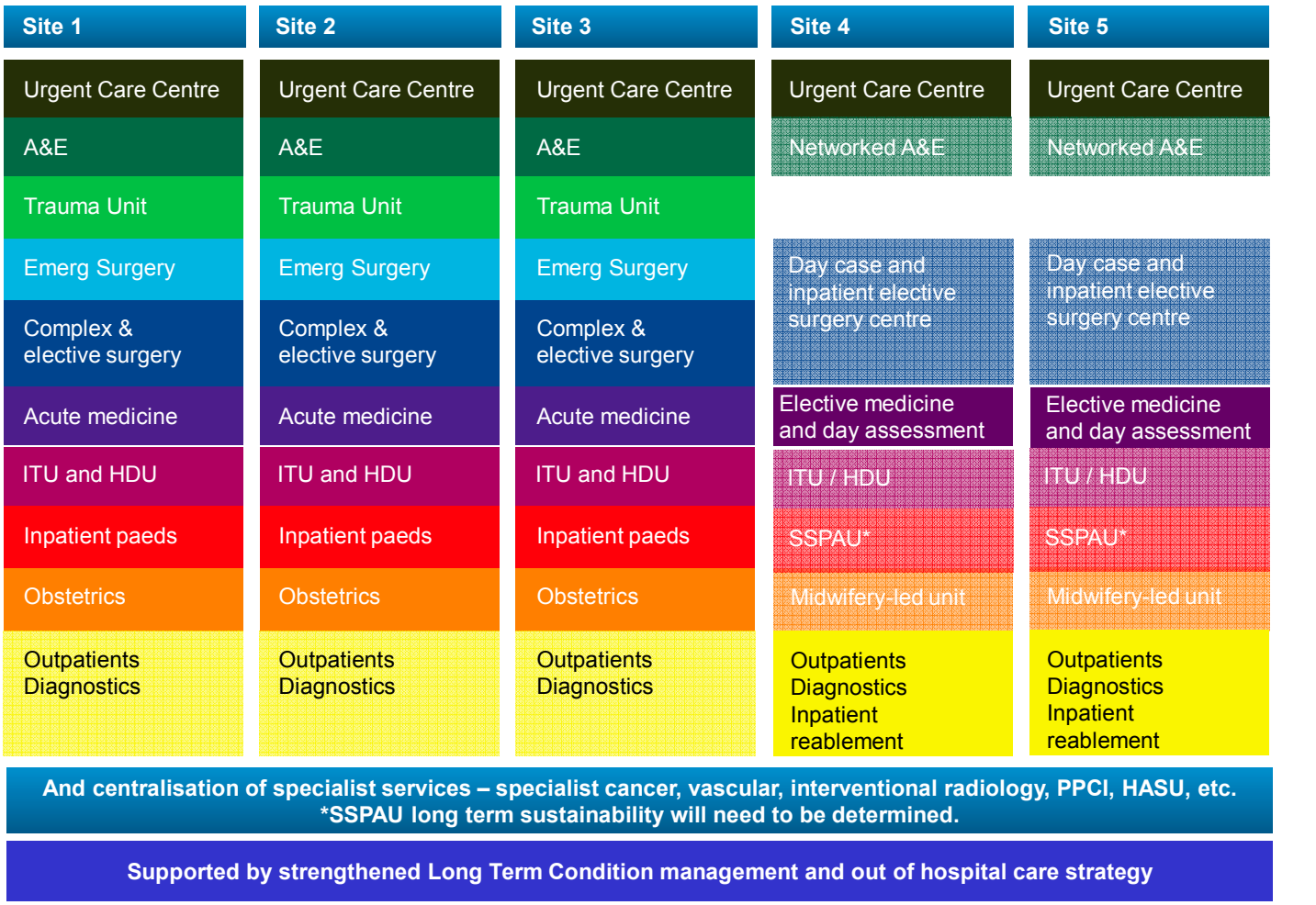
Site 1	Site 2	Site 3	Site 4	Site 5
Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre	Urgent Care Centre
A&E	A&E	A&E	Networked A&E	Networked A&E
Trauma Unit	Trauma Unit	Trauma Unit		
Emerg Surgery	Emerg Surgery	Emerg Surgery	Day case and inpatient elective surgery centre	Day case and inpatient elective surgery centre
Complex & elective surgery	Complex & elective surgery	Complex & elective surgery		
Acute medicine	Acute medicine	Acute medicine	Acute medicine	Acute medicine
ITU and HDU	ITU and HDU	ITU and HDU	ITU / HDU	ITU / HDU
Inpatient paeds	Inpatient paeds	SSPAU*	Inpatient paeds	SSPAU*
Obstetrics	Obstetrics	Midwifery-led unit	Obstetrics	Midwifery-led unit
Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics	Outpatients Diagnostics Inpatient reablement	Outpatients Diagnostics Inpatient reablement

And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
***SSPAU long term sustainability will need to be determined.**

Supported by strengthened Long Term Condition management and out of hospital care strategy


Model 6
Site 1
Site 2
Site 3
Site 4
Site 5
Urgent Care Centre
A&E
Trauma Unit
Emerg Surgery
Complex & elective surgery
Acute medicine
ITU and HDU
Inpatient paeds
Obstetrics
Outpatients Diagnostics
Urgent Care Centre
Networked A&E
Day case and inpatient elective surgery centre
Acute medicine
ITU / HDU
SSPAU*
Midwifery-led unit
Outpatients Diagnostics Inpatient reablement
Urgent Care Centre
Networked A&E
Day case and inpatient elective surgery centre
Elective medicine and day assessment
ITU / HDU
SSPAU*
Midwifery-led unit
Outpatients Diagnostics Inpatient reablement
And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
*SSPAU long term sustainability will need to be determined.
Supported by strengthened Long Term Condition management and out of hospital care strategy

Model 7


Site 1
Site 2
Site 3
Site 4
Site 5
Urgent Care Centre
A&E
Networked A&E
Trauma Unit
Emerg Surgery
Day case and inpatient elective surgery centre
Complex & elective surgery
Elective medicine and day assessment
Acute medicine
ITU / HDU
ITU and HDU
SSPAU*
Inpatient paeds
Midwifery-led unit
Obstetrics
Outpatients
Diagnostics
Inpatient reablement
And centralisation of specialist services – specialist cancer, vascular, interventional radiology, PPCI, HASU, etc.
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Supported by strengthened Long Term Condition management and out of hospital care strategy