The case for change

“Better care in the right place” is the tagline for the Healthier Together project, which is examining options to reconfigure hospital services across the south east Midlands.

It is investigating services delivered at five acute hospitals at Bedford Hospital Trust, Kettering General Hospital Foundation Trust, Luton and Dunstable Hospital Foundation Trust, Milton Keynes Hospital Foundation Trust and Northampton General Hospital Trust.

All five face similar problems to those being grappled with by the Royal College of Emergency Medicine guidelines, each emergency department should have 10 specialist A&E consultants to provide up to 16 hours of on-site shop floor cover seven days a week.

Across the south east Midlands the population is expected to grow from 1.6 million people to 2.1 million by 2031. This is the equivalent of three new towns the size of Northampton.

Birth rates in Corby, Luton and Milton Keynes are predicted to be higher than the national average.

With an ageing population, the region is also predicting a rise in those with long term conditions. The number of people with diabetes in the south east Midlands will rise from 84,000 in 2010 to 112,400 by 2020.

There are significant health inequalities across the area. In Corby, average male life expectancy is 75.2 years, compared to 80.8 years for men living in south Northamptonshire.

This all means the five hospitals face soaring demand in coming years.

Healthier Together has predicted workload at the hospitals, if they remain in their existing configuration, will rise 50 per cent over the next 30 years.

Strains emerge

Strain is already being felt at the five hospitals, which have all slipped beneath minimum staffing levels for consultants.

None of the hospitals has the correct number of senior consultants in A&E and it is already difficult to cover shifts and annual leave.

According to the Royal College of Emergency Medicine guidelines, each emergency department should have 10 specialist A&E consultants to provide up to 16 hours of on-site shop floor cover seven days a week.

Across the five trusts there are 22 A&E consultants, 28 fewer than the College of Emergency Medicine recommendations. Given the national shortage of consultants and the cost of recruiting them, the hospitals have said it would be seven to 10 years before they could meet the requirement.

It takes 14 years to train an A&E consultant, meaning that many trusts unable to recruit face no option but finding new ways of working.

There are also shortages in other areas such as stroke, maternity units and paediatrics, where in some cases there are only single consultants working in each department.

Four of the five hospitals do not meet the level of consultant cover for labour wards as suggested by the Royal College of Obstetricians and Gynaecologists, which suggests a minimum obstetric consultant cover of 40 hours a week.

Alongside the rising healthcare demand, and shortage of consultant level staff there is the question of finances.

HSJ has been told the south east Midlands faces a financial gap of around £48m over the next five years if the status quo remains.

The figure was determined from detailed business modelling for the five hospital trusts against the expected demand on services and rising costs.

The reality for the region is that no change is not an option.

The principles of the action plan

In a bid to tackle the problem the regional health bodies have come together to form Healthier Together, a partnership between 12 NHS organisations including all five acute trusts, two primary care trust clusters and five clinical commissioning groups.

Healthier Together, which launched in January, has had direct contact with more than 12,000 members of the public. It aims to convince them of the need for the system to change and gather views on what priorities should be.

The key aim of Healthier Together is to improve services to get better outcomes for patients while also ensuring services are viable in the long-term.

More than 200 hospital clinicians and GPs have been working together in six clinical working groups to explore detailed options for six specialty areas: emergency care, maternity, cancer, long term conditions, children’s services and planned care.

The clinical working groups, clinical senate and project board concluded in July that centralising specialist staff on fewer sites serving the whole region would offer the best outcomes and create a more viable long-term structure.

It is understood this will see the five hospitals working more closely together, operating in a network arrangement. Some treatments will be centralised at hospitals which can
support a greater level of expertise. One source involved with the project said: “This is not about downgrading, we can’t be islands in an ocean anymore; we have to be networked together.”

“This is a trade-off – you can’t provide a consultant in everyone’s front room and you can’t create a hospital for the whole of England.” As part of the plan, Healthier Together has said more routine procedures like blood tests and regular treatments will be delivered in the community, using GP surgeries and community facilities.

Improvements in surgery, drugs and equipment mean many procedures no longer require an overnight stay in hospitals.

The region is largely rural and some residents could face considerably longer journeys. A transport working group is analysing journey times for private cars, as well as ambulances and for those relying on public transport as part of the modelling.

No decisions will be made until after full public consultation on the detailed proposals, which will take place early in 2013.

Potential solutions

Two options for the five hospitals have been drawn up by clinicians. They are currently being tested with procedures no longer require an overnight stay in hospitals. The region is largely rural and some residents could face considerably longer journeys. A transport working group is analysing journey times for private cars, as well as ambulances and for those relying on public transport as part of the modelling.

No decisions will be made until after full public consultation on the detailed proposals, which will take place early in 2013.

Potential solutions

Two options for the five hospitals have been drawn up by clinicians. They are currently being tested with detailed modelling and analysis before the final proposal is drawn up.

The first option would see three hospitals provide 24/7 emergency services, including emergency surgery, a full range of maternity obstetric services and inpatient paediatrics. These hospitals would continue to offer the same level of acute medicine, outpatient appointments and daycase procedures as they do at present. The other two hospitals would have “networked” emergency departments, not handling the most serious cases, and midwife-led units, with the most difficult births being dealt with elsewhere.

Some planned surgery would move to these hospitals from the other three hospitals. The two sites would also host short stay paediatric units and outpatient appointments but lose emergency surgery. The two sites would also provide an expanded elective surgery centre for procedures such as hip and knee replacements. Under the second option the two hospitals with the reduced A&E services would also lose the acute medicine provision.

It is thought the reduced A&E departments would still see up to 80 per cent of their patients, with only the most seriously ill being taken to a more centralised centre of excellence. This already happens for some conditions such as major trauma, hyper-acute stroke and heart problems.

Evidence, particularly with hyper-acute stroke care in London, shows that centralising specialist care in one place can lead to reduced mortality and improved rehabilitation.

Political landscape

The review of acute services has been thrust unexpectedly into the spotlight by the resignation of Conservative MP Louise Mensch, which has led to a by-election in Corby on 15 November. This has prompted questions in the House of Commons at prime minister’s questions and political leaks revealing details of only some of the options being considered. This has led to a belief that Kettering General Hospital could be “downgraded” with the loss of hundreds of beds.

In Milton Keynes, Labour politicians have suggested that cutting other hospital services could add further pressure on services there. However, HSJ has been told any changes would be implemented over time and would involve capital investment to upscale services where needed.

Under some of the scenarios leaked to the public, Northampton General would gain 100 beds while Kettering General would lose 515 beds.

In Bedford there is now a Save our Hospital campaign launched by the Liberal Democrat mayor Dave Hodgson.

Sources close to the project say the interference by politicians risks alienating the public against the plans and could prevent the issues being properly debated and discussed. The NHS could therefore end up being more cautious, failing to make the required decisions.

One source at the review said: “Politicians do what politicians do but the options people have seen have only been a small part of the total.

“It is very unhelpful to make comments and remarks which spark fear in the public and make our job, of explaining and rationally trying to show why what we are doing is better for the patient, even harder.

“We will carry on with what we’re doing, at the end of the day, the risks associated with doing nothing are too great and the gains if we get it right are too good, not to press on.”

The final options, and locations, are expected to be revealed in January followed by a formal public consultation which will last for a minimum of 13 weeks.

A final decision on which model will be chosen is expected to be made by April.

Implementation of the plan could take between three to five years, HSJ has been told.

The likely scenario

One senior source involved with Healthier Together said: “We are six months away from making any final decision but it is very likely that when you need some complex treatment or surgery you will go to the best centre but there is still a lot more work to get through.”

Kettering General Hospital is the smaller neighbour of Northampton General Hospital and serves a population of around 300,000 people with approximately 600 beds.

It has already seen some vascular surgery and stroke care centralised at Northampton General. Last month it was found in significant breach of its authorisation by foundation trust regulator Monitor – partly for its failure to hit the A&E waiting times target over an 18-month period.

Monitor also raised concerns over the trust’s ability to deliver on its cost improvement plans and ordered the board to carry out a review of its governance by early December.

Bedford Hospital has around 400 beds serving a population of 270,000 people predominantly in north and mid Bedfordshire.

The trust is likely to merge with Milton Keynes Foundation Trust after it accepted it was not viable as a standalone FT.

Chief executive Joe Harrison has previously said the trust lacked the “necessary clinical critical mass and long-term financial viability” due to its size.

HSJ has been told by several senior sources involved with Healthier Together that these two hospitals are the most likely candidates to have their A&E departments downgraded, with the most serious high risk cases going to centres elsewhere.

But they are likely to gain some routine work. Kettering has an £18m short-stay surgery centre which opened in April 2007 and helped to
reduce most lengths of stay after an operation there to less than 48 hours.

The remaining three hospitals – Northampton General, Milton Keynes and Luton – will retain their A&E departments and offer more specialist services.

An insider on the review said the two trusts, Kettering General and Bedford Hospital, were the smallest sites and had the least sustainable clinical teams.

But the insider added that work was on-going as to exactly how the models would operate and no final decision had been made.

“If we do this, and get it right, it will be fantastic for the service and for patients,” the source added.

“It should lead to some real improvements in clinical outcomes.”