Wessex Clinical Senate

The Development of a Critical Treatment Hospital for North and Mid Hampshire

Report of the Wessex Clinical Senate Council

September 2014

EXECUTIVE SUMMARY

The Wessex Clinical Senate was asked by West Hampshire and North Hampshire CCGs and NHS England (Wessex) to provide assurance on the clinical service change proposals by Hampshire Hospitals for the development a new critical treatment hospital for North and Mid Hampshire as part of the NHS England service change process.

The Senate Council appointed an external review team and received its report which was considered on 11th September 2014. The Senate Council found that there were major changes proposed to the clinical care pathways for patients in the General Hospitals in Winchester and Basingstoke as well as in the new Critical Treatment Hospital. The Senate Council recognised the need for centralisation of services but agreed with the conclusions of the external review that there was insufficient documentary evidence around staffing, rotas, care pathways for patients in the General Hospitals and partnership working with other providers.

The Senate Council is currently unable to provide clinical assurance about the impact of these proposals on the safety and sustainability of care for the wider patient population in the Hampshire Hospitals NHS FT catchment area. The attention of commissioners is directed to a number of outstanding questions that require robust supporting evidence in order to achieve a level of assurance that would support progression to public consultation. The Senate Council would be willing to assist commissioners in the assessment of such evidence when comprehensive documentation is made available in response to the outstanding clinical issues.

INTRODUCTION

Wessex Clinical Senate was asked by West Hampshire and North Hampshire CCGs and NHS England (Wessex) to provide clinical advice on the service change proposal formulated by Hampshire Hospitals to develop a new critical treatment hospital for North and Mid Hampshire (Appendix A). This is part of the formal NHS England service change assurance process.

NHS England has a role to support and assure the development of proposals and the case for change by commissioners. The principles of the assurance are that it should be robust, consistent and supportive. At the heart of the NHS England assurance process for service change are the four tests from the Government's Mandate to NHS England . The four tests, intended to apply in all cases of major NHS service change during normal stable operations, are:

i. strong public and patient engagement;

ii. consistency with current and prospective need for patient choice;

iii. a clear clinical evidence base; and

iv. support for proposals from clinical commissioners.

In addition to these four tests, the NHS England assurance toolkit also identifies a range of best practice checks for service change proposals, these include:

i. clear articulation of patient and quality benefits;

ii. the clinical case fits with national best practice; and

iii. an options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and / or organisations.

PROCESS

An external chair of the review team was appointed by the Senate Chair. The Senate Chair and Manager worked in consultation with the review team chair to recruit the review team, drawn from a range of organisations (Appendix B). The review team reviewed the case for change and options appraisal. It answered a number of specific questions which were in the terms of reference, based on evidence presented to it and by visits to the two existing General Hospital sites at Basingstoke and Winchester.

The Clinical Senate Council considered the review team's findings on 11th September 2014 and has commented specifically on:

1) The comprehensiveness and applicability of the review.

2) The content and clarity of the review and its suitability to the population in question.

3) The interpretation of the evidence available to support its recommendations.

4) The likely impact on patient groups affected by the guidance.

5) The likely impact / ability of the health service to implement the recommendations.

THE CLINICAL SENATE'S CONSIDERATIONS

The Senate Council was impressed that the review team were able to produce their report in a shorter timeframe than set out in the guidance and commended the thoroughness of their report. The Council acknowledged the willingness of the review team to give up their time and their dedication to the process, including team members making themselves available for the visit to Hampshire Hospitals on 13th August 2014.

The Senate Council acknowledged the unanimity of the conclusions of the review team and agreed with all the findings.

1) The comprehensiveness and applicability of the review

The Senate Council was satisfied that the review had addressed the salient issues around the proposed development. It became evident during the course of the review that the language used to describe the health services which were under discussion needed to be consistent across all organisations for absolute clarity. For this reason, North Hampshire Hospital, Basingstoke and Royal Hampshire County Hospital, Winchester are referred to in this report as "the General Hospitals in Basingstoke and Winchester". "The Critical Treatment Hospital" refers to the proposed new building which could be based on a green field site between Basingstoke and Winchester or on the Basingstoke site. The option proposed for 'the development of a critical treatment hospital' is essentially a three hospital model rather than a one hospital model so it is referred to as such in this report. The Programme Director from Hampshire Hospitals confirmed to the Senate Council that the Trust proposed to admit non-elective patients to all three sites.

2) The content and clarity of the review and its suitability to the population in question

Senate Council commended the report for its clarity and noted the comments of the team chair that there was high level of consensus amongst the sixteen review team members on their answers to questions which were put to the team in the terms of reference.

The Senate Council concluded that the development of the Critical Treatment Hospital (CTH) would have a significant impact on the General Hospitals at Basingstoke and Winchester and would completely change the nature of the services provided there. The Senate Council recognised that the review team was not provided with sufficient evidence to assess the suitability of the proposed design for the group of patients whose needs are less acute and less organ- specific, particularly older or frailer patients who present with a range of inpatient care needs and whose co-morbidities are becoming increasingly challenging for the NHS to treat as people live longer.

The Senate Council noted that the review team also did not have sufficient information to assess the impact of the proposed design on:

- Patients with physical health problems who have mental health needs
- Patients with mental health problems who have physical health needs
- Patients requiring end of life care
- Patient access

The Senate Council observed that no agreed accurately described model of staffing was presented by the CCGs and Hampshire Hospitals and this was a significant gap in the clinical case for change. The review team would have liked to see the detail of the number of consultants and associate/trust grade doctors, advanced nurse practitioners and other nursing staff and therapists by specialty required to support the proposed three hospital model with detailed rotas and workforce plans.

There is a plan to retrain existing nursing staff to become Emergency Nurse Practitioners but the Senate Council was not assured without supporting evidence that this would be adequate to meet the needs of patients in the General Hospitals. Potentially, new 'Associate Specialist' doctors who have more general skills would complete training in 6-8 years' time. It is not clear how many of these the Trust is planning to employ. At present, without this information, concern remains that it may be impossible to recruit some of the staff on whom this model is dependent.

In paediatrics and obstetrics, the centralisation of services to ensure consultant present care 24/7 should improve outcomes and is in line with Royal College recommendations. However the Senate Council noted that in paediatrics, only one hospital in the UK had achieved this to date and was currently experiencing difficulties with recruitment. Hampshire Hospitals had proposed that in addition to being at the Critical Treatment Hospital 24/7, paediatric consultants would be present during extended hours in the Paediatric Assessment Units in the General Hospitals in Basingstoke and Winchester. Paediatric mental health, self-harm and alcohol/substance misuse patients would need to be admitted prior to psychiatric and social assessment and plans for the pathways for these vulnerable patient groups were not available. The predicted number of births in the Critical Treatment Hospital would require a large neonatal unit to be co-located there, which would also increase the number of consultants required. Based on current information, the Senate Council thought that there is a high risk that the three site model may prove unsustainable for paediatrics. Without seeing the staffing assumptions and rotas, no assurance could be given as to whether these services would be safe and sustainable initially and in the future.

The predicted number of births in the General Hospitals in Basingstoke and Winchester is high, particularly given that mothers tend to assume that there is obstetric and anaesthetic cover if they are in hospital. If mothers know that this is not the case in the midwife-led units, there is risk that they are more likely to choose the obstetric led service. This may increase public demand for obstetric beds in Basingstoke and Winchester, as well as increasing pressure on adjacent maternity units.

3) The interpretation of the evidence available to support its recommendations

The model proposed of three hospitals working together across a mixed rural and urban geography is unusual and the Senate Council was unaware of the existence of a similar model in the UK. The level of evidence showing how the three hospitals would work together would be higher than required for these other 'tried and tested' models as the impact of such a model on other health services is largely unknown.

The Senate Council was not presented with evidence or an options appraisal to support why Hampshire Hospitals opted for a model which separates outpatients from urgent and emergency care for all specialties. There was a concern that some acute admissions would require specialist opinions that would not be available at the Critical Treatment Hospital as some specialties would be based in outpatients at the General Hospital sites.

Accurate assessment of the deteriorating patient is critical to this three hospital model. The quality of assessment/clinical decision making on all three sites is vital to the success of this model which is why the review team asked to see the proposed staffing levels and rotas. The Senate Council was concerned that junior staff would be expected to work in new ways: deciding whether to contact senior staff at night and whether to call an ambulance or patient transport to transfer are big decisions which require simulation drills and cultural change and support through the use of technology. The Senate Council was not assured that there were plans in place that addressed these needs.

4) The likely impact on patient groups affected by the guidance.

The Senate Council noted that the review team was told that some analysis had been done on the number of patients who currently present at Winchester or Basingstoke who would have been transferred to the Critical Treatment Hospital had the new model been in place. However, the review team reported that this was based on a single week in the summer period. The chair of the review team expressed the view that they would have liked to see documentary evidence, data gathered over a longer time frame and the inclusion of the winter period.

There is concern that if the development of the critical treatment hospital went ahead as proposed without new pathways being agreed with primary, community and mental health services, the General Hospitals would become blocked with patients awaiting multi-agency

assessment. As mentioned earlier, the impact of the development of the Critical Treatment Hospital on patients whose needs are less acute and less organ specific, the older population, those with mental health needs and those requiring end of life care is unknown.

The Senate Council speculated that the General Hospitals in Winchester and Basingstoke could lend themselves to creative options/solutions of joint working with primary care, mental health and social care providers; as rehabilitation hubs delivering integrated care closer to home. The Council was surprised that this option does not appear to be under active consideration at present. The Council regarded this as a potentially missed opportunity that could deliver significant benefits to patients and to the wider health economy.

The potential impact of centralisation of paediatric and obstetric services is predicated on the location of the Critical Treatment Hospital and the sustainability of the proposed staffing models. There is concern that the paediatric access model proposed across three hospitals could make access more complex for the parent with a sick child and that an options appraisal for centralisation of this care should be conducted to identify if there are possible benefits from clarity of access and patient outcomes. Equally, the Senate Council was concerned that University Hospital Southampton will not be able to take more obstetric-led births without an additional delivery suite if patients decide not to travel to the Critical Treatment Hospital.

The Senate Council was not clear as to how many of the patients who currently receive their whole pathway of care in the general hospitals at Winchester and Basingstoke would be treated in the Critical Treatment Hospital and then transferred to the General Hospital sites in Winchester and Basingstoke for rehabilitation before discharge. The Council was told that a transfer between hospitals can add 3-5 days to the average length of stay so the impact on bed numbers required should be modelled.

5) The likely impact / ability of the health service to implement the recommendations

The Senate Council welcomed the general direction of this initiative which is to centralise services. Because of lack of evidence, the Senate Council could not answer the question that it was posed, whether this is a clinically appropriate solution for the delivery of health care to the population of this area of Hampshire. There is considerable potential to improve outcomes for patients who require urgent and emergency care, cardiovascular and cancer services, if the staffing model is sustainable. For other patient groups, there are still unanswered questions as to the balance of beneficial and detrimental effects.

Hampshire Hospitals NHS Foundation Trust and the CCGs are relatively new organisations which did not exist three years ago. The Senate Council was concerned that their ability to implement any change would be compromised if a decision is made to go to public

consultation before the outstanding clinical issues are addressed. The Council recognises that this decision ultimately rests with the commissioners.

CONCLUSIONS AND RECOMMENDATIONS

1. The Senate Council recognised that the "do nothing" option is not a viable one. Its advice to commissioners is that they ensure that evidence-based comprehensive options appraisals are prepared for public consultation so that the need for change is properly understood.
2. The Senate Council and its review team were not presented with sufficient information to provide commissioners with assurance that the development of the critical treatment hospital will benefit patients who will be treated in future at the General Hospitals in Winchester and Basingstoke.
3. The Senate Council was concerned that there should be clarity in any public consultation on what the options entail for the entirety of the Trust's clinical activity. The clinical impact is beyond that which can be fully described as 'the development of a critical treatment hospital' and is essentially a three hospital rather than a one hospital model.
4. The Senate Council members were concerned that there may be other options which may incur less clinical risk and may be more sustainable in the long term more than the option currently preferred by Hampshire Hospitals. These include options that have been implemented elsewhere in the UK which may be supported by evidence from audit of their impact on clinical care.
5. The Senate Council recommends that the CCGs and NHS England seek well-documented evidence to address the following outstanding clinical concerns:
    a. The relationship between the proposed Critical Treatment Hospital and the "Keogh" urgent and emergency care centres, in terms of catchment population and the clinical activity proposed was uncertain and commissioners should have this clarified in light of national guidance.
    b. The need to understand the impact on patient pathways and care by illustration of a range of clinical scenarios so that both commissioners and the wider public can appreciate the impact of the proposed changes.
    c. The detection, assessment and management of deteriorating patients in the General Hospitals, on a 24 hour, 7 day basis including the composition and skill levels of resident clinical teams, the ability to sustain such staffing and the access to appropriate diagnostics, including cross-sectional imaging, such as CT pulmonary angiography for embolism.
    d. The documentary evidence to support the recruitment of GPs, staff-grade doctors and nurses, the numbers required and proposed rotas should be provided before public consultation.
    e. The criteria for admission of non-elective patients to the General Hospitals should be documented. Evidence should be provided of collaborative working with primary care, community, mental health, social care and other

providers to ensure that admissions are only made where the patient is identified as having specific needs that can only be met by presence of the patient in a ward bed on the General Hospital sites.

f. In light of (e) above, evidence should be sought of the rationale behind the Trust's plans for the bed numbers and services on the General Hospital sites.

g. The paediatric access model proposed across three hospitals could make access more complex for the parent with a sick child. An options appraisal for centralisation of this care should be conducted to identify if there are possible benefits from clarity of access, sustainability of staffing and patient outcomes.

h. Evidence should be obtained from staffing plans and rotas of how the Trust will provide an on-site consultant review of each in-patient at least once every 24 hours, seven days a week, with support services such as diagnostics and therapies, while operating with the same number of beds and enhanced services on the Critical Treatment Hospital site.

APPENDICES

Appendix A. Terms of Reference

Appendix B. Review Team

Appendix C. Review Team's Report to the Senate Council