

# Better Healthcare in Buckinghamshire

Proposals to change and  
improve NHS services



**Consultation Document**

January 16 to April 16 2012

## Statement of support from clinical leaders

**“As clinical leaders of the NHS in Buckinghamshire, we have a responsibility to local people to ensure that we develop health services that are high quality, sustainable and affordable, both now and for future years.**

Our vision is to create a system of health care in Buckinghamshire that puts the patient at the heart, providing people with information to make decisions about their own health and well being and their care.

We believe that we can do more to prevent ill health, and to help people who become ill with long term conditions to better manage their illness. We also believe that we can do more to improve the quality of care and to achieve better outcomes for patients.

We believe that the best way to achieve this is by bringing together primary, community and secondary care clinicians in closer partnership, so that care is centred on the needs of patients and not blocked by organisational boundaries. This will also require the development of stronger links with social care, leading to the development of shared priorities and joint planning.

Where clinically appropriate and practicable, we believe that health services should be delivered in the local community. Only care that has to be provided in an acute hospital setting will be delivered there. As a result, our community services will grow, and our need for acute hospital based services will decrease. The result will be a more effective and efficient NHS in Buckinghamshire with prioritised use of resources, minimised waiting times, high quality services, improved patient outcomes and greater financial stability.

We believe that the proposals set out in this report, which were developed through the Better Healthcare in Bucks programme, reflect

our aim to provide patients with higher quality services, and better outcomes. We also believe that they are financially sustainable.

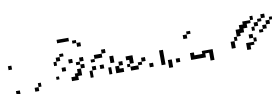
These proposals should not, however, be seen in isolation. As clinical leaders, our responsibility is to continuously review what we do and find new ways of improving services for local people, in partnership with our patients.”



**Dr Annet Gamell**  
Chair, Bucks Primary  
Care Collaborative



**Dr Graz Luzzi**  
Medical Director,  
Buckinghamshire  
Healthcare NHS Trust



**Dr Johnny Marshall**  
Chair, United  
Commissioning



**Dr Geoff Payne**  
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Buckinghamshire and  
Oxfordshire Cluster

These proposals have also been developed and agreed for consultation with our partners:

**Anne Eden**  
Chief Executive, Buckinghamshire Healthcare  
NHS Trust

**Chris Williams**  
Chief Executive, Buckinghamshire County  
Council

**Philippa Slinger**  
Chief Executive, Heatherwood and Wexham  
Park Hospitals NHS Foundation Trust

**Will Hancock**  
Chief Executive, South Central Ambulance  
Service

**January 2012**

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# 1

## Introduction

**The NHS in Buckinghamshire is proud of its services. We want to continue to change and develop them in a way that delivers safe, high quality care, and better meets the needs of our patients.**

Over the past year, we have set out to do this through the 'Better Healthcare in Bucks' programme. This document describes the proposals which have been developed by that programme. It has been produced by NHS Buckinghamshire and Oxfordshire Cluster (the Primary Care Trust or PCT) which is responsible for buying local health services on behalf of the local population. It has the support of the developing Clinical Commissioning Groups (CCGs), who are progressively taking over responsibility from the PCT from April 2012, and Buckinghamshire Healthcare NHS Trust (BHT), which runs hospital and community services in the County. The proposals have also been discussed with our colleagues in Heatherwood and Wexham Park Hospitals NHS Foundation Trust, South Central Ambulance Trust, and Buckinghamshire County Council. We have involved patients and the public in our engagement phase, as we value their views. The document sets out:

- the opportunities and challenges currently facing the local NHS
- how doctors, nurses and other clinical colleagues are approaching these opportunities and challenges
- what we have learned from patients and the public during our engagement and involvement events

- proposals for change to our acute hospitals. We are not proposing any changes that affect community hospitals
- how you can give us your views.

**There is a glossary on page 53 explaining some of the words and phrases used in the document.**

**We have aimed to provide a wide range of information for you to give us your views. You can find more on our website. If you have questions we have not answered, please do not hesitate to contact us.**

You can have your say in a number of different ways:

- by emailing **betterhealthcareinbucks@buckinghamshire.nhs.uk**
- complete the feedback form and return to:  
**Better Healthcare in Bucks**  
**Freepost RRGX-CBGA-TSLK**  
NHS Buckinghamshire  
3rd Floor Rapid House, 40 Oxford Road  
High Wycombe, BUCKS HP11 2EE

**The deadline for responses is 16 April 2012.**

A summary version of this document is also available by email or by phone from **01494 552256**.

At the end of the consultation period, we will report publicly on what you said, how this has influenced our proposals and what changes we plan to make, taking account of the results of consultation.

For more information:

**[www.buckinghamshire.nhs.uk/bhib](http://www.buckinghamshire.nhs.uk/bhib)**

# Have Your Say

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If you require this publication in an alternative format, including other languages or as an audio book, please contact us by emailing us at [betterhealthcareinbucks@buckinghamshire.nhs.uk](mailto:betterhealthcareinbucks@buckinghamshire.nhs.uk) or phoning **01494 552256**.

## 2

# Background

### The changing NHS

The NHS, both locally and nationally, is changing. There are many new challenges we have to meet, but also many opportunities to provide healthcare in new and better ways:

- Rising demand for healthcare in Buckinghamshire. We are all living longer, but not always in good health.
- Long term conditions including heart disease, stroke, diabetes and asthma affect tens of thousands of people in Buckinghamshire. The vast majority of patients with these conditions can be well cared for in the community, if the right services are on hand.
- Evidence shows that patients see better results and improved outcomes and survival rates if they are treated in specialist centres of excellence, but these need specialist equipment and also a critical mass of patients if clinicians are to maintain their skills<sup>1</sup>. We cannot provide centres of excellence everywhere. These centres of excellence now often work together in networks across a region, to ensure that all patients have access to high quality care – for example, cancer and critical care services have been networked for a number of years, and trauma and stroke services are being planned on a regional basis. Later on in this report we summarise some of this evidence, based on developments in other parts of the country.

In Buckinghamshire in 2010, 39,500 residents were aged 75 or over, and 11,750 were aged 85 or over. By 2026 the number of those aged 75 or over will have risen by 62% to 64,050, and those aged 85 or over will have risen by 90% to 22,350.

- Thanks to developments in diagnosis and treatment, we can do far more to look after patients at home and in the community. This reflects what patients say they want, and provides better outcomes. At the same time, when people have to go into hospital, it is usually for a far shorter period of time than would have been typical in the past. This means that we need to put more resources into our community services. In the future we should need fewer acute hospital beds. Treating people in the right place frees up hospital beds and services for those who really need it.

### Care for the Future

A regional review of the health system in Buckinghamshire and Berkshire (Care for the Future, launched in 2009) looked at the reasons why the NHS needs to change and the opportunities for developing high quality services which could stand up to pressures both now and in the future. This review involved doctors, nurses and other clinicians as well as representatives of patient groups and partner organisations.

The Care for the Future summary report<sup>2</sup>, published in 2011 by the Buckinghamshire and Berkshire PCTs, proposed that all of Buckinghamshire's hospitals had a role to play in the local NHS but that changes needed to be made. It also recommended that far more could be provided in the community, to help patients avoid hospital admission, or to be discharged more quickly when they no longer need hospital care.

## Better Healthcare in Bucks

In 2011, in response to Care for the Future and to ensure our health services are able to continue to adapt to the changes described above, Buckinghamshire and Oxfordshire NHS Cluster (the PCT) established the Better Healthcare in Bucks programme. We did this in partnership with Buckinghamshire Healthcare NHS Trust and our clinical commissioning groups (the groups of GPs and other healthcare professionals that will take over commissioning from the PCT).

The aim of Better Healthcare in Bucks is to develop health services which:

- are high quality, with excellent results for patients
- are accessible, with care close to home for most people
- offer a good patient experience
- can be sustained, despite future challenges

### **‘Localise where possible; centralise where necessary.’**

Over the past few months, doctors, nurses and other clinical colleagues (referred to as ‘clinicians’ in this report) have been meeting together through the ‘Better Healthcare in Bucks’ programme to discuss current opportunities and challenges and to look at how services should develop. All of the proposals in this document have been developed by hospital doctors, GPs and other clinicians, and have the support of their clinical colleagues.

The proposals were debated at two ‘clinical summits’ which brought together hospital doctors with their GP colleagues. They have also been discussed and developed in a number of other meetings involving clinical staff within BHT, within the Clinical Commissioning Groups (the GPs and other colleagues who are taking over commissioning from PCTs) and at the Clinical Commissioning Board which brings together clinical and other staff from the NHS and partner organisations.

In Buckinghamshire 13% of people reported that they have a limiting long-term illness compared to 18% in England and 15% in the South East. An ageing population means that the prevalence of long term conditions is expected to rise by more than 20% over the next 25 years. Nationally people with long term conditions are estimated to use 52% of GP appointments, 65% of outpatient appointments, 72% of bed days in hospital, and 69% of the total health and social care budget<sup>2</sup>

During September and October 2011 through our engagement and involvement programme, we held broader discussions with other colleagues, staff, patients, interested organisations, and members of the public, to explain to people why health services needed to change. We then passed comments and feedback on to the clinical teams developing the proposals. We found that there was strong support for our approach and for the principles we are following. A summary of our engagement and involvement activities and the feedback we received is set out in this report. During this time we have also worked closely with Buckinghamshire County Council Public Health Overview and Scrutiny Committee, so that they are kept informed on our progress.

While Better Healthcare in Bucks is a programme of work to improve the way in which acute hospital services are provided in Buckinghamshire, it should not be seen in isolation. In Buckinghamshire, as elsewhere in the country, the NHS is striving to create health services that are better integrated, with no artificial barriers between health and social care organisations or between hospital, primary and community services. Services designed around our patients needs, providing people with information to make decisions about their own health and well being and their care.

# 3

## Why we need to change in Buckinghamshire

### Why change the NHS?

Ever since its inception, the NHS has changed, reflecting advances in our knowledge and skills in medicine. As evidence continues to grow about how to achieve the best results for patients, we need to be continually looking for better ways to provide healthcare. For example, we know that stroke, trauma and cardiac patients do better when they are treated by specialist teams working together in centres of expertise.

***“There has been a wealth of clinical evidence for many years that specialist clinical services such as stroke, trauma and heart surgery should be concentrated in fewer centres. This would allow the latest equipment to be sited with a critical mass of expert clinicians who regularly manage these challenging clinical problems, and are backed by the most up to date research. The greater volumes of patients mean that doctors are better at spotting problems and treating them quickly. Survival and recovery rates would improve markedly with many lives saved. Patients may indeed have to travel further for some specialist care, but if it is significantly better care then we believe that centralisation is justified.”***

***“However, at the same time there is also strong evidence to support a large amount of more routine care, currently taking place in hospitals, being carried out closer to where patients live in the community with GPs playing a crucial role in the delivery of services.”***

The Presidents of the Academy of Medical Royal Colleges, April 2010<sup>3</sup>

### Expanding our community services - Care closer to home

We have already made a number of improvements to healthcare in Buckinghamshire. In 2010, we brought together community and acute hospital services under one provider of care, Buckinghamshire Healthcare NHS Trust (BHT). This has helped us to provide services in a more integrated way, and reduce the length of time patients need to spend in hospital. Over the past year we have invested in our community services, doubling the number of community contacts to ensure that more people are able to benefit from these services.

Our adult community health teams of nurses and therapists provide clinical support to help people stay at home rather than be admitted to hospital, or help them after they have been discharged following specialist treatment in hospital. They now provide care around the clock, 7 days a week and can be at a patient's side within one hour of a referral. They also work in the hospitals with the specialist medical staff ensuring patients have a smooth transition back home.

We also provide community hospital inpatient beds in Amersham, Buckingham, Marlow and Thame. These are for people who are too ill to be cared for in their own homes but do not need the specialist care of the acute hospitals. By September 2011 we had 80 community beds, nearly doubling the number of beds available in 2010. For many people the community hospitals provide the best place to rehabilitate after being in the acute hospital.

This has allowed us to reduce the numbers of patients needing rehabilitation in Wycombe and Stoke Mandeville Hospitals. The measure of 'acute bed days' with patients undergoing rehabilitation fell from 21,000 between April - December 2010 to 13,000 over the same period this year.

Alongside the inpatient services Buckinghamshire Healthcare NHS Trust is working with GPs to ensure a wide range of outpatient and diagnostics services are provided in these hospitals, as well as from the Chalfonts and Gerrards Cross community hospital, so that people can receive care as locally as possible.

The following examples show how we can now provide far more care in people's homes.

### **Intravenous (IV) Antibiotics at home**

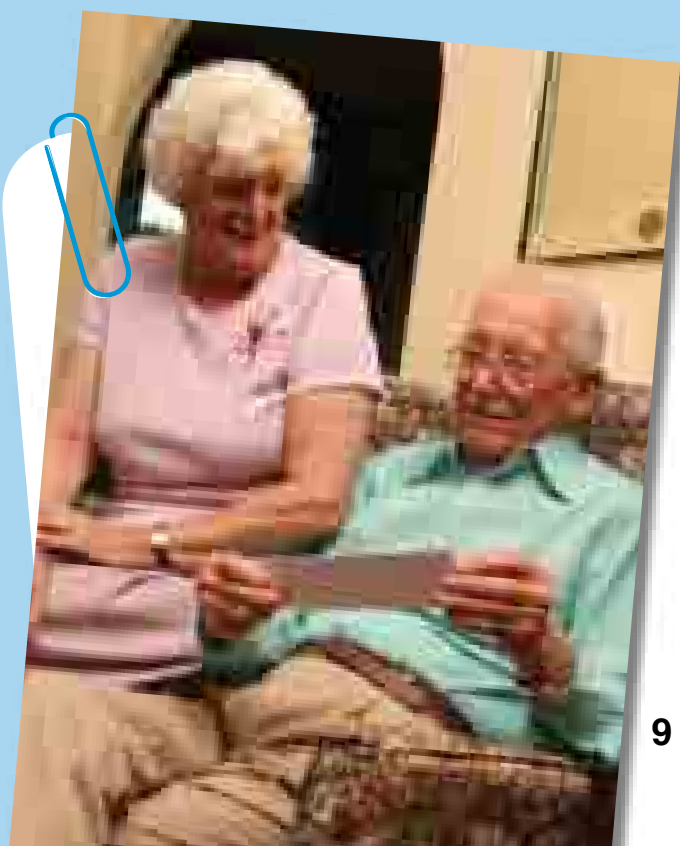
Some patients have conditions which mean that they need long courses of antibiotics given through a drip. In the past they would have had to stay in hospital. Now, thanks to the new home IV treatment service, people can be treated in their own homes by specially trained nurses. Patients needing antibiotics intravenously have 'access devices' fitted (a specialist skill), their drug dosage monitored regularly and blood tests. Over the past year (September 2010 to September 2011) the service has benefitted 140 patients, saved an estimated 2214 bed days which equates to a saving of £352,000 because patients now spend less time in hospital

***"This is a very successful service; patients are already telling us how they prefer to continue their treatment at home. This means they can be back with their families more quickly, sleep in their own beds and carry on with normal daily activities. If they do need nursing support, this can be arranged at a time that suits them, and it means patients have regular access to health professionals who can answer any queries or concerns. There are many more patients in the hospital who could benefit, so we hope the service will continue to expand in the coming months."***

Specialist Nurse Marie Coward,  
IV@ home service

***"Once at home I was visited every day for six weeks by district nurses, who would give me a daily infusion of the antibiotics. It was a great relief to be able to leave hospital so quickly, and get back to the peacefulness of my own surroundings and things. It would have been awful to stay in hospital, just because I needed this once-a-day dose of antibiotics. This is a great service, helping people to get back to the comfort of their own homes quickly, but in the knowledge that there is help and support at hand. The IV nurses even attended some follow-up outpatient appointments with me, to help explain what was going on."***

Buckinghamshire patient



## Setting up regional 'clinical networks'

We are now working with our colleagues across the region to set up new 'clinical networks' for specialist stroke, vascular, neonatal and trauma services. For example Stoke Mandeville Hospital has been designated a trauma unit, (a hospital in a Trauma Network that provides care for the seriously injured patients) and Wycombe Hospital has been designated a Hyper Acute Stroke Unit (HASU) providing specialist care for patients with a stroke.

## Hyper Acute Stroke Unit

Stroke is the third largest cause of death in England; 110,000 people in England have a stroke each year and there are 900,000 people living in England who have had a stroke. When people have a stroke, evidence shows that they do better if they are taken within three hours to a specialist centre which provides clot-busting drug therapy thrombolysis. Hyper Acute Stroke Units or HASUs provide this 24 hours a day, seven days a week. It has to be given alongside a CT scan, so specialists and scanning technology need to be located on one site. Hyper Acute Stroke Units or HASUs provide this therapy 24 hours a day, seven days a week.

The new service in Wycombe Hospital provides world class care for patients in Buckinghamshire and East Berkshire. Over 80% of patients stay on a designated stroke ward now, compared with approximately 54% in April 2011. The numbers of patients being given clot busting thrombolysis has increased three fold due to the 24/7 availability of stroke consultants. 100% of patients are scanned within 24 hours. A stroke early supported discharge service was introduced across Buckinghamshire in August 2011 which allows those stroke patients who are medically able to leave hospital to receive intensive rehabilitation in their own homes. All of this is leading to far better results for patients.



***“Time is of the essence if we want to get the best outcomes for patients. While a patient may have further to travel to the centralised stroke service at Wycombe, once they arrive there will be immediate access to specialists and thrombolysis which didn't happen before. We are already seeing improvements from this approach, with patient mortality and length of stay in hospital falling.”***

Dr Piers Clifford, Divisional Chair,  
Medicine, Wycombe Hospital

***“Our service is aimed at the 40 per cent of people admitted with mild to moderate stroke, which in Buckinghamshire is about 500 patients a year. We work to reduce the amount of time they spend in hospital by giving support which helps them to return to the home environment as soon as possible. The rehabilitation programme is much better provided in patients' own homes, because that is where they need to learn to function again. We help patients overcome the real challenges they face in their own environment, for example with the layout of their kitchens and bedrooms, and using equipment and furniture.”***

Todd Kaye,  
Physiotherapist and Team Leader,  
Early Supported Discharge Service



***“I woke and my hand felt floppy. I didn’t feel right, and it was very frightening. My husband called the GP who arrived and rang for an ambulance. I was taken to the new stroke centre at Wycombe Hospital. The staff were fantastic and I only spent a couple of weeks in hospital. Right from the start the nurses were talking about getting me back home to my husband and family. To start with the thought of going home was daunting; I wondered how I would cope. But my first home visit was with one of the occupational therapists, who assessed all the rooms and ordered me some special equipment to make things easier. I was visited regularly by nurses and the physiotherapist Todd Kaye, who gave me exercises to do, including walking around the garden and using my stairs for some things. I am already managing to move around the house without my sticks, and have been to the village supermarket to do a shop. When I first came out of hospital I felt anxious with everyone rushing around, but that feeling has gone now. It has been reassuring knowing that help is just a phone call away, I have numbers for occupational therapy, physio and the nurses.*”**

Buckinghamshire Stroke Patient

## Trauma

Major trauma (serious injury through accident or other events) is the biggest killer of people under 45 in this country. Overall in England, there are 5,400 deaths due to major trauma per year and many more than that suffer permanent disability as a result. The National Audit Office review in 2010<sup>5</sup> found that specialist treatment at a major trauma centre can increase survival rates by 20%, whether or not patients have to travel further by ambulance to reach them, and that across the South Central NHS region, results were not as good as they should be, compared with other areas.

To overcome these problems a new service was set up so that adults and children who suffer the most serious trauma in Buckinghamshire are taken directly to the major trauma centre at the John Radcliffe Hospital in Oxford. Stoke Mandeville has been designated a specialist trauma unit, for patients who are not quite so seriously injured but who need specialist care on a 24/7 basis. People who have less serious injuries, including simple fractures, can be treated at Wycombe Hospital, and this will continue to be the case.

**All these changes have made a big difference to patients in Buckinghamshire, but we still need to do more. We want to ensure high quality, safe, accessible and sustainable services for local people in the future, and ensure all our hospitals have a viable and sustainable future, but in order to do so – and to keep specialist services locally within Buckinghamshire – we need to bring specialist teams providing this life-saving treatment together on a single site. If the changes we are proposing are not made, our clinicians believe it will be increasingly difficult for them to maintain and provide safe services.**

# 4

## Future changes: what we have been discussing

**In Buckinghamshire our main acute hospitals are at Stoke Mandeville and Wycombe. At present we provide some services at one hospital only, and some services at both hospitals. For some of our key services we believe that their duplication across both hospital sites is unsustainable for quality, safety, staffing and efficiency reasons.**

There are a number of services where we believe there is a clinical case for making further changes.

- Emergency care
- General medicine inpatient care, including gastroenterology, diabetes, medicine for older people and respiratory services
- Elderly care
- Breast services
- Specialist 'networked services' (vascular services)

We also provide services at Amersham hospital, and at our community hospitals at Buckingham, Chalfont's and Gerrards Cross, Marlow and Thame, as well as extensive community and primary care services. This consultation document does **not** propose any changes to these services, although we will continue to invest in them and develop care closer to home for patients.

### • **Emergency care**

At the moment we run two emergency departments in Buckinghamshire. There is a full A&E, linked with the trauma unit, at Stoke Mandeville Hospital, and an Emergency Medical Centre in Wycombe

Hospital, with no trauma unit ('trauma' refers to patients who are seriously injured). These departments see patients who are transported by ambulance, either as a result of 999 calls or through GP referrals. They also see a large number of patients who walk in with minor injuries and illnesses and both, therefore, offer a GP service as well.

Currently, the two Emergency departments at Stoke Mandeville and Wycombe do not meet the levels of consultant staffing as recommended by the College of Emergency Medicine (2010)<sup>6</sup>. To support the two departments these guidelines suggest there should be 12 A&E consultants. BHT has a maximum of six A&E consultants. Recruitment is a national problem, and despite strenuous efforts, it is not always possible to maintain this number. Even if BHT could recruit 12 consultants, they would not see a sufficient number of patients to maintain their skills. This puts the services and patients at future risk.

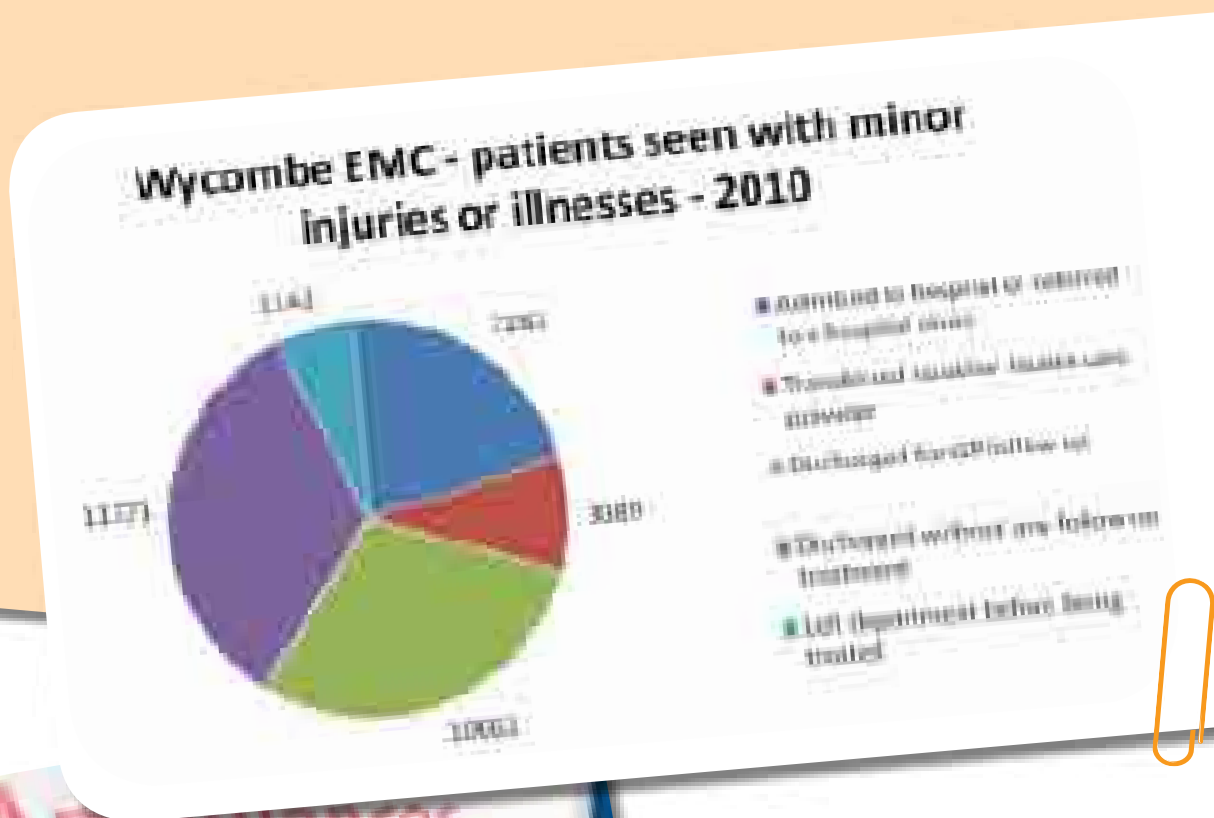
Experience at Addenbrookes Hospital in Cambridge shows that creating a "specialist emergency unit" with increased medical staff, and increased support improved the quality of care with reduced mortality rates and fewer patients being admitted to hospital.

By developing the A&E services at Stoke Mandeville Hospital, we aim to create the same level of medical expertise. We need to ensure that we have a high quality and sustainable A&E service in Buckinghamshire for the most seriously ill and injured patients, and that our A&E consultants are freed up to provide this. We also need to ensure that those people who currently choose to walk into hospital with more minor injuries or illnesses are properly assessed and either given or directed to appropriate treatment.

Many of the patients who walk in to the Emergency Medical Centre in Wycombe with minor injuries or illnesses (i.e. did not come by ambulance or GP referral) could be treated by their own GPs or through self-treatment. In 2010 of the nearly 34,000 patients who fit this description who attended the Emergency Medical Centre, over 33% needed no follow up treatment, 30% needed GP follow up, and 6% left

before being treated. Just over 30% were admitted, or referred to a clinic or another hospital. This is as shown in the chart below.

Because of the way in which the national funding system works, the local NHS already pays for these patients to be registered with a GP, then pays again when they visit the hospital and are seen by a specialist A&E consultant. This is money which could be better spent elsewhere.



- **General medicine inpatient care, including gastroenterology, diabetes, medicine for older people and respiratory services**

As with emergencies, we currently run two general medical services in Buckinghamshire at both Stoke Mandeville and Wycombe. This creates the same problems as with emergency care, and the existing clinical duplication is not sustainable. Centralising our medical admissions at Stoke Mandeville will enable us to develop specialist medical centres for gastroenterology, diabetes care, medicine for older people and respiratory there. This will enable better integration with other services at Stoke Mandeville with appropriate levels of critical care support.

- **Elderly care**

80% of people requiring an emergency admission have a long term condition such as diabetes, or a coronary or respiratory condition, and most of these will be older people. The Kings Fund (2010)<sup>7</sup> notes “people with several long term conditions have a markedly poorer quality of life, poorer clinical outcomes, longer hospital stays and are the most costly group of patients that the NHS has to look after.” These patients require a different approach which focuses on the patient as a whole not just their condition(s).

Much has been done over recent years to develop high quality, community-based services so people can be cared for in their own homes or much closer to home. Advances in medicine mean that many tests, treatments and procedures are now being provided for patients more conveniently outside of hospital. Multi-disciplinary community teams involving nurses, therapists and others, who work round the clock are being developed so that far more people can be supported to stay at home, which is what patients want. Far more work is being carried out to identify patients

with long term conditions such as lung disease, and to help them look after themselves with agreed healthcare plans and avoid a hospital admission wherever possible. Because of these developments, when people are admitted to hospital it is for a far shorter length of time, and with support to help them get home again as soon as possible.

The NHS Confederation believes that at least 25% of patients in hospital beds could be looked after by NHS staff at home.

***“Hospitals play a vital role, but we do rely on them for some services that could be provided elsewhere. We should be concentrating on reducing hospital stays where this is right for patients, shifting resources into community services, raising standards of general practice, and promoting early intervention and self care.”<sup>11</sup>***

We therefore need to do more to tackle the fact that there are still too many patients admitted to hospital when they don't need to be there or the problem could have been prevented by improved home or community care, (particularly frail elderly patients) and do more to look after patients in their own homes or in the community. This will also involve doing more jointly with social services. We outlined in Section 3 some of the steps we have already taken to strengthen community hospitals and our community services. We will continue this development, and aim to further increase the number of community nurse contacts in coming years to benefit more people. Our proposals also suggest a number of new initiatives which will help GPs manage more of their patients in the community or their own homes. Of course, people will continue to need hospital care when they are acutely unwell and this will be provided in a specialist inpatient centre at Stoke Mandeville Hospital.





- **Breast services**

In Buckinghamshire, breast services include screening and services to further investigate and treat those referred to us by their GP. The vast majority of screening is done in two mobile units which visit 15 sites around the county and this will continue, with the benefit of a new mobile unit with disabled access.

However the services currently provided at both Stoke Mandeville and Wycombe Hospitals is fragmented with clinics being held at various locations in different parts of both hospitals. This results in confusion for patients at what, for many, is a very anxious time. In addition, since December 2009, as part of improvements to the patient experience, all women with suspected breast problems and not just those with suspected cancer, need to be seen by a hospital specialist within two weeks, which has greatly increased the number of patients coming to the service.

We want to invest in new state of the art equipment and create a 'Centre of Excellence for Breast Services' at Wycombe Hospital, such that it will be the first choice for both patients and GPs. This centre needs to provide digital imaging, breast screening follow-up assessments, and other services for patients, including

specialist counselling. It also needs to have access to specialist imaging (e.g. MRI and nuclear medicine). Centralisation on one site would allow us to have all our breast services and expert staff in one place, allowing us to offer one-stop clinics where patients at their first appointment can be seen by a consultant surgeon, consultant radiologist and have all their tests done at the same time. We have already begun undertaking investment at Wycombe Hospital in the latest digital mammography assessment equipment and it is one of the few sites in the country offering pioneering sentinel node biopsy surgery, so this would make the ideal site. People who need surgery are already treated at Wycombe, and this would not change.

***“We know that the UK’s screening programme saves lives and are behind the move to extend the age group of women being offered screening. We have seen a 50 per cent increase in the number of women being referred to the breast service in Buckinghamshire, and we are having to respond by changing the way we organise ourselves to continue meeting the two-week quality standard. This standard requires the NHS to diagnose and treat any woman with suspected breast cancer within two weeks of referral to hospital by their GP (women with other breast problems are also seen within two weeks of referral).***

***Basing the unit at Wycombe may mean some women have to travel further for assessment and treatment. But I believe the quality benefits will outweigh the slightly longer journey because of the more coordinated, faster service we will be able to offer from the one location. Bringing multi-disciplinary teams and technology together is well proven to generate the best outcomes for patients.”***

Consultant Surgeon Mr Andrew McLaren

- **Specialist ‘networked services’ (vascular services)**

As we outlined in section 3, we have already been working with our colleagues across the region to set up new clinical networks for specialist stroke, neonatal and trauma services, and have already set up a new ‘Hyper Acute’ Stroke Unit at Wycombe Hospital, and designated Stoke Mandeville Hospital a trauma unit. We now need to make changes to reflect the clinical network’s proposals for vascular services. These are set out in detail in section 11.

### **Sustainable services**

Rising demand pressures from an increased ageing population and new treatments will continue to put pressure on our services, and we need to plan for sustainable services now. The existing duplication of services across our two acute sites, in terms of emergency and general medicine, is not sustainable in terms of quality or outcomes.

To be delivered safely some specialised treatments require levels of staff expertise that cannot be made available in all hospitals. In line with this, we believe that reorganising specialist services across our hospitals creates the opportunity to offer services that better meet the needs of local people, taking account of our ageing and growing populations.

By organising our specialist staff in ways in which they can work together in clinical teams we can make most of a valuable and scarce resource and can deliver higher quality care in a challenging financial environment. If the changes we are proposing are not made, we believe it will be increasingly difficult to continue to

provide the services safely on a permanent basis. This is the view of the doctors and other clinical staff who provide them now.

As part of our process, we have carried out an impact assessment which shows that our proposals will also help us to meet the challenges of social inequalities and needs of our minority ethnic populations.

The existing duplication of services across our two acute sites, in terms of emergency and general medicine, is not affordable over the longer term. Because of the changes in staffing and other practices, to continue existing services on both sites would require complete duplication, at a cost of at least £2 million per year for A&E alone. As



has already been outlined, BHT has been unable to recruit staff to key posts in this area.

It is important to highlight that, if the changes we are proposing took place, **most people would continue to go to the same hospital as now**, for example:

- most outpatients, apart from those attending for breast problems, would continue to go to the same hospital as now
- people requiring planned surgery will continue to go to the same hospital as now
- patients being treated as day cases would continue to go to the same hospital as now
- patients needing treatment for heart attack or stroke would continue to go to the same hospital as now
- patients requiring trauma care would continue to go to the same hospital as now
- children who have urgent needs or require an overnight stay in hospital would continue to go to the same hospital as now
- women receiving antenatal care and having their babies would continue to go to the same hospital as now



**Have Your Say**

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# 5

## our engagement process

**It is important that patients, the public and partner organisations are involved in the development of proposals for change at an early stage, so that they take into account the needs, views and ideas of local people.**

Over the past few months we have run the 'Better Healthcare in Bucks' engagement and involvement programme to discuss our initial ideas with members of the public, NHS staff and interested individuals and organisations. We have:

- sent information widely on what we are doing, and why and invited comments and feedback
- given presentations and held discussions with a wide range of organisations, including voluntary and partner groups, and local councils.

### Engagement themes

- People agree with our underlying principles and support the way in which we are developing our thinking, including the principle of creating care closer to home for most and specialist care when required.
- People understand why they may need to travel further for specialist hospital care but transport and access needs to be taken into account.
- People are also concerned to ensure that the quality of more local services is not affected by centralisation of specialist services and that there is consistency of quality throughout the NHS.

- run independently led involvement sessions for members of the public, and recorded what they say. 200 people took part in these
- carried out a survey to find out what matters most to people when they think about health care. 370 people participated in the public survey and 590 people took part in the staff survey

We held these discussions and listened to comments and feedback before any firm proposals for change were proposed. This meant we could feed in views and concerns to the clinicians who have developed the proposals at an early stage, before the proposals were finalised.

- People are happy to receive care closer to home, but they want to see enough qualified staff in place to provide this.
- People think that action should be taken to stop people using hospital emergency services when they don't need them, but far more information is needed to help people to decide where else to seek treatment.
- People want to be treated with dignity and respect and as intelligent adults. They want to see an NHS where services are better co-ordinated and communication between organisations improved.
- Although we did not specifically ask about primary care services, a number of people raised the fact that they felt it was difficult to get a GP appointment when they needed one.



In response, most people we engaged with said they support developing community services, and that:

- they would prefer to be cared for in a community setting if appropriate for their care
- they have confidence in using community based health services
- offering more support to help people manage their health conditions would prevent unnecessary admissions to hospital.

### **Taking account of engagement in our proposals**

We have taken account of these themes when developing the proposals in this consultation document. For example we have:

- developed our transport proposals and set up a 'transport summit' to explore other ideas
- reviewed the impact on patients
- begun to consider how we develop improved information and communication
- highlighted access issues to GPs.

You can find a full copy of our engagement report on our website, or phone us for a copy.

## 6

## The options for how services could develop in the future

**Since the publication of the 'Care for the Future' report in August 2011, GPs, hospital doctors and clinical colleagues have been considering how our hospital services in Buckinghamshire could be developed to meet the challenges and opportunities described earlier.**

Taking account of the 'Care for the Future' analysis, we identified seven potential options for how services could develop in the future:

**Option 1** – *Do nothing – leave acute services as they are now*

This option would leave acute services (including medical and surgical services) at Stoke Mandeville and Wycombe Hospitals as they are currently organised.

**Option 2** – *Duplicate full acute services on both sites and staff services to required levels for safety*

This option would involve us duplicating services and would require investment, including A&E and emergency and medical services in both Stoke Mandeville and Wycombe Hospitals.

**Option 3** – *Reconfigure acute services in one network between the two Buckinghamshire acute hospitals (with links to Wexham Park Hospital in Slough and for vascular services to the Oxford University Hospitals)*

This option would involve us reorganising acute services in one network between Stoke Mandeville and Wycombe Hospitals. There would also be strengthened links to Wexham Park and Oxford University Hospitals, in line with wider regional NHS proposals for strengthening specialist networks. The main service changes would be to:

- Refocus the Emergency Medical Services at Wycombe Hospital, supported by the A&E departments at Stoke Mandeville and Wexham Park hospitals
- Centralise specialist inpatient care for emergency medicine, respiratory, gastroenterology, medicine for older people, and diabetes at Stoke Mandeville Hospital, complemented by the specialist stroke and cardiac services based at Wycombe Hospital
- Centralise and create a specialist breast care centre at Wycombe Hospital



**Option 4** – *Centralise acute services on the Stoke Mandeville Hospital site*

This option would involve us centralising acute services on Stoke Mandeville Hospital, with only limited services, such as outpatients, at Wycombe Hospital. There would be an increase in patients using Wexham Park Hospital.

**Option 5** – *Centralise acute services on Wycombe Hospital*

This option would involve us centralising acute services at Wycombe Hospital, with only limited acute services, such as outpatients, at Stoke Mandeville Hospital. There would be significantly increased activity at Oxford University and Milton Keynes Hospitals because of the geography and access at the north of the county.

**Option 6** – *Provide limited acute services in Buckinghamshire, with all specialised care provided from outside Buckinghamshire*

This option would involve us providing limited acute services, such as outpatients, at Stoke Mandeville and Wycombe hospitals. All specialised acute care would be provided from outside Buckinghamshire.

**Option 7** – *Develop a new hospital to serve the Buckinghamshire population*

This option would involve building a new 600 bed hospital on a new site in Buckinghamshire. We have assumed that this would be located between Aylesbury and Wycombe. By comparison the new Frenchay Hospital in Bristol, opening with 800 beds in 2014 will cost £430m, so we have assumed this new 600 bed hospital would cost in the order of £325m.



## Option appraisal

These options built upon those developed and discussed by clinicians as part of the 'Care for the Future' process. We have undertaken high level consideration of

these options at our Clinical Commissioning Board, and at our clinical summits, and have reached the following conclusions about the pros and cons of each option:

### Option 1 - Do nothing – leave acute services as they are now

Pros	Cons
Would leave services unchanged and minimise need for change.	<ul style="list-style-type: none"> <li>would not resolve any of the clinical, safety, quality and financial reasons already described.</li> <li>would require significant investment to ensure our services could be maintained to the appropriate levels.</li> </ul>

We have rejected this option as being unsustainable on clinical and other grounds, and have not considered it further.

### Option 2 - Duplicate acute services on both sites and staff services to required levels for safety

Pros	Cons
This would optimise access for local population.	<p>We believe this option would not achieve the highest quality outcomes, and would also be costly as:</p> <ul style="list-style-type: none"> <li>in certain specialties, clinical staff would not see a sufficient number of patients to ensure they maintained their skills and achieved the best results. Patients would not be receiving a high quality safe service.</li> <li>it would therefore be difficult to attract suitable staff to an environment that delivered poor outcomes for patients.</li> <li>would not be making good use of expensive equipment and facilities (and we cannot afford to duplicate them on both sites).</li> <li>this option would be very costly, as it would require teams of doctors, nurses and other staff to be deployed on both sites. We estimate that to keep two full A&amp;E departments would add £2million a year to our current costs, even if enough staff could be recruited to fill the posts.</li> </ul>

We have rejected this option as being unsustainable on clinical and financial grounds, and have not considered it further.

**Option 3** - Organise acute services in one network, between the two Buckinghamshire acute hospitals (with links to Wexham Park and for vascular services Oxford University Hospitals).

Pros	Cons
<p>We believe this option would:</p> <ul style="list-style-type: none"> <li>• balance geography and population needs.</li> <li>• serve all of Buckinghamshire, minimising the number of patients who would need to travel elsewhere for care.</li> <li>• retain services at Wycombe and Aylesbury to allow targeted of services to population needs in those areas.</li> <li>• maximise skills of staff.</li> <li>• utilise the current buildings and services at both Wycombe and Stoke Mandeville and maintain the National Spinal Injuries Centre.</li> <li>• continue to provide East Berkshire with specialist stroke services, through the new HASU.</li> <li>• ensure that both Wycombe and Stoke Mandeville Hospitals have realistic and sustainable futures.</li> </ul>	<ul style="list-style-type: none"> <li>• for some patients in some services they will have to travel further for specialist services and treatment.</li> <li>• requires investment in our estate.</li> </ul>

We have retained this option for further consideration.

**Option 4** - Centralise acute services on Stoke Mandeville site

Pros	Cons
<p>This option would utilise the level of current investment in buildings and services, and would maintain the National Spinal Injuries Centre.</p>	<p>This option would:</p> <ul style="list-style-type: none"> <li>• not serve all of Buckinghamshire.</li> <li>• not serve East Berkshire for specialist stroke services.</li> <li>• be a major loss of services to the Wycombe population.</li> <li>• require major additional capital investment in new buildings as space is limited.</li> </ul> <p>The NHS would still be financially responsible for paying for the ongoing costs of the buildings constructed and maintained under the Private Finance Initiative (PFI) at Wycombe.</p>

We have rejected this option as having an unsustainable impact on the Wycombe population, and have not considered it further.

### Option 5 - Centralise acute services at Wycombe Hospital

Pros	Cons
<p>This option would utilise the level of current investment in buildings and services at Wycombe.</p>	<p>We believe this option would have even more disadvantages than Option 4. It would:</p> <ul style="list-style-type: none"> <li>• not utilise the level of current investment in buildings and services, not least the National Spinal Injuries service.</li> <li>• leave the NHS still financially responsible for the PFI at Stoke Mandeville.</li> <li>• not serve all of Buckinghamshire.</li> <li>• be a major loss of services to the Aylesbury Vale population, which is projected to grow significantly in the next five years.</li> <li>• require major additional capital investment in new buildings, as there is not enough space.</li> </ul>

We have rejected this option as having an unsustainable impact on the Aylesbury population, and have not considered it further.

### Option 6 - Limited acute services in Buckinghamshire with all specialist services provided from outside Buckinghamshire

Pros	Cons
<p>This option would maximise the effectiveness and sustainability of acute services outside Buckinghamshire.</p>	<p>We believe this option would have significant disadvantages for Buckinghamshire as it would</p> <ul style="list-style-type: none"> <li>• not utilise the level of current investment in buildings and services.</li> <li>• not serve all of Buckinghamshire.</li> <li>• potentially destabilise existing services be a major loss of services to the Bucks population, loss of National Spinal Injuries Centre.</li> <li>• increase travelling and access problems for the majority of patients.</li> <li>• lead to a loss of employment and economic investment in the wider Bucks economy.</li> <li>• the NHS would still be financially responsible for the PFI costs at Stoke Mandeville and Wycombe.</li> <li>• other providers may not be able to absorb activity.</li> </ul>

We have rejected this option as having an unsustainable impact on the Buckinghamshire population, and have not considered it further.

## Option 7 - Develop a new hospital to serve Buckinghamshire population

Pros	Cons
This option would provide a new purpose built hospital for Buckinghamshire.	<ul style="list-style-type: none"><li>• there is no obvious population centre.</li><li>• it would require major site and infrastructure investment.</li><li>• it is financially unaffordable in the current climate and unlikely to be affordable for the foreseeable future.</li><li>• NHS would still be responsible for Wycombe and Stoke Mandeville PFIs.</li></ul>

We have rejected this option as although this might initially seem an attractive idea, it is financially unaffordable in the current climate and unlikely to be affordable for the foreseeable future.

We have therefore rejected Options 1, 2, 4, 5, 6 at the initial stage of consideration, as they are obviously unachievable for the following reasons:

- do not meet the clinical needs of local population, and are not clinically supported.
- do not offer high quality, safe and sustainable patient services.
- restrict accessibility to some parts of the population.
- do not meet our financial needs.
- do not advance the views expressed during public engagement.

We have therefore not undertaken any more detailed appraisal of these options, as there is no advantage to considering them further.

In respect of option 7, we have also not explored this further. Although this might initially seem an attractive idea, it is financially unaffordable in the current climate and unlikely to be affordable in the foreseeable future.

Option 3 is our proposed option. We believe that reorganising services in this way is the preferred way to address the issues because it:

- will improve patient safety and quality.
- will retain staff and clinical expertise.
- best balances geography and population needs.
- will enable us to establish complementary roles for the Stoke Mandeville and Wycombe hospitals, with strong links both with other acute hospital providers and community services.
- builds on what people told us during our engagement phase.
- is affordable now and will, we hope, continue to be so in future years.

Have Your Say

▶▶▶▶ See page 49 for details ▶▶▶▶

# 7

## Option 3 - our preferred option

**We have been considering how we can develop *Option 3 – ‘Reorganise services in one network, between the two Buckinghamshire acute hospitals (with links to Wexham Park and for vascular services to Oxford University Hospitals) - to improve outcomes for patients, and to take account of the points raised during engagement.***

We want to ensure that people only get admitted to hospital if they really need hospital care. Because we are changing the way we deliver care, with far more provided in the community, with GPs able to access expert opinion, and with reduced length of stay, our doctors and their clinical colleagues believe we will need fewer beds in the future.

We have looked at other models elsewhere in the country, to help us develop our proposals. Investment in our community services, our proposals to centralise our specialist services and establish new services to better support frail elderly patients, will all help us to drive down the time which patients spend in hospital, meaning that we will need fewer beds.

We believe we can make significant reductions in the time some patients stay in Buckinghamshire hospitals. At the moment, our average length of stay for respiratory patients is 9.5 days, compared with an England average of 8.2 days. Our elderly patients have an average stay of 22 days compared with an England average of under 13 days.

We propose to develop services at each hospital in Buckinghamshire as follows. If our proposals are accepted, we would like to begin implementation from August 2012, phasing the proposals in over the next 18 months:

### Wycombe Hospital

At Wycombe Hospital doctors and other clinical colleagues propose developing a new model of care **for acute specialist and emergency services**. This would see cardiac and stroke emergency patients continuing to be admitted at Wycombe Hospital from refurbished facilities directly to the existing specialist units. As part of this Wycombe Hospital will retain the important vascular operations which prevent stroke from carotid artery disease (CEA). We will strengthen the links with the Oxford University Hospitals, and participate in joint working with them for other vascular services. In section 11 of this document we outline this in more detail, as this has been developed out of the regional proposals for vascular services across the whole of the NHS in Thames Valley and Hampshire.

The Wycombe inpatient specialist medical services for people with gastroenterology (gut), respiratory and diabetes conditions and medicine for older people will be centralised at Stoke Mandeville with the other services currently provided to create specialist medical centres, but local access will remain for the majority of patients e.g. outpatients. There will continue to be critical care beds for critically ill patients at both Wycombe and Stoke Mandeville. We will adjust the distribution of these beds to reflect the level of need.

We will maintain and improve **local access to urgent care services** for GPs and the public – with GPs able to get access to a wider range of services to help them keep their patients out of hospital. A **minor injury and illness service** will be based at Wycombe Hospital and will have access to all hospital diagnostics and consultant advice. Emergency nurse practitioners and GPs would support this service, which will be able to see, treat and discharge a high proportion of the public who currently attend the EMC but do not require admission.

A series of other **service improvements** are proposed, which together will help to avoid A&E attendances and admissions. They include:

- same day telephone advice for GPs from consultants, to help keep patients out of hospital
- 48-hour email advice from consultants for GPs about their patients
- telephone advice for ambulance crews on where to take patients, and on ensuring they are stabilised and reach there safely
- an assessment unit predominately for elderly and/or frail patients (more details on this are set out below).

All these elements would work together to help patients to stay out of hospital.

At the same time, we propose making changes to the GP led health centre at Wycombe hospital. The GP practice element of the health centre has not proved popular with local people and only 600 have registered as patients, whereas most GP practices will have over 6,000 patients. We propose asking these 600 patients to register with other GP practices in Buckinghamshire, where there is the capacity to take them on.

We will also work with our colleagues in Buckinghamshire urgent care (BUC), which provide our out of hours GP service and other local services, and the South Central Ambulance service, to ensure our proposals are consistent with the future plans for a '111' telephone access service, the new national non-emergency number for health services which will be implemented locally.

We will develop an **elderly care service** at Wycombe to include:

**A multidisciplinary assessment service.**

This would be predominately for patients who have symptoms that mean they are diagnosed as frail. In the main the service would cater for elderly patients although access to it is not determined on the basis of age. It will provide assessment of all aspects of a patients' needs from community staff and 'Medicine for Older People' clinicians, with input from GPs and social services, with a view to putting care in place that supports the patient to stay at home and avoid admission.

This will be a booked appointment service offering same day or next day assessments. In some cases community services would provide input to enable the GP to keep the patient at home overnight knowing that a detailed assessment will take place the next day. Exact opening/appointment times are yet to be finalised.

For patients who are getting better and wish to be closer to home, a **'step down' ward** will provide a facility to care for elderly and medical patients who are no longer in the acute phase of their treatment and who do not need as much input from doctors but whose care requirements cannot yet be met in their own homes. The ward will have input from 'Medicine for Older People' clinicians and will provide a community hospital type facility for Wycombe.

We have completed a detailed assessment of options for centralising **breast services**. These included keeping services on both Stoke Mandeville and Wycombe Hospitals, or centralising at one site. We have concluded that the preferred option is to create a Centre of Excellence at Wycombe Hospital for breast services, as this option provides the best quality of care, whilst having the least impact on travel times. This proposal will mean that 200 people who currently attend Stoke Mandeville Hospital for an initial assessment and 1,500 people who attend for outpatient appointments would go to the new Wycombe Centre.

We recognise that some women will have longer to travel, but that this is outweighed by the clinical and quality benefits. If women wish to be referred to other breast services, for example in Milton Keynes or Luton, then we will support this.

## Stoke Mandeville Hospital

At Stoke Mandeville the urgent care services will also be developed. A&E services will be strengthened by the centralisation of emergency service teams and they will support the **trauma unit**, working closely with the trauma centre at the Oxford University Hospitals.

Stoke Mandeville Hospital will provide emergency inpatient admission for medical specialties (e.g. general medicine, gastroenterology, respiratory, medicine for older people) except cardiac, stroke and vascular services which, as we have described, will be based in Wycombe. We will establish specialist inpatient medical centres for gastroenterology, diabetes care, respiratory and medicine for older people at Stoke Mandeville Hospital, with the majority of supporting care within the community.

Patients with conditions where diagnosis is uncertain, but who are likely to need inpatient care, will be treated at Stoke Mandeville.



## **Refurbished facilities at Wycombe and Stoke Mandeville Hospitals**

Under these proposals we will spend £2 million on refurbishing facilities both at Wycombe and Stoke Mandeville Hospitals. Some of these improvements are already part of our existing ongoing capital schemes.

On the Wycombe site, we will move the emergency services into new accommodation in the modern ('PFI') part of the Hospital. We will also create a new receiving area for cardiac and stroke patients arriving at the hospital to ensure that they are quickly and efficiently seen by the right clinicians in the right place. At Wycombe Hospital an area is being created that would meet the needs of the new day assessment unit, with good access for those less mobile.

At Stoke Mandeville we already have plans in place to invest in new facilities for the A&E department which are currently going through the planning process. We anticipate work starting later in 2012. This expanded capacity will easily be able to cope with any additional work that flows to Stoke Mandeville, should these proposals be accepted.

## **Community Hospitals and Community Teams**

Our proposals are based on the fact that we have recently made investment in our community hospitals or community services, which will help us keep people out of hospital and close to home. It is helpful to see how these have developed over the past two years. We have continued to invest in and support our community hospitals at Amersham, Buckingham, Chalfont's and Gerrards Cross, Marlow and Thame. We have invested nearly £2 million in bringing them up to modern standards, and have maintained or increased their bed numbers. They play a vital part in moving care away

from the acute setting and optimising our community teams and community hospitals. We aim to continue this by:

- specialist consultant roles working in the community taking a more preventative approach to healthcare
- developing step-down facilities for older people who no longer require acute care but are not ready to be cared for at home

Our community services focus on admission avoidance and support GPs to care for patients at home wherever and whenever possible. A range of services are either already available or will be developed to support this including an emergency service and 24 hour cover.

At Amersham Hospital there is currently an effective Day Hospital service which could be further developed.

## **Other hospitals**

Our proposals mean that we will need to commission some additional acute services from surrounding trusts for patients needing A&E or an emergency medical inpatient stay. The main alternative provider for these services is Heatherwood and Wexham Park Hospitals NHS Foundation Trust. Discussions with them have indicated that they have sufficient capacity to absorb these additional patients.

### What this will mean for patients

The following are some hypothetical examples which show how care for patients will change under these proposals:

Mrs A is a frail and elderly lady living on her own in High Wycombe. She frequently has dizzy spells and often rings her GP. In the past, she has been referred via the Emergency Medical Centre into hospital for further investigation and tests and often stays several days. Sometimes she is delayed further in hospital while suitable care is organised for her at home. Under the new proposals, Mrs A's GP would make an appointment for her with the new assessment centre at Wycombe Hospital the following day, and community support will be available to keep her safe and at home overnight. The assessment centre will diagnose her and provide information to enable her GP to keep her at home, including continued community support.

Jamie is a student in High Wycombe. Although he is registered with a local GP, he has attended the Emergency Medical Centre in Wycombe Hospital on several occasions with minor injuries he has sustained when playing football, because it is 'convenient'. When he sprains his foot in a football match, he goes there again. Under the new proposals, Jamie will still be treated, by the nurse led minor injury service, but he will be given information on more appropriate ways to get treatment for minor conditions.

Mrs B has her routine breast examination carried out in Buckingham. Her GP sees the results and refers her to a consultant, as he has some concerns. In the past, Mrs B could have seen someone in Stoke Mandeville, but she may have had to go to a variety of different clinics at different times, if she needed treatment, causing some stress. Under the new proposals, Mrs B has to travel further to Wycombe, but it is to the breast care 'centre of excellence' which has the latest equipment and specialist staff all in one place, easing her anxiety.



Mrs C has concerns about her five year old daughter, who has come home from her after school club with a rash. As Mrs C thinks she will have difficulty getting a GP appointment, she goes to the Wycombe Emergency Medical Centre with her daughter. Under the new proposals, Mrs C's daughter will be seen by the GP led minor illness service, which might treat her immediately, but which can also make an appointment directly with her GP for the following day.

Mr T has chronic obstructive pulmonary disease (COPD), a long-term respiratory condition. When his condition has flared up in the past he has come to the Emergency Medical Centre at Wycombe Hospital. Under the new proposals, Mr T and his GP will have a telephone number to call for all issues relating to his condition. The phone call will determine how Mr T is best supported, for example a specialist respiratory nurse might visit him at home instead of Mr T coming to the hospital or he may be admitted to Stoke Mandeville Hospital where specialist staff can treat and monitor him.

Mr V is an inpatient under the gastroenterology team following an emergency admission via A&E for internal bleeding. As a High Wycombe resident previously he would have been cared for at Wycombe Hospital. Under the new proposals, he will be an inpatient at Stoke Mandeville Hospital. His wife has further to travel to visit him but Mr V is under the care of the gastroenterology centre where he will be seen by the same gastroenterology consultant each day over the week he spends in hospital. This continuity in care reassures him and his wife, as well as the knowledge that the correct staff expertise and equipment are available at the gastroenterology centre to quickly deal with any complications of his condition. This increase in specialist knowledge available to help Mr V will minimise his stay in hospital and improve his recovery.

Mrs S has diabetes, she has gone to see her GP as she is worried about some recent symptoms. Under the new proposals Mrs S's GP will be able to contact the diabetes consultant by phone to discuss her symptoms if he thought her symptoms might require an admission to hospital. After discussion with the specialist Mrs S's GP determines that Mrs S does not need to attend the hospital today (as she would have done previously) as he can provide the appropriate treatment she requires.

### **Benefits of proposals**

We believe that our proposals will bring a wide range of benefits for Buckinghamshire patients. You can find details of the evidence and information we describe in this document, and other evidence we have reviewed, on our website.

There are a number of studies which demonstrate that centralising some specialist services brings better results for patients. The recent Kings Fund publication *Reconfiguring Hospital Services*<sup>8</sup> gives an overview of this evidence.

The proposals will enable BHT to focus its medical and A&E expertise on a single site and provide a more specialist, better resourced, higher quality service overall. Instead of patients being seen and admitted by the on call team (who in many cases will not be the 'right' team for their condition) patients will be seen by the appropriate team for their condition at a much earlier stage. These proposals will ensure that even with staffing resources which are becoming harder to recruit, we can still deliver higher quality care in a challenging financial environment.

Our proposals to improve local access to urgent care at Wycombe hospital will improve the links between acute and primary care. During our engagement phase, people told us that they were unclear about where to get appropriate treatment. Better co-ordination will improve this, as set out in the recent King's Fund report on integrated care<sup>9</sup>

By increasing the range of services we are able to provide through our community hospitals and our community teams directly into patients' homes, we can offer patients a more responsive service with a more preventative and planned approach to managing their healthcare needs.

Finally our proposals keep a cardiovascular centre in Wycombe, the area where ethnic backgrounds and areas of deprivation mean that these services are most in demand.

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## The detailed impact on our hospitals

### The detailed impact on Wycombe Hospital

**Summary:** Over 225,000 people came to Wycombe Hospital for outpatient, day case emergency or inpatient treatment in 2010/11. The vast majority of these people will still be able to have their care needs met at Wycombe Hospital. However those requiring specialist urgent care treatment or medical admission for conditions other than stroke and cardiology will be treated at an alternative hospital. This will affect 7,600 people per year – 3% of those who use Wycombe Hospital.

**Medical admissions:** Currently there is an average of 158 emergency medical admissions to Wycombe a week. Following the changes, some admissions will be prevented and patients supported at home by GPs and other services. Other admissions will mainly transfer to Stoke Mandeville, with some going to Wexham Park. The remaining medical admissions to Wycombe will be for stroke and cardiology patients, and we estimate these will average 43 a week.

**Surgical admissions:** Admissions to the planned treatment centre for patients needing surgery will not change.

**Outpatients and diagnosis:** These services will not change.

**Beds:** Wycombe Hospital currently has 226 beds consisting of 153 medical and 73 surgical beds. The proposals to reduce medical admissions will reduce the number of medical beds needed to 86. As the number of surgical beds will not change, the number of beds needed at Wycombe will total 159.

**Urgent care patients:** we expect the number of people attending Wycombe Hospital to reduce from 933 a week to 604, who will then be seen by the new minor injuries/illness service. We expect 258 of the people who currently attend the Wycombe Emergency Medical Centre a week to use Stoke Mandeville, 49 to use Wexham Park with the others using Watford and Oxford, depending on where they live.

## Wycombe Hospital

Outpatient services (adult and children)	No change proposed
Day case procedures (adult and children)	No change proposed
Elective treatment centre (planned surgery)	No change proposed
Midwifery-led birth centre	No change proposed
Antenatal care	No change proposed
Diagnostic services (for example x-ray, endoscopy)	No change proposed
Specialist stroke services (including hyperacute stroke and acute stroke)	No change proposed
Specialist cardiology services	No change proposed
Critical care support	No change proposed
Vascular service	Day surgery, diagnostics, outpatients and surgery to prevent strokes caused by carotid artery disease would remain unchanged. Complex inpatient surgery (including abdominal aortic aneurysms) proposed for John Radcliffe Hospital in Oxfordshire to do
Surgical admissions	Admissions to the planned treatment centre for patients needing surgery will not change
Outpatients and diagnosis	No change proposed
Urgent care service	For those who currently attend the EMC at Wycombe without having seen their GP or another clinician first, they will still be able to attend the new urgent care service. If your GP or ambulance service determines that you require urgent hospital attention you will be directed to the most appropriate A&E department (e.g. Stoke Mandeville or Wexham Park hospitals)
Breast care services	Proposal to centralise initial assessment and first outpatient appointments at Wycombe Hospital through the creation of one-stop clinics in a new specialist breast care unit. Chemotherapy to remain at Wycombe Hospital
Inpatient services	Proposal for emergency respiratory, gastroenterology, diabetes and medicine for older people inpatient admissions to be admitted to Stoke Mandeville Hospital. Creation of a step-down ward for those who no longer need acute hospital care at Wycombe Hospital
Multidisciplinary assessment service for frail or elderly patients	New service development for Wycombe Hospital. GPs will be able to refer into this service and obtain advice and support for patients to remain out of hospital
System of fast access for diagnostics, assessment and specialist opinion for GPs to help keep patients out of hospital	New service development for Buckinghamshire

***“The new model is about delivering the right treatment, in the right place, at the right time for our oldest and frailest patients. These patients day by day lose confidence in their ability to cope when they spend too long in hospital.***

***“The closer working between specialist surgery and medical teams concentrated at Stoke Mandeville will assure the best immediate treatment outcomes for patients in need of emergency care, while the centralisation of stroke and cardiovascular services alongside rehabilitation and discharge preparation means we can continue safely reducing patients’ stays in hospital.***

***“I believe the new model will not only yield quality benefits for patients, through better networking of clinical teams and services, but also support***

***the long term sustainability of our hospitals. This would be helped with the centralisation of specialist diagnostics, equipment and technology onto one or other of the acute hospital sites.”***

Consultant Geriatrician, Dr Syed Hasan



## **The detailed impact on Stoke Mandeville Hospital**

**Summary:** Over 330,000 people came to Stoke Mandeville hospital for outpatient, day case, emergency or inpatient treatment in 2010/11. The vast majority of these people will still be able to have their care needs met at Stoke Mandeville hospital. However those requiring initial assessment or outpatient appointments related to breast care will be treated at Wycombe hospital. This will affect approximately 1,700 people per year – 0.5% of those who use Stoke Mandeville hospital.

**Admissions:** there is currently an average of 100 medical admissions to Stoke Mandeville each week. The proposals mean that these will increase by an average of 36 each week, including three respiratory and one gastroenterology admissions per week.

**Beds:** currently Stoke Mandeville Hospital has 467 beds – consisting of 132 medical

beds, 72 surgical beds and 263 beds in other specialties (including the National Spinal Injuries Centre). We expect the number of beds to remain unchanged, as we will continue to reduce the hospital length of stay with greater use of our recently developed community services. This will allow us to cope with the increased number of admissions within the existing number of beds.

**A&E attendances:** the proposals mean that the number of A&E attendances will increase by 258 each week.

**Breast care:** at present 200 people attend Stoke Mandeville for an initial assessment and 1,500 for outpatient appointments for breast services. The proposals mean that the majority will transfer to Wycombe, with some choosing to transfer to Milton Keynes, Luton or elsewhere.

## Stoke Mandeville Hospital

Outpatient services (adult and children)	No change proposed
Day case procedures (adult and children)	No change proposed
Accident and Emergency Department (adult and children, including trauma and GP-led centre)	No change proposed
Emergency surgery (adult and children)	No change proposed
Maternity services (including antenatal, inpatient and neonatal care)	No change proposed
Paediatric services (including inpatient care)	No change proposed
Diagnostic services (for example x-ray, endoscopy)	No change proposed
Specialist plastics and burns services	No change proposed
National Spinal Injuries Centre	No change proposed
Specialist ophthalmology service	No change proposed
Critical care support	No change proposed
Cancer care and haematology	No change proposed for the majority of services. Proposal to centralise initial assessment and first outpatient appointments at Wycombe Hospital for people with breast problems through the creation of one-stop clinics in a new specialist breast care unit. Chemotherapy to remain at Stoke Mandeville Hospital
Inpatient services	Proposal for emergency respiratory, gastroenterology, diabetes and elderly admissions to be admitted to Stoke Mandeville Hospital
System of fast access for diagnostics, assessment and specialist opinion for GPs to help keep patients out of hospital	New service development for Buckinghamshire

# 8

## Access and Transport

### Issues identified during engagement

**Our engagement process has reiterated that transport and access is a key issue. People have said that quality and results are the most important considerations for them, and that they are therefore willing to travel if required for specialist care. However they have made it clear there need to be robust arrangements in place for transport and access.**

At the heart of these proposals is the need to ensure the best possible access to services. Care will be provided in patients' homes, in their localities through community clinics, or through their GPs in their surgery, whenever possible. Both Stoke Mandeville and Wycombe Hospitals will keep their diagnostic and outpatient services. Along with the development of the urgent care centre at Wycombe hospital, the vast majority of patients will still be able to receive their care locally.

### Developing our transport strategy

A transport subgroup has also been established including membership from Buckinghamshire County Council, South Central Ambulance Service (SCAS) and BHT to ensure that all of the transport implications of the proposals have been taken into account. Elements that are being developed within this include:

- improvements to car parking arrangements
- use of telemedicine to save patients having to travel to a specialist when a specialist can communicate with them from a different location

- working with Arriva buses and other public transport operators to improve public transport to hospital sites for patient, visitors and staff
- plans so we can move patients between sites should they need emergency care
- exploring what can be done to support on-foot patients, visitors and staff travelling between sites
- working with Buckinghamshire County Council and colleagues on other possibilities (for example, voluntary and community transport schemes).

### Ambulance services

Ambulance services have a vital role to play in the new service pattern. We are working with SCAS to develop:

- Doctor support to ambulance crews so that a wider range of conditions can be treated at the place of call out rather than bringing the patient into hospital
- Agreements with SCAS so emergency patients are taken to the right place for their care
- Arrangements with SCAS for patients who call 999 but don't need acute hospital care
- Giving access to ambulance crews to information about patients' current treatment plans
- Plans to support patients who do require access to specialist care



## Have Your Say

▶▶▶▶ See page 49 for details ▶▶▶▶▶

## 9

## Financial, workforce and other implications

**In the current economic climate, we must develop new ways of delivering better results and higher quality care within our resources, and the proposals set out below are designed to better use the available money for patient care. Both the PCT and Buckinghamshire Healthcare Trust (BHT) will come under significant financial constraints, which, should we take no action now, will lead to an unacceptable deterioration in service quality for our patients.**

Because of the changes in staffing and other practices, to continue existing services on both sites would require complete duplication, at a cost of at least £2 million per year for A&E alone. As has already been outlined, BHT has been unable to recruit staff to key posts in this area.

The existing duplication of services across our two acute sites, in terms of emergency and general medicine, is not affordable over the longer term. Rising demand pressures from an increased ageing population and new treatments will continue to put



# Have Your Say

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pressure on our services, and we need to plan for this now. We also have long term commitments through our Private Finance Initiative (PFI) commitments, which is how we raised investment for some of our newer buildings. This investment has to be paid back over a number of years.

With health resources limited, this document sets out the efficiency benefits which could be achieved if these proposals are accepted, for BHT and for the local NHS. The PCT, clinical commissioners and BHT believe these proposals are financially necessary to maintain sustainable services, and to support our QIPP (Quality, Innovation, Productivity and Prevention) plans. At the same time, by organising our specialist staff in ways in which they can work together in clinical teams we can make the most of a valuable and scarce resource and can deliver higher quality care in a challenging financial environment.

We have completed impact and risk assessments which have shown that these proposals will have an overall positive benefit on the local population. These assessments can be found on the Better Healthcare in Bucks website.



# 10

## Better Healthcare in Bucks - Conclusions

**This report sets out proposals which we believe will allow us to provide high quality, safe, accessible and sustainable care within Buckinghamshire, despite the challenges we are facing. We have considered a number of options and have decided that our preferred option is to reorganise services in to one network, between our two hospitals at Stoke Mandeville and Wycombe (with links to Wexham Park and Oxford University Hospitals).**

We have reached this conclusion through an open and transparent process, led by hospital doctors, GPs and their clinical colleagues. If our proposals are accepted, we hope to begin implementation on 1 August.



## Meeting the four tests

As part of our process, we are required to ensure we meet four tests set out by the Secretary of State for Health, Andrew Lansley MP, in May 2010. He stated that all proposed changes in the NHS must:

- be based on clinical evidence
- have the support of GP commissioners
- promote patient choice
- have engaged patients, public and local authorities

We believe we have met these tests:

- **Be based on clear clinical evidence:** The doctors presenting the need for change and developing the proposals have based their thinking on current evidence on what gives the best results for patients, as this report demonstrates. For example, we know that centralising some services gives much better results, even if people have to travel further for care. During their presentations and discussions, our senior doctors have explained this evidence to patients and the public.
- **Have the support of GP commissioners:** Local GPs have worked closely with hospital clinicians to develop these proposals. As well as holding two

clinical workshops which have brought hospital and primary care clinicians together for discussion and debate, there have been a variety of meetings at which representatives of both clinical teams have discussed Better Healthcare in Bucks. These proposals have the support of GP commissioners who are satisfied that they are the right way forward for their patients in Buckinghamshire.

- **Genuinely promote choice:** The proposals will not fundamentally alter a patient's right to choose where they are treated. Indeed, in the involvement events in the south and the north of the County, the importance of being able to access health services beyond the Buckinghamshire borders was raised by a number of participants and this is being taken into account as proposals are developed.
- **Follows a process which engages the public, patients and local authorities:** Our engagement and involvement report, published in November, summarised how we have engaged and involved the public, patients and local authorities in Better Healthcare in Bucks. We will continue to discuss our proposals and invite feedback during our consultation phase, which also provides a variety of methods through which people can voice their views.

## Introduction

**At the same time as we have been engaging over our BHIB proposals, a separate engagement on proposed changes to vascular surgery services has taken place with the public and key stakeholders across the NHS South Central region (Berkshire, Buckinghamshire, Oxfordshire, Hampshire and the Isle of Wight).**

Vascular services are for people with disorders of the arteries and veins. These include narrowing or widening of arteries, blocked vessels and varicose veins, but not diseases of the heart and vessels in the chest.

In order to achieve the best possible outcomes for vascular patients, it is proposed that in Thames Valley, complex vascular surgery is done at one specialist vascular surgery centre based at John Radcliffe Hospital in Oxford, which would provide 24 hour emergency and complex inpatient vascular surgery. The reasons this hospital was chosen are:

- The John Radcliffe Hospital is to be a major trauma centre and it will, therefore, be best placed to undertake complex emergency surgery around the clock.
- It already has a specialist vascular surgery team which can be built upon to provide a high quality service for all vascular surgery patients in Thames Valley.
- Geographical location.

## How options have been developed

In drawing up our proposals for change we worked closely with clinicians, patients and the public. Clinicians developed a service specification for vascular surgery working with GP commissioners, representatives from Local Involvement Networks (LINKs) and a small number of members of the public.

Hospitals interested in becoming a specialist centre for vascular surgery were then invited to submit plans showing how they would meet the service specification. These plans were assessed at review panels which included independent clinical representatives and specialists in vascular surgery. The results of the review panel were outlined in an engagement exercise during August and September 2011.

## Response to engagement

When we engaged with people in Buckinghamshire about this proposal, the feedback included concerns about travel times – both in terms of how long it would take the ambulance service to get to the nearest vascular surgery services unit, and the distance people would have to travel to visit relatives taken to one of the units.

The Buckinghamshire Public Health Overview and Scrutiny Committee (OSC) asked that, as the proposed changes to vascular surgery will potentially have an impact on Buckinghamshire residents, that there should be a formal consultation on the proposals.

In order to avoid confusion by issuing two separate consultation documents, we have agreed with the OSC that, although the two processes are separate, the vascular surgery services consultation will be included in this 'Better Healthcare in Buckinghamshire' consultation process as a standalone section. This section therefore sets out the proposals and options for vascular services.

### **What are vascular services?**

Vascular disorders used to be treated by surgery only. More recently, specialists have been able to treat many vascular disorders by reaching the site of the problem via the inside of the blood vessels. This is known as interventional radiology, and is a much less invasive approach. Making these advanced techniques readily available to all patients is one of the goals of the proposed changes to vascular services.

More detail about vascular disorders and how they are treated is detailed below:

**People with abdominal aortic aneurysms (AAA):** This is a condition in which the main artery in the abdomen becomes stretched and prone to bursting. Timely detection and treatment of AAA prevents later problems with rupture and bleeding, and can be life-saving. Treatment for AAA can be either by open surgery or by a much less invasive approach through the major blood vessels which is called endovascular surgery (EVAR).

**Screening people for abdominal aortic aneurysms (AAA):** people with aneurysms are unlikely to notice any symptoms prior to a rupture so a national population-based

screening programme is being rolled out, offering screening to men aged 65 and over.

The mobile community screening unit will use a simple, pain-free test called an ultrasound scan to look for an aneurysm. The test is very quick and usually lasts less than 10 minutes. The scan shows a picture of the aorta on a screen and it is measured. Those of a certain size are then booked for planned surgery at the designated vascular unit for their area. This greatly reduces the chances of the aneurysm causing serious problems or needing emergency surgery. Over time it is anticipated that the screening programme will reduce the number of emergency AAA operations, with more planned operations being undertaken.

### **People with strokes or transient ischaemic attacks (TIAs or mini-strokes):**

Sometimes, these problems with the blood supply to the brain occur because of a narrowing in a blood vessel in the neck called the carotid artery. This can be treated with an operation to improve the flow of blood and reduce the risk of future strokes. This is called a carotid endarterectomy (CEA).

**People with poor blood supply to the feet and legs:** Some people, particularly those who smoke or have diabetes, can develop narrowing in the blood supply to the legs and feet. This can cause pain on walking, ulceration and infection. Surgical or interventional radiological treatment can improve the blood supply, make walking easier and prevent the serious complications of inadequate blood supply.

**People with other conditions needing vascular services:** Vascular surgeons and interventional radiologists support a number of other services including cardiology, cardiac surgery, dermatology (skin conditions), clinical laboratory services, nephrology (kidney problems), neurology, plastic surgery, neurosurgery and other surgical disciplines.

### How are vascular surgery services currently delivered?

Across Thames Valley vascular surgery services are currently provided at the John Radcliffe Hospital, Wycombe Hospital, Wexham Park Hospital and the Royal Berkshire Hospital. The John Radcliffe Hospital in Oxford provides emergency vascular care 24 hours a day, seven days a week. The other hospitals each provide an emergency rota of one in four week days and one in four weekends. In 2010 they provided the following services, and undertook the following number of procedures.

### Why do we need to change the way we provide vascular surgery services?

Medical evidence shows that the UK does not compare well with other European countries for some vascular procedures. It has the highest mortality rates in Western Europe following elective abdominal aortic aneurysm surgery and is among the slowest nations for uptake of new endovascular technology, which allows some procedures to be undertaken by 'keyhole' style interventions which avoid the need for open surgery. Patients are not always treated by a vascular specialist and stay longer in hospital following their surgery than the rest of Europe<sup>10</sup>.

In summary the main reasons for changing the way we deliver vascular services are:

### To provide the best possible care for our patients

Treating vascular disease very well is not easy. Research shows that the chances of survival and improved quality of life after treatment of arterial diseases are greatest when patients are treated in large centres by a highly trained specialist team caring for a high volume of patients. The more operations carried out at a particular hospital, the more likely it is that treatment will be successful. Seeing more patients allows doctors and other staff to hone their

	emergency aortic aneurysm repairs	planned aneurysm repairs	carotid endarterectomies (CEA)	bypass of arteries in the groin	major amputations
John Radcliffe	27	101 (39 by EVAR)	90	74	44
Wycombe	8	34 (27 by EVAR)	86	50	13
Wexham Park	4	19 (14 by EVAR)	30	60	51
Royal Berkshire	2	17 (11 by EVAR)	10	26	41

skills and maintain them at the highest level, ensuring that patients get the care they need.

This means that we need to have a small number of hospitals carrying out higher numbers of operations, rather than lots of hospitals carrying out only a few operations each year.

### ***To ensure specialist doctors are available at all times***

In some hospitals, there are not enough consultants to provide high quality care for patients with vascular diseases 24 hours a day. By concentrating specialists in fewer hospitals and ensuring patients are taken to those hospitals promptly, we can ensure everyone gets the treatment they need, when they need it.

One particular issue is the availability of interventional radiology. Skilled interventional radiology consultants can use specialist techniques to save limbs and organs that might otherwise have to be removed. Changing the service so that round-the-clock interventional radiology rotas become possible will ensure that no-one misses out on these benefits because of where and when they become ill.

### ***To meet the standards set by our doctors***

Vascular specialists in the UK have set out how they think vascular services should be organised across the country, so patients get the best possible results. We have built on that work with specialists from NHS South Central developing our own service specification consisting of five core clinical standards for our future services; national guidance and clinical standards are provided on the PCT website<sup>11</sup>. We are determined to improve our local NHS so that these standards are met in full. We can only achieve this by changing the way that vascular services provided.

### ***To make sure that everyone has equal access to innovative procedures, such as keyhole techniques***

At the moment, patients in the region are not all able to access the latest treatments and techniques. For example, a type of treatment for blood clots which are blocking important arteries is not at present available at all times in every hospital in the region. We do not think that this is fair and want to make sure that all patients can benefit from innovations such as this. In addition, the demand and clinical support for a new treatment option called specialised interventional vascular radiology is rising. There is also a large and increasing repertoire of procedures that can be undertaken without the need for open surgery with equally good or better outcomes for some groups of patients. To enable delivery of these specialist vascular interventional radiology procedures, dedicated rotas are required to ensure care can be delivered 24 hours a day, seven days a week.



## Options for change

Services cannot currently remain as they are for the reasons listed above. Following extensive engagement and clinical discussion the Berkshire and Oxfordshire Overview and Scrutiny Committees have already agreed that a specialist vascular unit should be established at the John Radcliffe Hospital. We believe there are two potential options for Buckinghamshire.

### Option A

The John Radcliffe Hospital in Oxfordshire would provide all emergency and elective complex inpatient vascular surgery, including operations to prevent strokes caused by carotid artery disease (carotid endarterectomy or CEA) to Buckinghamshire, Berkshire and Oxfordshire residents.

Wycombe Hospital would keep vascular surgeons for day case surgery, diagnostics and local outpatient provision. In other words, patients requiring relatively straight forward treatment which is not urgent would still be seen at Wycombe.

Surgeons would travel to the John Radcliffe as part of an emergency rota to cover the Berkshire, Buckinghamshire and Oxfordshire area and to carry out elective complex inpatient surgery on their local patients with the full support of an expert vascular team.

This would increase the volume of patients being treated at the vascular unit at the John Radcliffe, thereby increasing the level of expertise at the unit. Consultant level doctors would be available 24/7.

Travel times to the John Radcliffe would be less than 60 minutes for complex inpatient surgery and even quicker for emergency patients travelling in a blue light ambulance.

### Option B

As option A above, but operations to prevent strokes caused by carotid artery disease (carotid endarterectomy or CEA) would continue to be provided at Wycombe Hospital for Buckinghamshire patients. Under this option the Hyper Acute Stroke Unit at Wycombe would have vascular surgeons on hand to carry out operations to prevent further strokes. Care would be closer to home for patients having CEA operations, minimising travel times. This option assumes that there is sufficient on site consultant time at Wycombe Hospital to provide a safe and effective service.

The option to continue to perform CEAs at Wycombe has been assessed by a national clinical assurance team (see below) and a vascular expert panel. Both have suggested that this option could only be viable for a limited period and would need to be reviewed in three years.



### **National Clinical Advisory Team**

We asked the National Clinical Advisory Team (NCAT) to look at our proposals and give us their advice. NCAT provides a pool of clinical experts to support, advise and guide the local NHS on local service reconfiguration proposals to ensure safe, effective and accessible services for patients.

The NCAT review took place on 7 October 2011 and concluded that:

‘The proposal to perform carotid endarterectomy in isolation at Wycombe Hospital needs careful consideration as to whether, given the transfer of inpatient arterial consultant sessions to Oxford (to deal with aneurysms and lower limb revascularisations) there is sufficient on-site consultant presence at Wycombe to offer these patients a safe and effective service, in light of the requirement for expedited carotid endarterectomy in the future. It is difficult to recommend an isolated carotid service in such a setting as this may weaken both hub and spoke.’



### **Vascular Surgery Expert Panel**

An expert panel was convened on 20 October 2011 to review Option B against the service specification. They concluded that the proposal to perform CEAs at Wycombe was clinically viable as a transitional arrangement provided it did not adversely affect the running of the shared emergency rota at John Radcliffe. If agreed the arrangement would need to be reviewed in 3 years time.

### **Financial implications**

The provision of an effective vascular service is relatively expensive. Vascular units have high bed occupancies and some patients may need prolonged hospital stay. The surgery is technically demanding with significant demands on both theatre time and critical care. Advances in endovascular treatment may offset some of this expense but many of these procedures are also technically demanding and time consuming and require sophisticated and often expensive interventional radiology facilities and disposables. Replicating these services in every hospital may not be cost effective, but must be balanced against issues of equality of patient access and aspirations for a local service.

The cost to Buckinghamshire and Oxfordshire Primary Care Trust, which commissions the service on behalf of patients, would be neutral. However, there would be a loss of income to Buckinghamshire Healthcare NHS Trust of £1.2million if all urgent and complex vascular surgery is undertaken at the John Radcliffe, which is reduced to £0.8m if carotid endarterectomy operations are retained at Wycombe. This income reduction has been taken account of by Buckinghamshire Healthcare Trust in its future financial plans.

## **Our response to the engagement exercise.**

When we engaged with people in Buckinghamshire about the proposed changes to vascular surgery services, the feedback included concerns about travel times – both in terms of how long it would take the ambulance service to get to the nearest vascular surgery services unit, and the distance relatives would have to travel to visit relatives taken to one of the units.

We recognise that the changes will mean greater travel for some patients. The Vascular Society of Great Britain suggests that a journey time of up to 60 minutes will not erode the benefit of going to a high volume centre. Buckingham, High Wycombe and Aylesbury are all within 30 minutes and Amersham within 40 minutes of the John Radcliffe when travelling in an ambulance under blue light conditions. To minimise travel for patients and relatives our service specification is explicit that outpatients, outreach and follow-up appointments will be at a patient's local hospital and that patients should be transferred back to their local hospital for post-operative care if required.

### **Preferred option**

The PCT has considered feedback during the engagement process and has thought carefully about the outcome of the NCAT review and vascular expert panel recommendations. Vascular services continue to evolve and given that the expert panel consider providing CEAs at Wycombe to be safe and clinically viable this is the option that the PCT would prefer to commission in the short term. This option will allow close links with the stroke service at Wycombe

and will minimise travel times which were highlighted as a concern during engagement.

During the next three years, John Radcliffe will continue to develop as a vascular centre and stroke services will have developed further at Wycombe. It would be beneficial to wait until these services are embedded before reviewing the need to move CEA operations to John Radcliffe.

### **Conclusion - Safe and Sustainable Acute Services - Vascular Surgery**

We believe that Option B is the preferred option: the John Radcliffe in Oxford becoming the vascular centre for Berkshire, Buckinghamshire and Oxfordshire areas, with operations to prevent stroke from carotid artery disease (CEA), continuing to be provided at Wycombe Hospital in the short term maximises the benefits, and minimises the risks for the provision of vascular surgery.

This arrangement would need to be reviewed in 2015 to ensure that it and its medical cover were still robust and sustainable.

You can respond to this section of the consultation document in the same way we are asking people to respond to our other proposals.



## Your comments

**We invite comments on the proposals we have set out in this document, and in particular whether you agree with Option 3. If you would like more detail on the proposals, please see our full consultation document:**

## Questions

### 1. Overall approach

What do you think about our overall proposals for services at Wycombe Hospital and Stoke Mandeville Hospital, with the majority of care provided locally and a small number of specialist services centralised to improve patient outcomes.

- Strongly support
- Support
- No opinion
- Against
- Strongly against

### 2. Emergency care

**2a.** What do you think about our proposals for developing urgent care services at Wycombe Hospital (creation of a GP and emergency nurse practitioner-led urgent care centre and GP access to expert opinion)?

- Strongly support
- Support
- No opinion
- Against
- Strongly against

**2b.** What do you like about our proposals for developing urgent care services at Wycombe Hospital?

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**2c.** What, if anything, concerns you about our proposals for developing urgent care services at Wycombe Hospital?

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**2d.** What would reassure you on any worries you may have?

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### 3 General medicine

**3a.** What do you think about our specific proposals for centralising specialist inpatient care for emergency medicine, respiratory, gastroenterology, diabetes and medicine for older people at Stoke Mandeville Hospital (whilst retaining the majority of general care at your local hospital)?

- Strongly support
- No opinion
- Strongly against
- Support
- Against

**3b.** What do you like about our proposals for centralising specialist inpatient care for emergency medicine, respiratory, gastroenterology, diabetes and medicine for older people at Stoke Mandeville Hospital?

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**3c.** What, if anything, concerns you about our proposals for centralising specialist inpatient care for emergency medicine, respiratory, gastroenterology, diabetes and medicine for older people at Stoke Mandeville Hospital?

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**3d.** What would reassure you on any concerns you may have?

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### 4. Elderly care

**4a.** What do you think about our proposals to develop new services for frail (and usually elderly people) in Wycombe Hospital, to help GPs to manage them in the community or home?

- Strongly support
- No opinion
- Strongly against
- Support
- Against

**4b.** What do you like about proposals to develop new services for frail (and usually elderly people) in Wycombe Hospital, to help GPs to manage them in the community or home?

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**4c.** What, if anything, concerns you about our proposals to develop new services for frail (and usually elderly people) in Wycombe Hospital, to help GPs to manage them in the community or home?

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**4d.** What would reassure you on any concerns you may have?

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**5. Breast services**

**5a.** What do you think about our specific proposals for developing a centre of excellence for breast care at Wycombe Hospital?

- Strongly support
- No opinion
- Strongly against
- Support
- Against

**5b.** What do you like about our proposals for developing a centre of excellence for breast care at Wycombe Hospital?

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**5c.** What, if anything, concerns about our proposals for developing a centre of excellence for breast care at Wycombe Hospital?

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**5d.** What would reassure you about any concerns you may have?

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**6. Specialist 'networked services' (vascular services)**

**6a.** What do you think about our specific proposals for developing vascular services at Wycombe Hospital?

- Strongly support
- No opinion
- Strongly against
- Support
- Against

**6b.** What do you like about our proposals for developing vascular services?

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**6c.** What, if anything, concerns you about our proposals for developing vascular services?

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**6d.** What would reassure you about any worries you may have?

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**7. Other comments**

Are there any other comments you would like to make?

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## 8. About you

Finally, please can you fill in the following details about yourself. You will not be identifiable from any information you give us. Please let us know which of the following applies to you:

### Responding as an individual or on behalf of an organisation (please tick as appropriate)

- Patient
- Member of public
- NHS staff

Organisation:-

- Voluntary organisation  (please state)
- Community organisation  (please state)
- Other organisation  (please state)

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Other  (please state)

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### Gender (please tick as appropriate)

- Male
- Female

### Age (please tick as appropriate)

- Under 15
- 15-24
- 25-44
- 45-64
- 65-84
- 85+

### Postcode

What is your postcode?

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### Health problem/disability

Are your day to day activities limited because of any health problem or disability which has lasted, or is expected to last at least 12 months? (Please tick one box only)

- Yes, limited
- Yes, limited, a little
- No
- Prefer not to say

## Caring for others

Do you look after, or give any help or support to family members, friends, neighbours or others because of either long term physical or mental ill-health/disability or problems related to old age? (Please tick one box only)

- Yes
- No
- Prefer not to say

### What is your ethnic group?

(Please tick one box only)

#### A White

- British
- Irish
- Any other White background  (please state)

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#### B Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed background  (please state)

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#### C Asian, or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background  (please state)

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#### D Black, or Black British

- Caribbean
- African
- Any other Black background  (please state)

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#### E Chinese, or other ethnic group

- Chinese
- Any other  (please state)

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#### F Prefer not to say

# Appendix 1: Glossary

**111:** the new non-emergency number for health in England, replacing NHS Direct's telephone advice line (although NHS Direct hopes to run it in many locations). The government hopes to have it available across the country by April 2013.

**Accident and emergency (A&E):** the emergency departments of hospitals that deal with people who need emergency treatment because of sudden illness or injury. The people they see can vary from patients with minor injuries or illnesses who walk into the department to the very seriously ill or injured brought in by ambulance.

**Acute care:** medical and surgical treatment usually provided by a hospital.

**Acute hospitals:** The hospitals people go to for major surgery and the treatment of very serious conditions.

**Ambulance: South Central Ambulance Trust (SCAS):** one of the 11 Ambulance trusts in England, mostly with the same names and coverage areas as strategic health authorities.

**Buckinghamshire Healthcare NHS Trust (BHT):** responsible for community health services provided in people's homes or from one of a number of local bases, community hospitals and acute hospital services at Stoke Mandeville, Wycombe and Amersham.

**Clinical commissioning groups:** the groups of GPs and other healthcare professionals that will take over commissioning from primary care trusts in England under Health Secretary Andrew Lansley's NHS plans. In Buckinghamshire, **Bucks Primary Care Collaborative** is an association of 33 GP practices in Amersham, Wycombe, and across South Buckinghamshire, serving a population of 305,000 and **United Commissioning** commission services for just fewer than 200,000 patients in each of the three localities within the Vale of Aylesbury area.

**Clinical network:** a network of health professionals from different NHS organisations working together across institutional and local boundaries, to provide care for a particular disease or patient group.

**Clinician:** a general term meaning hospital doctors, GPs, nurses, therapists and other healthcare professionals.

**Commissioning:** the process that PCTs go through to agree health services which a provider (such as an NHS Trust) will provide for a specified sum of money. Commissioning also involves monitoring these contracts to ensure best value for money.

**Community health services:** NHS services provided outside a hospital. Community health staff include district nurses, health visitor, community midwives, district dieticians, chiropodists and community psychiatric nurses. Many community staff are attached to GP practices and health centres

**DH:** Department of Health. The Whitehall department responsible for the NHS in England.

**Day case or day surgery:** a patient who has an investigation, treatment or operation and is admitted and discharged on the same day is a day case.

**Dermatology:** skin conditions

**Elective care:** care given at a planned/prearranged time rather than in response to an

**FT:** foundation trust. In England, a trust which has extra powers over its own operations. The government expects all non-foundation trusts to apply for foundation status over the next few years.

**GP:** general practitioners are doctors who work from a local surgery or health centre providing primary care for their patients who have registered on their list, and except for emergencies act as the gateway to acute and other care. GPs are also beginning to take on the role of **commissioners** of NHS services.

**Heatherwood and Wexham Park Hospitals NHS Foundation Trust:** provides hospital services to a population of more than 450,000 which includes Ascot, Bracknell, Maidenhead, Slough, South Buckinghamshire and Windsor.

**Inpatient:** an inpatient is a patient who has been admitted to a hospital and is occupying a bed.

**Integrated services:** services which are provided across professions and organisations according to people's needs.

**IV:** intravenous therapy, whereby antibiotics or other drugs are administered directly into the vein.

**John Radcliffe Hospital:** a teaching hospital in Oxford. It is now part of the Oxford University Hospitals with the Churchill and Horton General Hospitals and Nuffield Orthopaedic Centre.

**Local Involvement Networks (LINKs):** groups made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. Buckinghamshire has its own LINK.

**Local Authority:** an administrative unit of local government. There are several tiers of local government in Buckinghamshire. Buckinghamshire County Council is responsible for strategic planning, highways, traffic, social care services, education, libraries, and consumer protection. The four district councils within Buckinghamshire (Aylesbury Vale, Chiltern, South Bucks and Wycombe) are responsible for a range of services including local planning and housing and refuse disposal.

**Long term conditions:** conditions such as diabetes, or a coronary or respiratory problem. 80% of people admitted to A&E are suffering from more than one long term condition, and most of these will be older people. Helping people to manage their condition, through information and support, can help people to stay out of hospital.

**Medicine/medical conditions:** refers to conditions which do not usually need surgery and which are managed in other ways, such as with drug treatments.

**Mortality:** the number of deaths in a given time or a community; the proportion of deaths to population or to a specific number of the population; death rate.

**National Clinical Advisory Team or NCAT:** provides a pool of clinical experts to support, advise and guide the local NHS on local service reconfiguration proposals to ensure safe, effective and accessible services for patients.

**Nephrology:** kidney conditions

**NHS:** should stand for National Health Services, plural. The Department of Health in London is responsible solely for the English NHS.

**NHS Buckinghamshire and Oxfordshire Cluster:** the NHS primary care trusts (PCTs) which are the statutory bodies responsible for planning and securing health services and improving the health of the population of Buckinghamshire and Oxfordshire. The two operated separately until April 2011 but now have 'clustered' with a joint Board. PCTs will be replaced by clinical commissioning groups (formerly known as GP commissioning consortia) under government plans, with an original deadline of April 2013, although this timescale has since been made more flexible.

**Outpatients:** attend for a consultation, advice and/or treatment but do not stay in a hospital.

**Overview and Scrutiny Committee (OSC).** The Overview and Scrutiny Committee for Public Health Services in Buckinghamshire, which is run by the County Council, looks at the work of Primary Care Trusts, and the National Health Service (NHS). It acts as a "critical friend" by suggesting ways in which health related services might be improved. The Committee's role is:

- to review and scrutinise any matter relating to the planning, provision and operation of Health Services in the area of the Council
- to review and scrutinise the impact of the Council's services and of key partnerships on the health of residents in the County.
- to respond to consultations from the National Health Service on any proposal for a substantial development of Health Services in the area, or for a substantial variation in the provision of such service.

**Primary care:** the first port of call for many people when they develop a health problem is their local doctor, also known as general practitioner (GP). A group of doctors usually form a practice or surgery to serve a particular neighbourhood.

**Provider** is the name used to describe any organisation that provides a service to the NHS.

**Secondary care:** this means the same as acute care (see above).

**SHA:** strategic health authority (England only are set to be abolished under government plans in 2013. In summer 2011, the 10 SHAs were grouped into four clusters. NHS South of England now combines the South West, South Central and South East Coast areas.

**Social care:** essentially means non-medical care which is aimed at providing vulnerable people (such as the sick and elderly) with care and support to enable them to live their lives as fully as possible. In Buckinghamshire, this is commissioned by Buckinghamshire County Council.

**Specialised services:** these are services for which demand is relatively small but which require very specialist staff and equipment. They are therefore usually provided in a few large centres serving a wide population.

**Stakeholder:** an individual or organisation with an interest in health and health initiatives. Stakeholders can be organisations such as local authorities or individuals such as residents.

**Step down** facilities enable people to leave acute hospital and get ready to return home.

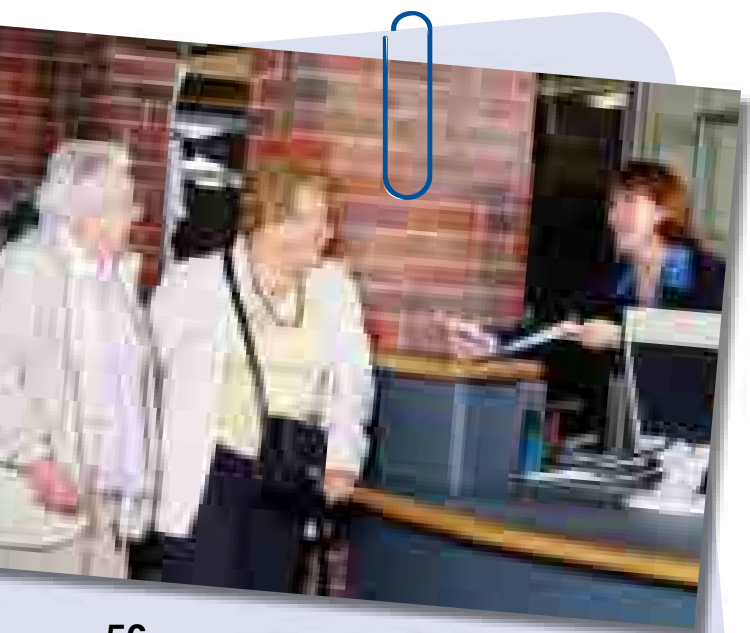
**Step up** facilities enable people to receive more support than is currently available at home.

**Telecare:** technology used to monitor and communicate with patients in their homes, often helping elderly people to remain in their own homes rather than moving into residential care.

**Telehealth or Telemedicine** is a broader term referring to healthcare supported through use of telecommunications used in both primary and hospital settings. It can include allowing staff to work from their home or another location such as a patient's home, letting one specialist assess stroke cases in several hospitals; or sharing operations through videoconferencing.

**TIA's or mini-strokes:** problems with the blood supply to the brain can occur because of a narrowing in a blood vessel in the neck called the carotid artery. This can be treated with an operation to improve the flow of blood and reduce the risk of future strokes. This is called a carotid endarterectomy (CEA).

**Trust:** the name used for most NHS bodies (including PCTs, acute and foundation trusts) in England, as well as combined health and social care trusts in Northern Ireland. Scotland and Wales have health boards.



**Vascular disorders:** these include

- People with abdominal aortic aneurysms (AAA): This is a condition in which the main artery in the abdomen becomes stretched and prone to bursting. Treatment for AAA can be either by open surgery or by a much less invasive approach through the major blood vessels which is called endovascular surgery (EVAR).
- People with strokes or transient ischaemic attacks (TIAs or mini-strokes): Sometimes, these problems with the blood supply to the brain occur because of a narrowing in a blood vessel in the neck called the carotid artery. This can be treated with an operation to improve the flow of blood and reduce the risk of future strokes. This is called a carotid endarterectomy (CEA).
- People with poor blood supply to the feet and legs: Some people, particularly those who smoke or have diabetes, can develop narrowing in the blood supply to the legs and feet. Surgical or interventional radiological treatment can improve the blood supply, make walking easier and prevent the serious complications of inadequate blood supply.
- People with other conditions needing vascular services: these include patients with cardiac, dermatology (skin conditions), nephrology (kidney problems), neurology, plastic surgery, neurosurgery and other problems

**Workforce:** the term generally used within the NHS to refer to HR/human resources issues.

## Appendix 2: What people told us

The 180 people who took part in our involvement and engagement events gave us a wide range of views, concerns and ideas for improvement. The Opinion Leader report, which is available on our website or on request by phone, goes into these in detail. The following is the Executive Summary of the Opinion Leader report:

### Providing the best patient experience

- When asked what aspects of services provided are most crucial for the NHS to get right in order to ensure patients have a good experience, participants' responses could be grouped around three major themes: clear and proactive communications, making it as easy as possible to access services and treating people with dignity, respect and intelligence.
- Ensuring effective communication between services and staff is seen as vital to a smooth journey between different parts of the NHS. Aside from within the NHS, it is also vital to ensure good communications are made with patients and their family or friends. Patients and their carers need to feel informed about their condition, the treatment they will receive, who will be providing the treatment and the time it will take for this to be completed. When communicating to a patient, staff have to be clear, comprehensive and use appropriate language tailoring it to their audiences. Something also commonly mentioned as pivotal to 'a good service' was communication about what services were available to people and where to go to access them.

***“The changeover in [nurses] slots of time are so quick that how could they brief one another”.***

**Participant, Buckingham**

- Physical access (namely transport links for those who can't drive, the elderly, disabled and seriously ill) was a key driver of patient satisfaction with the service they receive as was improving the cost and availability of parking at hospitals. A strong theme pervasive across all groups in all events was that treatment needs to be designed and provided around the individual needs – a phrase commonly used was 'patient centric' and strong elements of delivering this are making sure communication and access are prioritised.

***“You go see one consultant A and then B but B hasn't read your file so you just sit there for 20 minutes whilst he does”.***

**Participant, Buckingham**

- Respect given to the individual was seen as vital to providing a good patient experience. This includes having friendly staff who develop a rapport with the patient, and even down to the tone of voice they use. Taking time to listen to the patient is also key, as is taking their concerns seriously. Consistency of healthcare professional treating them was also important for some.

***“It is important to get clinicians to talk to patients and not treat them as a disembodied object”.***

**Participant, High Wycombe**



***“I’ll go where ever the specialist is, if I have had to do that”.***

**Participant, Chalfont St Peter**

### **Developing specialist acute centres**

- The general consensus across the groups on the proposition to have acute hospitals specialise some services was that it is a good idea, especially as anything that potentially leads to better outcomes is difficult to argue against. Most said that they accept that it will always be a problem to get people to understand why they have to travel further but the key point is to get them to understand that the reason they have had to travel is because they or their loved ones are getting the best treatment possible.
- However, there were several points raised across the groups in the events regarding the practicality of this proposed model of configuring acute hospital services and numerous suggestions as to what needs to be in place to make it work. For example, participants were keen to stress that movement of specialists and skilled health professionals to specialist centres must not mean that the quality of local or non-specialist services would decline.

***“I accept the specialist units, you’d go anywhere to get properly sorted out...but for ordinary problems you want it to be local”.***

**Participant, Marlow**

***“I agree with this as you as a patient want the best care possible”.***

**Participant, Buckingham**

- Participants across the events felt strongly that consideration and improvements to the transport infrastructure, especially the quality of the road network and the frequency and integration of bus services, must be made before changes are put in place, not during or after. However, participants were constructive in offering ideas for potential solutions to this issue, such as increasing the frequency and integration of local buses and encouraging and facilitating car sharing pools or volunteer taxi services.
- Some alternative models for acute service provision were discussed by participants across the events, such as a two-tier approach whereby patients are first sent to their local hospital to be stabilised and then transferred to the specialist centre or to reconsider the use of PCT boundaries when deciding where to send patients. For all models a vital element to consider was follow-up care.

***“By removing the really highly trained people – are we going to get second best at local? They won’t have enough experience to do safe procedures.”***

**Participant, Wycombe**

***“I’m all for community based care, because not everybody wants to be cared for in a hospital but we’ve got to have the right amount of people to be able to do it for the right amount of time”.***

**Participant, Marlow**

### **Moving care closer to home**

- When asked to discuss the NHS in Buckinghamshire’s proposals to develop more urgent care out of hospital and in the community the general consensus across the events was that too many people go to A&E when they could be cared for at other places or through self-treatment. However, there was a good deal of discussion as to the changes that need to be implemented in order to make this work. Participants felt that there was a need to raise awareness about what alternatives to A&E are available and how these could be accessed in order to prevent people travelling to A&E as the “default option”. Across the groups there was a strong appetite for more community hospitals and/or minor injuries units which would help deliver these aims. Quality is the vital element though: participants need to be confident that the care they would receive outside of the acute hospital was of a high enough quality (i.e. sufficiently resourced with the right equipment and qualified staff) otherwise A&E remains the “safest option”.
- In general, participants across the five events had similar views on the proposals to provide more local and community led care to elderly patients. The discussions outlined several important factors which should be considered before attempting to implement the proposed changes. The need for more specially trained staff for them to be able to provide high quality

***“It’s too late when you’ve trailed to A&E to see a sign saying you could have visited a walk in centre to receive that type of treatment.”***

**Participant, Marlow**

care to the elderly was seen as important and in urgent need of development. Participants commonly stated that more collaboration was needed among all the agencies and within the NHS in order to provide consistent care and to ensure the transition from hospital to in home or community care is a positive one. However, participants expressed concern and uncertainty as to how this proposal would be funded, with the preferred option being NHS or local funding.

- Providing community led care for patients with long term conditions was seen as a good idea, however, participants saw many problems existing at the moment, which would make this transition difficult to implement. The general feeling was that more funding needs to be available to allocate additional resources to care for patients in the community rather than in hospital: more trained nurses and more joined up communication among GPs, specialists, nurses, social carers, voluntary services and families as well as patients themselves. Furthermore, providing more information to individual patients as well as informing communities of opportunities available to them to improve their health was also seen as vital.

***“They’ve got to invest in alternative services. More GPs, more nurses, more health care assistants, better health care facilities”.***

**Participant, Chalfont St Peter**

***“People will say ‘well I don’t know where to go so I’ll go to A&E cause A&E I know’, so we need to have a much greater clarity of what the service is that’s there and what they provide”.***

**Participant, Buckingham**

## Appendix 3: List of Background material reviewed and references

**This list covers the material that we considered in preparing the BHIB proposals, and in the relevant material from the predecessor project ‘Care for the Future’**

- Academy of Medical Royal Colleges** – *Acute Health Care Services* – September 2007
- Academy of Medical Royal Colleges** – *Letter to Guardian, and article* – 28 April 2010
- Berkshire and Buckinghamshire PCTs** – *‘Care for the Future’* – June 2011
- British Geriatrics Society** – *Clinical Response to the downturn* - date
- Buckinghamshire PCT** – *QIPP and Operating plans* – December 2010 – date
- Buckinghamshire PCT** – *Joint Strategic Needs Assessment* – 2010
- Cochrane Database Systematic Review** - *Organised inpatient (stroke unit) care for stroke* – October 2007
- College of Emergency Medicine** – *Workforce Recommendations* - April 2010
- Department of Health** – *National stroke strategy* – December 2007
- Dr Foster intelligence** - *Inside your hospital, Dr Foster hospital guide - 2001–2011* – November 2011
- Durrow associates** – *Providing healthcare locally – the small hypermodern local acute hospital* – Autumn 2010
- Grimsby Telegraph** – *Louth Community Hospital* – 2010
- Hampshire, Southampton, Portsmouth and the Isle of Wight PCTs** – *Unscheduled care consultation* – September 2010
- Healthcare for London** - *Preliminary Stroke Strategy* – July 2008
- Healthcare for London** - *Cardiovascular services - Case for change* – 2010
- Healthcare for London** - *Health for North East London - Delivering high-quality hospital health services for the people of North East London* – November 2009
- Healthcare for London** - *A local hospital model for London, and Summary report* – November 2008
- Healthcare for London** - *Meeting the health needs of children and young people - Guide for commissioners* – Nov 2009
- Healthcare for London** - *Health for North East London - Pre Consultation Business case* – November 2009
- Healthcare for London** – *Integrated Strategic Plan 2010-15* – January 2010
- Healthcare for London** - *Stroke strategy for London* – November 2008
- Health Foundation**: *Getting out of Hospital* – June 2011
- Institute for Public Policy Research** - *Hospital Reconfiguration* – September 2006
- Institute for Public Policy Research** - *The Future Hospital - The progressive case for change* – January 2007
- Institute for Public Policy Research** - *The Future Hospital - The politics of change* – May 2007
- Intercollegiate Group On Trauma Standards** - *Regional trauma systems, interim guidance for commissioners* - December 2009
- Journal of Emergency Medicine** - *Does integrated emergency care reduce mortality and non-elective admissions? A retrospective analysis* – 2011
- Kings Fund** - *Reconfiguring Hospital services - Lessons from south east London* – February 2011
- Kings Fund** – *Briefing: Reconfiguring Hospital services* – September 2011
- Kings Fund** – *Avoiding Hospital Admissions* – October 2010

**Kings Fund** – *Integrated care summary* – September 2010

**McKinsey & Company** - *Framework for meeting the Quality and Productivity Challenge: Clinical Benchmarking – South Central SHA* – December 2009

**McKinsey & Company** - *Frontline lessons in health care transformation – McKinsey quarterly* – Autumn 2010

**McKinsey & Company** - *Developing a regional health system strategy– McKinsey quarterly* – Autumn 2010

**National Audit Office** - *Major Trauma Care in England* - February 2010

**National Clinical Advisory Team** - *Report - North East London* – 2009

**National Clinical Advisory Team** - *Outer South East London service Reconfiguration - Review of Clinical Case for Change* - 2007

**NHS Confederation** – *Clinical responses to the downturn* – December 2010

**NHS London** - *'Stroke victims in London have better access to life-saving treatment than anywhere else in the world'* press release - 2010

**Practical Commissioning:** - *The Commissioning Diaries - The birth of an idea* - 7 Feb 2011

**Royal College of Physicians** – *'Acute medical care -the right person, in the right setting first time - Report of the Acute Medicine Task Force'* - October 2007

**Royal College of Physicians** – *Statements* - 2010

**South East London PCTs** - *A "Picture for Health" Project Team perspective on the Implications of Fixed Costs and PFI Schemes for Service Redesign in SE London*

**Society for Acute Medicine** – *The interface between acute Medicine and critical care* – 2009

**South Central SHA** – *Major trauma network – Project Brief* - June 2010

**Stroke Unit Trialists' Collaboration** - *Organised inpatient (stroke unit) care for stroke. Cochrane Database Systematic Review* - 2007

**Professor Sir John Temple** - *Time for training: a review of the impact of the European Working Time Directive on the quality of training* - 2010

**UK Trauma Audit and Research Network** - *2001–2004 dataset. US National Trauma Data Bank®* - 2004.

**Vascular Society of Great Britain and Ireland** - *The Provision of Services for Patients with Vascular Disease* – 2009, revised November 2011

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- <sup>1</sup> **Office of National Statistics**, Census 2001
- <sup>2</sup> **Buckinghamshire PCT** – *Joint Strategic Needs Assessment* – 2010
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- <sup>5</sup> **Academy of Medical Royal Colleges** – *Letter to Guardian, and article* – 28 April 2010
- <sup>6</sup> **Cochrane Database Systematic Review** - *Organised inpatient (stroke unit) care for stroke* – October 2007
- <sup>7</sup> **National Audit Office** - *Major Trauma Care in England* - February 2010
- <sup>8</sup> **College of Emergency Medicine** – *Workforce Recommendations* - April 2010
- <sup>9</sup> **Journal of Emergency Medicine** - *Does integrated emergency care reduce mortality and non-elective admissions? a retrospective analysis* – 2011
- <sup>10</sup> **Goodwin, Nick.** *Managing People with Long Term Conditions.* Publication. London: Kings Fund, 2010.
- <sup>11</sup> **Mike Farrar, NHS Confederation** - *quoted in British Medical Journal* - 2011;343:d8336
- <sup>12</sup> **Kings Fund** - *Reconfiguring Hospital services - Lessons from south east London* – February 2011, and **Kings Fund** – *Briefing: Reconfiguring Hospital services* – September 2011
- <sup>13</sup> **Kings Fund** – *Integrated care summary* – September 2010
- <sup>14</sup> **Vascular Society of Great Britain and Ireland** - *The Provision of Services for Patients with Vascular Disease* – 2009, revised November 2011
- <sup>15</sup> **NHS Buckinghamshire**  
www.buckinghamshire.nhs.uk

# Better Healthcare in Buckinghamshire

You can respond to the consultation:

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**The deadline for responses is 16 April 2012.**

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