



# Beyond Darzi

**HOW SMALLER DGHs CAN HELP  
DELIVER THE NHS VISION FOR THE NEXT  
10 YEARS**

**A report for the Yorkshire and Humber SHA**

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## Contents

Foreword.....	1
Key recommendations.....	2
Introduction .....	4
Context.....	4
Political environment.....	4
Economic environment .....	5
Social Environment.....	6
Technology.....	6
Policy Drivers for change.....	7
Care closer to home.....	7
Quality and outcomes .....	7
Workforce.....	8
The challenge .....	8
Redesigning the local NHS.....	8
A possible framework for success.....	9
Integrated provider models .....	9
Competition policy.....	10
Workforce development.....	10
Workforce training and development.....	10
Making financial incentives work for the reform agenda .....	10
Efficiency and effectiveness.....	10
Local conditions .....	11
Acute service configuration.....	11
The management of Long Term Conditions .....	12
Clinical networks and alliances.....	12
Rurality and geography.....	12
Urgent care .....	12
Acute patient flows.....	13
Children’s services.....	13
Planned care .....	13
Conclusion .....	13
Acknowledgements.....	14

## Foreword

This report has been commissioned by the Yorkshire and Humber SHA and seeks to contribute to the debate already underway nationally and locally about the framework needed – both in terms of the national policy environment and the necessary local conditions – that will enable smaller District General Hospitals (DGHs) to contribute successfully to the delivery of the vision articulated in the NHS Next Stage Review (NSR) over the next 10 years.

Our approach aims to avoid offering detailed, prescriptive solutions because the local circumstances in each community will vary significantly, but rather to describe some of the policy areas and local conditions that will need to be considered prior to the publication of Regional and National Reports over the summer.

We have also sought to avoid ‘special pleading’ on behalf of the smaller DGH sector, However it does try to look at the issues in the context of the challenges and opportunities facing the small DGH sector, although these issues are also likely to impact larger DGHs.

It is important that policy makers, SHAs, commissioners and all players in the health and social care system think seriously about the issues highlighted in this report so that the network of smaller acute hospitals across the country are not put at unintentional risk.

## Key recommendations

### Policy makers should:

- Engage secondary care provider CEOs in a considered and sophisticated debate about the realities of delivering the NSR clinical aspirations
- Establish a second stage NSR exercise with a similar profile to the first stage. This second stage must take the clinical aspirations of the NSR and map out options for their realisation.
- Examine carefully more innovative solutions to specialisation than huge investment in tertiary centres
- Realistically cost a model of care (revenue and capital) affordable within the NHS envelope and challenge the assumption that reconfiguration can be done solely through local commissioning and market forces as naïve and likely to result in unintended consequences
- Map the clinical aspirations of the NSR against patient surveys and patient and public aspirations for the NHS.
- Examine a different model of provision than that of inexorable centralisation as presaged by some successful clinical networks with “devolution” as an overt and managed intended outcome.
- Develop the skills and confidence of hospital and community based staff to feel comfortable and confident working as part of ‘integrated care teams’ delivering services both in hospitals and in the community
- Give urgent consideration to the benefits of encouraging ‘vertical integration’ of local hospital, community and potentially elements of primary care services (e.g. Urgent Care out of hours) and new governance models to support this
- Undertake further work on the intelligent unbundling of the tariff and the application of tariffs which incentivise desirable reform of the system rather than penalising the continuation of the existing system
- Adopt an explicit set of principles regarding the design of services that not only meet local need but which are financially and clinically sustainable across a whole region.

### Local health and social care economies should:

- Decide whether or not local hospital services are required and if not commence a professional planned and carefully managed programme of change
- Drive an approach to use of technology that will allow more local care to be delivered, and provide easier access to a specialist opinion, for example through the use of telemetry, telemedicine, remote monitoring, digital transmission of images (even to other parts of the world), and potentially virtual outpatients.
- Consider the impacts of the demise of local small DGHs on the efficiency and effectiveness of the whole public sector at the local level.

## **Commissioners should:**

- Avoid unintended consequences on small DGHs of single issue/ specialist secondary care service commissioning approaches
- Consider the pros and cons for driving alternative models of specialist care aimed at ensuring the ongoing viability of local facilities
- Ensure that new service models are built around 'integrated care teams' working in both hospitals and the community, and ensure that 'shifts' in the location of care can be enabled and staff more readily redeployed to support traditional client groups in a more varied range of care settings (as has been successfully achieved in many areas of mental health services in recent years)
- Continue to reduce health inequalities by improving local access (including to secondary care), and take steps to commission service provision locally other than for the most complex component of a clinical episode i.e. that part which can only currently be delivered in a tertiary centre.
- prevent de-stabilisation of essential local secondary care services
- Consider the merits of commissioning services from single providers, who in turn assume responsibility for sub-contracting or delivering the required service to each locality in line with local requirements.
- Where they have a smaller DGH providing a range of services to the local population ask:
  - Do they wish to have a sustainable DGH in their locality?
  - What is the intended shape of hospital service provision in the future for each locality that is clinically sustainable and financially viable?
  - Are they prepared to pay a higher premium for services which they wish to see provided in their locality if the cost exceeds that provided for by the tariff?
  - What is a realistic appraisal of what will maintain clinical and financial viability for such local providers.

## **Providers should:**

- Be provided with the clear steer to enable all parts of the system - including smaller DGHs - to embrace change with confidence and enthusiasm and without fear that it automatically signals the demise of their organisations
- Be supported by policy makers and commissioners to prevent energy being consumed in generating defensive behaviours and blocking tactics - both by NHS managers and clinicians
- Strengthen clinical networks and alliances and support more collaborative and cooperative service delivery through new forms of structured contracts with responsibility delegated to a lead Provider.
- Share responsibility for leading the delivery and provision of different specialist services across a group of DGH Providers through cooperation and collaboration amongst DGHs whilst ensuring sufficient infrastructure in each locality to maintain a viable general service. This would also minimise the need to expand tertiary centre facilities and maximise utilisation of the residual DGH estate.
- Develop the concept of a lead Provider for a local service and encourage greater collaboration between Hospital and Community Services.

## Introduction

It is our view that the NHS Next Stage Review (NSR) has the potential to be the largest and most profound reorganisation and reconfiguration of clinical services since the design of the NHS in the 1940's. If a simplistic approach to design and implementation is taken it is doubtful that the opportunities presented by the NSR will be captured, and there is significant risk that they will be lost in undeliverable and potentially destructive programmes of hospital closure and mergers and public alienation from the NHS.

Concern must also be expressed about whether the NHS in its current state, having only recently emerged from its latest management reorganisation, and still grappling with many new constructs (new SHAs, new PCTs, Foundation Trusts, Care Quality Commission, etc.) and a new and complex operating framework, much of which remains untested, actually has the capacity and ability to take on a reorganisation of the scale anticipated.

Furthermore, many of the solutions emerging from the NSR to date are predicated on an unmitigated approach to centralisation of secondary and tertiary care services, envisioning a future landscape that would require a capital investment programme of the scale previously not adopted in the public sector outside of post war Housing, which is unrealistic in the current and indeed foreseeable economic climate. A far more sophisticated and considered approach is required.

As Chief Executives of small and medium sized DGHs, we believe that more work is needed to understand the collective implications of the individual clinical pathway groups. The clinical pathway groups have looked at very specific issues relating to types of conditions, or groups. They have not been set up to consider how we best then use our current asset base overall to deliver better quality and accessible care.

We are keen to engage in a high level debate as to how the clinical aspirations of the NSR can be realised without the scale of reconfiguration and destruction which many observers have predicted. If the intention is to see a wholesale "closure" of smaller secondary care providers we are keen to ensure that such events, should they be necessary, are achieved by design and not by default, that there is a clear strategic direction for organisations underpinning change and that the potential for unintended consequences are minimised. This is vital if we are to deliver the totality of care which patients and the public need.

We are grateful to the Y&H SHA for the opportunity to set out the issues which we believe need to be seriously considered if this major reorganisation of NHS clinical services is to be delivered with minimum harm.

## Context

### Political environment

The period in which the NHS NSR will report will be less than two years away from a general election. There is therefore danger of "drift" and loss of impetus with a consequent increase of cynicism and negativity amongst clinicians who have seen this exercise as an opportunity to influence the future of services. Their debate has largely not been about configuration, but has rightly focused on optimal patient pathways. If drift and negativity is to be avoided the challenge is to now examine in careful and planned detail the organisational vehicles able to best deliver those pathways. We contend that this must be realistic and must accept but not be inhibited by "constraints" of buildings.

Without a much greater focus on the design of the new system, there are likely to be consequences, planned or even unintended, for small and medium sized DGHs, some of which may not survive; history is not on our side in this regard – in the past, even when

bold reconfigurations have been clearly articulated and clinically endorsed albeit driven largely by budgetary pressures, significant compromises have had to be made as a consequence of political and public pressure to maintain local services and hospitals (e.g. Surrey and Sussex). Whilst innovative solutions have been found to allow smaller hospitals to remain viable, and which may offer models which other localities may wish to consider, there can be little doubt that these compromises are not ideal clinically, may not be sustainable in the long term, and may come at a significant cost. We would consequently not wish to advocate this approach.

It is most unlikely that a one size fits all solution for a reconfigured NHS will be found, and consequently the shape of local services will be significantly influenced by local circumstances and local politics. For example, there are likely to be entirely different approaches to how services are provided in very rural areas to that which can be delivered in major conurbations. The majority of DGHs fit neither description, often located close to town centres, operating as an integral part of the community and generally being one of the largest employers in the locality. Whilst it is important that we do not fixate on bricks and mortar but rather recognise that the issue is about access to knowledge and skills, we cannot ignore the importance of local access and local delivery to the local community, not just from a service perspective, but from an economic and social cohesion perspective. It is not beyond the wit of local people and authorities to recognise that hospitals are major employers and their presence or otherwise can have significant impacts on the local economy especially in areas significantly denuded of traditional industry.

Successful attempts to reconfigure services by agreement are rare; a crisis of some sort usually being a necessary prerequisite. Those which have occurred, for example the creation of mega-Trusts, do not generally demonstrate significant improvement in terms of cost, quality, outcomes, performance or efficiency, and indeed some could be categorised as having become dysfunctional and unmanageable. Experience suggests that we need in future to ensure that the consequences of major change programmes are thoroughly considered, and the impact on society more generally is part of that consideration. Once a major programme has begun, experience suggests that retraction is difficult.

Even attempting to bring services together on a smaller scale proves difficult; there are many examples where Commissioners have been unsuccessful in securing a reconfiguration of services across a locality, often due to clinical resistance, and equally as many where Providers have failed to come together to offer a centralised service, even when this was in the best interest of all those concerned, including the institutions themselves. Despite the 'clinical leadership' provided by this review, the assumption that this will secure greater acquiescence of the public, politicians, clinicians, managers and NHS staff generally to significant restructuring is not a foregone conclusion, and no matter how desirable, there remain and persist huge barriers to service reform that will require much stronger commissioning, more pragmatic provision or more likely, a combination of the two.

This summarisation of the "political environment" would suggest that the realisation of the NSR will be problematic without a second stage exercise with a similar level of profile to the first stage. This second stage must take the clinical aspirations of the NSR and map out options for their realisation.

### **Economic environment**

It is clear that the global economy is experiencing a downturn of unknown but significant proportions. Major investment in public service reform appears increasingly unlikely in the short-term, yet the reconfiguration proposals will undoubtedly have substantial and to date

unidentified financial consequences for both the health and local government sectors. At the very least there may be not inconsiderable 'double running' costs as services are deconstructed and reconstructed. Much of the anticipated benefit in terms of reduced cost (of health care) remains unsubstantiated.

New accounting standards designed to bring the UK into line with Europe appear likely to bring PFI schemes onto balance sheets, which will create significant financial problems for those organisations who have invested heavily in PFIs; affordability of the capital changes required by these reforms and the financial viability of clinical services in their reconfigured state may become major issues. For example, the cost of major PFI schemes necessary to allow tertiary and specialist centres to accommodate a significant shift of acute work to them will be enormous and potentially unaffordable within the tariff, whilst at the same time DGHs down-size and struggle to meet the cost overheads of an underemployed estate. More innovative solutions to specialisation than huge investment in tertiary centres need to be found.

The perhaps unintended consequences of current commissioning already create considerable financial pressure on secondary care providers. Single issue/ specialty/ service commissioning can unhinge the "macro" balance of services within a hospital (e.g. withdrawal of paediatrics is likely to unhinge maternity services). Withdrawal of single service can perversely increase the cost of other services through the fixed asset costs – hence services the commissioner wishes to purchase may be unaffordable to the provider. The NSR implicitly assumes a neutral cost implication which is both undemonstrated and unproven. It will be necessary in this next stage to realistically cost a model of care (revenue and capital) affordable within the NHS envelope. Our concern is that the assumption that this can be done solely through local commissioning and market forces is naïve and will undoubtedly result in the unintended consequences we wish to avoid.

A key question that needs to be answered, on a community by community basis is therefore "do we wish to retain a local Hospital?", because if the answer to that question is yes, then this is most unlikely to happen without a clear and unambiguous commitment to working collaboratively with DGHs to ensure the clinical and financial sustainability of these facilities.

## **Social Environment**

For the general public, local access is perceived as an acceptable trade off against quality, albeit that this runs counter to clinical advice. The economically deprived are those least likely to take up choice and the least likely to travel for care. The assumed centralisation of specialties potentially arising from the NSR could increase rather than reduce health inequalities, unless equal attention is paid to the need for local access, and steps taken to commission local service provision other than for the most complex component of a clinical episode i.e. that part which can only be delivered in a tertiary centre. The clinical aspirations of the NSR must be mapped against patient surveys and patient and public aspirations for the NHS.

## **Technology**

An issue that requires perhaps greater consideration than has hitherto taken place is the diffusion of tertiary technology towards the secondary care sector. Unless there is a deliberate shift of technology out from tertiary centres, more and more patients will go to tertiary centres by default in order to access it (technology). Despite concern by tertiary clinicians that they do not want secondary care work coming into tertiary centres from outlying areas, from a business perspective the present financial regime (PbR) provides

powerful incentives for this to happen, and indeed encourages it, and there is mounting evidence that diffusion is being resisted for this reason, even though this would be in the best interest of the population (e.g. local chemotherapy).

There are also likely to be significant technological advances that will allow more local care to be delivered, and for easier access to a specialist opinion, for example through the use of telemetry, telemedicine, remote monitoring, digital transmission of images (even to other parts of the world), and potentially virtual outpatients.

## **Policy Drivers for change**

Having considered the context within which changes implied by the NSR might occur, it is perhaps useful to also note the other Policy drivers which are influencing the NHS reform agenda most of which were of course presaged in the NHS Plan and each of which has incrementally had impact on the smaller DGH viability.

### **Care closer to home**

Government policy has, for some considerable time now, been seeking to increase the influence GPs have over the commissioning of NHS services and the range and proportion of care that is delivered closer to people's homes.

The mechanisms for achieving this have varied over time, but most have led to a focus on:

- Expanding the range of services delivered by primary and social care teams;
- Building community and intermediate services, particularly to promote greater independence amongst older people and those with LTCs;
- Seeking to reduce hospital referrals and traditional modes of planned secondary care delivery, through the establishment of 'tier 2' services to filter potentially unnecessary referrals to Hospital and increasing the range of diagnostic services that can be directly accessed by GPs other than via hospital specialists.

There has also been a push to increase competition in the delivery of planned secondary care services, through the introduction of ISTCs and of new diagnostic providers that increase contestability, drive efficiency and facilitate greater patient choice.

### **Quality and outcomes**

In more recent years, the Government and the NHS has given much greater prominence to the outcomes of care achieved for patients from the whole system and, importantly, how the configuration of services can contribute positively or negatively to these.

The Calman-Hine Framework and then the NHS Cancer Plan were probably the first examples of a national set of service standards that accelerated the move towards more specialist centres concentrating on the treatment of patients with rarer cancers, with a consequent reduction in the number of DGHs delivering more complex and/or less common surgical treatments. Successful networks have offered an opportunity to look at how a different model than inexorable centralisation might be developed but to be more than incidental this would need to be an overt and managed intended outcome.

There have followed a number of subsequent national frameworks (NSFs), some of which have sought to secure better outcomes for patients by concentrating specialist skills in specialist (tertiary) centres. This has resulted in patients often having to travel further, sometimes considerably further, for treatment that they previously might have expected to be able to safely obtain from their local DGH. It has also had the effect of reducing the complexity of the case mix seen and treated in DGHs. In the smaller DGHs in particular,

the consequent deskilling of local clinicians may have longer term consequences for clinical viability and sustainability of other local services. We doubt that this was intended as the NSFs are clearly framed to promote improved patient care. Whilst they clearly have done so, they have also had implications which have had potentially adverse impacts on other services and local access.

## **Workforce**

There have been very significant changes, particularly expansion, in the NHS workforce over the past decade, driven by increased investment through the NHS Plan to bring services up to the same level as Europe generally, and to meet the requirements of EU policies such as the Working Time Directive. This has particularly affected the training and service commitment contribution of junior doctors, and raised expectations in relation to “work-life” balance.

The increase in Consultant numbers has led to an expectation of, and call for a move towards a consultant-delivered, rather than a consultant-led service, which is a considerably more expensive model to operate and one which requires a steady supply of adequately trained Doctors.

The effect of this on smaller DGHs have been quite considerable, with the need to significantly expand the consultant workforce both to deliver the core DGH service and to respond to increasing trends towards sub-specialisation. It has also led many DGHs to need to carefully assess which services it is clinically feasible and safe for them to seek to continue to deliver locally on a 24 hour a day basis.

The role of DGHs in training the post-graduate workforce is also changing and further erosion of the role and function of DGHs, and changes in the way the medical workforce in particular is trained, which has resulted in a much lower contribution to service, may render the training of doctors in smaller DGHs an expensive and unattractive solution for providing continuity of care. On the other hand it is difficult to imagine how the current training and education programmes and MMC can be sustained without the considerable training contribution made by the smaller DGHs.

## **The challenge**

These drivers for change look likely to continue and in some cases to accelerate over the next 10 years, both on the basis of national and international trends and in the light of the emerging conclusions of the NHS NSR Clinical Working Groups’ recommendations.

The challenge for the NHS is:

1. How do we enable all parts of the system - including smaller DGHs - to embrace these changes with confidence and enthusiasm and without fear that they automatically signal the demise of their organisations?
2. How do we prevent lots of energy being consumed in generating defensive behaviours and blocking tactics - both by NHS managers and clinicians – so that they can help lead their local communities towards the delivery of the vision for the NHS coming out of the NHS Next Stage Review?
3. How do we minimise the potential for unintended consequences?

## **Redesigning the local NHS**

In considering these challenges, there are a further series of questions that need to be asked, and answered, by each PCT which currently has a smaller DGH providing a range of services to its local population:

- Do PCTs wish to have a sustainable DGH in their locality?
- What is the intended shape of hospital service provision in the future for each locality that is clinically sustainable and financially viable?
- Are PCTs prepared to subsidise services which they wish to see provided in their locality if the cost exceeds that provided for by the tariff?

If PCTs want to maintain a level of DGH provision within the local community then there needs to be a realistic appraisal of what will maintain their clinical and financial viability. This cannot be left to market forces, since uneconomic services will ultimately close, and therefore needs to be commissioned by design.

Having determined the range of services that PCTs wish to see provided locally, commissioners must take responsibility for planning and consulting on service reconfiguration options for their local community and not simply allow, or even facilitate, the demise of local services through acts or omissions that cause services to “wither on the vine”.

The needs of each locality cannot be considered in isolation from the range of services necessary within a sub-region, and the SHA will have an important role in ensuring that patients have equitable access to services which do not unacceptably compromise the delivery of national standards to local populations.

## A possible framework for success

In the following sections we have set out some proposals which we consider need to be addressed at a national and local level that could enable smaller DGHs to contribute successfully and enthusiastically to the delivery of the NHS vision over the next 10 years.

The following proposals (policy areas) need to be considered quickly, before the NSR outcomes are published in the summer, if the challenges outlined in this paper are to be successfully met:

### **Integrated provider models**

Urgent consideration needs to be given to the benefits of encouraging ‘vertical integration’ of local hospital, community and potentially elements of primary care services (e.g. Urgent Care out of hours), particularly in more sparsely populated areas and towns, possibly through the development of an Integrated Provider NHS Foundation Trust model. This would have at least three major benefits:

- i. Hospital and Community Service integration potentially leading to more seamless care;
- ii. The opportunity to incentivise a shift of Hospital based services into the community to drive the Out of Hospital care agenda, and
- iii. Spreading the asset base, thereby reducing the risk to DGH sustainability if new income streams to offset other losses (e.g. from centralisation) cannot be established.

The National Contract, Operating Framework, Commissioning Rules and Tariff System provide sufficient safeguards to ensure that community services will not be subjected to asset stripping which in the past has been cited as a major reason for keeping hospital and community services separate.

## **Competition policy**

Urgent consideration needs to be given to whether, with appropriate VFM and patient choice safeguards, SHAs and PCTs should be encouraged to support vertical integration, partnering and/or to limit competition between local hospital, community and potentially primary care providers where this will prevent de-stabilisation of essential services locally;

## **Workforce development**

There are serious concerns about the capacity of the workforce to deliver the reform agenda. Urgent attention needs to be paid to developing the skills and confidence of hospital and community based staff to feel comfortable and confident working as part of 'integrated care teams' delivering services both in hospitals and in the community (there are successful models from the mental health sector that we could and should be able to learn from here).

## **Workforce training and development**

Consideration must be given to the impact of new service models on national training programmes, which will have to adapt to ensure a workforce fit for the future. In particular, there may be almost immediate and significant consequences for the training of Doctors in reconfigured service delivery models.

Serious consideration should also now be given to whether the training of doctors should be undertaken on the basis that they are entirely supernumerary and do not contribute to the service commitment. If this issue is not addressed, Hospitals may increasingly consider withdrawing from training in order to ensure that minimum service standards are maintained during all working hours.

## **Making financial incentives work for the reform agenda**

Urgent further work is required on the intelligent unbundling of the tariff and the application of tariffs which incentivise desirable reform of the system rather than penalising the continuation of the existing system. This is important because the existing system although not perfect is well understood and known to work reliably and reasonably well, and will therefore remain the default position until such time as a better system emerges.

Consideration also needs to be given to whether PCTs should be able to provide tariff supplements to smaller DGHs in certain specialities where the quality standards set nationally risk making those specialities no longer clinically or financially viable (specific examples might include paediatrics and obstetric services).

Alternatively, the 'rurality component' of the revised PCT allocation formula could be used to help support the sustainability of such services locally;

Consideration should also be given to realigning incentives such that Acute Hospitals are supported in maintaining patients in the community rather than admitting them.

## **Efficiency and effectiveness**

There is a hidden danger in the current monetary approach to efficiency and effectiveness of creating a pressure towards larger units more able to "absorb" efficiency targets (but not necessarily deliver efficiency - this is currently paralleled in the national debate about Post Office counter services). A more sophisticated approach would provide for a full range of "efficiency thinking" (e.g. a local service which reduces travel time/ energy usage/ pollution/ congestion/ provides local jobs which reduce state benefit payments to the unemployed etc. etc. can easily be seen to be most efficient to the public purse.

Treating all efficiencies in the NHS as directly 'cash releasing' within the specific organisation has required some smaller DGHs (and other providers) to cut costs by reducing staffing levels, particularly where geographical constraints limit their scope to increase activity. If not addressed, this will make certain services in smaller DGHs no longer financially viable or alternatively risk compromising quality and safety.

The NHS has not always been a positive contributor to the wider agendas within the public sector. Some aspects of the approach to the NSR review and to efficiency targets could continue that trend at a time when the new drive for invigorated local strategic partnerships encourages otherwise. There has not been any real consideration of the impacts wider than clinical care of the demise of local small DGHs on the efficiency and effectiveness of the whole public sector at the local level.

The current deflationary approach to PbR is forcing down bed numbers without any confidence that primary care and community based provider services can cope with the consequences, and there is a deepening concern that the scale of investment necessary to provide alternatives to Hospital admission is simply not happening, despite substantial year on year increases in funding available to commissioners. This is reinforced by for example contractual penalties for readmissions, when the reason for readmission may be inadequate support for the patient in the community

## Local conditions

The following local i.e. SHA/Local Health Community level issues also need to be addressed at the same time as the above national policy areas are tackled.

### Acute service configuration

Where the explicit intention is to drive reconfiguration (after the type of consideration advocated in this report) SHAs and PCTs should provide clear leadership and support for potentially controversial service rationalisation/reconfigurations, especially where these would require the transfer of existing acute services to other sites in order to secure the viability of such services both clinically and financially.

Commissioners should consider the pros and cons for driving alternative models of specialist care aimed at ensuring the ongoing viability of local facilities, such as:

- Clinical Networks, possibly with Clinicians in a specialty employed by one Provider on behalf of the rest, with responsibility for ensuring the needs of each locality is met in line with commissioning requirements;
- Specialist service dispersal across a network. Different Hospitals within a sub-Region assume lead responsibility for particular services, including elective inpatient services, with the aim of securing a critical mass of work which provides a significant and long-term contribution to fixed costs and overheads of locality based Providers.
- The conversion of Acute DGHs to Elective Treatment centres, operating in a similar fashion to ISTCs.
- Tertiary centres focused on tertiary work, with neighbouring DGHs delivering a greater proportion of the region's elective secondary care, relieving capacity demands on the tertiary centre, and maximising use of the available estate.
- Reduced access to DGH acute services out of hours for specific services

- Conversion to GP led community/intermediate care/polyclinic facility with visiting specialists, diagnostic services and OP clinics

### **The management of Long Term Conditions**

SHAs, PCTs and providers should ensure that new service models are built around 'integrated care teams' working in both hospitals and the community, to share expertise and to ensure that 'shifts' in the location of care can be enabled and staff more readily redeployed to support traditional client groups in a more varied range of care settings (as has been successfully achieved in many areas of mental health services in recent years).

This may require PCTs to commission services in a more integrated way, or to support the vertical integration of existing services. It is important for PCTs to progress the development of alternative care settings and capacity, and to incentivise the care system to use them.

### **Clinical networks and alliances**

If the role of the SHA is to take greater overall responsibility for market development and market management, there will be a need to ensure that commissioning intentions are compatible with the outcomes required across, as well as within a sub-region, to ensure equity of access and to minimise the emergence of even greater health inequalities. This responsibility needs to be driven by an explicitly stated set of principles regarding the design of services that not only meet local need but which are financially and clinically sustainable.

SHAs and Commissioners should consider the merits of commissioning services from single providers, who in turn assume responsibility for sub-contracting or delivering the required service to each locality in line with local requirements.

Greater emphasis could also be given by SHAs to strengthening clinical networks and alliances and to support more collaborative and cooperative service delivery through new forms of structured contracts with responsibility delegated to a lead Provider.

Specialist services do not always have to default to provision by an existing tertiary centre. Sharing responsibility for leading the delivery and provision of different specialist services across a group of DGH Providers would encourage cooperation and collaboration amongst DGHs whilst ensuring sufficient infrastructure in each locality to maintain a viable general service. It would also minimise the need to expand tertiary centre facilities and maximise utilisation of the residual DGH estate.

Similarly, the concept of a lead Provider for a local service could encourage greater collaboration between Hospital and Community Services.

### **Rurality and geography**

SHAs and PCTs must consider where geographical constraints limit the scope of smaller DGHs to exploit patient choice and thereby 'spread the risk' across a broader number of commissioners to sustain the delivery of local services. Consideration needs to be given to what, if any, special arrangements may be needed for smaller DGHs in very sparsely populated and/or geographically isolated areas;

### **Urgent care**

The NHS next stage review reinforces the need for collocation of A&E and GP led urgent care centres to support integration, encourage greater joint working between primary and secondary care staff involved in the management of urgent and emergency care, to

minimise cost and to avoid duplication; SHA's need to ensure that where such models are not being implemented, this is in the best interest of the local community.

Whilst significant steps have been taken to manage demand and provide more care in the community, there has been insufficient progress to provide confidence that this is robust and sustainable, as continues to be evidenced by the high numbers of patients still attending A&E departments, the number of acute admissions which still occur and the frequency with which Hospitals are going on to "Red Alerts".

Consideration should be given to whether Acute Hospitals should be commissioned to coordinate the delivery of the Services response to urgent care out of hours rather than this being facilitated through a loose network of affiliated parties.

### **Acute patient flows**

Careful consideration should be given to the impact on patient flows of Ambulance staff being encouraged to "refer on" patients to alternative providers rather than taking them direct to the nearest A&E. This could best be handled through an 'integrated care' model where A&E and GP and other community-based staff work in both the local A&E and the alternative locations from which urgent care can be delivered;

Where ambulance services are given a mandate to 'by-pass' local A&E departments given certain conditions e.g. for possible stroke and heart attack victims, that this will inevitably mean many other conditions by-passing local A&E departments as well, rendering them, and associated acute services, increasingly unviable. It should not be assumed that smaller DGHs cannot provide such services, although it may require substantial internal reconfiguration and possibly additional investment – PCTs and local DGHs should be allowed to determine the best solution for their local population rather than insisting that only a tertiary centre can deliver such a service.

### **Children's services**

It is clearly appropriate that more care should be delivered to children and their families in the community rather than Hospital, but very careful consideration will need to be given to the implications for A&E and Obstetric Services in smaller DGHs if the level of senior paediatrician support is reduced as a result of the proposed move to 8 till 8 paediatric services.

### **Planned care**

Smaller DGHs should be supported by commissioners and the SHA in looking to exploit technology to enable a greater range of diagnostic tests and simpler procedures to be carried out from a greater range of locations.

Consideration should also support a greater volume of 'secondary care' planned work being delivered not in specialist/tertiary centres, but in other, reasonably local DGHs, freeing up capacity in specialist centres for more complex planned surgery and tertiary services; If patients are prepared to travel some distance to ISTCs then it is perhaps not unreasonable to expect them to travel to other local hospitals for routine elective work. Indeed much routine work could default to non-tertiary, centres.

## **Conclusion**

In putting this report together we have not argued for maintaining the status quo, nor sought to plead a special case for the protection of smaller DGHs, but rather to identify the particular risks of an unmanaged and ill considered approach to the NSR to the

communities and patients served by these hospitals, and have sought to put forward proposals that will help to mitigate that risk.

We have set out some of the key policy considerations that need to be addressed to help create the right environment to enable smaller DGHs to actively support and help lead the NHS towards the Darzi vision of a clinically-led, person-centred service over the next 10 years. It also seeks to set out some of the local conditions that SHAs, PCTs and smaller DGH providers will need to take forward in parallel.

Taken together, we believe they have the potential to help the NHS achieve the dual objectives of increasing the range and proportion of care delivered closer to people's homes whilst also sustaining as broad a range of acute hospital services as locally as possible, particularly in the many towns and more sparsely populated areas of England that are served by relatively small DGHs.

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