

James Paget University Hospitals 
NHS Foundation Trust

Report to: Board of Directors
Date: 27th October 2006
Title: **Acute Services Review**
Report of: Chief Executive
Report for: Information

SUMMARY

Attached is a paper discussed at the East of England Strategic Health Authority Board meeting on 14th September 2006 and a copy of the press release issued.

This is the current thinking and, together with the presentation to be given, will feed into discussions with the Governors and influence the Trust's strategic direction.

RECOMMENDATION

The Board are asked to note the paper.

EAST OF ENGLAND STRATEGIC HEALTH AUTHORITY

PUBLIC BOARD MEETING / 14 SEPTEMBER 2006 / FOR INFORMATION

Acute Services Reconfiguration

Report of Dr Paul Watson, Director of Commissioning

1 PURPOSE

- 1.1 This paper is intended to brief the SHA Board on some of the strategic challenges facing hospital services in the East of England and describe the review processes in place to plan hospital configuration in EoE in the future.

2 BACKGROUND

The District General Hospital

- 2.1 Most UK hospitals are configured on the “district general hospital” (DGH) model. This was set out in the national 1962 Hospital Plan and envisaged hospitals providing a full range of A&E, emergency medicine and surgery, elective care, maternity and out-patient services. These hospitals would serve a population of 250-300,000 and would be self-sufficient for most services. There are 19 such hospitals in EoE managed by 17 Trusts. Two of these hospitals (Addenbrookes and the Norfolk and Norwich) also have teaching hospital status. This means they have teaching and research functions and also provide more specialised services such as neurosurgery (Addenbrookes) and thoracic surgery (NNUH). Specialised services can also be provided by DGHs such as burns and plastic surgery in Chelmsford.

Challenges to the DGH Model

- 2.2 Commentators have questioned the sustainability of the DGH model. This has been mainly focused around three issues:-
- Medical Staffing – emergency hospital care has traditionally been provided by doctors in training. Restrictions in hours worked meant that more doctors are required to staff a 24/7 rota; for instance in 1990 a 24/7 rota could be staffed with three doctors. Following implementation of the European Working Directive (EWTD) in 2009 this could increase to as many as nine or ten doctors required. At the same time the supply of doctors in training is reducing due to changes in training schemes which means more emergency care will need to be provided directly by consultant staff. This had led some medical professional bodies to call for a reduction in the number of hospitals providing emergency care; perhaps by as much as a 50% reduction.

- Clinical Standards – some clinical services need a larger caseload than most DGHs can provide to guarantee the best possible clinical outcome. The classic example is cancer surgery where some cancers (gynaecological, urological and upper gastrointestinal) require a catchment of one million people to give the best achievable outcomes. Similar considerations apply to other services such as vascular surgery and neonatal intensive care. This means that some clinical services need to be centralised to one hospital which will then serve the current catchment of several DGHs.
- Financial sustainability – it has been suggested that some hospitals are too small to cover the costs required to provide comprehensive hospital services. The evidence here is mixed and not well understood. However it should be noted that financial problems in EoE hospitals do tend to be centred in smaller hospitals (of the ten smaller hospital sites in EoE only one, the James Paget in Great Yarmouth, does not have significant financial difficulties). It should also be noted that although hospital activity has historically risen steadily; this may not always be the case. The combination of patient choice, independent sector provision and transfer of secondary care into community settings may reduce hospital activity, at least for some Trusts.

3 REVIEW OF ACUTE SERVICES

3.1 In view of the issues outlined above, the SHA is embarking on a major review of acute services across the region. The objective of this review is to agree a pattern of hospital services for EoE that will be both clinically and financially sustainable. The initial phase of the review is a technical analysis of how the issues outlined above will affect EoE hospitals. This includes consideration of the following:-

- PCT hospitalisation rates – the sustainability of current PCT acute service commissioning will be examined; in particular whether commissioned activity is affordable within the PCTs' weighted capitation allocation. The effect on hospital activity of PCTs achieving affordable activity levels will be examined.
- Payment by results (PbR) – the effect on hospital finances of full application of national tariff will be examined to estimate whether local pricing is having an effect on financial balance.
- Clinical service configuration – existing and planned service reconfiguration will be surveyed, particularly where clinical services will need to be provided across hospital sites for clinical reasons.
- Independent sector provision – the effect of IS procurement on hospital activity will be examined.
- EWTD – the effect of EWTD on service viability will be examined.

3.2 The above analyses will be used to give a view on whether current configuration is sustainable and, if not, the degree of change that will be required. This will be completed over the next month. Once this is available, a formal process will be established, including structured stakeholder engagement, to prepare detailed service proposals for consultation. This phase will be completed early in the New Year.

4 SPECIFIC LOCAL ISSUES

- 4.1 **“Investing In Your Health”** – the current strategy for hospital and community services in Hertfordshire involves providing comprehensive emergency care from two rather than four sites with one of these sites also providing some specialised services. This would be supplemented by two additional surgical centres providing elective care. The Chief Executive Designate of the two Hertfordshire PCTs is leading a review of this strategy. This will examine whether the operational and affordability assumptions of the current strategy are clinically and financially sustainable, taking into account the impact of patient choice, payment by results and other effects such as mental health issues and, if not, what are the alternatives. This technical analysis should be completed as quickly as possible, the findings will be shared and a process of stakeholder engagement commenced if significant changes to the strategy are required
- 4.2 **Hinchingbrooke Hospital** – Hinchingbrooke Hospital has the smallest catchment population in EoE and is in particularly severe financial difficulty. This means that any changes to hospital configuration will affect Hinchingbrooke earlier than other hospitals. In view of this, a specific review of the future of services on the Hinchingbrooke site has been commissioned. This is examining:-
- a) Why the Trust has failed to achieve financial balance and the effect of PbR on Trust finances.
 - b) PCT hospitalisation rates – initial work suggests these are unsustainably high – the effect of affordable rates of hospitalisation on Trust activity is being estimated.
 - c) Whether the current portfolio of services on the Hinchingbrooke site can recover their costs once a) and b) above are applied.
 - d) If the current range of services cannot recover their costs, then the portfolio of services that could reasonably be provided on the site.
- 4.3 This work is working to a similar timescale to the Hertfordshire review.

5 RECOMMENDATION

- 5.1 The Board is asked to note the contents of this paper.

DR PAUL WATSON
Director of Commissioning
1 September 2006

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Acute Services Review for East of England

The East of England Strategic Health Authority (SHA) is beginning a review of acute services across its area. The objective of the review will be to agree a new pattern of hospital services for the region that will meet the demands of 21st century healthcare and be financially sustainable

Dr Paul Watson, Director of Commissioning for the SHA, explained: “ Most UK hospitals follow the ‘district general hospital’, or DGH, model that was set out in the National Hospital Plan in 1962, more than 40 years ago. This envisaged hospitals providing a full range of A&E, emergency medicine and surgery, elective care, maternity and outpatient services to population of between 250-300,000. There are currently 19 such hospitals in our region.”

However, a number of major issues have caused commentators to question the sustainability of this DGH model. These include clinical standards, medical staffing and financial sustainability.

Dr Watson continued: “Healthcare is changing almost daily, and medicine today is very different from 40 years ago. Modern clinical standards demand that some services need a much larger caseload than exist in most DGHs in order to guarantee the best possible clinical outcome. An example of this is cancer surgery where some cancer services, including gynaecological, urological and upper gastrointestinal; require a catchment area of one million people to give the best achievable outcomes. Other examples are vascular surgery and neonatal intensive care. This means that these clinical services need to be centralised in a hospital which would serve the catchment area of several of the current

DGHs.”

With regard to medical staffing, Dr Watson explained that emergency hospital care has traditionally been provided by doctors in training. Restrictions in working hours have meant that more doctors are required to staff a 24/7 rota. In 1990 a 24 hour rota could be staffed with three doctors, however, following full implementation of the European Working Directive (EWTD) in 2009 this could increase to nine or ten. At the same time the supply of doctors in training is reducing due to changes in the way they are taught. This means more emergency care will need to be provided directly by consultant staff leading some medical professional bodies to call for a reduction in the number of hospitals providing emergency care.

While it has been suggested that some hospitals are too small to cover the costs required to provide comprehensive hospital services, the evidence is not conclusive. However the financial problems in the region do tend to be centred in smaller hospitals. The combination of patient choice, independent sector provision and the transfer of more services that were traditionally delivered in secondary care into the community means that the number of people using each hospital will also change.

Dr Watson concluded: “In view of these issues we have decided to undertake a major review of acute services across the region to agree a new pattern of hospital services for the region that will meet the demands of 21st century healthcare and be financially sustainable.

The initial phase of the review is a technical analysis of how these issues are affecting hospitals in our region. This will give us a view on whether current configuration is sustainable and, if not, the degree of change that will be required.

“This will be completed over the next month and once this is done a structured process will be established, including discussion with our many stakeholders, to prepare detailed service proposals for consultation. This next phase should be completed early in the New Year.”

The current reviews of acute services in the area, “Investing In Your Health” – the strategy for community and hospital services in Hertfordshire, and the review of services at the Hinchingsbrooke Hospital, will continue and their results incorporated into the main review process.

Notes to editors:

- For further information please contact the NHS East of England press office on 01223 597545

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House, Capital Park, Fulbourn, Cambridge CB1 5XB; Tel: 01223
597500; Fax: 01223 597555; Website: <http://www.eoe.nhs.uk/> |
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