NHS
Bedfordshire
Clinical Commissioning Group

Agenda Item: 11

Governing Body Meeting
held in public

REPORT

Subject	Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan (STP): 'What We've Heard So Far Report'
Date	6th July 2017
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Executive Summary

In March 2017, the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan (BLMK STP) team undertook some pre-consultation engagement activity to find out what was important to people when considering any changes that might be made to hospital services within this region. This recognised that change would need to take place both in and out of hospital and was based on early clinical discussions around areas where focus and change might be needed to provide high quality, sustainable hospital-based care for local people (See Discussion Paper '*Seeking your views on transforming health and care in BLMK'* https://www.lutonccg.nhs.uk/page/downloadFile.php?id=14034 · PDF file).

This report: *'What we've heard so far'*, summarises staff, public/ patient and clinical views that came out of this pre-consultation engagement activity, gathered at a variety of staff and public engagement events and via an online questionnaire. This was published on 30th June on the BLMK STP website - www.blmkstp.co.uk. This feedback has been shared with the 16 BLMK STP partner organisations and programme team to inform developing plans across all of the priorities.

Recommendation
The Governing Body is requested to NOTE the content of the report.

Links to the business and risks

Relevant Strategic Priorities 2016/17 (please mark in bold)
1. Systematically implementing prevention, early diagnosis and early intervention
2. Commissioning services that deliver evidence-based care, in the right place and at the right time, including promoting self-care and empowering patients to manage their own conditions.

3. Making sure that care is high quality, safe and sustainable, that it improves health outcomes and wellbeing and provides a good patient experience.
4. Using the statutory framework with best practice governance and transparency principles to be fully accountable to our population in commissioning and operating as a part of the wider health system
5. Ensure that the CCG commissions and operates in a financial manner consistent with the regulatory framework, long term sustainability and best use of public money.
6. We will work in close partnership with all the organisations who commission or provide care for our population, to integrate services where it makes sense and to achieve seamless transitions of care for patients where services remain separate.
7. Embedding member, public, patient, carer, staff and other stakeholders' views through meaningful engagement into decision-making processes and commissioning intentions.

Links to Board Assurance Framework / Corporate Risk Register	Not applicable for this report
Details of additional risks associated with this paper ***(may include NHS England Assurance Framework / NHS Constitution)***	Not applicable for this report
Financial Implications / impact	None identified
Legal Implications / impact	None identified
Partnership work / public engagement implications / impact	To inform and help to shape the developing STP
Committees / groups where this has been discussed before	Not applicable
Other options available and their pros and cons	Not applicable
Background papers	None

Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan (BLMK STP)

What We've Heard So Far

30 June 2017

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1. Introduction

This paper summarises the feedback that has been gathered, and the clinical discussions that have taken place, following publication of the BLMK STP Discussion Paper *'Seeking your views on transforming health and care in BLMK'* on 1 March 2017.

This engagement is part of our pre-consultation activity and builds on the engagement and discussions that took place following the publication of the October 2016 BLMK STP submission to NHS England. Feedback from that engagement activity, a summary of which is available on the www.blmkstp.co.uk website, has been shared with clinical champions from our three hospitals to inform discussion and the development of ideas for future hospital services in our area.

We are once again extremely grateful to local people for taking the time to share their thoughts and opinions, which will help to shape our plans as the STP progresses.

2. Approach

On 1 March 2017, the BLMK STP published a Discussion Paper entitled *'Seeking your views on transforming health and care in BLMK'*. This paper has formed the basis of further public engagement, and discussion with local NHS staff and clinicians, centred around the areas where clinicians feel focus and change are needed in order to deliver high quality, sustainable secondary (hospital-based) care for local people.

Although the Discussion Paper and this feedback report are primarily focused on hospital-based services, work on the transformation of primary and social care is also progressing and will be considered alongside any potential changes for secondary care.

2.1 Public engagement

From 6 to 9 March 2017, eight public engagement events were held across the BLMK area, both in the daytime and evening to ensure as many people as possible were able to attend and provide their views. At these events, attended by **281** people, local clinicians talked through the latest thinking presented in the Discussion Paper, and round table discussion sessions were held to gather people's views. For each of the six priorities identified in the Discussion Paper, attendees were asked:

- What do you think overall of the idea/approach outlined?
- Do you consider this to be a priority area of change for the BLMK STP, and why?
- What issues do you feel the BLMK STP should be taking into account when considering this priority area?
- Do you have any other ideas or suggestions on how the BLMK STP could meet the challenges faced in delivering this aspect of health and care?

The key themes from these discussions were presented back to attendees during the sessions and there was also an opportunity for general questions and feedback.

On 1 March 2017, a copy of the Discussion Paper was placed on the www.blmkstp.co.uk website along with an online and downloadable paper questionnaire. This questionnaire was open for response from 1 to 31 March 2017 and received **548 responses** (516 from the public and 32 from NHS staff).

To ensure people had as many ways as possible to provide their feedback, responses were also invited by email, telephone and in writing. Two comprehensive email / written responses were received.

In addition, as part of the pre-consultation the STP team conducted some outreach work to gather feedback on the Discussion Paper, including from some of the harder to reach groups in the area. More detail on this is included in the engagement summary in section 2.4 below.

2.2 NHS staff engagement

During March 2017, **233 NHS staff** from our three local hospitals (117 in Bedford, 60 in Luton and 56 in Milton Keynes) attended 12 events to provide their feedback on the six key areas identified in the Discussion Paper for transforming secondary (hospital-based) health and care services in BLMK, and on the STP as a whole. The online feedback survey mentioned in section 2.1 above also attracted 32 responses from NHS staff.

2.3 Clinical engagement

Clinicians at our three local hospitals have been jointly exploring potential ways to address the key challenges facing our hospital services. This is the first time that all three hospitals have engaged their clinical teams jointly in a collaborative process to explore clinical models and, in total, more than 120 different clinicians have been involved in conversations in respect of 24 different hospital services. Clinical teams have been asked to identify opportunities for collaboration that do not require significant service change, as well as possible future models for service delivery together with the pros, cons and enablers for each model.

Nine clinical champions (senior consultants from each of the three hospitals) have met on a monthly basis to review progress, share learning and explore emerging themes. In addition, two meetings have been held with GP locality leads from the three CCGs[1] to share the emerging ideas from hospital clinicians and establish, from the outset, whether these are compatible with GPs' priorities for secondary care.

The outputs from these discussions have been summarised in this feedback document, to identify what clinicians consider to be the key considerations for the provision of future healthcare services across BLMK, and to provide a platform for further discussion from which formal options development can progress.

Before work began with the clinical teams, the STP team reviewed the work completed by two previous local healthcare reviews, 'Healthier Together'[2] (June 2011 to April 2013) and the Bedfordshire and Milton Keynes Healthcare Review (January 2014 to July 2016).[3] Significant amounts of the exploratory work from those programmes, including clinical standards and ideas for service models, have been considered by the clinical leads and taken forward into the STP process for further development. We also have some of the same clinicians involved in the STP process as were involved in previous reviews, ensuring that valuable knowledge and learnings from those reviews are being captured in our ongoing discussions.

[1] Each of our three Clinical Commissioning Groups (Bedfordshire CCG, Luton CCG and Milton Keynes CCG) is split into a number of geographic areas or '**localities**', with each locality being led by a local GP who represents all the GPs in their locality

[2] '**Healthier Together**' was a review of services provided from Bedford, Kettering, Luton & Dunstable, Milton Keynes and Northampton hospitals. More information at www.healthiertogethersoutheastmidlands.nhs.uk

[3] More information on the **Bedfordshire and Milton Keynes Healthcare Review** is available at www.bedsandmkhealth.org

2.4 Engagement summary

Method	Number of attendees / respondents			
Audience	Patients /public	NHS staff / clinicians	Democratic	Total
Public events in Milton Keynes (6 March), Central Bedfordshire (7 March), Bedford Borough (8 March) and Luton (9 March).	281			281
Public outreach events 16 March: Ramgarhia Sikh Temple (25 people) and Leighton Buzzard Carers' Café (20 people) 28 March: Future East event (95 people) 5 April: Bedford Locality Patient Group (15 people)	155			155
Clinical discussions		120		120
NHS staff events Bedford: 7, 21, 22, 29 March (114 people) Luton: 13, 14, 20 & 22 March (60 people) Milton Keynes: 8, 14, 22 March (56 people)		233		233
Online questionnaire (available online with the public summary from 1 to 31 March 2017)	516	32		548
Emailed responses			2	2

3. Overarching themes

The main themes coming through in the feedback from patients, elected representatives, clinicians and NHS staff are summarised below. Further summaries and detail are provided in section 4 (patient feedback), section 5 (NHS staff feedback) and section 6 (clinical feedback).

- **General views:** Many staff and public respondents felt there needed to be more detail in the plans and there were queries over some of the terminology used, in particular what was meant by 'unnecessary duplication' of services. Many felt that NHS underfunding was the fundamental problem and queried where the money would come from to support and deliver change. Many respondents also mentioned the need for greater public and local authority involvement in the plans.

Priorities and key considerations

- **A whole system approach:** There was widespread agreement that a whole system approach was needed, and that we must be clear where simultaneous transformation needs to take place in primary, community and social care to support changes in secondary care.

- **Admission avoidance / timely discharge:** There was agreement that one of the key priorities should be to reduce pressure on hospitals and beds by reducing admissions and speeding up discharge procedures. This would include improved GP services; simplified access for urgent care services; improved and 'stricter' triage both in and out of hospital; better care planning for the elderly and people with chronic, long term conditions; and community facilities for step up / step down care and rehabilitation.

- **Technology:** There was agreement that shared clinical information, and the technology to support this, was one of the most important enablers of integrated clinical services, with its absence being a real barrier to change.

- **Other priorities:** Other priorities mentioned were mental health and closer ties between health and social care.

- **Transport and travel:** The increased need for travel where there was any centralisation of services on fewer hospital sites was a major concern, especially for emergency care and maternity services. It was felt that special consideration needed to be given to elderly and disabled people, disadvantaged families and those relying on public transport, that detailed travel analysis would be required and that local authorities needed to be fully involved in transportation planning.

- **Education and prevention:** Many respondents mentioned the need for education to encourage people to take control of their own healthcare, what the NHS offers and how misuse can affect services. There was also a strong appetite from staff and the public for charging for missed appointments and 'unnecessary' attendances at A&E, for example resulting from alcohol or drugs.

Views on the six focus areas identified by clinicians

- **Emergency services:** NHS staff and patients felt that A&E departments should be retained at all three hospital sites, and expressed concern that removal or downgrading of A&E could impact on a Trust's viability and ability to recruit staff. There was general support for a single point of telephone contact for urgent care, so long as it was staffed by appropriately qualified staff, as patient's experience of the 111 service had not been positive.

- **Centralisation / separation of services:** There was overall support for having centres of excellence for certain specialties and also for mobile clinics. There was also a fair amount of support for separating planned and emergency surgery, although concerns were raised about the co-dependency of services and emergency back-up in the event of complications arising. However, NHS staff and patients all raised concerns that centralisation of services could result in de-skilling of staff, dilution of training and difficulty recruiting on any non-specialist or non-emergency sites.

- **Care closer to home:** There was general support for the provision of more care closer to home, so long as it was adequately funded and staffed so quality of care could be maintained. There was support for more services being delivered from GP surgeries, although many questioned how this would be achieved, given the shortage of GPs and difficulty recruiting. Areas that were commonly supported include local provision of X-rays

and blood tests, upskilling of practice nurses and care home workers, and outreach clinics from hospitals.

- **Maternity:** Many public and staff respondents said that maternity services needed to be expanded, and more staff recruited, to support the increasing number of births. Views from staff and the public on the separation of high and low risk births were mixed. Many felt this would not be feasible due to increased travel and the concern that a low risk pregnancy could very quickly turn into a high risk birth. However, others felt a midwife-led unit for low risk births would be feasible, so long as women had a choice. There was general support for routine check-ups and services being provided in the community and for home birth to be given greater consideration.

- **Paediatric (children's) services:** All groups felt that a paediatric emergency service must be retained at all three hospital sites to manage injuries and assess unwell children, referring them on to another hospital where necessary. There was a fair amount of support for the provision of complex and specialist paediatric services in centres of excellence on fewer sites, although there were concerns about travel and family support for unwell children who needed to stay away in hospital.

4. Patient and public feedback

In this section, we summarise the key points raised by the public about the STP as a whole and the ideas for hospital-based care that were presented in the Discussion Paper.

4.1 General feedback and summary

- **STP process / consultation:** Some respondents were concerned about the STP process, saying there had been a lack of true partnership working. People wanted local authorities / elected representatives and, to a lesser extent, CCGs to be more closely involved and it was mentioned that local authorities needed to be consulted on public transport, population, current and future needs. Questions were also raised as to whether patient organisations were represented on the decision making body and if unions have been involved. Some felt that the STP could not be impartial as the programme team were all based at the L&D. It was mentioned that people needed a better understanding of the process. Some mentioned they hadn't been aware of this pre-consultation until they were notified by Bedford Borough Council and that there needed to be more notice for public meetings, ensuring that people who were not computer literate were also able to take part.

- **Detail and clarity:** It was felt that the Discussion Paper was a good starting point but that more detail and clarity was needed, for example what does 'basic care for children' actually mean, what is an 'unwell child', what is a 'high risk birth' (e.g. severely premature or everybody who might need a caesarean) and what are the numbers involved? Several people said they would like examples to help them understand what any change would mean in practice. The term 'unnecessary duplication' (of services) continues to cause consternation, with people saying duplication is only 'unnecessary' if it can be removed without causing travel difficulties, especially for the elderly and vulnerable. Several people mentioned that the solutions were too short-sighted. *"We need real transformation, not a temporary fix."*

- **Statistics and evidence:** There were questions as to what evidence existed that the new models of care being considered would deliver benefits, and if they had been tested / proven to work elsewhere. Questions were also raised about the accuracy of the population statistics and growth predictions being used within the STP.

- **Is it all about saving money?:** Many people felt that the proposals were all about saving money and that, rather than reducing services, the NHS should focus on centralised purchasing and better management; less spending on management consultants and reviews; less use of private companies like Circle; reducing admin costs and paperwork through improved technology; and better staff recruitment / retention so less expensive agency staff were needed. *"There is a lot of concern about how the changes are money led, you need to emphasise the clinical benefits and how this is improving patient care."*

- **More services, not less:** While the majority of people recognised that far-reaching change was needed in the way hospital-based care is delivered, a significant number did not want to see any change to hospital services, especially in Bedford where people felt more, rather than fewer, services would be needed to meet the demands of the rapidly growing population. A number of patients cited positive experiences of Bedford Hospital, although they said it was clear that staff were stretched. There were a few comments that the threat of removal of services from the local hospital could have a negative impact on sustainability and economic viability of the town, as people wanted to live in a place with good all round hospital facilities.

Questionnaire responses: In order to tackle the challenges we face, to what extent do you feel that far-reaching change is needed in the way we deliver secondary (hospital-based) care?

19%
38%
10%
18%
15%

Strongly agree ■ Agree ■ Neither agree nor disagree ■ Disagree ■ Strongly disagree

- **Priorities and focus areas:** When asked what priorities the STP should be focusing on, the most commonly mentioned area was the maintenance of easy-to-access emergency services, followed by keeping maternity services at all three hospitals. Many people also mentioned the need to address underfunding of the NHS / make the case for increased funding and to fight off privatisation. Some felt that the key priority should be the integration of health and social care, and others said there needed to be more focus on mental health services. *"For many mental health conditions there is a stark choice between care at home by family with little/no support or intensive inpatient care."*

Questionnaire responses: Do you think our clinicians have identified the right six focus areas for the transformation of hospital-based care in BLMK?

47%
25%
28%

Yes ■ No ■ Partially

- **Balancing emergency and planned care:** Most people felt that emergency care needed to be prioritised above planned care and there was some support for separating the two. However, there were major concerns that this was not practical due to the two services sharing resources and medical expertise, and that separation could lead to increased costs through duplication, under/over utilisation of emergency beds and, in cases where planned care patients unexpectedly needed emergency treatment, safety issues. Many people felt that the real answer to this problem was to reduce unnecessary A&E attendances, speed up discharge and take action to address missed appointments.

- **Travel, transport and isolation:** For any centralisation of services, there was widespread concern that increased travel time, particularly for emergencies and maternity care, would increase health inequalities, most notably for older people relying on public transport, disadvantaged families and town dwellers who don't drive. It was felt that further strain would be placed on already stretched ambulance services and on the hospitals receiving patients, and that increased travel times and the need to transfer patients in emergency situations would increase stress and risk for patients. *"Increased travel times could mean the difference between life and death in emergencies."* There were also concerns that friends and family not being able to visit would increase patient 'isolation' and mitigate patient recovery, particularly for children. Parking at hospital sites was also cited as an issue.

  It was felt that a comprehensive travel analysis was needed. In terms of specific solutions, there were suggestions that the voluntary sector could potentially help with patient transport. One respondent mentioned provision of more transport at a community level, e.g. dedicated minibuses back to town centres before and after visits. Another said that the contracted transport for day patients (in Bedford?) was not working and should be returned to the Ambulance Service.

- **Centralisation / centres of excellence:** There was general support for specialist services to be provided in centres of excellence, but people would like to see good basic care and the emergency element of these services retained locally. *"For non-urgent care, the key issue is quality not accessibility."* However travel remained a concern for some and many respondents asked whether consultants could instead be moved between sites *"rather than making patients travel long distances."* Concerns were raised that one of the hospitals should not become a centre of excellence to the detriment of the other two.

- **Maternity and paediatrics:** While there was some support for concentrating high risk pregnancies and complex paediatric care in centres of excellence, major concerns remained about the increased need for travel, especially for expectant mothers. Many felt that maternity services should be expanding to accommodate the increasing number of births and there was concern about what would happen if a low risk pregnancy turned into a difficult birth, with unexpected complications. For paediatrics, the main concerns related to families being able to stay with and visit children if they were at a hospital further away. The point was made that, if issues in maternity and paediatrics were being caused by a lack of consultants, then the focus needed to be on recruitment rather than reconfiguring services. It was mentioned that the constant threat of these departments being downgraded may in itself be causing issues with recruitment. The links between maternity and paediatrics and the services that support them also needed to be considered.

- **Communication, care pathways, continuity of care:** It was noted that centralisation of services could only succeed if there was better communication between different parts of the healthcare system and better sharing of patient information, backed by technology. It was also mentioned that, especially for vulnerable or anxious patients, continuity of care would be vital and there were suggestions that a patient's care needed to be co-ordinated by one person, perhaps someone from the voluntary sector. It was mentioned that processes would also need to be looked at, for example the current referral pathways for all three Trusts are very different. There were also questions about how new models of care would affect existing care pathways between different healthcare providers, including those outside the BLMK area.

- **Maintenance of key skills:** There was concern that any centralisation of services (including high risk maternity and complex paediatric care) could result in a hospital losing the specialists it needed to support A&E services, leading to difficulty in recruitment and deskilling of the remaining staff who would no longer be dealing with unusual cases.

- **Workforce:** It was felt that staffing issues required a longer-term solution and that working conditions needed to be improved, recognising that today's NHS staff were looking for a better work-life balance. One respondent mentioned that rigid NHS contracts with 12-hour working patterns needed reviewing as they affected recruitment and deterred women returning to work after having a baby *"agency contracts offer more flexibility."* Other ideas included language training and protection of employment for overseas doctors and nurses, removing the limits on medical and nurse training for young people and taking pressure off existing GPs and other staff to protect them from burn-out and exhaustion in a period of rapid change.

Additional ideas for transforming secondary care

Respondents shared a number of further ideas for transforming secondary care. It should be noted that many of the areas mentioned (such as prevention, improved GP services, integrated working between health and social care, better hospital discharge and better use of technology) are already being worked on by the BLMK STP, having been highlighted as priority areas in the October submission to NHS England.[4]

- **Prevention:** Many people mentioned the need to deter people from going to A&E through promoting heathier living, prevention and better self management, and that people should be charged for 'self-inflicted' illnesses (e.g. smoking, type 2 diabetes due to poor lifestyle). It was felt people needed to be better educated about how to use the NHS, especially for non-British patients who are used to a different health set up in their home countries. *"It would help if people were more aware how much hospital procedures cost, then they may think twice about going to A&E."*

- **Better triaging:** There was support for A&E triage being 'stricter', sending non-emergency cases to an on-site GP-led urgent care centre, back to the patient's own GP or to a pharmacy as needed. Concern was raised that the 111 service was unable to triage or advise people as to what action to take.

[4] October 2016 BLMK STP submission to NHS England, available at www.blmkstp.co.uk

"People need to be able to speak to a medical professional. People don't trust the NHS 111 service like they did NHS Direct and this service sends people to A&E when they don't need to go."

- **Misuse of A&E:** Many respondents mentioned discouraging misuse of A&E by refusing treatment for alcohol and drug-induced attendances and having a separate area where these patients could be kept until the immediate ill effects had worn off.

- **Care closer to home / enhanced GP services:** There was general support for more care to be delivered closer to home, but questions as to whether this was realistic given the shortage of GPs and difficulty recruiting. It was felt that much of the pressure on A&E stemmed from not being able to get a GP appointment and that primary care services needed to be significantly improved with longer GP opening hours, GP call backs, better-promoted out-of-hospital urgent care services (e.g. walk-in centres / local minor injuries services), more advice from pharmacists and out-of-hours dental provision. People firmly felt that community-based care needed to be strengthened before tackling secondary care and that processes needed to be in place to ensure people didn't fall down the cracks / get lost in the system.

- **Care for the elderly:** For elderly people, it was felt that as much care as possible should be provided at home or in community settings, with a secondary care 'outreach' service supporting the care sector / nursing homes etc. so they could play a greater role in identifying problems and keeping elderly people out of hospital.

- **Hospital discharge and convalescing:** It was felt that faster / better discharge would help relieve pressure on hospital beds (King's Mill Hospital near Mansfield was mentioned as having a good process in place whereby a patient's destination for post-treatment was established as soon as they arrived). Respondents supported the use of cottage hospitals / step-down facilities for convalescing, especially for elderly patients, and there was a suggestion that the 29-bed Biggleswade Hospital could be used more extensively for this.

- **Technology:** Many people mentioned the need to make better use of technology, e.g. email / text appointments and reminders, video consultations. One respondent said we should look to use 'off the shelf' IT with minor modifications rather than trying to create something bespoke that could be hugely expensive and may not be supportable.

- **Other:** Other comments included the need for faster diagnostics, reduced waiting times, single sex wards for general admission and having staff available at hospitals who were trained to communicate with profoundly deaf patients. It was mentioned that we mustn't lose sight of patients' right to choose where and how their care is delivered and that not everyone had access to electronic communication methods. It was mentioned that there was no mention of drug and alcohol abuse, coronary care or eye care in the Discussion Paper.

Sections 4.2 to 4.7 below explore in more detail feedback from the public on the six clinical focus areas presented in the Discussion Paper.

4.2 Emergency care

- **Maintain local services:** There was almost unanimous agreement that 24/7 A&E services should be maintained on all three hospital sites, as it was felt increased travel (beyond 20 minutes) would put unnecessary strain on patients and could be life threatening. There were also concerns about increased pressure on ambulance services, especially at night, and that removal of A&E / emergency would have a knock-on effect on other hospital services and recruitment, threatening the hospital's existence.

- **Location and access:** One person mentioned that any centralisation of emergency care would need a *'good ambulance communication corridor'* and suggested the site should therefore be located on the A421 south of Bedford, close to possible future rail links to Bletchley/MK and even Cambridge.

- **X-ray facilities:** One person mentioned that having X-ray facilities in the community would reduce one of the main reasons for people attending A&E, namely to see if something was broken following an accident.

- **Clinical hub / 111:** Respondents acknowledged that multiple points of access for urgent care was confusing. There was general support in principle for the introduction of a clinical telephone hub to offer triage and direction to urgent care services, so long as this had well trained staff answering the calls. However, respondents' experience of 111 had generally been poor and confidence would need to be restored in a telephone-based service. "*Terrible 'computer says no' services like 111 are part of the problem and not part of the solution...Who do you complain to if 111 fails?"* Some people felt that calling 111 to book an appointment at a walk-in centre would just cause delays. Consideration would also need to be given to people who may have difficulty explaining their symptoms over the phone, for example elderly people, those with English as a second language or due to physical or mental health issues.

- **Centralised GP booking:** A few respondents mentioned they were not in favour of centralised GP booking, saying this would make the process more complicated and that they wanted to speak to someone who knew the doctors at the surgery they attended.

- **Rapid access care:** There was general support for improving rapid access care – people said they trusted paramedics and would like to see more coverage for home visits etc. However, clarification was needed as to how this would differ from the current system. One person mentioned that having more first responders to treat people at home may not be economical when patients were then sent to hospital for detailed checks anyway and another thought stationing paramedics at GP surgeries was an excellent idea.

4.3 Planned care

- **Balancing emergency and planned care:** Most people felt that emergency care needed to be prioritised above planned care. There was some support for separating the two in order to reduce waiting time and cancellations, and also to prevent situations where postponed planned care became an emergency or led to worsened conditions / longer recovery times. *"They really have to be separated to stop the whole NHS being eaten up by emergency services."*

- **Terminology:** Some people were confused as to whether 'separation' meant physical delivery on different sites and people would like more detail on how this would work, with examples.

- **Access to care:** Some respondents felt that delivering planned care from a separate site could work, as there was more time to plan for admissions and discharges with planned care, but that there may still be issues with transport and travel, especially for elderly patients. *"If this results in less people attending appointments due to time and cost constraints it will undoubtedly impact on the overall health in the area."* One respondent asked if better use of technology could help to avoid the need for physical separation of services and there was also a suggestion to rotate clinics on different days at different locations.

- **Interdependent services / use of resources:** A number of respondents felt that planned care needed to be 'managed' separately from emergency care, with separate systems and procedures. However, many expressed concern about physically separating the services as they felt the two were interlinked, sharing on-site medical expertise and resources, and that separation would lead to an increase in costs due to duplication of resources and staff roles. *"The same individual doctors usually provide both planned and emergency care, so careful planning is crucial to ensure individual skills such as orthopaedics, anaesthetics, general and vascular surgery, OMF and ENT do not become unavailable in one or other area."* Questions were also raised as to how separation could be achieved without ring-fencing resources, which could lead to under-utilisation if emergency flows were low, and lack of beds at times of unusually high demand. It was also mentioned that planned care could quickly and unexpectedly become emergency care, and that safety could be compromised if the services were separated.

- **Staffing and skills:** There was concern that doctors would not apply for posts at a hospital with no urgent care cover and that separation could lead to dilution of expertise and knowledge, with skills not being transferred between the two care areas.

- **Severity of illness:** One respondent suggested that planned care should be filtered to separate those conditions requiring complex, highly specialised treatment from those that required relatively routine treatment that should be delivered close to home, along with care for non-critical conditions. *"The separation of patients into different locations has more to do with the seriousness of their condition rather than whether their condition is planned or unscheduled. Hence, the key to this is where you draw the line as to what is a critical condition and what is not."*

- **Targets:** One respondent mentioned that it would help if targets were put in place that judged the overall organisation, rather than just parts of it.

- **Reducing demand on A&E / beds:** Many people felt that the real answer to this problem was to reduce unnecessary A&E attendances and that separating planned from emergency care would only work if emergency care was fully resourced. Faster discharges were also mentioned to free up much-needed hospital beds.

- **Third party support:** A few respondents mentioned making more use of private clinics and health centres for straightforward procedures including hernia operations, although many people were against private sector involvement. There was also a suggestion that the voluntary sector could get more involved in supporting provision of planned care.

- **Avoiding missed appointments:** Many respondents mentioned imposing penalties for missed appointments (charges and 'sending to the back of the queue') and more widespread use of text and telephone appointment reminders. *"Could there be a 'standby' system for missed appointments?"*

- **Managing cancellations**: It was acknowledged that cancellation and postponement of planned care could cause stress and concern. A few respondents suggested that cancellations should only happen once, with a guarantee that a re-booking would be made within a specified amount of time. Another mentioned that patients would be more understanding and their expectations better managed if hospitals could define what planned care could be acceptably cancelled, e.g. there may be a higher likelihood of cancellation for a hip replacement than for cancer surgery. Some respondents mentioned operations being cancelled because vital test results were unavailable or had been lost. *"The system should identify in advance where essential information is missing."* It was also mentioned that cancellations often happened because of sickness / absence in secondary care and there were questions as to how much cancelled operations cost the hospitals.

4.4 Centres of excellence

- **General support:** There was general support for the creation of centres of excellence for planned care, so long as they related to truly specialist services, but people would like to see good basic care and the emergency element of these services retained locally. It was mentioned that centres of excellence already existed (e.g. Papworth for heart conditions), but one respondent said that Bedfordshire CCG limited patient choice to attend these.

  "Generally, people are happier to attend a hospital where they feel they are getting up-to-date specialist attention for ongoing problems…Wider NHS experience indicates that centres of excellence offer far better care, and I would rather be treated by the best experts available if I had a serious illness."

  "The pooling of expertise and knowledge and the support from working in a team of specialists is likely to improve outcomes. Focusing expensive specialist equipment in fewer sites should help reduce costs and make maintenance of the equipment and training in its use easier."

  "Given the proximity of the three hospitals it makes obvious sense for all three to specialise in different areas and not duplicate high cost specialist services."

- **Travel / mobile clinics:** As with other areas of care, there were some concerns about the cost and stress of travelling to centres of excellence, and many respondents mentioned the possibility of having 'mobile' centres of excellence or satellite clinics, whereby key consultants and their teams moved between the hospitals to provide diagnosis and treatment, or make recommendation for the location of subsequent treatment.

It was felt this would work well where conditions relied more on the expertise of surgeons than high cost equipment. *"Specialists can conduct short-term off-site clinics and assessments more easily than specialist equipment and its staff can be relocated."*

- **Interdependencies:** Some respondents mentioned the interdependencies between specialisms, for example cardiac and renal (kidney) issues, and urged the STP to make sure any centralisation of care to one site did not compromise acute care provision at the other site(s). *"Royal College of Physician approval for medical training will be rapidly removed if there is no acute surgical support on site, thus rapidly affecting viability of the hospital as an acute site."*

- **Staffing and learning:** Concern was raised that the best staff would want to go to the centres of excellence, with the other hospital sites then struggling to recruit, and that centralisation would deprive other sites of expertise and reduce the ability of the majority of staff to learn from the unusual, leading to skills deterioration. A few respondents mentioned that there needed to be infrastructure in place to transfer knowledge and expertise, and share best practice from the centres of excellence. *"Can clinical staff collaborate across sites (e.g. using a wiki[5]) to learn from each other's experience? Is there a way of video-conferencing seminars between sites so clinical staff can continue to learn?"*

- **Specialties:** People would like to know which specialities would be affected by centralisation. The Moorfields model at Bedford was cited as a good example and other specialities where respondents felt centres of excellence could work were vascular surgery, plastics, burns, ENT, eye clinics / a mobile ophthalmology , oncology, heart, stroke, neurology, brain surgery, cardio-vascular, transplants, a one-stop clinic for all diagnostics, auto-immune disease and possibly neonatal care. A number of respondents said they would like to see a specialist regional cancer centre, rather than having to go to Cambridge or Oxford.

- **Virtual care:** A few respondents said that, with modern technology, knowledge and expertise could be shared virtually rather than needing to put people physically together. *"There will always be times when it would not be feasible to purchase a particular piece of expensive, specialised equipment for each site and times when there is no substitute for an expert being physically present – but these should be exceptional rather than a reason to centralise specialisms."* One respondent also mentioned the need to put telemedicine / video-conferencing in place to treat patients remotely if consultants were unavailable (e.g. off-shift or on leave). *"As an alternative to centres of excellence, have centres of knowledge and use technology e.g. teleconferencing."*

- **Communication:** Public respondents echoed the views of NHS staff saying that, if this were to work, there needed to be seamless communication and information sharing between sites, supported by the latest technology *"Notes go missing often enough already…referrals get lost in transit."*

[5] A **wiki** is a centralised website or database developed collaboratively by a community of users, allowing any user to add and edit content.

- **Joined-up care:** There was some concern about patients with multiple conditions who may have specialist care delivered at several different hospitals, increasing the potential for errors. "*Holistic care is supposed to be the aim, not fragmented care where patients do not even know who us responsible for them."* One respondent said that the whole patient pathway needed looking at, including transfers to secondary care and conducting reviews closer to home.

4.5 Care closer to home

- **General support:** The vast majority of respondents supported more care being delivered closer to home in convenient, familiar environments. People considered this to be a sensible, practical and workable solution, especially for elderly people, children and dementia patients, so long as quality of care could be maintained. People also wanted to see these alternative arrangements in place before any changes were made to secondary care. A request was made to formally involve the voluntary sector in the development of these proposals.

- **Some concerns (costs, workforce impact):** Some people questioned how this would be funded and staffed, especially given the cuts to social care funding and the shortage of GPs, and some did not support the move if this meant the 'closure' of any currently hospital-based services. There was some concern that moving services into the community could increase costs, especially for specialties like ENT where it would be expensive to provide the specialist equipment and support needed on multiple sites. Some people felt it could mean consultants spending more time travelling and said that care needs to be taken not to dilute expertise. *"Necessary expertise is needed in the field so that serious conditions are identified and referred."*

- **Specific services:** Specific services that respondents felt could be delivered closer to home were blood tests, diagnostics, X-rays, outpatient and follow-up clinics, warfarin clinics, weekend dressings clinics, routine surgery and blood transfusions, podiatry, ENT, hearing aids, a mobile ophthalmology van, physiotherapy, speech and occupational therapy, dietetics, pain management, diabetes, management of care for the elderly and chronic long-term conditions. Dermatology was also mentioned, although some people had had a poor experience of the recently outsourced dermatology service. People also mentioned the provision of specialist nurses for neurological conditions, continence issues etc, working more out in the community and liaising between hospital and GPs.

- **Location:** In terms of location, respondents mentioned co-location of service at GP surgeries (could different surgeries specialise in different areas, could GP surgeries use old equipment?), village halls (used in some areas for warfarin clinics), mobile clinics, chemists, sports centres, large care homes, cheap sites with lots of parking, cottage hospitals and better use of Bedford Hospital North Wing, Steppingley and Biggleswade hospitals. It was mentioned this may not work so well in rural areas due to travel distances, and mobile units were suggested.

- **Community and social care:** It was mentioned that there needed to be much better links between health and social care, especially across the boundaries, and there was a

suggestion that the STP should consider establishing a single community service provider for the whole area – one which had full knowledge of the needs of the people.

- **Home visits:** More home visits from district nurses and health visitors were supported, so long as infection control was observed and there was emergency back-up. Multi-skilling for people making home visits was also mentioned, to prevent multiple visits.
- **Continuity of care:** Respondents mentioned that there needed to be continuity of care, preferably co-ordinated by one person, with communications and transfer of patient data between sites or services of a very high standard, with the technology to back it up. *"The main problem would be the patients' medical notes – if not on the central computer, details could be lost."*

4.6 Maternity services

- **Priorities:** Respondents agreed that maternity services should be a priority area for secondary care transformation due to the strain that current services are under. For maternity services, people felt that patient safety and choice were paramount.
- **High / low risk pregnancies:** While the majority of respondents wanted to see full obstetrics services retained at all three hospital sites, especially given the expected increase in the number of births, there was some support for managing low risk pregnancies locally, with complex, high risk pregnancies being focused on centres of excellence. *"The chances are, high risk pregnancies will be known about in plenty of time before the birth…Although I would prefer maternity services to be kept at all three current sites, I think there is a case for having known high risk births at specialist centres. This a better solution that reducing availability generally which would mean far more mothers to be travelled no greater distances."* However, people would like clarity as to what constitutes a 'high risk birth' (e.g. severely premature or everybody who might need a caesarean) and what numbers are involved. Would pregnant mothers with mental health issues be considered high risk / looked after at an obstetrics unit?
- **Safety and travel:** However, concern remained that provision of full obstetrics units on fewer sites could increase 999 calls and that increased travelling for high risk mothers could increase risk and cause psychological and physical harm to mother and baby, including post-natal depression if it meant mothers and families were located further apart. A high number of respondents also mentioned that a low risk pregnancy could quickly turn into a complicated delivery, so local maternity units would still need quick access to consultant support and be able to respond quickly to emergencies (e.g. to provide an emergency caesarean). *"Perhaps a team of on-call obstetricians and /or consultants could be made available with a high speed car to get to the patient or hospital."*
- **Patient choice / community support:** Many felt that patient choice was paramount, and that mothers needed to be offered the choice of a midwife-led unit or obstetrics unit, as well as promoting other birthing alternatives such as home births and birthing centres. In doing so, any specific needs arising from different cultures and our ethnic communities would need to be taken into consideration. Some respondents supported the move towards less clinical environments for low risk maternity care, supported by community-based

midwives and GPs, with accessible day units for mothers having difficulties during pregnancy. There was also some support for moving antenatal and postnatal care from hospital sites into community health centres, to free up car parking space at hospitals and bring it closer to home for young families.

- **Staff and skills:** Views on sharing staff between sites were mixed, with some saying this would help to manage peaks and troughs and one person saying that, for her personally, it would be impractical due to family commitments. If this were to work, there would need to be shared protocols across the STP area. Some respondents mentioned that centralising high risk maternity could reduce the ability of the majority of staff to learn from the unusual, leading to skills deterioration. Several people mentioned that cuts in bursaries for nurse / midwife training had had an impact on recruitment and there were suggestions that self-employed maternity nurses / midwives and retired nurses may be able to offer support and ante-natal care for mothers.

4.7 Paediatric (children's) services

- **Priorities:** People agreed that paediatric care should be a priority for transformation of secondary care as we have a growing population of young people. It was considered particularly important for Luton, where there were lots of children with complex diseases..

- **Centres of excellence:** There was some support for separating paediatric services, with provision of specialist care for the most unwell children at centres of excellence, so long as emergency care was available at all three sites to provide early diagnosis and treatment or stabilise the child for transfer to a specialist site. It was mentioned that this already happened to some extent, with unwell children being treated at Great Ormond Street or Addenbrooke's. However, some concern was raised that transfers could put lives at risk in an emergency situation, as children can deteriorate very quickly.

- **Time and travel:** To a lesser extent than for some other types of care, some concern was expressed about travel distances, especially for disadvantaged families, parents with other children to care for and children with acute conditions needing regular care, necessitating multiple long distance trips. Some people questioned whether the model(s) of care being considered would mean it took longer for their child to receive treatment.

- **Family support:** The main issue raised in relation to any centralisation of paediatric services was the ability for parents and families to stay with and visit the child if longer distances were involved, as parental / family support was important to recovery by contributing to emotional wellbeing, could improve outcomes and shorten hospital stays. Suggestions included overnight accommodation for parents, a pull out bed or chair next to the child's bed and voluntary sector support for families while a child was in hospital. Parents also asked if the child could come back to a local hospital to convalesce once the acute stage was over.

- **Community-based care:** A number of respondents said they would prefer treatment to be provided on community sites or at their local GP surgery where possible, as this was more convenient and less traumatic than going to hospital. *"Could certain GPs specialise in general paediatrics and help to deliver services locally instead of relying on the hospital?"*

5. NHS staff feedback

The feedback in this section has been taken from the 233 people attending 12 NHS staff engagement events at our three local hospitals and 32 responses from NHS staff to the online survey. These sessions were attended by hospital staff and also members of our community teams.

5.1 General feedback and summary

- **General views:** Some felt the plans were very well thought out, made sense, were long overdue and a good start – others felt they were very simplistic and lacked detail. One respondent asked how the STP fitted with developments already planned at hospitals and how the CCGs decided to spend their commissioning budget. Staff also wanted more detail about finances and how budgets would work, for example would they be shared across the BLMK STP area? It was felt that patient and GP involvement in service design would be crucial to success.

- **Timescales**: It was recognised that transformation was a massive task and that timescales needed to be realistic. Staff urged the STP not to make widespread changes too quickly, and to first look at examples of good practice both in and outside BLMK, so change could be targeted rather than trying to reinvent the wheel.

- **Terminology and explanation:** Staff, like the public, would like clarification as to what 'removing unnecessary duplication' means, and also suggested that 'specialist centres' may be a better term than 'centres of excellence', as the latter may imply care elsewhere was not excellent. It was mentioned that the public needed to be made more aware of how services are currently structured in order to understand what change would mean.

- **Neighbouring areas**: Staff would like to know how the STP would work with neighbouring STPs, how any tertiary links with other hospitals / networks would be affected by any service change (including Hertfordshire for Luton), and the impact of change on sub-providers outside the BLMK area.

- **Relieving pressure on A&E / beds:** In terms of priorities, NHS staff felt that the focus needed to be on relieving pressure on A&E and hospital beds through admission avoidance and improved discharge procedures:

  - **Admission avoidance:** The enhancement of primary care services including more GP recruitment and reduced waiting times were seen as being fundamental for the STP plans to work. Staff also felt that options for urgent care needed to be simplified, so patients were clear where to go and how to access urgent care, e.g. walk-in centres, 111. *"Triage should be happening outside A&E to reduce the demand on beds"*. Staff also mentioned the provision of specialist-led community-based teams for complex elderly patients. One respondent said that, in order for admission avoidance to work, there needed to be a specialist consultant-led team with the ability to intervene early in the course of a patient's illness *"it won't work if it is based on pathways".*

  - **Timely discharge:** Ideas to support more timely discharge included an increase in nursing homes and community / cottage hospitals for step up and step down care,

especially for the elderly (e.g. at Biggleswade Hospital) and rehab services with adequate therapy, e.g. inpatient stroke services with specialist therapy input.

- **Other priorities:** Other priority areas mentioned were closer ties between health and social care, mental health, pain management and care of the elderly (that one respondent felt should be a separate service, given the steady rise in the elderly population).

- **Technology:** Staff in the focus groups felt that this was probably the most important priority, as there needed to be better communications amongst and within the system, especially shared patient records to support centres of excellence and more care closer to home. It was mentioned that the L&D emergency department used a different patient records system (Symphony). *"New systems that all staff can access across all sites is essential – without this nothing will work."* Staff also mentioned more use of IT / telemedicine for patient assessment and follow-up, and more use of Skype / Facetime consultations. However, staff felt consideration would need to be given to elderly and other patients who were unused to technology.

- **Maintaining A&E services:** Most staff felt that full A&E services needed to be retained at all three sites, with concerns that removing or 'downgrading' A&E could destabilise a Trust and render it unviable. *"Beware closure of a hospital by stealth e.g. by taking away too many services."* It was also mentioned that the uncertainty surrounding the future of hospital services was affecting recruitment.

- **Centralisation of specialised care:** There was some support for separating planned and emergency surgery on some sites, and the centralisation of specialist care / centres of excellence. However, concerns remained about the need for increased travel, overall quality of services, the threat of privatisation, co-dependency of services and the impact on staff skills and recruitment.

- **Maternity and paediatrics**: Staff were in overall agreement that maternity services needed to change, but views on the separation of high and low risk maternity care were mixed. For paediatrics, there was general support for complex and specialist treatments to be provided in centres of excellence, so long as emergency care, routine services and outpatients could be provided locally. However, these were the two areas where staff felt a lot more work needed to be done to come up with safe, quality and sustainable options.

- **Transport and travel:** Staff echoed patient concerns that increased travelling, and the difficulty this would cause for hospital visitors, could negatively impact recovery times and patient morale, especially for frail and elderly patients. They said that, if patients needed to travel further for treatment, the right infrastructure would be needed to provide joined up transport between the three hospital sites. *"Could there be a bus route between the hospitals? Could transport operators work alongside the STP?* Staff in Luton mentioned the possibility of providing 'patient hotels' for those facing long or difficult journeys to hospital. It was felt that a careful assessment of travel times and impact on ambulance services would be needed.

- **Staff and skills:** Many respondents raised concerns about the potential de-skilling of staff, dilution of training and difficulty recruiting if emergency and specialised procedures were

not carried out on all hospital sites. One respondent asked if staff could be rotated around BLMK to maintain skills and also prevent loss of staff from lack of stimulation. Respondents highlighted the need to recruit and retain high quality staff, to look after those staff – both frontline and back office.

- **Care closer to home:** There was general support for the provision of more care closer to home, so long as it was properly funded, with good parking and access, and adequately staffed so that expertise, quality of service and care could be maintained.

- **Co-ordinated care:** Staff mentioned the need for clear referral pathways and a structured support chain within the system and continuity of care, especially for the elderly and chronically ill.

- **Discharge / repatriation:** Staff mentioned that discharge arrangements would need to be considered and, for planned care, these would need to be in place prior to admission. Staff mentioned that consideration would also need to be given as to how patients would be repatriated to their local hospital following treatment in another location, and the costs / logistics of this – also, what happens if patients don't want to go back to their local hospital?

- **Funding, spending, budgets and management:** Some staff felt that NHS underfunding was the fundamental problem and said that money needed to be made available to support and deliver change. Staff highlighted the following areas that they felt needed considering:
  - Structure of the CCGs and Foundation Trusts, and layers of senior management e.g. across hospitals, CCGs, NHS England and the Department of Health.
  - Payment and tariff arrangements; introducing centralised buying and easier contracting processes without expensive tendering; enquiring into bad deals that had been made in past.
  - Handing control of social care and public health budgets to NHS organisations and ring-fencing funds for social care and mental health.
  - Reducing 'unnecessary' spending on administration and non-clinical services.
  - Reducing the drive for everything to be disposable due to health and safety fears.
  - Focusing on long term benefits rather than short-sighted solutions.
  - Less use of private consultant firms like Optum.

- **7-day NHS:** One respondent said they felt the current focus on a 7-day NHS was misguided, saying that availability of consultant opinion on a 7-day basis needed looking into but that there was little demand for 7-day GP services *"demonstrated in surveys of GP practices that have tried it."*

- **Education and prevention:** Several respondents mentioned the need for education to encourage people to take control of their own healthcare, what the NHS offers and how misuse can affect services. *"The slogan could be 'Our NHS, our responsibility'"*. Several respondents also mentioned the need for more preventative care and lifestyle / nutrition advice from school age, although this it was acknowledged this was not a cheap option.

- **Other:** Other comments were to remember patients with dementia, running non-clinical functions alongside the hospitals as one acute trust, and bringing back 'Nightingale wards' (large wards with no sub-divisions) so nurses could see all their patients, all the time.

Sections 5.2 to 5.7 below explore in more detail feedback from NHS staff on the six clinical focus areas presented in the Discussion Paper.

5.2 Emergency care

- **Mixed views:** Most staff would like to see A&E retained at all three sites, as they felt not doing so may increase the time before emergency care could be provided, put strain on ambulance services and affect the ability of people to visit and support patients. However, some felt the ideas outlined in the Discussion Paper were sensible, so long as primary care provision could be increased to reduce admissions. Staff also mentioned the need for urgent paramedic assessment and quick transfer to expert medical assessment (e.g. for stroke and head injury), and that patients must be stabilised before transfer to a specialist site, or at least have a trained member of staff with them while they travelled.

- **GP-led urgent care / minor injuries:** There was general support for provision of a 24 hour GP-led service on hospital sites and there was also mention of a 24 hour minor illness service, manned by clinical nurse specialists and sharing staff with the hospital's casualty department. However, one respondent mentioned that research had shown GP type services at A&E units increased the A&E workload.

- **Effective triage:** Many staff mentioned the need for effective triage (perhaps by clinical specialists as happens in some hospitals), using signposting and advice to prevent unnecessary A&E attendance and being able to send away patients who clinically didn't need to be seen in an A&E setting. Staff also mentioned fees for those attending A&E 'inappropriately' including alcohol and drug related attendances, 'health tourists' and users who have complications following private cosmetic surgery.

- **Single point of access:** The concept of a single point of access was supported, but some felt previous telephone services (111 and NHS Direct) had not worked and threatened patient safety. It was also mentioned that telephone-based options were not suitable for patients with hearing difficulties or learning disabilities.

- **Other:** Other comments were that key services need to be co-located, to develop the Royal College of Emergency Medicine ACP (advanced clinical practice) nursing role to assist middle grade doctors and attaching a 24/7 elderly care service to A&E.

5.3 Planned care

- **Priority:** In terms of priority, some felt planned care could be just as urgent as emergency care in that delays could lead to death or life changing disabilities / conditions, but that longer waits would be acceptable for some routine planned care. *"This would actually be better than having to cancel operations or appointments which is very disruptive and upsetting to patients."*

- **Separating planned and emergency care:** The majority of staff felt it was a good idea for particular hospitals to focus on planned surgery to prevent operations being cancelled, so long as outpatient clinics could be delivered locally. One respondent said that planned care could potentially be delivered on an entirely separate site from the current three hospitals However, staff felt that more detailed information, research and evidence would be needed around travel implications if this was to be further explored.

- **Practical concerns:** It was felt that some planned care would need back up to provide critical care in the post-operative phase. There was one comment from Luton that this approach could waste theatre space, as emergency procedures tended to fill up unused space in elective theatres. Questions were also raised as to what would happen if a planned procedure turned into an emergency *"Will an emergency team still be available?"* Some questioned how this would work in practice, when the same doctors currently managed planned and emergency care.

- **Other ideas for planned care**: Other ideas for planned care included clinicians being more mobile, ensuring patients were fit for surgery (e.g. by stopping smoking or losing weight), stopping non-medical procedures (e.g. cosmetic surgery), more planned care at weekends and better managing winter pressures so planned care was not sacrificed as a result.

5.4 Centres of excellence

- **General support**: Overall, staff felt it made sense to have centres of excellence for certain specialties, e.g. vascular surgery and orthopaedics, and that this would improve the quality of care. *"In the end we want the best possible treatment and I would be prepared to travel for this"*. Staff would like to see specialist care shared out at different hospital sites in the area, supported by locally-delivered outreach clinics and outpatient services, and networked with other hospitals, primary, social and community care. "*There is scope for each partner hospital to have its special strengths to offer to the whole."*

- **Concerns:** Staff had concerns about patient transport and potentially increased waiting times to see a specialist. They also mentioned that some specialist services couldn't work in isolation, e.g. neurosurgical input for a trauma centre; vascular surgical input for a renal (kidney) transplant centre; specialist radiology support for a cancer centre. One respondent mentioned that specialisms are already so split that it can take a long time to get a diagnosis, thus fearing exacerbation if specialisms were further separated.

- **Communication:** Staff said that access to systems and communication between different organisations must be seamless if this was to work. The need to speed up reporting (e.g. pathology) was also mentioned.

- **Staffing and skills:** Staff said we would need to ensure that the creation of specialist centres was not detrimental to other sites or their ability to recruit and retain staff. Recruitment and training would need to be considered and there were several questions about how this would impact staff, e.g. would they need to relocate / travel between sites.

5.5 Care closer to home

- **General support:** There was general support for the provision of more care closer to home, so long as it was properly funded, with good parking and access, and adequately staffed so the expertise, quality of service and care could be maintained. It was felt that the provision of more care closer to home could be beneficial to patients by reducing the stress of attending hospital, reducing travel time and providing easier access, especially for elderly patients.

- **Enhanced GP services:** Staff mentioned a number of ideas to enhance services offered from GP surgeries including upskilling practice nurses to run clinics; on-site physiotherapists for musculoskeletal (MSK) conditions and hospital consultants running a few sessions in GP practices. One respondent mentioned that blood tests would be better provided at GP practices, but that they were currently being prevented from doing so.

- **Other ideas for care closer to home:**

  - Supported outreach from hospitals, and outpatient units visited by clinicians and support staff for patients in initial recovery from surgery or acute medical illness
  - Cross organisational boundaries for on-call rotas
  - 8am to 8pm diagnostics available 7 days per week
  - Increasing the 'hospital at home' service
  - Community care for COPD (trialled in Bedford)
  - ENT services in the community supported by hospital-based specialist services (e.g. joint voice clinics)
  - Upskilling carers and care home workers to identify deteriorating patients
  - More MDT (multi-disciplinary team) type services for complex and chronic patients, better management of long-term conditions to prevent hospital admission, more support closer to home for patients with long term pain and supported end of life care plans
  - Properly-funded social services to support people in their own homes

- **General comments:** It was mentioned that the dermatology services currently being delivered out of hospital sites were *"not as good".* One respondent mentioned that community services should be provided by the community they serve, not an outside agency.

5.6 Maternity services

- **Mixed views:** Staff were in overall agreement that maternity services need to change. However, many felt it would not be possible to have one hospital managing low risk pregnancies and another for all high risk pregnancies, as a low risk pregnancy could very quickly turn into a high risk birth. One respondent said that highly specialist care delivered in a special care baby unit (SCBU) could be focused on one site. Staff from Bedford Hospital questioned how having a midwife-led unit on one site would work and be safe for mothers,

especially given the anticipated increase in births. However, some of the staff responding to the questionnaire felt that a midwife-led unit for low risk births would be feasible, so long as women had a choice. Staff at the L&D said there had been quite a few comments from mothers and clinicians to bring back maternity homes for low risk women, providing a supported environment to give birth without needing to be in hospital.

- **Increased travel:** Many staff felt that maternity care should be delivered as close to home as possible, as travel placed extra burden and risk on patients, especially for high risk births, as well as putting additional strain on ambulance services and reducing ability for family and friends to support the mother. *"Travelling further especially when heavily pregnant is difficult…increasing travel time in a high risk pregnancy might not be ideal".* One staff member asked if there would there be a provision for birth partners / fathers to not have to worry about car parking while supporting expectant mothers, especially if they are attending an unfamiliar hospital site.

- **Staffing:** Staff felt there needed to be plans in place to recruit more midwives and, if staff needed to work across hospital sites, guidelines and policies would need to be aligned.

- **Home birth, post and ante-natal care:** It was suggested that home birth could also be an option for low risk mothers. There was support for routine check-ups and services being provided in the community with a clear pathway for escalation of more complex or high risk patients.

- **Prevention:** One respondent mentioned the need for more focus on preventing unwanted pregnancies by upscaling primary care to deliver long-acting reversible contraceptives (LARCS) at GP practices.

5.7 Paediatric (children's) services

- **Specialist centres:** There was general support for complex and specialist treatments being provided in centres of excellence, so long as routine and outpatient services could be provided locally, with an emergency team available to stabilise the child before rapid transfer to a specialist centre.

- **Travel:** There were concerns about the cost and stress of increased travel, especially as there are a lot of disadvantaged children / families in the BLMK area, and the disruption that could be caused to the family if a child had to stay away in hospital.

- **Suggestions for paediatric care:** Suggestions included having a paediatrician available at larger GP facilities or health centres; triage through GPs and a 'one-stop clinic' for children where multiple tests / investigations could be performed, thereby reducing trips to hospital and reducing stress for children and their families.

- **Addressing current issues:** There was a comment that the management of current paediatric services, expertise, professionalism and quality of care needed to be reviewed before any further changes were made. *"There is a lot of time wasting and standing around".* One respondent also mentioned that the paediatric emergency department always got moved to a smaller unit for overflow, which then put pressure on staff and beds on the wards. *"We have no overflow ability like adults."*

6. Clinical discussions

The information in this section has been drawn from the ongoing discussions with more than 120 clinicians from our three local hospitals. Through these discussions, clinicians have identified the key considerations for the provision of future healthcare services across BLMK, which will provide a platform for further discussion from which formal options development can progress. The emerging themes have also been shared with GP locality leads for the BLMK CCGs.

The following summary is not an exhaustive description of the many different aspects of services and specific pathways that were discussed, but is intended to provide examples which are illustrative of the sorts of ideas generated from these discussions. [6]

6.1 General themes

- **A whole system approach:** Clinicians are agreed that changes to hospital services cannot happen in isolation. They feel that a whole system approach is needed to drive forward simultaneous strengthening of out-of-hospital services, along with critical redeployment of growth funding into transforming primary, community, mental health and social care. A consistent challenge from clinical teams has been about the absence of a whole system approach to certain disease groups and, in particular, **diabetes, end of life care and cancer**. They have also flagged a need for coherent and co-ordinated planning of prevention, community-based and hospital services for certain groups of services including children's care and mental health. Clinicians are also agreed that **mental health services** need to be embedded in delivery of all health provision, with better psychological support being provided for patients with physical health needs. As such, mental health service providers will need to be fully involved in the next stages of service design and planning.

- **Enabling change:** Clinicians identified a largely common set of enablers that need to be adhered to under any significant service change proposal.

- **Technology:** Overwhelmingly, clinicians said that access to shared clinical information, and the technology to support this, is the most significant enabler of integrated clinical services, with its absence being a real barrier to change. As a minimum, hospital clinicians need to be able to access any patient's information at any hospital site. Ideally, a summary of high level patient information from GP and social care should also be available. Technology needs to be able to interact with systems outside of BLMK, to support GPs whose patients are attending hospitals outside the BLMK area.

- **Closer working – staff retention:** There was strong consensus that unified working between the three local hospitals offered advantages, including enriched opportunities for career development. While some concern was expressed that unification of services may impede recruitment and retention of staff in some specialties, for example if travel to multiple sites was required, it was generally felt that the opportunities and benefits from a unified model would outweigh the drawbacks.

- **Closer working – quality and standards:** It was felt there was significant opportunity to drive up quality standards and share learning between teams, for example through

collaborative governance of services and cross-BLMK multi-disciplinary teams. As points of principle, it was established that (a) each service should develop effective ways of sharing knowledge and new learning and (b) that services should be measured by the quality and success of that service across the entire system, which would ensure teams are encouraged to support each other and share highly specialist skills and resources in a way that best serves patients across BLMK.

- **Transport / patient transfer:** It was recognised that any model where particular services were available on fewer hospital sites would have transport implications, and that these needed to be taken fully into account when considering options, with detailed travel times analysis being carried out. Clinicians felt that that novel conveyancing methods should be investigated and that local authorities needed to be fully involved in transportation planning. It was also noted that the hospitals' acute teams would need to be able to manage safe, prompt onward patient transfer and that the A&E teams' expertise in identifying, stabilising and providing first line intervention prior to transfer would need to be strengthened.

- **Working across boundaries:** It was recognised that any reconfiguration for hospital services would have an impact on flows of patients outside BLMK's boundaries, as well as internally.

Sections 6.2 to 6.7 below explore in more detail feedback from clinicians on the six clinical focus areas presented in the Discussion Paper.

6.2 Emergency care

Accident and Emergency (A&E)

Demand for services and the number of patients attending our hospital Accident and Emergency (A&E) departments have grown rapidly in recent years. Work to establish on-site GP facilities is helping to slow patient numbers, but increasingly more people are using A&E as their first port of call for urgent care needs. Teams are also managing an increasingly complex group of patients resulting from an ageing population, often with multiple conditions. All this has resulted in a growing need to provide consultant-delivered care late into the night, working closely with acute physicians. With all our A&E departments also facing staffing pressures, clinicians have been looking at ways to ensure admissions are managed consistently and safely across all BLMK hospitals.

- Clinicians have identified the key drivers for change within our hospital A&E departments as being the need for **sustainable staffing models** and **effective patient flow** into and out of the three hospitals. Specific ideas to address these drivers are outlined below (see also section 6.5 – admission avoidance, rehabilitation and hospital discharge / transitional care).

    - **Single point of access for urgent care:** The 5-year vision for BLMK sets out a strategic direction by which all patients access all forms of urgent and emergency care through a single point of contact – physical and mental health, social care and voluntary services included. Clinicians are agreed that a single point of telephone contact for urgent care would help to reduce hospital admissions by making it much simpler to direct patients to the nearest centre that can meet their urgent care needs. The STP is working on the

delivery of a user-friendly way to access urgent care services via the '111' telephone service, which would help prevent unnecessary A&E attendances.

- **GP-led urgent care services:** All three hospitals have GP urgent care services on site, where patients with minor illnesses can be sent. This is in line with emerging national best practice for urgent care provision.
- **Managing peaks of demand:** Clinicians have said that a combined and co-ordinated plan to manage surges in A&E attendances, and consistent escalation processes across BLMK hospitals, would enable teams to adopt best practice and ensure a robust approach to managing peaks in demand for services.
- **Staffing:** Through working together, clinicians have identified valuable opportunities to share best practice in recruitment of medical staff and to expand training for emergency nurse practitioners (ENPs).

- To ease pressure on A&E services, senior clinical nursing and medical staff have explored a number of different models and have established that the following may be feasible:
  - **Urgent care centre:** It may be possible for one site to adopt a model where an A&E department only treated minor injury and illness through an urgent care centre, usually led by GPs and emergency nurses with no on-site consultants. This would reduce the number of emergency medicine doctors needed but would increase the need for GPs (who are also in short supply) to be involved in delivering urgent care. It should be noted that there is very low clinical appetite for this model, due to significant numbers of more unwell patients needing to travel further to access emergency care, with a subsequent impact on ambulance services.
  - **High risk patients:** A&E could be configured so that the majority of patients were treated locally but the highest risk patients, often travelling in a blue light ambulance, were routed to a neighbouring hospital. This already happens with some conditions, such as emergency stroke and some heart attack patients, and could be applied to other areas such as out-of-hours emergency surgery. This could limit the need to maintain spare capacity across the system and ensure our most senior consultants are used to maximum effect. Robust transfer procedures and ambulance protocols would be needed if this model were to be considered.
- **Patient transfer:** In any model where patients need to be transferred to another hospital for treatment, clinicians have emphasised that it is essential for the local hospital to be able to stabilise patients and transfer them promptly and safely, both for the patients' benefit and also to prevent bottlenecks in A&E. The A&E teams' expertise in identifying, stabilising and providing first line intervention prior to transfer would therefore need to be strengthened.

Acute medicine

Acute medicine is concerned with the assessment, diagnosis and management of adults who come to hospital with a medical illness needing emergency treatment. Currently, all three of our local hospitals have an **'unselected medical take'**, meaning they treat patients with any medical condition, except for highly specialist services such as stroke, complex renal (kidney) conditions

and patients needing inpatient care from a specialist neurological team. In order to treat patients with such a wide range of often complex and multiple conditions, acute medicine requires a high number of consultants. As there is a national shortage of specialists to manage acute medical hospital admissions, recruitment is proving challenging and consultant numbers are not growing in line with the increasing requirements to deliver 7-day services.[7]

With our local hospitals each seeing a high number of patients (50 to 65 a day), clinicians have told us that it is hard to determine alternative models for acute medical care that do not entail transferring high numbers of patients between hospitals. However, they have explored a number of different options, as shown below.

- **Inpatient care only:** Under this model, one hospital site would only offer medical care on an outpatient basis, with patients needing an overnight hospital stay being transferred to another hospital. This would reduce emergency attendances for the hospital site offering outpatient care only, and remove the need for a high dependency unit.

- **Semi-selected medical take:** Under this model, care for specific conditions would be focused on one or two sites, reducing the overall need for specialist inpatient support. Such conditions could include disease of the heart and arteries requiring emergency angiography[8], flares of long term conditions such as Crohns or inflammatory bowel disease (IBD) needing specialist gastroenterology[9] support, admissions relating to chronic liver disease requiring hepatologist[10] expertise, complex respiratory disease or acute complications of diabetes such as diabetic ketoacidosis (DKA). The number of patients requiring this most specialist care is relatively low and focusing specialist support at fewer sites would enable 7-day specialist cover with fewer physicians. While it was recognised that clear ambulance and hospital protocols would be needed to avoid over or under transfer of patients, clinicians expressed considerable unease about this model, especially where there was a risk of transferring a patient to a second hospital, only to discover that they required services that were only delivered from the third.

Emergency surgery and trauma

All three hospital sites currently offer emergency surgery during the day and each has an overnight theatre to treat patients with life or limb threatening conditions. All the hospitals operate different staffing and operating models for emergency surgery.

With our hospitals facing shortages of middle grade doctors and theatre staff, clinicians have explored a number of different ideas for the potential reconfiguration of emergency surgery, which are discussed below.

- **Joint working for non-life threating surgery:** When surgeons and operating theatres are diverted to provide emergency surgery, surgery for patients with less urgent or non-life threatening needs (e.g. hand injuries) may end up being delayed. Clinicians are telling us

[7] Information from www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees

[8] An '**angiogram**' is an X-ray that uses a special dye and camera to take pictures of the blood flow in an artery

[9] **Gastroenterology** is a medical specialty looking after illnesses of the stomach and intestines

[10] A **hepatologist** is a doctor who cares for illnesses of the liver, gallbladder and pancreas

there are clear benefits in jointly managing patients needing non-life threatening surgery, so clinical expertise can be drawn from a neighbouring hospital when it is not available locally. Milton Keynes and Bedford hospitals are both exploring the need to put additional trauma sessions on site at the weekend, and this is another area where a joint solution may increase the level of theatre provision.

- **Centralised emergency surgery:** One option being considered is to provide emergency surgery on fewer sites, but to have more emergency theatres running at those sites. Theatres for semi-planned urgent surgery (e.g. surgical management of miscarriage) would remain at local sites, but may be centrally co-ordinated to give patients the choice of attending another hospital with a reduced waiting time or waiting a few days for surgery at their local hospital. This would also reduce the need to duplicate specialist equipment, such as operating microscopes, across hospital sites.

- **Centralised out-of-hours / inpatient surgery:** Another option is to centralise all out-of-hours surgery on one or two sites. This could enable optimal use of anaesthetists and theatre staff, but would require more patients to be transferred between sites. Clinicians also explored the possibility of limiting the number of sites where surgical patients are admitted overnight, which may mean less surgical staff are needed. Under this model, patients would be reviewed by a senior surgeon and either discharged (perhaps to return for semi-planned urgent surgery) or transferred to another hospital.

- **Emergency gynaecology:** Clinicians identified some clear advantages in centralising co-ordination of booking for some gynaecological emergencies, such as miscarriage, and most early pregnancy complications. It was felt that emergency gynaecology could follow the broader emergency surgical model, and either be accommodated within the emergency surgery bed base of the three hospitals or managed as 'urgent elective' cases through existing day care facilities.

6.3 Planned care

The vast majority of planned care for patients who are admitted to hospital relates to patients requiring surgery in theatre. As mentioned in section 6.2 above, when surgeons and operating theatres are diverted to provide emergency surgery, it can cause delays and cancellations for planned surgery. Clinicians have discussed a number of potential ways to address this, which are outlined below.

- **Separating planned and emergency surgery:** Clinicians felt that separating planned and emergency surgery would be beneficial in terms of protecting planned activity and offering best patient experience, and they would recommended this wherever possible. However, clinicians identified some specialties where they felt it would be clinically preferable to keep emergency and complex inpatient care together on the same site. This could include specialties where highly specialist theatre equipment or set up was needed (e.g. for complex head and neck procedures), or to ensure maintenance of skills of anaesthetists and theatre staff who may have to manage low numbers of emergency procedures.

- **Centralising planned inpatient surgery:** Clinicians felt that planned inpatient surgery could potentially be centralised in two ways:

- **By specialism**, so that specific expertise was focused on fewer sites. Clinicians felt that this could work for some specialties such as spinal surgery or highly specialist colorectal (bowel and colon) procedures and would be clinically beneficial. However, it would mean some patients needing to go to another hospital for treatment.

- **By severity of illness or injury**, whereby the highest risk and most complex procedures would be focused on one site, with lower risk procedures on another. However, clinicians felt this would present the additional complexity that a patient may deteriorate, or the severity of their illness or injury may be initially misjudged, which could result in an additional transfer of the patient between hospitals.

- **Gastroenterology**[11]: The gastroenterology team felt there was opportunity for joint working across the hospitals to increase cover between specialists for certain low volume, urgent endoscopy procedures such as ERCP[12].

6.4 Centres of excellence

Clinicians have acknowledged that each of the three hospitals would have some specialist types of care that could be considered to become a local centre of excellence. This would help to ensure we can deliver the most complex and specialist care safely in accordance with national standards, while enabling clinicians to build specialist knowledge and expertise to provide the very best levels of care.

- **Cardiology:** Cardiologists (heart specialists) are looking into the provision of highly specialist diagnostics and procedures (for example cath labs[13]) from a centre of excellence at one hospital site, with patients being transferred to the specialist centre by ambulance for treatment and returned to the local hospital the same day. Under such a model, high quality general care for inpatients and outpatients would be retained at all three sites.

- **Specialist medicine:** Clinicians have identified benefits in centralising specialist inpatient care for some medical conditions, including some respiratory conditions and intensive chemotherapy for cancers of the blood, bone marrow and lymph nodes. This would enable 7-day services to be delivered by fewer specialists, but could result in some patients being transferred to another hospital following A&E assessment.

- **Orthopaedics**[14]**:** The orthopaedics team has identified potential clinical improvements from centralising planned orthopaedic surgery to a single site, in terms of being able to dedicate beds and concentrate highly specialist therapies and specialist nursing support (e.g. enhanced recovery team). Such a move would need to be assessed carefully in respect of the impact on patient access.

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[11] **Gastroenterology** relates to the treatment of the stomach, intestines, gall bladder, liver and pancreas

[12] **Endoscopic retrograde cholangio-pancreatography**, a procedure that allows doctors to examine the pancreatic and bile ducts with a flexible, lighted tube (an endoscope)

[13] A **cath (catheterisation) laboratory** is a highly specialist facility for invasive procedures such as angioplasty or angiography (see the glossary for further definitions)

[14] **Orthopaedics** is the branch of medicine dealing with disorders of the skeletal system and associated muscles, joints, and ligaments

- **Gynaecology (women's health):** Similar to orthopaedics, clinicians identified clinical improvements from centralising planned gynaecological surgery to one site. There was also strong appetite to explore delivering most sub-specialist areas (such as urogynaecology[15], infertility, benign gynaecology[16] and recurrent miscarriage) through a single integrated team working across the three hospital sites. Under this model, outpatients and planned day surgery (which accounts for the majority of planned gynaecology services), would continue on all three sites, with inpatient procedures requiring highly specialist skills or expertise being delivered from a centre of excellence at one hospital site. Another model proposed was for all inpatient gynaecology surgery to be centralised on a single site, enabling care by nursing staff and therapists experienced in post-operative gynaecology, offering a shorter length of stay, a dedicated skilled point of contact and better patient experience.

- **Radiology:** The radiology team identified opportunities to reduce patient waiting times by spreading the timetable more evenly across the week (currently, some procedures are carried out by all three hospitals on the same day). This would mean that referring clinicians could access an urgent procedure more quickly, from any of the three hospitals, on a treat and transfer basis. Another area for consideration is the provision of a formal on-call (non-arterial) interventional radiology[17] within BLMK, potentially working with neighbouring hospitals to provide a collaborative on-call solution to a wider geographical area.

- **Cancer services:** Many local patients access cancer services from hospitals outside BLMK. The three local hospitals are each in a different cancer network, with specialist treatment provided by the John Radcliffe Hospital in Oxford, Cambridge University Hospitals and the Mount Vernon Cancer Centre. These networks will not be affected by the STP and patients will continue to access cancer care and treatment from neighbouring hospitals, as they do now.

Clinicians have identified a requirement wherever possible for dedicated hospital beds, to be used exclusively by specialist service(s), supported by specialist nursing staff and concentrating the provision of specialist equipment. To improve resilience of cover for more specialised clinics and procedures, clinicians have also identified a number of sub-specialties that could be delivered at a mobile clinic rotating between the three hospital sites, and some that could be brought back into BLMK from outside the area.

6.5 More care closer to home

It is understood that, currently, as many as one third of patients occupying acute hospital beds could be cared for in alternative settings. Part of the BLMK STP's overall vision for the future of local healthcare is for more services to be delivered closer to people's homes, with specialist skills and expertise from the hospitals being shared and integrated with those on offer in community settings, with primary care reaching into patients' homes, and with prevention being given the same prominence as treatment in health and social care planning. Clinicians explored

[15] A **urogynaecology** service treats women's issues such as incontinence, urinary tract infections, bladder pain and pelvic floor injury after childbirth

[16] **Benign gynaecology** involves treatment of a condition, tumour or lump that is non-cancerous, e.g. ovarian cyst

[17] **Interventional radiology** is a branch of radiology concerned with providing diagnosis and treatment of disease by a variety of procedures performed under the guidance of radiologic imaging (e.g. X-rays)

these themes and identified a number of areas where they felt services could better be delivered closer to home. These are summarised below.

- **Rehabilitation:** Clinicians are agreed that patients not needing intensive medical care following a hospital stay, operation or procedure could be better cared for in community settings, freeing up much needed hospital beds.
- **Admission avoidance:** Clinicians identified that hospital attendance and admission could be avoided and health outcomes improved – especially for children and frail, elderly patients – through the provision of consistent, 24/7 community and social care services that supported patients in their homes or community settings. For frail, elderly patients, better advanced care planning, supported by elderly medicine and specialist palliative care teams, and rapid intervention at home would also help to avoid hospital admission. GPs said they would support hospital-based geriatricians[18] reaching out to community teams, so long as there continued to be geriatricians based at all three hospital sites.
- **Hospital discharge / transitional care:** Clinicians are agreed that more generic community support is needed to provide step-up and step-down care before and after a hospital stay, as well as home intervention services and rapid patient assessment, particularly for frail, elderly patients or those with complex care needs. This would help to reduce unnecessary readmissions and 'bed blocking' in hospitals, where beds are being occupied by patients who no longer need acute medical care.
- **Outpatients and diagnostics:** Bedfordshire CCG is in the process of developing three community care centres across their area with basic diagnostic facilities, capacity for patient treatment and advice, and access to multi-disciplinary urgent and planned care. Clinicians feel that, with appropriate equipment and information links, many specialties could utilise this type of centre, for example ENT (ear, nose and throat), dermatology (skin, nails and hair), rheumatology (rheumatism, arthritis and other disorders of the joints, muscles, and ligaments), elderly medicine and gynaecology (women's care).

  Clinicians were also keen to understand whether a central out-of-hospital facility within BLMK could provide some high volume imaging functions, such as CT or MRI scans. However, equipment would still need to be maintained at the hospital sites, especially to support emergency admissions. They also identified some specialist diagnostics procedures (those requiring highly specialist equipment or with low patient numbers) that could be delivered centrally with outputs being shared across, and potentially outside, BLMK.
- **Specialist medicine:** There has been a shift towards providing medical specialties such as respiratory medicine, diabetes, and gastroenterology in community settings over recent years, providing support to emergency inpatients and often high volume planned care. It was felt that services like hepatology (liver and gallbladder) or complex sleep apnoea may benefit from having a central hub with satellite clinics, or an outpatient clinic that travels from place to place. As a minimum, it was felt that cross-support and close collaboration between sub-specialists in the three hospitals would maximise benefits in terms of shared

[18] **Geriatricians** are doctors specialising in treating older people and the diseases that affect them to lengthen life expectancy and improve quality of life

best practice and adopting consistent standards and clinical protocols. It was also felt that specialties such as diabetes would benefit immensely from integrated clinical information systems, as patients with these chronic long term conditions are currently very exposed to the organisational handovers that occur between primary, community and secondary care.

6.6 Maternity care

The NHS England 'Better Births' strategy[19] is driving change in local maternity systems to ensure better choice and promotion of normal birth pathways for women who are low risk. However, the strategy recognises the need to provide high quality obstetric-led maternity services for those women who require it.

Birth rates in BLMK are expected to rise above the national average in the next five years, with more women falling into high risk categories due to having their first baby later in life, or due to lifestyle and medical conditions such as obesity or diabetes.

It is acknowledged that women in BLMK place an extremely high value on their local maternity unit. Therefore, any change in the way services are delivered needs to be carefully understood in terms of access, and there would need to be clear benefit in terms of quality, safety or sustainability.

Clinicians' latest thinking in this area is outlined below.

- **Joined up working:** Any model for maternity care would need close integration between the hospitals and community teams, including community birthing centres which would most sensibly be co-located with community care centres.

- **Mobile services:** Because of the staffing pressures for obstetric consultants, clinicians strongly and consistently support partnership working between the three hospitals and have identified examples where a mobile service delivered by teams of specialist staff based at two or three sites could be offered at the local maternity unit, for example to support women suffering recurrent miscarriage.

- **Focusing consultant-led obstetrics units on fewer sites:** Clinicians have explored the option of reducing the number of consultant-led obstetrics units from three to two. This would mean that antenatal care for high risk pregnancies would still be delivered as close to home as possible, but births would be managed at one of the two hospitals with an obstetric unit, which would also have a neonatal intensive care unit (NICU) providing specialist care, e.g. for premature babies . Clinicians recognised that, for some women, the greatest risk requiring more specialist care may be during the earlier stages of pregnancy. Under this model, capital investment would be required at the two hospitals with obstetric units to ensure that delivery units and maternity facilities, such as theatres, were fit for purpose, and to support an increased number of births. This model may potentially require fewer supervisory midwifery staff, which could then support deployment of additional senior midwifes to community birthing centres.

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[19] NHS England commissioned National Maternity Review, *Better Births, Improving outcomes of maternity services in England, A five year forward view for maternity care*, February 2016

- **Midwife-led maternity unit:** Under the above model, on the hospital site without an obstetric unit, a midwife-led birthing unit would be provided to ensure low risk women continued to have local access to both antenatal and delivery maternity facilities. While there is no specific requirement for these facilities to be on a hospital site, corresponding capital investment would be required for an off-site unit.

- **Co-ordinated care:** Clinicians recognised that any transfer between midwife-led care and obstetric care (and vice versa) would need to be timely and seamless, and that it was the NHS's responsibility to make it absolutely clear to the mother, and the staff looking after her, who is accountable for her care.

6.7 Paediatric (children's) services

The rapid growth in demand from children with complex needs, and the growing population, is having a significant impact on the way children's services are currently delivered, requiring an increasingly expert skill mix to be available more hours of the day. Staffing pressures are a major concern, with trained paediatric medical and nursing specialists in short supply, and both L&D and Milton Keynes hospitals have outgrown their existing facilities.

Clinicians' latest thinking on how paediatric services could be configured to ensure the very best care for children is outlined below.

- **Local services for vulnerable patients:** Clinicians are fully agreed that services for the most vulnerable patients must be retained locally with, as an absolute minimum, a paediatric emergency service at all three hospital sites to manage injuries and assess unwell children, referring them on to another hospital where necessary.

- **Integrated working:** Clinicians from all three hospitals agreed that joining expertise in sub-specialty paediatric medicine could offer significant benefits for patients, especially where a co-ordinated service could be delivered from all three sites, perhaps on a mobile basis.

- **Separating planned and emergency care:** There was a strong appetite to explore separating planned and emergency care to maintain a positive patient experience and protect planned care from emergency pressures. However, it was acknowledged that anaesthetic paediatric expertise would still be needed at all hospital sites to support children with acute illnesses. Lower risk medical treatments could be delivered separately from the hospital's acute unit, as long as there was access to advice and guidance from paediatricians. However, some investigations and treatments would need to be on site with the acute unit in case of an unexpected outcome.

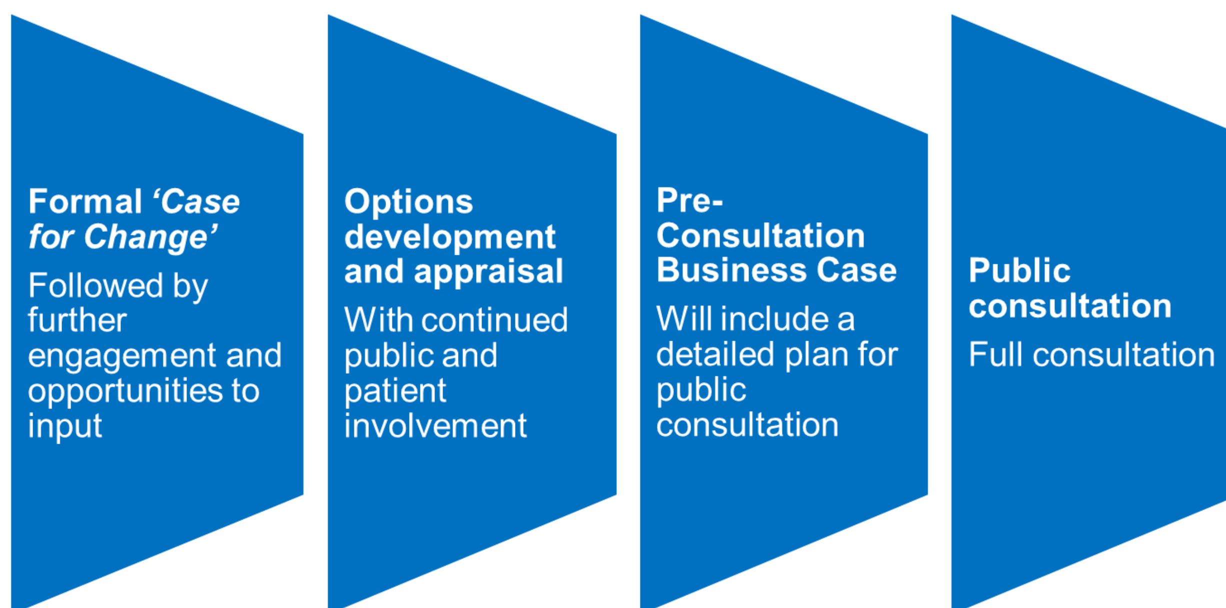
- **Acute inpatient care at fewer sites:** Clinicians acknowledged that it would be possible to centralise acute inpatient care for children on fewer sites, in which case the non-inpatient sites could adopt one of three models: (1) emergency care only, (2) day care and assessment but no 'blue light' emergencies or overnight beds, (3) inpatient care for up to 23-hour stays.

- **Increased community provision:** Clinicians said that any model where full inpatient care was not provided at all three sites would require a corresponding increase in community provision to support patients at home, especially for those children with complex and long term conditions for whom travel to another hospital might be especially challenging.

Note: In Bedford and Milton Keynes hospitals, the paediatricians support neonatal care, so this must be considered alongside obstetric and paediatric models for service delivery.

7. Next steps

The next steps in the process for the Sustainability and Transformation Plan are outlined below. The specific timings for these phases are currently being reviewed and further information will be published as soon as it is available.



The principles and outputs contained in this document will form a strong platform for the next stage in this process, namely the development of a formal **Case for Change**. This will include a written account of the need for change along with detailed demographics, socio-economic and health needs data for the BLMK area.

The feedback and views from patients, NHS staff and clinicians contained within this *'What we've heard so far'* document will be assessed and used to inform the development of more detailed options for health and social care services.

Following this, with continued involvement from key stakeholders groups including patient and public representatives, a long and short list of options will be developed, supported by detailed modelling of workforce and property requirements, transport costs, travel times and patient numbers. The short list will then be narrowed down to a set of preferred options, which will be evaluated against a set of criteria that includes financial impact, activity and capacity, travel implications , clinical standards and stakeholder feedback.

The preferred options, how these have been arrived at and how the STP has responded to views and concerns gathered from patients, NHS staff and clinicians through pre-consultation engagement will be described in a **Pre-Consultation Business Case (PCBC)**which would require NHS England approval of the PCBC prior to full public consultation.

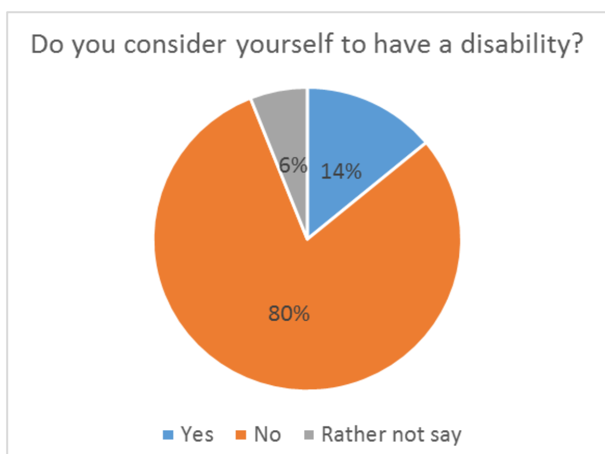
8. Analysis of responses

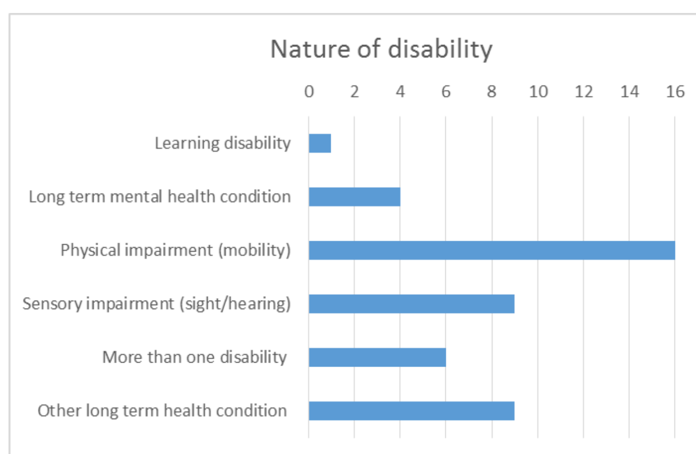
The following organisations were represented within the responses received:

- Access Bedford
- Age Concern Luton
- Age UK MK
- Barton Surgery Patient Participation Group
- Bedfordshire Clinical Commissioning Group
- Bedford Borough Council
- Bedford Borough Council Liberal Democrat Group
- Bedford Borough Youth Cabinet
- Bedford Hospital Charity
- Bedford Hospital NHS Trust
- Bedford Forum
- Bedford Locality Patient Group
- Bedfordshire and Luton Fair Play
- Brickhill Parish Council
- Bucks Vision
- Central Bedfordshire Council
- Cerner
- Chiltern Vale Patient Participation Network
- De Parys Patient Participation Group
- ELFT
- Falls and Fractures Prevention Group
- Future East Partnership
- Green Party
- Haynes Parish Council
- Healthwatch Bedford Borough
- Healthwatch Central Bedfordshire
- Healthwatch Milton Keynes
- Houghton Close Patient Participation Group
- Ivel Medical Centre Patient Participation Group
- Joint Health Overview and Scrutiny Committee (Bedford Borough and Central Bedfordshire)
- Kempston Town Council
- Leighton Buzzard Carers Group

- Luton Borough Council
- Luton Clinical Commissioning Group
- Luton and Dunstable Hospital NHS Foundation Trust
- Luton Law Centre
- Luton People's Assembly
- Marsh Farm Outreach CIC
- Maternity MK
- Meaningful Education Ltd. CIC presents Bedfordshire Dignity Network
- Mencap
- Milton Keynes Cancer Patient Partnership
- Milton Keynes Clinical Commissioning Group
- Milton Keynes Council
- Milton Keynes University Hospital NHS Foundation Trust
- Momentum
- MS Society
- Our Minds Matter
- Priory Gardens Patient Participation Group
- Putnoe Patient Participation Group
- Ramgarhia Sikh Temple
- Sandy Town Council
- SEPT
- Smarta Healthcare
- University of Bedfordshire
- Woburn Sands PPG
- Access Bedford

Online questionnaire respondent details (completed by around half of those who responded)





9. Glossary

A&E (Accident & Emergency) – a service available 24 hours a day, 7 days a week where people receive treatment for medical and surgical emergencies that are likely to need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery and other serious illnesses.

Acute care – short term treatment, usually in a hospital, for patients with any kind of illness or injury.

Angiogram – an X-ray that uses a special dye and camera to take pictures of the blood flow in an artery.

Angiography – radiography of the arteries, veins and heart chambers.

Angioplasty – surgical repair or unblocking of a blood vessel, especially a coronary artery

Benign gynaecology – treatment of a condition, tumour or lump that is not cancerous, e.g. an ovarian cyst.

BLMK – Bedfordshire, Luton and Milton Keynes.

Cath (Catheterisation) lab – a highly specialist facility providing invasive heart procedures such as angiography or angioplasty.

Clinical Commissioning Group (CCG) – health commissioning organisations which replaced Primary Care Trusts (PCTs) in April 2013. CCGs are led by GPs and represent a group of GP practices in a certain area.

Community care – health care provided to patients within the community rather than in hospitals or specialist inpatient facilities. Care may be delivered by a clinician visiting a patient at home, or from a GP surgery, community centre or sometimes a children's centre or school.

Consanguineous – being of the same blood or origin.

CT scan – a computed tomography (CT) scan uses X-rays to make detailed pictures of parts of your body and the structures inside your body.

Deficit – when spending is greater than income.

Diagnostics – the use of specialist equipment to determine the causes of a patient's symptoms or monitor their progress. Diagnostic processes can include blood tests, X-rays, ultrasound, CT and MRI scans.

Elective – a procedure or surgery that is planned and scheduled in advance.

Emergency nurse practitioner (ENP) – a senior emergency department nurse who has been specially trained to treat minor injuries without needing to refer to a doctor.

Enabler – something that provides the ways, means or knowledge to make something happen.

Gastroenterology – a medical specialty looking after illnesses of the stomach and intestines.

Geriatrics / geriatricians – doctors and services focused on treating older people and the diseases that affect them to lengthen life expectancy and improve quality of life

Governance – the in which an organisation or project is managed and organised, including how decisions are made.

Gynaecology – women's health.

Inpatient – a person who needs to stay in and be cared for in hospital overnight before, after or during their treatment.

Integrate – a principle of this programme which refers to creating more co-ordinated care for the patient, making sure all parts of the NHS and social services work more closely and effectively together.

Interventional radiology - a branch of radiology concerned with providing diagnosis and treatment of disease by a variety of procedures performed under the guidance of radiologic imaging (e.g. X-rays).

Localise – to deliver as much care as possible in the most convenient locations, making sure people have earlier and easier access to treatment.

MRI scan – MRI (magnetic resonance imaging) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.

Multi-disciplinary team (MDT) – a team made up of people from different parts of the health and social care system with different skills.

Obstetrics – the branch of medicine that deals with the care of women before, during and after childbirth.

Orthopaedics – the branch of medicine dealing with disorders of the skeletal system and associated muscles, joints, and ligaments.

Outreach – the extending of services or assistance beyond current or usual limits.

Paediatrics – a medical specialty that manages medical conditions affecting babies, children and young people.

Patient pathway – the route a patient will take from their first contact with an NHS member of staff (usually their GP), through referral, to the completion of their treatment.

Planned care – care that is planned, i.e. booked appointments, as opposed to unexpected, emergency care. Some planned care may be clinically urgent e.g. cancer pathways, whereas other planned care is more routine.

Primary care – services which are the main or first point of contact for the patient, provided by GPs, community providers and others.

Rehabilitation – restoring someone to health or normal life through support and therapy following illness or addiction.

Secondary care – hospital or specialist care that a patient is referred to by their GP or other primary care provider.

Specialty / sub-specialty – a specialty is a group of clinical services, especially within a hospital, led by specialist consultant(s) in that particular area, e.g. ear, nose and throat surgery, cardiology, rheumatology. A sub-specialty is a narrower field within a specialty are, for urogynaecology, fertility, and gynaecological-oncology are sub-specialties of gynaecology.

Step up / step down care – care provided in the run up to, or during recovery following a stay in hospital.

STP – the NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals, called sustainability and transformation plans (STPs), are place-based and built around the needs of the local population.

Sustainable – capable of being continued into the future as circumstances change.

Trauma – a physical or emotional injury that comes on suddenly, requiring immediate medical attention. A **major trauma** refers to a serious injury that could lead to permanent disability or death, such as a gunshot wound or injuries sustained in a car accident.

Unified service / unification – where one or more organisation, for example our three local hospitals, works together to provide a service.

Unselected / selected / semi-selected medical take – a hospital with an 'unselected medical take' will treat patients with any medical condition, except for highly specialist services. With a 'selected' or 'semi-selected' medical take, a hospital would limit the type of patients / specific conditions that would be admitted for treatment.

Urogynaecology – treatment for women's issues such as incontinence, urinary tract infections, bladder pain and pelvic floor injury after childbirth.