Steve Baker MP

Acute health services in Bucks

Some areas for investigation

Steve Baker MP
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Introduction

The state and future of Wycombe Hospital is the pre-eminent political issue in High Wycombe and the wider District. The loss of various acute services and beds over several years has been a constant source of anxiety, notwithstanding the reassurances of NHS managers. The result has been widespread public anger, disbelief, disillusion, cynicism and even despair.

This document sets out the case for a wide-ranging inquiry by the Buckinghamshire Health and Adult Social Care Select Committee into local acute services and their interaction with care for the chronically ill. It also indicates some specific questions which the Committee may wish to consider.

Emergency and Trauma surgery moved to Stoke Mandeville in August 2005. In October 2007, the Accident and Emergency Department was downgraded to an Emergency Medical Centre (EMC). In 2012 there was a further downgrade to a Minor Injuries and Illness Unit (MIIU). In parallel, consultant-led maternity and children's services were lost.

And yet today, eight years after the process began, members of the public continually ask me to secure the return of A&E to Wycombe. I would love nothing more than to do so. Unfortunately, after making every enquiry, I have no reason to believe the NHS can or will return a full A&E to Wycombe, despite public and political outcry. Consequently, local health services have become a constant political football.

To reduce hospital service provision to the level of party-political squabbling is unedifying. The issues are too important and all political parties support the NHS. It has long been a huge and complex organisation in which many changes have resulted from developments in clinical practice, technology and labour law, irrespective of the government of the day.

The following recent and typical email illustrates the scale on which the local NHS has failed to secure public understanding and support for change over several years straddling two governments:

> *... I have been living in High Wycombe for nearly 30 years. I have paid my full tax and insurance for all these years, so I am quite disgusted that our A & E and other parts of the hospital in High Wycombe have closed. Like a lot of people here, I feel very vulnerable, that should I have a stroke or a heart attack, I would not get to the hospital in Stoke Mandeville or Wexham in time to survive. Both hospitals take 40 - 45 minutes to get there from where we live and longer in bad traffic. I don't see this as acceptable. We all know that it is imperative for stroke victims to have treatment within a short time frame otherwise they will lose function in parts of their body and their speech, that's if they survive at all!! High Wycombe as I am sure you know, serves a very large community, so why was the hospital closed in the first place?*
>
> *... Give us back our hospital please.*

Wycombe Hospital is equipped with excellent units for two of the biggest killers: heart attack and stroke. Victims of these conditions in Aylesbury would be brought to Wycombe, not Stoke Mandeville but too many people in Wycombe still believe they must make it to Aylesbury.

Frequent news reports are undermining the orthodoxy that centralisation of acute services is in the public interest. Accident and emergency care, locally and across the country, is under serious strain.

The College of Emergency Medicine describes A&E departments as being "like warzones"[1], while the Care Quality Commission label A&E as "out of control"[2]. The King's Fund warned that waiting times for A&E patients had hit a nine-year high: the most common explanation was the large number of patients arriving at A&E who were not medical emergencies[3]. It seems A&E departments are being used to manage chronic illness with far-reaching problems for everyone else.

The Health Secretary has announced a fundamental review of emergency care due in April 2014. However, Bucks patients have a reasonable expectation that services should improve more quickly. They should not have to wait for the national review of A&E care to be published, scrutinised, responded to, discussed and eventually implemented.

It is in this context that we need a wide-ranging inquiry into acute care for Buckinghamshire.

This document sets out my perspective as the MP for Wycombe. It includes opinions and views which are representative of my experience but which require resources not at my disposal to explore fully so that conclusions and recommendations may be made.

The Buckinghamshire Health and Adult Social Care Select Committee has the authority to conduct such an inquiry. I have no doubt local people would welcome it.

Wycombe Hospital – a study in NHS change[4]

Wycombe has had three main hospitals and two smaller ones since the 19th Century:

- Major hospitals:
  - 1875 to 1923 – *The High Wycombe Cottage Hospital*, Priory Road
  - 1923 to 1971 – *The High Wycombe War Memorial Hospital*, Marlow Hill
  - 1965 to present – *Wycombe General Hospital*, Marlow Hill
- Minor:
  - 1929 to 1996 - *Booker Hospital*, Cressex
  - Unknown to 1976 - *Shrubbery Maternity Home*, Amersham Hill

The High Wycombe War Memorial Hospital was funded by local subscriptions and donations. It was nationalised in 1948. Since 1987, local charity *Scanappeal* has raised[5] nearly £10 million to provide advanced medical equipment to local patients.

[1] http://www.telegraph.co.uk/health/healthnews/10047646/AandE-units-have-become-like-warzones-top-doctor-warns.html

[2] http://www.nursingtimes.net/nursing-practice/clinical-zones/accident-and-emergency/ae-demand-out-of-control-warns-regulator/5058415.article

[3] http://www.kingsfund.org.uk/publications/how-health-and-social-care-system-performing-june-2013

[4] More at http://www.stevebaker.info/2012/02/a-brief-history-wycombe-hospital/

[5] http://www.scannappeal.org.uk/about/fast-facts/

It is little wonder the local newspaper runs its campaign under the slogan "Hand Back Our Hospital"[6].

Since nationalisation, our hospital has followed a trajectory common in similar towns:

- The state seized control of healthcare with high – one might say utopian – ideals.
- The acute care sector expanded, ensuring that Acute District General Hospitals became the dominant model of state hospital by the 1960s, but not everywhere.
- Community hospitals continued but in an increasing state of benign neglect: the relationship between DGH and community hospitals appears never to have been satisfactorily resolved. The regulatory framework of the NHS and the organisation of clinical labour favours larger hospitals. The population has grown, shifted and aged. Both factors are crucial for that relationship.
- Hospital working practices significantly changed following clinical and non-clinical developments. These include shorter training periods and reduced working hours leading to greater specialisation. In turn, that has encouraged centralisation to achieve greater footfall. Increasing technical specialisation, illustrated by the emergence of vascular surgery in its own right, has also driven centralisation. In the case of vascular surgery in Wycombe, pressure to centralise for theoretical quality seems to trump the local unit's actual performance.

Three conflicting perspectives therefore stand in tension:

1. The patients' expectation of maintaining local access to services, underpinned by an assumption that quality will always be acceptable,
2. The clinicians' commitment to absolute technical quality based on evidence for their speciality, often at the expense of patient preferences in relation to access, and
3. The managers' inevitable focus on resources.

Hospitals like those in Buckinghamshire feel the full force of these pressures. Politicians at all levels feel the keen desire of electors to preserve local services unchanged, even when centralisation is apparently the inevitable direction of travel of clinicians and managers. ***That direction of travel must face informed challenge.***

Consultations – an exercise in *Newspeak*

The *Better Healthcare in Buckinghamshire* (BHiB) consultation[7] was not a success despite great effort and expense. Public participation was poor, even amongst local politicians who could and can be relied upon to express strident views when there is the prospect of media coverage. There is no sense in Wycombe that local healthcare is now better, only that it has been further downgraded.

Despite the services of professional facilitators and journalists for the consultation, communication has been so ineffective that the public still do not understand what provision has been made for urgent care in Wycombe. I find *myself* explaining that people should dial 999 in the event of life-threatening injury or illness and 111 otherwise. The email above, lamenting the absence of a local A&E in the event of heart attack or stroke, was received months after BHiB. For emergency care to remain so poorly explained is not good enough.

[6] http://www.bucksfreepress.co.uk/news/healthnews/hand_back_our_hospital/
[7] http://www.buckspct.nhs.uk/bhib/

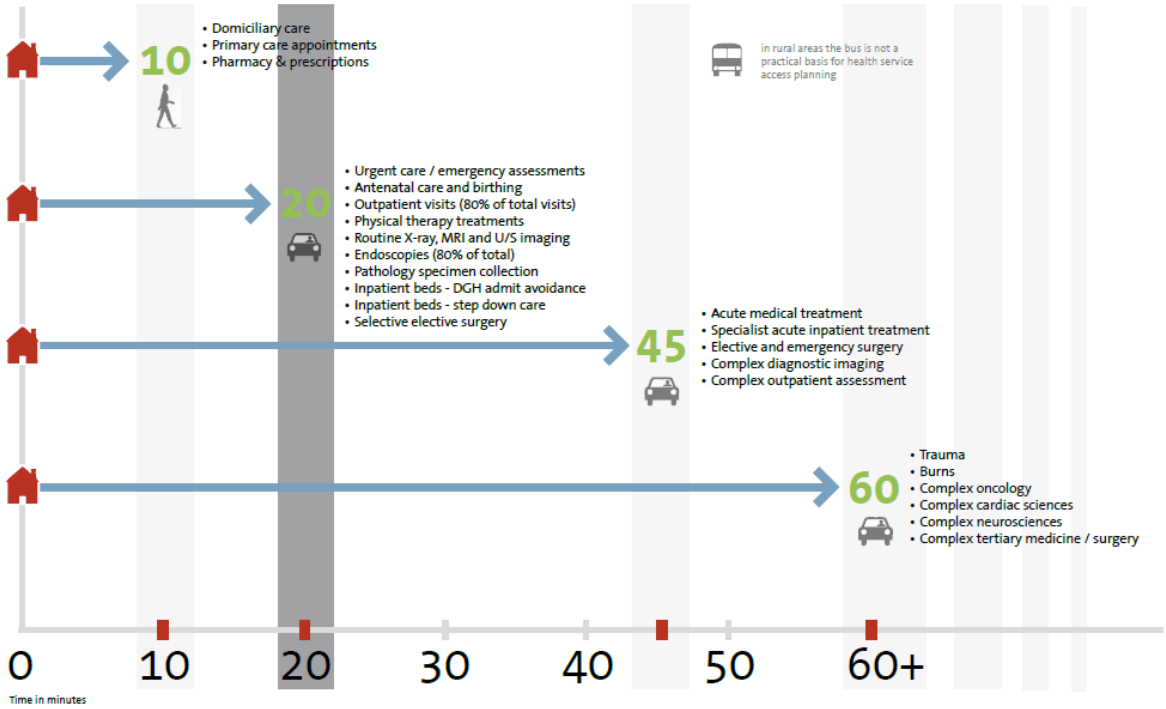
In common with most government activities to which the word "consultation" is applied, there was little evidence that the NHS was taking public advice or in any sense deliberating towards a decision. The decisions had been taken: there was no alternative. The consultation was an exercise in manufacturing the appearance of consent.

The consequences rumble on: a questionnaire produced recently by the well-informed campaign group SOHS is at Enclosure A. It includes questions as elementary as "Why is it so difficult for the NHS to clearly explain the services that are actually supplied through the MIIU at Wycombe?" It deserves an answer and a solution.

I took BHiB seriously and I do not regret it. It was necessary once. However, we ought not to be surprised that the public do not engage with exercises whose prime purpose is to legitimise after the fact decisions made by unaccountable public servants. ***Consultations must change.***

A vision for local acute care

The public are right to expect urgent care close to home. The health consultancy Durrow identifies a range of services which ought to be provided within about 20 minutes[8]:



Those services are:

- Urgent care / emergency assessments
- Antenatal care and birthing
- Outpatient visits (80% of total visits)
- Physical therapy treatments

[8] *Providing acute care locally – the (small) hypermodern local acute hospital*, Durrow – reproduced with permission.

- Routine X-ray, MRI and U/S imaging
- Endoscopies (80% of total)
- Pathology specimen collection
- Inpatient beds – DGH admit avoidance
- Inpatient beds – step down care
- Selective elective surgery

At least these services should be provided at Wycombe hospital and within 20-30 minutes of patients across Buckinghamshire. Their availability must be communicated effectively and positively: we cannot have a repeat of the destructive leaflet that was issued when the EMC was downgraded.

There is no doubt the topography of Bucks presents its own challenges; it is a long, thin county with a largely rural road network. This makes travelling distances to receive medical treatment more difficult. This factor ought to be taken more prominently into account. People may well choose to travel nationally or internationally for complex elective surgery. They ought not to have to go outside the town for cuts, burns, sprains, simple fractures and so on.

The NHS locally is close to achieving this range of services in principle but the public are dissatisfied. There have been far too many inexcusable failures to communicate and make the most of what we have.

Key issues

Absence of an A&E department

The central issue for the public in Wycombe and the surrounding area remains the loss of Wycombe's A&E and the consequent fear of death.

Wrapped up in the term "A&E" is faith that life-saving medical care will be delivered quickly, if only one can get through the door. It may well be that our cardiology and stroke units can deal with two of the biggest killers. The MIIU ought to be capable of delivering a large proportion of the urgent care local people need.

Neither captures the public imagination: time and again, I find people believe they must self-drive to Stoke Mandeville or Wexham Park in emergency.

Questions:

- ***What effect has the loss of (A) the A&E Department and (B) the EMC from Wycombe had on mortality for patients from (i) Wycombe and (ii) other areas served by Stoke Mandeville and Wexham Park?***
- ***What effect has the loss of (A) the A&E Department and (B) the EMC from Wycombe had on (i) adjacent hospitals and (ii) the ambulance service?***
- ***Which urgent conditions can be treated in Wycombe? Why has this not been effectively communicated? (Even campaigners remain unsure.)***
- ***Which additional conditions could reasonably be treated in locally?***

- ***What are the practical consequences, in simple terms, of not having "A&E"? How can any detrimental effects be ameliorated?***
- ***In what circumstances would an A&E department ever be returned to Wycombe Hospital?***

Access to emergency care at other A&E units

Stoke Mandeville's A&E is about 35 minutes from High Wycombe by car along the poor quality A4010 through Princes Risborough. Wexham Park Hospital is nominally 26 minutes away, but woe betide the patient who must travel East on High Wycombe's London Road at the wrong time without the benefit of blue lights and sirens.

Whether travelling by ambulance, car or bus, journeys to the nearest A&E departments are unsatisfactory. Services must be in place to avoid unnecessary travel.

Questions:

- ***Who is travelling to adjacent hospitals' A&E departments by (A) private and (B) public transport who need not do so and why?***
- ***When should people call an ambulance?***
- ***When should people drive to an A&E department instead of calling an ambulance?***

A&E waiting

Current waiting times at A&E departments are a matter of national news and Parliamentary politics. Both miss the point. To wait as long as four hours for emergency treatment is scandalous. Indeed, between producing the first and final drafts of this document, I received a most strident complaint from a lady whose three-year-old child had waited three hours. The NHS must do better.

If it is the case that A&E departments are overloaded because patients attend whose condition is not an emergency, this must be understood and stopped in everyone's interests.

Questions:

- ***What are the facts about local A&E waiting times for (A) patients and (B) ambulances? Who is waiting for how long for what treatment?***
- ***What is the impact on the ambulance service of A&E waiting?***
- ***Is the rigid pursuit of waiting time targets counterproductive and how? Are people admitted who ought not to be?***
- ***What proportion of local A&E attendances are not emergencies?***
- ***Who are the patients who present at local A&E departments with conditions which are not emergencies?***
- ***To what extent and why are the chronically ill presenting at A&E?***
- ***How are patients subsequently discharged from hospital and to where? Is difficulty discharging the chronically ill from acute hospitals a factor increasing A&E waiting times?***
- ***To what extent and why do people present at A&E who require primary care?***
- ***Why are patients attending A&E whose condition is not an emergency or otherwise acute?***

- ***Why are non-emergency patients not being sent away from A&E rapidly? Are ideological factors obstructing common-sense clinical practice?***

Integration of services

Wycombe's MIIU has repeatedly failed to refer people to the adjacent cardiology[9] and stroke[10] units. Some have been sent to Stoke Mandeville for assessment only to return. This is absurd and clinicians know it. It ought never to happen, irrespective of the preferred patient pathway.

The integration of health and social care components ought to offer far greater improvements in quality, efficiency and patient experience than advancing technique in individual services. If scarce A&E resources are being misused because the chronically ill cannot obtain the treatment they need elsewhere, the opportunity for improvement is far more immediate than likely timescales for improved clinical practice.

Efforts towards integration should be directed for maximum benefit: towards the heaviest users of health care, the chronically ill and the elderly. Those improvements should be guided by proven industrial process improvement techniques, such as Lean[11], which drives out seven wastes, the symptoms of root problems:

1. Overproduction
2. Unnecessary inventory
3. Inefficient and unnecessary transportation between facilities
4. Unnecessary motion within facilities
5. Waiting times
6. Defects and rework
7. Inappropriate processing

A few moment's reflection presents examples: ambulance waiting is obvious and treatment of the chronically ill at A&E would be inappropriate processing. As another example, the replacement of computer system operators with clinicians to carry out triage may be superficially more expensive but perhaps not if overproduction (excess ambulance call-outs) and inappropriate processing (substitution of A&E for a GP appointment) are reduced.

Patient choice ought to be properly defined: it is not an end in itself. The purpose of choice is to facilitate exit from unsatisfactory arrangements into better ones, thereby improving cost, quality and service. It is the flipside of competition. It is not intended to create confusion at times of stress: it is not clear on what basis a patient or family member is expected to decide which A&E to go to when asked by the ambulance crew, for example.

Questions:

- ***To what extent are co-located services working well together and to what extent are there wasteful failures?***

[9] http://www.dailymail.co.uk/health/article-2241094/A-young-mum-believed-having-heart-attack-taken-hospital-staff-told-999-treat-her.html
[10] Constituency correspondence
[11] Via the obsolescent www.institute.nhs.uk

- ***How frequently are patients subjected to wasteful processes ("patient pathways")?***
- ***Who is responsible for each patient pathway and how are they improving it?***
- ***How do geographically dispersed services work together, or not?***
- ***Are staff equipped with the skills necessary to identify and eliminate wasteful processes?***
- ***To what extent is management equipped to foster continuous improvement?***
- ***In cases of absurd failure, why are common sense decisions not being made? Do people not know what to do? Do they not know how to do it? Are they afraid to do it? Is management in the way?***
- ***What is the role of patient choice and competition in improving the cost, quality and service of the NHS locally?***

Poor accountability

People in Wycombe justifiably feel that their repeated rejection of proposed changes is irrelevant to the NHS. The NHS locally claims "majority support for the BHIB proposals"[12] but this is not borne out by contact with my constituents. People may well support the extension of treatment in homes and other community settings plus the improvement of local diagnostics but this cannot be taken to imply support for downgrading urgent care services. The divergence between public opinion on this point and the NHS' presentation of that opinion is itself a serious problem.

No doubt there are incremental changes to NHS institutions which would alter incentives and improve accountability. These would include more patient involvement in commissioning decisions and direct local ownership of healthcare providers. I am working on these proposals separately.

Questions:

- ***To what extent are consultations genuine attempts to deliberate with the public?***
- ***To what extent do consultations manufacture consent and the appearance of consent?***
- ***How can NHS decision makers in relevant bodies be removed and by whom?***
- ***What are the formal methods of appeal against commissioning decisions by (A) CCGs and (B) NHS England?***
- ***What are the powers under law of (A) the Health and Adult Social Care Select Committee, (B) the Health and Wellbeing Board, (C) the County Council, (D) the individual members of Parliament and (E) the Secretary of State?***

Conclusion

We have fewer services of narrower scope than in the past. Within the parameters of the medical profession as it has become, there is no prospect of regaining the breadth and depth of services which the public have come to expect as a legacy of the 1960s' model of acute district general hospital. Anyone who says otherwise is at best ill-informed, however stridently they may express themselves: working conditions and clinical practice have made it impossible.

Furious dissatisfaction with Members of Parliament was the force which drove me into politics. I want integrity in public debate and I think electors do too. It would be wonderful to promise the

[12] http://www.buckspct.nhs.uk/bhib/

return of A&E to Wycombe but it is not that simple: I would be lying if I said I thought the NHS could do it.

None of this is any excuse for failing to provide essential urgent and acute care in High Wycombe. An attempt is being made but it is occasionally half-hearted and the results are not yet good enough.

Communication with the public has had poor results from ill-judged messages for considerable expense. The NHS has failed to persuade the public and their representatives that centralisation is in their best interests. These arrangements were promoted on the basis that they would improve clinical quality. That assertion is being undermined by current events.

For those of us who take an interest in these matters, there seems to be an air of distain for criticism of the NHS, whether constructive or not. The public debate seems unlikely to change until there is both an open acceptance that local acute care falls short of widespread expectations and a concerted attempt to resolve those shortcomings without indulging in unrealistic promises.

Despite its protected budget, the NHS must achieve unprecedented productivity increases if it is to cope with demographic and clinical changes. That will require sustained application of industrial best practice, common sense, tact, determination and forbearance.

Our Health and Adult Social Care Select Committee is the principal forum within which to hold local NHS officials to account. In calling for a full Committee inquiry into acute services in Buckinghamshire and their interaction with care for the chronically ill, I feel confident that the necessary transformation can be delivered.

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Enclosures:

A – *SOHS Questionnaire – BhiB Review*
B – *Providing acute care locally – the* $^{(small)}$ *hypermodern local acute hospital*, Durrow