

**Buckinghamshire Independent
Review Panel**

**Report on the Review of Medical Services
to Community Hospitals within NHS
Buckinghamshire**

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Chairman**

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High Wycombe**

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CONTENTS

1	The review panel	3
2	Background to the review	3
3	Collection of evidence.....	5
4	Review of evidence.....	6
4.1	Background and previous patterns of medical cover	6
4.2	Medical cover provision prior to the new contract.....	7
4.3	GP training – a clarification.....	9
4.4	Public engagement.....	9
4.5	Procurement process	11
4.6	Operation of the contract.....	13
4.7	Impact of changes	18
5	Conclusions	21
6	Recommendations.....	24

APPENDICES

Appendix 1	Map of community hospitals showing patient distribution.....	25
Appendix 2	Questionnaires.....	26

Review of Medical Services to Community Hospitals within NHS Buckinghamshire

Following a meeting of the Buckinghamshire Local Authorities Overview and Scrutiny Committee for Public Health Services on 11th September 2009, NHS Buckinghamshire agreed to the establishment of a review to consider medical cover to its community hospitals. This was endorsed by the Trust's Board on September 29th 2009.

1 The review panel

The review panel comprised:

- David Lunn OBE LLB, Non Executive Director, NHS Buckinghamshire (Chairman)
- Jonathan Coombes, Service Manager, Community Hospitals, NHS Oxfordshire
- Dr Nigel McFetridge, independent GP Advisor, Berkshire
- Alan Passmore, Buckinghamshire LINK representative
- John Wrigley, Chairman of Buckingham Hospital League of Friends
- Richard Freeman, NHS Commissioner (Community services), NHS Buckinghamshire

Support to the panel;

- Richard Mills, Director of Strategy and Planning, NHS Buckinghamshire
- Clare Blakeway-Phillips, Assistant Director - Partnership Development NHS Buckinghamshire
- Lesley Mallinder, Patient and Public Involvement Manager, NHS Buckinghamshire

2 Background to the review

During 2009, Community Health Buckinghamshire undertook a procurement process for the provision of medical cover to community hospital beds. Following the completion of this process, the successful bidder was The Practice plc. The new contract commenced on 1st September 2009.

There had been considerable local interest in this decision and anxiety about the change. The Board was presented with a petition of over 4,000 signatures against the change at its meeting on 29th September 2009. The petition read: "Thame Community Hospital. We strongly support our local GPs in their bid to continue their excellent medical cover for our community hospital – a

service they have provided successfully for many decades. We do not want a drastically reduced level of cover. We do want a high-quality cohesive service which allows continuing personal care for the very important elderly patients in our local population. We urge Bucks PCT to permit local GPs to continue providing medical cover to Thame Community Hospital". A number of questions were also asked from members of the public present at this Board meeting.

The Buckinghamshire Local Authorities Overview and Scrutiny Committee for Public Health Services (PHOSC) was asked to consider whether the proposed level of care offered by the new provider amounted to a substantial change in service provision that might affect patient care.

At its meeting on 11th September 2009, the PHOSC received presentations from NHS Buckinghamshire, The Practice plc, and other interested parties.

At that meeting, NHS Buckinghamshire acknowledged the public concern raised in parts of the county about the new contract for the provision of medical cover to community hospital beds. This had focused on the number of hours to provide medical cover in the contract and the breaking of the link with local GP practices.

In response, NHS Buckinghamshire proposed to initiate a review of the new arrangements for GP cover of its community hospitals, particularly about the number of hours for patient care in the new contract arrangements, and the links with local GP practices.

The PHOSC supported this review as it felt that the change in hours outlined in the new contract, to be provided by The Practice plc, constituted a substantial change to the previous level of provision provided by local GP practices.

It was agreed that a thorough review should be conducted into how the contract was being delivered and that the review should include consultation with the public.

It was the opinion of the PHOSC that the review should clarify whether the new proposed level of cover would impact detrimentally on the delivery of care to inpatients. Therefore the review needed to clearly demonstrate whether the level of provision previously delivered differed from that provided following implementation of the new contract and how this impacted on patients.

Following further discussion with the PHOSC it was proposed that the review would be established with the following terms of reference:

- To consider whether the new level of cover impacted detrimentally on the delivery of care to inpatients. Therefore, the review needed to clearly address whether the previous level of provision differed from that provided in the new contract. As part of this, the review should consider the number

of hours for patient care in the new contract arrangements, and the links with local GP practices.

- To consult as appropriate, primarily by receiving and considering evidence from interested parties and groups
- To report to the NHS Buckinghamshire Board at its meeting on November 24th 2009

It was agreed that the review would not consider bed capacity nor the Minor Injury Unit in Buckingham Hospital, as neither issue was linked to the change of provider of medical cover.

3 Collection of evidence

3.1 Invitation to provide evidence

NHS Buckinghamshire wrote to the following organisations and individuals which were considered to be “interested parties and groups” giving them the opportunity, if they wished, to provide evidence in writing for the review panel to consider:

- Staff involved in the procurement of the new service
- Practices which previously provided the service
- The organisation which had been awarded the new contract (The Practice plc)
- The League of Friends from each community hospital
- Buckinghamshire County Council
- Aylesbury Vale, Chiltern, South Bucks and Wycombe District Councils
- Thame, Buckingham and Marlow Town Councils
- Buckinghamshire Local Involvement Network.

An invitation to submit evidence was put on the NHS Buckinghamshire website; moreover, a press release and radio interviews advised the public of this invitation.

3.2 Questionnaires

NHS Buckinghamshire sent questionnaires to staff working in the community hospitals and to GPs who had not provided medical cover to the community hospitals. Structured interviews were carried out with patients currently in the hospitals.

Copies of all three questionnaires are attached as appendices.

3.3 Interview with nurses

Jonathan Coombes, the independent nursing member of the panel, requested that an informal meeting be arranged between him and nurses from the community hospitals so that he could gather more evidence of the nursing staff view on previous and current service provision. This took place on the morning of 12th November in Thame Hospital and two other members of the Panel were present (John Wrigley and Richard Freeman).

3.4 Meetings of Panel

The review panel met on 2nd November 2009 to review the evidence submitted and to hear evidence from representatives of NHS Buckinghamshire, The Practice plc, the practices who previously provided the service (Chalfont St Peter practices, Marlow Medical Centre, North End Surgery on behalf of the three Buckingham practices, The Rycote Practice (on behalf of Thame and Princes Risborough practices), Buckingham Hospital League of Friends, Buckingham Hospital and North Bucks Health Action Group and Thame League of Friends.

The panel (except for Jonathan Coombes) met for the second time on 9th November to consider all the evidence received including the oral evidence heard on 2nd November. Members requested that additional background information be gathered by the support team and this was available for the third meeting which took place on the afternoon of 12th November. Nigel McFetridge was unable to attend the third meeting.

3.5 Public Meetings

Senior managers from NHS Buckinghamshire attended public meetings about the medical cover issue held in Buckingham (22/10/09) and Thame (29/10/09) as well as the Local Community Partnership meeting for South West Chilterns and Marlow on 13th October. They were able to hear the views of a large number of local residents and these views were subsequently reported to the Panel.

4 Review of evidence

4.1 Background and previous patterns of medical cover

The panel first considered the background to the provision of medical cover, including the changing organisational arrangements in Buckinghamshire over the last decade, and the previous patterns of medical cover.

Buckinghamshire PCT was formed in October 2006 by an amalgamation of the former Aylesbury Vale, Wycombe and Chiltern and South Buckinghamshire PCTs which had themselves been formed in 2002 from the break up of Buckinghamshire Health Authority. (In October 2009 the Board of

Buckinghamshire PCT agreed to change the name by which the organisation would normally be known to NHS Buckinghamshire. For legal purposes its name remains Buckinghamshire PCT.)

The Panel was made aware that there were community hospitals in Thame, Marlow, Buckingham, Chalfont St Peter (The Chalfonts and Gerrards Cross Hospital), and community beds in Amersham hospital which had been transferred when Chesham Hospital closed in 2005. The arrangements for medical cover varied across the hospitals. They reflected historical arrangements and local circumstance.

The community hospitals in Chalfont St Peter, Marlow and Chesham had been part of the South Buckinghamshire Hospital Trust. Unusually at that time in the NHS, this Trust had managed the acute hospital services at Wycombe and Amersham, as well as the community hospitals and community services. In 2002 there was a re-organisation of the NHS and these hospitals were transferred to the newly formed Chiltern and South Bucks PCT (Chalfont St Peter and Chesham) and Wycombe PCT (Marlow). With the closure of Chesham Hospital, new medical cover arrangements for the Waterside Unit at Amersham Hospital and The Chalfonts and Gerrards Cross Hospital were commissioned from The Practice plc and the Chalfont practices under a service level agreement (SLA).

The beds in the other hospitals (Thame, Buckingham and Marlow) also had medical cover provided by local GPs, originally through bed fund arrangements. Over the last ten years these arrangements had changed locally, and had gradually concentrated on fewer GPs and practices providing the cover. This change was accelerated by the introduction of the new GMS contract in 2003. It was understood that no contracts were in place for medical cover provided in any of the community hospitals and GPs invoiced for activity undertaken. It has subsequently emerged that there were in fact SLAs or contracts in place for Waterside Unit and The Chalfonts and Gerrards Cross Hospital. These were found to be similar to the one currently in place.

Since at least 2005, firstly the predecessor PCTs and then Buckinghamshire PCT had reported significant financial deficits. Medical cover to community hospitals was not on CHB's cost improvement programme and putting this service out to tender was not done as a cost reduction exercise.

4.2 Medical cover provision prior to the new contract

Prior to 1st September 2009, medical cover was costing £350,000-£400,000 per annum and was provided as follows:

- Waterside Unit, Amersham (since July 2008, known as Waterside and Chalfonts Unit) – The Practice plc.
- Chalfonts and Gerrards Cross Hospital, Chalfont St Peter – Chalfont surgeries provided the service (unspecified number of hours) under a SLA from 1st March 2005. From July 2008, they supported 8 beds in Amersham.

- Buckingham Community Hospital – three Buckingham practices.
- Thame Community Hospital – Prior to July 2009, a GP trainee was based in Thame community hospital and was available for medical cover (hours provision unknown) as well as carrying out other task such as audits, supporting outpatients etc from 2002 to July 2009. For approximately two months prior to the new contract, one GP from The Rycote Practice visited the hospital for up to one hour a day on weekdays.
- Marlow Community Hospital – Marlow Medical Group using a Foundation Year 2 trainee doctor (overseen by a GP).

The Rycote Practice was responsible for a GP training placement at Thame Community Hospital, an arrangement that was innovative when it was introduced in 2002. The practice received payment for overseeing this registrar who was based in the community hospital. Training activities took the registrar out of the hospital for about 30% of the week. For the remainder of their time, he or she provided medical cover as well as other services such as support to visiting consultants, audits, and other learning activities. The placements changed every three months. The Deanery terminated this training placement in July 2009 to prepare for changes in medical training. This termination was independent of the contract for medical cover.

Nursing staff reported the following at their meeting with Panel members:-
The situation at Thame had been that there were very high levels of provision of medical cover from The Rycote Practice via GP trainees, up to 5 hours per day 5 days per week. However, it was noted that the level of security even within this system depended upon the varied practice and experience of the Doctor in place at the time as would be the case for all models.

Most recently, for around 2 months prior to the award of contract to the new providers, Thame Community Hospital had received up to one hour's medical input per day from The Rycote Practice. It was identified that this amount of time was seen as 'fine' as the Doctors knew the systems in place and had good working relationships with the staff as they had a history of working together. Staff felt that this previous model for medical cover was responsive, allowed for an appointment system and met the needs of the patients.

Regarding Buckingham Community Hospital, the hospital had received medical support from three local practices with up to 14 GPs visiting the site to treat their own registered patients. There were no formal visit times and no management systems in place to ensure visits were booked. This did cause problems for the nursing staff who were unable to plan for visits to avoid meal times etc and it was noted that as GPs treated only their own patients there had been occasions when GPs had been in the hospital and had refused to treat patients who nursing staff had asked to be seen, as they were not registered with that practice. Demands on nursing time in relation to such ad hoc medical visits were considered high.

Whilst admissions were 'clerked' on the day, most visits were reactive and followed a 'request to see'. As such, no regular visits were made and it was not unknown for patients to go a week without being seen by a GP. The benefit of local surgery support was noted in some instances such as amendment to drug charts as they could be carried over to the practice and left for amendment as needed.

In terms of safety the old service was reported as feeling safe but in reality there was limited real support or backup unless available around practice times or as an ad hoc visit arrangement with no fixed visit plan.

4.3 GP training – a clarification

Training for GPs has recently changed. All GP trainees are now required to have three years' speciality training, 18 months of which is in general practice and 18 months in an acute hospital. This is an excellent development as it allows all GP trainees the opportunity for additional 'community experience', not just those on placements within Buckinghamshire Intermediate Care services and Thame Community Hospital.

To allow this move to universal community experience to occur, the 'community' three-month posts within Thame Community Hospital and intermediate care were removed by the Deanery.

All GP trainers can arrange an opportunity for community experience for their trainee GPs whilst they are in their six months primary care training in Year 2. This GP experience can be in the community hospital or community care or in another service that meets the trainee GP's learning needs. This would be a targeted experience that meets the registrar's learning needs, not service needs and would therefore be for much less than three months.

As these short term learning opportunities will be supernumerary 'experiences' in outpatients, clinics, services and community, the supervision and training grant will remain with the original trainer. This means that the money for the supervision will not go to the Rycote Practice as was previously the case.

There is therefore an opportunity to look to new ways of supporting learning for all GPs in Aylesbury (12) and Wycombe (12) rather than limiting to those placed in the community hospital (4)

4.4 Public engagement

Since 2001 there has been a series of Acts requiring NHS bodies to involve patients and the public in their work at all levels and particularly in proposals to change services. The most recent legislation is the NHS Act 2007. This amended Section 242 of the NHS Act 2006 (previously Section 11 of the Health and Social Care Act 2001) which specified the duty on NHS bodies to involve and consult service users.

Under the new Act, Strategic Health Authorities, Primary Care Trusts, NHS Trusts and NHS Foundation Trusts must make arrangements for people who receive or may receive services to be involved in:

- the planning and provision of those services;
- developing and considering proposals for changes in the way those services are provided; and
- decisions to be made affecting the operation of those services.

The Act says that people can be 'involved' either by being consulted or provided with information or in other ways. The Act also says that 'involvement' can be either direct or through representatives.

As a result of a previous challenge in the Court of Appeal, the requirement to involve where there is an 'impact' at the point of delivery has been clarified and it is now clear that people do not need to be consulted about changes in service provider where the manner of service delivery and range of services available remain the same.

("Real Involvement" Department of Health October 2008 P.22).

No involvement was carried out in the process of tendering the medical cover. This appears to have been because the CHB staff involved saw this as a re-procurement of an existing service, rather than a service change. The reasoning was that there would still be GP medical cover, and the range of duties to be provided was not being changed – indeed it was thought to be enhanced in many cases. The contract between the PCT and CHB for community hospitals was not being changed.

The requirements relating to "substantial variation" in services are different. Excerpts from Centre for Public Scrutiny Guide to Variations in Health Services are below.

"Regulations under section 7 of the NHS Act 2001 require NHS bodies to consult relevant overview and scrutiny committees on any proposals for substantial variations or developments of health services. This duty is additional to the duty of involvement or consultation under section 11 i.e. other stakeholders should be consulted and involved in addition to OSCs.

A 'substantial variation or development' of health services is not defined in Regulations. Proposals may range from changes that affect a small group of people within a small geographical area such as changes in the timing of podiatry services within a health centre, to major reconfigurations of specialist services involving large numbers of patients across a wide area. The key feature is that there is a major change to services experienced by patients and future patients.

OSCs and NHS bodies are encouraged to develop local agreements or sets of criteria about what might be regarded as 'substantial' in the local context."

"As there is no national definition of 'substantial', the Department of Health guidance and good practice identified across the country indicate that in deciding whether a proposal is substantial, the following issues should be considered:

- a) changes in accessibility of services;*
- b) impact of the service on the wider community and other services, including economic impact, transport and regeneration;*
- c) number of patients affected. Changes may affect the whole population of a geographical area or a small group. If a change affects a small group of patients it may still be 'substantial', especially if patients need to continue to access that service for many years;*
- d) methods of service delivery, e.g. moving a particular service into a community setting from an acute hospital setting.*

The evidence used to identify these should include feedback from patients and the public".

4.5 Procurement process

While CHB is legally part of NHS Buckinghamshire, it has developed into an arms' length organisation in accordance with Department of Health policy. The PCT commissions CHB to deliver community health services to the people of Buckinghamshire and this process is formalised in a community contract following a national template for this document. Within the contract are separate specifications for each service line, including a specification for community hospitals. However, this is a high level contract that identifies in broad terms what CHB is required to deliver, such as: the location of hospitals; the bed capacity; admission criteria; and outcomes to be achieved. This does not tell CHB how to run the hospitals; rather, it sets the boundaries and within this CHB is expected to take the necessary steps to deliver the services in a clinically safe way. In order to do this, CHB utilises the resources at their disposal including staff. However, when they need additional resources, CHB has to sub-contract them. One such instance is the provision of medical cover, at a level necessary to ensure that CHB's delivery model is delivered in a clinically safe way.

CHB had been concerned at the variation in equity of medical cover at community hospitals, costs and performance management processes. It had attempted to discuss how best to address this with the practices that were providing medical cover but had not been successful. It therefore had no option (under European tender law and NHS Buckinghamshire's standing financial instructions) but to tender the service.

The underpinning principles of the process were transparency, equal treatment and no discrimination. Support could not be offered to the less experienced bidders as equal treatment of applicants had to be shown.

However, the local practices had had a dry run with the first attempt at going out to tender. The electronic portal used provided a reliable audit trail. Terms and Conditions used were the standard Alternative Provider of Medical Services (APMS) contract.

The tender process carried out could be summarised thus:

- The service specification was developed based on national guidance (BMA, 2007). This document sets out key working tasks for medical providers based on the number of beds.
- The procurement process started in 2008, with existing providers only. At this stage, a bed price pricing mechanism, set at £3600 per bed, was proposed. The Marlow and Buckingham practices did not agree this pricing mechanism, and therefore CHB cancelled that procurement and started again with a full open tender using a pricing mechanism based on the number of hours cover provided.
- The hours of GP medical cover proposed in the tender documentation were based on: the minimum time the nurses reported that the GPs currently spent in the hospitals (but not the time the GP trainees spent in the hospitals); and on cover provided to other similar providers e.g. Community Health Oxfordshire, NHS Medway, East and West Berkshire. For example, NHS Medway's contract for medical cover is for three sessions a week for a 50 bedded inpatient unit and outpatient clinic.
- An advert with summary of service specification was issued on 'Supply2Health' portal in mid March 2009. GPs were also notified that the tender was about to be issued.
- The Pre Qualification Questionnaire (PQQ) was issued on 'Bravo' portal on 16th March 2009, with a closing date of 16th April. The seven PQQ submissions received were opened on 17th April 2009. The evaluation period then began.
- The Evaluation – scoring meeting was held on 30th April 2009. All Pre Qualification Questionnaires (PQQs) were scored, and their finances reviewed. One bidder failed to pass PQQ, and the remaining six bidders were accepted for Invitation to Tender (ITT) stage and notified via Bravo. One bidder wanted to make a fundamental change to their PQQ but as evaluation had already been completed this was not allowed and the bidder withdrew from the process before the ITT was issued.
- Invitations to Tender (ITTs) for the four separate community hospital lots were issued on Bravo on 14th May 2009 with a closing date of 15th June 2009. Bidders were advised they must respond to each ITT that they were interested in, and provide prices for two options, based on two levels of specified number of hours of medical cover per week. The evaluation criteria and scoring detail were included in the ITT documentation. The ITT submissions were opened on 16th June 2009.
- The Evaluation – scoring meeting was held on 2nd July 2009. All Invitation To Tender submissions (ITTs) were examined for each hospital lot. With

the exception of The Practice plc who did not raise the number of hours under Option 1 as an issue, all four other bidders stated that they believed them to be unviable. Two bidders (Masonic House and the Rycote Practice) did not accept that the lower hours provision (Option 1) was feasible and did not price it and therefore their scoring could not be completed. In the panel review we have, however, noted that at the time that the old cover ceased, The Rycote Practice were, under their own arrangements, only providing 5 hours medical cover a week to Thame Community Hospital, a figure closer to the lower option of medical cover (4 hours) than the higher option (8 hours). Moreover, according to the staff of Buckingham Community Hospital, medical cover actually averaged out at one hour a day under the old system, a figure equal to the cover under the new contract.

- Scores and Pricing were evaluated to determine cost per point. The winning bidder for each hospital lot and for both the higher and lower hours options, based on cost per point, was The Practice plc, although it was not the lowest absolute bid in all cases.
- CHB decided to award contract for Option 1, the lower hours.

The PCT's Procurement Advisor stated that the tender from The Practice plc was not considered to be 'a loss leader' as he was aware that other PCTs in the region were paying less for similar cover.

As with all public sector organisations, NHS Buckinghamshire has standing financial instructions which delegate authority to let moderately sized contracts to senior managers. CHB had the authority to carry out the tender process without reference to the Board of NHS Buckinghamshire. With hindsight however it can be seen that the sensitivity of the change was not recognised and the Panel felt that it would have been preferable for this issue to have been discussed by the Board. Moreover, CHB stated that they regretted not engaging the community in the procurement of medical cover.

It was also acknowledged that there had been insufficient involvement of GPs in the development of the service specification.

4.6 Operation of the contract

Following commencement of the new contract, a number of issues relating to the contract and the manner in which it had been developed and let were identified and submitted to the review panel from groups such as GPs, Leagues of Friends and other concerned individuals. The main ones were as follows:

- Some GPs suggested nurses were not happy to take decisions and were not ready to take over greater responsibilities
- It was reported that patients valued being treated by their own GP

- The level of medical cover now provided was felt not to be enough by GPs and the public were concerned to hear that it was less than what they were told it had been previously. Four hours was felt to be insufficient but the GPs felt that eight hours would be sufficient.
- A few specific instances of where sub-optimal care had been provided were cited including one drug error.
- Lack of public involvement in the design of the service specification
- The public and GPs reported unhappiness that the contract had gone to a commercial profit making company. Some GPs commented that they believed this had been taken on by them as 'a loss leader'

The panel considered how the current contract was being provided.

CHB considered that having a contract in place was a great improvement, resulting in a better definition of overall care and responsibility. The contract had been in place for only two months but the following observations were made by CHB.

A contract monitoring system was in place and was working well. The key aim of the system was to facilitate admitting patients to hospital, discharging them as soon as they were able to return to their home and problem solving in relation to patient care plans. Patients need not be seen everyday, but in a planned way as identified by the nurses in consultation with the patients. Therefore, ward rounds were not considered a key part of the role as prior experience had shown that these were not universally made and had not resulted in greater benefits to patient care. Fortnightly contract monitoring meetings were taking place to review how the service was working and key performance indicators helped to inform these discussions. These key performance indicators, such as patient length of stay and inappropriate admissions, also helped to inform the monitoring of the contract.

A clinical governance system was now in place which was said to give greater assurance of the quality of service provided. Such a system was not in place before. The Practice plc had a named Clinical Governance lead and a tested model was in place to capture mistakes and near misses and for quality assurance. An issues/concerns folder had been provided to each unit in which doctors or nurses could note issues or give feedback on the service. Issues or mistakes were dealt with on the day and The Practice plc responded with a formal report within a week. There had been few complaints or significant events reported either before or after the introduction of this contract. However, the panel noted that it would expect to see an increase in reporting of all significant events with the start of a new service and better reporting protocols and the Panel would be worried if this was not the case.

An early warning tool was now being used to identify patients who might be at risk of deterioration in their condition. This should help ensure proactive care and the prevention of urgent events, thus avoiding the need for urgent medical review and intervention.

In the event of a patient requiring emergency care, emergency services using 999 would be called as in any other emergency situation. It was considered inappropriate practice to call a GP first in these circumstances as they would mostly have to call 999 in any case and it could result in time being lost before an experienced emergency practitioner arrived. Urgent (non emergency) calls would be dealt with by telephone advice and a visit if necessary, as in other settings. It was reported that The Practice plc was not always easy to contact. CHB was working with the ambulance service to identify different ways that paramedics could work with staff for urgent responses.

Patients in community hospitals had clinically complex problems, not medical problems requiring complex technology, as the community hospitals in Buckinghamshire did not have complex technology i.e. piped oxygen etc. The wards were changing from medically led units to nurse led units (50%-70% of patients could potentially be looked after in their homes by community teams). However, The Practice plc had discovered that the nursing skills across the community hospitals were variable but they were working with the staff to address this. CHB had put in a development programme for the nurses to support them through these changes.

A number of those giving evidence raised the issue of the variable number of beds in the community hospitals. CHB described how the number of beds did vary, as a tool developed by Katherine Fenton, Director of Nursing at South Central, was being used to assess current capacity and capability of nurses. By using this tool, the skills and ability of nurses could be compared against the complexity of patients and therefore identify the number of patients who could be cared for safely. Thus any reduction in the number of beds available for use related to the number of suitably qualified nursing staff available and not to the financial situation of NHS Buckinghamshire*.

Use of this had resulted in CHB beds being closed but the tool would also help the organisation identify when beds could be opened safely.

There was a difficulty in recruiting nurses and advanced practitioners and it was recognised that there was a need to make the job adverts more appealing to nurses who would be qualifying next year with degrees.

The nursing staff reported as follows:

Regarding Thame, current provision was on a par with the immediate past, i.e. daily visits of up to 1 hour. Issues with the current model focused around the unresponsive nature of the service, the timing of the visits, some difficult relationships depending again on the doctor visiting, support for families and the view that as yet there had been no 'complex' patients to test the system. It was noted that GP attendance at multi disciplinary meetings was not seen as

* This tool compares data on nurse-specific quality indicators, such as those for falls, pressure ulcers and nutrition. It is based on the 'acuity/dependency' tool developed by the Association of UK University Hospitals, which helps categorise patients depending on their conditions (for example 'stable' or 'unstable') and can then be used to help inform staffing levels, skill mix and workforce development needs. This is the only ratified tool that has been developed as an acute based measure

necessary and had not occurred in the past. A simple fit for discharge note was all that was necessary for the multi disciplinary teams to plan future care and treatment around discharge.

On the question of safety it was noted that the current system of provision of medical cover was not significantly different from that which was in place immediately prior to the new service and in either case it depended upon the level of dependency of the patients admitted and level of clinical support offered, including medical, nursing and allied health professional (AHP) support. As such the need to develop clear access and service criteria and to manage admissions avoiding medically unstable and complex admissions was seen as key to future success.

The idea that nursing staff had become de-skilled was strongly opposed in the discussion. Nurses did recognise the need to improve and advance skill sets in order to progress the development of the hospital as a nurse led unit. All staff were very much in support of such developments.

Regarding Buckingham, current provision was said to deliver between 30mins and 2 hours of GP input each day depending on patient need and 'jobs to do'. An average of 1 hour per day was estimated. Key issues around current practice centred on the need to develop improved working relationships which would be facilitated by attendance by the same GP more often. It was felt that this would avoid duplication and would ensure a greater level of continuity of care for patients and staff. The level of advice and support between visits was not considered appropriate as there were occasions when calls to The Practice plc on the dedicated number were not answered. Issues around the 'clerking' of patients after visits and especially on Friday afternoons were highlighted but it was felt that with good access criteria and transfer management systems it may be safe in individual cases for patients admitted on a Friday to be seen on Monday as they should be medically stable and in receipt of a treatment plan from referring teams.

When asked whether the staff would like to return to the previous system for medical cover, they stated that they would not like to do so although the idea of having the previous providers delivering to the current contract was attractive.

Additional comments raised by nursing staff were firstly, that the levels of clinical complexity presented by patients as experienced by staff were noted to be increasing over time. The implementation of tools aimed at monitoring the deteriorating patient were seen as helpful in reducing the need for urgent doctor attention or emergency situations and as such were well supported.

Secondly, clear evidence of training needs analysis for all nursing staff was shared during the meeting. All staff present were of the belief that the key to improving safety was not solely related to increasing medical support time but more to the development of nursing and allied health professional (AHP) skills in managing more complex patients.

The Practice plc was discussing a possible contract variation with CHB to include visiting later in the day to reduce issues developing in the night or week-ends. The Practice would also need an increase in hours to cover its involvement in developing units mature enough to be fully nurse-led.

The Practice plc felt they worked well with the nurses. It agreed that good working relationships were needed with local GPs. It was currently experiencing some animosity and one of their GPs had withdrawn from the service due to these difficulties.

Current gaps in the service that The Practice plc identified were attendance at multidisciplinary team meetings, time to talk to families and phlebotomy by nursing staff.

The Practice plc reported that they would have a surgery in Milton Keynes from December 2009 and planned that one of the GPs from this surgery would be available to provide medical cover to Buckingham Hospital. It was happy to employ GPs local to the hospitals so long as they complied with The Practice plc clinical governance arrangements and systems and processes.

The Practice plc reported that they felt they were providing a structured and safe service.

Summary of feedback on medical cover from surveys

- **Patients:** 22 out of 37 patients in the community hospitals were interviewed between 9th and 16th October using a structured questionnaire. All the patients responded positively to the medical care provided (consistency of GP and happy with the doctor). One patient said he was happy with the new doctor but against the new arrangements. Two patients had been in the hospital prior to Sep 1 and both reported improvements now. One reported that previously “you had to beg to see a doctor”.
- **Staff:** 37 staff working in the community hospitals responded to a confidential staff questionnaire. It was noted that two community hospitals’ responses had not been put in sealed containers so were not necessarily confidential. Of these, 18 thought the revised arrangements were the same or better while 19 thought the service was worse. The concerns related to lack of continuity of care, nurses feeling unsupported (less GP cover), and they would like a doctor presence at team meetings. The positive comments related to better continuity of care, more doctor time with patients, daily ward round now.
- **GPs:** 19 GPs (out of approximately 57 practices who do not provide medical cover to community hospitals themselves) responded to a questionnaire. 9 of these GPs had referred patients to a community hospital. 7 had tried and been unsuccessful in the past and 3 had not had the need. The quality of care was felt to be good but few had had experience of the service since September 09. The one GP who had, rated it as excellent. It would seem from some of the comments that some GPs do not understand the revised arrangements that had been commissioned.

4.7 Impact of changes

The table below outlines the beds and GP medical cover provided at each hospital before and after 1st September 2009

Hospital	Before 1 September 2009	After 1 September 2009
Amersham (Waterside)	<ul style="list-style-type: none"> • 18 beds open • 10 Hours medical cover 	<ul style="list-style-type: none"> • 18 beds open • 8 Hours medical cover
Buckingham	<ul style="list-style-type: none"> • 8 beds open • Average 1 hour per day 	<ul style="list-style-type: none"> • 8 beds open • 5 Hours medical cover
Chalfonts and Gerrards Cross	<ul style="list-style-type: none"> • Beds transferred to Waterside Summer 2008 	
Marlow	<ul style="list-style-type: none"> • 8 beds open • 10 -15 Hours medical cover incl F2 	<ul style="list-style-type: none"> • 8 beds open • 4 Hours medical cover
Thame	<ul style="list-style-type: none"> • 8 beds open • Around 25 hours including cover provided by GP Registrar. 5 hours for 2 month preceding new contract 	<ul style="list-style-type: none"> • 8 beds open • 4 Hours medical cover

The table below summarises the differences in service before and after 1st September 2009.

Before 1 September 2009	After 1 September 2009
<ul style="list-style-type: none"> Reactive service 	<ul style="list-style-type: none"> Planned daily visits
<ul style="list-style-type: none"> Medical cover provided for 1/3 of patients' time in hospital, 2/3 provided by OOH service 	<ul style="list-style-type: none"> Medical cover provided for 1/3 of patients' time in hospital, 2/3 provided by OOH service
<ul style="list-style-type: none"> Different arrangements in different hospitals 	<ul style="list-style-type: none"> Equity of service
<ul style="list-style-type: none"> Some hospitals served by training doctor or training GP 	<ul style="list-style-type: none"> All hospitals served by qualified GPs
<ul style="list-style-type: none"> Admissions and discharge criteria unchanged 	<ul style="list-style-type: none"> Admissions and discharge criteria unchanged
<ul style="list-style-type: none"> Medical clerking varied depending on the medical model on site 	<ul style="list-style-type: none"> Medical clerking within 24 hours (excluding week-ends)
<ul style="list-style-type: none"> Availability of GP support to families dependant on medical model on site 	<ul style="list-style-type: none"> Needs to be clarified within contract specification to coincide with GP visit time
<ul style="list-style-type: none"> Some GPs blocked admissions if not from own practice 	<ul style="list-style-type: none"> Admissions open to all GP patients
<ul style="list-style-type: none"> Practice varied but overall, GPs rarely attended team management meetings 	<ul style="list-style-type: none"> GPs not yet attending team management meetings
<ul style="list-style-type: none"> Patients with clinical (as opposed to medical) complexity cared for 	<ul style="list-style-type: none"> Patients with clinical (as opposed to medical) complexity cared for
<ul style="list-style-type: none"> No tool for early warning scores for patients whose condition is deteriorating 	<ul style="list-style-type: none"> Trigger tool to provide early warning scores for patients whose condition is deteriorating
<ul style="list-style-type: none"> Emergency response - 999 	<ul style="list-style-type: none"> Emergency response - 999
<ul style="list-style-type: none"> Urgent response – GP from local surgery 	<ul style="list-style-type: none"> Urgent response – telephone advice and visit if required

<ul style="list-style-type: none"> • Some patients treated by their usual GP but majority treated by different GPs (see map in Appendix 1) (continuity of care) 	<ul style="list-style-type: none"> • Majority of patients not treated by their usual GP. (continuity of care)
<ul style="list-style-type: none"> • Usually see the same GP while in hospital (continuity of care) 	<ul style="list-style-type: none"> • Usually see the same GP while in hospital (continuity of care)
<ul style="list-style-type: none"> • No formal systematic quality assurance system in place 	<ul style="list-style-type: none"> • Formal systematic quality assurance system in place
<ul style="list-style-type: none"> • GP hours available for providing medical cover difficult to define as previously reported as 'hours available'. It would seem 5 hours/week minimum 	<ul style="list-style-type: none"> • GP hours spent providing medical cover 4-8 hours (depending on hospital) but suggest more required while nursing development takes place
<ul style="list-style-type: none"> • No contract in place except for Waterside Unit 	<ul style="list-style-type: none"> • Contract and service specification in place
<ul style="list-style-type: none"> • No system for monitoring of performance 	<ul style="list-style-type: none"> • Fortnightly contract monitoring meetings including monitoring of key performance indicators

5 Conclusions

5.1 Service Specification

It was generally agreed that the service specification is right for supporting a sustainable model for providing in-patient care in the community hospitals. However, the Panel did feel that there were flaws in the writing of the specification, in particular:

- A failure to clearly understand how medical cover was being provided prior to 1st September (including the flaws in the old system that the Panel subsequently discovered).
- A failure to engage with GPs.
- Insufficient thought was given to the transition to a fully functioning, nurse-led model that would be capable of functioning with the level of medical cover provided under Option 1.

Notwithstanding these issues, the Panel concluded that these flaws did not lead to a result which had a detrimental impact on patient care and safety, though the hours may need to be re-negotiated. (Please see recommendations).

5.2 Question of Substantial Variation

The contract between NHS Buckinghamshire and CHB for the provision of community hospital services remained the same. Given that the contract in question is just for 10 hours a day, five days a week, CHB was actually only re-tendering the medical cover for in-patients for one third of their care. The other two thirds remained with the out of hours service (evenings, nights and week-ends). The service to the Waterside Unit (largest ward) remained virtually the same.

Questions were raised regarding not being able to see one's own GP when in hospital under the new contract. It was identified that there were different arrangements in different hospitals.

- Patients in Marlow Community Hospital were seen by a foundation year 2 trainee who was overseen by one GP who also visited.
- In Thame, patients had usually been seen by GP registrars who rotated every three months. For two months prior to September 1st, this changed and a GP from The Rycote Practice visited for one hour a day.
- In Waterside and Chalfonts Unit patients were unlikely to see their own GP.
- Patients in Buckingham hospital were more likely to be able to see their own GP (i.e. if they were registered with a Buckingham practice).

Thus in the majority of cases, the likelihood of seeing one's own GP was minimal (see map I appendix 1) yet this was seen as a substantial change from the public perspective. From a professional viewpoint, there is a debate over whether the benefit of being seen by one's own GP in this setting outweighs the benefit of being seen by another GP who can bring a fresh viewpoint. Of course, during weekdays, patients' surgeries are open so GPs in those surgeries are always contactable to discuss patients' care should the need arise. Once in the community hospital, patients are now seen usually by the same GP or one of two GPs.

The table on page 15 indicates the average number of hours of medical cover provided pre and post September 1st 2009. It had been reported that previously some practices had provided many hours cover. On examination, it would appear that what was being reported was GP availability, not necessarily, care provided. The most concern was raised in Thame. However, it was discovered that once the GP registrar placement was terminated, cover came from one local practice and only amounted to five hours a week. No concerns had been raised regarding this as it was presumably felt to be adequate. The hours suggested under the new contract were to support a nurse-led unit and were based on minimum local GP input to date and benchmarking with other hospitals.

The Panel considered the guidance on the question of "substantial variation" as detailed in Section 4.4 and concluded that the change in medical cover arrangements was not a substantial variation of service.

5.3 Tender

Due to the size of the contract, an open tender was required in line with NHS Buckinghamshire's standing financial instructions and EU procurement legislation. Therefore in going out to open tender, CHB had acted in accordance with the PCT's procedures.

5.4 Decision to Award Contract

The decision to award the contract was appropriate as:

- The procurement was handled properly.
- The contract was let properly based on the bids submitted.
- The tender did include alternative hours version. The Practice plc was the winner on both bases.

There was therefore no case to revoke the contract.

5.5 Links with local GP practices

The General Medical Council's "Good Medical Practice" guidance states that GPs are responsible for the care of their patients. However, when a patient is referred to another organisation such as the community hospital, the doctors in that organisation are responsible until the patient is referred back to their

GP. During that period, the patient's GP still has a duty to collaborate and communicate effectively with colleagues looking after their patient.

It is also vital for local GPs to have close links with community hospitals to help ensure community hospitals have a future and are developed and used in such a way as to provide community services which might previously have been carried out in acute or other settings.

The panel concluded that the public's concern that the tender was awarded to a commercial organisation was unfounded. GP practices are similarly profit making businesses, which contract independently with the NHS. Thus there is no material difference between the two types of organisation.

5.6 Nurse/therapy led units

Nursing development opportunities will reduce dependency on medical input. However, time was required for this transition from a medical to a nursing model. The nursing staff do not consider the current levels of medical support to be unsafe when considering the numbers of beds provided for and the levels of complexity being managed. All staff were very supportive of the community hospitals being run as nurse or therapy managed units.

It was felt by the nursing staff that improvements in current service should focus upon the following:

- The development of clear admission and access criteria aimed at managing the medical and broader clinical needs of patients in line with service provision.
- Improving the level of support provided by doctors in between visits by improving telephone support and ad hoc visit options.
- Improving the working relationship between the nursing and visiting medical staff from The Practice plc.
- Improving the skill sets and advancing the levels of nurse knowledge for a more complex client group.
- Ensuring that the public were aware of the role of the doctor and the role of the nurse.

5.7 Links with other service changes

The PCT is planning to review the community hospital beds, as part of its development of the integrated care model, and to support its aim of shifting patients from acute hospitals to community care.

There are also significant discussions taking place across Buckinghamshire and Berkshire over the level of acute hospital beds required in the future, triggered by issues at Wexham Park Hospital.

There is a link between these pieces of work, and any changes to the community hospital beds will have implications for the medical cover arrangements, which will need to be taken account of in due course. This

may be the time to reconsider community hospital services and how they are delivered.

5.8 Hours of provision

The NHS is a complex organisation working in an unpredictable environment and therefore needs adaptable systems and people. It is proposed that the contract for medical cover has flexibility based on learning from experience, and that the lower hours do not in all cases allow for this. We have therefore made recommendations about the number of hours which should be provided.

6 Recommendations

Recommendation 1 - Substantial variation

There are different perceptions as to what constitutes substantial variation. A tool is needed to help identify what constitutes substantial variation, which could be applied in the future. Other areas use such tools and NHS Buckinghamshire should discuss these with Buckinghamshire Overview and Scrutiny Committee with the aim of agreeing such a tool.

Recommendation 2 – Number of hours of medical cover

The tender was offered on a lower and higher hour basis dependent on the size of the ward (4/5/8 and 8/10/16 hours a week). The contract was agreed on the basis of the lower level. While this might be sufficient once the nurse-led model is fully developed, it was felt the hours needed to be re-negotiated for a temporary period on an individual hospital basis while this development occurred. It is proposed that the contract for medical cover has flexibility based on learning from experience. The starting point could be that the medical cover is provided between 4/5/8 and 8/10/16 hours a week while the nurse development programme is completed in order that the units can become mature enough to be fully nurse-led units. A timescale should be agreed for this transition period and the service continually reviewed to ensure the contract meets service requirements. As The Practice plc would have been awarded the contract on the basis of either the lower or higher number of hours, there is no reason to re-tender the medical cover.

Recommendation 3 – Multidisciplinary team working

The doctors providing medical cover should discuss with the nurses how best to enhance their team working, including the points in 5.6.

Recommendation 4 – Future role of community hospitals

There is an urgent need for NHS Buckinghamshire to define the role for its community hospitals within its commissioning strategy. If this results in a significant change in the level of community beds this would need to be taken account of in the hours of cover provided in the future.

Recommendation 5 – Links with local GPs and League of Friends

NHS Buckinghamshire and Community Health Buckinghamshire should explore ways of creating closer links with each community hospital's League of Friends and local GPs.

Recommendation 6 – Provision of information

NHS Buckinghamshire should immediately carry out an awareness raising campaign aimed at both the public and health professionals to publicise and explain the services provided at each community hospital.

Recommendation 7 – Patient and public involvement

CHB should have involved patients or carers in the drawing up of the service specification. The PCT should re-double its efforts to ensure patient and public involvement informs its commissioning of services.

Recommendation 8 – Accountability to the Board

Community Health Buckinghamshire should report back to the Board of NHS Buckinghamshire after three months to confirm that all identified issues have been addressed.

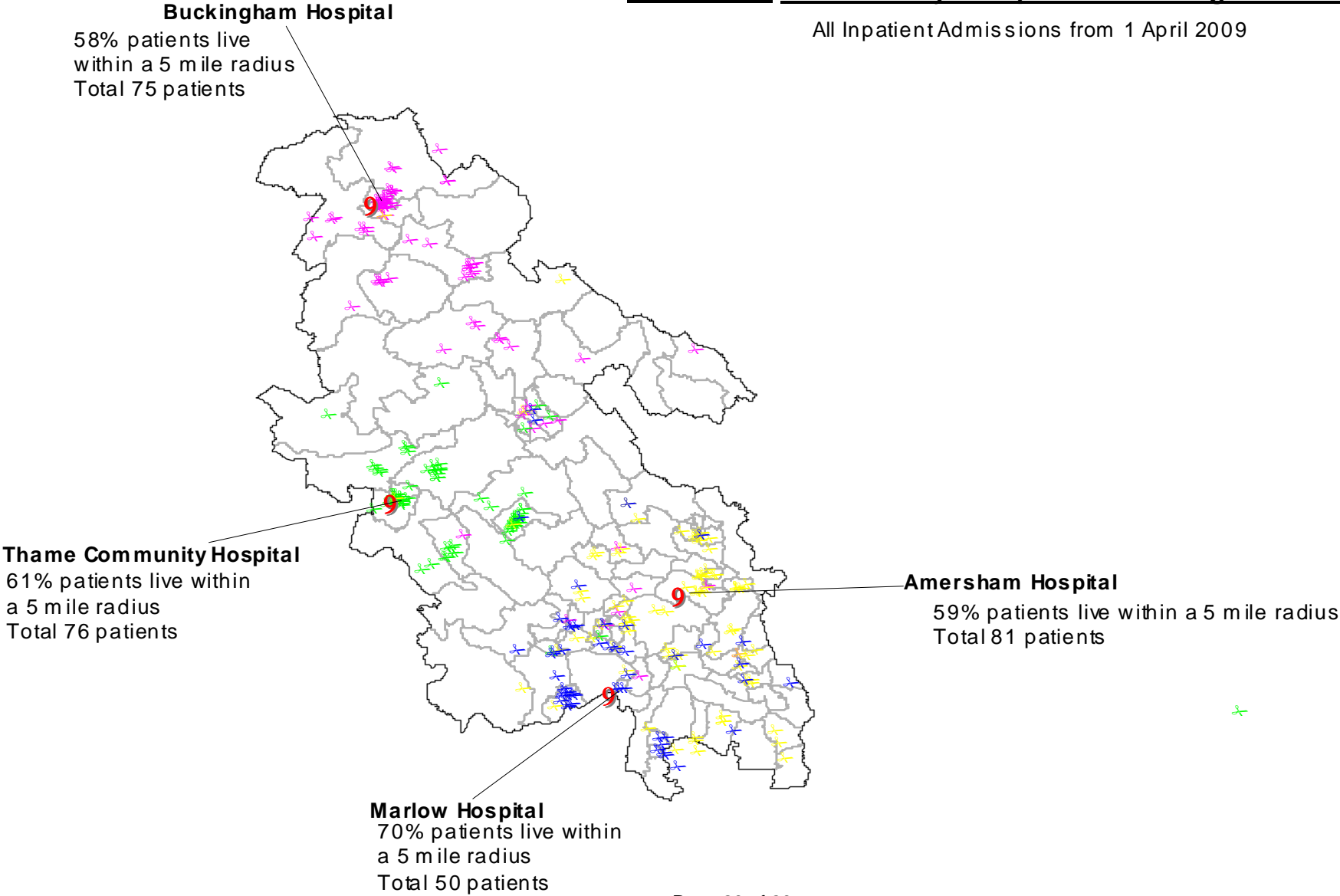
APPENDICES

Appendix 1 Map of community hospitals showing patient distribution.

Appendix 2 Questionnaires

Appendix 1 Community Hospitals showing Patient Distribution

All Inpatient Admissions from 1 April 2009



Appendix 2

COMMUNITY HOSPITAL STAFF QUESTIONNAIRE



Dear colleague

The PCT is carrying out a review of the medical cover provided to community hospitals in Buckinghamshire. As part of this review, it is keen to gain the view of staff working in the community hospitals. It would be very helpful if you completed this short survey and left it in the envelope/box provided by the ward manager before **Monday Oct 19**. All responses will be anonymous and confidential. Thank you so much for your feedback.

BEFORE 1/9/09

POST 1/9/09

1. Which hospital do you work in?

2. What do you think about the quality of medical support?

Excellent Good Average Poor

Excellent Good Average Poor

3. What do you think about the amount of time spent by GPs in the hospital?

Plenty Sufficient Too little

Plenty Sufficient Too little

4. What do you think about the continuity of GP care provided?

Excellent Good Average Poor

Excellent Good Average Poor

5. What is your view on the response time for GP attendance when requested by hospital staff?

Excellent Good Average Poor

Excellent Good Average Poor

6. Overall, what impact do you feel the change in medical cover since 1st September has had on patient care?

7. What impact has the new contract for medical cover had on nursing/therapy staff development?

8. What impact has the new contract for medical cover had on a shift basis?

Do you have any other comments?



PATIENT QUESTIONNAIRE

(For patients previously in a Community Hospital)

1. Which hospital were you in?
2. When were you there?
3. How long were you in the hospital?
4. Were you seen by a GP? Yes No Don't know
5. If yes, how many times? Daily Often Sometimes Once
6. If more than once, did you see the same doctor each time? Yes, same one 2 different ones Several different ones Don't know
7. Did you already know the doctor/doctors? Yes No
8. Did you see the doctor as much as you wanted to? Yes No
9. Do you have any other comments?



QUESTIONS FOR GPs WHO DID NOT PROVIDE MEDICAL COVER TO COMMUNITY HOSPITALS

Dear colleague

The PCT is carrying out a review of the medical cover provided to community hospitals in Buckinghamshire. As part of this review, it is keen to gain also the views of GPs who have not provided medical cover to community hospitals. It would be very helpful if you completed this short survey (5 questions) and send it to Clare Blakeway-Phillips, at gpcover.enquiry@buckspect.nhs.uk by October 19 2009. These responses will be completely confidential to Clare Blakeway-Phillips. Thank you so much for your feedback.

1. Have you referred a patient to a Community Hospital in the past year?

Yes No

2. If not, why not?

3. If yes, what is your view of the quality of care your patient/s received?

- a) Before 1st September 2009 Excellent Good Average
 Poor
- b) Since 1st September 2009 Excellent Good Average
 Poor

4. Why?

5. Do you have any other comments?