

South East Coast

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Clinical  
**senate**

**The Clinical Co-Dependencies  
of Acute Hospital Services:**

A Clinical Senate Review

Executive Summary

December 2014

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## Executive summary

Health care systems and their commissioners, in partnership with providers and the public, have to consider the most appropriate configuration of their hospitals so that their clinical services are adequately supported by other specialties, and they are fit for purpose, sustainable, accessible and deliver the highest possible quality of care. There is now a major national focus on the future shape and function of hospitals, triggered by the Royal College of Physicians' Future Hospital Commission, NHS England's Urgent and Emergency Care Review, Monitor's report 'Smaller Acute Providers' and most recently NHS England's landmark Five Year Forward View and the Dalton Review.

Whilst there are many factors that will need to be considered in hospital configurations, the clinical relationships and dependencies of hospital-based services on each other is key, whatever their size. There have previously been targeted reviews of selected specialist service dependencies, previous work in London on the core service dependencies in acute hospitals, and now NHS England national specifications for a wide range of specialist services. The Kings Fund has also recently published their review of the evidence for the reconfiguration of hospital services, in which certain key co-dependencies are described. To date though, there has not been work published on the mutual dependencies of the full range of services found in typical acute hospitals, particularly outside of large conurbations where hospitals are generally more widely dispersed.

On this basis, the seven Sussex CCGs (through their Collaborative) sought from the South East Coast Clinical Senate (SECCS) generic, evidence-supported clinical advice on the necessary relationships between acute hospital services, to inform their future local discussions and planning. The remit of the review was to provide generic advice, not region or locality-specific, and to identify evidence where it exists, or clinical consensus where it did not, to describe what services needed to be provided in the same hospital (either based there, or inreaching), and what could be provided on a networked basis. It is therefore hoped that this report will be seen as helpful in other counties and regions across England.

A literature review was conducted, and a clinical reference group established to lead the work. Eleven acute services were chosen as the principle components of current acute hospitals: A&E (Emergency Medicine), Acute Medical Take, Acute Surgical Take, Critical Care (ITU), Trauma, Vascular Surgery, Cardiac, Stroke, Renal, Consultant-led Obstetric Services and Acute General Paediatrics. In our region, the work on co-dependencies that the cardiovascular strategic clinical network (SCN) was already undertaking for the commissioners was integrated with the clinical senate's project, and all four of the SEC SCNs participated in this review.

The clinical dependencies of these 11 major acute services on 52 hospital based services was reviewed, and a four-level system for describing the strength of the dependencies was developed: Purple (needing to be based on the same site); Red (visiting or inreach services sufficient); Amber (patient could transfer to another hospital or site for ongoing care through network arrangements); or Green (loose or no direct relationship). The CRG's early conclusions were tested with wider



clinical and patient and public engagement at a clinical senate summit (held in September 2014) and the methodology and conclusions further refined.

Influencing the purely clinical considerations are a range of critical cross-cutting themes impacting on the location of hospital-based services or on planning new models of provision, which must be taken into account:

- The patient and public representatives participating in this clinical senate work made a number of strong and clear points. The driver for any service change should be an improvement in patient outcomes and experience; the importance of communication, both between professionals across patient pathways, and between the professionals and patients and their carers; making services as local and accessible as possible, including early repatriation to local care as soon as appropriate if the patient had required transfer to a specialist centre; ensuring early and meaningful dialogue with the public and patients about any proposed service change (recognising the wide demographic range of users of the NHS whose views should be taken into account); that changing the configuration of services cannot alone be relied on to fix underlying quality issues; and that for some patients, particularly the frail elderly, a more local 'bronze standard' service may be preferable to a 'gold standard' service that requires the patient to be treated far from their own and their family's home.
- Ambulance and transport services are key enablers of greater networking of hospital services, including by extending the competencies and responsibilities of the paramedic profession. However, they are a finite resource, and the additional demands on these services, such as for secondary transfer of patients to specialist centres and back, must be fully considered in any service change for their impact on primary conveyance from home to hospitals and back from hospital to the community.
- There are major workforce challenges in delivering the needed 7 day and 24/7 services both in hospitals and in the community, which of themselves are fundamental drivers for change. This relates not just to a pressure to centralise services, but also to rapidly align workforce planning with future NHS and social care needs and new models of care, and to increase the flexibility and adaptability of the workforce to mitigate against shortages in key areas, as well as recognising where shortages do and will exist, and addressing them urgently.
- Due importance should be given to the teaching, training and research agendas whenever service change is considered. There are opportunities from greater integration of and coordination between providers for all these three areas, which will maximise the skills, recruitment and retention of the workforce, and research activity (and income), but there are also significant risks if pathways become fragmented through poorly planned reconfigurations or expansion in alternative providers.

It was clear from the evidence review that in only a few areas were there randomised controlled trials or high quality formal studies in this field to guide the assessments. However there were many guidelines, particularly from the medical royal colleges and specialist societies, to refer to which specified some of the necessary relationships. In addition, a number of designated specialties, such as Major Trauma and Vascular Surgery, have NHS England national definitions and requirements as produced by the national clinical reference groups, which are referred to. In



areas without specific guidance, the clinicians involved in this project worked to achieve a consensus, based on experience and judgement.

Once the clinical dependencies grid was completed, it became possible to identify core groupings of services required to be based in the same hospital site. In particular, hospitals with emergency departments (A&Es) receiving all acute adult patients (an 'unselective take') need on-site acute and general medicine, acute surgery, and critical care (ICU). Therefore such hospitals need to provide the supporting clinical services that are required by all or any one of these four core inter-related acute specialties, and these are described in the report and can be read off the grid. These amalgamated requirements delineate what an emergency hospital should provide on-site as a minimum.

The dependencies of the other more specialist services were also reviewed, and are identified. Other than services such as Major Trauma or Vascular Surgery hubs, where requirements are clearly specified, the 'spoke' services in these networks, such as Trauma Units, Vascular Surgery spoke units, or non-interventional cardiology services, are likely to be more heterogeneous, and dependent on the nature of and distance from their network hub, and the existing co-location of related services.

Note should be made that rapidly available acute mental health services (liaison psychiatry) was considered a key requirement of all reviewed acute services.

Telemedicine-assisted ways of working is identified as a powerful enabler of more effective networking and leveraging of specialist services over a wider geographical area, thereby reducing unnecessary patient travel and inconvenience. The impact of development and wider roll out of such technologies will of course affect the grid ratings shown in this report.

It is important to understand that clinical senates are advisory bodies, not statutory, so the recommendations from this report are not mandatory. Given the absence of a large evidence base for this co-dependency review, and a reliance on clinical consensus and judgment in many areas, it must be also be acknowledged that consensus of any kind is open to bias on a range of fronts, is not cast in stone, and is challengeable. However this independent, clinical report aims to provide a baseline from which to have detailed local discussions about necessary co-dependencies and co-locations, and to explore different ways in which services could be delivered if not physically based on the same site.

Finally, developing strong and more integrated relationships between provider organisations and their clinicians within and across regions is essential to maximise the range of options available to provide the highest quality services in the most accessible and sustainable way possible.

