NHS NORTH YORKSHIRE AND YORK
BRIEFING PAPER ON WHITBY HEALTHCARE
STRATEGIC OPTIONS AND INTERIM PLANNING

1. Purpose of the paper.

1.1. This paper provides a summary of the strategic options for hospital type services in Whitby, and identifies the interim solution for 2010-11 as part of taking forward the strategy in the short and medium terms.

2. Introduction

2.1. Whitby is a relatively isolated coastal town surrounded by the rural areas of the Esk valley. The area is served by six General Practices with a combined population of 27,427.

GP Practice	Registered Population
Whitby Group Practice	14,975
Staithes – Croft and Johnson	2,653
Egton – Drs Fester and Horner	2,291
Danby – Drs Pearce and partner	2,316
Sleights – Drs Emad and partners	3,615
Sandsend – Dr Suckling	1,577
Total	**27,427**

2.2. The area is served by Whitby community hospital, that provides a limited range of healthcare services, including inpatient wards, outpatient clinics, minor injury unit, endoscopy and minor surgery services.

3. Strategic context

3.1. Rurality and health inequality. The area is geographically isolated with many population groups being over 45 minutes from the nearest large hospital. The area includes some of the most deprived wards within the PCT, including demonstrating some of the worst health outcomes. For diseases such as coronary heart disease, the local incidence is 50% greater than the PCT average.

3.2. Critical mass and national guidance. Whist the factors of rural isolation and health inequality suggest a need for greater local access to services, the national policy drivers for clinical quality standards increasingly demand minimum levels of patient catchments populations, and levels of activity. This presents challenges to smaller district hospitals (such as Scarborough) and even more so to the provision of a range of services at community hospitals.

3.3. Strategic importance of the area. The potential non-elective catchment population of Scarborough and North East Yorkshire Healthcare NHS Trust (SNEY) is over 200,000; however, the actual elective catchment population (as demonstrated through referral patterns) is closer to 150,000. Should that level decline further, a number of the Trust services may become unviable, including some of the currently provided cancer services. Thus the 27,000 patient population in the Esk valley, has a strategic significance to SNEY, and to the delivery of the Scarborough locality strategy.

3.4. The competing strategic drivers present challenges to the development of a coherent, clinically and financially sustainable strategy for healthcare services in Whitby.

4. Current situation

4.1. Since April 1st 2010, the range of services provided at Whitby hospital has been slightly reduced.

4.2. The planned establishment of the midwifery-led unit at Scarborough Hospital has seen the end of inpatient maternity services in Whitby.

4.3. An inability to maintain staffing levels resulted in the temporary suspension of overnight Minor Injury Unit (MIU) services, pending further recruitment.

4.4. Concerns regarding the quality of the theatre estate prompted the suspension of Gastrointestinal (GI) endoscopy and minor surgery under General Anaesthesia (GA).

4.5. Although the majority of MIU services, the provision of two wards, outpatient clinics, and some minor surgery remain, the unit is seen by the local population (including the clinical population) as under continued threat and suffering a 'death by a thousand cuts'.

4.6. The PCT has commissioned a number of recent reports into the safety and appropriateness of services in Whitby.

4.7. The Turner and Townsend report identified the necessary capital work required to bring the theatre suite to compliance with national standards.

4.8. A JAG[1] assessor performed a pre-JAG assessment of the unit and whilst identifying a number of areas of improvement necessary for full JAG accreditation status, she did indicate endoscopy could continue at the unit if there was a deliverable action plan in place.

4.9. Two consultant anaesthetists from the British Association of Day surgery (BADS) conducted a review of day surgery general anaesthesia at Whitby. Although they did not recommend re-establishing general anaesthesia as previously delivered, the option of a GP delivered service (with appropriate governance and support from SNEY consultants) remained in their view a viable option for the short to medium term (that is within 5 years).

5. Locality strategy and community hospitals

5.1. The PCT and partners have developed a locality strategy and the strategic options for Whitby need to support delivery of that strategy. The key elements from the strategic workstreams are:

- Urgent Care
- Rehabilitation and intermediate care
- Elective care and Diagnostics
- The expert consulting system supported by strategic alliances

5.2. The strategy for Whitby Hospital (as all community hospitals) must recognise the need for effective use of capital resources. The current site is excessively large, badly sited, provides poor patient access, and has and will continue to require significant maintenance.

6. Healthcare need for services in Whitby

6.1. The issue is not that of addressing all the health needs of the population in Whitby and the Esk valley, but that of which hospital type services should be based in a Whitby healthcare facility.

6.2. From a combination of the Health Needs Assessment of the local population and the requirements of the local strategy, the key themes, therefore, will be:

- to provide local, prompt access to assessment and treatment for those needing urgent care;

[1] JAG – Joint Advisory Group on Gastrointestinal Endoscopy

- to provide local access to a range of rehabilitation services, delivering intensive rehabilitation and support to effectively re-able patients;
- to provide local, prompt access to diagnostic tests and where desirable minor surgery;
- to provide outreach specialist outpatient services to promote access and to support patient management by local GPs.

6.3. **Urgent Care**. For urgent care it is necessary to more clearly define the role of the MIU (that is primarily nurse led) and of associated urgent care. The unit has treated patients with conditions beyond the scope of a traditional MIU, and continued provision of such 'MIU Plus' should be more clearly defined. The adoption of a Resident Medical Officer (RMO) role (as opposed to the current medical staffing arrangements) may facilitate the development of an acute assessment area. However, analysis of clinical appropriateness of care and activity volumes will be necessary to establish the viability of such a unit. The historic activity flows through the over-night MIU facility (on average less than one patient per night) suggest 24/7 MIU provision in Whitby is not necessary or cost-effective.

6.4. **Rehabilitation**. Whitby runs two inpatient wards, providing a range of care. Although a large number of patients accommodated on the wards are nominally there for rehabilitation, the unit does not offer intensive rehabilitation to an optimum model. There is a requirement for greater input from therapists and a focus on the units' actively rehabilitating patients to return home as soon as possible.

6.5. The concept of 'GP beds' in part reflects a need for a place of safety for vulnerable patients, and as such this need is increased by the lack of overnight district nursing and community services. Discussions with local GPs suggest that the current resources may be used more appropriately to strengthen community infrastructure, and more intensively support a possibly smaller hospital bed base.

6.6. It is considered there will remain a need for some form of inpatient palliative care facility, probably along very similar lines to the current highly regarded Heather unit.

6.7. **Diagnostic services**. Much of the focus on diagnostic services will be on GI and urological endoscopy. It is likely the large majority of patients in the area who need endoscopy can have the procedure in a properly configured unit in Whitby. For the unit to function effectively the PCT and partners will need to design usage to maximally use such a facility. The hospital currently provides a 10 bedded day case unit annexed to one of the wards, which appears to be sufficient for the likely volume through the unit (even with greater usage).

6.8. Where spare capacity allows the provision of minor surgery in the unit this can be done alongside sessions for endoscopy. The forecast case-mix needs to be determined by primary and secondary care clinicians.

6.9. **Outpatients.** For a large number of specialities outpatient services can be appropriately delivered in a location away from a major hospital. Thus, there should be a continued provision of such services in Whitby. This will require close working and strategic alliances with partner agencies, particularly SNEY and South Tees Hospitals NHS Trust.

6.10. The business case developed in 2006[2], included a proposed service configuration similar to that arsing from the above strategic themes. This

[2] *Bid for Community Hospital Funding to Modernise Local Services to Deliver Real Benefits to the Local Population in Whitby*. North Yorkshire and York Primary Care Trust.

indicated a significantly smaller building footprint (6,425m^2 as against 10,515m^2) than currently provided at Whitby Hospital.

7. Strategic options

7.1. The proposed options are:

a) Status quo. This would provide a degree of ‘stability’, in that there would be no planned changes to service in the short-term. However, it would provide no attempt to satisfy the strategic needs and fails to address the outstanding issues.

b) Close Whitby hospital. This would provide a potentially large financial saving and remove further uncertainty as to its future. However, it would fail to support delivery of the strategy, is only a longer-term proposal, and would produce significant political and clinical hostility.

c) Fully develop Whitby hospital. This would require maximising the use of the current hospital site. Whilst this would be politically achievable, it is will inevitably be obstructed by national clinical standards and the needs of the wider health economy. The result may be poorer quality care for greater overall cost.

d) Relocate services to a new build. As discussed earlier, the needs for service provision based around urgent care, rehabilitation, diagnostics, and outpatient services suggests a much smaller facility than currently provided. Whilst there would be undoubted benefits of service provision and costs of capital in a smaller unit, the benefits would be greatly increased by co-location with a social care facility. NYCC have a strategic aim to vacate the local authority care home in the vicinity, which would provide the possibility of relocating hospital services alongside a 50-60 extra-care home complex.

e) Relocate services and implement an interim solution for Whitby Hospital. This option is essentially the same as option ‘d’ but with a short-term proposal for the development of services within the existing resources.

8. Option appraisal

8.1. The evaluation criteria developed by the PCT, applied to the options provides the following scores:

Criteria	Un-weighted Scores Option a	Option b	Option c	Option d	Option e
Effectiveness and cost-effectiveness	5	7	2	6	8
Quality, safety and clinical governance	5	10	3	7	7
Patient and carer experience	6	1	8	6	7
Feasibility and sustainability	2	2	1	7	7
Policy and strategy	4	2	2	7	8
	22	**22**	**16**	**33**	**37**

9. Interim solution

9.1. We propose an interim solution based on implementing as much of the preferred service model as can be provided within current resources and physical facilities.

9.2. The main elements of the interim solution are:

- Invest in the necessary structural work and equipment replacement to bring the current theatres to compliance with national standards.
- Maximally use the current theatre accommodation to improve local access to services and to gain most efficient use of services.
- Reconfigure rehabilitation and community services to more fully embrace the concept of the 'virtual ward' where the hospital inpatient services and community services provide mutual support, through establishing 'Hospital at home' type services (as used successfully recently in Ryedale) and by increasing the effective rehabilitation provided in Whitby Hospital.
- Redesign MIU on a shorter opening time, and assess how best to use the current medical staffing and out of hours resources to support urgent care.
- Develop planning with NYCC Adult and Community services to identify options for a 'New Whitby Hospital'.

9.3. The recent Turner and Townsend report identified the cost of the theatre upgrade at £347k. With the additional cost of replacement endoscopy washers, and VAT this cost may approach £500k. However, we believe the investment is necessary to:

a) Provide local access
b) Provide capacity to an electively challenged health economy
c) Maintain the elective catchment of the locality.

9.4. Furthermore, investment will send a strong statement of intent to the local, including clinical, population and this may allow delivery of the wider service reconfiguration.

10. Actions

10.1. The PCT proposes to:

- Support the plan for capital investment into the Whitby theatres.
- Establish a project team to properly develop a costed business case and project plan for the work.
- Re-establish endoscopy services at Whitby with the acceptance of a planned suspension when the timescale for the capital work is confirmed.
- Discuss with SNEY their desire to maintain GA services at Whitby.
- Develop a plan for the strengthening of community infrastructure by shifting resources into community services.
- Develop and implement a model for the revised management of MIU.

11. Conclusion

11.1. There is a clear need to complete further work on the Whitby strategy. However, it is important that the development of services and the vision for hospital based services in Whitby is established and opportunities for service redesign are realised. The PCT should pursue options for a ‘New Whitby Hospital’ whilst confirming the vision for a locally provided facility.

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