Fit for the Future: Developing and using an 'evidence file'

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To the APHA Scientific Meeting November 6 2007



A brief history

The challenge

The response

The result

FIT FOR THE FUTURE EVIDENCE FILE

NHS South East Coast

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What and why

- The purpose of this pack is to provide managers, clinicians and other stakeholders, including the public and the media, with an evidence-based information resource
- It is designed to answer (some) of the questions posed during the Fit for the Future process and stimulate local discussion
- The pack has been formatted purposely in PowerPoint[™] to allow audience presentation and selection of content to audience need
- The intention is to add to or modify the pack in response to progress on Fit for the Future

Structure of pack

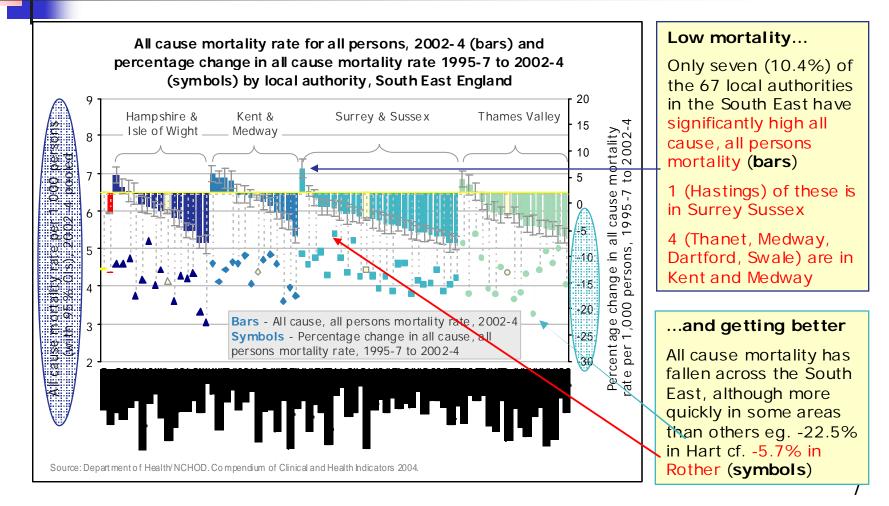
- Section 1: Demography
- Section 2: Health status
- Section 3: Health inequalities
- Section 4: Case for change
- Section 5: Redesign principles and factors
- Section 6: Urgent and emergency care
- Appendix: Supplementary charts

SECTION 3

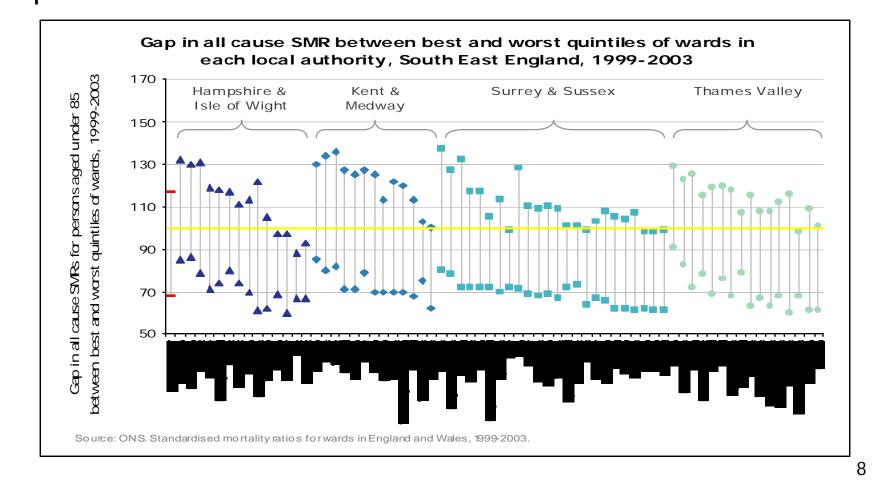
HEALTH INEQUALITIES

See also charts in the Appendix

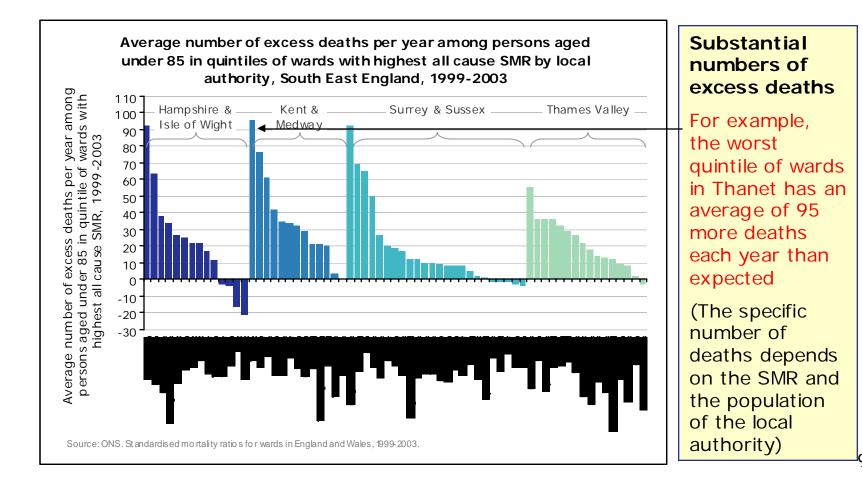
Mortality rates compare well with the national average



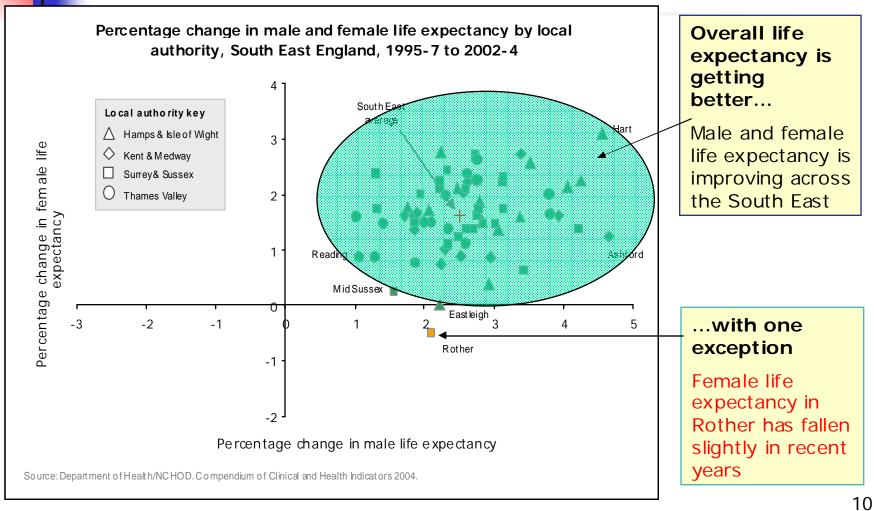
Nevertheless, health inequalities are found in all parts of the South East



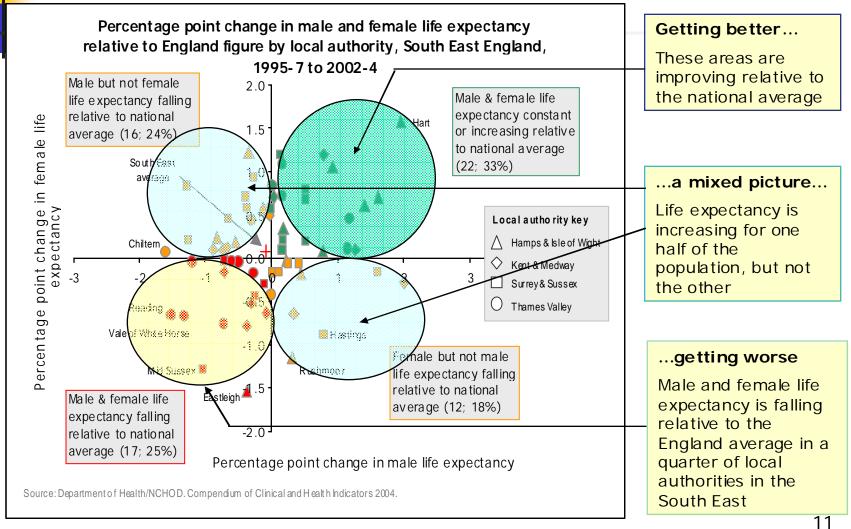
And these inequalities correspond to large differences in the numbers of deaths



A similar pattern emerges when life expectancy is examined



Although some places are losing ground...





CASE FOR CHANGE

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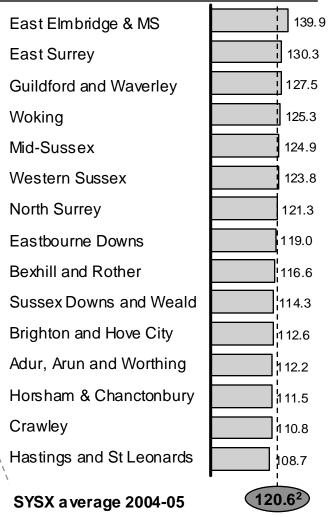
SYSX spends more on healthcare than other SHAs

£m per 100k unified weighted population

SHAs¹, 2003-04

North West London114.9South West London114.9South East London114.9Avon, Gloucestershire & Wiltshire111.3Surrey & Sussex110.4North Central London110.2Thames valley107.9Hampshire & isle of Wight106.7Nortolk, Suffolk & Cambridgeshire105.2West Yorkshire104.7Bedford & Hertfordshire103.7Northumberland, Tyne & Wear102.6South Yorkshire102.6Kent & Medway102.5South Yorkshire101.8West Midlands South101.4Trent101.2Leicestershire, Northamptonshire & Rutland101.4Shropshire & Staffordshire101.0Cheshire & Merseyside100.9Cumbria & Lancashire100.9Ounty Durham & Tees Valley99.3Birmingham & The Black Country98.2North East London97.5England average 2003-04104.6 ¹			
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	Birmingham & The Black Country	98.2	1
England average 2003-04	North East London	97.5	
England average 2003-04		•	
	England average 2003-04		

PCTS within SYSX², 2004-05



*Note SY SX figure from SHA cut and average for PCTs within SY SX are not same as sources are different (including different y ears) Source: 1 SHA cut from Programme Budget Spend, 2003-04; 2 PCT cut from SY SX PCT finances 2004-05 team analysis

July 22 2005 Version SYSX has high waiting list admissions

000s per 100k HCHS age and need weighted population, 2003-4

SHAs	Total admissions ₁	Waiting List admissions	A&E attendances	Emergency admissions	ОР* ₁
Dorset and Somerset	26.	6 8.5	28.2	8.8	a b b b b c c c c c c c c c c
Leicestershire, Northamptonshire and Rutland	26.2		24.2	9.1	6 3.8
North & East Yorkshire and Northern Lincolns				9.5	84.3
Shropshire and Staffordshire	25.4		29.7	8.5	83.0
Avon, Gloucestershire and Wiltshire	24.9		38.6	8.4	97.9
South West Peninsula	24.7	8.7	32.7	9.0	83.9
Norfolk, Suffolk and Cambridgeshire	24.5	9.8	27.0	8.6	98.5
Northumberland, Tyne & Wear	24.2	10.6	G1.1	9.1	119.0
Surrey and Sussex	23.9	9.8	34.9	8.5	99.8
Cumbria and Lancashire	23.8	9.1	28.7	8.8	79.7
Trent	23.7		25.6	8.8	\$1.7
Hampshire and Isle of Wight	23.6	8.8	26.6	9.1	90.0
South Yorkshire	23.4	7.6	35.9	8.7	125.7
Bedfordshire and Hertfordshire	23.2	9.7	29.0	8.3	94.5
Thames Valley	23.1	¦8.2	31.6	8.2	107.2
West Yorkshire	22.8	9.4	34.4	9.1	100.9
County Durham and Tees Valley	22.4	7.2	27.3		86.7
South West London	·21.9	·8.2		2.6 7.6	140.9
Greater Manchester	i21.9	8.4	35.9	8.3	116.7
West Midlands South	21.5	7.8	34.2	7.9	91.8
Cheshire & Merseyside	21.4	7.6	41.4	9.1	112.7
South East London	21.4	8.4	37.2	7.4	127.1
North West London	20.9	8.1	46.	1 7.2	133.5
Birmingham and the Black Country	20.7	7.6	32.4	8.1	115.7
North Central London	20.0	۲.6	51	.6 7.3	19
Essex	1 <mark>9.4</mark>	7.6	30.4	6¦.8	92.8
North East London	18.8	6.0	36.7	7.1	107.3
Kent and Medway	17 <u>'</u> 3	6.8	34.1	7.0	91.2
England average * First and subsequent attendances, and first and s	22.7	8.5	34	8.4	104

* First and subsequent attendances, and first and subsequent DNAs Source: HAS; Public HES; team analysis

14

SHAs

Surrey and Sussex has above average attendances in A&E, minor injury units and walk-in centres

unscheduled attendances and admissions, 2003–04 Unscheduled attendances* Admissions from type 1 A&E

Unscheduled attendances* 000s per 100k HCHS age-need

weighted population

South West London	52.6
North Central London	 _ 51.6
North West London	<u> </u> 46.1
Cheshire and Merseyside	<u> </u>
Avon, Gloucestershire & Wiltshire	 38.6
South East London	37.2
North East London	<mark></mark> 36.7
South Yorkshire	35.9
Greater Manchester	35.9
Surrey and Sussex	34.9
West Yorkshire	34.4
West Midlands South	34.2
Kent and Medway	34.1
South West Peninsula	32.7
Birmingham and the Black Country	32.4
North and East Yorkshire and N Lincolnshi	re 🔤 32.4
Thames Valley	31.6
Northumberland, Tyne and Wear	 31.1
Essex	3 0.4
Shropshire and Staffordshire	29.7
Bedfordshire & Hertfordshire	29.0
Cumbria & Lancashire	28.7
Somerset & Dorset	28.2
County Durham & Tees Valley	27.3
Norfolk, Suffolk & Cambridgeshire	<mark>_</mark> ¦27.0
Hampshire and Isle of Wight	<mark>_</mark> ¦26.6
Trent	2 5.6
Leicestershire, Northamptonshire & Rutlan	d 24.2
England average	33.7

000s per 100k HCHS age-need weighted population
6.2 6.6 5.6
6.5 5.3
6.4 5.7
5.4 6.0
5.4
3¦5 4.4 4.8
5.1 4.6
4.9
5.1 4.1
5.1 4.2
4.6 3.9
¦4.7 \≱.3
3.8 3.9

5.0



Ratio of A&E admissions to total unscheduled attendances

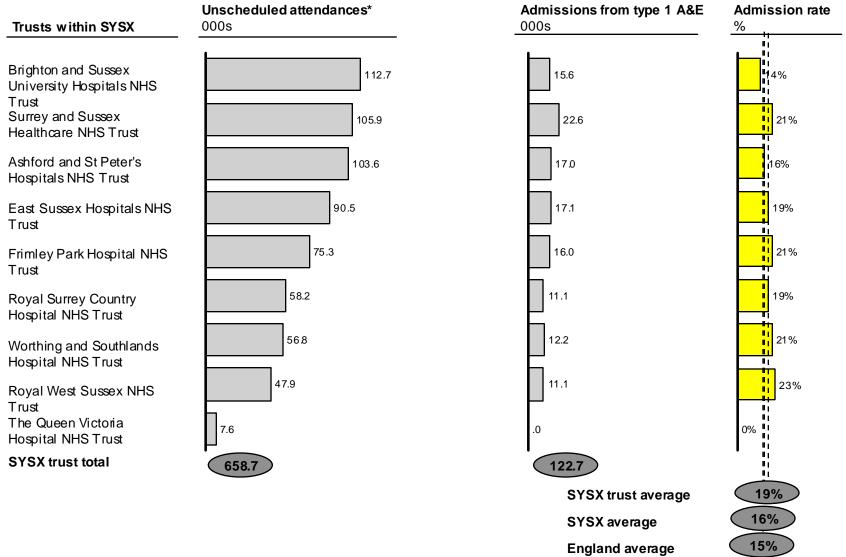
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	16%
\langle	15%

* Including Minor Injury Units and Walk In Centres Source: HAS; team analysis

July 22 2005 Version

SYSX Acute Trusts have above average rates of admission from A&E

A&E attendances, admissions and admission rates, 2003–04



* Including Minor Injury Units and Walk In Centres run by trusts Source: HAS; team analysis

July 22 2005 Version

Breakdown of acute average length of stay by providing SHA

days, average length of stay in Acute Trusts, 2003–04

SHA	SHA crude ALOS		England Acute ALOS case-	mix adjusted to SHA
Northumberland, Ty ne & Wear		6.4	5.3	6.1
Cheshire & Merseyside		5.9	4.9	5.5
North West London		5.8	4.5	5.2
Surrey & Sussex		5.8	5.2	5.8
West Midlands South		5.6	4.8	5.5
North Central London		5.6	3.8	4 <mark>,</mark> 7
North East London		5.6	4.5	5.1
Greater Manchester		5.5	4.4	5.0
North & East Yorkshire & Northern Lincolnshire		5.5	4.9	5.6
Trent		5.4	5.3	6.0
Avon, Gloucestershire & Wiltshire		5.4	4.5	5.1
Kent & Medway		5.3	4.9	6.0
Somerset & Dorset		5.3	5.1	5.8
WestYorkshire		5.2	4.6	5.2
Birmingham & the Black Country		5.2	4.1	4 <mark>.</mark> 7
Essex		5.1	4.6	5.2
South West London		5.1	4.3	4.9
Bedf ord & Hertfordshire		5.0	4.7	5.3
County Durham & tees valley		4.9	4.7	5.3
South East London		.8	4.0	4.5
Leicestershire, Northamptonshire & Rutland	4	7	4.3	<u>_4</u> .9
Shropshire & Staffordshire	4	7	4.4	5.0
Norfolk, Suffolk & Cambridgeshire	4.	6	4.4	4.9
Cumbria & Lancashire	4.	ſ	4.7	4.9
South Yorkshire	4.5	5	4.0	4.5
Hampshire & Isle of Wight	4.5	\$	4.3	4.9
Thames Valley	4.2			4.3
South West Peninsula	4.0		4.7	5.0
Acute Trust aggregate		5.1	4.5	5.1

Top quartile based on SHAs, does not include uncoded activity Source: Record level HES, 2003–04; team analysis SYSXTrusts England Acute top guartile

England Acute average

SHA	SHA elective day case ra	ite	England Acute elective day c	ase c	ase-mix adjusted to SHA
Shropshire & Staffordshire		73	60	7	67
Trent		72	67		73
Northumberland, Ty ne & Wear		71	66		72
Leicestershire, Northamptonshire & Rutland		70	66		72
Bedf ord & Hertfordshire		70	68	i	72
Somerset & Dorset		69	69	i l	74
North & East Yorkshire & Northern Lincolnshire		68	67		73
County Durham & tees valley		68	65	ET.	71
Surrey & Sussex		67	66		71
Essex		67	62	Щ-	67
West Midlands South		66	64		70
WestYorkshire		64	67		73
North East London		63	68		74
Kent & Medway		62	63		70
Cheshire & Merseyside		61	63	Ш	68
North West London		59	63	Ľ	69
Avon, Gloucestershire & Wiltshire		59	56		63
Norfolk, Suffolk & Cambridgeshire		57	55	I I	61
Birmingham & the Black Country	£	6	53	I I	61
South West Peninsula	5	5	55		61
South West London	54	ł	58	1	67
Greater Manchester	5	ł	58]¦	64
South Yorkshire	5	ļ.	52	i 	59
South East London	53		58	_i	65
Hampshire & Isle of Wight	51		54	i	62
Thames Valley	48		50	i	57
Cumbria & Lancæshire	47		54	l į	63
North Central London	43		51	_i	59
Acute Trust average		60	60	_	66

*Top quartile based on SHA

Source: Record level HES, 2003-04; team analysis

SYSXTrusts

England Acute top quartile**

England Acute average

July 22 2005 Version

Benchmarking suggest large reductions in hospital bed days are feasible

	SYSX spells 000	SYSX ALOS (all ages)	Kaiser ALOS (>65)	Medicare California ALOS (>65)	Medicare USA ALOS (>65)
Stroke	4.8	14.73	4.26	5.84	6.53
COPD excl bronchitis	3.1	5.63	3.80	5.35	5.37
Bronchitis and asthma	2.7	6.46	3.09	4.23	4.41
Coronary bypass	0.3	10.45	9.64	8.62	9.98
Acute MI	3.0	5.02	4.35	5.14	5.46
Heart failure and shock	2.3	7.07	3.70	5.28	5.37
Angina pectoris	4.0	3.15	2.20	2.58	2.56
Primary hip replacement	2.4	9.29	4.54	5.41	5.46
Primary knee replacemen	t 2.5	8.90	4.18	4.53	4.39
Potential bed	days sav	ed (000)	102	76	71

Source: Ham et al. 2003. Hospital bed utilisation in the NHS, Kaiser Permanente and the US Medicare programme, BMJ, 327:1257-60, rHES 03/04

Clinical case for change 1/7

- Units (or staff) treating more patients achieve better outcomes – volume effect
- Trend toward specialisation and sub-specialisation with growing evidence of better outcomes for certain diagnoses treated in specialised units or by specialised teams – resource centralisation effect
- Effective Health Care December 1996
- Soljak M; BMJ 2002; 325:787-8
- Improving Outcomes Guidance, NICE November 2004
- Intercollegiate Working Party for Stroke, National Clinical Guidelines for Stroke, Royal college of Physicians 2004

Clinical case for change 2/7

Specialization can have a great impact on quality

Treatment	Mortality reduction Percent	Comments
Pancreatectomy	63%	 Difference between hospital volume =1 and >10 per year
Abdominal aortic aneurysm	58	 Difference between few (<6) and many procedures in hospital per year
Colorectal resection	42	 Difference between surgeon volume <5 and >10
Breast cancer	37	 Difference between yearly hospital volume <10 and >150
Intestinal operations	29	 Difference between hospitals performing more and less the 40 operations a year
Acute myocardial infarction	17	 30 day mortality difference between 1st and 4th quartile

Source: NHS: Effective Health Care December 1996; Journal of clinical oncology

Clinical case for change 3/7

- Advances in technology may favour centralisation angioplasty as treatment for acute heart attacks, a technique that should only be undertaken in specialised units
- American College of Cardiology/American Heart Association Clinical Competence Statement June 2000
- Advances in technology may also favour moving care into community (including home) settings
 - Near patient testing
 - Telehealth and telecare systems

Clinical case for change 4/7

- Centralisation and decentralisation are not mutually exclusive
 - Centralisation is vital for some services where there is evidence of a positive relationship between large volumes of activity and clinical outcome

Delivering high quality surgical services for the future. Royal College of Surgeons of England, 2006

 Decentralisation may be appropriate where advances in technology or changes in staff skill use allow services previously delivered in hospitals to be delivered in other settings closer to the patients home

Our health, our care, our say. Department of Health, 2006

Clinical case for change 5/7

- Expert opinion from Medical Royal Colleges on population base to support specific services
 - Major trauma 3 million
 - Emergency surgery 450,000 1 million (depending on surgical speciality)
 - Level 3 neonatal care 1 million
 - Paediatric surgery 500,000

Better care for the severely injured. Royal College of Surgeons and British Orthopædic Association, 2000

Delivering high quality surgical services for the future. Royal College of Surgeons of England, 2006

The provision of vascular services. The Vascular Society of Great Britain and Ireland, 2004 Report of the Neonatal Intensive Care Services Review Group. Department of Health, 2003. Children's surgery – a first class service. Royal College of Surgeons (Paediatric Forum), 2000

Clinical case for change 6/7

- Specific arguments supporting need for change apply to maternity
 - Units delivering more than 4000 births per year should have 24/7 consultant cover
 - Obstetric units also require dedicated obstetric anaesthetic services

The future role of the consultant. Royal College of Obstetricians and Gynaecologists, 2005 Towards safer childbirth: minimum standards for the organisation of labour wards. Royal College of Obstetricians and Gynaecologists and Royal College of Midwives, 1999. CNST Maternity Clinical Risk Standards. NHS Litigation Authority, 2006

Clinical case for change 7/7

- Changes in medical workforce and a growing trend towards consultant led care, linked to
 - European Working Time Directive (and)
 - Changes to junior medical training (Modernising Medical Careers)
- Modernising Medical Careers The new curriculum for the foundation years in postgraduate education and training, Department of Health, April 2005



URGENT AND EMERGENCY CARE

Urgent care, travel times and the "golden hour" 1/6

- Much of the evidence on the relationship between travel time, treatment and clinical outcome is focused on trauma
- This frequently refers to the "golden hour"

Urgent care, travel times and the "golden hour" 2/6

- The "golden hour" paradigm is founded on the idea that trauma patients have better clinical outcomes if they receive definitive care within 60 minutes of the occurrence of their injuries
- There are no sufficiently large, well-controlled studies in civilian populations to support or refute the concept of the "golden hour"
- Lerner EB, Moscati RM, Acad Emerg Med 2001; 8(7): 758-60

Urgent care, travel times and the "golden hour" 3/6

- Two other issues may also be relevant:
 - identification of patients for whom total out-of-hospital time will affect outcome ('rapid field assessment')
 - the actions taken before the patient reaches the definitive care setting ('pre-hospital response')

Urgent care, travel times and the "golden hour" 4/6

- An appraisal of the literature suggests that prehospital assessment may not identify those patients for whom total out-of-hospital time will affect outcome and even if such patients are identified then outcome may be not affected positively by prehospital intervention
- The role of paramedics in either discharging patients from the scene or deciding on appropriate destinations has not been adequately studied to confirm its safety and effectiveness in the UK

Cooke M et al, NCCSDO 2004

Urgent care, travel times and the "golden hour" 5/6

- The evidence for pre-hospital intervention is strongest for arterial reperfusion after acute myocardial infarction (AMI), that is, thrombolysis after heart attack
- Boyle R. *Mending hearts and brains Clinical case for change*; London: Department of Health, 2006
- Best practice recommends extending paramedic thrombolysis for appropriate patients where the call to hospital time is greater than 30 minutes
- Carver J, Boyle R, Chamberlain D, Fisher J, Quinn T, Henderson K and Dancy M. *Review of Early Thrombolysis*; London: Department of Health, 2003
- In the future primary angioplasty may become the first treatment for AMI – this is a specialised technique that will be undertaken in specialist centres

Boyle R. Mending hearts and brains – Clinical case for change; London: Department of Health, 2006

Urgent care, travel times and the "golden hour" 6/6

- Evidence to-date on the impact of walk-in centres and urgent care centres (for example, minor injuries services) on GP services or attendances at A&E is inconclusive
- Cooke M et al, NCCSDO 2004
- Conclusion what is more important is getting to the right hospital, not necessarily the nearest hospital
- Emergency Access clinical case for change: Report by Sir George Alberti, the National Director for emergency access

S1: DEMOGRAPHY

Slides courtesy of Del Herridge, Kent and Medway HIS and Graham Evans, Senior Analyst at South East Coast SHA

S3: HEALTH INEQUALITIES

Slides courtesy of Robert Kyffin, Senior Public Health Intelligence Officer at GOSE and Graham Evans, Senior Analyst at South East Coast SHA



Slides courtesy of Graham Evans, Senior Analyst at South East Coast SHA S7: Hospital utilisation series

Data from UHCE Epidemiological Database (courtesy of Professor Michael Goldacre) and SEPHO HES analysis

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So what did we learn?



Closing comments and open mike