NHS Harrow

NHS Brent

The North West London Hospitals NHS Trust

Report to: NHS Harrow Overview and Scrutiny Committee

Report from: NHS Harrow, NHS Brent and North West London Hospitals NHS Trust

Date of Meeting: 28th July 2009

RE: Brent, Harrow & North West London Acute Services Review – Progress report and future options.

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1. Background

In November 2008 NHS Harrow, together with NHS Brent and North West London Hospitals NHS Trust (NWLHT) commenced a strategic review of the acute services commissioned by the primary care trusts and provided by NWLHT, which aims to:

- Develop a shared understanding of the nature and scale of both challenges and opportunities; and
- Develop proposals for service reconfiguration that will deliver high quality, safe patient services, which are clinically viable and financially sustainable and are consistent with the implementation of Healthcare for London and local PCT commissioning plans.

The project will present proposals that:

- Reflect the shift of services from secondary to primary and community care;
- Enable hospital services to be delivered in a way that is clinically and financially sustainable;
- Are supported by clinicians;
- Are consistent with Healthcare for London planning;
- Are capable of demonstrating to the public and their representatives that they will receive safe, accessible and high quality services; and
- Are within the resources available to the local NHS.

The review is overseen by a Project Board, which is led by the Chief Executive of NHS Brent and comprises the three NHS Chief Executives, local authority representation, clinical and managerial representatives from the three sponsoring organisations and LINks representatives from Brent and Harrow. The Project Board has been advised by a Clinical Reference Group, chaired by the Co-Chairs of NHS Brent Professional Executive Committee and involving clinicians and managers from all three NHS organisations. Tribal were appointed to provide consultancy support to the review.

2. Progress to date

The review has included the following main phases:

- **Strategic Positioning** – SWOT analysis workshops were held with Harrow and Brent PCTs, Harrow and Brent councils and NWLHT between January and March 2009 to

explore strategic positioning and perceptions around the current strengths, weaknesses, opportunities and threats.

- **Drivers for Change and Scenario Planning** – workshops were held between February and March to explore the key issues driving change, including the local population needs derived from the Joint Strategic Needs Assessment, the potential to expand the range of services currently provided in primary care, workforce issues, technological advances in care and changes in clinical practice and the need to bring together highly specialised services.

- A subsequent series of workshops were held in March and April involving clinicians, managers and members of the public focussing on:

  - Planned care
  - Emergency care
  - Rehabilitation and intermediate care
  - Children's services
  - Women services (including maternity and gynaecology)

  Each scenario workshop recognised the same 'fixed and semi fixed points' across the local health economy. From these new patient pathways were defined covering hospital and primary / community care provision as well as potential configurations of services across the two hospital sites. The scenarios formed the key options described later in this paper.

- **Modelling the impact of Commissioning Intentions –** the potential shift in activity from the hospital to primary and community care settings as outlined in PCT plans has been modelled to help shape future service provision.

- NWLHT has completed a detailed review of the assumptions and proposed bed reductions derived from benchmarking. The Trust has modelled future bed reductions by specialty through benchmarking against median performance and believes that it can release a total of 70 inpatient beds over two years through improved productivity.

- **Public Engagement**
  Participate, a social communications agency specialising in public engagement and consultation, have been appointed to deliver the deliberative events. An initial meeting has been held to discuss the logistics of the events, review the objectives and begin to plan the methodology for recruitment of participants and scope out the agenda. It is proposed that the LINks representatives are involved in planning the events and testing out the proposed approach.

3. Drivers for change

The drivers for change workshops agreed the following key messages that needed to be addressed by the ASR process:

- Different practices on each of the hospital sites – need to implement common care pathways and protocols for each service / specialty
- Duplication of resources on each site – both in terms of workforce and facilities – opportunities explored around consolidation of services, particularly acute surgical and paediatrics to resolve critical mass of staffing and minimise duplication
- IT integration required across sites

4. Options for future configuration

The Clinical Reference Group, guided by the outputs from each of the scenario planning workshops, has developed four scenarios:

1. Scenario 1 - Do Minimum: services configured as now but reflecting the implementation of Healthcare for London stroke and trauma proposals (subject to the outcome of consultation) and maximising the use of CMH as the main elective surgical centre.
2. Scenario 2 – Reduction in duplicate service configuration. As scenario 1, with a particular focus on improving emergency surgery and paediatric services in line with best practice.
3. Scenario 3 – Full replication of services at CMH. As scenario 1, plus extending the current emergency surgical cover at CMH.
4. Scenario 4 – Further centralisation of services at NWP. CMH becomes an elective only centre – no emergency medical or surgical activity would take place at CMH and the only non-elective activity would be in an urgent care centre.

The options were assessed by the Clinical Reference Group against a range of clinical, operation and financial criteria summarised in appendix 1.

Scenario 2 is the emerging preferred option for a range of reasons including:

- It enjoyed the greatest clinical support and provides critical mass to create safe and sustainable services
- Reflects the Trust's clinical vision:
    - NPH should develop as a major acute site, that also provides:
        - Local hospital services for the people of Harrow, Brent & beyond
        - Specialist hospital services for colorectal diseases, OMFS and rehabilitation
    - CMH should develop as a local hospital for the people of Brent with an expanded elective centre serving a wider population
    - Some services should move from acute settings to primary and community care
- The right clinical teams are in place to deliver the service
    - In addition to exacerbating the Trust's CIP requirement, it is highly unlikely that sufficient senior clinical staff could be recruited to support scenario 3
- Analysis to date demonstrates the most affordable and supports NWLH's cost improvement programme (CIP)
- Ensures the right flexibility to respond to changes in demand resulting from NW London provider landscape review

5 Current service arrangements and case for change

5.1 Current configuration – paediatrics

Two separate paediatric services are provided on the CMH and NPH sites supported by two rotas with five consultant teams on each rota.

Overall 83% of Paediatrics care can be provided on an ambulatory basis. At Central Middlesex Hospital only 12.8% of paediatric patients currently require an admission, which means there is a strong case for a Paediatric Assessment Unit to support a more ambulatory model of care.

5.2 Current configuration – acute surgery

There is currently a restricted 9-5pm surgical receiving model at CMH. Patients who arrive out of hours (between the hours of 5pm and 9am during the week and at weekends) may need treatment that is not provided on the Central Middlesex site. Hospital consultants will assess and stabilise these patients and if necessary will transfer to the Northwick Park Hospital for their surgery and after care.

Concerns were voiced regarding access to opinion in hours and seniority of opinion out of hours (particularly for the ambiguous abdominal pain patient). Similarly inter hospital transfers not allocated blue light priority.

6. Number of patients affected

The main impact of scenario 2 will be for patients requiring acute paediatric and surgical care. When assessing the impact of patient transfers a similar range of sensitivities are applied eg how will patients exercise patient choice, where will the LAS take the patients to etc.

6.1 Paediatrics

Scenario 2 required that a PAU would provide assessment, diagnosis and treatment for all children arriving at A&E. For those with complex health needs there would be observation beds available for monitoring purposes. If the child needs admitting they would be urgently transferred to Northwick Park hospital. Only 13% of paediatric patients currently require an overnight stay in hospital.

Children requiring A&E services between the hours of 10pm and 8am would need to attend their nearest hospital with 24 hour paediatric A&E. This would not include Central Middlesex Hospital. London Ambulance Service will have clear protocols to divert patients to the most appropriate hospital. For most patients this will be either Northwick Park or St Mary's hospital.

The Paediatric Assessment Unit (PAU) Model is a robust model of care and will require senior consultant level input, specifically for assessment and review. The proposed 8am - 10pm model would mean 77% of patients would still be seen at the Central Middlesex Hospital.

All planned paediatric outpatient appointments and day-case operations will continue to be done at the Central Middlesex Hospital site.

Conservative impact[1] for scenario 2 - 2.7 transfers per day

6.2 Acute surgery

Patients who arrive at Central Middlesex at any time of day may need treatment that is not provided on the Central Middlesex site. Hospital doctors will carry on assessing these patients, to make sure they get the right treatment and if necessary they will be transferred quickly to the Northwick Park Hospital for their surgery and after care. This makes sure that patient treatment is safe even if the treatment is not provided on site.

London Ambulance Services will divert patients who require surgical opinion to the closest hospital site. For most patients, London Ambulance will divert to either Northwick Park or St Marys hospital.

The assumed 3.2 transfers per day include the following patients already transferred as a result of clinical change introduced in the last 18 months:

- All complex surgical cases; and
- All out of hours emergency cases.

The net impact of withdrawing emergency surgery during the day is therefore minimal (less than 1 case per day).

Conservative impact[2] for scenario 2 - 3.2 transfers per day / net new impact <1 transfer per day

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[1] Based on Tribal leakage model

[2] Based on Tribal leakage model

6.3 Summary table demonstrating numbers of patients affected by each scenario.

	Patient Type	Number of spells per year			Average spells per day – all hospitals
		Spells at other hospitals	Spells remaining within NWLH	Total spells moving[3]	
Scenario 1 Do Minimum	Acute Surgical	449	368	817	2.2
	Acute Medical	No change	No change	No change	No change
	Paediatric Admissions	No change	No change	No change	No change
Scenario 2 No Emergency Surgery at	Acute Surgical	651	527	1,178	3.2
	Acute Medical	No change	No Change	No Change	No change
	Paediatric Admissions	542	444	986	2.7
Scenario 3 Expansion of Services at CMH	Acute Surgical	0	162	162	0.4
	Acute Medical	No change	No change	No change	No change
	Paediatric Admissions	No change	No change	No change	No change
Scenario 4 Elective Site only at CMH	Acute Surgical	651	527	1,178	3.2
	Acute Medical	4,059	2,612	6,671	18.3
	Paediatric Admissions	1,355	1,109	2,464	6.8
	A&E Attendances (from CMH)	18,653	20,045	38,698	78.6

7. Financial analysis

Detailed activity and financial modelling is currently being undertaken to support each scenario to enable it to be assessed against the objectives established for the overall acute services review.

When considering the financial impact, a range of sensitivities has been applied to each scenario including:

- Likely bed savings from achievement of reduced length of stay, better day case percentage etc;
- Likely leakages to other hospitals. In other words, will patients decide to travel to St Mary's (rather than NPH or CMH) if they or their child is unwell or will GPs decide to change current referral rates and refer patients elsewhere. Finally although the majority (75%) of Brent patients do not use the London Ambulance Service (LAS), where are the LAS likely to take patients requiring acute surgical or paediatric care?

[3] To either NPH or an alternative hospital

These sensitivities help inform the best, likely and worst case forecasts. The current range is:

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Likely case surplus/(deficit)	595	952	(146)	(592)
Best case	3,629	4,319	2,412	4,142
Worst case	(805)	(448)	(1,546)	(1,992)

Note: These calculations are indicative and have yet to be approved by the ASR Project Board

8. Key dependencies

- The case for change and proposed clinical model rests on securing clinical support from both hospital and primary care clinicians. Scenario 2 has Trust wide clinical support and a further workshop will take place in July to engage with local GPs to ensure that there is similar support.
- NHS London will require a pre-consultation business case (PCBC), Gateway Review and Independent Clinical Review prior to consultation.
- The changes outlined above would need to be confirmed as consistent with the wider sector review of acute reconfiguration work currently underway and not pre-empt it.
- Changes to clinical services are not permissible in a pre-election period.

9. Next steps

Health Select has received regular reports from NWLHT outlining their current financial deficit and the need to take urgent steps to address this deficit in 2009/10, together with the need to ensure a sustainable solution moving forwards. Following consideration of the pre-consultation work undertaken to date, the Acute Services Review Project Board, in consultation with NHS London, will consider whether further engagement work needs to be undertaken to explore the scenarios further or whether it is more appropriate to recommend to the Health Select Committee that consultation should commence on the scenarios derived from the scenarios identified. It would not be planned to consult on scenarios which are not clinically of financially sustainable.

The recommendation concerning the way forward will be available by the end of July. NHS Harrow, NHS Brent and NWLHT have asked that Brent and Harrow health scrutiny committee's consider meeting together to discuss the outcome of the acute services review, which is scheduled for 28th July (the date of the Harrow's normal OSC Meeting).

Appendix 1 Overall evaluation of scenarios

Scenario	Key advantages	Key disadvantages
1	The de-minimis scenario this is least organisationally challenging. Retains acute medical receiving patients mainly over 65, (with the exception of stroke and ST elevated MIs, complex trauma) currently the largest group of patients admitted to hospital. Continues to provide a limited surgical receiving service on the CMH site. This maintenance of medical receiving provides emergency care physicians 24/7 and gives extended clinical support to the Urgent Care Centre. A paediatric acute receiving service remains on the CMH site Operationally achievable in terms of theatre sessions and beds.	This scenario is clinically unsustainable in the medium to longer term. The key issue in this configuration is that in order to provide a clinically robust systematic approach to the management of surgical non elective cases, the Trust would require to provide two full surgical teams and two full receiving rotas which is not achievable in terms of the recruitment & retention of surgeons. This scenario requires all surgical admissions requiring urgent surgery to be transferred after 5pm Monday to Friday and at weekends. This currently involves the transfer of 1073 out of hours cases in 2008/9 (57%) of all surgical admissions to the CMH site. 75% of patients who attend the A&E department at CMH are self referred as opposed to the UK norm (25%) this current system where acute surgical receiving stops at 5pm, is difficult to manage. The flow of GP referred patients can be re-directed after 5pm however the redirection of self referred patients is significantly more difficult to achieve. The evidence suggests[4] that the transfer of urgent critical and non critical patients will require more staff time in preparing patients for transfer, escorting patients and very significant amounts of ambulance time. For patients who are admitted through A&E at CMH who require urgent surgical intervention (examples include: bleeding ectopic pregnancy, GI bleeding or a direct arterial injury) the evidence [5]is that giving fluids and delaying surgery will result in poorer outcomes. It is acknowledged that this is a low frequency but a high risk occurrence. This type of risk is inevitable in this scenario where patients have to be transferred out of hours. The current arrangements are not based on robust and systematic approach to acute surgical receiving and therefore attract a much higher risk profile.
2	This option maintains the full	Self referred patients who require surgical

[4] Acute Health Services Report of a Working Party, September 2007 Academy of Medical Royal Colleges

[5] Acute Health Services Report of a Working Party, September 2007 Academy of Medical Royal Colleges

Scenario	Key advantages	Key disadvantages
	medical receiving service with no surgical receiving. Enables the separation of elective and non elective care and protects elective capacity. This scenario will enable more planned elective care including day surgery to be provided on the CMH site and increase access and reduce waiting times further. Any medical patient who is admitted who requires detailed assessment or treatment by a surgeon will be automatically transferred to Northwick Park. This clinical profile provides a clear and systematic basis for the provision of emergency care. This scenario will involve a small number of self referred patients who might present at CMH being transferred to NPH compared to Scenario 1 which will generate a greater number urgent non critical transfers. Therefore fewer transfers with less staff time and ambulance resource required. In a medical receiving only unit with no emergency surgical provision the major high risk group – are gastro cases self referred or GP referred who present with abdominal pain which subsequently turns out to require a surgical intervention for example patients with an upper gastrointestinal bleed. Currently this represents only 571 patients of all CMH admissions. Of the 571 patients with an upper GI bleed only 7% currently require surgery. Operationally achievable in terms of theatre sessions and beds. All surgical receiving cases currently being managed on the CMH who require surgery can be accommodated within Northwick Park theatre complex with one additional theatre session per day and is therefore achievable. The transfer of in-patient activity to the NPH can be	assessment and /or treatment will be transferred to Northwick Park. No access to dedicated theatre or team for emergency surgery. No facility for admitting children who require an overnight stay in hospital PAU only. Potential delays by the LAS in transferring patients who present inappropriately at CMH A&E and require surgery, these cases are not treated as a "blue light" emergency because they are already being managed within emergency care.

Scenario	Key advantages	Key disadvantages
	accommodated within the proposed bed model.	
3	Full profile of services on both sites. Reduce patient's transfers although some transfers will be required for specialist care which will only be provided at NPH e.g. stroke or services such as severe trauma at St Mary's Hospital. Operationally achievable in terms of theatre sessions and beds.	Duplication of scarce consultant resources across two sites with small volumes of non elective surgical and paediatric provision on the CMH site. No separation of non elective and elective care with the resulting detrimental effect on performance and utilisation in the management of planned care Two paediatric teams providing a one in five rota which is not viable given the requirements of the EWTD – which requires a minimum of 8 consultants receiving on one site.[6] Specialty teams are split between two sites difficult to utilise the skills of the team to maximum effect. To resource this scenario will require significant additional consultant posts to staff receiving rotas on each site 24/7 and is therefore financially unviable. In order to ensure adequate case mix and volume in terms of training and accreditation staff will be required to rotate across both sites. This may make jobs less attractive and difficult to recruit to.
4	All acute receiving resources in terms of medicine, surgery and paediatrics will be consolidated on one site at NPH allowing rotas to be brought together and better utilisation of scarce consultant resources. Will enable an expansion of planned care including increased day surgery volumes to be provided on the CMH site. Enables the separation of elective and non elective care and protects elective capacity. Enables the paediatric service to attract and retain staff by consolidating the receiving rota with sufficient consultants to comply with the EWTD on the NPH	Potential significant loss of activity to the Trust as a result of patients presenting at an alternative A&E department outwith NWL Acute Hospitals. Reduction in acute infrastructure to back up Urgent Care facility on CMH site if patients continue to self present. Paediatric cases which are urgent and need to be admitted will require to be transferred to the NPH site; this will place added demands on staff at CMH and the London Ambulance Service and may create delays in treatment. Acute medicine case mix has changed over the last ten years with more medical cases with more and more older patients requiring admission to hospital[7]. In this scenario older patients will have to be admitted through an alternative A&E department and subsequently transferred back to CMH to be closer to relatives and families. A&E and care of the elderly inpatient wards

[6] Royal College of Paediatrics and Child Health, Short Stay Paediatric Assessment Units Advice for Commissioners and providers, 2009

[7] Acute Health Services Report of a Working Party, September 2007 Academy of Medical Royal Colleges

Scenario	Key advantages	Key disadvantages
	site. Operationally achievable in terms of theatre sessions and beds.	establish relationships and ways of working with local social services teams. This scenario will mean A&E and ward managers on the NPH site will be dealing with both Brent and Harrow social services departments with differing protocols and processes. This is likely to create delays in the discharge pathway and cause patients to have to stay in hospital longer than medically required.