BETTER CARE WITHOUT DELAY

IMPROVING LOCAL AND NATIONAL HEALTHCARE IN HARROW & NORTH BRENT

CONTEXT AND OBJECTIVES

- Harrow PCT, Brent PCT and North West London Hospitals (NWLH) are implementing a major restructure of health services. This restructure is associated with a major hospital rebuild and redesign at Northwick Park;
- The major drive for the project is improved patient care and better health for the local population;
- The project aims to demonstrate that effective health services can be provided locally by harmonising Primary Care, local hospital and more specialist services to prevent inefficiencies, gaps in provision, delays and duplication of effort;
- There is a major subsidiary objective to develop the Northwick Park and St. Mark's campus as an attractive place to work for all staff;
- Staff, patients and the local community will be involved in the development, implementation and communication of the project.
- The project aims to provide Specialist as well as District General Services for the population of outer North West London.

PHILOSOPHY

The development is based on 9 main concepts:

- **Integration of Hospital and Community services:** Better outcomes can be achieved by a far greater integration of hospital and community (including social care) services;
- **Rapid Response:** The removal of waiting lists and queues and the provision of immediate expert assessment for patients with acute problems when required will lead to better health outcomes, more efficiency and prevention of crises;
- **Case Management:** Integration and enhancement of community centred case management services will prevent admission to hospital and facilitate earlier discharge;
- **Incentivised Local Teams:** Services will be organised around patient populations with empowered and incentivised expert teams combining hospital and community skills. Leadership of these teams will be shared by community and hospital clinicians;
- **Rapid Throughput:** Services will concentrate on solving problems promptly and returning people to their homes as quickly as possible through close liaison between hospital and community services, active case management and accelerated recovery programmes;
- **Local Provision of Care:** The majority of acute care will be provided by the local hospital and primary care services working together;
- **Harmonisation of Approach:** Equity of access for patients will be achieved by a more systematic approach across the patch including the adoption of joint protocols by the PCTs and NWLH
- **Integrated Patient Pathways:** patient pathways will be developed which emphasise that the patient journey starts and ends in the community with the hospital providing "high tech" specialist skills and resources where appropriate.
- **Flexibility:** We aim to build healthcare premises for 2010 to 2050 with the flexibility to develop facilities as situations change.

HARROW AND NORTH BRENT SERVICE MODEL

1. Summary

To deliver these concepts the strategy behind the Harrow & North Brent development is to create a series of 'super teams'. These teams could include:

a. A strengthened **Primary Care** infrastructure
b. An integrated **Rehabilitation** service for Brent and Harrow
c. A range of **Local Specialist Teams** combining hospital and community expertise
d. An **Urgent Treatment Service** to deal with minor injuries and illness, Out of Hours Primary care and Primary Care problems presenting at the Hospital.
e. An integrated 24hr/7day **Acute and Critical Care Team**;
f. A systematic **'Pull through' elective service**
g. An integrated **'Full Spectrum' Children's Service**
h. Rapid response **Diagnostic Services**
i. A range of responsive **Support Services**
j. Enhanced **Supra District Specialty Services** including St Mark's Hospital

2. A Strengthened Primary Care Infrastructure

The main features of the new strengthened Primary Care infrastructure in North Brent & Harrow will be:

- Agreement and implementation of protocols and best practice standards;
- Full Access to diagnostic facilities where investigation in the community is appropriate.
- Improved access to specialist opinions, diagnostics, intermediate care and support from specialist and hospital care;
- Shared care with cooperative working between hospital and Primary Care teams
- Improved communication infrastructure including e-mail access to opinions and electronic test results;
- Enhanced development and training opportunities including access to PWSI opportunities
- Appropriate hospital support to enable the care of Long Term Conditions in Primary Care.

3. An Integrated Rehabilitation and Intermediate Care Service

This service will combine in-patient ward teams; therapy teams and community-based services to provide an integrated intermediate care service.

The service will have 3 main arms:

- An integrated community based assessment and case management team combining social and healthcare skills;
- An integrated inpatient team with beds at Northwick Park and with a close relationship with the community based assessment service and other teams;
- An integrated rehabilitation service

Key features of this service will be case management, admission prevention, prompt discharge planning, rehabilitation and follow-up out of hospital.

4. A Range of Specialist Teams:

The local population will be served by a series of specialist teams whose function will be to provide:

- Programmes of disease management;
- Rapid access specialist opinion/reviews for GPs and inpatients;
- 24/7 support and assessment services to the acute services;

These teams will combine community and hospital skills and will be characterised by:

- Joint community and hospital leadership;
- Organisation by patient populations e.g. musculo-skeletal rather than by profession;
- Self management and responsibility for delivery of services and adherence to targets;

- Incentives to deliver against targets;
- Rapid access for GPs, inpatients and other professionals;
- General advice and support for Primary Care
- Community based support and follow-up

5. An Urgent Treatment Service

Minor injury and illness services in A&E will be combined with Primary Care Urgent services to provide a single team with the ability to:

- See and treat minor illness and injuries;
- Provide Primary Care registration and follow-up;
- Link easily into specialist services.

The Urgent Treatment Service will be characterised by:

- The principle that all attendees of the service are appropriate;
- Quick throughput due to pooling of hospital and Primary skills and dedicated diagnostics;
- Equity of access to services across the patch irrespective of GP opening times;
- Registration of unregistered patients and Primary Care follow-up including vaccination and immunisation;

This service will have three main elements:

a. Minors
b. Walk-in Primary Care
c. OOH primary care

These three aspects of the service will be "community facing" and aim to guide patients back to appropriate further care in the community, either in the patient's own practice or in the PCT PMS practice.

6. An Integrated Acute and Critical Care Team

This will combine the skills of A&E, Primary Care and acute medical and surgical teams to provide a rapid 24hr/7day decision-making and treatment service.

Major A&E assessment services, ITU, HDU, CCU, Recovery and level 1 critical care (patients with more acute problems) around the wards will be integrated into one Acute unit. There will also be outreach and community support.

The main principles of the Unit are:

- Decision-making and care planning begins immediately upon entry into the unit;
- The unit has sufficient senior skills and diagnostics to deal with the majority of patients rapidly and safely;
- The Acute Unit staff have a broad range of general acute skills;
- The team running the unit have ownership of the service and the ability to make decisions in consultation with specialists

7. High Throughput 'Pull Through' Elective Services

There will be beds and theatre time dedicated to treating elective cases. The relevant ECC teams will be able to control and organise the se resources to ensure smooth throughput of patients. Surgical and theatre teams will be geared up to ensure the maximum number of cases processed through laparascopic techniques. Key characteristics will be:

- Book-able dedicated resources;
- Systematic pre-assessment and case management of patients;
- Low waits for services;
- Rapid throughput due to emphasis on minimally invasive techniques and Accelerated Recovery Programmes

8. Full Spectrum Children's Services

The key feature of the new system is a fully integrated children's team that will deal with children's care through from health promotion to assessment and treatment. This team will provide:

- A targeted programme of prevention and promotion linking all local education, social and health services;
- An agreed approach to the provision of Primary Care to children including use of protocols, access to advice on best practice, a network of quick access to specialist Health Visiting/Specialist HealthCare Practitioners and regular monitoring/audit of approaches to management, referral and Child Protection;
- Rapid access opinions and assessments from the Children's team including same/next day e-mail advice, one-stop clinics and daily office-based clinics;
- Emergency drop-in services run by the Paediatric team;
- Continuous decision-making and assessments for patients under observation;
- Ongoing community-based care and case management from Practitioners with a Special Interest (PwSI) and Specialist Health Visiting and the Paediatric community team
- Close working in partnership with the Local Council and Primary Care services.

9. **Rapid Response Diagnostic Services** including:

- Radiology
- Cardiology tests
- Pathology
- Pharmacy
- Other diagnostics

The key characteristics of these services will be:

- Shared access and ownership between community and hospital;
- Access by patient need rather than requesting clinician or patient location.
- Rapid access and reporting matching capacity to demand;
- Electronic ordering and access to reports;
- Spread of expertise to allow widening of process bottlenecks
- Access to specialist advice on investigation to support appropriate use by Primary Care

10. Responsive Support Services including:

- Non-clinical support services;
- Renal dialysis;
- Birthing centre;
- Workplace nursery, staff residences and other support accommodation and services.

11. Supra District Specialty Services with dedicated resources for major services such as St Mark's Hospital.

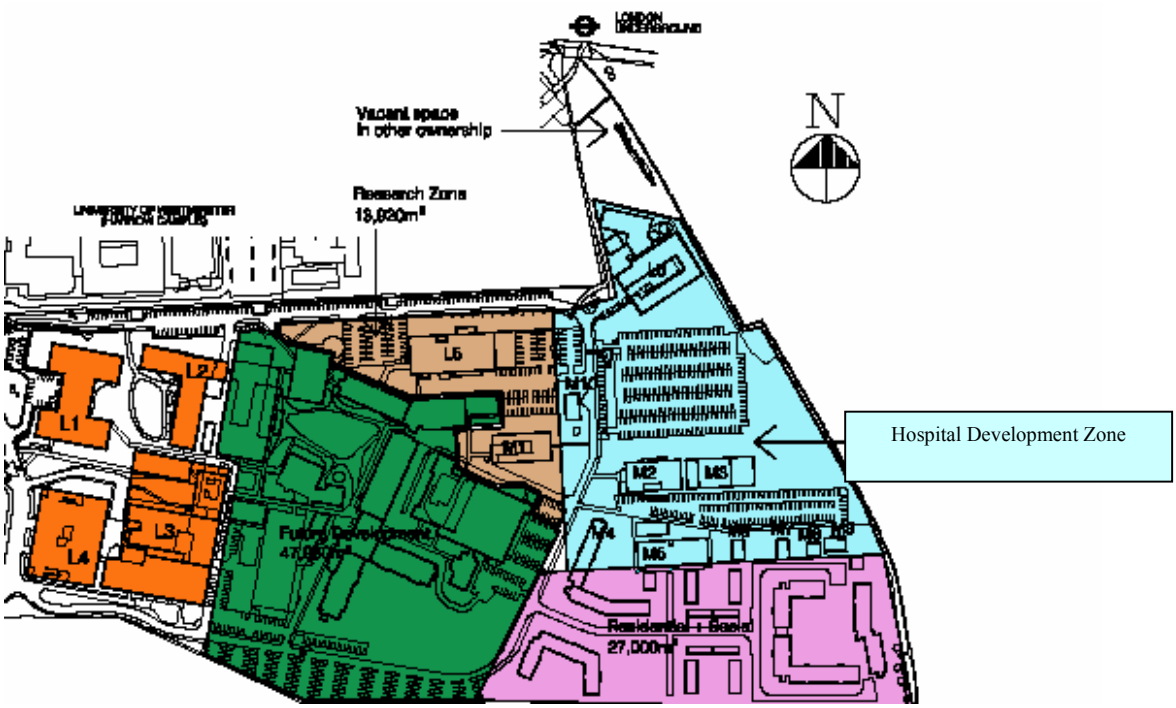
DELIVERING THE SERVICE MODEL-NORTHWICK PARK & St. MARK'S STRATEGIC OUTLINE CASE

1. Options for the site

To help deliver the new service model, a Strategic Outline Case for the rebuild of Northwick Park and St. Mark's Hospital was approved by the Department of Health in July 2004.

One of the options considered in the Outline Case was a new build at the back of the site containing the majority of the services but excluding maternity, mental health and primary care developments (for which a separate zone has been identified at the front of the site)-estimated capital costs of £305m.

The site for the new build option at the rear of the current hospital is shown in the plan below:



The development zone identified in the plan is on the existing car park and landscape at the back of the site adjacent to the Metropolitan Open Land. The benefits of this site are:

- It is big enough to accommodate most of the existing hospital;
- It can be built whilst the existing hospital continues to function;
- The hospital will be near to the tube station enabling buses and tube to meet at the entrance;
- The hospital will be surrounded by parkland.

The actual site for the hospital will be developed to respond to the clinical model.

2. Time-scale

Construction on site is planned to commence in 2007 with a completion target of 2010.

The major milestones in meeting these deadlines are:

- Agreeing the Clinical Strategy May 2005
- Formal Consultation August 2005
- Outline Planning Approval August 2005
- Agreement of Outline Business Case October 2005

- Advertisement of Scheme January 2006

The assumption is that the hospital will be procured through the Private Finance Initiative (PFI).

3. Programme Structure

The Programme of development will be controlled through a Programme Board with a series of sub-groups including:

- A Clinical Redesign Board;
- Project Boards including 1 for NPSM;
- Infrastructure Groups;
- A Public Liaison Forum.

The Programme Board will include representatives from: all main stakeholders and will be constituted as follows:

4 x HPCT
4 x BPCT
4 x NWLHT
1 x CNWL

To include key clinicians from the Clinical Redesign Board

2 x Directors of Social Services
1 x Representative via the Liaison Forum
1 x Imperial College
2 x SHA including the capital lead
1 x Programme Director

The role of the Programme Board will be:

- Strategic Decision making
- Approving the overall service model(s)
- Receipt/consideration/approval, as necessary, recommendations from the Clinical Redesign Board and Project Boards
- Steering consultation
- Communicating progress
- Engaging key partners
- Agreeing affordability/budget
- Monitoring delivery
- Reporting to LSP
- Reporting to Boards
- Ensuring co-ordination of the work of the various Project Boards

Appendix A

Changes to Patient Experience

The impact of the new Brent and Harrow System on patient experience is illustrated in the following example:

Patient	Traditional System	New Brent and Harrow System
An elderly patient with chronic respiratory or heart disease	The patient may have contracted their illness due to lack of knowledge over health and lifestyle issues and it may have taken some time to be diagnosed due to poor access to diagnostic services.	Promotion Programmes will be more effective with direct input from the specialty teams (who will have a stake in their effectiveness) and the patient is therefore more likely to avoid the condition in the first place. Having contracted the condition there is a better chance of quick recognition better Primary Management of Long Term Conditions and access to diagnostic services.
	Where a problem occurred such as exacerbation of the condition the patient might see their GP	The patient is likely to have a greater understanding of their problem and will be more assertive in contacting services. Better Case Management will provide continuing support and integrated care. This will be provided by a widely based team drawn from General Practice, District Nursing, community matrons, PwSI, CDP, pharmacy, social services, voluntary agencies and carers.
	The GP has little specialist back up directly to hand and therefore is likely to refer the patient to outpatients to see a specialist. The GP may have to choose between and emergency admission and a long wait for an outpatient appointment.	The GP will have access to immediate support from specialists by e-mail or telephone together with access to rapid reporting diagnostics. The GP may therefore be able to diagnose the potential problem without a formal hand-over of care to the hospital.
	The threshold for this referral will depend on the GP and their approach, knowledge and experience	The GP will have access to PCT guidelines on the approach to take together with advice and support from PwSI. This should produce a more equitable access to the service for the patient.
	The patient may then be put on a queue of several weeks	If a specialist opinion is required it will be accessed rapidly within the next 1-2weeks and the patient will potentially have a 1-stop assessment of their requirements with an immediate diagnosis.
	During this time the exacerbation might worsen and they may get admitted to hospital through A&E	Following on from the specialist assessment treatment will have started that should minimise the need to turn up as a hospital emergency.
	Whilst in hospital, access to previous care plans, patient history can be limited	If the patient does have an acute attack, they could contact a Chronic Disease Practitioner (CDP) who may be able to provide medication adjustments/other interventions that prevent admission. If admission is still necessary, the CDP, who knows the patient, will be able to liase with staff in the Acute Unit to case manage the treatment.
	Although very sick, the patient may end up on a ward with less sick patients on the basis that they are over 65 as opposed to any criteria of need.	Whilst they are very ill, the patient will be nursed on the acute unit by staff whose main skill-set is the treatment of sick patients.

	Planning the discharge for the patient can start quite late in the inpatient process leading to delays	The process of recovery and return to home will be case managed for the patient as soon as the crisis arises.
	Once back at home, the patient does not have access to ongoing specialist support for their condition and they may have little information or knowledge of their problem. This could lead to a delay in returning to home where there is little support and also a repeat of the exacerbation and hospital admission.	The patient will receive support at home from the community arm of the team.