NORTH WEST LONDON HOSPITALS NHS TRUST

CLINICAL MODEL

VERSION 1.2

7TH AUGUST 2006

CONTENTS

SECTION 1: BACKGROUND AND INTRODUCTION

BACKGROUND

1. This is the first draft of the Clinical Model for North West London Hospitals NHS Trust (NWLH).

2. It is presented to the Board to provide an early opportunity for comment on the emerging key elements of the model.

3. The Clinical Model forms the NWLH's response to National, Regional, Local and Trust factors which influence the way in which care will be provided in future years.

4. It has been developed through workshops and individual conversations with clinicians and managers from both NWLH and the host PCTs. Leadership has been provided by the Medical Director, Nurse Director and [the Director of Strategic Development].

5. The following sections set out :

- The context for the Clinical Model;
- The guiding principles which have shaped its development and;
- The [nine] key functions which comprise the Clinical Model.

INTRODUCTION

6. The Clinical Model is a high level description of the key functional elements of the Trust's services setting out how they will be developed and what the revised patient pathways will look like.

7. When the Clinical Model is complete it will describe [nine] functional areas spanning the key elements of service. To date, four have been worked up in detail:

I. Emergency Care
II. Elective Care (Surgery & Gynaecology)
III. Rehabilitation and Intermediate Care
IV. Outpatients/Chronic Disease Management.

8. There is ongoing work to develop the model for:

V. Paediatrics
VI. Obstetrics
VII. Specialist Services (OMFS, RRU, Cancer Services and Kennedy Galton)
VIII. Therapies
IX. Diagnostics

9. The first four functions are described at a high level in Section 4 together with diagrams show planned patient flows.

SECTION 2: CONTEXT

10. North West London is preparing to consult on a number of 'Strategic Options' for the future deployment and delivery of its services. It is undertaking this work to respond to clinical and financial pressures and its aims are to rationalise and reconfigure delivery capacity between sites and between acute and community settings for long term viability.

11. Each of the 'Strategic Options' will be evaluated to determine the extent to which they support the Trust's strategic imperatives, in particular it's Clinical Model.

THE NATIONAL & REGIONAL CONTEXT

12. The national scene continues to present both opportunities and threats to the services that acute hospitals provide and the way in which they provide them.

13. Strategies are being developed for London and in particular the inner North West London. More locally, the PFI development at Hillingdon is forcing the pace of thinking as to how services will be delivered. Whilst most of these issues will be for the Strategic Options process to consider the Clinical Model must be mindful of regional developments.

14. The following table sets out some of the key issues that must be considered in the development of the Clinical Model.

- ***Patient Choice*** makes the subjective experience of the patient and the GP is increasingly significant in terms of activity planning.
- ***Payment by Results and the National Tariff*** is becoming increasingly geared to incentivise movement of activity out of the acute setting. Inefficiencies will be penalised and reference costs must be at or below the tariff.
- ***Fitness for Purpose*** provides an opportunity for secondary care providers to manage certain primary care services supporting seamless transfer of patients from acute to step down beds. Commissioners will have more power and tougher choices may be made about which services are commissioned from which providers.
- ***Foundation Trusts*** have freedoms which potentially allow them to compete more effectively in certain markets than NHS Trusts.
- ***Regulation and Performance*** assessments now have a greater emphasis on self regulation through the Annual Health Check and there is greater emphasis than ever on quality.
- ***The SHA review and the Pan London agenda*** in relation to the provision of health services will influence the Clinical Model.
- ***The Community White Paper*** requires the divestment of certain activities traditionally delivered in the acute environment to be moved to community settings.
- ***Plurality,*** the increase in the number of potential providers of a particular service creates competition forcing acute trusts to focus on developing critical mass in core services and divesting in non acute workloads.
- ***Practiced Based Commissioning*** will drive GPs to seek efficient providers for long term service viability, and also support the creation of stronger primary and community care services where these can be delivered more profitably than in secondary care.

THE LOCAL CONTEXT

15. The intense financial pressures being faced by the local health economy together with a challenging agenda of innovation and service change

must be reflected in the Clinical Model. The development of the PFI hospital at Central Middlesex and the planning for a reconfiguration of the Northwick Park and St Mark's site has promoted increased dialogue between NWLH and its host PCTs and this thinking must be captured in the Clinical Model.

- ***Better Care without Delay*** promotes the integration of hospital and community services and will support better outcomes through single patient pathways, across social, primary and secondary care, delivered by joint clinical teams.
- ***Expert Teams*** combining acute and community skills, organised around the patient populations improving access and expediting diagnosis and treatment.
- ***Rapid Response*** promoting reduction in waiting lists and early provision of expert opinion.
- ***Rapid Throughput*** through active case management and accelerated recovery supporting prompt discharge underpinned by a team that will work across the acute and community settings to improve the transition for patients.
- ***Harmonisation of Joint Access*** protocols for social, primary and secondary care.
- ***Northwick Park and St Marks Hospital*** provides a full range of emergency and elective care for patients from Brent and Harrow. Tertiary services are sited at the NPSM hospital.
- ***Central Middlesex Hospital*** has a new building which was opened in March 2006, this has emergency and elective services with an expert consulting facility.

TRUST CONTEXT

16. The vision for NWLH :

"We aim to be the most Patient Centred and Innovative acute hospital provider in London,"

17. The local health economy is joined in its ambitions to work closely to ensure seamless and cost effective transition of patients between elements of care in different settings managed by different providers. NWLH plans to play a lead role with Brent tPCT, Harrow PCT, Brent and Harrow Local Authorities to deliver it vision.

18. The model is intended to describe a system which promotes health, delivers emergency, planned healthcare which recognises the fundamental shift toward Primary care and community based services.

19. NWLH and its local health economy partners have already done a significant amount of joint work , particularly associated with the development of new services allied to the acute PFI projects and community based developments. The distillation of this work provides a basis for the development of the Clinical Model.

20. The following bullet points identify key themes:

- Emphasis on access and throughput ensuring patients receive prompt and efficient treatment and must not be waiting in queues, for diagnostic and treatment.
- Earlier access to expert assessment must be provided to patients with acute problems to improve clinical outcomes.
- There must be close liaison between hospital and community services through active case management and accelerated recovery programmes.
- Joint protocols providing equity of access for all patients must be achieved by adopting a systematic approach that will span the PCT and acute trust to provide a seamless system for patients.
- Services must be developed such that they are flexible and able to adapt to changes in service approach, evidence based clinical advances and technology led change.
- Shared governance arrangements must support this model of care, and there will be an emphasis on enabling patients to move smoothly between services regardless of organisation. There will be mechanisms in place to ensure clear lines of accountability for care across organisations.
- The Clinical Model must deliver improved productivity and efficiency and must support more effective demand and capacity planning to underpin corporate recovery.

21. In summary, the Clinical Model must be developed in line with three key guiding principles. These are:

1. Patient centred care.
2. Responsiveness to clinical acuity.
3. Evidenced based practice.

22. These Guiding Principles are expanded upon in Section 3 and are used to develop the Clinical Model on a function by function basis.

SECTION 2: GUIDING PRINCIPLES.

GUIDING PRINCIPLE 1:

PATIENT CENTRED: THE SERVICE IS TO BE DESIGNED TO MEET THE NEEDS OF THE INDIVIDUAL PATIENT.

23. Choice is a driver for change. Both commissioners and patients will increasingly influence the ways in which organisations respond to their needs. They will demand effective treatments delivered in a timely and appropriate manner in an environment which makes them feel empowered and part of the decision making process.

24. Practice based commissioning will enable GP's to innovate and transform patient pathways. Primary care will provide first contact with patients for diagnoses, treatment and referral.

25. A network of community based health care services will be expanded and developed to increase the range and volume of health services provided closer to peoples homes. They will include a range of services e.g. high volume and low complexity outpatient services.

26. Minor elective procedures and an urgent treatment service will form part of an integrated health care network. This will ensure that the acute trust works in true partnership with our primary and Social Care colleagues.

GUIDING PRINCIPLE 2:

APPROPRIATENESS: EVERY PATIENT WILL BE MANAGED IN THE MOST EFFECTIVE MANNER, BY THE MOST APPROPRIATE STAFF, IN THE MOST SUITABLE ENVIRONMENT, ACCORDING TO THEIR CLINICAL NEED, AND THEIR LEVEL OF ACUITY.

27. The current model does not support the rapid assessment and treatment of the unstable and undiagnosed patient. In elective surgery the process is disjointed and unpredictable.

28. The acute hospital is geared to managing the complex case mix. In order to do this staff need to be appropriately trained with the appropriate skills being available in the appropriate place.

29. Patient treatment plans should eliminate the need for multiple handovers, delays in decision making and management of the disease process. Numerous studies have shown that where several handovers occur then this is detrimental to both clinical outcomes and length of stay.

30. The proposed model is an acuity based model and takes into account illness severity. Patient acuity is most fundamental in determining the priority and the sequence of tasks required to successfully manage the presenting patient.

31. Ensuring such a skilled and appropriate work force will require the continued commitment to education and training, as well as ensuring that all of the clinical team are competent in their respective disciplines.

GUIDING PRINCIPLE 3:

EVIDENCED BASED PRACTICE, ALL PATIENTS WILL RECEIVE CLINICAL CARE THAT IS BASED ON PRINCIPLES UNDERPINNED BY A BODY OF EVIDENCE.

32. Evidenced based practice (EBP) is an approach to health care wherein health professionals use the best evidence possible, i.e. the most appropriate information available, to make clinical decisions for individual patients. EBP values, enhances and builds on clinical expertise, knowledge of disease mechanism and patholophsiology.

33. It involves conscientious decision making based not only on the available evidence but also on patient characteristics, situations and preferences. It recognises that healthcare is individualised and ever changing and involves uncertainties and probabilities. Ultimately EBP is the formalisation of the care process that clinicians have practised for generations.

34. There are set standards that inform and provide guidance on how clinical care should become more evidence based:.

1. National and European guidelines and regulations.
2. Legal frameworks
3. Medical and Ethical policy
4. Current Literature and Research Evidence
5. National Service Frameworks
6. Established Protocols
7. Clinical audit/variance analysis

SECTION 3: NINE KEY FUNCTIONS

35. As explained in the introduction this section is under construction and currently contains the draft narrative for the first four functions.

1. EMERGENCY CARE

36. The new clinical model supports having a multi-skilled and dedicated clinical team that will support patient flows as well as providing a set base for key clinical teams to be located to drive the patient process. Delineating between majors and minors will facilitate improved patient care. This will also provide a structured approach to patient pathway management.

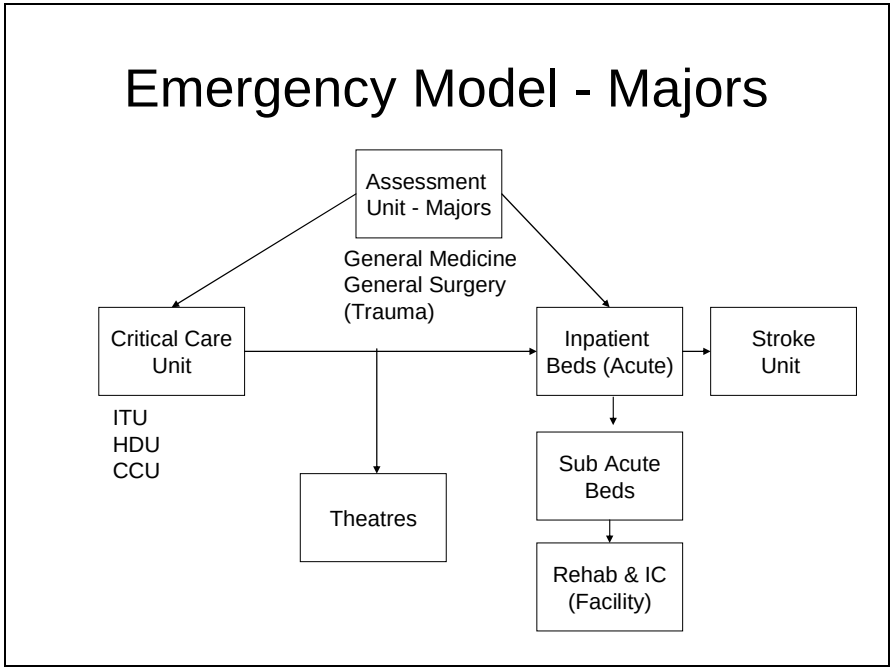
FOCUS ON EMERGENCY CARE

37. The new model ensures that there is a consistent response to patient management regardless of where, when or how the patients access the system. In addition the patient's needs are to be met by the professional best able to deliver the service supported by diagnostic and specialist advice which will be readily available to deliver timely assessment and treatment.

38. We will ensure that patients are seen on the basis of 'see and treat'. There will be a multi-disciplinary approach with integrated working. The focus will be on preventing admission into in patient beds (approximately 30%) with the ability to hold patients until a clear decision is made.

39. Where possible the assessment area will initiate the agreed hospital based care pathway. Patients will move into the appropriate area either High dependency/Critical care or a home ward. The predicted length of stay in this area if unable to discharge will be 48 hours.

40. We will ensure that information follows patients in real time utilising information technology and where that is not available a paper system that is clear and traceable.



MINORS

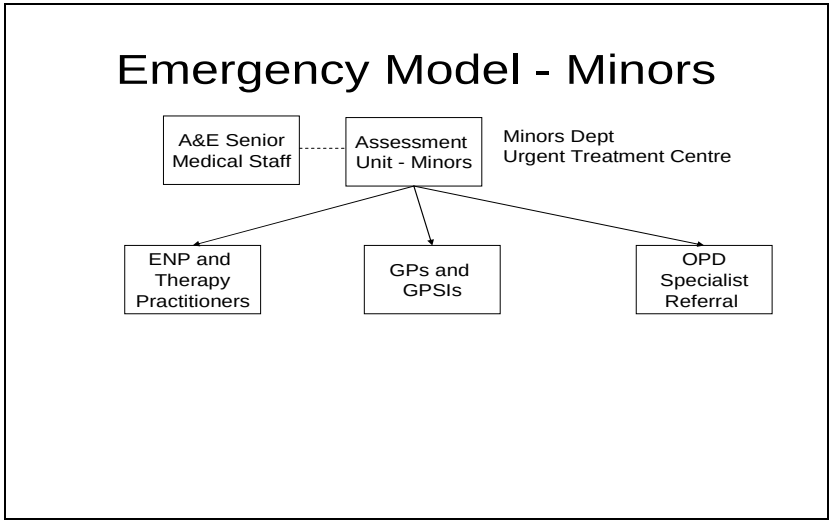
41. This is a Primary care led service requiring primary care expertise, closely linked to the acute assessment and diagnostic service. This will be

accessible 24 hours a day. A triage process will lead to assessment and treatment and once treated the patient will return home. If triage highlights a major illness or injury there will be direct access to the acute assessment facility.

42. This service will also capture any patients at an early stage of illness which can then be appropriately managed by the General Practitioners team.

43. By developing this integrated model with the PCT, out of hours nursing, intermediate care team and mental health services the patient experience will been enhanced by the direct access to both the community and acute specialists.

44. This model enhances the objective of seamless care with the potential to establish joint posts and joint protocols between the organisations.



2. SURGICAL CARE

45. Having a dedicated facility for surgical care is key to delivering the Clinical Model, in addition to treating day surgery as the norm for elective surgery. There is a need to maximise pre-admission and post discharge recovery in primary care.

46. The key features of this element of the model will ensure that appropriate referral and screening takes place in primary care. The surgical process requires optimising the patient in the pre operative phase using the skills of the appropriate clinicians.

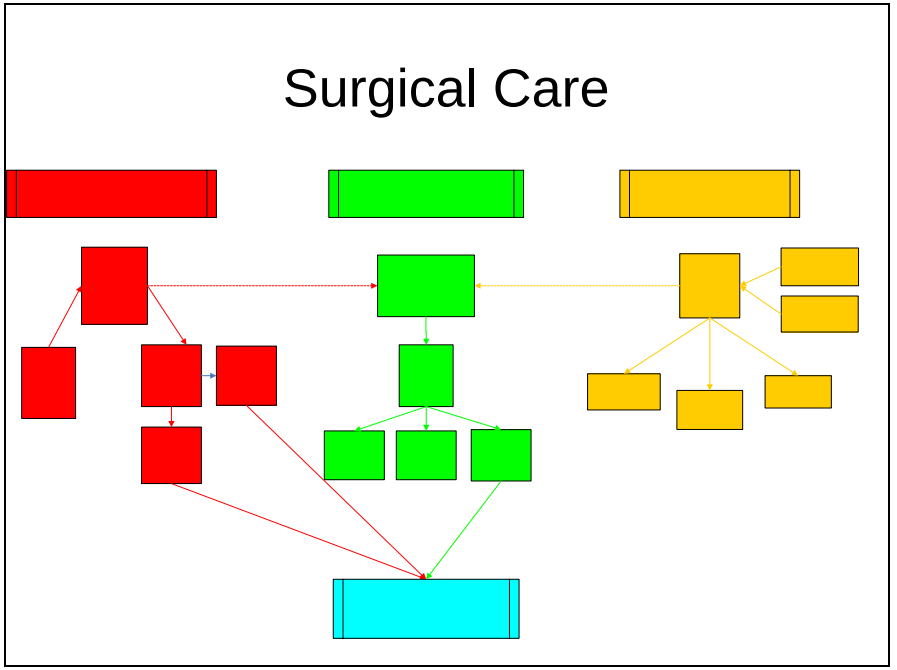
47. Engagement with the patient in a meaningful way by discussing options and providing patients with the relevant information concerning the proposed treatment plan has been clearly shown to enhance recovery times. This should occur in a dedicated pre surgical area.

48. In the immediate post operative phase and for complex surgery a longer period of time i.e. 24 hours will be spent in a Level 2 type facility. Following this stage patients will be cared for in their home ward or discharged to be further managed at home by the outreach teams.

49. Pre-assessment to identify anaesthetic surgical and post surgical needs which will be delivered by a combination of doctors, nurses and support therapists. This will ensure that the patient is as fit as possible for the surgery and anaesthetic. It minimises the risk of late cancellations by ensuring that all essential resources and discharge requirements are identified and co-ordinated.

50. A bed slot will be pre-booked for the patient who will be admitted into a pre-surgical area, allowing for a bed to be allocated after the procedure has taken place if this is necessary.

51. Patients admitted as an emergency will have been stabilised prior to entry into the surgical facility.



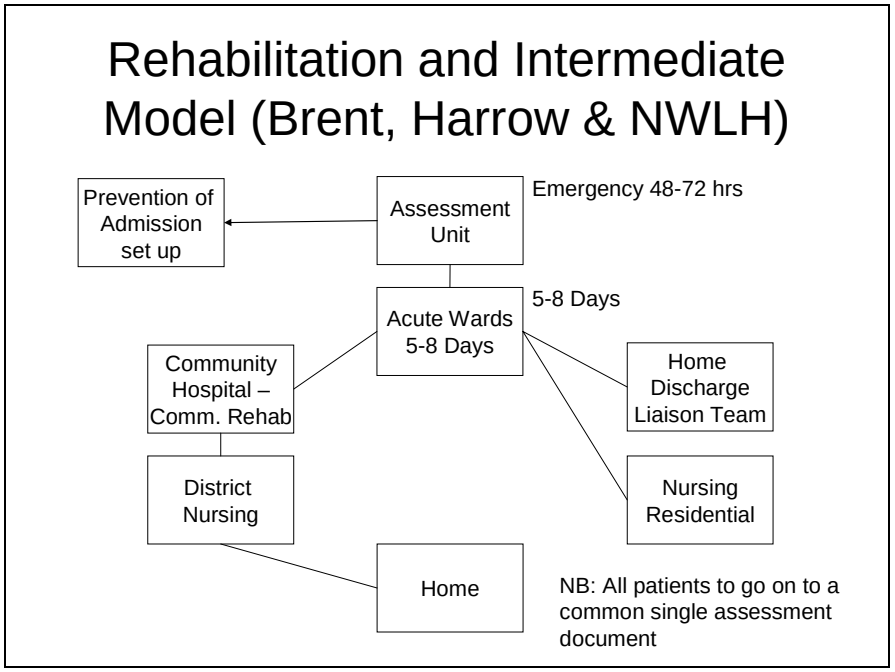
3. REHABILITATION AND INTERMEDIATE CARE

52. The Rehabilitation and Intermediate Care aspect of the clinical model, focuses on having a shared systematic approach to how we harness the services available across Brent, Harrow and NWLH.

53. This system would benefit patients by providing an integrated service that is supported by a single assessment document.

54. The key principles include:

1. A joint clinical strategy that support patients across Brent, Harrow and NWLH has been agreed.
2. Front end support team for the emergency cases.
3. An integrated service – combining community and acute trust resources.
4. Development of a 'Menu' of services that will support an integrated service.



4. OUTPATIENTS/CHRONIC DISEASE MANAGEMENT

55. The Modernisation of outpatients in this model is centred a round ensuring that the demand management and booking service is fully exploited.

56. Multi-skilling of staff to take on a more pro-active role in this area is key to it's success. Providing a responsive and timely approach to accessing an expert opinion is critical.

57. Development will focus on:

- Demand/ capacity/ speciality specific.
- Patient experience
- Efficiency
- Modernised workforce
- Systems management.
- Deliver clinical and managerial targets.