



Health Partnerships Overview and Scrutiny Committee – Supplementary Agenda

Tuesday, 20 September 2011 at 7.00 pm
Committee Rooms 1 and 2, Brent Town Hall, Forty Lane, Wembley, HA9 9HD

Membership:

Members

Councillors:

Kabir (Chair)
Hunter (Vice-Chair)
Beck
Colwill
Daly
Hector
Ogunro
RS Patel

first alternates

Councillors:

Mitchell Murray
Leaman
Clues
Baker
Sheth
Aden
McLennan
Naheerathan

Second alternates

Councillors:

Moloney
Ms Shaw
Cheese
Kansagra
Van Kalwala
Al-Ebadi
Mistry
Oladapo

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The press and public are welcome to attend this meeting

Supplementary Agenda

Introductions, if appropriate.


Apologies for absence and clarification of alternate members

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Report to follow.



- Please remember to SWITCH OFF your mobile phone during the meeting.
- The meeting room is accessible by lift and seats will be provided for members of the public.
 - Toilets are available on the second floor.
 - Catering facilities can be found on the first floor near the Paul Daisley Hall.
 - A public telephone is located in the foyer on the ground floor, opposite the Porters' Lodge

	<p>Health Partnerships Overview and Scrutiny Committee 20th September 2011</p> <p>Report from the Director of Strategy, Partnerships and Improvement</p>
<p>For Action</p>	<p>Wards Affected: ALL</p>
<p>Paediatric Services at Central Middlesex Hospital</p>	

1.0 Summary

- 1.1 The Health Partnerships Overview and Scrutiny Committee will receive an update from North West London NHS Hospitals Trust on their plans for the Paediatric Assessment Unit at Central Middlesex Hospital. Members will recall from the committee's previous meeting in July 2011 that the trust wishes to close the PAU. There were a number of reasons for this:
- The reduction in demand for services at the PAU following the opening of the Urgent Care Centre at Central Middlesex Hospital in April 2011.
 - The impact that reduced demand is having on staff at the PAU, who are concerned that they are becoming "de-skilled".
 - The financial demands of retaining a service that is not treating enough patients to even cover its costs – the service could lose at least £345,000 per year if demand remains consistent with current levels
- 1.2 Before the current arrangement for paediatric services were introduced by North West London NHS Hospitals Trust, a 12 week formal public consultation took place, as it was considered that the changes being proposed by the trust constituted a significant service variation. However, the trust does not want to run a 12 week consultation for this service change, but consult informally with service users instead.
- 1.3 The committee considered this issue at its meeting in July 2011 and at that stage asked to see the results of the informal consultation with service users before deciding whether to recommend whether a formal consultation should take place, or not. The committee was especially keen that consultation took place with Sickle Cell patients, and their families, as specialist service are to remain at CMH. The results of the informal consultation should be available and members should satisfy themselves that patients are happy with the proposed changes to paediatric services at CMH.

2.0 Recommendations

- 2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report from North West London NHS Hospitals Trust on the future of

paediatric services at Central Middlesex Hospital and decide whether or not to recommend that a full public consultation takes place on the proposals.

Background Papers:

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Report to: Brent Health Partnerships OSC

Report from: The North West London Hospitals NHS Trust
and NHS Brent

Date of meeting: 22nd September 2011

RE: Emergency Paediatric Services at Central Middlesex
Hospital

1. Purpose of report

This report follows the submission of a report to the 26th July 2011 Committee meeting, which described in detail the impact of the Brent Urgent Care Centre on paediatric services at Central Middlesex Hospital and the rationale and detail behind proposing an amended model of emergency care that decommissions a severely underused Paediatric Assessment Unit.

It was agreed by this Committee that a public consultation was not required as the proposal did not constitute a significant change to services. However, it was requested that a further period of informal engagement should be undertaken to provide the Committee with the assurance it needs through satisfaction of the four new tests laid out in the NHS Revised Operating Framework (2010/11). These are:

- Clear Clinical Evidence base
- Impact on Choice
- Support from GP Commissioners
- Strengthened public and patient engagement

This report does not seek to replicate the detail of the background statistical data that was included in the first report to this Committee, but rather to focus on how the 4 tests have been satisfied. Please refer to the previous report for the raw data underpinning this proposal.

2. Background

In 2010, after listening to more than 1200 parents, children, doctors and nurses, a new configuration of services for children at Northwick Park and Central Middlesex Hospitals was introduced to reduce unnecessary admissions and improve links with community child health services. The key elements of this new configuration were:

- i. A new GP led Urgent Care Centre (UCC) which is open 24/7 at CMH and 12/7 at NPH and staffed by Paediatric nurses.
- ii. A new consultant led Paediatric Assessment Unit (PAU) open every day 24/7 at NPH and until 10pm at CMH.
- iii. Centralised emergency surgery and overnight care at NPH
- iv. Internal ambulance service to NPH for children coming to CMH out of hours and requiring emergency consultant care.

Twelve months on the new configuration of services is being reviewed to ensure that they continue to provide local children with the best care possible.

2.1 Findings of the Annual Review

- The 24/7 Urgent Care Centre at Central Middlesex has been a huge success, effectively treating 9 in 10 of all children coming to Hospital for an emergency.
- The Consultant-led PAU at Central Middlesex is severely underused. Less than one child per day is admitted to it. As a result the staff are becoming de-skilled from lack of activity. This alone creates an urgent clinical need for action.
- The numbers of children requiring the PAU at Central Middlesex have steadily reduced over the last six months and will continue to do so as the UCC becomes more established.
- More parents are exercising informed choice and using Central Middlesex for non-life-threatening emergencies and their regular outpatient services. Both patients and the LAS are using NPH and neighbouring Hospitals for life threatening emergencies.

2.2 Proposed Way Forward

In the light of these findings we think it is sensible to decommission the severely underused PAU service at Central Middlesex, thus freeing PAU staff to treat more children elsewhere during the day. This would remove unnecessary duplication of services and further consolidate Northwick Park as an emergency and specialist Hospital. This will make the best use of the skills and time of consultants and nurses and better align our services to patient choice – i.e. the way patients actually use them. The amended configuration of emergency hospital services are represented in the following table:

	Northwick Park Hospital	Central Middlesex Hospital
Accident and Emergency Services 24/7 general service	✓	✓
Urgent Care Centre for non life threatening emergencies	✓	✓
Day care in the Children's Ward Appointments, operations + observation beds	✓	✓
Night Care in the Children's Ward In patient services	✓	
Emergency Surgery Centralised expertise at NPH	✓	
Emergency Paediatric Assessment Unit Emergency Consultant Care 24/7	✓	
Specialist Sickle Cell Day service Established and trusted outpatients service at CMH		✓

2.3 Benefits to Children

- Better use of hospital staff – which means more access to consultants and senior nurses for life-threatening emergencies
- Specialist emergency equipment and staff where patients actually use it – which means we are listening to patients to create even stronger and safer overnight wards at Northwick Park
- Simpler one-stop-shop service – Which means that 9 in 10 of all children who need emergency non-life-threatening care can be seen by the Urgent Care Centre at Central Middlesex 24 hours a day, 7 days a week.

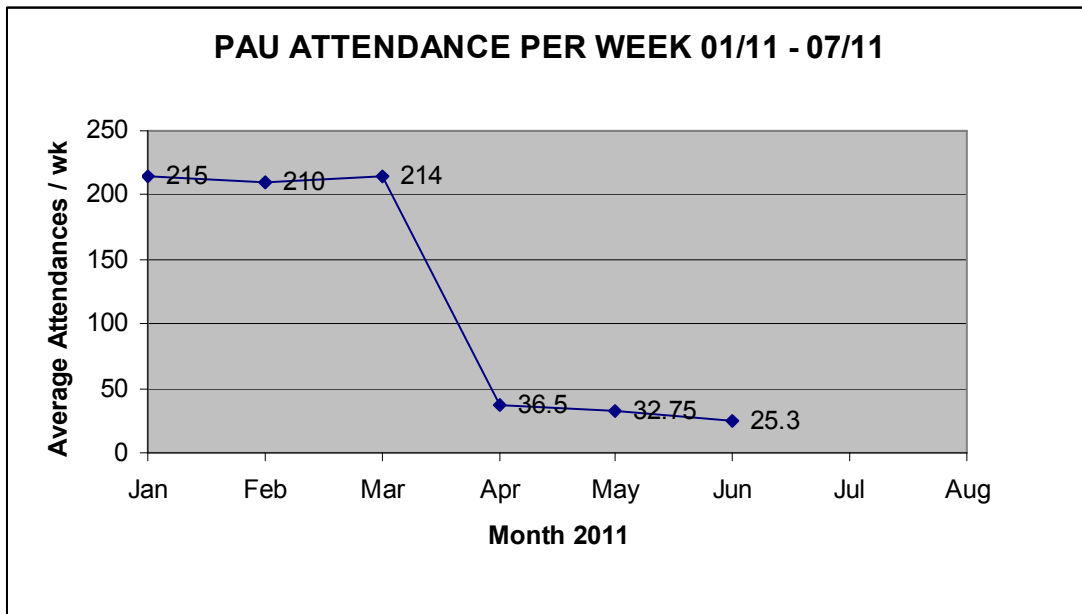
The report will demonstrate how this proposal meets the 4 tests outlined in section 1.

3. TEST ONE: Clinical evidence base

3.1 Evidence for reduced Demand for the PAU services

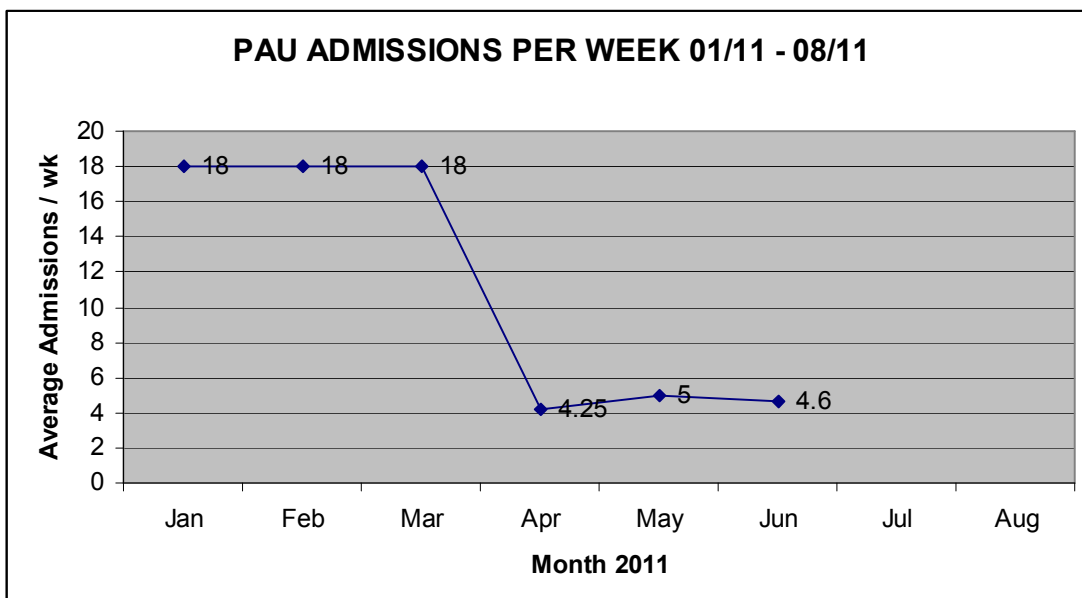
88% REDUCTION IN PAU ATTENDANCES

Statistical data from NWLHT clearly demonstrates that the CMH PAU has undergone an inverse exponential reduction in weekly 'attendances' since April 2011:

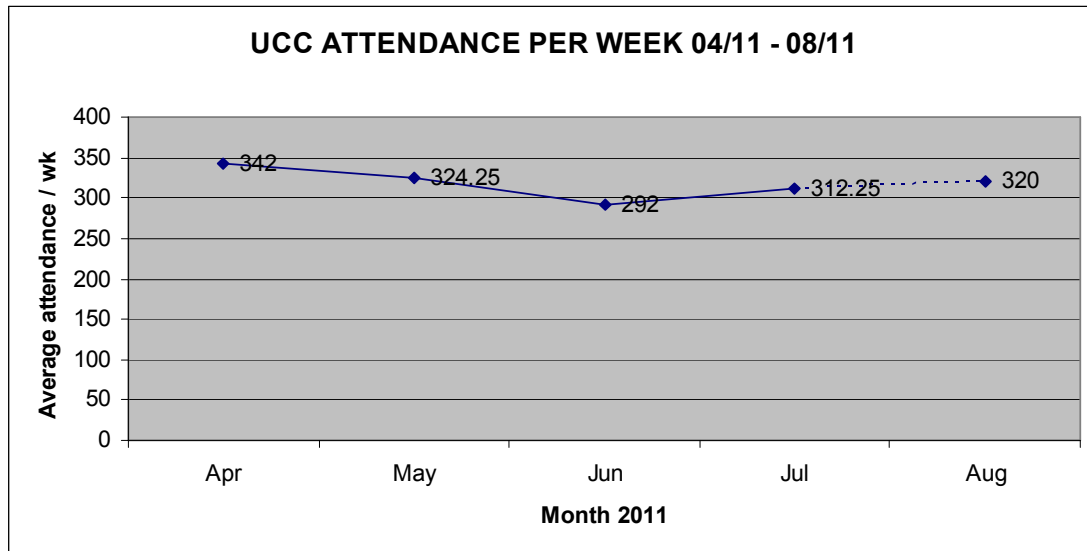


75% REDUCTION IN PAU ADMISSIONS

Correspondingly, weekly 'admissions' have dropped from an average of 18 per week to only 4.6 per week. This is equivalent to 0.65 of a child admitted each day.



All of the evidence points clearly to the fact that the dramatic drop in PAU attendance and admission is as a direct result of the success of the Urgent Care Centre that launched in April 2011.



In the period April to August 2011, out of an average weekly total of 329 emergency presentations at CMH, an average of 318 were seen and effectively treated by the UCC.

This means that on average the UCC is seeing and effectively treating 9 in 10 of all children presenting for emergency care at CMH.

Closer analysis of the data further demonstrates an increasing trend.

This is clear clinical evidence in support of the proposal to decommission the PAU at Central Middlesex with immediate effect.

Financial Imperative

Although the financial implications of an underused acute service were covered extensively in the previous report, it is necessary to restate its conclusions:

The PAU is losing an average of £6,629 per week at present activity levels (direct costs less direct income). The actual loss for the trust is much greater when the 28% overheads are applied.

3.2 UCC, capacity and clinical pathways

The UCC provides an excellent level of service. This is partly evidenced by no formal complaints registered about the UCC service in the period April – August 2011 and further suggested by an overall reduction in paediatric complaints across the trust in the same period. On the contrary, there is much anecdotal evidence of praise for the new service, based upon comments recorded throughout our engagement with patients and public.

The UCC has a clear clinical governance framework in place and is working to the highest standards. Teething issues were identified early on in the service that centred on appropriate onward referral pathways. These were immediately resolved and have since been reviewed to satisfaction by an independent panel of local GP commissioners.

The issue for this report is ensuring that the UCC and partners can effectively manage any complex emergency cases and implement protocols effectively and immediately, when the new configuration goes live. The evidence for this has been summarised in the following 2 sections:

3.3 Risk Assurance Framework

The Reconfiguration Team has identified the following as the most significant risks to the Trust in achieving the proposed reconfiguration:

- i) Critically unwell child arriving at CMH;
- ii) Delayed transfer for child from CMH to inpatient unit;
- iii) Loss of nursing staff who will not wish to transfer to NPH for the centralised service;
- iv) Unable to support the need for high quality care for sickle cell patients transferred to NPH
- v) Lack of specialist support for children receiving surgical care in ACAD

The reconfiguration team has developed the following risk assurance framework which is monitored on a monthly basis.

Risk name	Description/impact of risk	Impact	Likelihood	Risk rating	Mitigation
Failure to manage a critically unwell child arriving at CMH	UCC and A&E staff unable to manage complex children who self-present	3	1	3	<ul style="list-style-type: none"> • The UCC specification requires the service to deploy a paediatric trained nurse on (24/7). All GPs and nurses must be qualified in level 3 safeguarding. • All permanent (ie non

Risk name	Description/impact of risk	Impact	Likelihood	Risk rating	Mitigation
					<p>locum) nursing and medical staff in CMH A&E have attended APLS/PILS training.</p> <ul style="list-style-type: none"> Nursing and medical staff began rotating between CMH A&E and paediatrics from September 2010 to ensure there was cross fertilisation and better integration. A&E transfer matrix in place to support CMH staff to ensure that patients are quickly and safely transferred. St Mary's have agreed to accept the rare critically unwell child (column 5 of the matrix) who arrives at CMH. CMH A&E staff will contact LAS control room (as per LAS' critical transfer protocol). The LAS will continue to take all 999 calls to Northwick Park instead of CMH.
Delayed transfer for child from CMH to inpatient unit	A child waits longer than 60mins for a transfer to an inpatient unit	2	4	8	<ul style="list-style-type: none"> Service standards agreed with the Trust's private ambulance service so that patients do not wait inappropriately. This system is currently well established for emergency surgery and has been operating in paediatrics since October 2010; A&E transfer matrix in place to support CMH staff to ensure that patients are quickly

Risk name	Description/impact of risk	Impact	Likelihood	Risk rating	Mitigation
					and safely transferred.
Unable to support the need for high quality care for sickle cell patients transferred to NPH	The current paediatric service may be undermined as patients requiring overnight care are transferred to NPH. NPH staff too inexperienced to manage the patients overnight.	2	2	4	<ul style="list-style-type: none"> The majority of children using the CMH service are seen and discharged on the same day and will not require transfer; Combined training programme in place for nursing and medical staff to ensure necessary skills transfer.
Loss of nursing staff who will not wish to transfer to NPH	Staff currently based at CMH will not want to work overnight at NPH	3	1	3	<ul style="list-style-type: none"> Senior nursing staff have been actively involved in the design of the clinical model. Staff concerns that they are becoming deskilled (due to reduced demand) and therefore recognise the need to centralise service.

3.4 High Risk Groups

Upon this framework we are developing a series of detailed clinical pathways and levels of service to mitigate any increased risks that the proposed changes could have to high priority groups. We have identified 4 such groups and focussed our non clinical and clinical engagement on better understanding how they would be affected and the steps we would need to take to ensure provision of the best level of care.

High Priority Group 1: Critically Unwell Child

The protocols for dealing with all children that self-present at Central Middlesex from the sick to the critically unwell child have been well established over the last 12 months. Led by A+E Consultant Tony Bleetman and Paediatric Consultant Wolfgang Muller these protocols have been developed specifically to help Emergency Department (EM) staff and the UCC deal with the full range of unexpected paediatric emergencies. *We are fully assured by our clinical leads that risk to this group has been minimised and managed appropriately.*

High Priority Group 2: Sickle Cell

In the 6 month period between March 2011 and September 2011, 15 children with sickle cell emergencies self presented at Central Middlesex Hospital. Of the 15, 10 children were treated and discharged on site and 5 were transferred and admitted to Northwick Park without incident. Even though the numbers are small, we consider this group high priority as risk of morbidity is high. During this most recent engagement period we met with 2 groups of sickle cell patients and parents and had a robust discussion about their needs and concerns. We are working with specialist sickle cell paediatric consultants Michelle Afif et al and have agreed to meet with patients and parents again in 4 weeks time to present our full proposal for sickle cell services at CMH and NPH. It is worthy of note that the system as it has been operating over the last 12 months has worked well for patients and the proposed changes detailed in this report, should have a negligible effect on their experience, in practice. *We are fully assured by our clinical leads that through their commitment to consistent engagement with patients and parents the risk to this group will be minimised and managed appropriately.*

High Priority Group 3: Safe guarding

Consultant Paediatricians Wolfgang Muller and Dr Arlene Boroda, who is the designated Paediatrician for NHS Brent, have agreed a high level pathway for ensuring that safeguarding issues are identified and actioned appropriately by UCC and EM staff. This includes the referral pathways of external agencies like GUM clinics, social care and the police. It also covers data collection and supervision of cases. They are in the process of detailing these protocols. *We are fully assured by our clinical leads that the risk to this group will be minimised and managed appropriately.*

High Priority Group 4: Mental Health

The aforesaid existing matrix for managing self-presenting children at Central Middlesex from the sick to the critically unwell child as developed by Tony Bleetman et al, includes provision for children with Mental Health emergencies. However, Paediatric Mental Health Services in the round is in urgent need of a singular multi partner working group to ensure that the complex needs of patients are always met, particularly in an emergency. NWLHT has committed to establishing this group with CAMHS Service Director, Jackie Shaw and clinical lead John Knottenbelt who is already leading the development of emergency protocols. CAMHS works across 8 Boroughs and commissioning contracts can differ between hospitals, so the complexity of provision will benefit from a singular group that will work to develop a singular matrix referral system across the CAMHS service. *We are fully assured by both the CAMHS service and our clinical leads that the existing matrix will provide a safe system for the management of Paediatric mental health emergencies with the commitment to enhance and develop them further.*

4. TEST TWO: Impact on Choice

9 in 10 of all children are receiving effective treatment by the Urgent Care Centre which demonstrates clearly that this service is in line with what patients need and how they use the service.

The 1 in 10 patients that require emergency consultant care are often frequent users of emergency services. Sickle cell patients have described to us that the process of transfer to Northwick park was efficiently and effectively implemented.

As the reconfiguration continues to embed itself and GP's promote simple sign posting advice to patients we believe that the downward trend of life threatening self-presenting emergencies at Central Middlesex will continue to decrease thus helping to further minimise risk.

Patients of course retain the right to choose which Hospital they want to be transferred to.

Based upon our engagement with patients and public and the observable trends of patient activity, we are assured that the impact on patient choice is negligible.

5. TEST THREE: Support from GP Commissioners

The Brent GP Commissioning Executive (GPCE) received a verbal presentation at their meeting on 14/09/11. This was attended by Brent GP Commissioners and clinical leads.

They were satisfied that the proposed decommission of the severely underused PAU is required as quickly possible to satisfy both urgent clinical and financial concerns. There was recognition and acceptance of our commitment to reviewing the pathways for our 4 high priority groups. Gp commissioners are keen to ensure that pathways for patients with sickle cell are enhanced and they support patients to understand the pathways and exercise choice. GP Commissioners have asked to have the opportunity to formally approve the proposed pathway for sickle cell patients.

We are satisfied that GP Commissioners and GP's have been sufficiently engaged in this process and will continue to be so engaged. We are assured by their support for this proposal.

6. TEST FOUR: Public and Patient Engagement

NWLHT and NHS Brent undertook another discrete engagement exercise for a two period between 1st September and 15th September 2011. This section summarises the engagement activity and the feedback received. 104 stakeholders were directly engaged and fed back their comments on the proposal. A further 1000+ were sent the information through e-networks both within and without the NHS community. *Please note that we are in a process of continuous engagement and have been since February 2009. Our engagement with key stakeholders: Clinicians, frequent users, commissioners and priority groups will continue as it is one of the ways that we ensure quality and consistency with patient choice.*

6.1 Activity Summary

	Stakeholder	Method of Engagement	Date	Participants
NHS				
1	PCT safe guarding leads	presentation	12-Sep-11	2
2	CNWL - Mental Health Services	presentation	15-Sep-11	2
3	Harness Consortium via GPCE	presentation / written feedback	14-Sep-11	5
4	Wembley Consortium via GPCE			
5	Willesden Consortium via GPCE			
6	Kingsbury Consortium via GPCE			
7	Brent Community Services	written feedback	n/a	3
VCS				
8	BRENT parent Forum	presentation	14-Sep-11	2
9	BRENT LINK	presentation	13-Sep-11	5
10	Brent Multi-faith Forum	presentation	06-Sep-11	9
11	HASVO	presentation	15-Sep-11	5
FREQUENT USERS				
12	BRENT Parent Carers - One Voice	presentation	14-Sep-11	10
13	BRENT SICKLE CELL - Parents	presentation	13-Sep-11	20
14	BRENT Sickle Cell - Broken Silence	presentation	06-Sep-11	3
YOUNG PEOPLE				
15	BRENT YOUTH PARLIAMENT	presentation	14-Sep-11	4
16	BRENT YOUTH MATTERS	presentation	13-Sep-11	16
17	HARROW YOUTH PARLIAMENT	presentation	07-Sep-11	20
				106

6.2 Engagement Feedback

Due to the time constraints that the production of this report was under, the detailed feedback received from each stakeholder that was engaged is being prepared as a separate appendix to this report and will be made available at the OSC meeting or shortly thereafter.

Without exception we found that every stakeholder that was engaged (bar one young person in Brent) expressed their positive support for the immediate need to decommission the PAU service at Central Middlesex. The reasons cited were clear: to prevent any further deskilling of clinicians and to stop the wastage of both human and economic resources as a result of gross under use.

However, each stakeholder equally raised the same concerns and sought the same assurances that this Health Partnerships OSC seeks.

This is a summary of the chief concerns that were raised and our responses to them:

- i) ***I understand that less than 1 in 10 children that self-present at Central Middlesex require admission for emergency consultant care but... If there is no emergency consultant care at Central Middlesex, how will you ensure that when you do receive a critically unwell child that he/she will receive the care that they need?***

We have managed the same arrangement for out of hours care for the last 12 months and even longer for emergency surgery. This proposal only extends our current arrangement to cover daytime emergency care as well. This means that NWLHT in partnership with the local health economy already has experience of this arrangement and we have the clinical pathways in place to manage it (e.g. safe guarding, critically unwell) or are in the process of establishing them (e.g. Sickle cell crisis management). We are committed to reviewing our clinical pathways to make enhancements and improvements wherever we can. We assure you that any changes to services are made with clinical sign off and will always be clinically safe.

- ii) ***Central Middlesex has a long standing, well trusted and well respected paediatric sickle cell service. We do not trust that Northwick Park staff have the expertise or experience to manage a crisis properly as things stand now. We understand the offer of 'same team, different location' but we want complete clarity about the level of provision that you will provide at both Hospitals.***

We agree that sickle cell services at both Hospitals needs to be clarified. Having met with 2 groups of sickle cell patients and parents

during this specific wave of engagement, we intend to develop detailed proposals for the future of sickle services at both Hospitals. We will meet with families again in 4-6 weeks to share these proposals and work towards agreeing an acceptable model of service. In the last 6 months, 5 Sickle cell patients that self-presented at Central Middlesex after 10pm were transferred and admitted to Northwick Park. Some of these families were present at the engagement event we held on the 13th September. We heard from those patients that the internal ambulance service worked well but there were mixed experiences concerning the quality of care received at Northwick Park. One was very happy with care while another felt that pain relief was not administered as well as it should – which is critical in a crisis. There should be no disparity in care and we would like to hear more from the families concerned to listen to their feedback and advice. As one participant rightly said, “UCC and NPH staff need to be able to recognise a sickle cell crisis and know exactly what to do”. Much work has gone into training the nursing staff at Northwick Park over the last 6 months but it will take time to build trust in the service there. These proposals extend the current arrangement for out of hours emergency care to cover the day as well. As such the change raises issues about where services should be located in the long term and what that means for patient choice. We will continue to work with clinicians and patients to agree this before decommissioning take place.

iii) *Whilst I fully see the clinical and financial need for this change, I think you need to ensure that CMH A+E have the staff to manage a paediatric emergency*

We agree and are currently updating our skills audit to ensure this is still the case and decide whether or not we need to ‘up skill’ the team. The UCC has a full time paediatric nurse as part of the agreed service level with Care UK and all clinical staff are trained to level 3 safe guarding. A+ E consultants are trained in emergency paediatric care which means they can stabilise a child ready for transfer to the appropriate Hospital (as determined by matrix protocol and patient choice).

iv) *Will you inform people of the changes?*

Yes. We will develop clear communication tools for the general public, our patients and GP’s to use and distribute across Brent and neighbouring Boroughs. We will work to target frequent user groups like sickle cell patients and children with long term conditions such as autism and mental health. This will help to further reduce the incidents of self-presenting children at Central Middlesex requiring emergency consultant care. It must be kept in mind though that over 9 in 10 of all children will still be effectively treated and discharged by the UCC.

7. Conclusions and Recommendations

7.1 Conclusions

We submit this report as our evidence of meeting the 4 tests set out by the revised NHS Operating Framework 2010/11. The report clearly demonstrates that:

1. There is a clear and uncontested clinical evidence base for urgent and immediate decommissioning of the PAU at Central Middlesex
2. Based on the observable trends in patient activity and the engagement feedback recorded, as well as the fact that similar arrangements have been in place for over 12 months, it is clear that this change will have a negligible impact, if any, on patient choice.
3. The GPCE, which represents all 4 of the GP Commissioner groups, has given its support for the decommissioning of the PAU at Central Middlesex. They support the approach to ensuring that the clinical pathways for priority groups are in place. They have requested they be asked to formally approve the proposed pathway for sickle cell patients and that this be available by 30th September.
4. Within 10 working days, we directly engaged over 100 people from key stakeholder groups in both Brent and Harrow covering patients, commissioners, clinicians, parents, frequent users and young people. Their feedback was conclusive in terms of their support for the proposal with the aforementioned concerns, of which we are fully committed to and already engaged in resolving.

7.2 Recommendations

The Health Partnership OSC is asked to agree that this is not a significant change and to support the following recommendations:

- The NWLH PAU service is decommissioned at CMH from October 15th 2011, subject to the agreement and sign off of the critical clinical pathways by Clinical leads and GPCE.
- The paediatric outpatient service and Brent Sickle Cell service will remain at CMH.