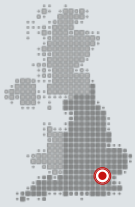
HSJ LOCAL briefing

hsj.co.uk/briefing

March 2012

LONDON ACUTE RECONFIGURATION



HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

ben.clover@emap.com
@benclover

In brief

Issue Accident and emergency services across north west London are set to be significantly reconfigured, with plans due to be published for consultation in June.

Context North west London currently has eight full A&E units. But projections show the £3.4bn health economy will be unsustainable in its current form, with a potential overspend of £1bn by 2015. Clinical quality is another factor in the "case for change", especially regarding emergency consultant cover in the evenings and at weekends.

Outcome The NHS North West London cluster is expected to propose a reduction in the number of A&Es, probably resulting in the closure of three departments. The final decision on which units will go is likely to be affected by existing merger plans and the influence of local politicians.

NHS chief executive Sir David Nicholson said in November that there was an "18-month window" for major acute reconfiguration before the approach of the next general election.

NHS London is taking up this opportunity in the south-west and north-west of the capital. While the Better Services Better Value review in the former has said one of the four acute trusts should lose A&E and maternity services, the north-west's reconfiguration is on a bigger scale.

The north-west's current configuration saw a total of 879,000 patients in 2010-11.

NHS North West London primary care trust cluster has argued quality needs to improve.

The cluster said in February: "If high quality hospital care is to be delivered, there is a clear need to consolidate some services in North West London."

The argument is also financial.

Between the two foundation trusts at either end of the patch, Chelsea and Westminster in the east and Hillingdon in the west, are four of London's most financially challenged hospital trusts: North West London Hospitals, Ealing Hospital, West Middlesex University Hospital and Imperial College Healthcare.

All have question marks over their viability in their current form.

Ealing and North West London are investigating a merger, Imperial is predicting a deficit for several years to come and West Middlesex's future as an independent organisation was being considered as part of a review of services across it and Imperial.

A McKinsey analysis carried out for NHS London showed none of the NHS hospital trusts in North West London were viable by 2014-15. Imperial could "become viable after an extended period" but it said West Middlesex, North West London and Ealing were "not viable under any tested scenario".

The cluster last year subsumed all the separate strategic projects these organisations had commissioned into one bit of work led by McKinsey.

It is due to produce the consultation options in mid-April.

The national context

Whether the cluster and by extension NHS London can achieve the change they are planning will be a test of several key parts of government health policy.

If London can convince the public that the out-of-hospital services are a sufficient replacement for the acute services they are used to then it bodes well for the drive to shift services into primary care.

NWL has an integrated care pilot in its inner-London boroughs, and will soon expand it to Brent and Harrow.

If there is the political will to sanction iconic changes in closely-fought constituencies then there is a good chance it can be done elsewhere. If clinical commissioning groups across the eight boroughs are persuaded and fight the case in public then it looks good for GPs taking the full system-leadership role when primary care trusts have gone.

The more optimistic leaders in the patch think London's success with stroke and trauma networks might even have changed the game on reconfigurations, that the public now recognise the clinical arguments for consolidating services in a way that weakens the "it's just a service cut" argument.

Finally, it would be a triumph of management over politics in London's NHS, a realisation of the ideas set out in Lord Darzi's Healthcare for London plan of 2007, halted by Andrew Lansley when he took office.

Those likely to be unaffected

The McKinsey modelling is not yet complete but there is already a developing consensus on the likelihood and location of places standing to lose services.

Senior sources told HSJ there were two "fixed points" in the patch which for ambulance journey-time reasons had to keep their A&Es - Hillingdon in the far west and Northwick Park, one of NWLH's two units, on the Brent/Harrow border.

Although the volume and casemix of patients seen by these units may change because of what is happening elsewhere, no-one thought moving them from these sites was desirable or feasible.

St Mary's, part of Imperial, is also considered very unlikely to see A&E and the raft of related departments move away. This is despite it not being protected by its location like Northwick Park and Hillingdon,

The St Mary's site is one of London's major trauma centres, a flagship policy for the strategic health authority. The difficulty of shifting the interdependent services was described as "nightmarish" by one senior clinician.

This leaves the units at West Middlesex, Charing Cross, Chelsea & Westminster, Ealing and Central Middlesex. There is an A&E at Hammersmith Hospital but this is not a facility that takes trauma and acute surgical emergencies.

Central Middlesex Hospital has been operating a reduced-hours service since November. A review of the unit by the cluster said it had "become too dependent on locums of variable quality and reliability and it was better to close the department at night in a planned way and redistribute the patients than to risk a sudden and unplanned failure of the department".

The likely losers

The configuration of emergency services in north west London is not a new issue.

One senior NHS figure with experience of the patch told HSJ: "The area has always been significantly over-bedded and there's always been a question mark over the A&Es. Do you need Ealing and West Middlesex A&E? Do you need Charing Cross and St Mary's?"

The same names came up in all the conversations about where made most sense to close services: Ealing, Central Middlesex and Charing Cross.

The key difference providers and commissioners expressed was the scale of the change.

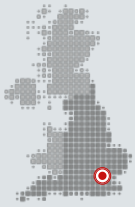
One source said the options being considered for Ealing and Charing

HSJ LOCAL briefing

hsj.co.uk/briefing

March 2012

LONDON ACUTE RECONFIGURATION



Cross were "potentially a great deal more radical" than replacing A&E with community services and an urgent care centre. The view fits with a review ordered by NHS London last year.

An unreleased McKinsey report from July and seen by HSJ modelled a "reconfiguration scenario" based on its forecast figures up to 2014-15 and saw "site closed" judgements for Ealing and Charing Cross hospitals.

A senior figure explained the case for downgrading Ealing: "On paper it's a 100,000-attendance A&E, but actually the urgent care centre is seeing between 50-70 per cent of that business. In reality it is a 60-70 per cent primary care attendance. So we would be talking about moving around 30,000 patients a year."

The source added that other units should be able to take on this activity.

"Ealing's population north of the A40 already go to Northwick Park; Southall's, in the south and west, would go either to West Middlesex or Hillingdon, just over the A312, which already serves a South Asian population in Hayes and Harlington. Being in the middle has always been Ealing's vulnerability."

A senior clinician in the patch acknowledged the strategic case for making Ealing one of the losers but pointed out the high acuity of part of the hospital's casemix.

They told HSJ: "Those patients are very sick. So I can't see it being less than an acute receiving area."

The point about an urgent care centre removing a proportion of an A&E's patients was also made about Central Middlesex Hospital. The PFI hospital has had a Care UK centre since last March, and is acknowledged by commissioners and providers alike to have been a success.

One provider told HSJ: "The general approach of the commissioners seems to be 'let's put a UCC in front and see what falls off'.

"At Central Middlesex the approach was far more successful than they had imagined because the local population was, frankly, using it as a GP surgery."

A senior figure in commissioning said: "The UCC at Central Middlesex had the effect of taking a lot of activity away from the hospital. That is one of the things driving the closure of the unit. It treats majors as well as minors, it's quite a comprehensive service."

But it was suggested that diverting A&E activity would be more problematic at Central Middlesex than at Ealing, indicating a less significant change was likely.

A source in the provider sector told HSJ: "Northwick Park is running flat-out at the moment, so the chance of Central Middlesex losing everything is fairly minimal.

"The extra £21m [DH capital funds for a refurbishment, announced in March/last month] will allow Northwick Park A&E to cope with the situation it has now. It will also upgrade the urgent care centre. A proper centre will free up capacity to take the strain."

NWLH has already indicated Northwick Park's urgent care centre should function more like Central Middlesex's.

One commissioner said a uniform approach to the centres was something London had not got right, with strong contracts in some areas driving real change, while others registered little effect.

But a senior figure at Imperial said the St Mary's urgent care centre seemed to have raised overall attendance, stimulating attendance from a group of patients they hadn't seen before.

Imperial

All of the possible scenarios outlined to HSJ included Imperial College Healthcare Trust losing an A&E. Most people thought it would be Charing Cross's which disappeared.

The NHS London McKinsey projection showed it as one of its "sites closed". A senior figure at Imperial said consolidating its units on one site was both "likely and appropriate".

Considered against its nearest equivalents it made no sense to keep Charing Cross's A&E open, another source, on the commissioning side, said.

Chelsea & Westminster Hospital's estate is relatively new while "Charing Cross is falling down", HSJ was told.

Charing Cross also comes off worse when pitted against St Mary's, because of the latter's status as a trauma centre.

Significant reconfiguration within Imperial has long been rumoured but HSJ was told this was the first time it had been actively pursued.

"People think there's been a secret plan in a safe in Imperial somewhere and there actually hasn't. They didn't want the political fallout," a senior figure said.

But a well-placed source at Imperial stressed that investment would be required to remodel the trust's services.

"When you close an emergency department somewhere between 20 and 25 per cent of those patients disappear. If you close Charing Cross some of them may go to Chelsea & Westminster and some of them may go south of the river.

"But If Imperial consolidated its departments to one site we would need investment for beds and building extra capacity at St Mary's will be difficult.

"Most of the emergency departments in North West London were built for far fewer patients. None of them are really ideal for an increase in volume and a more acute casemix."

What happens now?

NHS North West London will make a case for reconfiguration this summer which is both clinical and financial.

One individual who will have a key role in making the case said the high-profile success of programmes like the stroke pathway could have altered the shape of the debate.

"The stroke reconfiguration has really done a lot of good to the way people see these changes," she said. "They can recognise a clinical case for these things in a way that is new."

On the medical front, Ruth Brown, vice president of the College of Emergency Medicine, said: "Most of the members in London recognise that reconfiguration is inevitable."

Another senior clinician told HSJ the consensus across their colleagues was "that there are probably too many emergency departments and we understand that North West London could have fewer".

But the clinical evidence is not as clear-cut as the cluster might hope for when making its case.

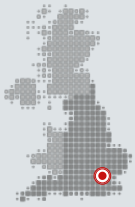
The strategic health authority study of avoidable deaths over weekends and evenings had a headline figure of 520.

But the unreleased McKinsey modelling exercise, seen by HSJ, shows Ealing, often considered the exemplar of a trust that should see its work moved elsewhere does well, despite its small size. It sees less than half the avoidable deaths assigned to Imperial, for example.

The financial case is more straightforward.

The McKinsey model, which covers a three-year period, shows the acute spend in the cluster to be unsustainable. It says that the planned reductions in hospital spend by the commissioners will render

LONDON ACUTE RECONFIGURATION



some trusts unviable.

What has not been produced so far is a financial case for consolidating emergency services, of how much can actually be saved by stopping providing a service at a site.

The only publicly available projection is the outline business case (link provided earlier) for the Ealing/North West London Hospitals merger, which estimated savings of £69.5m in the most radical modelled scenario. This scenario would see all acute inpatient medical care taken from Ealing.

Perhaps unsurprisingly the level of optimism about the achievability of the reconfigurations varies.

Although commissioners are braced for a "bumpy" ride from councillors and MPs in Ealing and Hammersmith & Fulham boroughs they still possess a degree of confidence.

On the provider side the view was bleaker.

Although the cluster's timetable anticipates "transition to implementation" of the plans in December one senior figure told HSJ: "In one year's time we will still be dealing with the genuine concerns from consultation. It will still be 'we are going to save all our hospitals'.

"If I was a member of the public I would like to see community services and primary care work better before I was happy to stop going to hospital. I would like to be there in a year's time but suspect we will still be dealing with people's very real concerns."

In three months' time the scale of those concerns will start to be known.