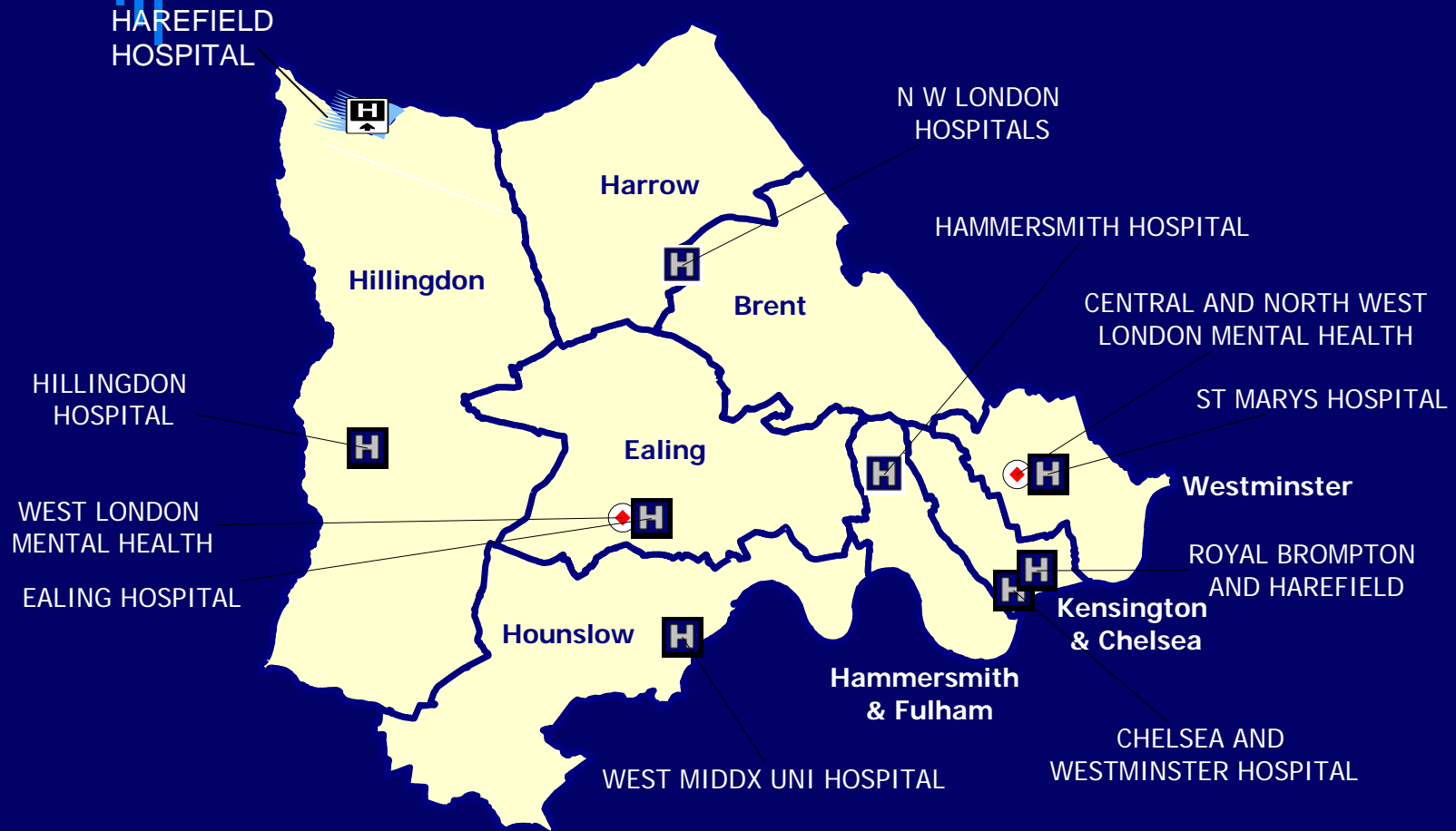


Inter-hospital Transfers

North West London Cardiac Network

Maria O'Brien, Network Director

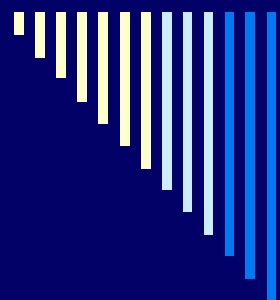
NWL Acute Trusts and PCTs





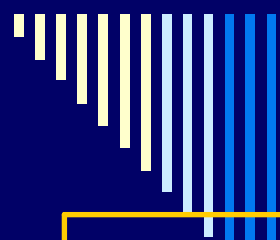
NW London Demographics

- Population: 1.85m
 - 35% of residents from ethnic minority groups
 - Healthcare: 8 PCTs, 7 acute hospital sites & 4 tertiary sites
 - Patient flows:
 - 95% of all NW London patients are treated within the Network
 - Significant out of sector flows
 - 40% of the work flow from 2 of the tertiary sites originates from outside of NW London
 - 75% of the work flow to the remaining 2 sites originates external to NW London
 - The above factor needed to be understood when considering capacity and performance
-



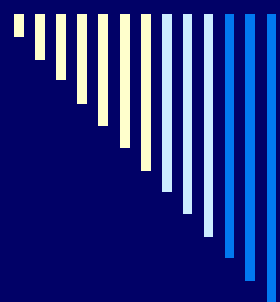
External NW London Patient Flows

- Royal Brompton
 - Heatherwood and Wexham Park Hospitals, East Berkshire
 - Kingston Hospital & Queen Mary's Hospitals, SW London
 - Royal Surrey Hospital, Guildford
- Harefield
 - Slough
 - Luton and Dunstable Hospital
 - Queen Elizabeth II, The Lister and Watford Hospitals, Hertfordshire
- Hammersmith
 - Wycombe and Stoke Mandeville Hospitals
- St Mary's
 - Hemel Hempstead and Watford Hospitals



NW London Catheter lab capacity

Hospital	Number of labs
Hammersmith	2 (3)
St Mary's	2 (3)
Brompton	4
Harefield	3
North West London Trust (Angiography + PCI)	1
Ealing (Angiography only)	1
Total	13 (15)

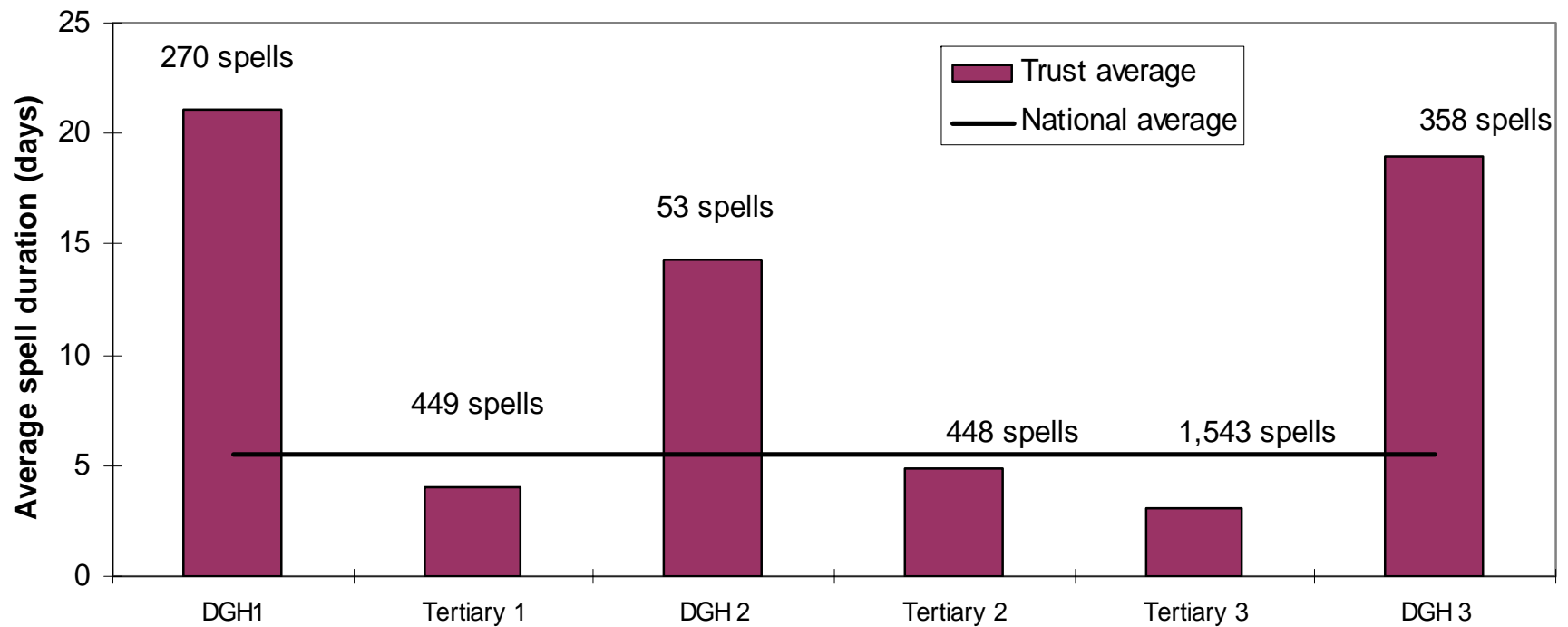


The Problem 2004/2005

- ❑ Waits in some NW London Acute Trusts of 6-8 weeks for Cardiology common (surgical waits often longer)
- ❑ Numbers of patients and time waiting frequently escalated to CEO & SHA CEO level
- ❑ Poor response from NW London organisations to 2004 national IHT survey
- ❑ SHA analysis of NW London centres indicated waiting times in excess of the 15.3 days national average
- ❑ Viewed against a context of significant NW London capacity
- ❑ Some correlation seen between time waited & mortality

Local Picture – NW London

Cardiac Catheterisation: HRGs E13/E14



Source: Admitted Patient Care Data 2003/04



The Approach

- ❑ NWLCN asked by CEOs to lead supported by the SHA
 - ❑ Local data collection and analysis at operational level
 - ❑ Number of presentations at CEO level detailing extent of the problem
 - ❑ CEO's at all referring and tertiary centres asked to identify a senior management and clinical lead for their organisation
 - ❑ Individual interviews arranged with the identified organisational leads to scope the problem and highlight areas of good practice
-



Findings: Initial audits

- Main themes identified:
 - Problems related to the referral process: identification, assessment, risk stratification and referral of patients
 - Issues surrounding scheduling and waiting list management & poor data collection
 - Poor optimisation of patients pre transfer
 - Lack of co-ordination across network centres
 - Commissioning issues
-



Areas of good practice

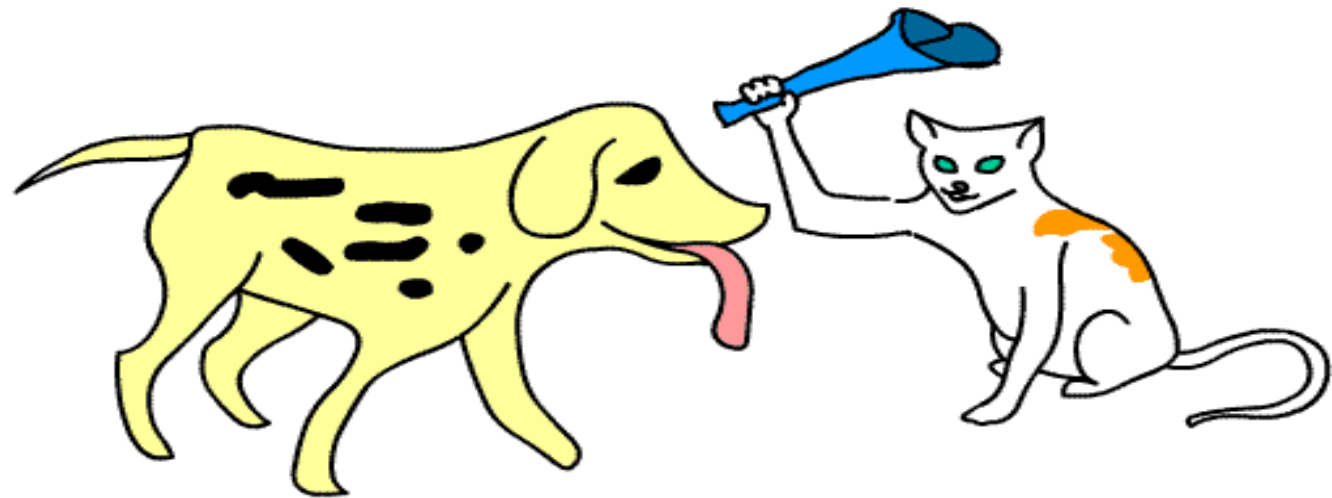
- Treat and return
 - Standardised referral & ICPs
 - Primary PCI (Los 10 Vs 4 days)
 - Trust co-ordinators to facilitate IHT management
 - Early discharge with guaranteed surgery date
 - Data collection processes
-

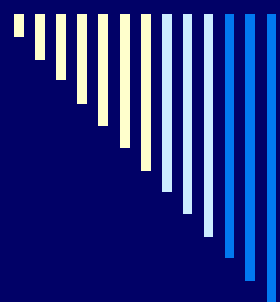


Agreeing the way forward

- Reports formulated & fed back to CEOs and organisational leads
 - Convened:
 - A high profile evening meeting across the network to discuss findings and agree next steps
 - Established a series of ongoing meetings to take forward required improvements
 - Agreement to concentrate on Cardiology: largest numbers & start of the pathway
-

Gaining Consensus





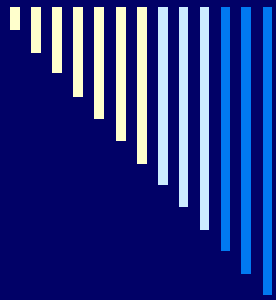
Acceptance that:

- ❑ Current waiting times and existing practices unacceptable
- ❑ Centres **MUST** start working together across the network and not in isolation
- ❑ Change required by both referring and provider centres to improve the current situation

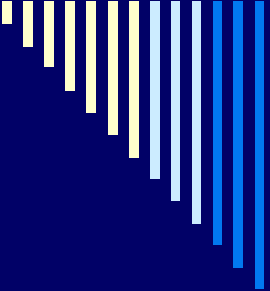


What was agreed?

- Agreement from all organisations that a NW London approach essential to agree a model for **both** inter-hospital transfers & Primary PCI across the sector
 - Agreement that significant & speedy progress was required to address access times & inequalities
 - Agreement to work towards implementation of a 48 hr target from referral to transfer for treatment
 - Agreement to standardise referral processes
-



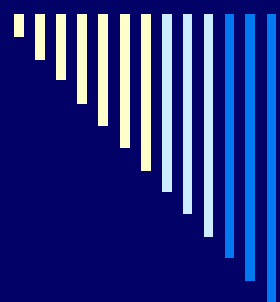
- Agreement to build upon existing arrangements between hospitals and cardiac centres to gain rapid access for acute patients
- Agreement to develop a centralised system for monitoring utilisation of existing capacity, demand from acute centres and to facilitate transfer of patients to alternative centres where delays occur
- Agreement that NW London clinicians, managers & commissioners would work together to resolve



What was done?

- 48 hr target

- Provided focus & concentrated minds to required progress
 - Clinically appropriate goal
 - Enabled recognition that:
 - Consensus required at all levels across NWLCN to manage IHT effectively
 - Teams would need to change existing ways of working
 - Clinical advantage of 'hub and spoke' model - 48 hr target would potentially dismantle this
 - Where clinical links effectively working; agreement not to intervene unless patient waits exceeding weekly threshold
 - 48 hr target remains the benchmark:
 - Organisations assessed against 48 hr target & alongside existing clinical hub and spoke models
-



What was done?

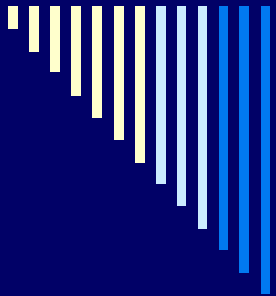
- Risk assessment & referral

- Review of existing referral protocols
- Development of a standardised risk assessment and referral form to enable standardisation of practice, reduce inequalities and facilitate data collection and monitoring
- Risk assessment based on TIMI risk score for NSTEMI
- Some reservations/resistance from clinicians but agreement to implement eventually reached for all centres
- SIMs assisted implementation and roll-out at a local level across the Network

Timi Risk Score

A Risk Assessment in Non-ST Elevation MI and Unstable Angina			TIMI RISK SCORE
History	Points	Applicable to: Patient with ischaemic chest pain at rest within past 24hours, with ST deviation and/or +ive cardiac marker.	
	(Circle if yes)		
Age >=65	1	Circle the points for any factors that apply, and add up points total	
CAD Risk Factor:			
(>2 ticks, score 1)	1		
Chol	<input type="checkbox"/>		
FH	<input type="checkbox"/>		
HT	<input type="checkbox"/>		
DM	<input type="checkbox"/>		
Current Smoker	<input type="checkbox"/>		
Known CAD (>50% stenosis)	1		
Prior Aspirin use	1		
Presentation			
>=2 Episodes angina in last 24 hours	1		
Elevated Cardiac Markers	1		
ST Deviation >=0.5mm in any lead	1		
Risk Score Total			

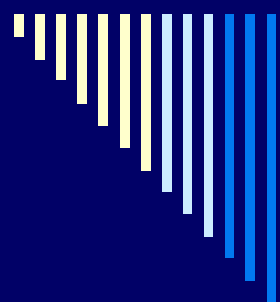
Risk Score	Risk of Death, MI or Revasc. at 14 days	Risk Category
0-1	5	Low Risk
2	8	Intermediate Risk
3	13	
4	20	High Risk
5	26	
6-7	41	



What was done?

- Treat and Return

- ❑ Negotiation with all NW London centres to implement day case 'treat and return' agreements with provider centres (support gained from LAS/private ambulance services)
 - ❑ Initial reluctance by some centres overcome through combination of peer pressure, training and persuasion!
 - ❑ Tertiary centres supported training of DGH nursing staff, introduction of written protocols and phased implementation
 - ❑ Review of existing 'treat and return' strategies to ensure that capacity adequate to meet demand (slots increased)
 - ❑ 'Treat and return' protocols established across all centres to facilitate PPCI
-



What was done?

- Primary PCI

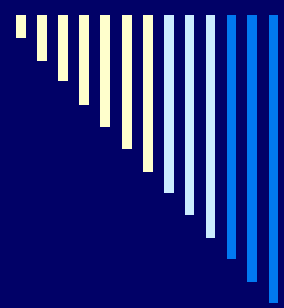
- ❑ Agreed sector wide model for roll-out of PPCI on a staged basis to all residents across NW London
- ❑ Part of the national pilot for NIAP
- ❑ Achieved by Oct 2005, 24/7 PPCI available to all NW London residents
- ❑ Provision via 3 centres working together
- ❑ Enabled improved throughput for STEMI relieving pressures in local centres & A&Es
- ❑ Ongoing evaluation has consistently demonstrated significant reduction in LoS across all centres



What was done?

- Central co-ordinator

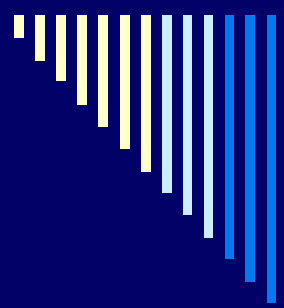
- Job description developed and post recruited to
 - Remit:
 - To establish systems to monitor clinical and non clinical data via risk assessment forms
 - To assess utilisation of capacity within the treating centres on a daily basis
 - To monitor demand
 - To intervene to move patients to alternative centres where delays occur
 - Interaction:
 - Established operational links within each referring and treating centre (Co-ordinators or senior nurses)
 - Establish robust systems for monitoring
 - Establish data base for inputting and monitoring data across all centres
 - **BUT VOLUME OF PAPER UNMANAGEABLE!**
-



Network Approach

- IHT Web-based referral system

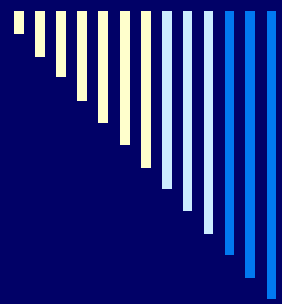
- ❑ NWLCN Board commissioned web based IT referral system (links to all centres via NHS net, secure, date stamp, calculates risk by incorporating paper version of risk stratification form, fields to export to external national audit)
- ❑ Enables centres to view who is waiting at the DGH and the 'hub'
- ❑ Enables centres to refer elsewhere
- ❑ Enables centres to see and compare waiting times
- ❑ Facilitates clinical and non-clinical audit
- ❑ Roll out based on 'hub/spoke' model
- ❑ Roll out concentrated initially in NW London with subsequent extension to external NW London centres



IHT Web based referral system

– progress to date

- Centres currently using the system:
 - St Mary's Hospital
 - Hammersmith Hospital
 - Charing Cross Hospital
 - Northwick Park Hospital
 - Central Middlesex Hospital
 - West Middlesex University Hospital
 - Ealing Hospital (commenced Feb 06)
 - Stoke Mandeville (commenced Feb 06)
 - Hemel Hempstead (commenced Feb 06)
 - Wycombe Hospital (commenced Feb 06)
- Centres due to 'go live'
 - Hillingdon Hospital
 - Harefield Hospital
 - Royal Brompton
 - Chelsea & Westminster
- Final Stages
 - Lister, QE11, Royal Surrey, Kingston, Luton & Dunstable, Watford, Heatherwood, Wexham,



How has the project been supported & evaluated?

- ❑ Ongoing audit: waiting times
- ❑ Discovery Interviews
- ❑ Patient questionnaire developed by Heart2Heart Network User Forum
- ❑ Reinforcement and monitoring by IHT co-ordinator
- ❑ SIMs supporting ongoing work locally
- ❑ IHT co-ordinator visiting centres
- ❑ Ongoing Trust commitment



Where are we now?

- ❑ **Significant** improvement of waiting times noted but further ongoing improvement required to achieve 48 hour target
 - ❑ Effective roll-out of the IHT web based system to all centres external to NW London referring in to the Network
 - ❑ Further development of IHT Co-ordinator role (data validation, training, software development, movement of patients)
 - ❑ Linking system to local cardiology data bases
 - ❑ Need to tackle surgery (3 month audit ending Feb 2006 to assess extent of the problem) – continues to remain a problem
-