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To: NHS North West

NCAT Report

A New Health Deal for Trafford

Date: 15 May 2012

NCAT Visitors
Dr Chris Clough, Dr Irving Cobden

1. Introduction

1.1. NCAT was asked to provide a clinical assurance of the plans for Trafford General Hospital (TGH), now part of Central Manchester Healthcare Trust (CMFT) following a recent acquisition. There had been a previous NCAT visit to provide advice to reconfiguration on 6 March 2012 by Catherine McLaughlin and Dr Simon Eccles. There had been a previous OGC Gateway visit in January 2012 which had given the Trust plans an amber assessment. The visitors met with staff from TGH and had a tour of the hospital, this was then followed by meetings with key stakeholders and patients. It was unfortunate that the senior responsible officer and the CEO of CMFT did not attend.

1.2. Documents provided and people met are listed in appendix 1.

2. Case for change and proposals

2.1. Trafford General Hospital (TGH) provides a number of acute general hospital type services to the local population of Trafford. The population of Trafford was approximately 213,000 in 2007 and it is estimated that ½ this population accesses healthcare services elsewhere (University Hospital of South Manchester NHS Foundation Trust (UHSM), Central Manchester University Hospitals NHS Foundation Trust (CMFT) and other providers including Salford Royal NHS Foundation Trust). Thus a population of about 100,000 would expect to use Trafford General Hospital for a number of acute hospital services. These would include urgent care type services – minor injuries and minor illnesses services, medical admissions, selected acute surgical admissions but over the previous few years a number of cases had been diverted elsewhere; for instance acute stroke care, acute coronary care, complex trauma and seriously ill patients. Acute

paediatric services and maternity services had previously been transferred to other Manchester hospitals as a part of the Making It Better strategy to provide better maternity and paediatric services across the whole of Manchester.

2.2. Although presently there is no concern about the clinical safety of services provided at TGH, and outcomes from care appear to be good, there is a pressing clinical case to consider the medium and long term future of the service at Trafford General from the point of view of sustainability and future clinical safety if the numbers of specialist cases presenting at Trafford continued to fall, leading to concerns about the continued competencies of medical staff who were not being exposed to sufficient numbers of cases to maintain their skills. Thus, even without considering affordability issues, there is a sufficient clinical case to look at the services at Trafford and consider what would be the future nature of service provision. Hence there has been a good deal of patient and clinical engagement to consider the consequences of these threats to clinical safety and sustainability.

2.3. It must be recognised that there have been financial issues facing the Trust for many years with a “black hole” in income estimated at £14-19 million per year due to a number of factors including insufficient activity. It was in this setting an acquisition of the Trust by CMFT took place. CMFT have continued to support the options appraisal and review of different models of care.

2.4. Additionally it is recognised that the health economy overall in Trafford has suffered by an inappropriate high level usage and investment in secondary care facilities to the disadvantage of community and primary care services. Thus although there has been a good deal of commitment towards integrating care from all stakeholders, so far there has been a difficulty in implementing a robust integrated care model due to a lack of available resources, and possibly a failure of leadership which has had to focus on the more pressing problems of financial viability.

2.5. The NHS Greater Manchester project team has brought together the document A New Health Deal for Trafford, which is a draft pre-consultation business case (May 2012), which does have the support of commissioners and the major providers (including CCGs and CMFT). It considered five possible models of care which could be provided at TGH.

- The first model of no change, with continuing provision of acute surgery, A&E services, acute medicine and rehabilitation, inpatient surgery, day case surgery and outpatients has been rejected as not providing the changes in clinical services required to ensure sustainability and not delivering the savings required to meet future commissioning intentions.
- Models 2a and 2b propose that there would be no acute surgery on site and no inpatient surgery but continuing day case surgery, retention of outpatients and the creation of an elective orthopaedic centre. The difference between models a and b was that an urgent care centre would be provided under model a, open from 8am to 8pm; under model b open from 8am to midnight. It was felt that these models did offer a short to medium solution to both the clinical and financial drivers and should therefore be included in the public consultation but that they may not be sustainable over the long term.
- Model 3 was similar to model 2a and 2b, but the urgent care centre would then become a minor injuries/illness unit with fixed opening hours (to be defined). Again acute surgery and inpatient surgery would not be provided; day case surgery would, an elective orthopaedic centre would be developed, outpatients would be preserved. In all these 3 cases the acute medical take would be selected. Certain clinical conditions would not be brought to TGH by ambulance in this scenario, but in the event that they might present as walk in patients they would be treated and stabilised, and transferred to CMFT. These clinical presenting conditions were pre-hospital early warning score (PHEW) > 4, acute coronary syndrome, ortho-trauma, airway compromise – that is progressive breathing difficulties despite intervention, unconscious patient, uncontrolled bleeding, CVA less than 4 hours, patients under the age of 5, obstetrics and gynaecology emergencies, very severe uncontrolled pain and out of hospital cardiac arrest.
- The conclusion of the options appraisal was that model 3 would take a number of years – approximately 3-5 years to implement and would also require a further development of integrated care services in Trafford and/or the provision of alternative secondary care capacity.

- The last model to be considered – 4 – was a further development of model 3; acute surgery, inpatient surgery would not be provided on site but day case surgery would; elective orthopaedic surgery would be developed, outpatients would be preserved as would rehabilitation. The A&E would become a minor injuries/illness unit but the key difference to all the other models is there would be no provision of acute medicine on site. Option 4 has been dismissed as having little or no clinical support.

2.6. To conclude, it was agreed by the voting members of Trafford Strategic Programme Board that two proposals should go forward for public consultation:

- Proposal 1 - to implement clinical model 2a, followed by clinical model 3.
- Proposal 2 – to implement clinical model 2b, followed by clinical model 3.

To reiterate, the key difference between these two proposals was that in model 2b the urgent care centre would be open 8am to 12pm, model 2a urgent care centre open 8am to 8pm.

3. Views that we heard

3.1. The choices are somewhat limited for public consultation because of previous good engagement of the public. We think these are the only possible choices we can legitimately propose to the public. The intention is to consult people local to the hospital, but there will be a requirement to consult more centrally in Manchester because there are consequences for patients in central Manchester, some of whom in future will be expected to travel to Trafford for their elective orthopaedic surgery.

3.2. Acute medical admissions number about 17 on average. They are referred either through from the A&E department or by GPs but assessed initially in the receiving room before transfer to the acute medical unit. All our consultant physicians take part in the on call rota. Although some physicians have their bed-base on the Medical Assessment Unit and look after those patients with a short stay , we have no true acute physicians as all our consultants are also specialists; they all perform twice daily ward rounds when on call.

3.3. Much of the work of the critical care unit is to support the on-site care of surgery patients. We are presently a level 3 unit and ventilate up to 60 patients a year. If

though in future we take out medical patients it will be difficult to maintain our competencies in management of complex cases and the intention is that these patients will be resuscitated on site and transferred to other units.

3.4. Clearly at the moment we have a selected medical take, and with the two proposals for consideration this will become highly selective. Our prediction is that the numbers of patients will fall to 8-10 patient admissions per day with model 2 a and b, and down to 4-6 patients a day with model 3. We recognise there will be a problem in ensuring training opportunities if we cannot guarantee sufficient case mix for training of medical specialties and emergency medicine specialty. The postgraduate dean though has been helpful in supporting us her, and giving support to rotations between ourselves and Manchester Royal Infirmary (MRI) to ensure the full range of training opportunities arise, but whether this deanery approval continues in the long term is unclear

3.5. We suspect that GPs referring patients, and patients themselves, are choosing where to present themselves. Thus this further reduces the complexity and acuity of patients presenting to TGH.

3.6. There is strong support for an integrated model of care from the commissioners and all providers, but as yet this has not turned into reality as there has been little significant investment in integration. The problem was that prior to the CMFT acquisition there was a requirement to maintain trust income and hence the survival of the trust. Post acquisition we hope this will no longer be an issue.

3.7. We do have GP walk in service next to the A&E Department but there is no single common access hence patients will be redirected if they choose the wrong door to go through. We don't think this has led to gaming or double charging.

3.8. Although the urgent care centre will have fixed hours of opening, the medical admissions will continue 24/7 but obviously out of hours this will only be available through GP referral. We have good diagnostic support including CT scan 24/7 but the radiographers will be on call from home, hence this could produce a delay in diagnosis in certain situations.

3.9. We are predicting a 7-8% increase in attendances at Wythenshawe Hospital, (UHSM), above and beyond the 85,000 who presently attend our emergency department. With the increase in income we should be able to expand our workforce to deal with this increased level of work and have little difficulty with recruitment and retention of staff. Our main concern though is about the physical

space of the emergency medicine department which will need expanding if we are to accommodate this rise in activity. Already we suspect we are seeing a drift in activity to our department.

3.10. We are engaged in bringing together community and social services in phase one and look forward to a fully integrated model in phase two. This should create greater efficiencies of care, and we would hope to develop a single point of access so that, wherever possible, patients are kept in their own home supported by community teams and this too will help us in getting patients out of hospital. Unfortunately though we have very limited access to intermediate care in Trafford. Community care matrons could make a real difference to improving care within the community, but presently there are only 5 and they are only able to accept low risk patients.

3.11. We have strong support for the plans to reconfigure surgery. Surgeons at both sites (TGH, CMFT) will provide elective orthopaedic care from modern, state of the art theatres. TGH has an excellent reputation in this regard. General surgery will be entirely day surgery and presently we are operating at a level of 80% day surgery in keeping with best national practice. There is the potential to provide other day case surgery such as ophthalmic surgery.

3.12. The paediatric service is presently subject to a service level agreement between TGH and UHSM. Only children with minor ailments or minor injuries are treated within the present A&E department within a child-friendly environment. Any sick children presenting to the emergency department will be promptly transferred to Wythenshawe following appropriate resuscitation (if needed) and this can be provided by trained emergency medicine consultants. (In future the situation may change as CMFT have substantial children's services provided through the children's hospital and may well wish to provide the services at Trafford. This could be facilitated because emergency medicine consultants will rotate between TGH, MRI and Manchester Royal Children's Hospital in order to maintain their competencies.

3.13. The question to be posed is what sort of services should Trafford Hospital provide, as in this geographical area we are well provided by three teaching hospitals 8-10 miles apart. The organisation needs to become both sustainable and affordable. We need to be honest with the public that models 2a and 2b will evolve to model 3,

and whilst we are not envisaging evolving further to model 4 there may be continuing issues of sustainability and affordability that push us in that direction.

3.14. CMFT expects to make significant savings if TGH moves to model to 2a/2b and the Trust will be able to deliver this model within tariff. The savings would come from reorganising surgery, delivering less critical care, moving to a fixed hours urgent care model and losing some specialty support. There are good opportunities for CMFT at Trafford being able to develop off site elective care surgery, which is very popular with the orthopaedic surgeons, and having facilities to be able to transfer patients closer to their homes when their acute care episode at MRI is completed.

3.15. There are good opportunities to rotate staff to other hospitals within the CMFT hospitals, and to ensure sustainability of middle grade rotas and consultant rotas. There are training opportunities for a number of staff groups including nurses who will be able to rotate from the urgent care centre into the A&E department for CPD.

3.16. The Trafford LINk group recognise that, in order to develop a good primary care service, money needs to be directed away from secondary care. There is a real problem with health inequalities in Trafford, particularly north in the area, and these groups who traditionally receive poor primary care services would benefit from the development of better GP and primary care services.

3.17. For those living close to Trafford Hospital, within Trafford, there are difficulties in transport and it would be helpful if this could be addressed within the business case. It is this group of patients with more health needs who access public transport and who will need help in traveling to Wythenshawe and elsewhere when their relatives are admitted acutely.

3.18. We need to tell the story of how services can be improved by this reconfiguration so that the public understands why this needs to be done. We are hopeful that the acquisition by CMFT will help progress and bring other services to TGH. It is not good enough just to communicate with the public, we need a public relations exercise to tell the story of why this needs to be done.

3.19. We do have some worries about North Western Ambulance Services. We hear that a van is being transferred out of the area, and patients will worry that they won't be able to be brought to the hospital in time, particularly at times when there is traffic congestion when the Trafford shopping centre becomes busy.

3.20. A good example of a local success story would be the closure of Withington Hospital and its replacement with popular local services – we could do something similar here in Trafford. There are fantastic possibilities here at Trafford which we need to develop.

3.21. The public's main concern is often how can they get to their GP in and out of hours as access can be poor.

3.22. We are very pleased that the Council has been part of the steering group for these proposals but there are a number of concerns about how the financial gap can be closed when the transitional funding comes to an end in the next 12 months. Whilst CMHT may be able to make savings, these may not necessarily be passed on to the commissioners, who will still be expected to commission services elsewhere if patients presently being seen at Trafford are seen at other hospitals for their care. Hence we need a whole picture view of how the health economy can function. We do have the prospect of active integration of community and social services, but these come at a time there are 30% cuts in the social services budget.

3.23. We do think there needs to be wider strategic picture – how does this reconfiguration fit in with the Safe and Sustainable strategy for the whole of Greater Manchester for instance. It would be flawed to go out to public consultation without plans for integrated and intermediate care. Throughout all this there has been a lack of clear strategic direction and of a plan which will address all these different issues, and we are still unclear as to what is going to happen to the real estate at the hospital.

4. Discussion

4.1. Trafford General Hospital is a relatively small hospital delivering a mixture of services including acute services to a population of about 100,000. Small hospitals with a small population base like this are struggling throughout the country to provide high quality services which are sustainable and affordable for the local health economy. It came as no surprise to hear that TGH was having similar problems. Already, and understandably, in keeping with national strategic policies patients with stroke and acute heart attacks are bypassing the hospital as are patients with serious trauma. We heard that patients themselves will often make that decision about whether they have the right sort of problem that could be dealt

with by their local hospital. If seriously ill they may well elect to go to one of the large teaching hospitals which are within a short distance of Trafford. Additionally we heard that the ambulance service often makes this judgement too and will triage patients to whichever hospital they think will provide the best service. Although there are formal protocols which ensure safety of the patients, there are matters of personal judgement here too.

4.2. Small hospitals in geographically isolated places need to survive and provide vital acute services to the local population but this is not the case for Trafford General as there are three large teaching hospitals within easy reach. We think the project team is correct to identify that there are clinical, sustainability and future safety problems at Trafford General Hospital if it goes on practicing the way it does. Already in certain areas there have been recruitment and retention problems, and it is not automatic that these will be sorted out by the acquisition of TGH by CMFT.

4.3. It is right to start with the patient pathway and examine this to ensure that patients will receive the right care at the right time in the right place. Acute care in the modern age requires a team approach with access to senior clinical opinion as soon as possible and in the best possible scenario this should be available 24 hours a day, 7 days a week. Whilst it would be possible to employ such a workforce in a small hospital, it is obvious that this would not be an efficient use of resources. Not only that, there are clinical safety issues. The evidence is that if clinicians, particularly surgeons, only see a small number of patients they will not maintain their skills and competencies.

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4.4. We therefore support the clinical case for change made here, but we recognise that there are affordability issues in continuing to provide a significant emergency and acute service at Trafford General Hospital. TGH has had a significant income and expenditure mis-match over many years, and has been sustained by additional payments from the commissioners to ensure their financial viability. CMFT have now taken on this financial risk. We have accepted the case that the additional money presently being invested in secondary healthcare services in the Trafford area could be better spent elsewhere and would produce better health outcomes,

particularly in those areas where there are significant health inequalities. We would support the planned integration of healthcare within Trafford, and would hope that money saved through reconfiguration of acute services could be directed into more community based and primary care services, in particular ensuring integration of those services with secondary care. It is only by making such efficiency gains that savings in the overall healthcare economy can be made long term, and quality preserved with good health outcomes.

4.5. Turning to the specifics of the planned reconfiguration presently TGH does not offer the full range of A&E services and, as above, we heard that patients are already being diverted with a number of conditions avoiding admission to TGH. In order to be a fully-fledged A&E service TGH would need significant numbers of emergency medicine consultants supported by middle grade trainees and appropriately specialty-trained nursing staff. For the reasons given this is neither a clinically sustainable or affordable option. Moving to an urgent care system will enable TGH to deliver a safe service within fixed hours, and the proposals going out to public consultation indicate this may be either 16 or 12 hours. We would not strongly favour one of these options over the other, but suspect the public may well favour keeping the urgent care service open and available for as many hours as possible. As indicated in the plans for options 2a and 2b this may mean only seeing an extra 4-5000 patients per year. We heard there were no significant concerns at either Manchester Royal Infirmary or University Hospital South Manchester in absorbing the additional activity that would accrue to them out of hours.

4.6. We were pleased to see that the present service already does have an alongside walk in centre staffed by local general practitioners working 12 hours a day. This unit did not share a single portal of access with the A&E department; patients most often would first be triaged by the A&E nurse and then directed to the primary care type service if thought appropriate. Not only does this form of working put an unnecessary delay in these patients accessing the right sort of service, but we suspect it will mean that fewer patients are actually seen by the walk in centre than would be the case if the A&E department, as presently configured, shared a single

point of access and triage process. This should be taken into account when designing the next steps of urgent care.

4.7. From a practical standpoint, the major difference between what is being offered now in the A&E department and what will be offered in the next step as proposed in the urgent care service will be the fixed hours, and secondly a more rigorous process for pre-hospital assessment to ensure that the right patients are seen at TGH. We were very pleased to see the list that has been developed by the clinicians and NWAS (see above) which identified clearly which patients should go where. This will ensure continuing safety of the service. It will mean that fewer numbers of patients will attend TGH, and this will have income considerations, and secondly it will mean that fewer patients will be admitted to TGH with acute medical problems.

4.8. We think that essentially the new urgent care system will evolve fairly quickly to becoming a minor injuries and minor illnesses service. If the minor illnesses service is further developed more activity can be accommodated within the walk in centre primary care led service. The main activity of this service in future may well be minor injuries, and we would strongly support this model of care. It can be nurse-led and delivered, and provide a highly effective service both from a clinical and cost effective standpoint. It is good news that the future service will be part of CHMT as there should be no future problems with sustainability of the service if staff are rotated from the Manchester Royal Infirmary, the Manchester Children's Hospital, and these rotations and training opportunities should be available both to doctors (consultants and trainees) and nurses. To conclude, we support these changes and hope the public will recognise that this is an inevitable evolution of what is happening within the service anyway. A small hospital like Trafford can provide safe, cost effective minor injuries services and minor illnesses services.

4.9. Turning to acute surgical and acute medical services we strongly support the plans for surgery at TGH. There is no place for the management of acute surgical problems out of hours in a small hospital such as TGH. These patients need to be managed by appropriately staffed surgical teams supported by the full panoply of critical care and medical services. We strongly support the continuance of elective surgery at TGH. This is a good opportunity for the local population to be able to

access high quality elective surgical care in their local hospital. Not only that, it will provide the service for a population from a much broader geographical area. Cold site surgical centres work very well as they are not affected by the constant pressure from acute admissions. They are popular both with consultant surgeons and their patients, as care can be delivered in a calm, safe environment largely free from hospital acquired infections. The facilities at TGH, we heard, were first rate with appropriate up to date modern theatres to provide this. It is envisaged that there will be an elective orthopaedic site, and that most of the general surgery could be provided on a day surgery basis. We were pleased to hear that presently TGH is hitting national norms for day surgery intervention. Thus there should be no difficulty in changing to this form of practice. There will need to be an appropriate assessment of patients to ensure that only those patients fit enough to undergo surgery within TGH are identified. We did point out there are models of post-operative support that can enable hospitals that deliver elective surgery to widen the scope of this patient base, but it makes sense to start out with a cautious approach. Those patients with additional medical problems, particularly the frail elderly who require orthopaedic surgery, will in the first instance go to the MRI.

4.10. Our main concerns are about the continuance of an acute medical service at TGH. As indicated above, largely there has been a process of pre-hospital triage going on already, which has meant that the numbers admitted daily average about 17 – a small medical take by DGH standards. It is expected that the numbers will fall with the pre-hospital assessment processes as above to about 8-10 patients a day with the urgent care centre, and subsequently with model 3, with the MIU, to 4-6 patients daily. Hence there must be concerns that this activity will be insufficient to maintain expertise within the admitting team, and provide an appropriate training environment. We were reassured to hear that the postgraduate dean had reassured TGH that training could continue at Trafford if these jobs were part of a rotation within the Manchester area, particularly within CMFT. Nevertheless at some point it will become clear that the training experience is insufficient and problems of clinical safety may emerge if consultants are unable to maintain their expertise. Not only that, it is an inefficient use of resource to continue operating in this way.

4.11. The key thing that defines whether an acute medical service can continue or not is the presence of critical care. We heard that in future critical care services would continue to support the on-site surgical service, but wherever patients require ventilation, that is level 3 ITU services, those patients would be ventilated on site and transferred to the MRI. This is not an ideal solution and subsequent clinical pathways that are being developed should ensure that the potential for transfer is kept to a minimum.

4.12. There was a general acceptance from all those that we interviewed that TGH was on a journey prompted by the potential for clinical safety issues, sustainability and affordability, and that inevitably would lead to the progressive down-scaling of the acute medical services. At the moment the service is supported by physicians who have other specialties such as gastroenterology, respiratory medicine etc who are trained in general medicine. There are no acute physicians. In future many of the medical admissions units in large DGHs will be staffed, particularly during the day, with specifically trained clinicians who have an acute medicine specialty accreditation. It is unlikely that TGH would be able to recruit and retain such individuals.

4.13. For all these reasons we think that at some point in the coming years it will become clear that acute medical patients should not be admitted to TGH, and that inevitably model 4 will become the solution. This model is not part of the consultation because it is said not to be acceptable to many clinicians. However, the unit envisaged in Model 3 – taking 4-6 medical patients of low acuity – and what would be possible in a (level 4) service that had an on-site step-up element within an intermediate care facility, backed by a truly integrated system that delivered care through primary care, skilled nursing, physio etc with the involvement of elderly care consultants for example, would probably be minimally different, if at all, in terms of the patients managed successfully there. We think there is an opportunity to look ahead and plan what TGH of the future should look like, and part of that should be how it plays its part within integrated care for the local population. With its current facilities it could well provide a good intermediate care service. Intermediate care can be both step up and step down, and should enable patients who have been admitted to the bigger hospitals to come back

nearer to home for continued rehabilitation prior to discharge to their homes or elsewhere. It would enable local GPs to step up care for brief inpatient interventions and avoid admission for those patients, often frail and elderly, who may not fare as well within large DGH settings. There is an opportunity here to consider how elderly care physicians and rehabilitation teams could support a really dynamic intermediate care and rehabilitation service, and this would play to the strengths of TGH which already has a neuro-rehabilitation unit.

4.14. Our conclusions are that the present plans are safe, and are an evolutionary approach to the provision of acute medical services on site. We suspect that the long term future of TGH may well not be to provide acute medical services, but there is a strong case for it to be part of a solution for provision of care for the frail elderly patient presenting acutely.

4.15. During our walk round we were able to talk to staff, and are grateful for their honest views about their hospital. TGH is a pleasant environment with good open spaces around it. There needs to be a strategic view which understands its place within the local health economy. Commissioners working with the providers need to describe to the local population how such a resource can be used effectively and cost efficiently. We suspect there is an opportunity here to describe a future for this site which could be shared by a number of providers, providing a number of different services. We heard from CMFT that the acquisition of this site does give them several opportunities, and we would agree with that. Their initial assessment indicated that there were financially viable services which could be delivered from the TGH site, which would mean they could live within standard tariff. This does miss the wider point made by the commissioners, of the fear that Trafford patients would continue to overly use secondary care services elsewhere, north and south of the borough, which would mean the overall cost envelope remained the same. It is therefore a pressing concern that future commissioners, ie the CCGs, and the main providers work together to articulate this vision for TGH, but at the same time address the concerns about the need to reduce overall investment in secondary care to meet this financial challenge. This will mean investing in integrated medical care solutions. Our view was that in future TGH could well survive and provide the following services – minor injuries, primary care led minor illnesses services,

diagnostics, elective surgical care, outreach outpatient services for a number of secondary care providers, step-up and step-down intermediate and rehabilitation care (? palliative care).

5. Conclusion

5.1. The proposals that have been recommended for public consultation can be strongly supported.

5.2. There is a requirement to explain to the public during the consultation process what has already happened to the provision of acute services at TGH, and why it is important to continue to provide safe sustainable services there in the future. The project team should articulate a clear vision for acute services for patients in Trafford and a future vision for the hospital which is sustainable and affordable. Case vignettes describing the patient pathway before and after reconfiguration are one way of communicating to the public that future health services will be of high quality, safe and accessible.

5.3. The NCAT visitors have concluded that there will continue to be an evolution of services at TGH which in many ways has already started, and that journey may well end with acute medical services, as commonly understood by clinicians, not being provided on the TGH site (model 4). As the numbers of acute general medical admissions fall there will inevitably come a time when the service will become neither safe nor affordable. Additionally workforce pressures may intervene.

5.4. Looking ahead, TGH needs to become a hospital which provides those services which should remain local to their patients. One component of this is intermediate care. Presently there has not been much thinking about intermediate care and this should considered as part of the whole integration of primary care, secondary care and social services when addressing the problems of long term conditions. TGH is in a good position to offer intermediate care with both step down and step up facility, enabling care of the frail elderly in particular closer to their homes, supported by multi-disciplinary care and helping CMFT transfer patients from the acute facilities to more appropriate care closer to their homes. There are many

synergies between intermediate care and provision of rehabilitation on the TGH site, and possibly palliative care.

5.5. TGH, as a future hospital site, will be able to sustain quality services for minor injuries, minor illnesses, elective surgical care, diagnostics, outpatients and intermediate care. This is a strong model of care which should be supported by the local population. The management of minor illnesses can be improved now by the adoption of a single point of access for all patients who walk into the A&E and GP led services. This should speed access to the appropriate service and ensure that those patients who can be managed by primary care will be seen within that service,

5.6. There is disquiet about the financial consequence of adopting the new model. If patients who are presently attending Trafford attend secondary care facilities elsewhere generating tariff payments. We were reassured by CMFT's stance on the financial viability of TGH but recognise that there still may well be on-going financial repercussions for the PCT and subsequently the CCG. This should not delay implementation of the outline proposals, but continued strategic planning is required to develop a whole system approach to management of urgent care within Trafford.

5.7. The NCAT visitors strongly support the attempts to create a more integrated care model for Trafford patients and would hope that, when decisions have been finalised on the acute sector provision, due focus and leadership is given to development of integrated care plans. There has been much talking about these plans but very little doing, and it is time to move into an implementation phase.

6. Recommendations

6.1. That after due consideration the proposals for reconfiguration are put to public consultation.

6.2. The project team responds to NCAT's report within one month, and produce an action plan to be agreed with the SHA.

Appendix 1

NCAT Visit – Trafford 15 May 2012

Documents Received

- A New Health Deal for Trafford, draft Pre-consultation business Case May 2012
- Draft notes from NCAT meeting 6 March 2012
- A&E data Trafford General Hospital
- New Health Deal for Trafford clinical Model
- Presentation Dr Nigel Guest, Dr John Simpson

People met

Alison Starkie	Programme Manager, NHS Greater Manchester
Mark Edwards	Associate Director Performance CMFT
John Simpson	Clinical Head of Division CMFT
George Kissen	Medical Director NHS Trafford
Jane Eddleston	Critical Care lead for Greater Manchester
Andy Hickson	Associate Director Commissioning NWAS
David McNally	Reconfiguration Lead NHS North West
Jonathan Berry	GP Provider Lead (Trafford)
Mandy Bailey	Chief Nurse UHSM
Claire Heneshan	Chief Nurse Trafford
Nigel Guest	CCG Accountable Officer
Darren Banks	Director of Strategic Development CMFT
Gina Lawrence	Director of Commissioning Trafford PCT
Ann Day	Trafford LiNK
Bonnie Hatfield	Trafford LinK
Anne Higgins	Exec Director Communities/Direct Adult Social Care, Trafford Council
Michael Young	Trafford council – Lead member Health/Health & Wellbeing Board