PORTSMOUTH HOSPITALS NHS TRUST

UPDATE ON EMERGENCY MEDICAL SERVICES RECONFIGURATION –NOVEMBER 2003

1. INTRODUCTION

This paper provides an update on the current position regarding the Emergency Services Reconfiguration, commenced in October 2002, and reports on progress following a previous paper that was presented to Trust Board in July 2003.

The previous paper provided an assessment of progress that had been achieved up until July 2003, outlined some actions that were planned and proposed a potential adjustment to the current model. This proposal centred around the swapping of post acute medical and acute elderly wards between sites. This was seen as a way of providing more acute direct admitting beds that would help to reduce patient moves and improve the efficiency around the patients flow. It was agreed that a detailed risk assessment should be carried out to test the feasibility of this proposal and that work on improving processes should continue. The purpose of this paper is to update the Board on the work that has been carried out and current thinking on how best to move forward.

2. SOME KEY ISSUES REGARDING RECONFIGURATION

The previous paper highlighted the drivers for reconfiguration and some of the benefits and difficulties experienced. These can be summarised as follows:

2.1 Drivers:

- Rising volume of emergency workload and imbalance of that workload between sites.
- CHI review of December 2001 which raised concerns about the system for managing emergency medical patients, multiple moves and in particular the care of elderly patients.
- The need to reduce junior doctors' hours, which would not be possible if we were to continue running acute services on more than one site.
- Difficulties in recruiting Consultant staff.

2.2 Benefits:

- All patients are now seen by a Consultant on the post-take ward round. Prior to reconfiguration as many as 50% of patients did not see a consultant.
- A greater proportion of patients are looked after by a Consultant in the relevant medical sub specialty.
- The system for managing acute medical and elderly patients has been integrated as recommended by the CHI Review, 2001.

- There has been a reduction in the number of outliers in surgical beds, although this has been rising in the last few months.
- There is a more equitable distribution of workload amongst physicians which has been acknowledged by those physicians who have benefited.
- Up to 37% of patients are discharged from MAU within 33 hours. (In September, this peaked at 42%)
- Junior Doctors working hours targets for SHOs and PRHOs have been achieved at Band 2b.

2.3 Difficulties:

- Lack of continuity for patients through multiple ward moves (both within QA and to SMH).
- Lack of continuity for patients through multiple Consultant and junior medical staff.
- Delays in admissions, both through volume of patients and multiple moves. This is seen in the back up of patients in A&E and sometimes on ambulances. This is linked to both systems and growth.
- Delays in bringing patients into hospital.
- Complaints from GP's about the rapid turnover of patients through MAU, and the perception of large numbers of readmissions (details of readmission rates through MAU and generally are attached at Appendix A).
- Transfers to SMH have not occurred in the volumes anticipated. This is linked with a period of increased delayed transfers of care(DTC's). (The plans for reconfiguration built in an assumption of 35 DTCs. For much of this year the figures have been in the range of 50 – 60 per week in PHT beds, plus a further number in elderly care beds).
- Disruption to the supervision and education of junior doctors, to the extent of serious concerns raised by the Deanery and Royal College of Physicians regarding training.
- Difficulties in tracking patients through the system owing to the multiple transfers.
- Opening of unfunded beds, staffed by agency staff, which in turn provides no continuity of nursing care.

3. PROCESS IMPROVEMENTS

The ongoing work related to the emergency medical services reconfiguration needs to be seen in the context of the Emergency Services Collaborative (ESC). The purpose of this is to support trusts in making sustained improvements to enable them to achieve the national target of 100% of patients being admitted, transferred or discharged from A&E within 4 hours by June 2004. The target for March 2004 is 90% of all patients. The ESC works across all directorates and a detailed report on progress to date is provided at Appendix B.

Much of the work that has taken place on reconfiguration since July has therefore focussed on process improvements. While improvements have been made, it should be noted that the Trust has only achieved 90% of patients being admitted, transferred

or discharged from A&E in two weeks this year. This is however an improvement on our position last year when we were only admitting 70% of patients in 4hrs. We are confident that the strategies are correct but recognise that the pace of change is slow. Experience has shown from elsewhere that reconfiguration of services on this scale needs to be seen as an iterative process and can take up between 18-36 months to imbed. Problems remain around the admission of emergency patients to most specialties, although these are greatest for emergency medicine and elderly care.

Actions taken to address the difficulties outlined in section 2.3 include the following:

Multiple ward moves:

- Elderly care use their wards more flexibly now, transferring a proportion of patients directly from MAU to SMH.
- Guidelines for 'outlying' patients have been developed which helps to reduce 'inappropriate' outlying, where patients are subsequently transferred back to more acute settings. (Outlying includes moving patients to beds on the QAH site which are targeted at less acute patients and moving patients to other specialties).
- An outlying nurse has been operating from Medicine since August, supporting the nursing staff on surgical and orthopaedic wards. This helps to ensure that patients' needs are not overlooked and discharges are followed through.
- Victory ward will be allocated to one of the medical teams during November, rather than being an 'outlying' ward as is currently the case. This will increase the bed stock that can take patients directly from MAU, thus removing one ward transfer during their stay. This also helps to speed up the movement of patients from MAU.

Continuity of Care

- Three of the Medical teams have altered their internal working patterns which has allowed greater continuity of care from junior doctors, and improved supervision by seniors, thus providing greater consistency in planning and organising care. The reorganisation focuses on dividing work between two sub teams and there has been positive feedback from both junior doctors and consultants about this change.

Delays in admissions

These remain significant but steps taken include

- Introduction of '3 hour' champions in A&E. This helps to focus on the time patients have been waiting and the interventions required. This can work when workload is under control but when there are peaks in demand and a backlog of patients it is less effective.
- More flexible use of the Observation ward
- A pilot of an additional post-take ward round in the afternoons on MAU. The success of this is being audited. There is variable feedback but the Deanery and Royal College have stressed the importance of this from a junior doctor and training perspctive.
- Elderly care Consultants have participated in the weekend post-take ward rounds on MAU since July 2003.
- A discharge nurse participates in the morning post-take ward round and focuses on arranging the discharge of patients direct from MAU.

- An elderly care specialist nurse works with the elderly care Consultants on the post take ward round and organises transfers to elderly care. This system has been extended to cover weekends.
- Ward managers on the Medical wards in QA have been removed from the rota to allow them to focus on bed management issues and improving discharge planning. This is still in its early stages but there is some evidence of achieving morning discharges.
- A 'pull ' system has been piloted in cardiology and similar systems, linked to daily targets for each specialty have been introduced in November.

GP complaints about perceived inefficiencies in MAU/the admissions process

Concerns remain, but again, progress has been made

- Senior clinical staff in MAU take referrals from GP's, where there is some doubt as to whether admission is required. Some GPs dislike this system but others have commented on its usefulness. This is evidence to suggest from elsewhere that senior clinician to GP discussion can prevent admission by offering alternative ways of managing the patients.
- A locum consultant in MAU has been appointed and two MAU Consultant posts were advertised. Interviews in early November were unsuccessful, although it may be possible to appoint to one post at a later date.
- The nurse led DVT service continues to update and improve its processes.
- Readmission rates have been reviewed and there has been no significant change over the last 6 months (see appendix 1). Attempts to benchmark this against similar units are now being made.
- A number of patients have been identified as having multiple attendances in MAU. These patients are now being targeted to ensure that there are agreed care pathways in place that avoid some of these patients having to access care via MAU.

Transfers to SMH

- Discharges are being focussed on the morning but the benefits of this have not been realised as there have been problems with the transport service. This has now been put out to tender in an attempt to improve the service.
- Issues remain around the planning and management of patients and discharges from SMH but these are being addressed (see section X)

There have also been issues about the speed of transfer between MAU and wards on the QA site. Steps to address this include:

- Use of a transfer team. It is proposed to extend this in November.
- Ward based pharmacy services are being extended to reduce the time waiting for discharge drugs.
- An extended discharge lounge is the first phase of the new SAU project. This should be available in December.

Supervision and education of junior doctors

- The pilot of an afternoon post take ward round in MAU is a direct result of a recommendation form the College and Deanery.

- Junior doctors have reported far greater satisfaction since the change in internal team arrangements and there is improved supervision.
- Juniors in MAU are currently involved in a review of working arrangements in MAU with the aim to improve the supervision of patients and juniors in MAU.
- PRHO rotas at SMH have been revised to bring them back to a Band 2B rota.
- There are a number of meetings with junior doctors which has improved communication.

Tracking patients
A system to track patients has been put in place. This has involved extra cost but is an important safeguard until a more effective routine system can be developed. It is currently being reviewed but is likely to need to continue.

Unfunded beds:
- These remain open. A small cohort of PHT staff are now on one of the wards which helps improve continuity of care. Further recruitment is taking place. Unfunded beds, without any other infrastructure improvement remain an expensive and inefficient way of working.

4 PROPOSED CHANGES TO THE MODEL

As reported in July, consideration has been given to a fundamental change to the model and work has continued to assess the viability of this. Opinions have been varied and other options have emerged. It is important that there is clarity over what is planned and how it will lead to improvement before any change is made. The July report outlined two main options (1 and 2). The details of the options and latest position with each is shown below:

4.1 Option 1

The Department of Elderly Medicine should take over the 80 post acute general medical beds at SMH All medical beds at QAH including unfunded beds would then be used as acute beds. All patients would continue to go through the medical assessment unit and then on to an acute ward (both elderly medicine and general medicine) at QAH with a further move to post acute care at SMH if necessary.
The perceived benefits of this option are:

- greater continuity once the patient is at SMH (adult post acute patients would be under the care of an elderly care consultant rather than the 'physician of the week' system).
- 'Acute' medical staff resources could be used to strengthen the QA rotas.

Potential disadvantages:

- does not reduce the number of moves for patients.
- additional investment required for Elderly Medicine junior medical and consultant staff to support this.

The Steering Group, in consultation with the Physicians' Advisory Group, have decided not to pursue this option. While it may be seen as the long term direction of travel, it has been felt that the scale of investment required would not allow this to be

a short term option. Currently, Elderly Care aim to take 25% of the take, but are rarely able to achieve this with their current bed allocation and difficulties with discharge. This means that this workload currently falls upon the Acute Physicians and their teams. The longer term aim is for them to take 40% of the take, which reflects the proportion of elderly frail patients being admitted.

4.2 Option 2

Elderly medicine acute beds at QAH (75) would swap with general medical post acute (80 beds) at SMH. All patients would still be admitted through the MAU but from MAU all acute elderly patients requiring admission, and who were fit to travel to SMH, would move to SMH. All general medical patients requiring admission from MAU would be admitted to acute medical beds in QAH. All current medical and elderly medical beds at QAH would be used as direct admitting acute beds. (Elderly patients, too ill to be transferred to SMH, would be cared for by Elderly Care physicians at QAH in a small number of beds identified for that purpose).

Perceived benefits:

- at least one less move for patients, as all wards would be 'direct admitting ' from MAU.
- greater continuity, therefore, of both nursing and medical care, through patients being more likely to remain on their dedicated ward and under the same Consultant.
- the opportunity to develop a centre of excellence for Gerontology at SMH in conjunction with the University of Portsmouth.

Potential disadvantages:

- the scale of change in terms of ward and staff moves is significant.
- costs associated with revised junior doctor rotas and ward reallocation
- potential perception that this could be seen as disadvantaging the elderly, through moving them to SMH.
- A move away from PFI model of acute / post acute care, in the short term.

Further work on this model has taken place. In particular a risk assessment has taken place and a review of junior doctor rotas. The proposed model was also altered to address concerns about the number of acute elderly beds remaining on the QA site and a fear that a complete swap could undo the much improved joint working between the Elderly Care and Acute physicians. The revised model would be for at least one acute elderly ward to remain on the QA site and for one post acute medical ward (possibly nurse led) to remain on the SMH site.

From the risk assessment, a number of issues emerged:

Clinical support services: There is a view that clinical support issues can be addressed. A key concern for Elderly Care is the availability of consultant opinion from other services. Other services have stated that this could be provided. The final service to clarify is the availability of carotid dopplers. Patients requiring urgent gastroscopy would transfer back to the QA site.

Transport: There have been significant difficulties with the transport between sites and this is a major concern to the Elderly Care service as it could lead to delays in discharges and transfers to the wards late in the day, which is not appropriate for elderly patients. To address these problems, the current service has been put out to tender.

Junior doctor rotas: In order to support an enhanced acute workload at SMH, junior doctor cover would need to be strengthened. Cover arrangements are also required for the two wards that would remain on either site. Overall, the rotas proposed suggest that an additional 10 SHO posts are required. These would be 6 at Band 2B and 4 at Band 1A and would cost in the region of £370,000. (to be checked). At least 4 additional SpR posts would be required. Four posts are available within the current plans for Elderly Care but there is now a concern that an additional 2 posts would be required to fully meet the EWTD. The posts are not currently funded and would cost in the range £ -£)

Other costs: Further costs would potentially be incurred. These relate to transport (result of tender awaited) and the move of wards between sites. The wards in South block are smaller than those at SMH, meaning that there would be financial ineffiencies for PHT in the move – moving from three wards to four, requiring additional ward manager and ward clerk posts. There would also be a need for additional staff to run the rotas. This would be an additional 5 staff. The costs of these posts would be in the region of £167,000. There should be efficiencies for elderly care in a move to larger wards, but these are unlikely to be of the same scale and previous experience suggests that such costs are hard to extract and move around the system.

Timescale: Elderly care have a number of ward moves taking place over the winter period connected to the South Block decant and would not be willing to transfer further wards prior to April. This timescale would, however allow some more detailed public consultation to take place.

Loss of integration: There is considerable concern that some of the closer integration and improved working that has been achieved between the Acute physicians and Elderly Care consultants could be lost by these changes, with a physical separation of services. Under this option, although a ward would remain for each service on each site, this concern remains.

4.3 Option 3

A further option has emerged during discussion. This is to strengthen the post acute model so that there is improved flow and appropriate continuity of care. Currently, a different Consultant attends SMH each week to review patients. While all attend, this is not their area of expertise and any continued medical focus on discharge is lost. There is a view that moving to a more nurse led model of care may be appropriate, although it should be stressed that medical input would continue to be required for this group of patients.

Potential benefits:

- Maintains the post acute focus – does not keep patients who do not require facilities on the QA site.
- Does not involve the potential disruption of ward moves but creates a greater impetus at SMH.
- Improves the care for the post acute group of patients.
- Is in keeping with the longer term PFI model of care and allows some earlier closer working.
- Can release inappropriately used Consultant and SpR time back to QA. (this level of support may be required but not necessarily from consultant Physicians).

Potential disadvantages:
- The precise medical support required needs to be modelled and may be difficult to sustain.
- Does not reduce the number of patients moves.
- Requires investment in specialist nursing roles and some therapy.
- Will take time to develop roles and implement.

In order to assess the degree of medical input required, the Elderly care consultants carried out an audit in early November. The initial results of this suggest that there might be up to one ward's worth of patients who could be cared for in a nurse led unit. The other patients required differing degrees of medical input and further discussions are continuing (see below). Moving SMH to a totally nurse led environment would clearly not be appropriate. However, the post acute model could be improved by nurse specialist involvement, particularly in focussing on the rehabilitative aspects of a patient's needs and in discharge planning. Closer integration with PCTs (intermediate care and community hospital teams) in the appropriate management of these patients would also be achieved.

4.4 Option 4

Option 4 has emerged as a hybrid option based on options 1 and 3. There has been an increasing concern about the wisdom of a swap of wards as envisaged in option 2, both in terms of scale of disruption, move away from service integration and cost. Option 1 is a longer term option that cannot be afforded in the short term in the way envisaged.

Option 4 involves the elderly care service taking over the Consultant responsibility for an additional post acute ward at SMH as soon as possible, but the junior medical cover and nursing support continuing to be provided by PHT staff. This ward would then operate to the same criteria as the current elderly care wards at SMH and would be able to take appropriate patients directly from MAU. (This option would avoid the delays of the option 1 model). In addition, work will commence on developing protocols for a nurse led ward at SMH.

Potential benefits:
- Increases the bed stock available to Elderly Care and thus should enable them to take their 25% share of the take.
- An increased number of beds able to admit patients directly from MAU, thus reducing patients moves and transfer delays.

- Improved continuity for this group of patients.
- First step possible to be implemented in the short term.
- Avoids the concerns of separating Elderly Care and Acute General Medical services.
- Avoids the potential disruption to systems that a larger scale change would entail.
- Closer integration with PCTs helps prepare for post PFI model and also helps to increase understanding of alternative care solutions that need to be developed in the community.

Potential disadvantages:
- Some costs will be incurred –eg increased nurse specialist input
- Does not enable the removal of Acute Medical input to the SMH site of Option 1, in the short term.

5. CONCLUSION

A great deal of work has been carried out to improve processes and systems. The impact of some of this work is still to be felt and the need for improvement in meeting emergency admission targets is acknowledged.

The previous options presented to the Board have now been assessed in detail, and alternative options have emerged as a result of this and further discussion. A hybrid option, combining elements of options 1 and 3 has been developed and the EMSR Steering Group would now wish to move forward with this, enabling incremental changes and a focus on developing the post acute model of care.

6. RECOMMENDATION

The Trust Board is asked to:
1. Note the current position regarding emergency services reconfiguration an
2. Note the current position regarding the Emergency Services Collaborative
3. Approve further work on and the implementation of Option 4

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