Worcestershire Reconfiguration CRG Summary

Clinical Redesign Group

Chair: Dr Kiran Patel, Medical Director (NHS England, West Midlands)

1. Consultation summary

2. Revised model

3. Report to Programme Board and Next Steps

Consultation

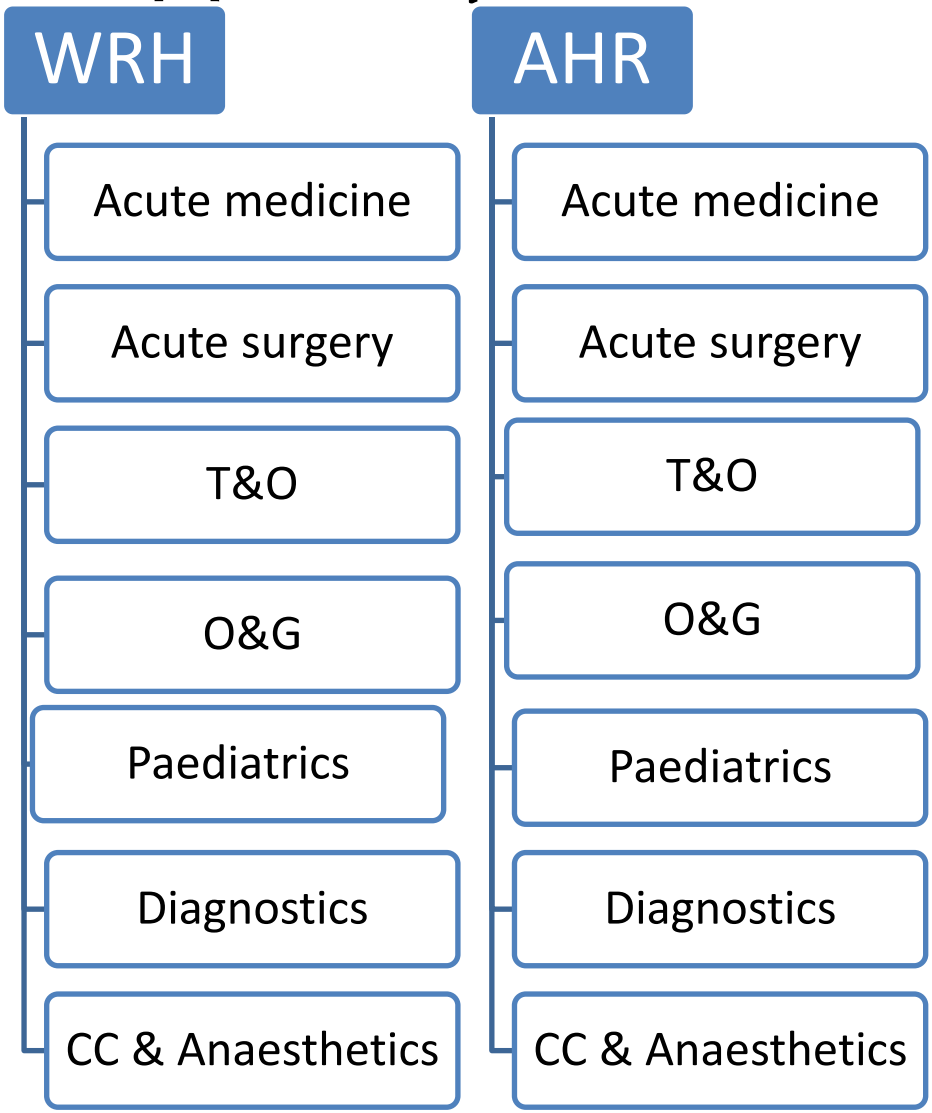
One of the concerns of the Clinical Senate centred around lack of clinical consultation and therefore a focus of the CRG was clinical consultation, summarised as below:

- All CCGs and ED supporting Clinical Directorates represented on CRG
- Weekly updates following CRG meetings by email to all clinicians across Worcestershire
- Internal Trust face to face meetings and drop in sessions with Medical Director
- Initial model developed and consulted upon across clinical workforce of Worcestershire
- Comments collated and model revised as a consequence
- Revised model shared across clinical workforce for 2 week period. Not formal consultation but responses received and discussed at final CRG meeting
- Clinical Model shared with Programme Board w/c 19.10.15

- Case for change from Consultation
  - Services will evolve but we need to move on now and stop deliberating – current services are suboptimal and not delivering
  - Case for change now needs articulating
  - Can we see what flows may go from WRH to AHR to ease pressure e.g. step down beds, rehab – and properly resource and grow these services? Need to mitigate increased flows into WRH site
  - Capacity at WRH site – beds and theatres, a critical issue in terms of deliverability of model
  - Clearly some suboptimal relationships between clinicians and departments across the 2 sites and this is apparent in consultation comments

- Ongoing concerns from Consultation and CRG deliberation
  - Paediatric service: the model removed PAU from the modified option 1 on the basis of clinical safety and supported by independent external review. This leaves a service with no emergency paediatrics at Redditch.
  - Clear concern about not advocating a shift of all paediatric services to WRH site – mitigated by 24/7 UCC but details of this will need development and commissioning.
  - Will the 3 CCGs collectively support the revised model? – concerns expressed, particularly by GPs in north Worcestershire.
  - Primary care offering to non ED services: Cognoscente that the development of Urgent and Emergency Care definitions from NHS England will impact on what the primary care offering will be in terms of specification. An UCC for example may need to provide paediatric basic life support and have full resuscitation provision.
  - Acute physicians at AH continued to articulate lack of support for the model although mitigation to concerns was available. Ongoing clinical engagement will be required, particularly to address concerns around lack of consultant review and transfer of patients to WRH in centralised specialties
    - » Consider retention of surgical consultant review at weekends and Bank Holidays as a core offering and review after audit of current service
    - » Reinforce concept of inpatient beds at WRH where core specialty is not acute medicine or medical.

Current Model of ED and Direct Support Specialties

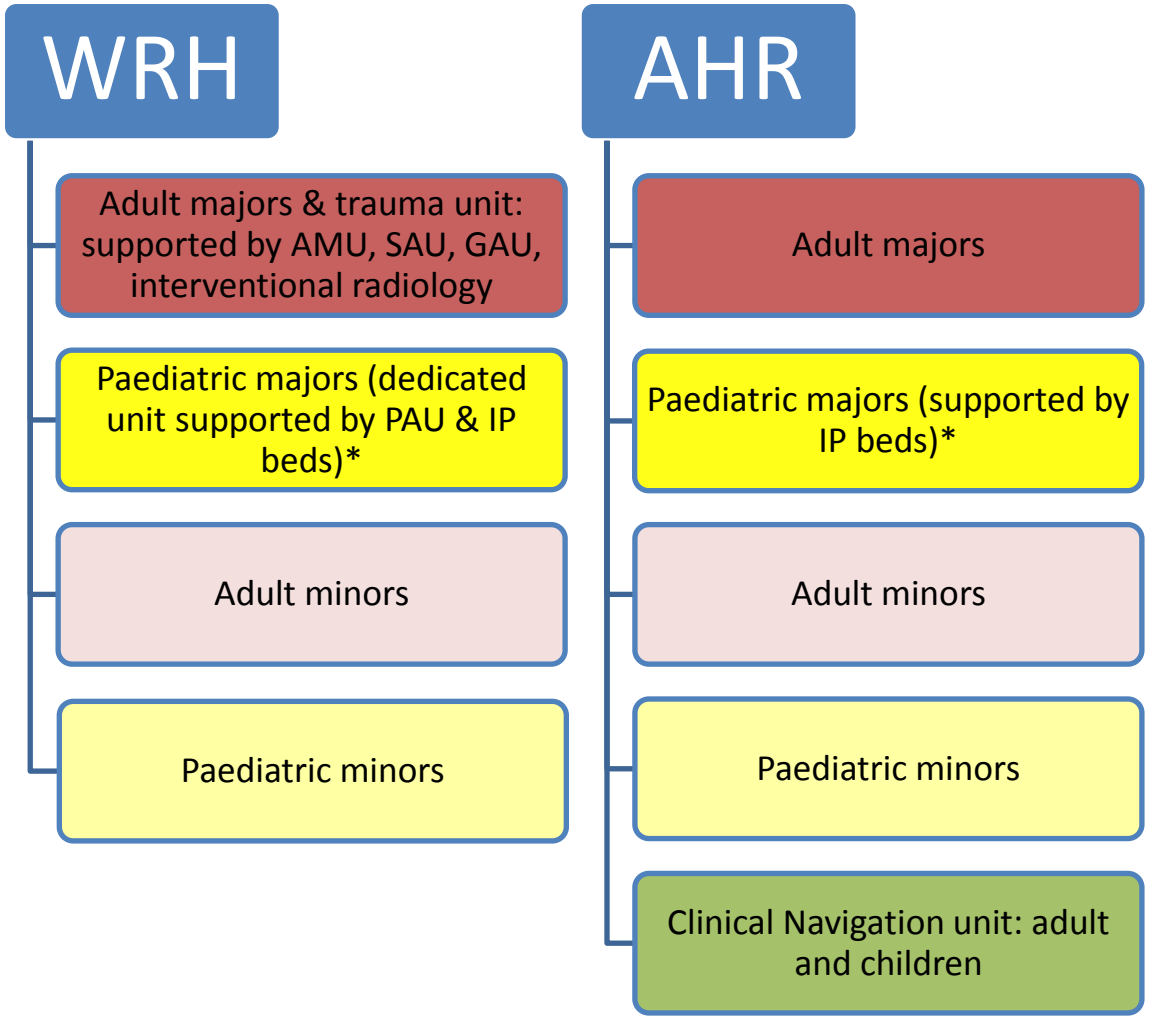


Why is the current model unsustainable?

- Quality issues
  - Inferior outcomes with current configuration of expertise
  - Consultant vs non-consultant delivered service inequity
  - Paediatrics: patient safety will be compromised if there is a Children's and Adult's ED at Redditch which does not have the infrastructure to support emergency resuscitation and stabilisation of sick children 24 hours a day.
- Operational
  - Site pressures
  - Suboptimal use of capacity and flow
- Workforce issues
  - Recruitment challenges in medical staff resulting in high locum cover (ED, surgery, paediatrics) unequally distributed across the 2 sites
  - Recruitment challenges in paediatric nursing staff for IP and ED
  - Insufficient activity in some areas to maintain skillset and training for trainees (in an era of reduced specialty trainees and GP trainees)
  - Internal site based preferences resulting in duplication of some services

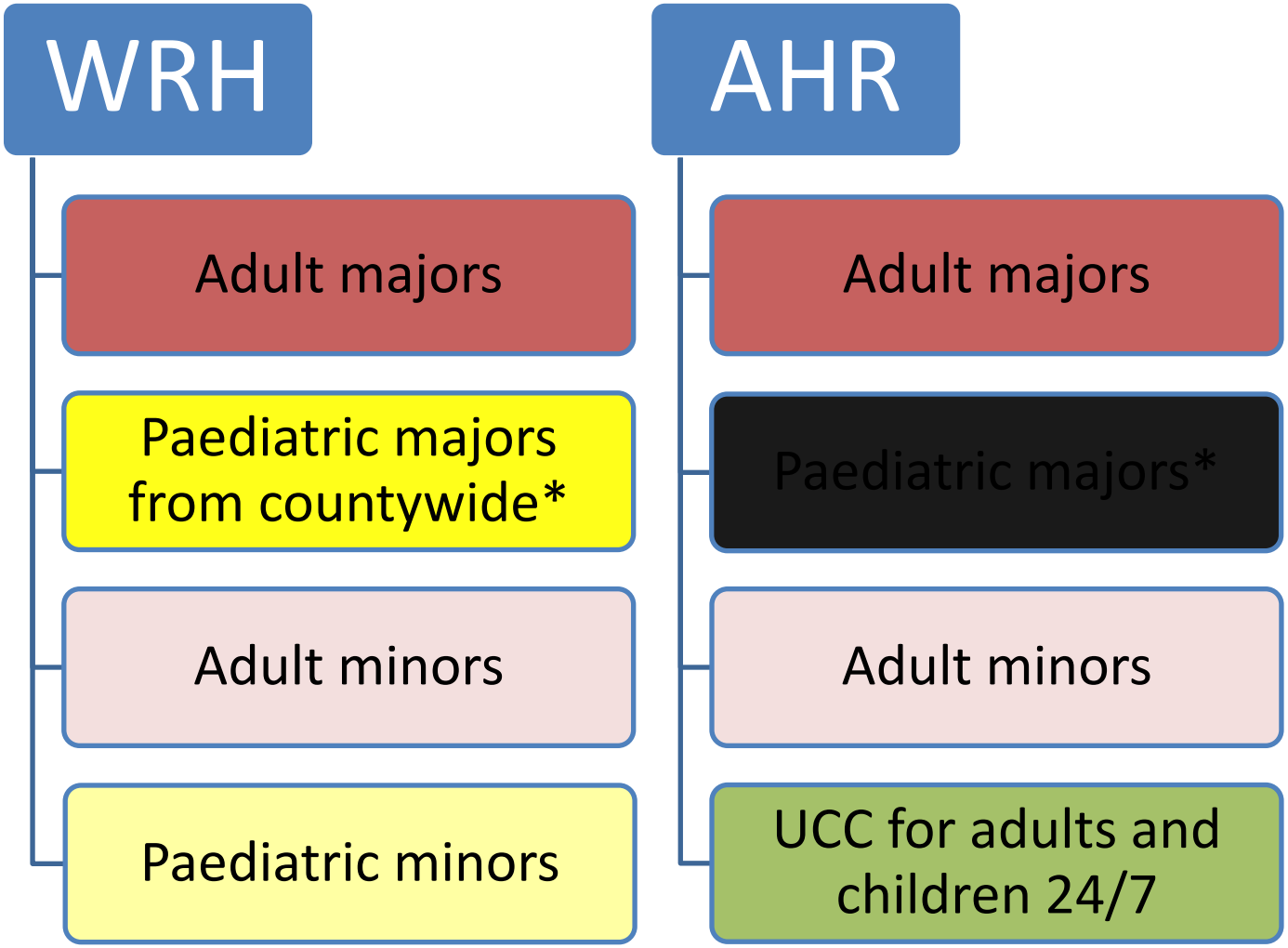
Emergency Department (ED)

Current Model: ED



*KIDS retrieval team for critically ill children

Future Model: ED & UCC at both sites



*KIDS retrieval team for critically ill children

Recommendations

- ED rostering to be countywide for OC availability of consultants and communications to highlight that.

- *Redditch to have an UCC (Urgent care centre) for adults and paediatrics, in addition to an adult only ED at AHR. CNU to be re-tendered to provide 24/7 services as an UCC to reduce risk of diversion of children to AHR ED when CNU closed.*

- *Model and pathways for UCC to be articulated and provider clarified.*

Paediatrics

Paediatric Model: Current

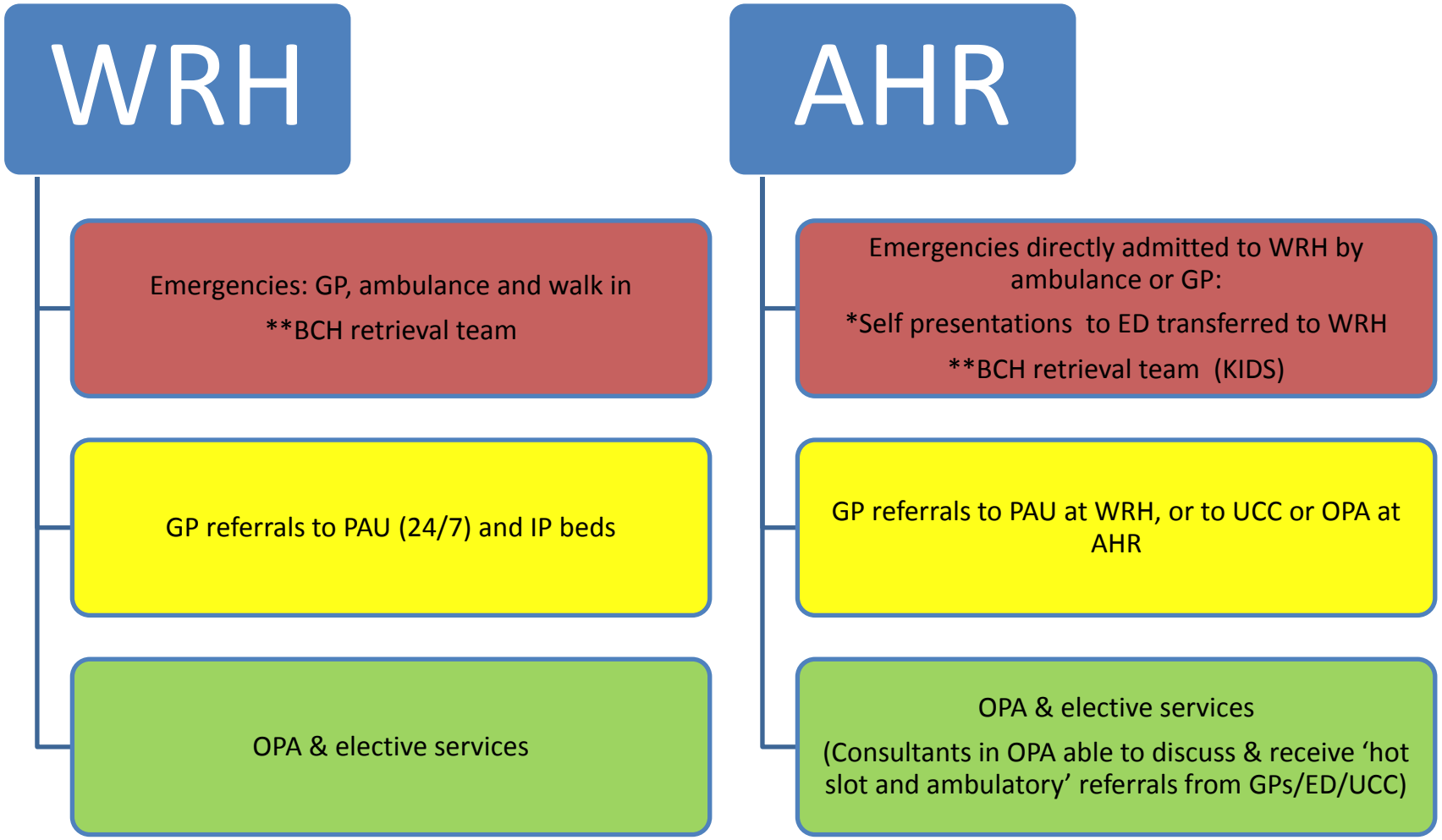
WRH

- Emergencies: GP, ambulance and walk in
- GP referrals to PAU & IP beds
- OPA & elective services

AHR

- Emergencies: GP, ambulance and walk in
- GP referrals to IP beds
- OPA & elective services

Paediatric Model: Future



*Mitigation of risk: Self presentations seen by ED staff and stabilised prior to transfer (if necessary, critical care, ED and paediatric consultants available for advice and call-in in exceptional circumstances)

Why might there be no PAU at AHR?

- PAU at AHR
  - Still doesn't deliver high quality outcomes as full support services at WRH site. Inequity of outcome unmitigated despite presence of PAU (internal and external independent clinical view)
  - Underused
  - Expensive – not good use of resources
  - Small No of patients
  - Difficult to staff
  - See and treat can be managed by UCC/MIU type setup
  - Expand OPA paediatrics at AHR site?

Additional comments about future paediatric model

- SUDIC arrangements on WRH site as children will not be brought to AHR site
- AHR site ED will have full paediatric resuscitation equipment and support from resident anaesthetics team for emergencies, backed up by OC consultants in ED, paediatrics and anaesthetics
- Mitigating against excessive flow of paediatric cases to WRH:
  - The Manchester Triage Tool used in Shropshire may help WMAS determine conveyance location to allow some ambulance transfers to Redditch UCC rather than direct to WRH
  - Clear articulation of role of UCC or alternative primary care offering in line with NHS England guidance
- As in Kidderminster, as the public becomes less likely to present acute paediatric cases to Redditch, the need for consultant presence out of hours at Redditch will diminish, so a transition period may be required. During the transition period, consultants could provide an out of hours availability which will largely be advice and guidance, but in exceptional circumstances to provide a safety net during transition, physical attendance at AHR. This will be audited to ensure workforce is adequately resourced.

Paeds: Workforce nursing

	WRH		Alex	
	Establishment	Staff in post	Establishment	Staff in post
Trained nursing staff	30.79 (Riverbank) 8.92 (Hospital at home County wide service) 7.97 (Outpatients Country wide service)	32.23 8.12 8.80	18.91 (Ward 1)	17.71
Total Trained:	47.68	49.15	18.91	17.71
Nursing Support	7.40 (Riverbank) 1.60 (Outpatients Countywide Service)	7.29 1.60	7.20 (Ward 1)	7.20
Total nursing support	9.0	8.89	7.20	7.20

Paeds: Workforce medical

Site	Grade	Establishment	HEWM posts	Trust posts	Current Establishment	Shortfall to meet proposed model (Countywide)
Worcester						
	Consultant	10 wte with 8 on duty rota	N/A	10	9.65	0.55
	ST Grade	8 wte	8 wte	0	6 wte	3.4
	FY Grade	11 wte	11 wte	0	11.2 wte	0.8
Redditch						
	Consultant	6 wte	N/A	6 wte	5.8 wte	
	ST Grade	6 wte	2.0 wte	4 wte	2.6wte	
	FY Grade	10 wte	10 wte	0	9.2 wte	

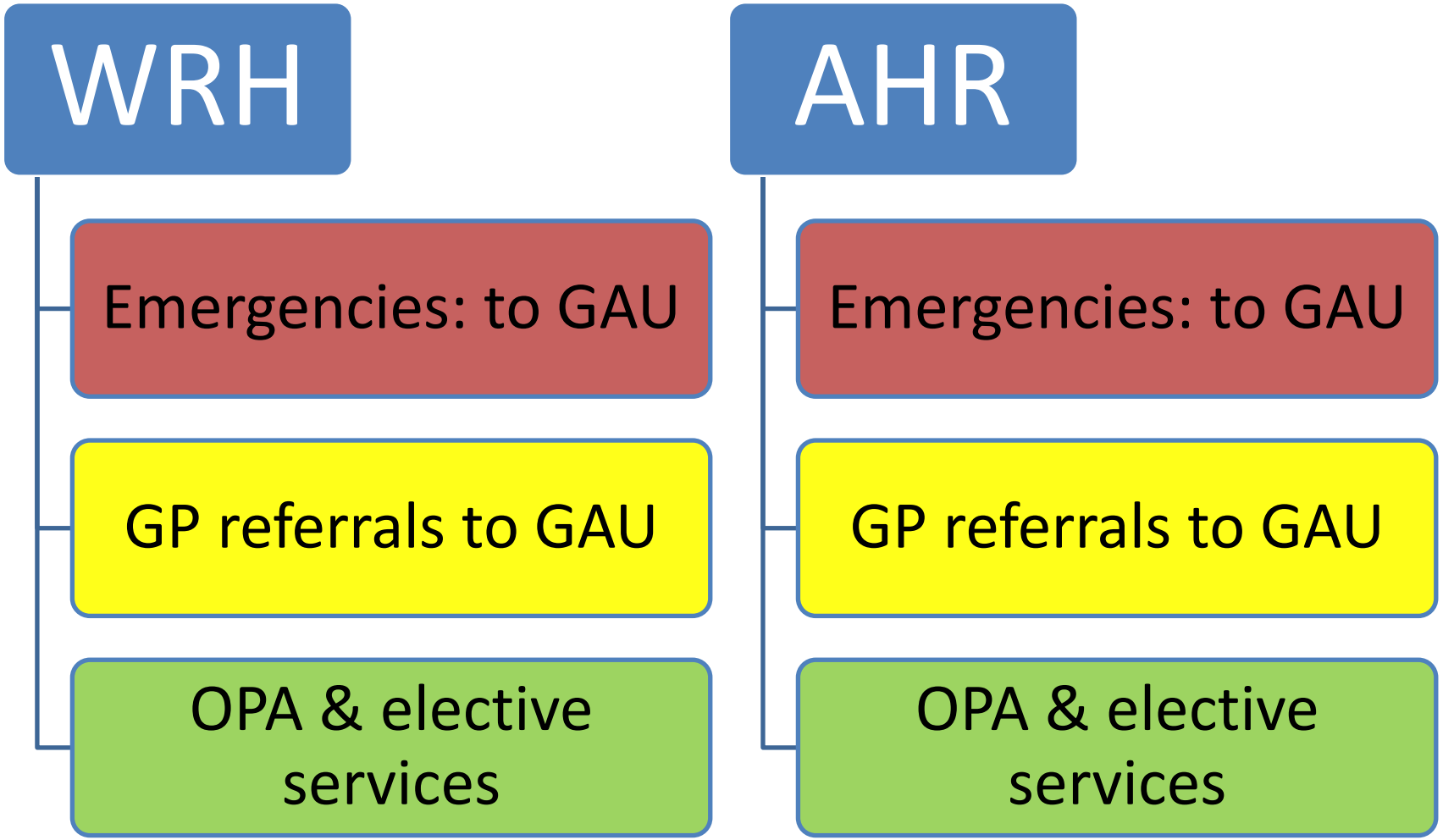
If extended opening hours for a PAU at AHR are required up to 4 additional consultants will be required on the rota in order to provide consultant presence at the Alex 7 days per week as well as the enhanced weekend and out of hours cover that will be required at WRH to meet RCPCH standards and deal with an increase in acute workload of up to 50% at WRH. PAU can be provided but is not the clinically preferred option. In time as consultants who no longer do 'on call' retire they may not need to be replaced as their work would be undertaken by colleagues

Paeds Capital expenditure for new model

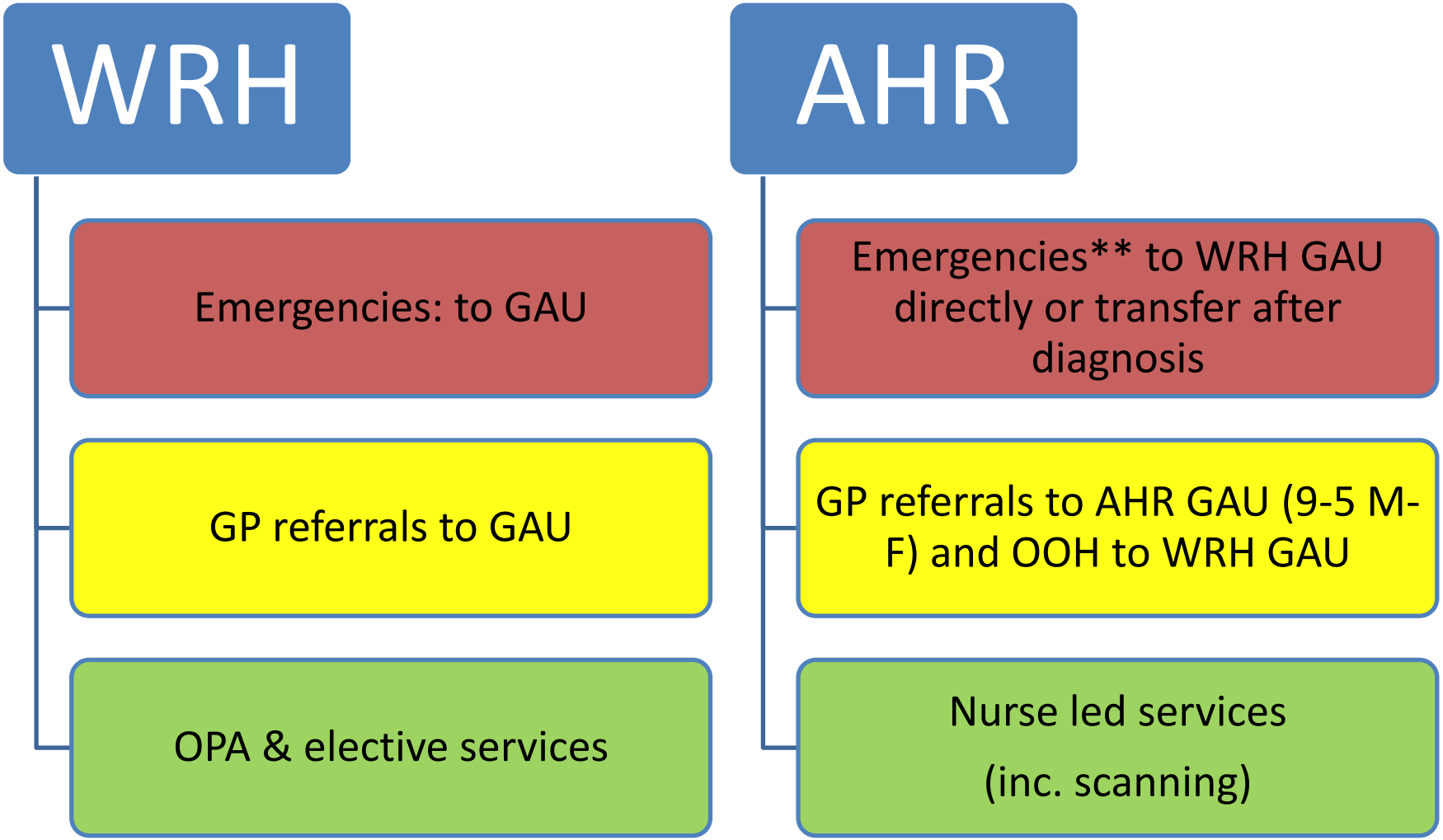
- Relocation of children's outpatient clinic area to Ward 1 at the Alexandra Hospital
- Conversion of two existing multi-bed rooms on Riverbank ward to cubicle areas.
- Expansion of TCU at WRH
- PAU at WRH

Gynaecology

Gynae Model: Current



Gynae Model: Future

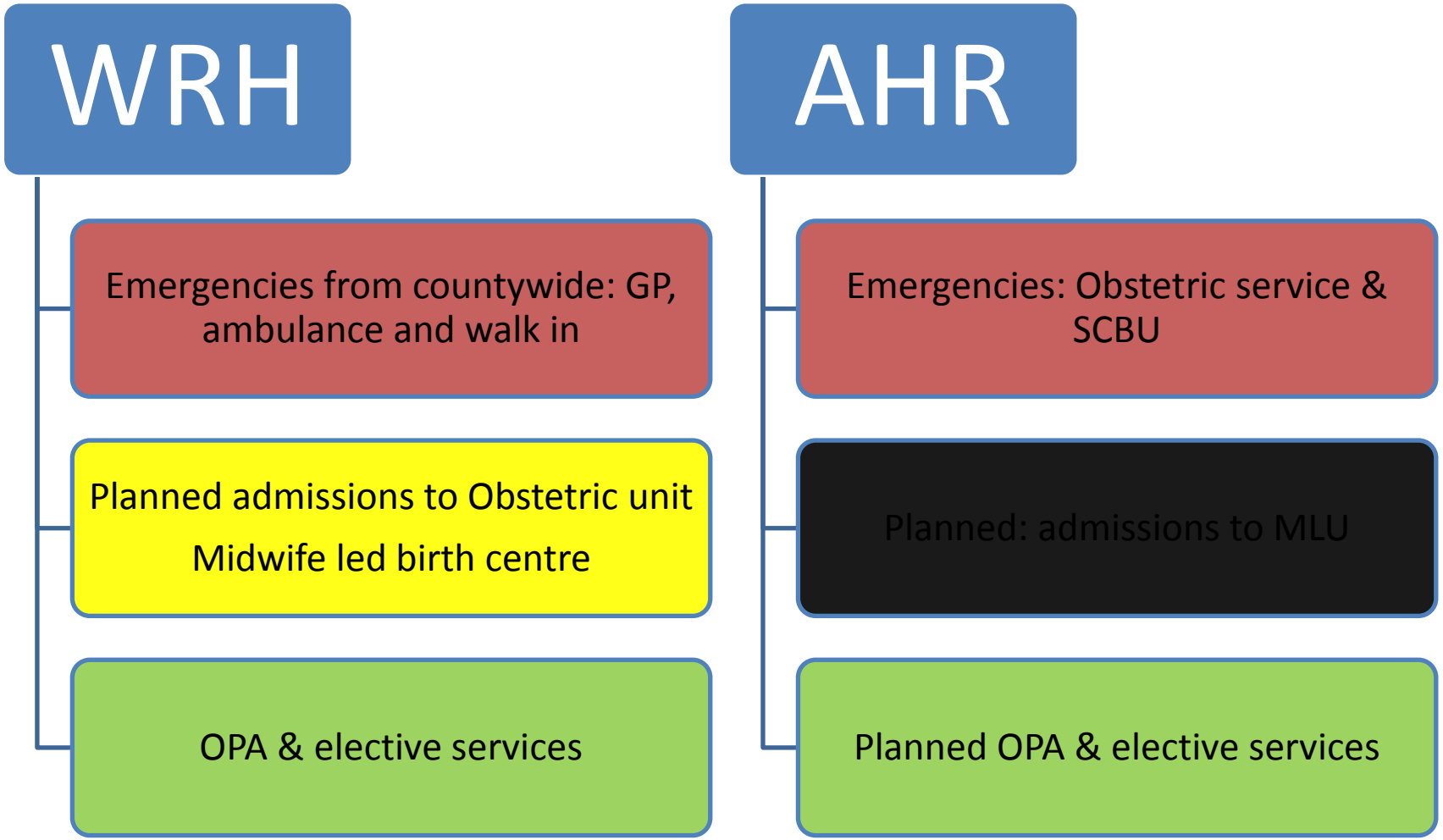


*OOH scans at AHR provided by radiology service

**Where surgery is required an on-call consultant may be required to go to AHR if patient is not fit for transfer by WMAS (i.e. ruptured ectopic pregnancy / major PV bleed).

Maternity

Maternity Model: Current*



* Prior to Nov 5th 2015

Maternity Model: Future

WRH

- Emergencies from countywide: GP, ambulance and walk in
- Planned admissions to Obstetric unit
  Midwife led birth centre
- OPA & elective services

AHR

- Emergencies: directly to or transferred to WRH
- Planned: Potential to consult on a standalone Midwifery Led Unit in the North of the County
- MAU: Planned OPA and diagnostic Services

Workforce: O&G Medical

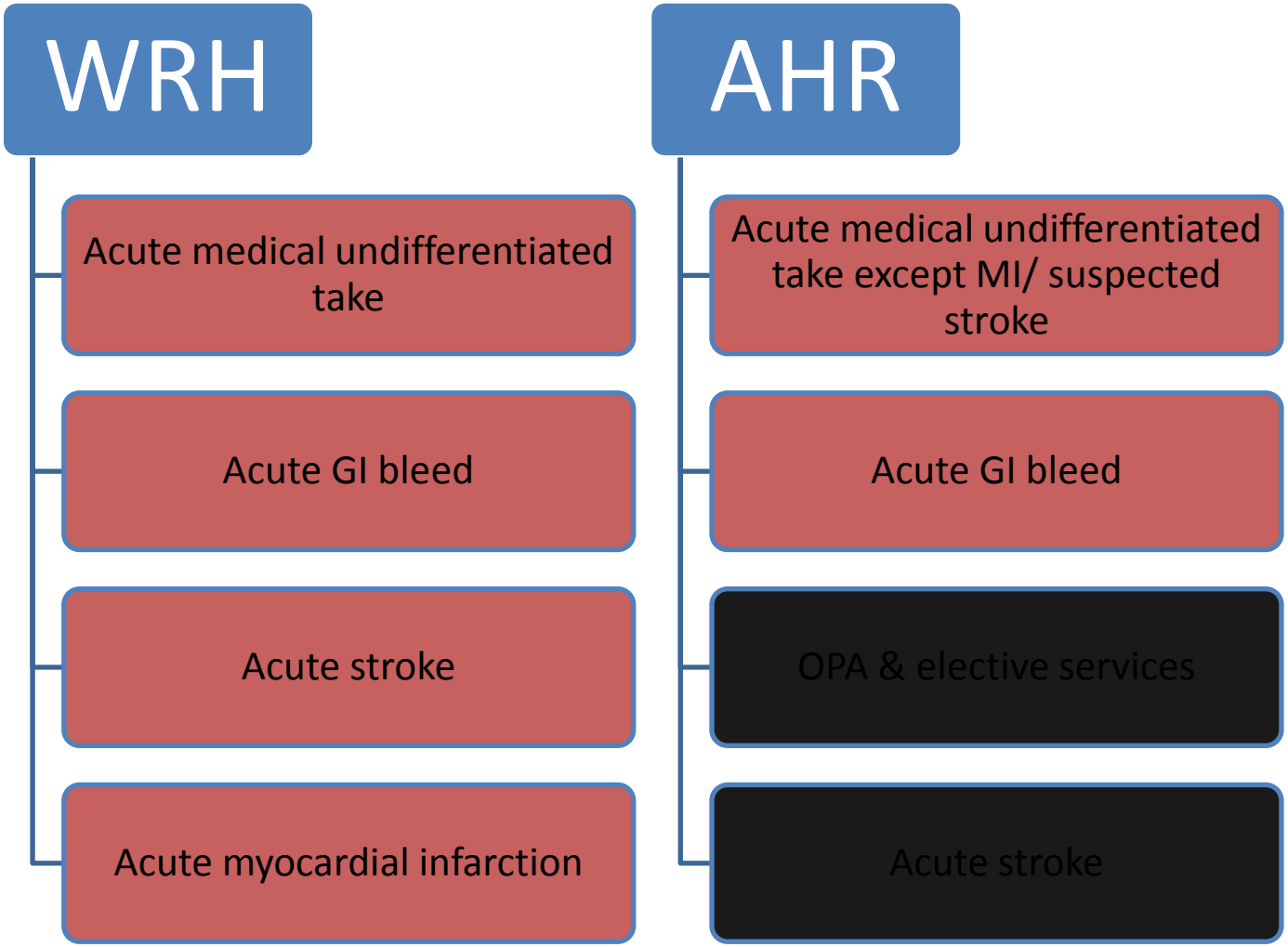
Site	Grade	Establishment	HEWM posts	Trust posts	Current Establishment	Shortfall for new model (Countywide)
Worcester						
	Consultant	13.5	N/A	12.5	12.5	1
	ST Grade	8	5	1	7	1
	FY Grade	8	8	0	8	0.4
Redditch						
	Consultant	5	N/A	5	5	
	ST Grade	8	0	1	1	
	FY Grade	8	7.6	0	7.6	

Workforce: O&G Nursing

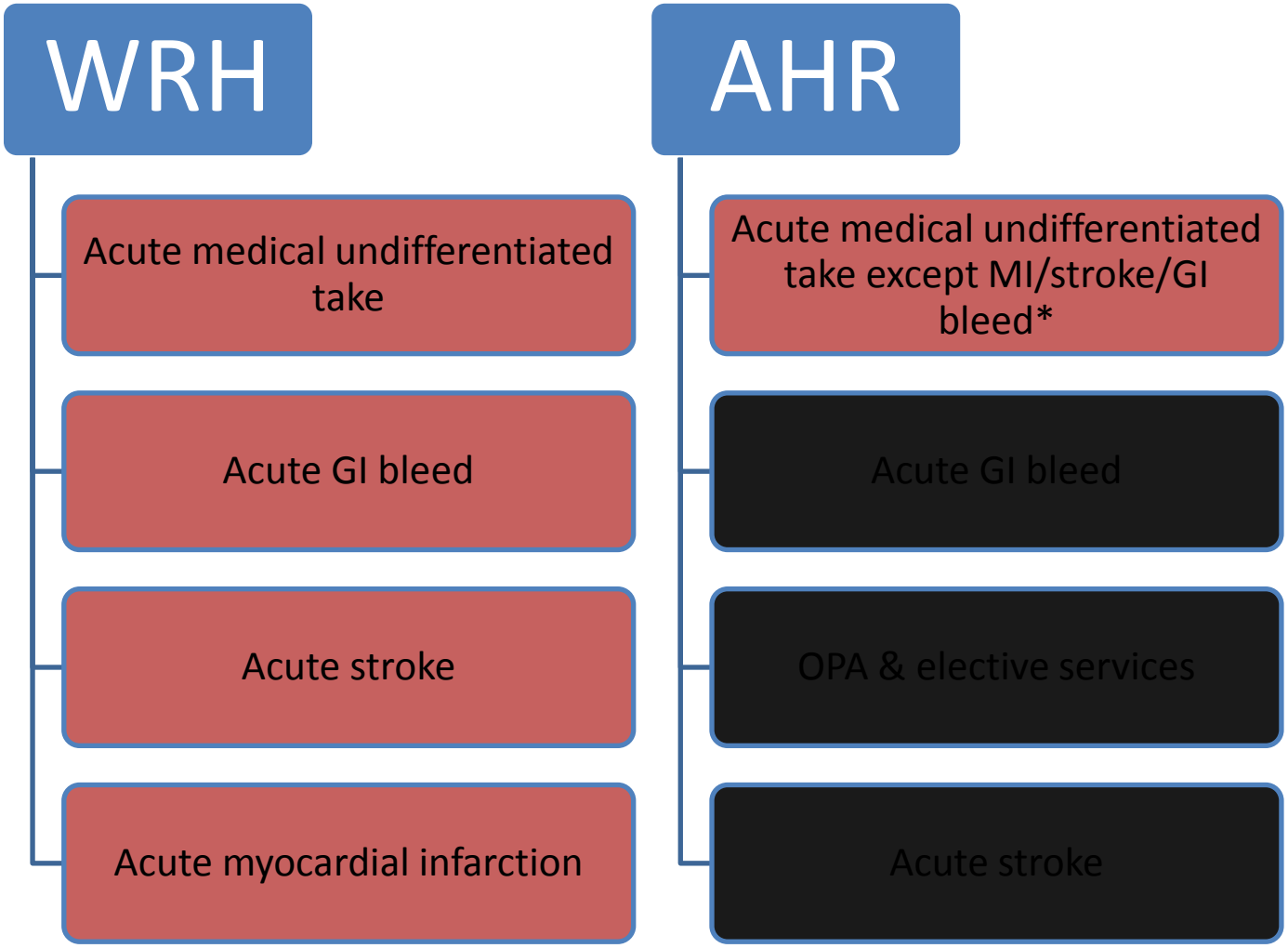
	WRH		Alex		Shortfall for new model (Countywide)
	Establishment	Staff in post	Establishment	Staff in post	
Trained Nursing staff	17.34	15.36	1	1	2
Specialist Gynae nurses, County wide	8.0	6.5			1.5
Midwifery support workers/ Nursery Nurses	6.99	8.32			-1.3

Acute Medicine

Acute Medicine Model: Current



Acute Medicine Model: Future



* GI bleed pathways currently in development and may be single or dual site

General Surgery

Surgery Model: Current

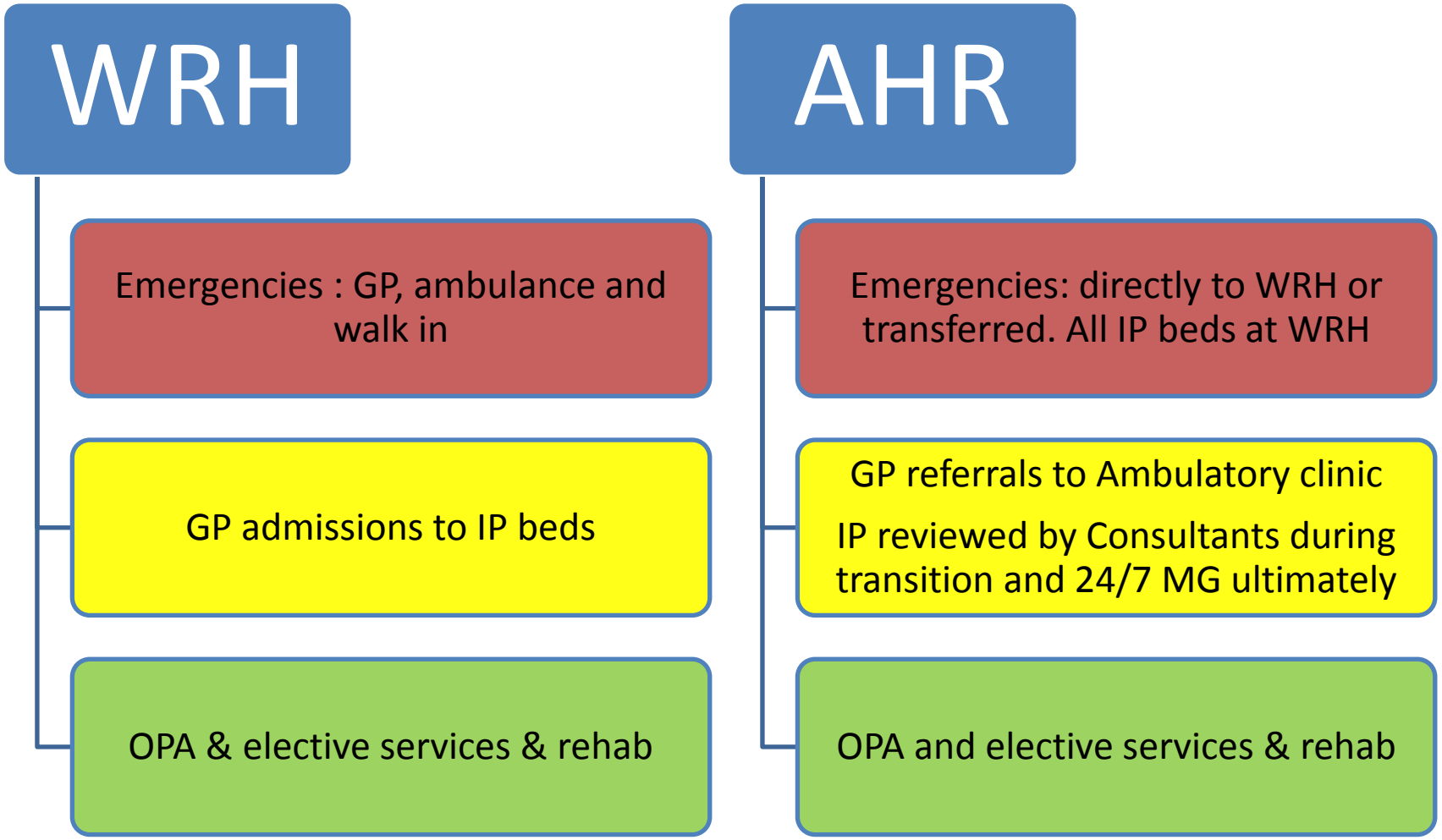
WRH

- Emergencies : GP, ambulance and walk in
- GP admissions to IP beds
- OPA & elective services & rehab

AHR

- Emergencies: GP, ambulance and walk in
- GP admissions to IP beds
- OPA and elective services & rehab

Surgery Model: Future



Rare occurrences will be dealt with appropriately based on clinical need and the acute surgical team will travel to the patient.

Workforce: General Surgery: Medical

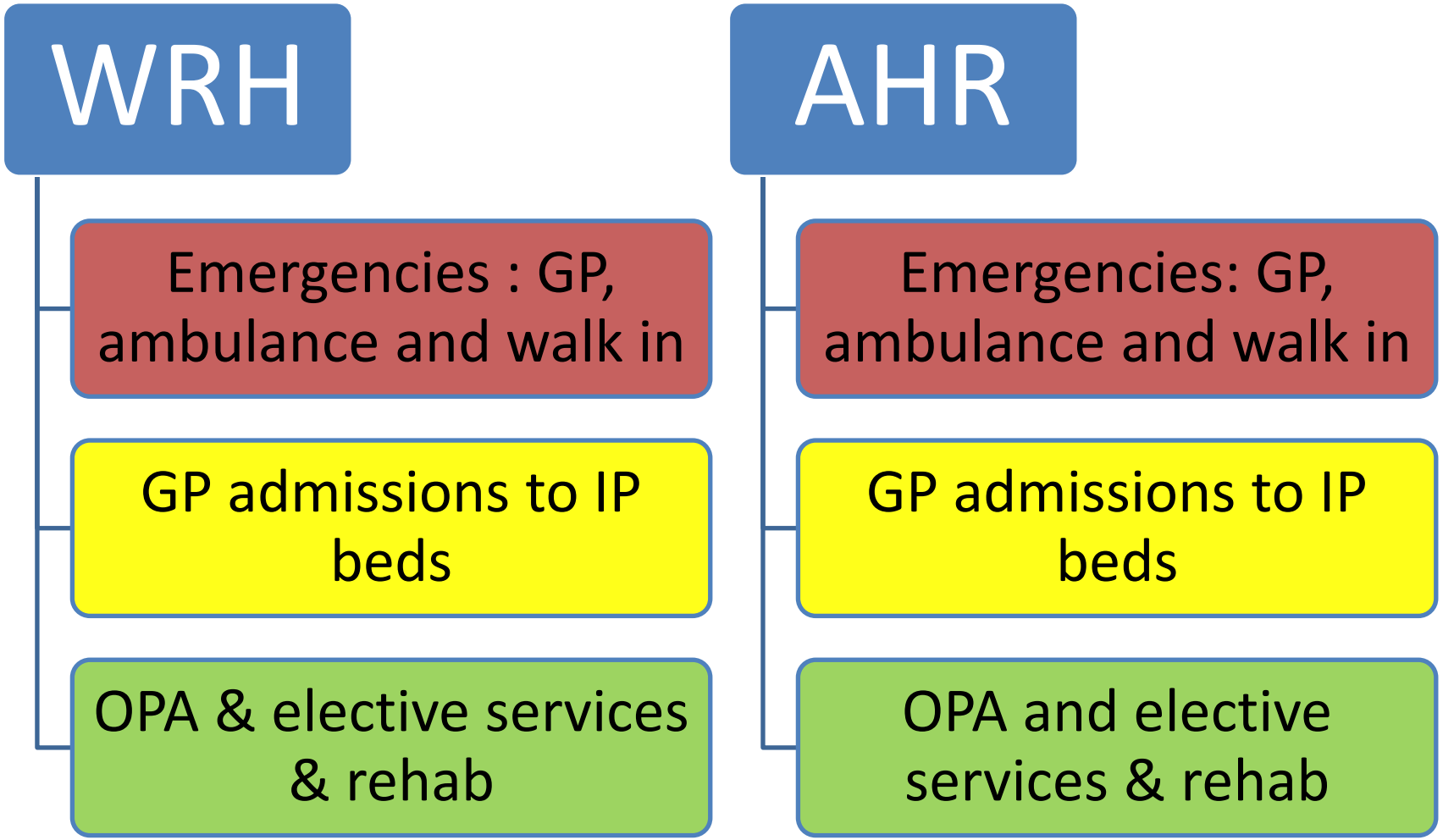
Site	Grade	Establishment	HEWM posts	Trust posts	Current Establishment	Shortfall for new model (Countywide)
Worcester						
	Consultant	9			9	2
	ST Grade		8		8	4
	FY Grade					
Redditch						
	Consultant	5			5 (2 locum)	
	ST Grade	7	2	5	7	
	FY Grade					

Workforce: General Surgery: Nursing

	Countywide		Shortfall for new model (Countywide)
	Establishment	Staff in post	
Trained Nursing staff			2 for ambulatory clinic
Specialist Gynae nurses, County wide			Consider physician assts etc.

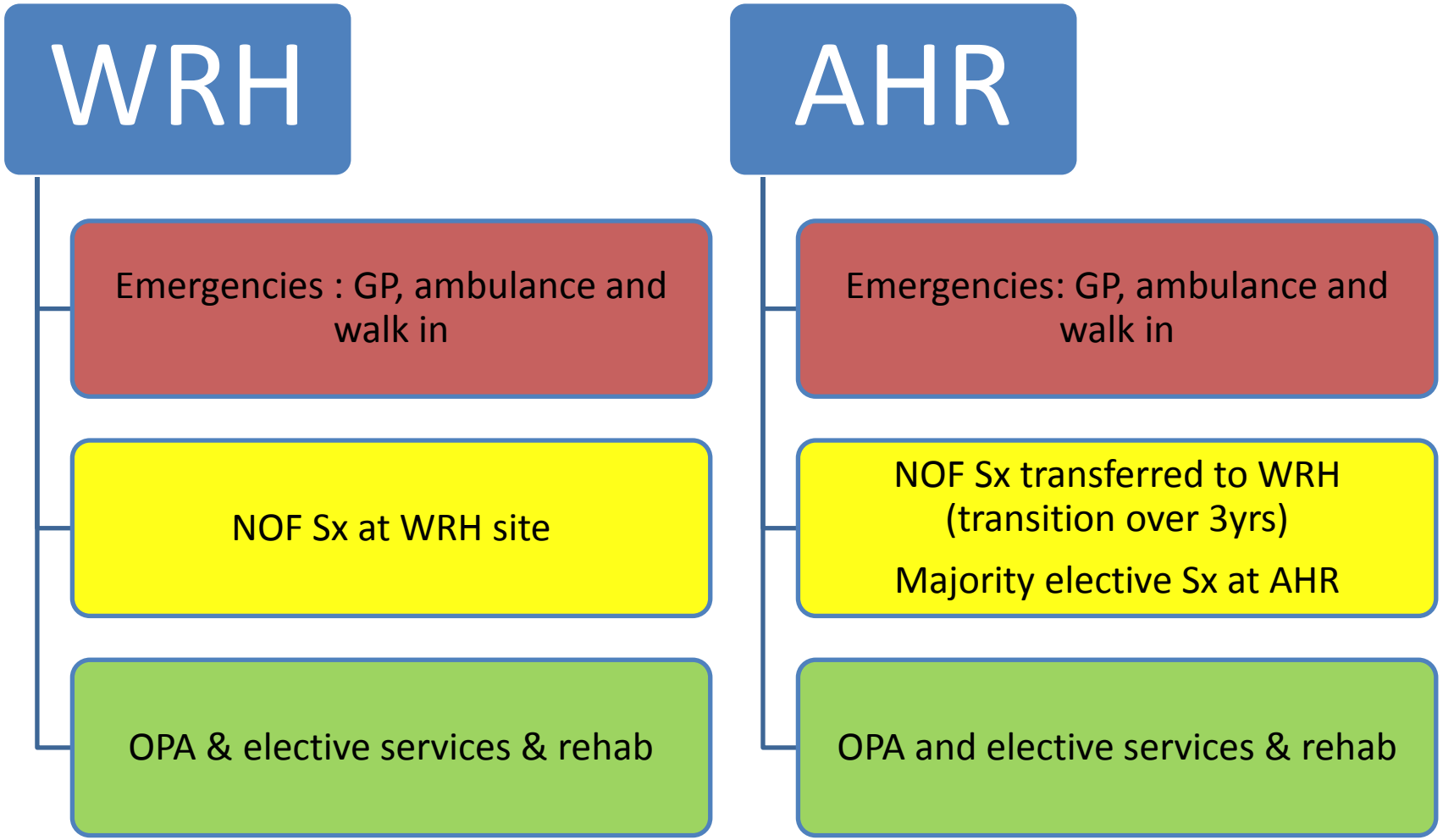
T & O

T&O Model: Current



Each site has resident FY Dr, OC non resident middle grade and OC Consultant

T&O Model: Future



Countywide Consultant rota (1st and 2nd OC system potentially), countywide middle grade, site based FY Dr

Workforce: T&O Medical

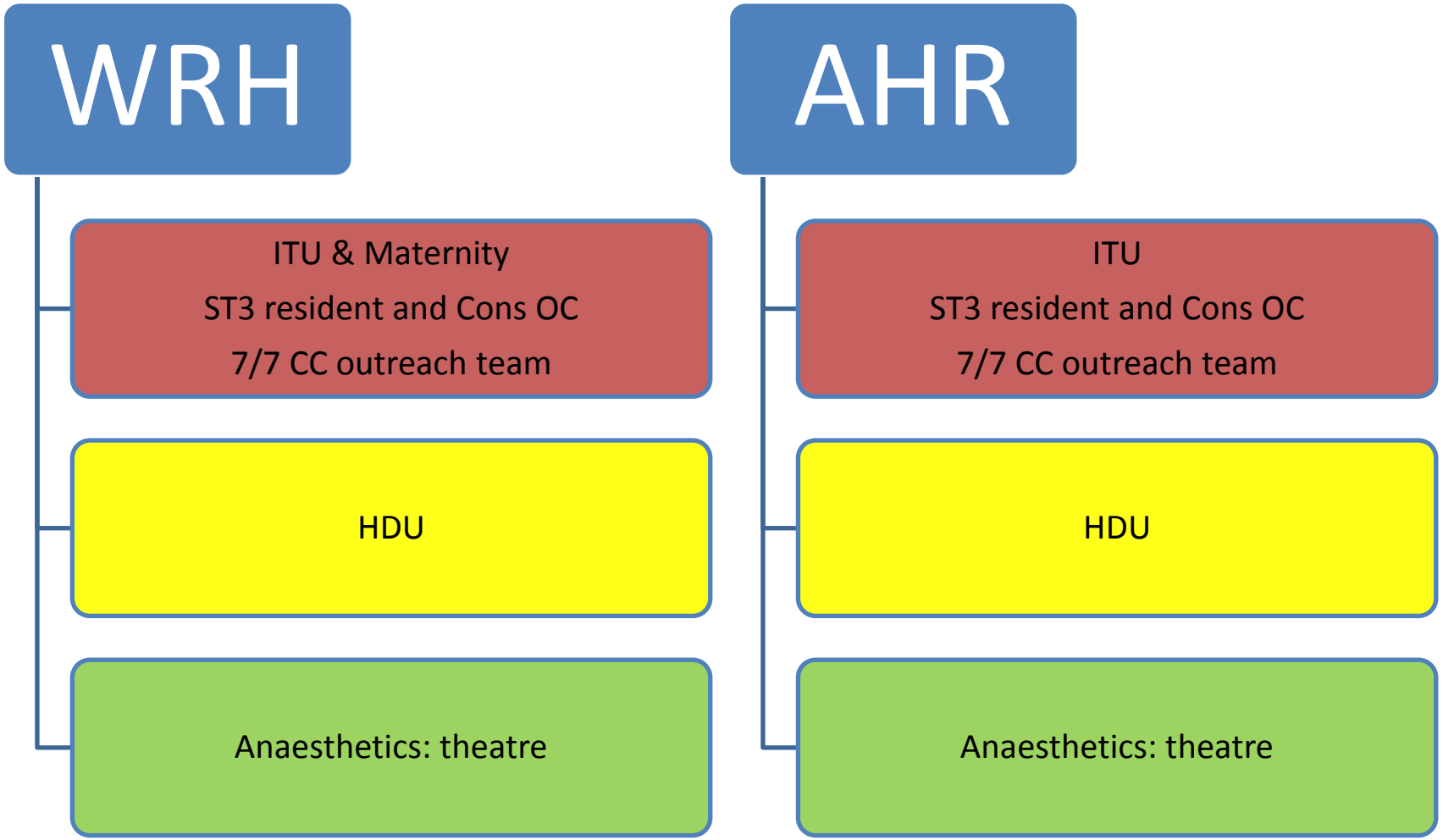
Site	Grade	Establishment	HEWM posts	Trust posts	Current Establishment	Shortfall for new model (Countywide)
Worcester						
	Consultant	8	N/A		8	2
	ST Grade	7	3	4	7	3
	FY Grade	6	6	0	8	
Redditch						
	Consultant	8	N/A		6	
	ST Grade	8	6	2	1	
	FY Grade	9	9	0	7.6	

Workforce: T&O Nursing

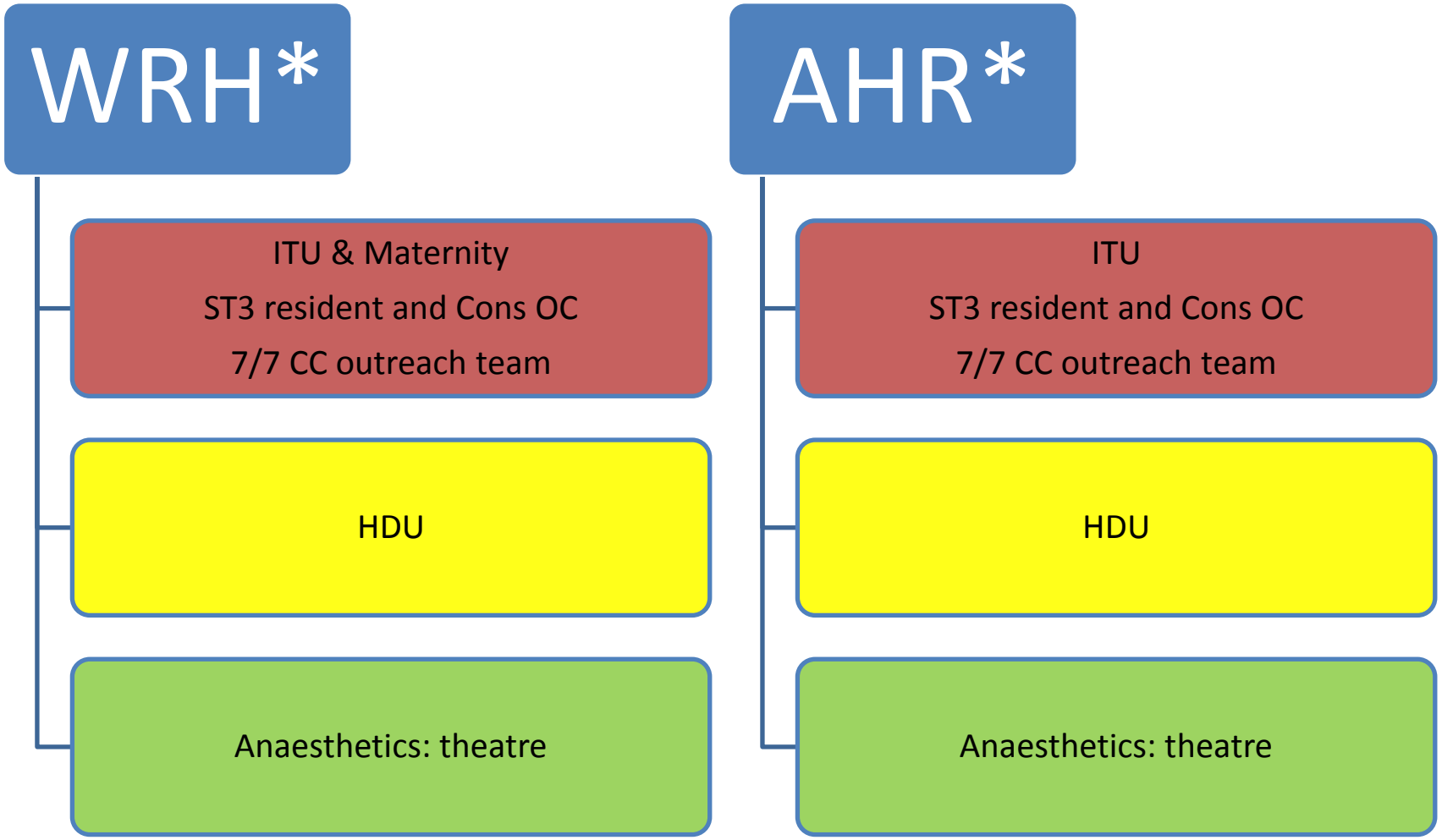
	Countywide		Shortfall for new model (Countywide)
	Establishment	Staff in post	
Trained Nursing staff	5	5	
Specialist Gynae nurses, County wide	2	2	

Anaesthetics and Critical Care

CC & Anaesthetics Model: Current



CC & Anaesthetics Model: Future



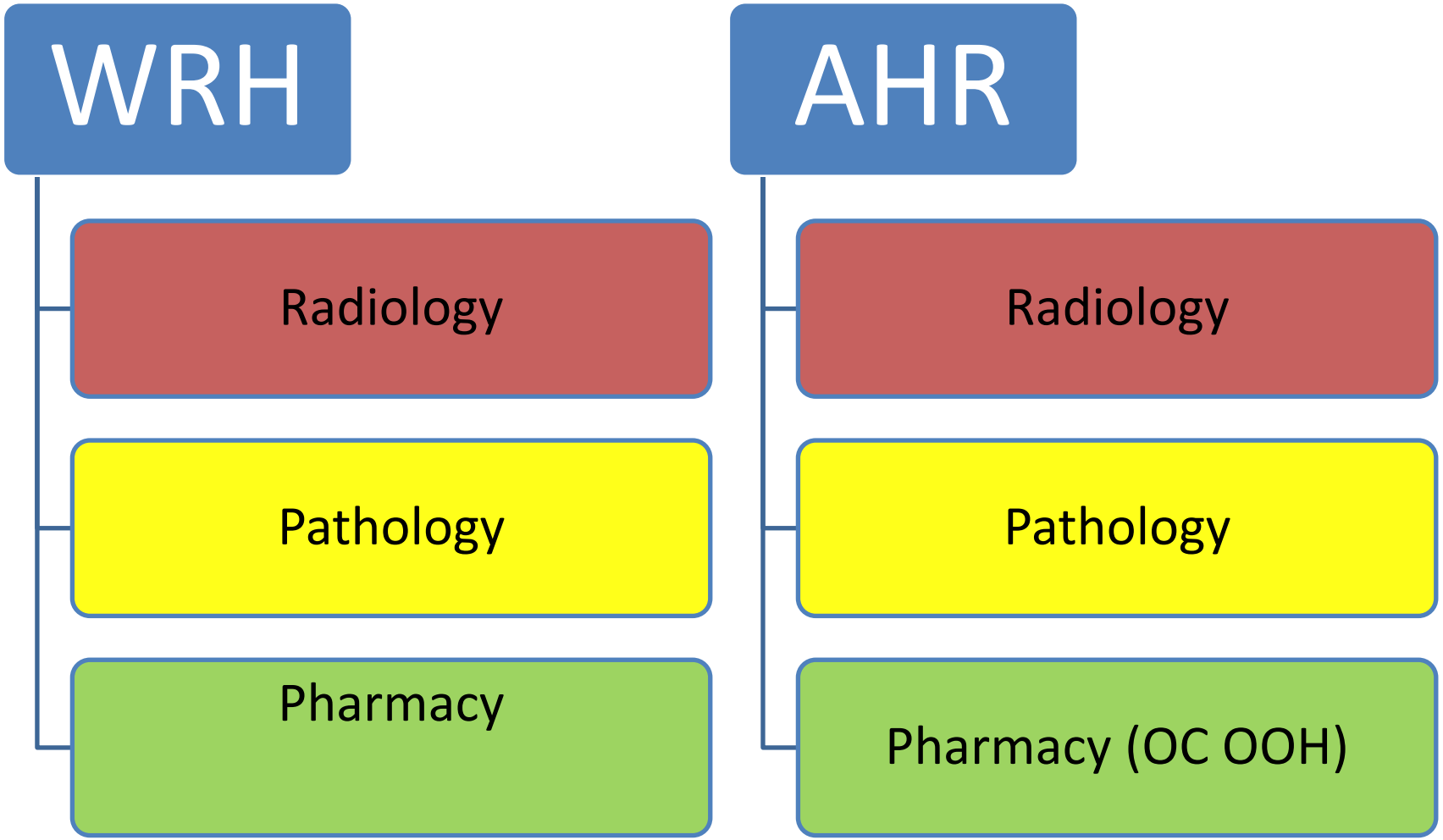
*where interhospital transfer support reqd OC Consultant will come in to enable transfer

Workforce: Anaesthetics & CC

Site	Grade	Establishment	HEWM posts	Trust posts	Current Establishment	Shortfall for new model (Countywide)
Countywide						
	CC Consultant	9			8	
	Anaesthetics Cons	50			46.8	2
	ST Grade			11		
	FY Grade					
Nursing	Matron	1			1	
		135			135	

Clinical Support Services

Clinical Support Services Model: Currently 24/7 except where stated



Clinical Support Services: Workforce

Directorate	FT Subjective	Condensed Subjective	M4 1516 Funded WTE
Pathology	Medics - Consultants	Medics - Senior	18.63
	Medics - Consultants Total		18.63
	Medics - Other	Medics - Junior	2.00
	Medics - Other Total		2.00
	Non Clinical	Admin & Clerical	10.62
		Senior Managers	2.00
	Non Clinical Total		12.62
	Scientific, Technical & Therapeutic	Clinical Scientists	3.80
		MLSO	101.43
		Non Theatre ATO	34.53
		Non Theatre MTO	24.26
	Scientific, Technical & Therapeutic Total		164.02
Pathology Total			197.27
Pharmacy	Non Clinical	Admin & Clerical	5.53
		Senior Managers	0.00
	Non Clinical Total		5.53
	Scientific, Technical & Therapeutic	Non Theatre ATO	27.33
		Non Theatre MTO	52.25
		Pharmacists	63.07
	Scientific, Technical & Therapeutic Total		142.65
Pharmacy Total			148.18
Radiology	Medics - Consultants	Medics - Senior	29.25
	Medics - Consultants Total		29.25
	Medics - Other	Medics - Junior	0.00
	Medics - Other Total		0.00
	Non Clinical	Admin & Clerical	47.67
	Non Clinical Total		47.67
	Nursing & Midwifery	Nursing - Trained	3.40
	Nursing & Midwifery Total		3.40
	Scientific, Technical & Therapeutic	Radiographers	191.09
	Scientific, Technical & Therapeutic Total		191.09
Radiology Total			271.41

Next Steps to be considered by Programme Board

- Model paediatric flows from AHR in light of no paediatric ED
- Audit paediatric activity and flow to CNU – prospectively and retrospectively
- Consider development of Primary care offering aligned to ED in AHR to inform public of planned offering
- Consider resourcing ongoing surgical consultant review at ARH pending review of audit of current provision. This may accommodate some of the concerns of acute medicine at ARH.
- Audit capacity at WRH to take additional paediatric admissions diverted from AHR catchment
- WMAS contract and costings for interhospital transfers