Paper ref:	TB (10/18) 019

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Acute Care Sustainability 2019		
Sponsoring Executive	Toby Lewis, Chief Executive		
Report Author	Jayne Dunn, Director of Commissioning		
Meeting	Trust Board	**Date**	4th October 2018

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

The Board is invited to discuss, challenge and confirm the advice of the executive that both A&E departments can be maintained to 2022 under the assumptions cited.

We should discuss the shortlisted options, recognising that they remain work in progress – and seek to agree that the ambition for care standards should as stated. The paper for next time will then set out how this can be achieved consistent with our Midland Met model.

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	X	Public Health Plan		People Plan & Education Plan	X
Quality Plan	X	Research and Development		Estates Plan	X
Financial Plan	X	Digital Plan	X	Other *[specify in the paper]*	X

3. Previous consideration *[where has this paper been previously discussed?]*

CLE and its estate development committee working group on quality and sustainability

4. Recommendation(s)

The Trust Board is asked to:

a.	ACCEPT the work done to date to develop a short-list of options
b.	REQUIRE the Chief Executive to bring proposals to the next Board for submission to the CCG

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		3021					
Board Assurance Framework		Risk Number(s): BAF 5 and BAF 10					
Equality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	31-10
Quality Impact Assessment	Is this required?	Y	X	N		If 'Y' date completed	31-10

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 4 October 2018

Acute Care Reconfiguration 2019

1. Summary:

1.1 The Board, and partners, accepted in 2014 that acute care configuration could only be sustained in present form to 2018-19. We are now faced with doing so to 2022. We have revisited our then assumptions and found routes to mitigate most change sufficient to sustain two adult A&E departments. Reviewing our workforce "triggers" and conscious of our safety harms we should, unless we suffer staffing losses we do not expect, be able to cope. If expectations of consultant cover and such change in the next four years we will not necessarily be able to meet those standards as we will have very little 'flexibility' in our system. We will anyway prepare intensively for our Urgent Care Centre model, which will be from 2020-21 staffable as a plan B.

1.2 We want now, or rather after consultation and constriction by 2019, to move to a much more consultant delivered acute medicine model of intensive input over the first 48 hours of care. On a seven day basis our patients will benefit from immediate evaluation and treatment planning. We are finalising consideration of three routes to that aim:

a) A major increase in acute physicians through traditional recruitment
b) Reconfiguring respiratory medicine from Sandwell to City to release medical time to contribute "at the front door"
c) Co-locating frailty and acute medicine to create a joint service in our AMUs.

1.3 In reality a blend of all three approaches may be needed. Over the next four to six weeks we will work intensively to determine how best to guarantee a 14 hour standard for 90%+ of our admissions seven days a week, alongside monitored bed medical input and a hugely expanded AMAA offer. These are the 'Midland Met' standards. Or put more accurately, these are the clinical standards we promised local people we could offer from 2018-19 and stated that those standards were modern medical norms. We cannot defer them unless they are unachievable. They offer quality gains and training gains. The Board is invited to agree that they are aims we must deliver to fulfil our 2020 vision.

1.4 Separately, and to a different timetable, we note the emerging apparent conclusions of the CQC about paediatric care in emergency departments. This reflects views formed in other inspections. Since 2016 we have invested in children's A&E, and Midland Met will create dedicated 24/7 service. It is impossible to provide that model twice from 2019. We believe that we have a safe alternative approach and will explore that with our regulators and commissioners.

2. Context:

2.1 Following the liquidation of Carillion in January 2018, it became apparent that there would be a significant delay to opening the Midland Metropolitan Hospital (Midland Met) and therefore a need to run acute clinical services on 2 sites (City and Sandwell Hospitals) for an extended period i.e. until 2022. The most significant risks identified in relation to safely sustaining acute services on 2 sites for this extended period primarily relate to maintaining a senior medical workforce at the 'emergency front door' (i.e. Emergency Departments and Acute Medical Units). This paper presents the work the Trust has undertaken to identify key actions to mitigate the most significant clinical risks. In particular 3 acute medical specialty reconfiguration options are proposed for further development and appraisal ahead of agreeing which option/s should be the subject of public engagement from November 2018 in order to agree a preferred option in March 2019 for delivery by the end of October 2019.

3. Process

3.1 Following the liquidation of Carillion in January 2018, the senior clinical leadership identified key clinical risks associated with the need to run acute clinical services on 2 sites for the extended period until Midland Met opens i.e. 2022. The potential need to consolidate some acute services onto a single site in order to mitigate the most significant risks was recognised and a number of reconfiguration options identified.

3.2 The Trust has established an executive led fortnightly clinical group, the Midland Met Quality & Sustainability Committee to develop and review the reconfiguration options. This committee identified the following planning assumptions relating to any acute service reconfiguration/ consolidation ahead of Midland Met opening:

- Current 2 site service working is safe but increasingly challenging to sustain
- Reducing to a single Emergency Department (ED) would be a last resort and if required the ED would be based at City Hospital (given its close proximity to Midland Met) and available real estate to create additional clinical space if required (Sandwell Hospital does not have this expansion opportunity within its real estate).
- Any acute service reconfiguration/consolidation to a single site would require some form of public engagement with time allowed for this (typically minimum 12 weeks)
- Until Midland Met opens:
    - Critical Care will need to remain on both City & Sandwell sites
    - Cardiology specialist inpatient facilities will remain at City Hospital
    - Paediatric inpatient facilities will remain at Sandwell Hospital
    - Maternity & Neonatal inpatient and high risk outpatient facilities will remain at City Hospital
    - Day case & 23 hour stay surgery will continue on both sites

- Ideally clinical haematology/oncology inpatients & chemotherapy to remain at Sandwell Hospital
- Ideally stroke unit to remain at Sandwell Hospital.

3.3 Appendix 1 provides details of the process followed, risks identified and the long list of options considered.

4. Options

4.1 The aspiration is to maintain a 24/7 Emergency Department on each of the City and Sandwell Hospital sites up until Midland Met opens. The most significant risk identified in terms of sustaining this aspiration ***relates to maintaining a senior acute medicine workforce that enables medical patients admitted as an emergency to have a senior medical/consultant review within 14 hours of admission to the Acute Medical Unit (AMU), 7 days a week.*** Mitigating this risk is likely to require further consolidation (reconfiguration) of medical specialties onto a single site in order to release senior medical capacity to support front door acute medicine. From the long list of options three have been identified for further development:

Option 1: Do Nothing - Acute service configuration to remain as now.

4.2 The table below summarises the current distribution of clinical services by site.

Service	City Hospital (inc. BTC & BMEC)	Sandwell Hospital
24/7 Emergency Department	✓	✓
Acute Medical Unit (AMU & AMAA)	✓	✓
Critical Care Unit	✓	✓
Day Case & 23 hour stay planned surgery	✓	✓
Diagnostic Services	✓	✓
Outpatient Clinics (including antenatal clinic)	✓	✓
Children's Inpatient Unit	✓	-
Paediatric Assessment Unit	✓	✓
Maternity services	✓	-
Surgical Assessment Unit	-	✓
General Surgery beds	-	✓
Trauma & Orthopaedic beds	-	✓
Gynaecology beds & emergency assessment unit	✓	-
ENT & Urology beds	✓	-
Stroke Unit	-	✓
Cardiology beds & cardiac cath. Labs	✓	-
Older People Assessment Unit (OPAU)	-	✓
General medical beds	✓	✓
Respiratory medicine beds	✓	✓
Gastroenterology beds	✓	✓
Haematology beds	✓	✓
Elderly Care beds	✓	✓

4.3 In this option the mitigating actions for the significant risks identified would include:

- Expanded AMAA on both sites (to reduce admission to AMU)
- A revised consultant workforce provision with time released from fully established medical speciality rotas to support the acute physician rota covering AMU and AMAA or
- Acute medicine consultant rota (covering AMAA and AMU) on one site to be filled by acute physicians whilst on the rota on the other site is filled by consultants from other medical specialties (primarily respiratory medicine, elderly care, with some support from gastroenterology and cardiology).

Option 2: Reconfigure Respiratory Medicine inpatient beds to City Hospital

4.4 The table below summarises the distribution of clinical services by site under this option. The change from the current distribution is highlighted.

Service	City Hospital (inc. BTC & BMEC)	Sandwell Hospital
24/7 Emergency Department	✓	✓
Acute Medical Unit (AMU & AMAA)	✓	✓
Critical Care Unit	✓	✓
Day Case & 23 hour stay planned surgery	✓	✓
Diagnostic Services	✓	✓
Outpatient Clinics (including antenatal clinic)	✓	✓
Children's Inpatient Unit	✓	-
Paediatric Assessment Unit	✓	✓
Maternity services	✓	-
Surgical Assessment Unit	-	✓
General Surgery beds	-	✓
Trauma & Orthopaedic beds	-	✓
Gynaecology beds & emergency assessment unit	✓	-
ENT & Urology beds	✓	-
Stroke Unit	-	✓
Cardiology beds & cardiac cath. Labs	✓	-
Older People Assessment Unit (OPAU)	-	✓
General medical beds	✓	✓
Respiratory medicine beds	**✓**	**-**
Gastroenterology beds	✓	✓
Haematology beds	✓	✓
Elderly Care beds	✓	✓

4.5 In this option the main mitigating actions for the significant risks identified would be;

- Consolidation of respiratory medicine beds, including non-invasive ventilation unit (NIV), onto the City Hospital site alongside Cardiology beds. This would create efficiencies in senior clinical cover & patient pathways for patients admitted with chest conditions, enabling,

- Release of senior medical time from respiratory medicine & possibly Cardiology to support Acute Medicine (AMU & AMAA) cover at City possibly to the extent that acute medicine consultants could primarily be focused at Sandwell.

Option 3: Reconfigure Respiratory Medicine inpatient beds to City Hospital & Elderly Care inpatient beds to Sandwell Hospital

4.6 The table below summarises the distribution of clinical services by site under this option. The changes from current distribution are highlighted.

Service	City Hospital (inc. BTC & BMEC)	Sandwell Hospital
24/7 Emergency Department	✓	✓
Acute Medical Unit (AMU & AMAA)	✓	✓
Critical Care Unit	✓	✓
Day Case & 23 hour stay planned surgery	✓	✓
Diagnostic Services	✓	✓
Outpatient Clinics (including antenatal clinic)	✓	✓
Children's Inpatient Unit	✓	-
Paediatric Assessment Unit	✓	✓
Maternity services	✓	-
Surgical Assessment Unit	-	✓
General Surgery beds	-	✓
Trauma & Orthopaedic beds	-	✓
Gynaecology beds & emergency assessment unit	✓	-
ENT & Urology beds	✓	-
Stroke Unit	-	✓
Cardiology beds & cardiac cath. Labs	✓	-
Older People Assessment Unit (OPAU)	-	✓
General medical beds	✓	✓
Respiratory medicine beds	✓	-
Gastroenterology beds	✓	✓
Haematology beds	✓	✓
Elderly Care beds	-	✓

4.7 In addition to the mitigating actions identified in option 2, this option would:

- consolidate elderly care inpatient medicine at Sandwell (where the demand is greatest & alongside the stroke unit) creating efficiencies in senior clinical cover & patient pathways which would enable release of senior medical time from elderly care medicine to support Acute Medicine (AMU & AMAA) at Sandwell;

- Facilitate acute medicine consultant rotas to enable these consultants to provide input and in particular leadership to the AMUs at both sites.

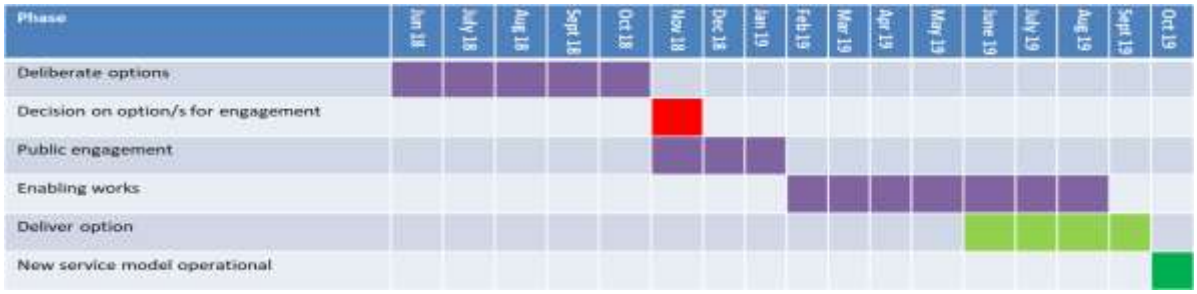
5. Evaluation Criteria

5.1 Further work is required to develop the 3 options in more detail (including activity & capacity changes, estate expansion, cost implications, risks etc). The Midland Met Quality & Sustainability Committee has identified a set of weighted evaluation criteria to assess each option against. At a summary level these are:

	CRITERION:	AGREED WEIGHTING %
1	Quality & Safety	30
2	Clinical Workforce & Sustainability	25
3	Capacity & Deliverability	20
4	Affordability	15
5	Integration & Strategic Fit	10
		100

6. Timeline & Next Steps

6.1 The key date for implementation of any required acute service reconfiguration and the related new service model becoming operational is the end of October 2019 i.e. before the onset of increased winter related demand in acute medicine. The diagram below summarises key actions and timelines to meet this date.



6.2 The next key milestone to take this work forward therefore is to agree the options for public engagement in the week commencing 29th October 2018 in order to commence public engagement in November. Appendix 1, section 5 summarises the steps required to reach this milestone. The process to agree the option/s for public engagement needs to be agreed.

7. Recommendations

7.1 This paper has presented 3 acute medical specialty reconfiguration options and related actions to mitigate the most significant risks identified in relation to safely sustaining acute services on 2 sites for this extended period until Midland Met opens in 2022 i.e. maintaining a safe senior medical workforce at the 'emergency front door' (i.e. Emergency Departments and Acute Medical Units). To achieve the proposed milestone for delivering any acute service reconfiguration before the end of October 2019 (and therefore ahead of the additional winter demand to acute medical services in winter 2019/2020) the Board will need to make a final decision for wider consideration by its November meeting.

APPENDIX 1:

Midland Met Delay:
Process to Assess Clinical Risks and Identify Reconfiguration Options

1. Introduction

Following the liquidation of Carillion in January 2018, it became apparent that there would be a significant delay to opening the Midland Metropolitan Hospital (Midland Met) and therefore a need to run acute clinical services on 2 sites (City and Sandwell Hospitals) for an extended period i.e. until 2022. This paper summarises the process the Trust has undertaken to identify and assess clinical risks associated with the delay and identify potential reconfiguration options required as mitigating action for the most significant risks.

2. Governance

The strategic risk associated with the need to run acute clinical front door services on 2 sites (City and Sandwell Hospitals) for an extended period i.e. until 2022, with the associated likely need to reconfigure (consolidate) some inpatient services to one site to support this is captured on the Board Assurance Framework (BAF 10) with the associated operational risk captured on the Trust risk register (risk 3020).

The Trust has established an executive led fortnightly clinical group, the Midland Met Quality & Sustainability Committee to develop and review the reconfiguration options along with monitoring KPIs relating to the most significant risks. This Committee is chaired by the CEO with members from the executive, senior Clinical Group leaders, Sandwell & West Birmingham CCG leads, and NHSI. The Trust Board has had routine oversight since its June development session.

3. Clinical Risks

Following the liquidation of Carillion, the Chief Operating Officer, Medical Director and Chief Nurse with support from the Clinical Group triumvirate teams identified key clinical risks associated with the need to run acute clinical services on 2 sites for the extended period until the Midland Metropolitan Hospital (Midland Met) opens i.e. 2022. These were then reviewed by senior clinicians and operational managers at a workshop in April. The table below summarises the 19 clinical risks identified with the most significant risk scores being highlighted in **bold**:

	Risk	**Risk Score**
1	Gastroenterology consultant recruitment	12
2	**Elderly Care – growth in demand & consultant recruitment**	**20**
3	**Acute Medicine Consultant Recruitment**	**20**
4	**ED Consultant & Middle Grade Recruitment**	**25**
5	7 day clinical services	15
6	CQC Going for Good	12
7	**Community Bed Base Expansion**	**20**
8	**Paediatric & Neonatal Registrar Cover**	**25**
9	**Maternity Capacity**	**16**
10	Critical Care: Risk to recruitment and retention of senior trained staff	12
11	System reconfiguration of urgent care causing confusion to the public:	16

12	Project team – retention of organisational and programme knowledge	15
13	Senior leaders and executive team – recruitment & retention	16
14	ED standard delivery	15
15	Planned care – reputation	9
16	Aston University – training capacity	9
17	Research - under performance in clinical trials:	8
18	Emergency planning	12
19	Trust credibility & reputation – impact on recruitment, retention & performance	16

Further work with senior clinical leads was then undertaken to:

- Confirm clinical service risks & assessment scores
- Identify 'tipping points' when high clinical service risks are likely to crystallise
- Confirm mitigating actions for high clinical service risks to prevent reaching tipping points
- Confirm mitigating actions if a tipping point is reached.

The most significant risks in terms of sustaining acute services on 2 sites for the extended period until 2022 primarily relate to maintaining a safe medical workforce at the 'emergency front door' (i.e. Emergency Department & Acute Medical Unit). **In particular within acute medicine there are 5.4 wte vacancies out of a funded establishment of 12 wte posts. The identified 'tipping point' for this service is 6 vacancies.** The likely need to reconfigure some acute services in order to mitigate these risks was identified and a number of options explored.

4. Options

The table below summarises the potential reconfiguration options that have been considered.

Option	Comment/Assessment	Outcome
Do Nothing (maintain current acute service configuration)	Deploy alternative mitigating actions (e.g. expanded AMAA, other medical specialities to release senior medical time to support front door acute medicine).	Consider further
City Hospital: 24/7 ED & medical wards; Sandwell Hospital: 12hr ED & surgical wards	Significant new risks related to: * increase in out of hours cross site ambulance transfers (for surgical emergency patients presenting to City Hospital). * Loss of Trauma Unit (TU) status for Trust (City site would not meet TU std) with increased pressure from diverted activity to TU in neighbouring hospitals. *public confusion as to opening hours of the ED at Sandwell & associated risk of emergency patients self-presenting to Sandwell when the ED is closed. *need for surgical 24/7 on site middle cover on both sites (to cover ED at City & surgical wards at Sandwell).	Exclude from further consideration

City Hospital: 24/7 ED, medical & emergency surgery wards; Sandwell Hospital: Urgent Care Centre & elective surgical wards	Significant new risks related to: * need to significantly increase size of ED at City whilst department still operational. *insufficient bed capacity at City to accommodate all medical & emergency surgery beds. *increased risk of all children's ED attendances being at City Hospital whilst main inpatient unit and medical cover at Sandwell (currently blue light ambulances conveying children primarily attend Sandwell ED). *need for surgical 24/7 on site middle cover on both sites (to cover ED at City & major elective surgical inpatients at Sandwell).	Exclude from further consideration
City Hospital: 24/7 ED, medical & emergency surgery wards; Sandwell Hospital: Urgent Care Centre, AMU, & elective surgical wards	Significant new risks related to: * need to significantly increase size of ED at City whilst department still operational. *increased risk of all children's ED attendances being at City Hospital whilst main inpatient unit and medical cover at Sandwell (currently blue light ambulances conveying children primarily attend Sandwell ED). *need for surgical 24/7 on site middle cover on both sites (to cover ED at City & major elective surgical inpatients at Sandwell). *need for acute medical 24/7 on site senior medical cover for both sites (to cover AMU & medical wards at City & AMU at Sandwell). *increased patient transfers from Sandwell AMU to medical wards at City.	Exclude from further consideration
City Hospital: 24/7 ED, AMU, medical wards and all respiratory medicine beds; Sandwell Hospital: 24/7 ED, AMU, medical wards (but no respiratory medicine beds)	*Retains 24/7 ED & AMU on both sites. *Consolidating respiratory medicine beds on City site alongside Cardiology beds would create efficiencies in senior clinical cover & patient pathways enabling release of senior medical time from respiratory medicine & possibly Cardiology to support Acute Medicine (AMU & AMAA) cover at City possibly to the extent that acute medicine consultants could primarily be focused at Sandwell.	Consider further

City Hospital: 24/7 ED, AMU, medical wards (but no elderly care beds) and all respiratory medicine beds; Sandwell Hospital: 24/7 ED, AMU, medical wards (but no respiratory medicine beds) and all elderly care beds	*Retains 24/7 ED & AMU on both sites. *Consolidating respiratory medicine beds on City site alongside Cardiology beds would create efficiencies in senior clinical cover & patient pathways enabling release of senior medical time from respiratory medicine & possibly Cardiology to support Acute Medicine (AMU & AMAA) at City. *Consolidating elderly care medicine at Sandwell (where the demand is greatest) would create efficiencies in senior clinical cover & patient pathways enabling release of senior medical time from elderly care medicine to support Acute Medicine (AMU & AMAA) at Sandwell. *Facilitates acute medicine consultants to provide input and in particular leadership to the AMUs at both sites.	Consider further

Based on the above the Midland Met Quality & Sustainability Committee concluded that the aspiration should be to maintain a 24/7 Emergency Department and AMU on each of the City and Sandwell Hospital sites up until Midland Met opens. The most significant risk identified in terms of sustaining this aspiration relates to maintaining a senior acute medicine workforce that enables medical patients admitted as an emergency to have a senior medical/consultant review within 14 hours of admission to the Acute Medical Unit (AMU), 7 days a week. Mitigating this risk is likely to require consolidation (reconfiguration) of medical specialties onto a single site in order to release senior medical capacity to support front door acute medicine and hence the 3 options identified for further consideration.

This further consideration includes developing each option against the categories of:

- Impact on acute medicine rotas
- Impact on activity & patient pathways
- Impact on capacity (physical & workforce)
- Impact on support services; both clinical (e.g. Imaging) & non-clinical (e.g. transport)
- Impact on other specialities & training opportunities
- Impact on external stakeholders and in particular the ambulance service, primary care, social services, other hospitals
- Additional operational risks
- Impact on costs (income, capital & revenue)
- Equality & Quality Impact Assessments.

Once the options have been developed in more detail an option appraisal will be required using the evaluation criteria identified by the Midland Met Quality & Sustainability Committee and currently being tested with patient and public representatives. These evaluation criteria are:

	CRITERION:	AGREED WEIGHTING %
1	Quality & Safety	30
2	Clinical Workforce & Sustainability	25
3	Capacity & Deliverability	20
4	Affordability	15
5	Integration & Strategic Fit	10
		100

5. Next Steps & Timeline

The next key milestone to take this work forward is to agree the options for public engagement in the week commencing 29th October 2018 in order to commence public engagement in early November. The table below summarises the steps required and target dates to deliver this milestone.

Step	Target Date
Map workforce required to ensure emergency admission review of all patients within 14 hours 7/7	16.10.18
Review how AMAA development might reduce the AMU bed base & impact on medical staffing load	16.10.18
Determine how we could deploy recruitable specialties into our AMU staffing	16.10.18
Develop physical capacity requirements & costs for reconfiguration options	16.10.18
Meet WMAS & identify patient flow implications for reconfiguration options	16.10.18
Test evaluation criteria with public representatives	w/c 8.10.18
Agree engagement plan	16.10.18
Collate option descriptions, costs etc	19.10.18
Option Appraisal	w/c 22.10.18
Agree options for CCG consideration and engagement	1.11.18