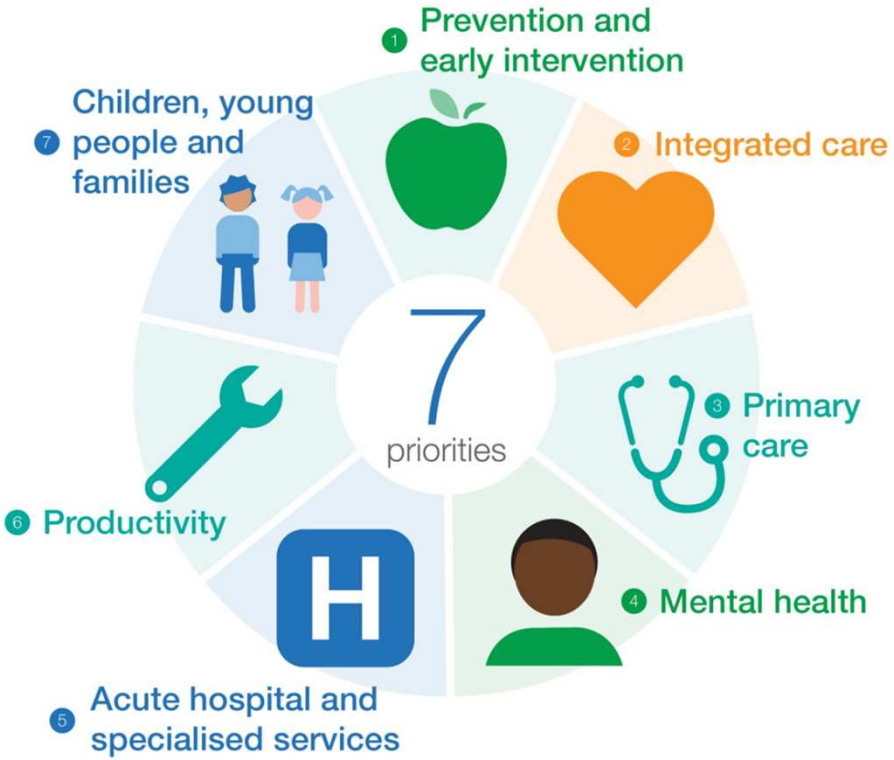
Shaping Future Care

Acute Services Review
13 July 2017



Summary background

- Case for change driven by:
  - Growth in demand
  - Significant workforce issues
  - Difficulty meeting national service quality standards

- Over 25 clinical workshops to discuss how to resolve
- 100+ clinicians, managers, patient reps involved
- Unprecedented level of partnership working
- Reviewed three priority services and a range of other ‘vulnerable’ services
- Presenting today the clinical recommendations – which is the first stage of the Acute Services Review

What was reviewed?

- The three main service areas under review are as follows:

  - Urgent and emergency care: led by Adrian Harris, Medical Director, RD&E

  - Stroke: led by George Thomson, Medical Director, Northern Devon Healthcare

  - Maternity, paediatrics and neonatal: led by Rob Dyer, Medical Director, Torbay and South Devon

1. Urgent and emergency care

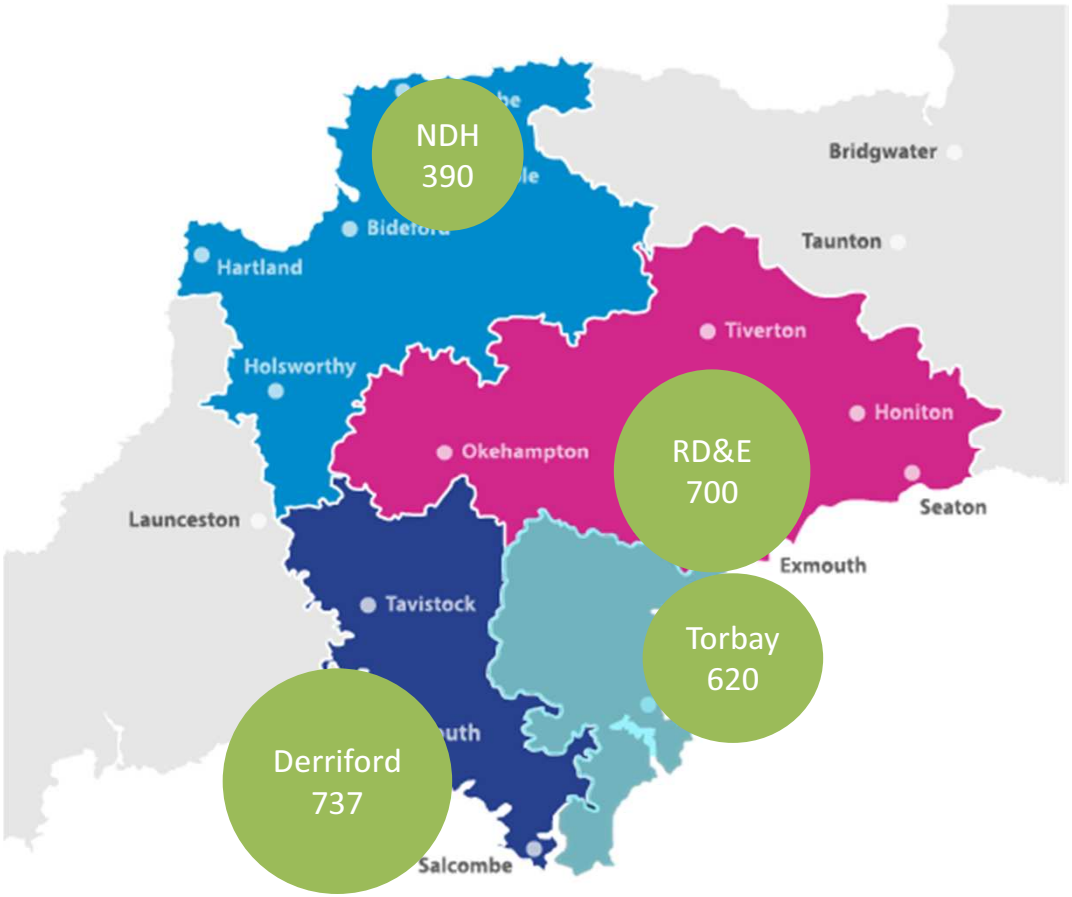
- Proposal to keep 24/7 ED services at all 4 Devon hospitals
- This ensures that key emergency services for the population of Devon continue to operate at our four main hospital locations
- How these urgent and emergency services operate in a sustainable way needs to be enhanced
- In particular how the four sites are better networked with workforce solutions required to ensure that we have enough nurses, other clinical staff and doctors at junior, middle grade and consultant levels to provide safe, reliable care 24 hours a day, 7 days a week

2. Stroke

- We will continue to provide first-line emergency response for people experiencing symptoms of a stroke at all four hospitals. This will include rapid stroke assessment, diagnostics and thrombolysis
- These services will be supported by ‘Acute Stroke Units’ (ASUs) at all four sites, and will ensure rapid intervention and aftercare for those with a stroke
- We will work towards clinical best practice to improve outcomes for stroke patients by developing two specialist ‘Hyperacute Stroke Units’ (HASUs) in Exeter and Plymouth

Levels of hyperacute activity across Devon

Demands and costs of the service



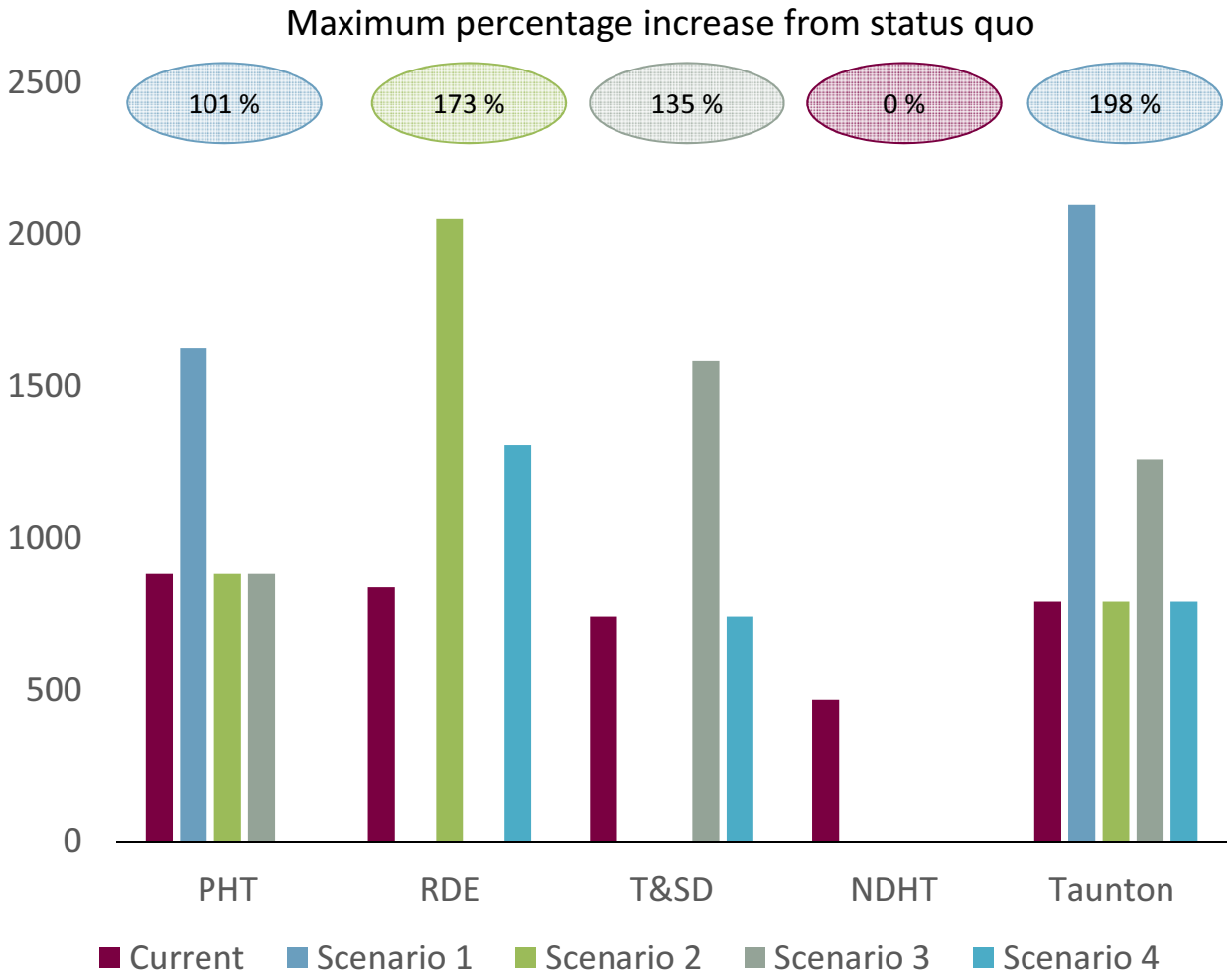
- Across Devon there were 2,450 stroke admissions
- Plymouth Hospitals, the Royal Devon and Exeter and South Devon and Torbay Hospitals see around 2 people per day
- Northern Devon has a lower volume of activity (around 1 per day)

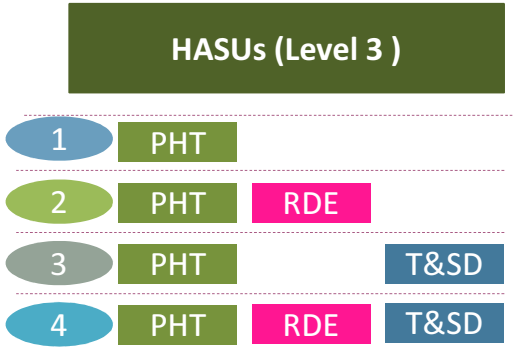
Source: Trust data returns, April 15/March 16, Carnall Farrar Analysis

Stroke: Admissions to HASU, including stroke mimics

Number of stroke admissions to HASU at each trust

Number of admissions (2015/2016)





- Scenario 1: Patients from T&SD go to PHT, patients from RDE and NDHT go to Taunton
- Scenario 2: Patients from T&SD and NDHT go to RDE
- Scenario 3: Patients from RDE go to T&SD, patient from NDHT go to Taunton
- Scenario 4: Patients from NDHT go to RDE

SOURCE: AHSN analysis of DFT data (June 2016), AA routeplanner, November 2015, Carnall Farrar Analysis (2017), Trusts data returns 2015-16

Stroke pathway: Required staffing for 7 day service

	HASU	ASU	Rehabilitation Unit	ESD
	WTE per 5 bed	WTE per 5 bed	WTE per 5 bed	WTE per 100 referrals
Physiotherapist	1.1 WTE	1.18 WTE	1.18 WTE	1 WTE
Occupational therapist	1.0 WTE	1.18 WTE	1.18 WTE	1 WTE
Speech & Language therapist	0.6 WTE	0.6 WTE	0.6 WTE	0.4 WTE
Dietitian	0.15 WTE	0.1 WTE	0.1 WTE	
Rehab support worker	The split between trained therapist and rehab support workers will depend on the size of unit and the number of assessments needed, the numbers above include trained and untrained			1 WTE
Medcial	2*daily stroke consultant ward rounds	Daily consultant ward rounds	Assess to medical decisions	Assess to GPs and stroke consultant
Nursing	2.9 WTE/Bed	1.35 WTE/Bed	1.35 WTE/Bed (40:60, reg/unreg)	0 – 1.2 WTE
Psychology	It is recommended that psychology staff are based in community stroke services with the ability to in reach to inpatient parts of the stroke pathway as and when required. The BPS has recommended staffing levels of 2 registered psychologists and 1 non registered assistant for populations of 500,000			

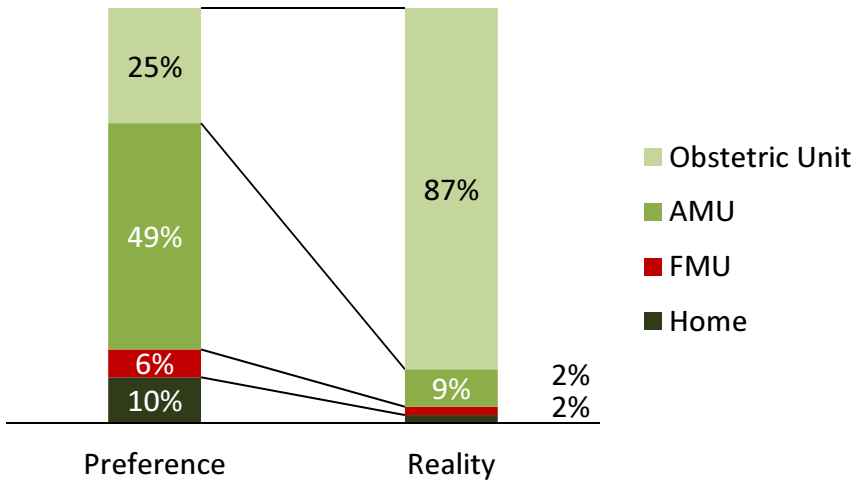
Source: Stroke workshops, Dec 2016/ Jan 2017 RCP stroke 2016 guidelines, Fisher R, Gaynor K, Kerr M & and Walker M. (2010). Stroke Early Supported Discharge Consensus Activity, National Stroke Nursing Forum. (2010), Rhoda Allison, Carnall Farrar Analysis

3. Maternity, paediatrics and neonatal

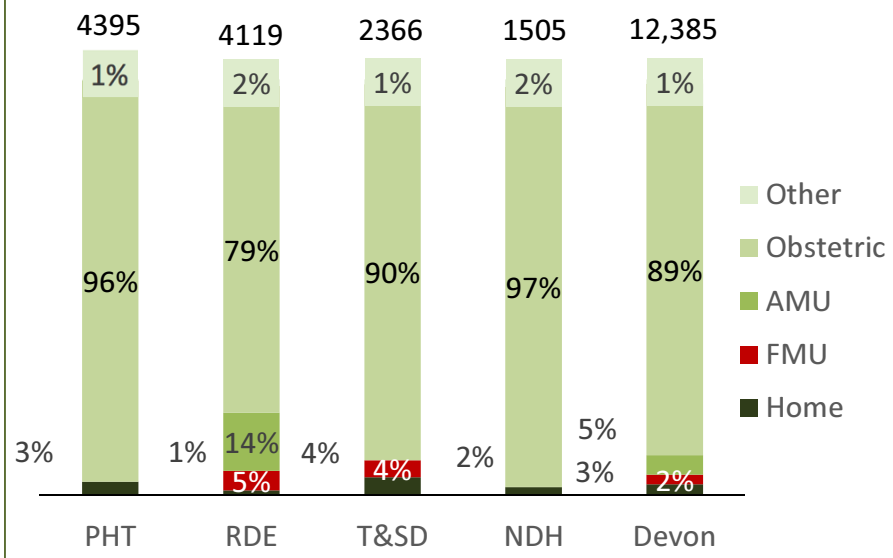
- Retain four sites for maternity, neonatal and paediatric inpatient care
- Doing so in a way that is safe and resilient in and out of hours is a challenge, given our current and predicted workforce constraints
- Maternity:
  - Retain consultant-led maternity services at all four main hospital sites
  - Clinicians have recommended that we adopt the strong evidence base for midwifery-led units co-located with consultant-led units
  - Of the 12,285 births in Devon last year, 89% took place in the main specialist hospital maternity units, with a further 5% at the Alongside Midwifery-led Unit at the Royal Devon & Exeter. Only 2% of births in Devon took place in the four standalone midwife-led units, with 4% of births supported at home or in other settings

Clinicians indicated a preference for alongside midwifery-led units (AMUs)

Nationally indicated birth place preferences and reality



Place of birth, Devon



- Standalone midwifery-led units are deemed a safe option to provide service and choice for multiparous, low-risk mothers. Alongside units are preferred through evidence of improved safety and uptake by women.
- Throughout the workshops it became clear that patient choice about place of birth is of great importance it was however also agreed, that choice should always be second to patient safety
- If a four site option is adopted, all four providers should offer giving birth at an alongside midwifery led unit (AMU)
- The option for a standalone MLU in North Devon without NDDH obstetric support has been ruled out due to travel times to the nearest providers and due to the expected negative impact on workforce
- The extensive travel times from North Devon to an alternative provider would also mean that home births would no longer be possible if the obstetric service was to be stopped. Therefore, no one would be able to give birth in North Devon, which makes the option unviable.

SOURCE: King's Fund (2014), *Reconfiguring maternity services;* Better Births (2016), South West Maternity Dashboard (2016)

3. Maternity, paediatrics and neonatal

- Retaining neonatal services at all four main hospital sites is also recommended, further developing the networking arrangement between neonatal services across Devon – move to ANNP staffing model
- Propose to expand ambulatory paediatric assessment units, which provide a responsive alternative to hospital admission, and will provide the necessary number of inpatient beds on all four hospital sites
- Review paediatric surgery across devon
- Address the requirement for CAMHs admissions to acute beds

Vulnerable services

- Histopathology: accessed through local hospital, reported through 2 or 3 new specialist digital labs
- ENT: Services will be delivered in all 4 acute hospitals in Devon with comprehensive services being retained in Torbay, Exeter and Plymouth hospitals and a satellite service in North Devon building on the successful partnership between the Royal Devon & Exeter and North Devon District
- Neurology: Devon-wide referrals and networked delivery
- Other reviews still underway (breast surgery, dermatology interventional cardiology, interventional radiology, vascular)

Next steps

- Modelling clinical and financial sustainability
- Detail for workforce and networking solutions
- Recommendations to CCG Governing Bodies and Trust Boards
- Informing wider staff, stakeholders and public
- Consultation - where significant change proposed