TRUST BOARD IN PUBLIC	Date: 29th November 2012 Agenda Item: 2.1
REPORT TITLE:	Opportunity to Deliver Better Medical Care at SaSH - Presentation
EXECUTIVE SPONSOR:	Des Holden Chief Medical Officer
REPORT AUTHOR:	Dr Virach Phongsathorn Clinical Chief – Medicine
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	

Purpose of the Report and Action Required:		(√)
Introduction to the Presentation of opportunities to deliver better medical care at SaSH.	**Approval**	
	Discussion	√
	Information/Assurance	

Summary: (Key Issues)
The Medical division are proposing changes to ways of working which will in turn improve the delivery of medical care within the organisation.
Relationship to Trust Corporate Objectives & Assurance Framework:
Objective 1: Deliver safe, high quality co-ordinated care.

Corporate Impact Assessment:	
Legal and regulatory implications	N/A
Financial implications	Will need further discussion
Patient Experience/Engagement	Will deliver improvements to patient experience
Risk & Performance Management	Will reduce risk and improve performance management
NHS Constitution/Equality & Diversity/Communication	N/A
Attachments:	

Opportunity to Deliver Better Medical Care at SASH

1. Introduction

The Medical Division provides inpatient care at SASH in 12 wards. Within these wards there are 37 beds in the Acute Medical Unit, 37 in the cardiology ward and Coronary Care Unit (9), 125 general medical beds and 118 designated elderly medicine and stroke beds. In addition, our consultants provide senior input to 3 rehabilitation wards at Crawley Hospital.

More than 95% of the medical admissions are emergency admissions (unscheduled care). The delivery of inpatient care for medical patients at SASH is of similar pattern to our peers.

The main quality standards are:

1. All newly admitted patients are seen and reviewed by a consultant within 13 hours of admission.
2. Continuous supervision of the acute admissions from Monday to Friday by acute physicians from 0800 to 1900 in collaboration with the consultant physician on call.
3. As a supplement to standard 1, all our newly admitted cardiological patients are seen by the on call cardiologist within 24 hours of admission on their early morning post-take ward rounds 7 days each week.

Currently on Saturday and Sunday our Division has 3 consultants working in addition to specialist registrars, senior house officers (ST2/ST1/FY2) and junior house officers (FY1). The acute physician on call attends to all 37 patients in the Acute Medical Unit from 0800 to 1500. These are newly admitted patients and potentially could be more unstable than patients in other wards. The consultant general physician on call undertakes the morning post-take ward rounds from 0800 to 1100 or 1200, depending on the number of admissions. He/she then remains available on call throughout Saturday and Sunday. He/she also attends the hospital from 1700 to 1900 or 2000 to see all patients admitted during that particular day. The on call cardiologist undertakes the morning post-take ward rounds for cardiology patients and then reviews patients in the Coronary Care Unit and Holmwood Ward. The cardiologist is available to be called throughout Saturday and Sunday as well.

Our quality and safety data along with the mortality rate are generally around mid table, however, the interpretation of such data requires caution as there may be some issues regarding data quality and completeness. The length of stay data for our Division is better than average but not within the top quartile.

2. Opportunities

There is a recognition that currently the level of supervision for the medical inpatients in our Trust and in other Trusts nationally is not as good during the weekend compared to the weekdays. In 2010, the President of the Royal College of Physicians wrote to all physicians recommending a strengthening of the medical input during the weekends. The letter clearly recognised the large number of medical beds in all the Trusts and by implication recognised that we currently cannot expect all the patients to be seen each week-end day as it would mean that there would need to be a major increase in the medical manpower in order to achieve this. The

President recommended that there is an increase in the consultants' presence during the weekends such that each ward is visited for a review of the situation and the unstable or deteriorating patients are seen by the consultants during the weekend. This is likely to be the first step in the journey of achieving a level of care during the weekend which is at the same level as during the weekdays as the final objective.

The Medical Division therefore proposes an alteration of the consultants' commitment during the weekend with an additional 3 hours of work within the Trust by the on call consultant physician both on Saturday and Sunday. The pattern would be such that there is an enhanced consultant involvement on Friday evening. On Saturday and on Sunday there would be a consultant's presence within the Trust from 0800 to 1900. The pattern would be that the consultant acute physicians would be working in the Acute Medical Unit from 0800 to 1500. The on call general physician would undertake the post-take ward round from 0800 to 1100 or 1200 and undertake the review of ward patients with the ward cover junior doctors from 1400 to 1700. The consultant would then undertake the intra-take ward round from 1700 to 1900. In addition, the consultant cardiologist will be present from 0800 to around 1200 for the morning post-take ward rounds and review of cardiology patients. We are engaging in the discussion related to the consultant cardiologists' job plans with the aim to have more consultant cardiologist presence and/or involvement on Saturday and Sunday as well. As mentioned above, this is likely to be the first step in the equalisation of the medical input during the weekdays and during the weekend.

In addition, the Medical Division is improving its service through the introduction of ambulatory care pathways which are now well embedded which allow for patients with a number of medical conditions to be managed as an outpatient instead of having to be admitted. The improvement of the handover process for the weekend has already been in place for some time. We have undertaken some work across primary and secondary care in order to try to avoid unnecessary admissions, in particular amongst frail, elderly patients who are in care homes. The appointment of additional respiratory physicians would allow us to strengthen the high dependency respiratory care for our inpatients in addition to repatriating a number of patients who are currently being managed in the tertiary care centres.

Dr Virach Phongsathorn
Clinical Chief – Medicine
November 2012