Collated 9a Feedback and position statements on overnight working June 2019.

Collected on behalf of the Hospital Medical Advisory Committee (HMAC) at Weston General Hospital

Paediatrics

Bristol and Weston paediatric medical and nursing staff, together with the CCG, have formed a Clinical Practice Group that tackles both Healthy Weston and merger issues. It has input from SWAST as well. Our department was very much part of the model 9a development and we can deliver it. We need more staff, and currently the discussions are around what exactly that means. Which skills and how many hours a week. We are discussing our combined data with SWAST in order to predict what this new model means for ambulance numbers. The CCG understand and accept that investment is needed to deliver the model.

Emergency Medicine

The main view of the emergency department in regards to opening overnight:

1. At present we couldn't staff the ED overnight with x1 middle grade. Our staffing numbers are not at this time robust enough. It would put at risk gains we have made in improving patient care over the past week. It may also affect future recruitment.

2. If the ED back door is open to ambulances overnight the nursing numbers need to be improved. Currently we only have x 2 guaranteed nurses on over night (x1 band 5 and x1 band 6). Between 3-12 patients a night are bedded in ed. These patients require x2 nurses for every 8 patients. This will need increased if the numbers increase through the back door.

We couldn't support overnight opening for a few years (at least) until we stabilise the service we have.
We are not against a 24/7 service, but we need to be able to prove we can safely provide a 14/7 service first. Staffing numbers and quality are our biggest issues. We are

starting a secondment program hopefully imminently, which will both increase the quality of our middle tier but also will be attractive to potential recruits.

General Medicine

Following the recent evaluation of the 24/7 ED model proposed by the consultant body the Dept of Medicine met to discuss the implications for the acute medical service.

The preferred remaining CCG model of overnight care includes medical registrar/s overnight to deal with all acute medical admissions, including those 'undifferentiated' patients brought by ambulance.

The consultant physicians believe that this is not an appropriate or safe level of staffing as such patients may have diagnoses beyond the training and experience of medical registrars. We feel it is essential that any patients admitted overnight should have the benefit of a proper assessment, diagnosis and treatment by doctors skilled in the appropriate areas.

We therefore propose that in the absence of an overnight ED-trained registrar and appropriate specialist support, the undifferentiated ambulances should not be accepted after 8pm to ensure that all patients are properly assessed and diagnosed while specialist teams are still available.

General Surgery position on overnight staffing

At a meeting of general surgical consultants* on 6 June 2019 the issue of overnight staffing was discussed. It was unanimously agreed that we would wish to implement the introduction of an overnight on-call surgical registrar/middle-grade doctor on a 1:8 rota in the same way as our orthopaedic colleagues have been doing successfully for sometime.

This is now possible as we have recently expanded the middle-grade number of doctors in general surgery from 4 to 8 and so this change can be introduced at little or no cost to the Trust.

Immediate advantages:

(1) Increased availability of more senior support FY2/CT colleagues in the care of:
- (i) Existing post-operative surgical patients
- (ii) Surgical emergency admissions admitted before 10pm
- (iii) Offer general support to urological inpatients

(2) Increased availability of advice for medical/orthopaedic/ITU colleagues

(3) Ability to assist surgical consultants whenever operating beyond 10pm

(4) Adding to the general body of doctors available in the hospital overnight increasing overall safety and resilience

Potential future advantages:
The facilitate and support
(1) The re-introduction of overnight surgical admissions from GP
(2) The re-introduction of overnight surgical admissions from paramedic ambulances

(3) The support of medical colleagues with medical emergencies admitted overnight from all sources.

Trauma and Orthopaedics Department Position Statement on 9A model

The implementation of the 9A model, as interpreted, requires minimal alteration in the way the orthopaedic services are currently delivered, with a possibility of an increase in the volume of elective orthopaedic activity. There are however critical interdependencies with other specialities that could affect our ability to deliver a safe, effective and accessible service, if the 9A model were to be implemented as initially proposed.

One of our areas of concern with the model out to consultation was the proposed downgrading of Critical Care services, and the effect this would have on our ability to manage our elderly patients with Neck of Femur fractures, as well as more elderly patients presenting for elective total joint arthroplasty. We are however cautiously reassured by the alternative model we understand has been proposed by Critical care clinicians from around the region that seeks to maintain and improve access to high level critical care locally at Weston General Hospital. This would allow us to continue to provide care locally for elderly patients presenting either with Neck of Femur fractures or for elective joint arthroplasty, with multiple comorbidities, safely and to a high standard.

We as a department therefore feel, on the whole, that the 9A model, with the current proposed modifications, is a reasonable basis to commence planning of services for the future. However, it's success will depend on further detailing, which we appreciate is a work in progress, and we seek to be continually involved in this process.

Specific points of comment are:

1. The availability of adequate medical and ITU support to level 3 at all times. This is especially pertinent to the Neck of Femur Fracture service. As these patients are often elderly with multiple comorbidities, we would require access to these to ensure that all ASA grades can be treated locally, as a significant proportion of these patients will be ASA 3-4.
2. We would maintain the pathway for overnight admissions for Neck of Femur fracture patients, as is the current practice.

3. We would require continued support from an orthogeriatric service, which could be configured within the framework of the frailty service proposed within the 9A model
4. We would also continue to care for ambulatory trauma patients (e.g. wrist and ankle fractures)
5. We would require investment into the development of the elective service, especially the arthroplasty and daycase services, with ring fencing of elective beds to avoid day of surgery cancellations due to increased acute workload.

Microbiology and Pathology

As a diagnostic support service, Microbiology (as well as the whole of Pathology) is set up to adapt to deliver a service to whatever configuration Weston will end up with.

Critical Care

The anaesthesia team had a broad range of views regarding the CCG proposals.
Whilst some members supported a full 24/7 service in all areas (and even expansion of services going forwards), others were more favourable of more limited working such as keeping ED as per the "temporary change" and ceasing overnight NELA cases. There is universal acceptance of the need for enhanced paediatric cover during ED opening hours.
There was unanimously *no* support for a total removal of level 3 facilities due to issues of then providing appropriate support to the ED, wards and surgery when necessary for deteriorating/cardiac arrest patients.
The lack of level three status was also criticised for the effects it would have on recruitment of both medical and nursing staff.