The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

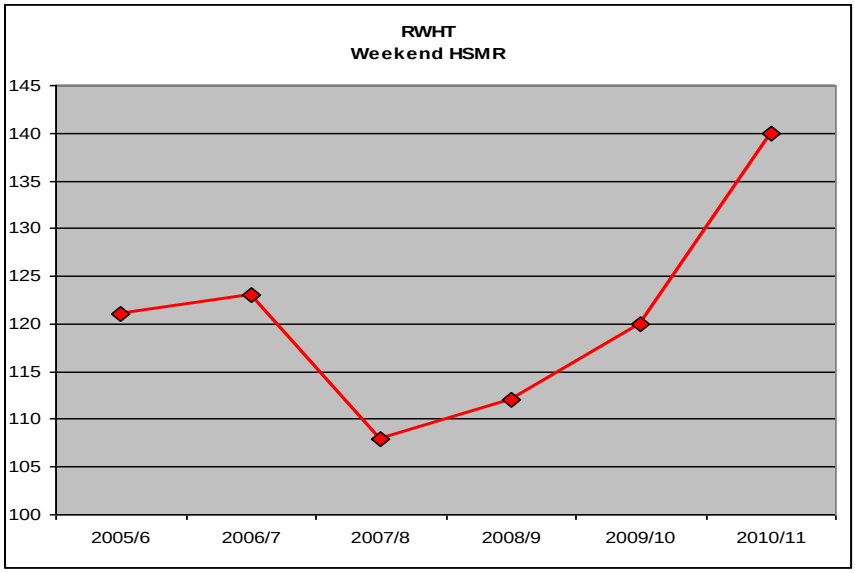
Meeting Date:	23rd April 2012
Title:	7 Day Working Across Medicine
Executive Summary:	The Royal Wolverhampton Hospitals NHS Trust (RWHT) is looking to introduce "routine" 7 day consultant working across all in-patient areas in an effort to ensure that the quality of clinical management and safety of all in-patients is optimised, and to minimise preventable and avoidable morbidity and mortality to its' in-patient population. These proposals are entirely in line with national recommendations and guidance from the Royal Colleges, DoH and Specialty Associations. To implement 7 day working across the organisation requires expansion of the consultant workforce, specifically in the medical sub specialities and will require the appointment of 8.2 additional wte consultant physicians (see below)
Action Requested:	Approval
Report of:	Medical Director
Author: **Contact Details:**	Tel 01902 695958 Email jonathan.odum@nhs.net
Resource Implications:	£1m
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details	
1	**Introduction** In addition to the importance of the first 24 hours of medical care, attention is now focused on the effect of weekends versus weekdays on hospital mortality. Over the last decade there have been several papers looking at the "weekend effect" on all patients admitted as medical emergencies. Four very large studies (USA, UK & Spain) found significantly increased hospital mortality rates for medical patients admitted as an emergency over a weekend compared to a weekday. The difference in mortality rates was based on the assessment of between 641,860 to nearly 30,000,000 emergency admissions. A much more recently published paper (2012 JRSM) reviewing mortality rates of in-patients across England and Wales identified an 11-15% increase in mortality for patients admitted on a Saturday or a Sunday. **Royal College of Physicians** The Council of the Royal College of Physicians have released a position statement (2010): "While much of the work of the consultant physician will be on the acute medical unit, provision should be made for a daily consultant visit to all medical wards. In many hospitals this will require input from more than one physician". In addition, a report by the Royal College of Physicians (2007) recommend "modern acute hospitals will require daily clinical review of the entire bed base by a competent clinical decision maker to ensure efficient patient flows and to reduce length of stay". **The Royal Wolverhampton NHS Trust (RWHT)** The RWHT has had an elevated Hospital Standardised Mortality Rate (HSMR) since 2005, and for 2010-2011 it was 113. The HSMR has largely been driven by elevated standardised mortality rates (SMRs) in sub specialty disease groups in General Medicine, including: septicaemia; complex elderly with respiratory disease; elderly patients with cardiac disease; patients with acute kidney injury and patients with stroke (see below). The Trust has had to investigate significantly elevated SMRs in various specific diagnostic groups over the last 4 years and report on the outcome of these investigations to the CQC. These investigations have been comprehensive and thorough and have generally not identified significant issues or problems within the Trust which have been thought to contribute to the patient deaths. However, each investigation has identified its' own specific issues which have required addressing with specific action plans in their own right. There are many factors other than death which impact upon a hospitals' HSMR, but one particular issue which has been an ongoing cause for concern nationally is the fact that SMRs for patients admitted over the weekend is approximately 10-15% higher than

for those patients admitted during the week, in the United Kingdom.

Reasons for the higher SMR for patients admitted at the weekend are unclear and are probably multifactorial. However, one concern is that senior medical cover across clinical areas at the weekend is provided on an on-call basis and is therefore more "sparse" than compared with routine week day cover. The worry is that this may contribute to a difference in clinical care patients receive over the weekend compared with weekdays

The SMR for patients admitted at the weekend at RWHT is one of the highest in the country (see table below). This is despite a significant "improvement" in the HSMR over the course of the current year to date (April 2011- January 2012).



Source Dr Foster

HSMR based on all CCS groups

Weekend HSMR calculated on Saturday and Sunday admissions.

We (RWHT) have considered the possibility that this may in part be due to there being less senior medical availability at the weekend (particularly in the general medical sub-specialities) although the case note reviews of deceased patients have not specifically identified this as being a definite causative factor.

Nevertheless, it remains the case that across most of the medical wards at RWHT at the weekend medical cover is provided on an on-call basis only and this exposes the possibility of clinical care at the weekend being below the standard of that provided routinely during the weekdays. It is noteworthy to remember that it is the SMRs of the medical subspecialities which are elevated and contribute significantly to the HSMR (see below).

Year	Weekend HSMR	Weekday HSMR	% Difference
2005/6	121	108	12.0
2006/7	123	104	18.3
2007/8	108	97	11.3
2008/9	112	107	4.7
2009/10	120	115	4.3
2010/11	140	104	34.6
*2011/12**	*108*	*95*	*13.7*

Source Dr Foster: HSMR based on all CCS groups: Weekend HSMR calculated on Saturday and Sunday admissions.

2011/12 based on 10 months data (Apr11-Jan12), figure presented is rebased.

	Diagnosis group	Spells	Deaths	Expected	Excess Deaths	SMR
1	Pneumonia	1296	368	289.7	78	127
2	Acute cerebrovascular disease	834	230	196.8	33	116.9
3	Acute myocardial infarction	1652	126	126.1		99.9
4	Congestive heart failure, nonhypertensive	544	97	89.5	8	108.4
5	Cancer of bronchus, lung	195	88	65	23	135.3
6	Acute and unspecified renal failure	206	77	47.5	30	162.1
7	Fracture of neck of femur (hip)	591	74	60.9	13	121.6
8	Chronic obstructive pulmonary disease and bronchiectasis	919	73	58.1	15	125.7
9	Septicemia (except in labour)	187	71	64.1	7	110.8
10	Gastrointestinal haemorrhage	657	69	46.8	22	147.4
11	Acute bronchitis	1174	52	48.9	3	106.2
12	Senility and organic mental disorders	210	43	16.9	26	254.1
13	Other perinatal conditions	475	39	22	17	177
14	Aspiration pneumonitis, food/vomitus	68	32	30	2	106.6
15	Other lower respiratory disease	238	28	19.7	8	142.2
16	Secondary malignancies	100	28	23.7	4	118
17	Urinary tract infections	827	27	27.6		97.8
18	Noninfectious gastroenteritis	707	27	21.2	6	127.6
19	Respiratory failure, insufficiency, arrest (adult)	95	26	31.1		83.5
20	Pleurisy, pneumothorax, pulmonary collapse	233	25	18.9	6	132.3

Source Dr Foster: HSMR based on all CCS groups: Weekend HSMR calculated on Saturday and Sunday admissions. Admission Type: Non-elective: *2011/12 based on 10 months data (Apr11-Jan12).

Two subspecialties of general medicine routinely provide consultant cover for their specialty base wards at the weekend (gastroenterology and renal medicine) and both will confirm the benefits that this provides in terms of quality and safety to the patients resident on those wards. For gastroenterology, (which has only provided 7 day working across its' home ward since March 2010), there is clear evidence of improvement pre and post introduction of this practise using the surrogate markers of quality of clinical care: discharge rates and length of stay.

Proposal for 7 day working

Following discussion within and between the sub specialities of general medicine there is now a clear cut desire of the consultant physicians to provide routine 7 day working across all the wards and clinical areas to achieve the following specific aims:

1. To deliver thorough and comprehensive ward rounds across all the medical wards at New Cross Hospital on both Saturdays and Sundays in addition to those carried out during the weekdays.

2. To provide sub specialty in reach support to all other areas of the hospital, to manage and advise on patients appropriate to their specialty both on Saturdays and Sundays (and Bank Holidays) in addition to during the week. There is clear national evidence that sub specialty in reach is beneficial to patient outcome and quality service provision.

Benefits to the Care of Patients and the Health Community

The potential benefits of introducing 7 day working across the medical sub specialities are enormous.

1. The quality and consistency of clinical care will/should improve.
2. Patients will be actively managed by consultants 7 days each week
3. Discharge rates of patients will improve
4. Support to nursing and other staff will improve
5. Communication with patients and relatives will improve.
6. Patients will be managed much more by consultants from their own specialty
7. More likely to be looked after on the appropriate specialty ward
8. Sub specialty advice will be available 7 days/week
9. Potential improvements in morbidity and mortality

Requirements

To enable routine working across all the medical wards by all sub specialty directorates in Medicine additional consultant appointments are needed. Detailed reviews of individual consultant job plans and sub-specialty directorate job plans have been carried out and have identified the short fall in consultant manpower that is required to implement routine weekend working. The requirements are different for each sub specialty.

Based on the working practice of clinicians on D18, D15 and Clinical Haematology Unit (CHU) approximately 4.5 - 6 hours of work will be required over the two days (1.5 – 2 PAs). There are 8 national holidays per annum (9 for 2012) and it would be appropriate to include this in the calculations of PAs required per annum i.e. 112 days (52 weekends plus 8 Bank holidays). The total number of PAs required will be 84-112 per annum per 28 bedded medical ward (depending on case mix).

The in reach sub-specialty service to other areas will involve more work and will require an additional 1PA each weekend (per directorate) depending on case mix.

In order to achieve the above, funding is required to appoint 8.2 wte consultants as follows:

1. Diabetes consultant – 1 wte
2. Renal consultant -1 wte (appointed March 2012)
3. Respiratory consultants – 2 wte
4. Care of Elderly consultants- 3 wte
5. Acute Physician consultant-1 wte
6. Oncology consultant-0.2wte

Conclusion

Risk of death for all emergency admissions is 10 – 15% higher in those patients admitted at the weekend compared with the weekday.

To ensure ward rounds are undertaken as a matter of routine on all medical wards every weekend and all National Holidays.

Funding is required to appoint 8.2 wte consultants as outlined above.

THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST | **Version:** 1 | **Ref No:** 485

Business Case / Service Change Costing : | **7 Day working**

CAPITAL COST:-				Capital £ Year 1	Life Years	Capital £ Year 2	Life Years	Total Capital £		
								0		
								0		
TOTAL CAPITAL				***0***		***0***		***0***		
ACTIVITY & OTHER INCOME:-			Activity			Tariff		Income		
			Year 1	Year 2 FYE		Year 1	Year 2 FYE	Year 1	Year 2 Recurring	
Description						£	£	£	£	
Reablement Funding - Community Respiratory Consultant								108,142		
Reablement Funding - Community Geriatrician								73,523		
TOTAL INCOME								**181,665**	**0**	
REVENUE COST:-										
Note: All entered as minus values (-£)								Spend		
Pay Costs								12/13	13/14	
Description	Department	Date wef		Pay Band	PAs/ Other	Cost per WTE £	WTE	Year 1 £	Year 2 Recurring £	
Pay - Direct Clinical										
Consultant	Diabetes	Jun 12			10.0	108,142	1.00	(90,118)	(108,142)	
Consultant	Respiratory	Sept 12			10.0	108,142	1.00	(63,083)	(108,142)	Business Case ref 403
Consultant	Community Respiratory	Apr 12	Reablement Fund		10.0	108,142	1.00	(108,142)	(108,142)	Business Case ref 403
Consultant	Acute Physician	Sept 12			10.0	110,285	1.00	(64,333)	(110,285)	
Consultant	Care of the Elderly - Post 1	Sept 12			10.0	110,285	1.00	(64,333)	(110,285)	
Consultant	Care of the Elderly - Post 2	Sept 12			10.0	110,285	1.00	(64,333)	(110,285)	
Consultant	Community Geriatrician	Aug 12	Reablement Fund		10.0	110,285	1.00	(73,523)	(110,285)	
Consultant	Renal	Dec 12			10.0	113,498	1.00	(37,833)	(113,498)	
Consultant	Oncology	Apr 12			2.0	108,142	0.20	(21,628)	(21,628)	
Acute Medical rota		Apr 12				110,285	0.55	(60,657)	(60,657)	
							8.75	(647,983)	(961,349)	
Pay - Clinical Support										
Med Sec Band 4	Care of the Elderly	Sept 12		4		24,163	1.50	(21,143)	(36,245)	
Med Sec Band 3	Care of the Elderly	Sept 12		3		20,797	0.50	(6,066)	(10,399)	
							2.00	(27,208)	(46,643)	
Total Pay Costs							10.75	(675,191)	(1,007,992)	
Non Pay Costs										
Non Pay - Direct Clinical										
							0.00	0	0	
Non Pay - Clinical Support										
							0.00	0	0	
Total Non Pay Costs							0.00	0	0	
TOTAL CLINICAL AND CLINICAL SUPPORT COSTS							**10.75**	**(675,191)**	**(1,007,992)**	
TOTAL CONTRIBUTION TO TRUST OVERHEADS								**(493,526)**	**(1,007,992)**	
AS PERCENTAGE (Should be 20% or above)								-272%	#DIV/0!	
OVERHEAD COSTS:-										
TOTAL OVERHEAD COSTS								**0**	**0**	
TOTAL EBITDA								**(493,526)**	**(1,007,992)**	
MARGIN AS PERCENTAGE (Should be 10% or above)								-272%	#DIV/0!	
CAPITAL CHARGES:-										
Note: All entered as minus values (-£)										
Impairment										
Depreciation										
Rate of Return										
TOTAL COST OF CAPITAL								**0**	**0**	
NET SURPLUS								**(493,526)**	**(1,007,992)**	
MARGIN AS PERCENTAGE (Should be 3% or above)								-272%	#DIV/0!	

Divisional Accountant | **Divisional Manager / Director**

Name: | Name:

Date: | Date: