The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	27th June 2011
Title:	Interim Single Emergency Portal- Update
Executive Summary:	This report presents the background to the project initiated in 2010 to prepare the business case for developing the interim Single Emergency Portal (SEP) in C block, and the work undertaken by the project team which ultimately led to the project being terminated at the steering group meeting in May 2011 on the basis of the capital costs required to proceed. The report includes details of the clinical model proposed for the provision of services through the interim SEP, and in Appendix 1 presents the details of the facility options prepared by the Estates department
Action Requested:	To note the content of the report
Report of:	Medical Director
Author: **Contact Details:**	Dr Jonathan Odum Tel: 01902 695958 Email jonathan.odum@nhs.net
Resource Implications:	N/A
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

THE INTERIM SINGLE EMERGENCY PORTAL

PROJECT REPORT

June 2011

BACKGROUND

In October 2010, the RWHT implemented a project to develop the interim Single Emergency Portal following the conclusions of the discussions regarding the clinical model in 2009. At that time (2009) there was unanimous agreement across those Clinical Directorates providing emergency care that the SEP model of care would significantly improve the quality and efficiency of clinical management compared with the current processes in place.

In addition, it was decided that the Trust would pursue the concept of amalgamating the Accident and Emergency Directorate with the Acute Medicine Directorate to form an "Emergency Care Directorate" and to co locate these departments in order to implement the integrated working practices. The intention was that this would significantly improve the pathways for and outcomes of patient management .

There was strong support for the implementation of the SEP from both a location and organisational perspective. However, the original estimated capital outlay required for a "new build" SEP was in the order of £60m and consequently it was acknowledged that it would take some years for a project of this size and cost to come to fruition.

As there was strong support for the principles and outcomes of the SEP with integration of the various clinical teams, the Trust set up the project to develop an "interim SEP" with the intention of implementing this model of service pending the development of the business case for the proposed new build.

A project team was formed in October 2010 with the intention of writing the business case for the interim SEP with a view to completion of the capital development by the end of 2012.

In February 2011 a draft outline business case was submitted to the two Divisional Management Teams. The proposal included the creation of ED1 (emergency department 1) as the first portal of entry for ALL emergency admissions (irrespective of specialty-with some exceptions) and an ED2 (emergency department 2) as the ward for emergency patients who required admission for urgent care, who could not be fast tracked to a specialty ward, for a period of up to 48 hours. The capital costs were in excess of £17m and the proposed operational costs of staffing the unit were purported to be around an additional £1m per annum.

The proposed location for the development of the interim SEP was C block, where the A/E department is currently located.

On the basis of the above clinical service model the calculated bed requirements were approximately 105. In addition, refurbishment of the existing A/E department was required to accommodate the increased clinical throughput. An out-patient facility was also required.

In addition, the space available in C Block, which would house the conversion option (as opposed to the new build) was insufficient to accommodate the facilities required for the proposed clinical model. There would also be significant disruption for the departments already resident in C Block.

For the above reasons (cost and space) a review of the proposals regarding the interim SEP was undertaken and a decision made by the Project group to revise the proposals regarding the model of service delivery to try to ensure the most cost effective use of capital outlay to achieve the clinical benefits intended to be gained from the interim SEP. Therefore the model was revised as described below.

MARCH 2011 - THE NEW MODEL FOR THE SINGLE EMERGENCY PORTAL

The principle of integration of the clinical teams from Emergency Medicine and Acute Medicine into a single emergency department has unanimous support from the clinicians in both areas (and also from management). Similarly, co-locating the clinical areas from where both services are delivered as an essential component of integration is also strongly supported for governance and quality reasons.

Thus the new model which was proposed is as follows:

There would be an ED1 managed predominantly by the Emergency Physicians with input and support from the Acute Physicians, and an ED2 managed by the Acute Physicians with input and support from the Emergency Physicians and the specialist Physicians (see below).

ALL emergency medical patients would go to ED1 for initial triage and assessment and ED2 would provide care for those admitted patients who will either require up to 24 hours of observation or treatment before discharge, or will be transferred to a specialist ward for ongoing treatment. Some patients would still be fast tracked into departments such as Stroke, Heart and Lung, etc and that decision would be made in ED1 or in ED2 following assessment of those patients.

Specifically, in the new model the ED2 beds would only cater for 24 hours worth of care post admission and not the 48 hours as previously considered in the initial project proposal.

An in-reach service will be provided into ED2 by sub-specialty Physicians (Renal, Diabetes, Respiratory, gastroenterology etc) in order to complement the service and management provided by the Acute Physicians and to help facilitate discharge and expedite transfers to appropriate specialty wards when required. It is expected that this will provide a more effective pathway for patients and enable them to reach the specialty and clinical area most appropriate for their condition.

The specialty Directorates will manage the specialty beds and they will be expected to lead on the transfers to these beds from ED1 and ED2. There will be more efficient use of specialty beds ensuring that they are more available for patients who need specialty care. The intention is to have earlier diagnosis, reduced admissions and re-admissions and earlier discharge.

It was agreed that patients requiring acute surgical assessment would go directly to the surgical unit in D3.

Emergency paediatrics will be managed as at present

ED2 will have an out patient department which will accommodate current A&E clinic patients and those EAU patients who can be managed on an out patient basis rather than as an admission.

The capacity requirements of ED1 and the bed requirements for ED2 were calculated using historical activity data of patient attendances and admissions through A/E and EAU. In addition, activity modelling was undertaken using presentation by diagnostic category using HRG codes. Diagnostic specific patient pathways are being developed to “streamline” patient management to ensure the most efficient use of the outpatient and in-patient facilities.

The new proposals regarding ED1 and ED2 provide the essential benefits required of the emergency department, particularly for emergency and acute medicine patients.

Within ED1 the new DH quality indicators will have to be achieved and it is the intention to bring senior decision making to the beginning of the pathway and to provide consultant cover for longer periods of time especially at night. Diagnostics will be available 24/7and discharge planning and activation will be predominant throughout the hospital.

ESTATES REQUIREMENTS

In order to calculate the facilities required in the new interim emergency department the following statistics were examined: A&E attendances; EAU attendances; A&E clinic activity; EAU AMB (ambulatory) activity < 4 hours; EAU AMB activity > 4 < 8 hours; EAU AMB > 8 hours; emergency admissions < 24 hours and emergency admissions of > 24 hours.

The calculations showed that approximately 50 beds and 5 clinic rooms were required in ED2 and that some refurbishment of the existing A/E department was required to accommodate the increased activity (although to a lesser degree than with the original model) and to develop it into the ED1.

CAPITAL REQUIREMENTS

For further details please see appendix 1.

The costing of the work required within C block to provide the facilities of ED1 and ED2 was calculated to be approx £17m, and after detailed discussions with the estates design team the project group decided that it would not make a recommendation to proceed with the full business case to develop the interim SEP in C block on the basis that the project was too expensive. At the Steering Group meeting held in May 2011 this decision was ratified and the project formally terminated.

At this meeting it was also agreed that the Executive team would consider the future options for developing a SEP at a later stage.

Appendix 1

Estates Briefing Paper on Emergency Portal Project

June 2011

Background

The development of a new Emergency Centre forms part of the master plan for the site redevelopment at New Cross Hospital (as the last phase of Stage 1 – following on from provision of new catering and pathology). Costs of this building which included all emergency services and replacement theatres were estimated to be in the region of £60million (2008/09). During 2009/10 in development of the long term capital programme, the LTFM and the Trust's FT application it was obvious that although the Trust could release the capital funds in the longer term these could not be released within the timescales of the build programme. It was also increasing unlikely that Treasury funding would be available to support this type of development. Consequently it was agreed that the new Emergency Centre be put on hold for the short to medium term and that an interim Emergency Portal through refurbishment be investigated.

Initial work undertaken in advance of formal Project start up

In February 2010 Strategic Healthcare Planning (Architectural Lead on the then Technical Advisory Team to the Trust) were asked to do an initial feasibility assessment on collocating the emergency services within the A&E block (Block 14). This assessment consisted of a rudimentary space planning exercise with initial costs. At that time the new clinical service model had not been finalised and capacity for the physical environment had not been determined. However, this assessment looked at providing the accommodation currently situated in the existing EAU (circa 50 beds and clinic) in block 14 on floors above the A&E department and what this would mean in terms of displaced accommodation. This building was fully occupied with the exception of C3 which was only used for winter pressure capacity. The assessment assumed no work to the Accident and Emergency Department on the ground floor and gave two options for moving services out to free up the required space for the emergency services collocation – any re-provision of the displaced accommodation being on the basis of 'like for like' space. The assessment took no account of the condition of building services within the block and whether these were suitable to support the reconfigured space. This initial costing exercise identified a budget estimate of £7.9m which was put into the capital programme (awaiting further more detailed work) to ensure some funding was allocated to this project. Additional funding had already been earmarked for backlog maintenance identified as part of the condition survey carried out in 2007/08 at £1.08m.

Development of the Interim Emergency Portal

The Project was formally launched by the formation of the Project Steering Group, with associated sub groups in November 2010. The work was led by the Clinical Model work stream, who had yet to definitively agree the service model and capacity required for the interim portal. The physical solution for the project was expected to be capable of maintaining service provision to the required standards for a minimum of 10-15 years.
Since the original feasibility study the number of emergency beds had increased due to the emergency surgical bed development on D4.

A number of options were developed from a design perspective based on the various clinical models put forward by the clinical work stream. Due to the dynamic nature of the project work all of these designs and associated costs were at a very outline level and needed detailed design to determine robust costs. Appendix 1 outlines those options considered during the life of the project development.
During this process it became very apparent that the space originally identified for release in Block 14 was insufficient to provide accommodation for the required emergency services capacity – now (January 2011) at 105 beds with associated clinical support services.
Although a decision was ultimately made (late March/early April 2011) to review the service model and leave surgical emergency beds in situ on D4 thereby reducing capacity/allowing fit, other requirements such as the need to extend and reconfigure the accident and emergency department (to facilitate access of all emergency patients through one portal) absorbed any funds that had been released by reducing the bed capacity.
In addition the only existing space available for decant space was the vacated EAU, considered not to be suitable for use (from a clinical and operational perspective) on the basis that this would be needed in the future for additional bed capacity. This led to displaced accommodation having to be provided in a new build (either traditional or modular) adding further to the cost.
One of the initial responsibilities of the design team during this project work was to survey Block 14 to establish the condition of the building services to support the newly configured emergency space. This identified that extensive work was needed to ventilation plant and other services and because the configuration of the existing space did not lend itself to the new requirements (i.e. much of this being OPD space which needed converting to beds) all bed head services, lighting and ventilation ducting etc would need to be provided new or considerably reconfigured.

The final options determined by the Steering Group for development and for inclusion in the outline business case were as follows:

Option	Description	Cost
1	Minimal work to A&E including replacement of obsolete equipment	£1.7m
2	Refurbishment of Block 14 including extension to and major reconfiguration of A&E, refurbishment of 2 floors for emergency medical beds, clinic and support services and new build for displaced services (ENT/Maxillo Facial/Orthodontics OPD)	£17m
3	New build (A&E, medical emergency beds and satellite radiology only)	£30.3m

(All costs provided by Quantity Surveyor and based on latest building indices and phasing programme for option 2 as at 25/5/11)

The leaning within the members of the Project Steering Group was towards a preferred option of Option 2 but at this stage this had not been confirmed by formal option appraisal.
The costs provided were based on the level of design work done to date and whilst there was potential for these to be reduced with further detailed design, the costs associated with Option 2 were clearly not representing good value for money. This was also in the context of other constraints and issues associated with this option as follows:

- Retention of this building in the medium to long term did not fit with site strategy - identified as a building for demolition in Stage 2 of the site redevelopment;
- Poor accessibility to the rest of the hospital via steep ramps on all floors including ground floor;
- New build for ENT/Maxillo Facial/Orthodontics OPD services did not fit with site strategy and proposed location would compromise later site development;
- New build for ENT/ Maxillo Facial/Orthodontics OPD services and extension to A&E would require planning approval which could have led to protracted discussions with planners on the basis that this did not fit with the planning approval just granted for the site redevelopment;
- Considerable phasing and sub phasing of the project would be required particularly in A&E causing considerable disruption to patients and service delivery;
- Although capacity requirements could be accommodated this would not comply with Health Building Notes in terms of space requirements although other strategies such as EMSA could be achieved.

On this basis the Project Steering Group agreed to stop the project to allow more time to develop the clinical service model, clinical pathways and working practices which in turn would establish the required capacity and adjacencies to support the new service model.
Following on from this decision it was agreed that some capital works would still be required to the existing accommodation particularly in A&E to allow service continuity, comply with new quality standards and improve the patient environment, the latter issue being highlighted as requiring attention in PEAT audits and recent LINK visit.

Recommendation

It is recommended that a minimal reconfiguration and refurbishment of the area/s should take place to ensure service continuity and compliance for a minimum of a further 5 years allowing time to embed the new clinical service model. A budget estimate of circa £1.5m has been included in the capital programme in lieu of the interim emergency project and scope of works is being defined in readiness for submission of a business case to the Trust Board at the earliest opportunity.

At the same time it is recommended that the Trust consider the provision of a new build for the department which would allow collocation of services on the site of the old catering building and adjacent car park (scope and phasing to be determined).