The Shrewsbury and Telford Hospital NHS Trust

**Paper 10**

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| **Recommendation**<br>☐ **DECISION**<br>☑ **NOTE** | **The Trust Board**<br>is asked to **RECEIVE** and **NOTE** the update on progress with the development of the Emergency Department service continuity plan. |
| **Reporting to:** | **Trust Board** |
| **Date** | Thursday 28th September 2017 |
| **Paper Title** | Progress Report on the Development of the Emergency Department Service Continuity Plan |
| **Brief Description** | The medium and long term vision for the health service within the county is being developed through the NHS Future Fit programme. This programme envisages a new model of sustainable safe care including a network of urgent care centres supported by a single emergency centre.<br>This paper follows on from previous papers considered by the Trust Board which have highlighted the risks and challenges that are being faced in relation to maintaining a safe and effective urgent and emergency care service on both PRH and RSH sites, and the contingency plans to address this.<br>This paper provides the Trust Board with a progress update on the current position with regards to the development of the detailed service continuity plan. There is an expectation that an interim plan to meet the Board's timeframe for implementation of 3 months can be met, but further engagement with stakeholders is required to bring this to a conclusion. |
| **Sponsoring Director** | Chief Operating Officer |
| **Author(s)** | Associate Director of Service Transformation |
| **Recommended / escalated by** | |
| **Previously considered by** | Executive Directors |
| **Link to strategic objectives** | Patient and Family<br>Safest and Kindest<br>Innovative and Inspirational Leadership<br>Values into Practice |
| **Link to Board Assurance Framework** | • If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards (RR 561)<br>• If there is a lack of system support for winter planning then this would have major impacts on the Trust's ability to deliver safe, effective and efficient care to patients (RR 1134)<br>• If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients (RR 668) |

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| | • If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve (RR 423)<br>• Risk to sustainability of clinical services due to shortages of key clinical staff (RR 859) |
| **Equality Impact Assessment** | ● **Stage 1 only (no negative impacts identified)**<br>● **Stage 2 recommended (negative impacts identified)**<br>● negative impacts have been mitigated<br>● negative impacts balanced against overall positive impacts |
| **Freedom of Information Act (2000) status** | ● **This document is for full publication**<br>● **This document includes FOIA exempt information**<br>● **This whole document is exempt under the FOIA** |

The Shrewsbury and Telford Hospital NHS Trust

Paper 10

# Progress Report on the Development of the Emergency Department Service Continuity Plan

*Thursday 28th September 2017*

## 1. BACKGROUND

The Trust has been engaging with its stakeholders to develop the service continuity model in the event that it cannot sustain two Emergency Departments (ED) due to reaching the tipping point in either its Consultant or Middle Grade workforce.

Two stakeholder sessions were held on 16th June 2017 and 11th August 2017. The stakeholder group was joined by NHS Improvement and CQC representatives in August.

The preferred service continuity model is the reduction in operating hours of the Emergency Department at the Princess Royal Hospital from 20.00 hours to 08.00 hours, 7 days a week and to establish a 24 hour Urgent Care Centre (UCC) on that site.

Therefore, the principles underpinning the Sustainable Services Programme (SSP) model of ED and UCC services was used as a basis for planning activity.

Putting Patients First, the stakeholder group felt very strongly that any additional patient journeys should be avoided and current service delivery maintained at PRH wherever possible.

## 2. PROGRESS TO DATE

### *2.1 Stakeholder Workshop 16th June 2017*

At this workshop stakeholders were reminded of, and supported, the contingency plan to:

- Implement an Urgent Care service co-located with the existing ED department at PRH;
- Close the PRH A&E to ED classified patients during the night (20.00 – 08.00);
- Use the Sustainable Services Programme (SSP) principles of ED and UCC services as the basis for planning activity;
- Increase capacity at RSH to manage the additional 'ED' patients and those needing admission from PRH during the night;
- Address pathway challenges at PRH overnight e.g. Women and Children, Stroke, Head and Neck.

Following this workshop further activity analysis was undertaken with the specialty teams to enable them to model the impact on an overnight closure on the following services:

- Stroke;
- Head & Neck;
- Cardiology;
- Women & Children (mainly paediatrics);
- Acute Medicine.

### *2.2 Stakeholder Workshop 11th August 2017*

At this workshop each of the specialty teams presented the impact of an overnight closure on their respective service pathways, with options to maintain service delivery including risks and opportunities. This detail surrounding each of the five specialties is outlined in the following table.

| Specialty | Impact and Mitigation | Workforce | Associated Costs | Facilities required / other considerations |
|---|---|---|---|---|
| Stroke | Minimal impact for the Stroke service and current pathways. Patients continue to be treated at PRH in the same way as they are now. Patients presenting at RSH will be transferred to PRH as they are now. | No impact | No impact | Risk of deteriorating patients requesting resuscitation. Mitigated by robust adherence to protocols by West Midlands Ambulance Service (WMAS) taking high risk patients to other centres (loss of income) |

| Specialty | Impact and Mitigation | Workforce | Associated Costs | Facilities required / other considerations |
|---|---|---|---|---|
| Head and Neck | In the current service model there is no service at RSH. Adult and paediatric emergency and elective service including Cancer surgery all at PRH. Patients presenting to RSH are transferred to ED at PRH (small numbers *check*). Consultant on call cover is across both sites.<br><br><u>Mitigation</u><br>Middle grade speciality review will need to be available at RSH due to increased number of referrals. Patients to be transferred direct to H&N Ward (Ward 8). MG also required to assess if patients suitable for direct transfer to the ward. | X 2 ST 3-8 | £0.30m (at agency rates) | Is the additional MG workforce available?<br>Can it be recruited in 3 months<br>Increased hand offs for patients |

| Specialty | Impact and Mitigation | Workforce | Associated Costs | Facilities required / other considerations |
|---|---|---|---|---|
| Cardiology | • RSH will need to receive more acute cardiac patients and increase inpatient bed capacity<br>• Need to transfer patients from RSH to PRH the next day if they require cardiac procedures<br>• Potential impact on New Cross Hospital, Wolverhampton depending on clinical need. Some patients may be taken there rather than RSH.<br><br><u>Mitigation</u><br><br>• Assessment area in UCC allowing direct access into CCU/Cardiology where patients are seen by the Medical Team at PRH with support from on call Cardiology Consultant (also protects walk in patients);<br>• Robust clinical pathways e.g., arrhythmia (into SATH e.g. CCC / GP / WMAS);<br>• On call Consultant Cardiology Service and 7 | 0.7 wte ST 1-2 | £0.08m (at agency rates) | Loss of income<br>Increased hand-offs for patients<br>To increase number of inpatient beds at RSH, patients who may usually expect to be admitted to RSH may be admitted to PRH to create capacity at RSH for overnight admissions.<br>Impact on patient access. |

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| | day working (already in place but may need additional);<br>• Joint working with acute medical team at PRH;<br>• Protection of cardiac beds at PRH to facilitate direct admission and transfer from RSH as required. | | | |

| Specialty | Impact and Mitigation | Workforce | Associated Costs | Facilities required / other considerations |
|---|---|---|---|---|
| Women and Children's<br><br>A. Obstetrics<br><br>B. Gynaecology<br><br>C. Fertility<br><br>D. Neonates | Limited impact – redirection of pregnant women requiring ED services will create pathway complexity but this already exists and can be managed.<br><br>No change to pathway providing UCC able to accept and manage significantly unwell gynaecological conditions (with support from onsite gynaecological services)<br><br>Current pathway does not rely on ED services<br><br>Only affected if Tier 2 medical support at night (1x Middle Grade doctor) is diverted to PRH ED leaving neonates without a senior medical decision maker<br><br><u>Mitigation</u><br><br>Provide a paediatric emergency team (non trauma) to manage all children presenting out of hours at PRH UCC with triage being provided by UCC Specialists and enhanced support will prevent children being taken unnecessarily to RSH and then subsequently transferred as an inpatient to either the PRH in patient ward or Children's Assessment Unit (CAU). A SWOT analysis of this proposal is included at ***Appendix A*** | Associate Specialist 2.73 wte<br>APNP 2.73 wte<br>Band 6 RSCN 2.62 wte<br>Band 5 RSCN 2.62 wte | £0.88m (at agency rates) | Potential for an increase in no of women presenting at ED RSH and needing redirection and for intensity of on call at RSH to increase<br><br>Is this additional speciality workforce available?<br>Can it be recruited in 3 months? This model has been designed on the assumption that a collocated UCC at PRH is in place overnight and on the following;<br>• The UCC has skilled clinical/medical staff trained in APLS/NLS and Level 2 competency and experience in dealing independently with the urgent ill/minor injuries; health needs of paediatric and gynaecological patients.<br>• The UCC has a workforce skilled in the triage of patients attending.<br>• General Medicine and Medical Specialties, Orthopaedics, Gynaecology, Anaesthetics, Head & Neck, Ophthalmology and Critical Care services continue to be provided |

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| | | | | 24/7 at the PRH site. Any change particularly in anaesthetic or critical care support at the PRH site would fatally flaw the plan.<br>• All major trauma services for children and adults continue to be provided by RSH as the trauma unit.<br>• A non-resident Consultant Paediatrician will remain on-call at RSH.<br>• WMAS and Powys ambulances are fully briefed and involved in planning and delivering the alternative pathways when implementing Option C. Scenario planning would be required however with ambulance services in order to test the model.<br>• Between 20:00 and 08:00 the UCC would be supported by current arrangements to support EM 24/7 by the resident and non-resident specialties including medicine; surgery; orthopaedics; head and neck; ophthalmology etc.<br>• The inpatient ward and CAU at PRH continues to function in its current state.<br>• The RSH paediatric medical day unit continues to function in its current state.<br>• Any children attending RSH ED during 20:00hrs and 08:00hrs; requiring transfer to PRH would be transferred and accompanied if necessary by staff primarily from RSH ED – potential workforce impact for ED. |

| Specialty | Impact and Mitigation | Workforce | Associated Costs | Facilities required / other considerations |
|---|---|---|---|---|
| Acute Medicine | Inability to redirect high acuity direct GP referrals from the Acute Medical Unity into ED or at times when capacity in PRH AMU is constrained.<br><br><u>Mitigation</u><br><br>Pathways in place for referrals to RSH. PRH needs to create sufficient capacity to manage daily take plus additional capacity needs to be available at RSH. | 0.75 wte Consultant | £0.18m | More referrals to RSH and impact on already constrained impatient capacity |

### *2.3 Increasing inpatient capacity at RSH*

Inpatient bed capacity is already constrained at RSH by the ability to recruit sufficient substantive staff to staff its current bed base and there is no empty space where additional bed capacity could be created. The Unscheduled Care Group would need to consider admitting acute medical and cardiology patients who would normally be admitted to RSH to be admitted at PRH to create capacity at RSH to manage an increase in overnight admissions. In this scenario patient access may be adversely affected.

### *2.4 Urgent Care Centre (UCC)*

The development of a UCC at PRH is deemed to be critical in reducing the impact of an increase in ED attendances and emergency admissions at RSH. It is also vital to keep an urgent care presence for the population of Telford & Wrekin and also reduces the risk of increased ambulance journeys between sites. The stakeholder group discussed the skills needed to run a 24 hour UCC and the likelihood to recruit the required workforce within 3 months.

### *2.5 Overall Impact*

As can be seen there are no easy solutions to mitigate the impact on specialty service delivery and WMAS through a reduction in opening hours of the ED at PRH. Reducing the workforce risks in ED will potentially adversely impact on specialities that have previously consolidated their workforce.

Patient experience and access is likely to be compromised.

The stakeholder group identified the main risks to delivery of the service continuity plan as:

- Ability to deliver this solution within the 3 month timeframe set by the Board;
- Cost;
- Workforce availability; particularly for the Urgent Care Centre and the Paediatrics Emergency (non trauma) team.

On this basis it was agreed to establish Task & Finish Groups to further develop the preferred contingency options in the following areas:

- Urgent Care Centre – key staffing skill set to be identified;
- Paediatrics Emergency (non trauma) team – focus on workforce risks;
- PRH ED staffing – risks and opportunities
- Communications and engagement – to develop the ideas presented during the workshop.

## 3. CURRENT POSITION

Work on the areas described above has commenced and early work has confirmed that this contingency plan could not be delivered within a 3 month timeframe due to the lead-in time to recruit to the UCC service and Paediatric Emergency (non trauma) team. There are also significant concerns that this workforce is available. As this remains the preferred option and is aligned with the future direction of urgent care services as part of sustainable services, an interim solution which can be delivered within 3 months now needs to be discussed with the stakeholder group.

It is vital that we continue with this engagement strategy which is proving itself to be invaluable. The next stakeholder session will take place on the afternoon of Friday 13th October 2017.

## 4. WORKFORCE PLANS

There has been a slight improvement in Middle Grade vacancies.

Locum cover remains the first option to address any gaps which may occur as a result of resignation in both the Consultant and Middle Grade tiers.

Following a recent meeting between the Medical Directors of SaTH and UHNM, there is agreement to re-advertise for joint Emergency Department Consultants. They are, however, unable to support us with any Consultant or Middle Grade sessions.

A workshop was held on 18th September 2017 to consider University Hospital of Leicester's approach to internal international recruitment. A SaTH specific plan is now being developed.

## 5. ACTION REQUIRED

The Trust Board is asked to ***RECEIVE*** and ***NOTE*** the progress with the development of the service continuity plan. There is an expectation that an interim plan to meet the Board's timeframe for implementation of 3 months can be met. This will come back to November Board for approval along with the preferred option.

*Debbie Kadum*
*Chief Operating Officer*
*28th September 2017*

**Appendix A**

| Description | Strengths | Risks | Mitigation against identified risks |
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| **Providing a paediatric emergency (non-trauma) team at PRH** | • Centralised workforce on PRH site. Clinical risk shared and supports skills transfer between UCC and Paediatric team<br>• Paediatric on call resource centralised on one site<br>• Controls demand on RSH emergency services<br>• Controls number of children being transferred from RSH to PRH<br>• Clear message for patients and public about where to attend out of hours<br>• Compliant with national directive to provide streaming provision at the front door | • Availability of required workforce (medical and nursing)<br>• Favourability of roles/hours<br>• Affordability - financial risk to the Trust<br>• Tolerability of alternative pathways to WMAs and Powys ambulance services<br>• Reduced paediatric skills provided at RSH<br>• Insufficient ED staff to transfer paediatrics from RSH to PRH<br>• Incorrect attendance of a child at RSH with potential delay in transfer and deterioration<br>• Incorrect attendance of a mother/gynae patient at RSH with potential delay in transfer and deterioration | • Learning from other areas who may have implemented this approach<br>• Review with medical staffing and workforce similar roles and explore recruitment options<br>• Financial appraisal and risk assessment against cost improvement of ED service suspension against recruitment costs<br>• Clear pathway development with WMAS and Powys ambulance services. |