NHS
The Shrewsbury and Telford Hospital
NHS Trust

Recommendation ☑ **DECISION** ☑ **NOTE** (select)	Trust Board is asked to note the content of this report and make a decision on the viability and sustainability of maintaining both Emergency Departments remaining open overnight. The Trust Board is asked to consider carefully the risks raised in this paper relating to the inability of the current workforce to continue their current working patterns in order to maintain the status quo and keep two ED's open 24 hours a day. 1. The Trust Board is asked to agree that there is sufficient evidence to support implementation of reduced operating hours of one of the Emergency Department between 20:00 and 08:00 2. If the Trust Board concur that a closure of one ED overnight is the only option available due to the fragility of the workforce available, Trust Board is then asked to determine which option they consider would best mitigate the risks to patients until a longer term strategic solution can be agreed and delivered. Option 2: a closure of PRH ED overnight 20:00-08:00 Option 3: a closure of RSH ED overnight 20:00-08:00 The Trust Board is asked to approve Option 2 as the preferred option. 3. The Trust Board is asked to approve the proposed clinically-led approach for implementation with an expectation of enacting the changes during October 2018. 4. The Trust Board is asked to remit the proposal to the Quality and Safety Committee who will be asked to review the plan to implement the restriction of hours and to provide additional assurance to the Board. The expectation would be that a meeting of the Quality & Safety Committee wold be convened within two weeks to complete this task.
Reporting to:	**Trust Board**
Date	27th September 2018
Paper Title	Emergency Department Contingency Plan
Brief Description	The purpose of this paper is to provide Trust Board with an updated position regarding key services that have particular workforce challenges.
Sponsoring Director	Nigel Lee, Chief Operating Officer
Author(s)	Karen Barnett, Assistant Director for Unscheduled Care
Recommended / escalated by (Tier 2 Committee)	n/a
Previously considered by (consultation / communication)	Trust Executive Committee

Link to strategic objectives (see over)	SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm SAFEST AND KINDEST - Deliver the kindest care in the NHS with an embedded patient partnership approach VALUES INTO PRACTICE - Value our workforce to achieve cultural change by putting our values into practice to make our organisation a great place to work with an appropriately skilled fully staffed workforce
Link to Board Assurance Framework (see over)	(RR 561) (RR 668) (RR 859)
Equality Impact Assessment (select one)	○ **Stage 1 only (no negative impacts identified)** ◉ **Stage 2 recommended (negative impacts identified)** ○ negative impacts have been mitigated ◉ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status (select one)	◉ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

The Shrewsbury and Telford Hospital NHS Trust

Strategic Objectives 2017/18

PATIENT AND FAMILY - Deliver a transformed system of care (VMI) and partnership working that consistently delivers operational performance objectives

SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm

SAFEST AND KINDEST - Deliver the kindest care in the NHS with an embedded patient partnership approach

HEALTHIEST HALF MILLION ON THE PLANET – Build resilience and social capital so our communities live healthier and happier lives and become the healthiest 0.5 million on the planet through distributed models of health

INNOVATIVE AND INSPIRATIONAL LEADERSHIP - Through innovative and inspirational leadership achieve financial surplus and a sustainable clinical services strategy focussing on population needs

VALUES INTO PRACTICE - Value our workforce to achieve cultural change by putting our values into practice to make our organisation a great place to work with an appropriately skilled fully staffed workforce

BAF Risks

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)

If we do not work with our partners to reduce the number of patients on the Delayed Transfer of Care (DTOC) lists, and streamline our internal processes we will not improve our ‘simple’ discharges (RR 951)

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)

If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage (RR 1204)

If we do not have the patients in the right place, by removing medical outliers, patient experience will be affected (RR 1185)

If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision (RR 1186)

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)

If we are unable to resolve the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties & address the modernisation of our ageing estate & equipment (RR 670)

If we do not deliver our CIPs and budgetary control totals then we will be unable to invest in services to meet the needs of our patients (RR1187)

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)

Risk to sustainability of clinical services due to shortages of key clinical staff (RR 859)

Executive Summary

This paper has been developed as a response to the previously well documented ongoing workforce challenges faced by the Emergency Departments at The Shrewsbury & Telford Hospital NHS Trust (SaTH) over several years. The impact of the workforce challenges is felt in delivering timely assessment, intervention and monitoring of patients in our Emergency departments, potentially compromising patient safety and quality.

We monitor quality and safety indicators on a daily basis. There is a growing anxiety internally and externally in SaTH being able to maintain an appropriate level of safety for patients across two Emergency Departments overnight.

We are experiencing both nursing and doctor workforce challenges, and have done so for many months. The nursing workforce is becoming more fragile due to ongoing recruitment issues. The main challenge within nursing is in the recruitment of competent band 5 staff and retaining band 6 nurses who have stated that they feel vulnerable in leading the department, particularly at night on the PRH site. Due to these recruitment challenges in nursing, currently on average 30% of the nursing shifts across both departments are being provided by agency staff.

In addition, the service has been continually compromised by a significant vacancy rate within the senior doctor cohort since 2014. Whilst there have been appointments of more consultants to the service in recent months, there has also been retirement of two consultants within the same timeframe. There is also a significant challenge in relation to the appointment of a middle tier workforce. Within the current requirement of 20 WTE (whole-time equivalent) there are currently 11.1 WTE substantive middle tier doctors working across both sites.

This significant deficiency in workforce has been mitigated for many years, but only through an over dependency on agency medical workforce. Due to a combination of factors however we have over the last year experienced difficulties in attracting agency staff. This has acutely highlighted the lack of a stable and sustainable medical workforce, which has been brought to Trust Board on a number of occasions since 2014. Operationally, this translates into the departments being deficient in the quantity of senior medical staff, and the mitigations put in place are neither sustainable nor safe for staff and patients. Day shift medical staff are continually filling the gaps in night shifts, including Consultants, leaving day and evening shifts short of senior medical staff, crucial for the safe and effective running of the departments. This lack in senior medical workforce is also significantly impacting on their capacity to provide the leadership and supervision of staff. In addition and in part directly related to the lack of senior medical staff, the nursing workforce is becoming more fragile. Retention and recruitment of nurses is proving difficult in this context.

The consequence of not being able to provide a workforce which is both consistent and provides appropriate quality in both the medical and nursing workforce impacts on the Trust's ability to maintain the expected level of service provision and has given cause for concern in terms of maintaining patient safety on a sustainable basis.

This paper provides the background and reasons for the deterioration in the ability of the Trust to continue to provide Emergency Department services at both sites and clearly identifies and analyses the challenges regarding the current service provision.

The paper goes on to describe and appraise the risks and mitigation associated with a reduction in service of each Emergency Department overnight.

The Trust Board is asked to consider carefully the risks raised in this paper relating to the inability of the current workforce to continue their current working patterns in order to maintain the status quo and keep two ED's open 24 hours a day.

1. The Trust Board is asked to agree that there is sufficient evidence to support implementation of reduced operating hours of one of the Emergency Department between 20:00 and 08:00

2. If the Trust Board concur that a closure of one ED overnight is the only option available due to the fragility of the workforce available, Trust Board is then asked to determine which option they consider would best mitigate the risks to patients until a longer term strategic solution can be agreed and delivered.

   Option 2: a closure of PRH ED overnight 20:00-08:00
   Option 3: a closure of RSH ED overnight 20:00-08:00

   The Trust Board is asked to approve Option 2 as the preferred option.

3. The Trust Board is asked to approve the proposed clinically-led approach for implementation with an expectation of enacting the changes during October 2018.

4. The Trust Board is asked to remit the proposal to the Quality and Safety Committee who will be asked to review the plan to implement the restriction of hours and to provide additional assurance to the Board. The expectation would be that a meeting of the Quality & Safety Committee wold be convened within two weeks to complete this task.

Introduction

This paper is the culmination of, and describes, a series of circumstances that have led to a position where the model of Emergency Department provision at The Princess Royal Hospital, Telford (PRH) and The Royal Shrewsbury Hospital (RSH) is becoming unsustainable. This is not a situation that any health economy wants to find itself in. However, patient safety and staff wellbeing is, and must always be, the Trust's first and foremost concern.

This paper details the current risks associated with our current position and the mitigations that have been undertaken to date. It then describes the future options for consideration by the Trust Board.

The objectives of the report are:

- To describe the current situation with regards to emergency services at The Shrewsbury & Telford Hospital NHS Trust,
- To recommend the options for mitigation of the current risks that have been identified within the Emergency Department, including reducing the hours of provision of one ED overnight
- To provide clarity on the potential implications to other services in the event of one of the Emergency Department recurring service overnight at one of the two sites.

Background context

Since 2014 the Trust Board has been kept informed of the significant workforce challenges in the Emergency Departments at PRH and RSH. In December 2015 the Trust Board received a paper which outlined the risks and challenges being faced at that time in relation to maintaining two Emergency Departments at the PRH and RSH sites. This original paper was in response to the challenge facing the Trust around the continued availability of sufficient medical workforce to provide two 24-hour Emergency Departments and associated clinical services. In March 2016 the public meeting of the Trust Board received a paper outlining a number of options to maintain safe and effective urgent and emergency care services.

The risk relating to the workforce issue was, and remains, the greatest risk on the Trust's Board Assurance Framework and Trust's Risk Register. It has previously also formed part of the programme of review and scrutiny by the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin.

The outcome of the Board discussion in March 2016 to mitigate the identified risks was to identify three potential options to be contained within the contingency plan, which were to be developed further with key stakeholders and patient and public engagement. The preferred plan identified at the March meeting was to seek mutual aid from other Trusts across the region, in order to maintain adequate consultant staffing levels to sustain the safe, effective functioning of two 24-hour Emergency Departments.

The rationale for this decision was that it would cause the least disruption to patients and the service delivery of a number of specialties and would continue to deliver a safe, effective and readily accessible urgent and emergency care service for Shropshire, Telford & Wrekin and Powys patients.

Actions since March 2016

Mutual Aid

Whilst there have been a number of discussions with neighbouring Trusts and with Regulatory Bodies, it has not been possible to source additional workforce from other

organisations. A joint appointment approach was supported by University Hospitals North Midlands (UHNM), with two joint consultant posts being advertised. Unfortunately no applications were received.

NHSI supported a further session with neighbouring trusts in July 2018 – including University Hospitals North Midlands (UHNM) and The Royal Wolverhampton NHS Trust. There was no agreement reached at this to provide SaTH with additional medical staff.

Consultant and middle tier support

The substantive consultant and middle tier workforce has continued to support the junior medical workforce in order that the ED has been able to function overnight. Since April 2018 there have been many occasions where gaps in night shift cover has required intervention due to rota gaps. This has been mitigated by:

- the consultant "acting down" and working as a middle tier doctor through the night,
- one of the registrars being taken off duty in the day in order to work the night shift

Our consultant workforce are clear that this level of additional work in order to maintain a safe ED overnight is not sustainable. In June 2018, the clinical lead and medical director for unscheduled care met with the Trust's medical director, chief executive and chief operating officer to discuss the need for an alternative solution to be swiftly found. The action from this meeting was for the business continuity plans that had previously been developed to be reviewed and a programme of work set in motion to fully develop the options, to culminate in a Trust Board decision in September.

Further to the executive discussing the ED position with NHSI, a risk review meeting was held on 14th August 2018. The risk review concluded that the current position was unsustainable and therefore additional action was required.

Contingency planning

In February 2018 the Emergency Department Contingency Plan was received and approved at the Trust Board. This document described the process of closure of ED at PRH overnight for a short period of time (up to two weeks) should the workforce position be that no middle tier doctor was available to be on site for both PRH and RSH. This approach was taken due to the requirement to maintain Trauma Unit provision at RSH and therefore the Emergency Department had to be on the same site as the Trauma Unit.

Following review by the Executive Directors of the fragility of ED service delivery, the business continuity plan has been further developed in order to ensure that should it need to be enacted, the safety of care for patients could be maintained.

The risk that the implementation of this option causes to the delivery of other specialties has not changed, however the risk of not enacting it, due to the fragility of the ED situation continues to be of concern for our patients and our staff.

The formal Risk Review on 14th August 2018, chaired by NHSI and NHSE, requested that the Trust review the assumption that PRH was the most appropriate to close overnight and to undertake a further options appraisal exercise in order to collate the collective risks associated with closing either ED overnight.

Quality and Safety Indicators within the Emergency Department

Due to our concerns in relation to the impact of the workforce situation on quality and safety, and as part of its governance role in monitoring the quality and safety of care in the Emergency Departments, the Clinical Governance Executive received a report in June 2018 that reviews quality & safety metrics related to clinical care provided in the Emergency Departments. This assessment has been reviewed regularly and updated as appropriate.

The recent CQC visit in August 2018 highlighted some further quality and safety concerns in relation to the identification, monitoring and treatment of patients with Sepsis. As a result, a significant of additional work has been undertaken by the Executive and middle management in the Trust to develop internal assurance mechanisms in relation to patients' safety in the Emergency Departments.

Commissioners have raised also concerns about the number of the more serious harm categories reported in the departments over recent months and have asked us to comment on whether they point to a reduction in safety in the areas. The charts below show the reported moderate and above incidents per department since April 2017 (up to July 2018) and shows that since the last report that RSH has reported one incident that resulted in a patient's death.

All incidents reported 2015/16 – 2017/18

The below show the number of incidents reported by category and by department:

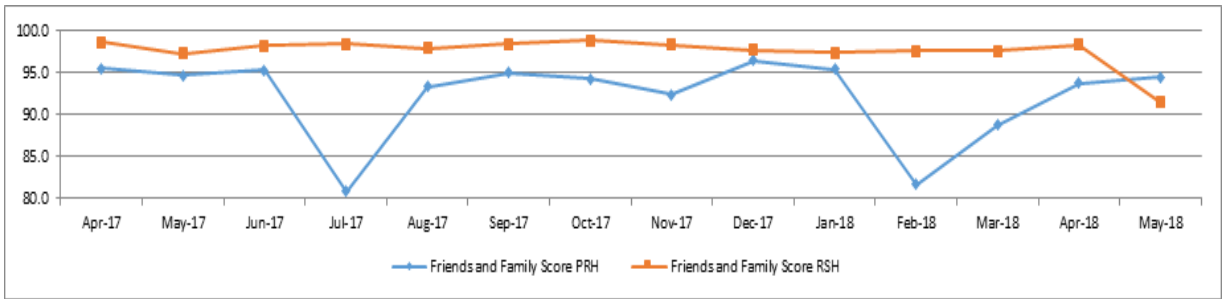
RSH ED			
Harm level	15/16	16/17	17/18
None	122	192	238
Low	246	326	402
Moderate	38	17	3
Severe	23	8	1
Death	0	0	2
TOTALS	**429**	**543**	**646**

PRH ED			
Harm level	15/16	16/17	17/18
None	203	201	172
Low	216	284	379
Moderate	36	10	5
Severe	14	21	0
Death	1	3	2
TOTALS	**470**	**519**	**558**

In RSH ED, the number of severe and moderate harm incidents reported reduced from 2015/16 to 2017/18 but number of deaths reported on Datix increased. This could potentially be related to the stronger processes in place for reviewing the accuracy of the level of harm identified by the reviewer recently as processes have been refined as already referred to above.

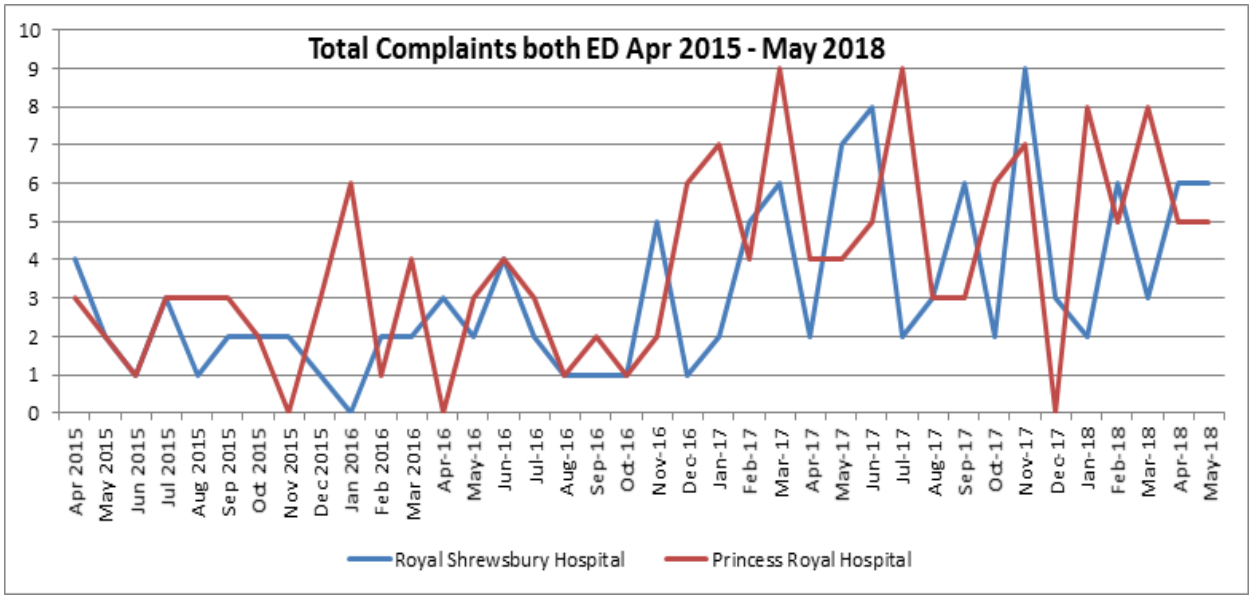
However, the number of low harm (defined as any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS funded care) have increased over the same time period in both areas.

The Friends and Family Test score for PRH ED rose from 89.9% in 2015/16 to 94.4% in 2016/17. During 2017/18 the score dropped below 90% of people that would recommend the service to Friends and Family on three occasions – July 2017, February 2018 and March 2018. Response rates have dropped in recent months reducing the validity of the data.



Complaints received from patients and relatives

Monthly reports on complaints and requests for Patient Advice and Liaison Services (PALS) received have demonstrated an increase in complaints relating to the Emergency Departments since December 2016 (figure 19). Concerns over clinical care represent a high proportion of PALS enquiries and there is some indication of an emerging trend of increase from PRH ED (personal communication from Complaints manager).



The highest number of complaints during 2017/2018 related to clinical treatment (54) followed by waiting time (30) and values and behaviour of staff (29).

At the risk summit in September 2018, Healthwatch Telford & Wrekin indicated that they had not received any external complaints/concerns addressed to them in relation to the Emergency Departments at SaTH. We will work with both Healthwatch organisations to develop mechanisms for them to be able to collate and monitor feedback in relation to our Emergency Departments.

The current staffing position within the Emergency Departments

The gaps in Consultant staffing, and more recently Middle Tier doctors have been brought to the attention of the Trust Board on many occasions over the last five years. These gaps have been amongst the Trust's highest risks on the Risk Register for most of that period.

The nursing workforce position has become increasingly challenging in recent months with more registered nurses raising concerns about the vulnerability they feel, particularly when they are working nights at PRH. The recruitment and retention of the nursing workforce is increasingly challenging. This is currently identified as a risk of 20 on the Trust Risk Register.

SaTH have been constantly working to improve the workforce position. The recruitment activity that has been undertaken can be seen at appendix 1.

Nursing workforce

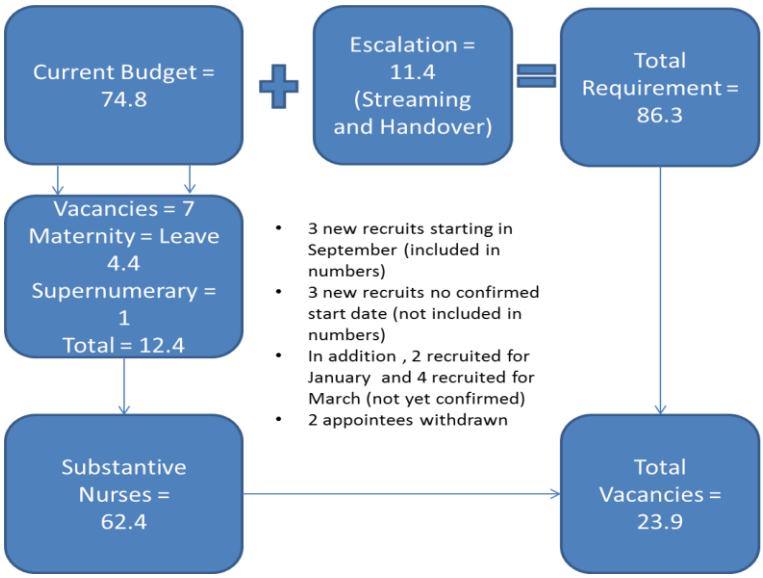
The main challenge within the nursing workforce is in the recruitment of competent band 5 staff and retaining band 6 nurses. The band 6 nursing staff have stated that they feel vulnerable in leading the department due to a lack in workforce, particularly at night on the PRH site.

In order to provide more senior leadership and support for our nursing teams, Practice Educator roles have been introduced on both sites. Their role is to provide development and support to the teams and to develop consistency and competencies for the workforce.

New roles have been created within the department, including Emergency Care Practitioner (ECP) and Advanced Care Practitioner (ACP) positions. Additional ECPs have been recruited (April 2018), increasing the numbers from 5 to 11 WTE. ECP trainees are currently completing their competencies with an expectation that they will be fully trained and working independently as ECPs by January 2019.

Further investigation is taking place with regard to the role of the Paramedic in an ED.

Following recent band 6 recruitment, RSH appointed 1 substantive band 6 Nurse and 1 secondment band 6 Nurse. In addition, 2 registered nurses, currently working outside of the organisation, accepted band 5 positions and some staff currently on maternity leave return in the autumn. However, in the last 2 months there have been resignations of 7 band 5 nurses and 3 band 6 nurses.



Medical workforce

The current ED consultants, particularly the substantive staff, continue to change both shifts and roles (covering the middle tier) on a regular basis. Between April 2018 and end August 2018, there have been 50 middle tier overnight shifts which have not been able to be covered by either substantive or agency middle tier doctors, which have then required the consultants to 'act down'. This has resulted in the reduction in capacity during the daytime, as well as an increase in working hours for the consultants. Despite these considerable challenges the Trust has been able to maintain – albeit with increasing effort – Emergency Department care at both PRH and RSH. It has only been as a result of the considerable and continued discretionary effort that the service has been maintained safely during the last few months, and is not a sustainable position.

Figure 1 below demonstrates the size of the problem in relation to the medical workforce. Due to the numbers of doctors available on the rota, and the necessity to cover the nights adequately, significant gaps occur during the day and evening shifts.

During core hours, when activity is at its highest, the medical workforce has 5 fewer senior decision makers than is required (50% shortfall) to ensure patients are seen rapidly when they arrive in the department and that an effective plan is developed in order to support good quality care for the patient.

At night, the number of doctors on duty reduces and this impacts significantly on Trust's ability to provide time and care for the patients that remain in ED through the night and on the work required to manage the backlog of activity that has built up through that period.

	Actuals			Required (SATH Clinical View)			Shortfall		
	Consultants	Middle Grade	Junior	Consultants	Middle Grade	Junior	Consultants	Middle Grade	Junior
Time of day	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount
12am - 8am	0	2	3	0	2	3	0	0	0
8am -5pm	3	2	6	4	6	6	-1	-4	0
5pm - 12am	1	2	6	4	6	5	-3	-4	1

Figure 1 – Medical Workforce

On an average day, this rota includes 1 locum consultant and 4 locum middle tier doctors, which impacts on the development of team-working and a consistent approach within the department. The majority of agency and locum doctors support out of hours provision, which potentially impacts on the safe quality care at this time.

Due to the significant gaps at the middle tier, our consultants often 'act down' to cover the middle tier rota. This impacts on their consultant duties and further limits senior decision-making presence and supervision throughout the day.

Consultant Workforce

The Royal College of Emergency Medicine recommends that 20 WTE consultants are required to deliver sustainable emergency services across both sites at The Shrewsbury and Telford Hospital NHS Trust. Whilst the RCEM recommendation supports the position that more doctors are required, the current consultant body within SaTH believes that it is possible to provide a sustainable service across both sites with 10 WTE consultants all of whom can fulfil on-call commitments.

There are currently 4 substantive consultants, one of whom retires in October 2018. There are 5 agency consultant staff working with us currently. The recruitment activity undertaken has resulted in one new consultant starting in October 2018, one starting in January 2019 one in February 2019, and another at a date yet to be confirmed – a net increase, over the coming months, of 2 substantive consultants.
There are 5 agency consultants that have worked in the department on a long-standing arrangement. They also contribute to the on-call rota.

Middle Tier Workforce

The Royal College of Emergency Medicine recommends that there should be a middle tier doctor on each site 24 hours a day. To have substantive middle tier cover 24 hours a day they advise equates to a rota with 16 doctors per site. The current consultant body within SaTH believes that it is possible to provide a sustainable service across both sites with 20 wte middle tier doctors (10 wte each site) all of whom fulfil full rota commitments.

There are currently 11.1 WTE substantive middle tier doctors in total working across both sites (including Specialty doctors, associate specialists and 8 ST3 Trainees). Of these, there are 5 substantive staff that are unable to work on the night rota, due to health and/or contractual reasons, which impacts on our ability to sustainably maintain a role of middle tier staff for both sites overnight.

Our locum middle tier workforce is less consistent than our locum consultant workforce, hence there is a reliance on middle tier doctors, who are less familiar with the department. The impact of a reduced middle tier workforce affects the flow through the department, as

the number of senior clinical decision makers is reduced, which increases the wait for patients to be seen and assessed, creates a further delay in deciding appropriate care plans for patients, which in turn means that patients stay in the department for longer.

Junior doctor workforce

The recommended number of junior doctors is 10 on each site. There currently are 18 junior doctors provided by Health Education England (West Midlands) who rotate into the Emergency Department: 8 for PRH and 10 for RSH. Within the current rotation, there are 2 vacancies in the training doctor positions and SaTH has appointed and funds 2 HEE recognised junior doctor posts to provide adequate cover.

The junior doctor rota is a complex and full shift pattern, as a result, there are a significant number of shift changes made on a daily basis to maintain the junior doctor rota on both sites. Multiple day shifts are altered to ensure good night shift coverage. This can affect patient flow during the day and night, and may affect the job satisfaction and teaching of the junior doctor workforce.

An overview of the current Emergency Service activity provided at SaTH

SaTH currently has a 24-hour Emergency Department in both the Royal Shrewsbury Hospital site and the Princess Royal Hospital site. Appendix 2 provides more detail regarding the services SaTH provides.

Between 2,800 and 3,400 patients attend Emergency Department each week (figure 2) in the first half of the financial year 2018/19 and, on average, 78.7% (figure 3) were seen, treated and left the department within 4 hours of attendance. This is significantly below the national target of 95%.

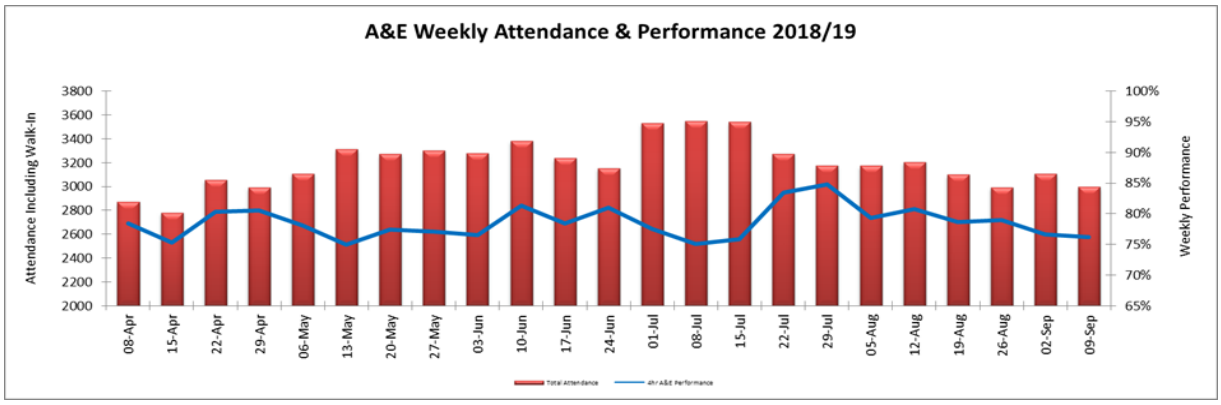


Figure 2

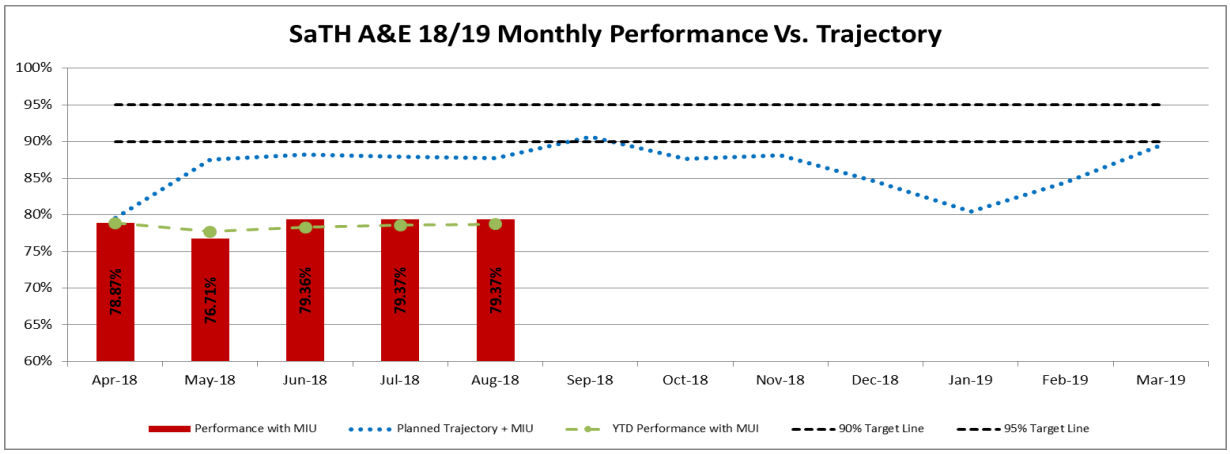


Figure 3

PRH is the busier of the two departments, however a significantly higher proportion of patients with minor illnesses or injuries attend PRH than RSH. In addition PRH, as the main Paediatric centre for the Trust sees more children than RSH. RSH hosts the Trauma unit and as such more complex surgical patients attend RSH by ambulance. Any surgical patient that attends PRH and requires admission is transferred across to RSH and then admitted via the Surgical Assessment Unit (SAU). There is no SAU currently at PRH.

There are a number of services and pathways that are interdependent upon the provision of Accident & Emergency Services which need full consideration in any decision related to change in Emergency Service provision. These are detailed fully in the report and are listed below for reference.

	Princess Royal Hospital	Royal Shrewsbury Hospital
Interdependent pathways	• Women's & Children's services • Head and Neck services • Stroke services • Access to appropriate radiology	• Trauma • Acute Surgical services – general surgery, vascular surgery and urology

There are some services that we do not expect to be affected by an Emergency Department closing overnight, especially if all ambulances are diverted to neighbouring Trusts.

- Maternity services – the main interdependence for maternity is critical care and availability of intensivists to support emergency caesarean operations. The critical care and anaesthetist capacity will remain at PRH should ED at PRH close.
- Child Assessment Unit (CAU) will continue to accept GP referrals and direct access to CAU as long as previously arranged.
- Critical Care – critical care will be less impacted if either site closes as long as all ambulances are diverted to neighbouring Trusts.
- Urgent Care Centre (UCC) – Primary care led GP services based at PRH and RSH will not be affected as patients will continue to access them up to 8pm.
- GP direct admissions to AMU will not be impacted as AMU will continue to accept GP admissions via ambulance or walk-in as long as previously arranged.

If PRH ED were closed overnight the impact on RSH/other providers would be:

- 690 additional ambulances per month = 23 per night between 20:00 hrs and 08:00 hrs;
- 420 self-presenting adult attenders per month = 14 per night between 20:00 hrs and 08:00 hrs; (based on 60% of the current number of self-attenders still attending an alternate site overnight)
- 300 self-presenting children per month = 10 a night (no assumption on reducing child attendees has been made)
- 270 additional admissions per month = 9 per night between the hours of 20:00 hrs and 08:00 hrs;
- 60 child admissions per month = 2 per night between the hours of 20:00 and 08:00hrs

If RSH ED were closed overnight the impact on PRH/other providers would be:

- 600 additional ambulances per month = 20 per night between 20:00 hrs and 08:00 hrs;
- 450 self-presenting adult attenders per month = 15 per night between 20:00 hrs and 08:00 hrs; (based on 60% of the current number of self-attenders still attending an alternate site overnight)
- 90 self-presenting children per month = 3 per night
- 390 additional admissions per month = 13 per night between the hours of 20:00 hrs and 08:00 hrs;

Further detail with regard to the current level of activity within the departments can be found at appendix 3 (ambulance conveyance) and appendix 4 (ED activity overnight)

Review of the Options

As requested by the Risk Review on 14th August, a review of the options available to the Trust was undertaken on 28th August 2018. The options appraisal workshop was attended by clinical and operational staff within SaTH, NHSI, NHSE, CCGs, Local Authorities, WMAS, ShropComm, ShropDoc, Royal Wolverhampton Trust and Healthwatch.

The options that were reviewed focussed on the closure of one ED, alongside the practicalities of how the public would access emergency care if one ED was closed. The outcome of the options review was that the following options needed further investigation with the clinical teams:

- **Option 1:** Maintain the Status Quo
- **Option 2:** Close PRH ED overnight and divert ambulances to neighbouring Trusts, and accept that self-presenting patients could choose to attend RSH or EDs at neighbouring Trusts.
- **Option 3:** Close RSH ED overnight and divert ambulances to neighbouring Trusts, accepting that self-presenting patients could choose to attend PRH or EDs at neighbouring Trusts.

An options appraisal has been undertaken and can be found at appendix 5.

A quality impact assessment for each service has been undertaken to understand the impact of each option. A summary of the risks and impact within these documents has been included at appendix 6. Individual service quality impact assessments are available for scrutiny.

Within the Quality Impact assessment, each speciality was asked to identify the issues relating to each of the three options and provide rationale for each concern. A risk rating and score has been applied to each concern, in order to ascertain the level of risk for each issue. The higher the score, the bigger the perceived issue and risk.

Summary of benefits of each options

The summary table below is designed to support the reader to gauge if there is any positive benefit from maintaining each site for different specialist services. The
□ = benefit to maintaining this site for this service
X = this is not available if this option was approved

	Option 2 Close PRH ED overnight – keep RSH open	**Option 3 Close RSH ED overnight – keep PRH open**
Paediatric specialist support on site 24/7	x	□
Access to SAU and surgical specialties on site	□	x
Full access to radiology – CT, MRI, Interventional Radiology	□	x
Stroke services on site	x	□
Additional bed base available to flex if required	□	x
Regional coverage, including Wales	□	x
Public transport routes more accessible from outlying areas	□	x

Summary of risks of each option

The options appraisal at appendix 5 and the risk & impact analysis at appendix 6 demonstrate that Option 2 is the preferred option. Based on the balance of the key risks, including the feasibility of transferring and accommodating services in the alternate site, the recommendation is for a reduction in hours for PRH ED overnight.

Neither site has the capacity to accommodate a total ambulance transfer overnight. Closure of either of the ED sites overnight presents different risks:

- The reduction in hours at RSH could present significant risk due to the single CT scanner and single MRI at PRH (which would leave the region vulnerable with single points of failure as well as the challenge of accommodating additional activity); procurement and installation would require additional building works and a long lead-in time. PRH also has limited physical capacity to increase the bed numbers at the site, with the infrastructure also limited in capacity to accommodate modular buildings. Furthermore, it is not feasible to create an additional and parallel set of surgical, vascular and trauma services on the PRH site whilst maintaining the service overnight at RSH. The impact of greater travel time for patients further afield in Shropshire and mid Wales would also be increased.

- Closing PRH could also present risk, particularly for Paediatrics and for stroke patients; mitigation for Paediatrics has been discussed with ED and Paediatrics services, and the stroke service will put a direct pathway through AMU in place.

There are some mitigations that can be developed by the clinical services in relation to direct access pathways. This would reduce the number of ambulances diverted out of area, particularly for the following conditions:-

- Stroke out of hours (PRH closure) – this pathway would be in place immediately
- Paediatrics out of hours (PRH closure) - this pathway would be in place immediately
- Cardiology out of hours (PRH closure) – to be finalised
- Fractured Neck of Femur out of hours (both sites) – to be finalised

This would reduce the impact for the patients and families, ambulance services, social care and community services.

Finance impact

The current situation is costing the organisation an additional £2.3m this year due to the reliance on, and increased cost of, agency staff.

Option 2 – closing PRH overnight would cost the organisation a net £3.4m (full year effect) based on loss of income due to less activity and associated reduction in workforce.

Option 3 – closing RSH overnight would cost the organisation a net £ 3.3m (full year effect) based on loss of income due to less activity and associated reduction in workforce.

This could rise to between £5.4m and £6.6m respectively in worst case scenario.

There will also be additional costs associated with the additional capacity required within the ambulance service and non-emergency patient transport.

Detail can be seen at appendix 7.

Equality Impact Assessment

An Equality Impact Assessment can be found in Appendix 8. This assessment will require more work over the coming weeks, and will require an action plan to mitigate the risks that have been identified.

Stakeholder involvement

There have been significant amount of engagement and involvement in the development of

the service quality impact assessments, the development of this report and the equality impact assessment.

Next Steps

Implementation

Whilst the sustainability of both EDs overnight presents a significant challenge, it is also imperative that should it be determined this is no longer sustainable, any new model of care overnight for patients in the region and for SaTH is delivered. A balance needs to be struck between making an immediate change, which may exacerbate forecast risks, versus a lengthy process that would prolong the existing risks. A process that includes clear communication to the public, clear communication and expectations across the hospital teams, and a detailed dialogue on the outcomes and decisions of the Board with key partners such as the Ambulance Service will be required. A Task & Finish group, led by senior clinicians with involvement of all parties, will be convened with the expectation of enacting the changes during October 2018.

Staff Engagement and support

The Emergency Department teams are experiencing an unsettled time given the ongoing conversations regarding the departments; if a decision is made in regard to option 2 or 3 then it will be critical that staff are supported through any change. This includes understanding the personal impact for individuals and the level of support is required.

There will be no job losses as a result of changing opening hours, it may be possible that staff will be asked to work at an alternative site/base or change their working hours. As an employer we recognise that this can be an anxious time for individuals and teams. We are absolutely committed to supporting our teams and will undertake the following:

- Regular staff briefings
- Question and Answer sessions
- Staff Consultation and Engagement, where appropriate
- 121 conversations about any changes to ensure we support our people.
- Increased access to Freedom to Speak up Guardians
- Training and support
- Engagement with Staff Side colleagues.

We will meet weekly with staff and staff side colleagues to ensure we are responsive and providing the appropriate assistance.

Governance Process

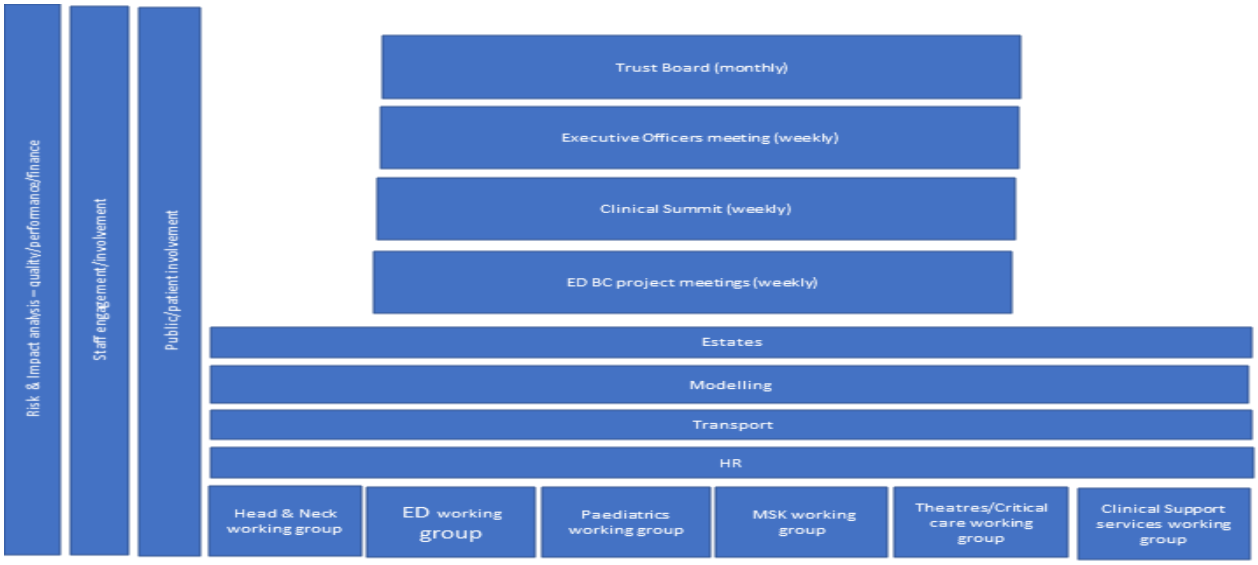
The Trust has established a formal governance structure for the further work to be undertaken to ensure that our Services are delivered in a safe and sustainable manner.

The Task & Finish Group will have a membership representation from SaTH and major external stakeholders including the local clinical commissioning groups, NHSE and NHSI.

The Task & Finish Group will be responsible for implementation and oversight will be through the Trust's Quality & Safety Committee.

This structure illustrates the Governance arrangements currently in place in order to provide assurance and communication routes at each decision point;

Governance Structure



Measuring Impact

In order to be able to track the impact of the overnight closure, a set of metrics will be developed to encompass a range of indicators. This will measure impact in relation to performance, activity, quality indicators, finance and workforce.

Activity

It is intended to identify demand by both ambulance conveyance and walk in activity in order to;

a) actively identify and understand demand diverted to alternate SaTH site (walk-in patients)
b) actively identify and understand demand for new direct access pathways (ambulance patients)
c) compare activity to the predicted demand as a result of the closure,
d) compare activity to the historic demand profiles,
e) understand ambulance activity to determine changes in conveyance profile
f) Understand the flow through the closed ED and at what point all patients have left the closed ED.

Performance

ED performance metrics are already routinely collated, including the 4 hour standard, 12 hour Decision to admit standard, time to assessment and time to treatment. These will continue.

In addition metrics that will identify any impact on other services will be reviewed including:-

- Referral to Treatment – particularly for affected services (ENT, Maxillo-Facial, Paediatrics, T&O if PRH ED closed overnight) and Surgical, Vascular, Trauma & Orthopaedics, Urology if RSH ED closed overnight)
- # Neck of Femur
- Stroke Performance

New metrics will also be developed to measure impact on neighbouring Trusts

- Number of Repatriation requests
- Repatriation time from referral to admission

We will also monitor any impact on Social Care through their DTOC performance

Quality

Quality Indicator are routinely collected and presented to Quality & Safety Committee. This report will form part of the intelligence in determining the impact of closure.

Finance

Finance data will be reviewed to determine if the cost reductions are being made where income loss and reduced activity is being seen.

ED performance and activity metrics will be reviewed daily and other metrics will be reviewed weekly in detail at each working group meeting in order to identify issues, solutions and agree actions to address performance proactively.

Summary & Conclusion

The Trust continues to provide services for 2 EDs on a 24/7 basis, but there is a growing concern about the ability of the services to maintain the appropriate level of patient safety on a sustainable basis. Concerns raised by internal governance processes, by the nursing and medical staff themselves, and by recent regulatory assessments have added to the level of anxiety. The challenges of retaining and recruiting both nursing and medical workforce for the EDs are significant, and more recently the increase in nursing vacancies has applied greater pressure. In sum, SATH are not currently able to maintain both EDs overnight.

Closure of either of the ED sites overnight presents different risks. The closure of RSH would present significant risk due to the single CT scanner at PRH, the bed capacity available at the site, and the challenge of creating an additional and parallel set of surgical, vascular and trauma services. The impact of patients further afield in Shropshire and mid Wales would also be increased. Closing PRH would also present risk, particularly for Paediatrics and for stroke & cardiology patients; mitigation for Paediatrics has been discussed, and stroke will put a direct pathway through AMU in place. Balancing the level of activity, feasibility of transferring services and options to mitigate safety risks, closure of PRH overnight is the preferred option.

Either option will require the open site to prepare for additional activity, and for SATH to work with system partners to manage the activity and a level of repatriation. Once a decision is made, there will be a requirement to finalise a robust implementation plan, to ensure pathways are clear and the public communication is provided

Recommendations to the Trust Board

The Trust Board is asked to consider carefully the risks raised in this paper relating to the inability of the current workforce to continue their current working patterns in order to maintain the status quo and keep two ED's open 24 hours a day.

1. The Trust Board is asked to agree that there is sufficient evidence to support implementation of reduced operating hours of one of the Emergency Department between 20:00 and 08:00
2. If the Trust Board concur that a closure of one ED overnight is the only option available due to the fragility of the workforce available, Trust Board is then asked to determine which option they consider would best mitigate the risks to patients until a longer term strategic solution can be agreed and delivered.

    - Option 2: a closure of PRH ED overnight 20:00-08:00
    - Option 3: a closure of RSH ED overnight 20:00-08:00

    The Trust Board is asked to approve Option 2 as the preferred option.

3. The Trust Board is asked to approve the proposed clinically-led approach for implementation with an expectation of enacting the changes during October 2018.

4. The Trust Board is asked to remit the proposal to the Quality and Safety Committee who will be asked to review the plan to implement the restriction of hours and to provide additional assurance to the Board. The expectation would be that a meeting of the Quality & Safety Committee would be convened within two weeks to complete this task.

The Shrewsbury and Telford Hospital NHS Trust

Appendix 1

Recruitment campaigns

Consultant workforce

Figure i below, highlights the number of recruitment campaigns have been released and the level of success. There has been relative success in the number of candidates that have applied for posts in the last 6 months. This indicates the campaigns have been broader and more extensive (also highlighting the investment of £312 million in our hospitals) and this has contributed to a greater level of interest.

SaTH Campaigns	Number of Times Post Advertised	Number of Applications Received	Number of Candidates Shortlisted	Number of Appointments
Previous 6 Months	4	4	4	3
6 to 12 Months	2	No applicants	0	0
1 to 3 Years	4	No applicants	0	0
Recruitment via Agency Campaigns		Number of Applications Received	Number of Candidates Shortlisted	Number of Appointments
Previous 6 Months		5	3	0
6 to 12 Months		3	2	0
1 to 3 Years		5	0	0

Figure i – Consultant Recruitment Campaigns

Middle Tier doctors

The recruitment activity of middle tier doctors has run in parallel to the Consultant recruitment and the actions taken have been similar to that of Consultants including support from a number of recruitment companies. Figure 4 indicates that despite an improvement in the number of candidates that have applied, it is the suitability of candidates at the senior level that has been problematic. The national shortage of middle tier ED medics has contributed to the low levels of successful appointments.

SaTH Campaigns	Number of Times Post Advertised	Number of Applications Received	Number of Candidates Shortlisted	Number of Appointments
Previous 6 Months	4	31	5	2
6 to 12 Months	5	15	4	1
1 to 3 Years	2	0	No applicants	0
Recruitment via Agency Campaigns		Number of Applications Received	Number of Candidates Shortlisted	Number of Appointments
Previous 6 Months		49	25	1
6 to 12 Months		7	2	0
1 to 3 Years		41	42	3

Figure ii – Middle Tier Recruitment Campaigns

Nursing Staff

Recruitment of registered nurses is a centralised function and run as part of a continuous programme of events throughout the year. This includes open days and recruitment events which are run as a 'one stop' event where they are interviewed and undertake assessments on the same day.

The Emergency Department has also invested in a nursing campaign specifically for ED. This launched throughout May and included the development of a professional advert and candidate pack advertised on line via the RCN and Nursing Times.

SaTH campaign	Number of times advertised	Number of appointment
Previous 6 months	14	13
6-12 months	10	8

Figure iii – Nursing Recruitment Campaigns

The Shrewsbury and Telford Hospital NHS Trust

Appendix 2

An overview of Shrewsbury & Telford Hospital NHS Trust

- **Shrewsbury & Telford Hospital NHS Trust serves the population of Shrewsbury, Telford, Wrekin and parts of Mid Wales.**
- **The overall population within the footprint is 470,000 people.**
- **The man commissioners of urgent and emergency services are Telford & Wrekin CCG, Shropshire CCG and Powys CCG**
- **Telford & Wrekin CCG has a large, younger urban population with some rural areas. Telford is ranked amongst the 30% most deprived populations in England. The population is approximately 170,000 and set to grow to 180,000 by 2020. The percentage of people who are over the age of 85 is set to increase by 130% by 2020.**
- **Shropshire CCG covers a large rural population with problems of physical isolation and low population density and has a mix of rural and urban aging populations. Shropshire has a population of approximately 308,000 which is set to rise to 320,600 by 2020.**
- **Powys Health Board has a very rural population spread over significant distances, covering quarter of Wales with a population of 133,000 people.**
- **Public transport is more accessible in Shrewsbury than in Telford.**
- **In 2017/18 over 29,000 attendances to ED were seen overnight at RSH and PRH Emergency Departments**
- **The conversion rate from attendance at ED and admission is 26% across both PRH and RSH**

The Shrewsbury and Telford Hospital NHS Trust (SaTH), is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales.

Our main service locations are the Princess Royal Hospital in Telford (PRH) and the Royal Shrewsbury Hospital in Shrewsbury (RSH), which together provide 99% of our activity.

Both hospitals provide a wide range of acute hospital services including accident & emergency, outpatients, diagnostics, inpatient medical care and critical care.

There is currently a full 24-hour emergency department situated at both Royal Shrewsbury Hospital in Shrewsbury and Princess Royal Hospital in Telford. In previous years specialist services have been reconfigured across the sites to enable those services to become more sustainable, due in large part to the workforce challenges that these services have experienced.

During 2012/13 the Princess Royal Hospital became the main specialist centre for inpatient head and neck surgery with the establishment of a new Head and Neck ward and enhanced outpatient facilities. It also became the main centre for inpatient Women and Children's services following the opening of the Shropshire Women and Children's Centre in September 2014.

During 2012/13, the Royal Shrewsbury Hospital became the main specialist centre for acute surgery with a new Surgical Assessment Unit, Surgical Short Stay Unit and Ambulatory Care facilities.

Together the hospitals have just over 700 beds and assessment & treatment trolleys.

SaTH is the main non-elective provider for Telford & Wrekin clinical commissioning group and Shropshire Clinical Commissioning Group and in part for Powys Health Board.

Current accommodation

	Princess Royal Hospital	Royal Shrewsbury Hospital
Emergency Department	4 resuscitation spaces 8 majors cubicles 4 minors cubicles 1 paediatric 2 fit to sit spaces (1 trolley, 4 seats) 2 rapid assessment cubicles 1 isolation cubicle 6 CDU spaces 2 UCC rooms Plaster room Theatre space for minor procedures or isolation	4 resuscitation spaces 12 majors cubicles 3 minors cubicles (open until 11:30pm) 1 fit to sit space (4 seats) 1 ambulance assessment cubicle 5 UCC consulting rooms (open between 10am-10pm) Rapid assessment space with 4 trolley spaces within adjoining theatre recovery area (that is not currently being utilised as a theatre)
Acute Medical Unit	17 beds with adjoining Ambulatory care area with 3 bed spaces	16 beds with adjoining CDU with 9 bed spaces (CDU is often used as an overspill for AMU)
Core bed base	294 core beds	352 core beds
Escalation bed base	14 escalation beds (ward 8)	16 escalation beds (ward 27) Planning underway for additional 30 bedded unit

Figure iv

Specialist services provided at each site

Princess Royal Hospital	Royal Shrewsbury Hospital
Women's Services – including maternity and gynaecology in-patient wards, inpatient and daycase surgery, out-patient **Children's Services** – including direct support to ED, specialist neonatal unit, child assessment unit, in-patient ward and out-patients **Ear, Nose and Throat** –including direct referral from ED, day case and in-patient surgery and out-patients **Stroke** – Thrombolysis on the Stroke unit, HASU, acute stroke and rehabilitation wards, TIA clinic, out-patients **Cardiology** – day case and in-patient interventions within the Cath Lab, CCU and in-patient wards **Acute Medical Unit** **Ambulatory care** – Area adjacent to AMU that includes 3 trolleys and 3 chairs **Medical in-patient wards** – respiratory, elderly, renal and general medical wards **Orthopaedics** – emergency surgery (predominantly for #NOF), elective surgery for joint replacement **Radiology** – 1 MRI and 1 CT scanner in place – the CT scanner is due for replacement in 2019 **Intensive care Unit**	**Acute Medical Unit –** with adjacent CDU **Medical in-patient wards** – respiratory, cardiology, elderly, renal and general medical wards **Surgical Assessment Unit** **Vascular surgery** including direct referral from ED, day case and in-patient surgery and out-patients **General surgery** including direct referral from ED, day case and in-patient surgery and out-patients **Urology** including direct referral from ED, day case and in-patient surgery and out-patients **Orthopaedics** – fracture clinic, emergency trauma surgery, elective surgery for joint replacement **Intensive Care Unit and High Dependence Unit** **Ambulatory care Unit** **Radiology – 2 x MRI scanners, 2 x CT scanners** **Cancer Services**

Figure v

Appendix 3

Ambulance conveyance

WMAS have provided data, figures 19-24, regarding ambulance conveyance to PRH and RSH overnight, between the hours of 20:00-08:00.

Conveyance of PRH between 20:00-08:00

April	Total	Ave per day	Under 16	Ave per day	Ambulance Arrival	% of demand	Ave per day	Average time in department
Number of attendances	1434	47.80	268	8.93	523	36.47%	17.43	04:10:58
Majors	564	18.80	9	0.30	392	69.50%	13.07	06:34:59
Minors	831	27.70	247	8.23	130	15.64%	4.33	02:41:32
Type 3	39	1.30	12	0.40	1	2.56%	0.03	01:14:02

May	Total	Ave per day	Under 16	Ave per day	Ambulance Arrival	% of demand	Ave per day	Average time in department
Number of attendances	1663	55.43	323	10.77	678	40.77%	22.60	04:42:09
Majors	642	21.40	5	0.17	500	77.88%	16.67	07:33:38
Minors	968	32.27	295	9.83	177	18.29%	5.90	02:59:35
Type 3	53	1.77	23	0.77	1	1.89%	0.03	01:18:35

June	Total	Ave per day	Under 16	Ave per day	Ambulance Arrival	% of demand	Ave per day	Average time in department
Number of attendances	1640	54.67	313	10.43	601	36.65%	20.03	04:44:50
Majors	649	21.63	17	0.57	477	73.50%	15.90	07:30:36
Minors	945	31.50	276	9.20	123	13.02%	4.10	03:01:35
Type 3	46	1.53	20	0.67	1	2.17%	0.03	01:07:04

The postcode areas where the conveyance commences

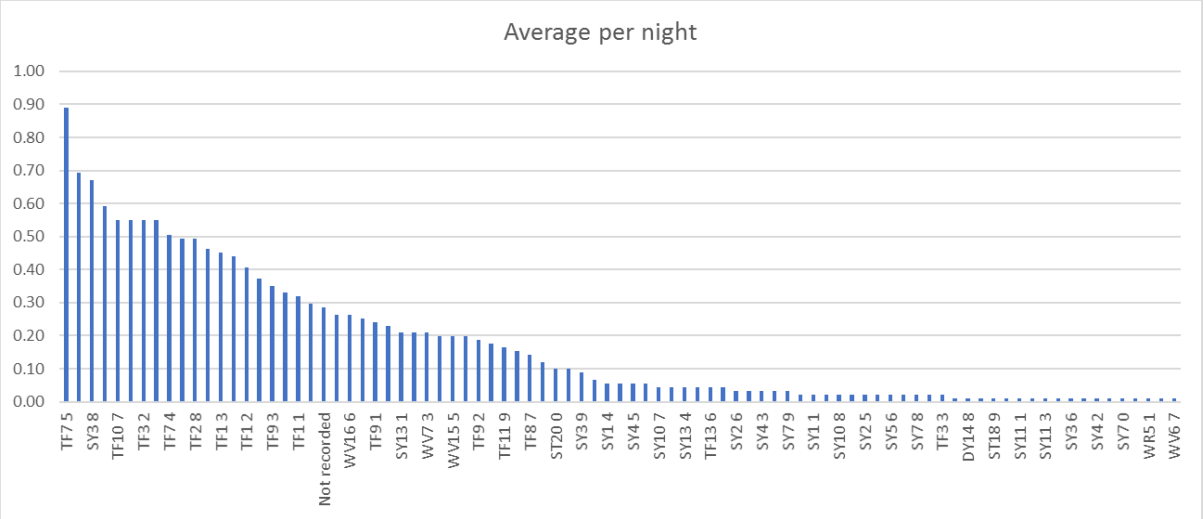


Figure vi

The predominant patient conveyances to PRH are from the following areas: -

Average per night	Postcode Sector Group	Area
0.89	TF7 5	Madeley, Sutton Hill
0.69	TF3 1	Randley, Hollinswood
0.67	SY3 8	Frankwell, Shrewsbury
0.59	TF4 3	Dawley, telford
0.55	TF10 7	Newport
0.55	TF2 9	Priorslee
0.55	TF3 2	Randley, Hollinswood
0.55	TF4 2	Dawley, telford
0.51	TF7 4	Madeley, Sutton Hill
0.49	TF2 6	Priorslee
0.49	TF2 8	Priorslee
0.46	TF1 6	Wellington
0.45	TF1 3	Wellington

Figure vii

Conveyance of RSH between the hours of 20:00-08:00 by WMAS

April	Total	Ave per day	Under 16	Ave per day	Ambulance Arrival	% of demand	Ave per day	Average time in department
Number of attendances	1260	42.00	102	3.40	598	47.46%	19.93	05:26:44
Majors	786	26.20	25	0.83	535	68.07%	17.83	07:05:21
Minors	412	13.73	74	2.47	59	14.32%	1.97	02:51:44
Type 3	62	2.07	3	0.10	4	6.45%	0.13	01:46:35

May	Total	Ave per day	Under 16	Ave per day	Ambulance Arrival	% of demand	Ave per day	Average time in department
Number of attendances	1487	49.57	150	5.00	722	48.55%	24.07	05:40:36
Majors	921	30.70	33	3.70	682	74.05%	22.73	07:32:02
Minors	509	16.97	111	0.20	36	7.07%	1.20	02:45:02
Type 3	57	1.90	6	0.20	4	7.02%	0.13	01:47:45

June	Total	Ave per day	Under 16	Ave per day	Ambulance Arrival	% of demand	Ave per day	Average time in department
Number of attendances	1433	47.77	147	4.90	634	44.24%	21.13	04:57:03
Majors	931	31.03	51	1.70	600	64.45%	20.00	06:23:44
Minors	447	14.90	92	3.07	30	6.71%	1.00	02:19:30
Type 3	55	1.83	4	0.13	4	7.27%	0.13	01:50:09

The postcode areas where the conveyance commences to RSH

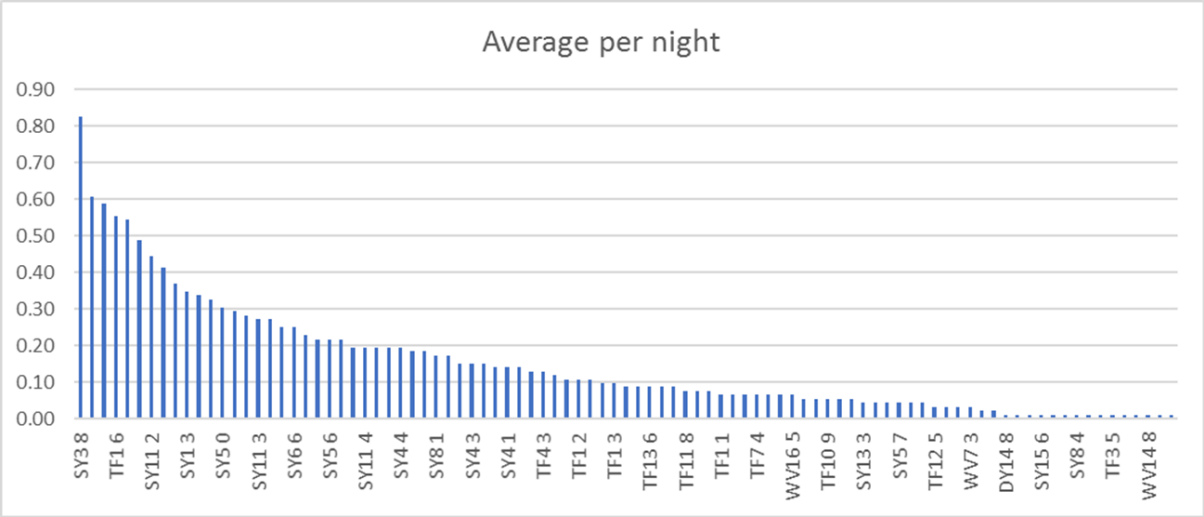


Figure vii

The predominant patient conveyances to RSH are from the following areas: -

Postcode Sector Group	Average per night	Postcode Sector Group	Area
SY3 8	0.83	SY3 8	Bicton
SY2 5	0.61	SY2 5	East Shrewsbury
SY1 4	0.59	SY1 4	Shrewsbury Town centre/North Shrewsbury
TF1 6	0.55	TF1 6	Wellington, Telford
SY1 2	0.54	SY1 2	Shrewsbury Town centre/North Shrewsbury
SY13 1	0.49	SY13 1	Whitchurch
SY11 2	0.45	SY11 2	Oswestry
SY1 1	0.41	SY1 1	Roushill

Figure ix

Patients with a Welsh GP attending ED

Ambulance arrivals via welsh ambulance service

PRH	Child		Adult			
	Attendances per annum	Admissions per annum	Attendances per annum	Attendances Per week**	Admissions per annum	Admissions per week**
Expected own transport arrivals (21.00-08.00)	40	12	127	0.3	33	0.6
Expected ambulance arrival (20.00-08.00)	47	31	111	0.3	71	1.4

RSH	Child		Adult			
	Attendances per annum	Admissions per annum	Attendances per annum	Attendances Per week**	Admissions per annum	Admissions per week**
Expected own transport arrivals (21.00-08.00)	249	16	1030	3	118	2.3
Expected ambulance arrival (20.00-08.00)	25	2	931	2.5	522	10

**Numbers are small and so calculated a per week demand rather than per night demand

The Shrewsbury and Telford Hospital NHS Trust

Appendix 4

Activity within the Emergency Departments at Night

Princess Royal Hospital (PRH)

The Emergency Department at Princess Royal sees approximately 60,000 attendances per year, with 19,000 being between 20:00-08:00; averaging 175 attendances throughout a 24-hour period, *(based on 17/18 data)*

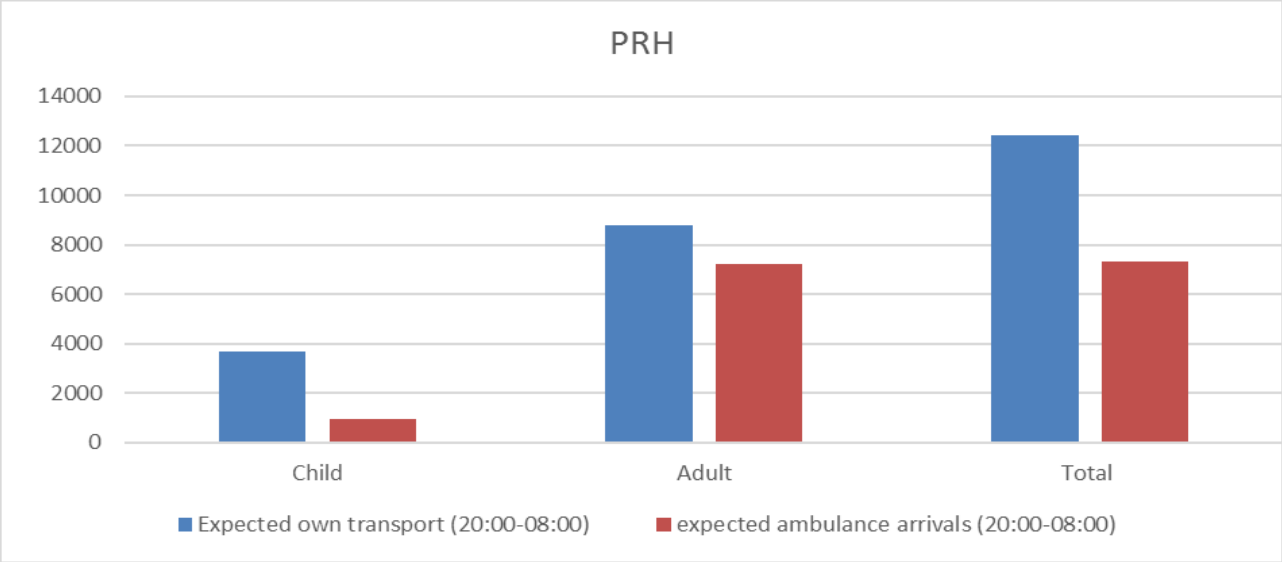


Figure 10

In 2017/18, there were 12,000 patients that self-presented at the Emergency Department at PRH between 20:00-08:00. Of these attendances 4,500 attendances were children. There were 7,200 patients that arrived by ambulance between 20:00 – 08:00.

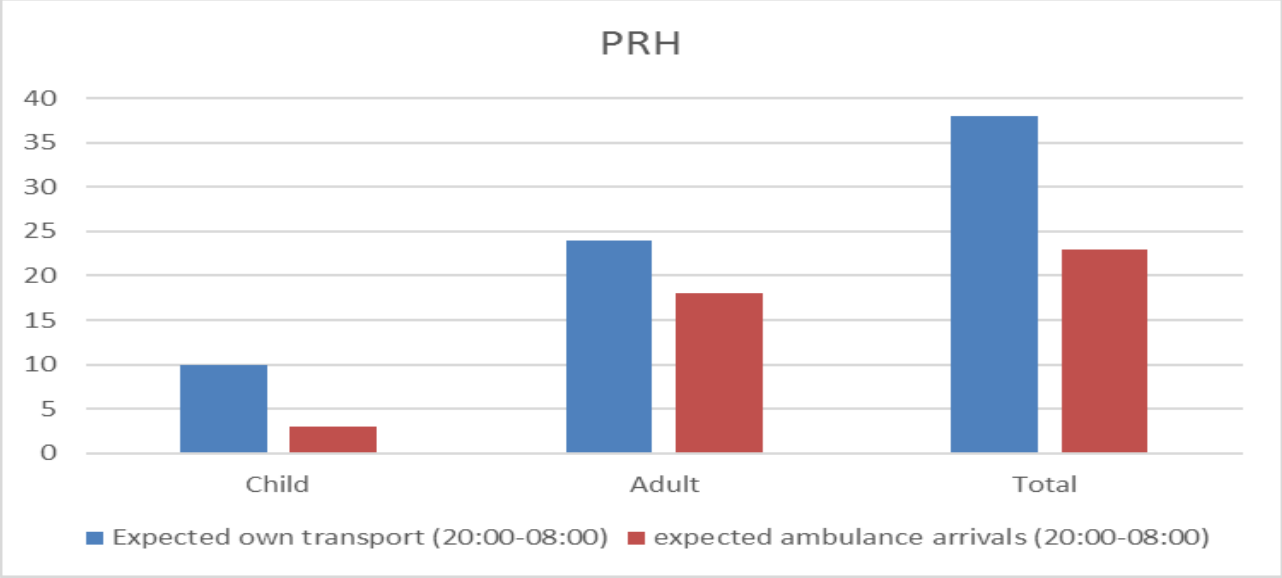


Figure 11

On average 13 children per night attend PRH ED – 10 are brought to hospital by their carers and 3 are conveyed by ambulance.
On average 41 adults per night attend PRH ED – 24 self-present and 17 are brought by ambulance.
Patients within Shropshire & Telford who have experienced a suspected Stroke will be conveyed immediately to PRH where the HASU is based.

Royal Shrewsbury Hospital (RSH)

The Emergency Department at Royal Shrewsbury Hospital sees approximately 47,000 attendances per year, averaging 150 throughout a 24 hour period.*(based on 17/18 data)*

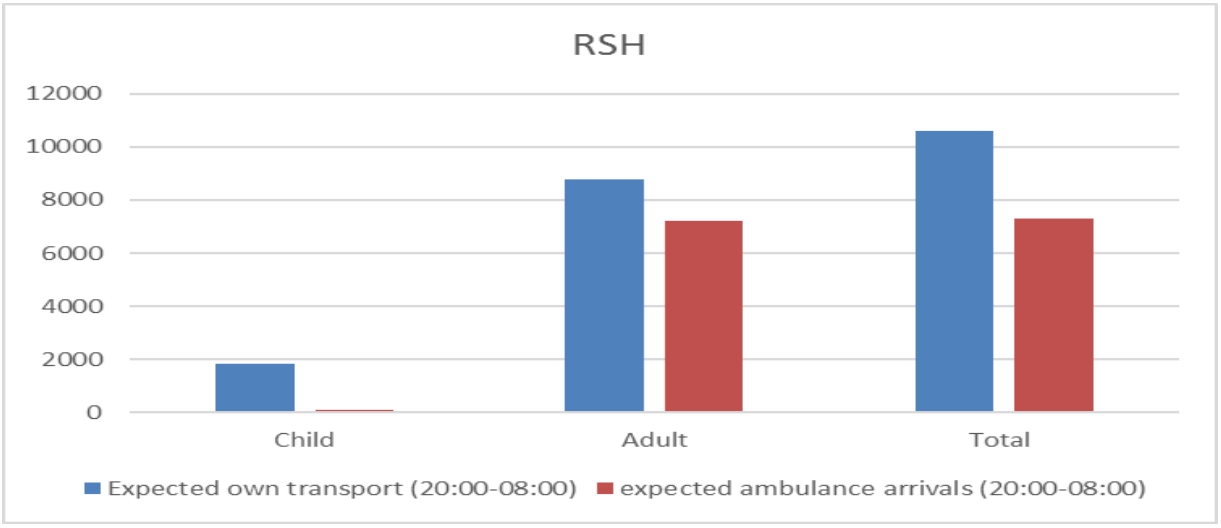


Figure 12

In 2017/18, there were over 10,000 patients that self-presented at the emergency department at RSH between 21:00-08:00 and there were over 7,000 patients that arrived by ambulance between 20:00 – 08:00. Of these attendances, 1,800 attendances were children.

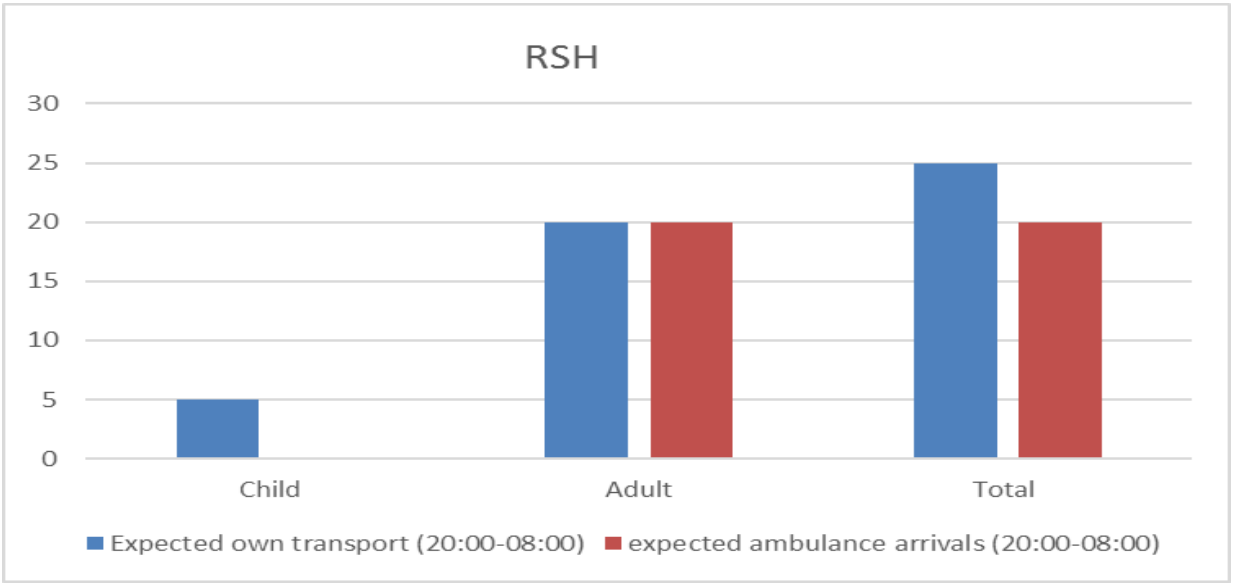


Figure 13

On average 5 children per night attend RSH ED – most children are brought to hospital by their carers as the ambulance pathway for children is to directly convey to PRH.
On average 40 adults per night attend RSH ED – 20 self-present and 20 are brought by ambulance.
Patients within Shropshire & Telford who have experienced significant trauma or require a surgical specialty opinion will be conveyed directly to RSH where the surgical team and SAU are based.

Speciality Admissions following attendance at an Emergency Department

Figure 16 below show the admission rates (on average) following attendance at each site through the night (20:00-08:00)

	Medicine	Surgery	Paediatrics	Gynaecology	H&N	TAO	Stroke	Total
PRH	6.5		2	1	0.3	0.8	1	11.5
RSH	8	3.5				1		12.5

Figure 14

N.B Surgical patients that attend at PRH are transferred to RSH for admission on to the Surgical Assessment Unit. Gynaecology patients that attend at RSH will be admitted to the SAU, or will be transferred across to PRH, Children who attend at RSH will be transferred to the PRH Paediatric unit if admission is required.

Appendix 5

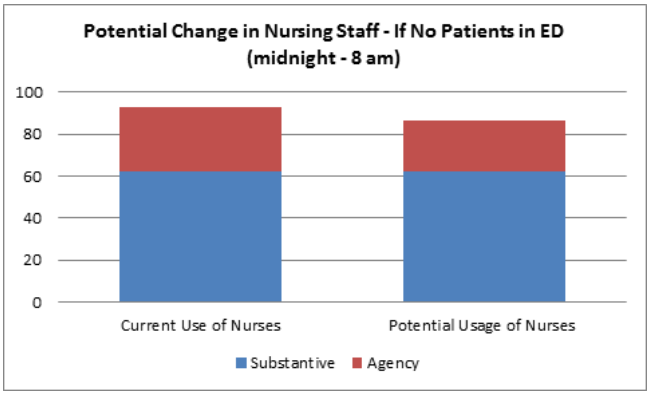
Options analysis

Option 1: Maintain the Status Quo

Analysis:

This option continues the same level of service as currently provided. It would require the current workforce to continue to work additional shifts, with consultants "acting down" and some shifts through the day being left unfilled to ensure that night shifts can be filled.

The level of fragility in maintaining two Emergency Departments has reached a critical point. The service has a heavy reliance on agency and locum staff (figure 22), to maintain delivery, this method of staffing can often lead to substantive staff working additional hours, extra shifts and working down. This goodwill cannot continue and is not an effective manner to deliver such a critical service. Through a change in operating hours the risk associated with staffing would be reduced; it also provides greater assurance regarding the ability to fill shifts, as illustrated below. This means that patient experience could be improved and higher levels of assurance in terms of safety.



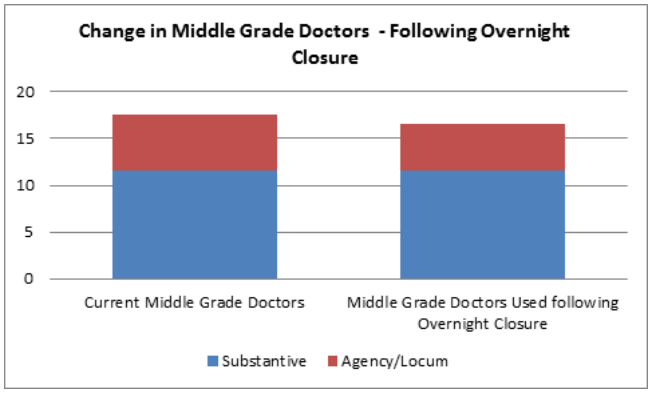


Figure 18

Impact analysis

A review of safety indicators in the Emergency Departments at PRH and RSH has been completed on a monthly basis and reviewed at the ED Clinical Summit.

Impact on Patients & carers

- Patients wait a long time in the department, waiting to be seen and treated which impacts significantly on the quality of care received, on their health and wellbeing in the department and on the experience that patients and carers have in the department.

- Patients have access to specialty medical and nursing staff once they have been referred from ED - this is usually on the same site, as the previous reconfigurations have ensured that patient pathways are smooth and accessible and that ambulance staff are aware of where to take patients with different specialty requirements.

- There is no confusion for patients and the community who require access to emergency medicine.

Impact on Staff

- Staff well-being is impacted due to the additional hours they are working and the number of agency/locum staff they work with on different shifts, limiting the opportunity to develop a close and functional team

- Staff within the Emergency Department have been living with a high level of uncertainty for a significant amount of time

- Increasing staff resignations and an inability to recruit have resulted in the service becoming unsustainable

Impact on SaTH

- Inability to improve the 4-hour ED target and the added pressure associated with the additional scrutiny this brings

Resource Implications

- Impact on the financial position of the Trust due to the increased agency/locum requirement within ED to maintain 2 EDs overnight

- There will be times, as happens now, that there is no APLS trained doctor in ED and, as a result, there will be a requirement to request support from other specialties, specifically Paediatrics, to provide a senior doctor on site overnight.

Impact on system

- No additional impact on Social care colleagues in assessing and supporting discharge for patients

Impact on neighbouring Trusts

- There is no anticipated additional impact on neighbouring Trusts in needing to accept additional demand

Impact on Ambulance service

- The Ambulance service will not have additional journeys to make, although there may be longer waits for handover in the department

Contingency Plan

To reduce the risks associated with this option, additional medical and nursing staff are required to be available within our EDs overnight. As previously described, the organisation has been actively undertaking recruitment activities for the last 5 years, without achieving the desired impact. Additionally, neighbouring Trusts have been approached, both by SaTH and by NHSI, and no Trust is willing, or able, to offer resource support.

Risks identified

The risk is considered high due to the inability to maintain the status quo.

- Continue to request our own staff to undertake additional shifts, thus maintaining a fragile and unsustainable ED that could at any point be unable to offer a full service across both sites.

- Likely that during any given evening there is a strong likelihood that the Trust will be required to implement an emergency business continuity option of closing one ED overnight in a potentially uncontrolled way.

This mitigation, therefore, does not reduce the risks associated with this option, and potentially could increase the risk significantly.

Option 2: Close PRH ED overnight

Analysis:

This option will mean that:

- PRH ED closes to both ambulance conveyances and to self-presenting patients at 20:00.
- The Urgent Care Centre will close at 20:00
- GP direct referrals will continue to be accepted to the Acute Medical Unit as current pathway.
- GP direct referrals to the Child Assessment Unit will be accepted as current pathway.
- Maternity admissions to the labour ward will continue as current pathway.
- Paediatric patients that would be conveyed by ambulance to PRH will be diverted to neighbouring organisations – in this case, the Royal Wolverhampton NHS Trust.
- Additional pathways will be developed to support direct access for certain conditions e.g. Stroke patients that have been identified as FAST positive will be conveyed by ambulance to PRH AMU through a new pathway.
- The general public will be advised that if they need to attend the Emergency Department as a walk-in/self-presenting patient they will need to attend the New Cross Hospital, RSH or Wrexham Maelor Hospital during the hours of 20:00-08:00.
- All ambulances will be diverted to the Emergency Departments in neighbouring organisations, in this case the Royal Wolverhampton NHS Trust.
- Additional ambulances will be provided to ensure ambulances are available on the patch if emergency ambulances are conveying patients out of the area to neighbouring organisations
- Patients who are in the department, and still require the support of the Emergency Department when the “doors close”, will continue to be cared for by the nursing team in ED, until they move to a bed or are discharged. Nursing staff will be provided for in in the department overnight whenever patients are in the department.

Patients requiring the following services will be most impacted by this option:

- ED
- Paediatrics
- Gynaecology
- ENT
- Maxillo-Facial services

Impact analysis

If PRH was to close overnight the highest risk is associated with the management of the critically ill child at the RSH site. Therefore the paediatricians and ED clinical leads have worked together with the Medical Director to agree a pathway that mitigates this risk.

The pathway proposed for an injured or critically ill child presenting at Royal Shrewsbury Hospital will be, for the “Out of Hours” period

i. Assessment by middle tier Emergency Department doctor with paediatric resuscitation competency (PALS or equivalent)

ii. Support, as required, by the on-site resuscitation team including the senior resident Anaesthetist / Intensivist
iii. Consultant Paediatrician on call with requirement to be present on scene in no more than 30 minutes.

In the rare (but potentially possible) circumstance that a critically ill child is brought to the Princes Royal Hospital site, despite there being no emergency department Out of Hours, care will be provided by

i. The senior resident on call for Paediatrics
ii. The resuscitation team including the senior resident Anaesthetist / Intensivist
iii. Consultant Paediatrician on call with requirement to be present on scene in no more than 30 minutes

During the day (0800-2000) the existing level of cover will be maintained, namely:

i. At PRH full Emergency Department care with Consultant presence and full Paediatric care via the Paediatrics team at the dominant site
ii. At RSH full Emergency Department care with Consultant presence and on call support by designated Consultant Paediatrician

Impact on Patients & Carers

- Patients requiring urgent assessment and intervention between the hours of 20:00 – 08:00 in the Telford and surrounding area, who previously would have self-presented at PRH ED, will need to attend alternative premises for their care. This could be either at RSH (19 miles from PRH), Wrexham Maelor Hospital (39 miles from PRH), New Cross Hospital (24 miles from PRH)

- Patients who call an ambulance between 20:00-08:00 will be conveyed to their next nearest hospital in England (New Cross Hospital or Royal Stoke University Hospital)

- The main affected group of patients in this option will be children as the current Women's and Children's centre is based at PRH, and frail elderly patients who are more likely to call an ambulance during the night

- There will be further to travel for carers/relatives of patients who stay in hospital

- Patients are likely to be seen more quickly at a neighbouring hospital due to the level of staff that are available within neighbouring Emergency Departments

- Patients who are admitted may have a longer length of stay due to access to social care and discharge pathways that will need to be developed with the Royal Wolverhampton Trust.

- WMAS have paramedics on board every ambulance and are confident that longer ambulance journeys will not compromise patient safety or patient outcomes.

Impact on Staff

- The Emergency Department staff will be able to staff RSH ED adequately overnight to meet the demand expected.

- There will be an increase in workload for colleagues in Paediatrics who will be required to provide additional support in RSH overnight.

- Staff in specialties based at PRH are anxious about the quality of service patients would receive when a patient is diverted away from PRH

Impact on SaTH

- There is a risk of partial loss of service to alternative Trusts e.g. as a result of patients being admitted overnight requiring cardiology interventions – it is likely these patients would receive this work at the admitting organisation.

- There could be insufficient bed base to move patients from ED thus impacting on patient flow, 4 hour ED target and poor patient experience

- There will be a loss of income for SaTH as a result of a reduction in ED attendances overnight

- There will be a requirement for more inter-site transfers which will require additional private ambulance cover overnight

- There may be a reduction in day case head and neck cases and conversion to more in-patient cases due to the risk of post-operative complications and patients having no access to the emergency department at PRH.

Resource Implications

- There may be an increase in cross-site transfers of patient overnight which will require additional ambulance support

- There will be a need for WMAS to provide additional ambulances to mitigate the impact of ambulances travelling further to take patients to neighbouring Trusts

Impact on system

- There will be impact on social care pathways for patients requiring additional support on discharge from neighbouring Trusts

- There will be an increase in activity at neighbouring Trusts, and as such, Commissioners will be paying for more services from these bodies

- There will be a challenge in relation to the payment mechanisms in relation to patients that are repatriated back to SaTH from neighbouring Trusts

- There will be impact on mental health services in managing patients that are conveyed by ambulance to neighbouring Trusts

Impact on neighbouring Trusts

- Increased activity in ED, will be experienced, predominantly by New Cross Hospital.

- Increase in admissions within neighbouring organisations, predominantly to Paediatrics and the Acute Medical Unit.

Impact on Ambulance service

- Increased travel conveyance for patient overnight

- Potential increased handover time due to the volume of ambulances being received at neighbouring hospitals

- Increased transfer of repatriated patient back to SaTH from neighbours

- Welsh Ambulance Service are reviewing their journey times and how they could manage the impact on patients and on the local population in Powys.

Contingency Plan

The impact on patients, ambulance and other organisations could be mitigated with a number of direct access pathways that have been explored. These include Stroke (potentially 5 ambulance

attendances per night) and cardiology (potentially 3 ambulances per night). If direct pathways were created then this reduces patient journeys to Royal Wolverhampton Hospitals. This could create a reduction of 8 ambulance journeys night going out of county, potentially reducing length of stay for these patients, by having easier access to relevant social services and discharge planning and income loss for the organisation.

The Royal Wolverhampton NHS Trust (of which New Cross Hospital is part) has included a PRH closure into their winter modelling and have confirmed that they could absorb the expected activity that could be diverted to them. However they have indicated that this would be much improved and more supported if an agreed robust repatriation process can be developed.

The ambulance service has advised that, as long as there was additional investment to provide additional ambulances into the patch to ensure that the area had adequate ambulance coverage whilst ambulances were conveying patients to New Cross Hospital, they feel comfortable that patient safety would not be compromised.

An additional transport ambulance may be required between sites to support inter-site transfers

Paediatric services have advised that they will support training and onsite support into ED at RSH during the day to build skills, confidence and competence for the ED team to manage the initial minutes should a critically ill child attend ED as a walk in patient.

ENT services will review their day case protocols to determine which day case patients would need to be converted to in-patient cases in order to provide a safe post-operative service to their patients.

Emergency Department would require an additional Registered Nurse (RN) and 1 additional HCA in the ED at RSH to manage the additional demand.

If direct pathways are created, AMU at PRH would require one additional RN to support the Stroke and Cardiology direct admissions. This may eventually come from the ED staff but in the first instance there is a request to have one additional band 5 nurse overnight added to the rota.

Risks identified

The risk is considered more manageable through the temporary overnight closure of the PRH site as;

- Patients who call an ambulance between 20:00-08:00 will be conveyed to the New Cross Hospital or Royal Stoke University Hospital, New Cross has already modelled the impact and has provided assurances that the demand can be managed both now and during the expected winter pressures.

- There is a risk of partial loss of service to alternative Trusts, e.g. as a result of patients being admitted overnight requiring cardiology interventions that will be undertaken elsewhere, and Orthopaedic patients who will require emergency surgery and rehabilitation at the hospital of admission.

- Paediatric risks will be minimised by the diverting ambulances to nearby Trusts. There will be a risk as there is now of a critically ill child walking being brought to PRH or RSH overnight where there will be more limited access to specialist paediatric input immediately. This is mitigated by the revised emergency pathway that will be implemented.

- There could be insufficient bed base to move patients from ED thus impacting on patient flow, 4-hour ED target and poor patient experience.

Option 3: Close RSH ED overnight

Analysis:

This option will mean that;

- RSH ED closes to both ambulance conveyances and to self-presenting patients at 20:00 .
- The Urgent Care Centre will close at 20:00
- GP direct referrals will continue to be accepted to the Acute Medical Unit as currently is the pathway.
- The general public will be advised that if they need to attend the emergency department that they will need to attend PRH, Wrexham Maelor or New Cross Hospital during the hours of 20:00-08:00
- All ambulances will be diverted to the Emergency Departments in neighbouring organisations.
- Additional ambulances will be provided to ensure ambulances are available on the area if emergency ambulances are conveying patients out of the area to neighbouring organisations
- Patients who are in the department, and still require the support of the Emergency department when the “doors close”, will continue to be cared for by the nursing team in ED, until they move to a bed or are discharged. Nursing staff will be provided for the department overnight if patients are still in the department.

Patients requiring the following services will be most impacted by this option:

- Emergency Department
- General surgery
- Vascular surgery
- Urology
- Trauma and Orthopaedics
- Radiology

Impact analysis

If RSH was to close overnight then consideration would be required on the provision of emergency surgery overnight on the PRH site, with a number of surgical services (urology, general surgery, vascular) needing to be re-provided on the PRH site. This would impact on theatre capacity and bed base at PRH. These surgical specialties moved to a single site model in 2012 due to the workforce issues they were experiencing at the time. There would be a shift in risk from ED to surgical specialties with a closure of RSH. In addition, there is a risk associated with accessing appropriate radiology as PRH only has one CT scanner , which is 8 years old, and its unreliability and impact on services at periods of down time has justified it being the highest capital risk in the Trust (20). There would be significant risk in running our entire ED service overnight relying on this one scanner.

RSH is currently the designated Trauma Unit and as a requirement acute Surgical & Vascular services needs to be co-located with an ED and with appropriate access to SAU, surgical theatres and ITU/HDU accommodation. If RSH is closed liaison with the Trauma network will be necessary and a downgrade to DGH will be likely. This would mean there would be no Trauma Unit in the local area unless all required services were centralised at PRH and a new application was successful.

Impact on Patients & carers

- Patients requiring urgent assessment and intervention between the hours of 20:00 – 08:00 in the Shrewsbury and surrounding area, who previously would have self-presented at RSH ED, will need to attend alternative premises for their care. This could be either at PRH (19 miles from PRH), Wrexham Maelor Hospital (30 miles from PRH), Royal Stoke Hospital (41 miles from RSH), New Cross Hospital (37 miles from RSH)

- Patients who call an ambulance between 20:00-08:00 will be conveyed to their next nearest hospital in England (New Cross Hospital or Royal Stoke University Hospital).

- The main affected group of patients in this option will be patients who have an acute surgical condition.

- People from Powys and the Welsh Borders and the south of county would have much further to travel to receive emergency care and/or visit relatives.

- There will be further to travel for visitors of patients who stay in hospital

- Patients are likely to be seen more quickly at a neighbouring hospital due to the level of staff that are available within neighbouring Emergency Departments.

- Patients who are admitted and require a longer length of stay will be repatriated back to SaTH within 72 hours of their in-patient stay. This could impact on a slightly longer length of stay for these patients.

- WMAS and WAS have a Paramedic on board every ambulance. WMAS have stated that they are confident that longer ambulance journeys will not compromise patient safety or patient outcomes.

- Public transport to PRH and Telford is more difficult to access from outlying areas and therefore would potentially impact more on people in rural communities who do not drive or have access to a car (it takes 3 hours to get to PRH from Whitchurch by public transport).

Impact on Staff

- The Emergency Department staff will be able to staff PRH ED adequately overnight to meet the demand expected

- Staff in specialties based at PRH are anxious about the quality of service patients would receive when a patient is diverted away from PRH

Impact on SaTH

- There would be more ambulance diverts away from SaTH if RSH was the ED to close overnight.

- The organisation would need to revoke the Trauma Unit status with the Trauma network.

- There would be less ED activity and potentially emergency surgical activity therefore impacting in reduction in a loss of service to neighbouring Trusts.

- There will be insufficient bed base at PRH to move patients from ED thus impacting on patient flow, 4-hour ED target and poor patient experience

- There will be a requirement for more inter-site transfers which will require additional private ambulance cover overnight

- Access for Welsh patients has been considered as part of the appraisal process and it is felt that a closure of RSH will impact Welsh patients more

- The CT scanner at PRH is reaching the end of its valid lifespan and, as such, is at risk of unplanned maintenance requirements. By closing RSH ED overnight this transfers all emergency CT activity overnight to this one unit. Breakdown of this unit could further compromise patient safety and also delay diagnosis for patients who require a scan.

Resource Implications

- Emergency Department would require 1 additional RN and 1 additional HCA in the ED on each shift at PRH to manage the additional demand.

- An additional transport ambulance will be required between sites to support inter-site transfers as PRH bed capacity has no flexibility in increasing bed base to manage additional Emergency admissions.

- There will be a need for WMAS to provide additional ambulances to mitigate the impact of ambulances travelling further to take patients to neighbouring Trusts.

Impact on system

- There will be impact on ShropComm pathways for patients that require a community hospital bed on discharge from neighbouring Trusts.

- There will be impact on social care pathways for patients requiring additional support on discharge from neighbouring Trusts.

- There will be an increase in activity at neighbouring Trusts and Commissioners will be paying for more services from these bodies.

- There will be a challenge in relation to the payment mechanisms in relation to patients that are repatriated back to SaTH from neighbouring Trusts.

- There will be impact on mental health services in managing patients that are conveyed by ambulance to neighbouring Trusts.

Impact on neighbouring Trusts

- New Cross Hospital has modelled the activity expected with a PRH ED overnight closure and are accepting that they can manage this level of demand. However, UHNM and Wrexham that are likely to receive more patients with a RSH closure are less confident that they can manage additional demand in their organisations. The additional ambulance diverts that have been modelled would put additional pressure on them and potentially impact negatively on patient safety and their performance

- Increase in admissions within neighbouring organisations, predominantly, to Trauma and Surgical patients, with the corresponding impact on emergency theatre capacity, ITU capacity and Surgical Assessment Unit capacity required for these patients.

Impact on Ambulance service

- Whilst Wrexham may be a nearer hospital to divert patient to from RSH, the handover time at Wrexham Maelor is consistently and significantly longer than other hospitals and therefore WMAS is reluctant to convey diverted patients to Wrexham as an alternative.

- Potential increased handover time due to the volume of ambulances being received at neighbouring hospitals.

- Increased transfer of repatriated patient back to SaTH from neighbours.

Contingency Plan

The ambulance service has advised that, as long as there would be additional investment to provide additional ambulances into the area to ensure adequate ambulance coverage whilst ambulances were conveying patients to neighbours they feel comfortable that patient safety would not be compromised as they have a Paramedic on every ambulance.

Risks identified

The risk is considered less manageable than the temporary closure of the PRH site as:

- There is little contingency to support the greater impact that closing RSH would have on our neighbours than on the PRH closure as they are less supportive of this option.
- Patients who call an ambulance between 20:00-08:00 will be conveyed to non-supportive local Trusts, as no agreement or modelling of the modelled the impact has taken place for both now and during the expected the winter pressures.
- There could be insufficient bed base to move patients from ED thus impacting on patient flow, 4-hour ED target and poor patient experience.
- An additional transport ambulance may be required between sites to support inter-site transfers.
- If the PRH CT scan did break down then there would be a requirement to receive patients at PRH ED and then do an inter-site transfer for CT diagnostics. This would increase travel time for patients and potentially put patients at risk during their transfer to and from RSH.

The preferred options for each service, along with rational can be found

Service	Option 1 Maintain Status Quo	Option 2 PRH Overnight Closure	Option 3 RSH Overnight Closure	Rationale
ED		X		More room with RSH ED to expand to manage increased demand overnight.
Acute Medicine	X	X		More opportunity to increase bed capacity at RSH to manage additional demand overnight.
Cardiology	X		X	Concern with impact for patients on the interventional cardiology especially in relation to interventional cardiology. A new direct pathway can be created.
Stroke	X		X	Direct access pathway requires development if no PRH ED available overnight.
Theatres	X	X		Concern with regard to level of skill to perform emergency paediatric surgery at RSH if PRH closes. However, equal level of concern for PRH staff to perform emergency surgical procedures due to the theatre staff having sub-specialised in recent years. If paediatrics can be diverted, then PRH closure is preferred as there are more acute surgical procedures undertaken at night at RSH that could not be performed without significant staff and equipment changes at PRH.
Critical Care	X			Concern in relation to the capacity of ITU at both sites to manage additional demand. Will require transfer teams during the day to ensure enough capacity available in ITU overnight for the open ED.
Paediatrics	X		X	Concern for critically ill and injured child pathway if no immediate access to emergency paediatric skills at RSH if PRH closes overnight.

Gynaecology	X		X	Patient attending at RSH will require transfer to PRH for access to Gynaecology specialist access.
Obstetrics	X		X	Patient attending at RSH will require transfer to PRH for access to Obstetrics specialist access.
Head & Neck	X		X	Concerns of access to right level of specialist input for critically ill patient with compromised airway if PRH closes overnight. Also concern for elective day case pathway due to risk of bleed post-operatively.
General Surgery	X	X		Concern with providing emergency surgical intervention overnight at PRH and access to SAU if RSH closes. Trauma site access at RSH will be compromised if RSH is closed overnight.
Urology	X	X		Concern with providing emergency surgical intervention overnight at PRH if RSH closes.
Trauma & Orthopaedics	X		X	Trauma site access at RSH will be compromised if RSH is closed overnight. However there is a concern related to the management of the paediatric orthopaedic patients at RSH if PRH ED is closed overnight. There is also significant concern about diverting patients with #NOF should either ED close overnight.
Vascular Surgery	X	X		Concern with regard to providing emergency surgical intervention at PRH if RSH closes due to the lack of equipment, accommodation, radiology kit and skills available.
Radiology	X	X		Concern with the fragility of the single CT scanner at PRH. If the CT's not functioning at PRH and RSH is closed there will be no ability within the organisation to provide emergency scanning.
Total	14	8	7	

Figure 19

Option 1: Maintain a full A&E service 24/7 at both PRH and RSH (Status Quo)

	Risks	Risk RAG	Mitigating Actions
1	Not able to safely fill the middle tier rota due to a national recruitment shortage	**5 x 4 = 20**	• Continual active recruitment for all posts • Meeting with the deanery to discuss reallocation of training posts • Implemented local recovery plans • Permanently have vacancies out for locums • Developed a Trust wide vacancy management strategy • Role substitution through nurse clinicians, physicians associates and emergency nurse practitioners • International recruitment opportunities • Skype interviews undertaken to support international recruitment • Offered trust contracts and contracts for service • Advertised on Doctors.net • Consultant tier doctors acting down to
2	Unable to deliver training requirements to medical workforce as stipulated by HEE	**4 x 5 = 20**	
3	Potential for substantive staff to become ill due to pressure	**4 x 5 = 20**	
4	Potential further reductions in workforce due to increased demands	**4 x 5 = 20**	
5	Significant risk to patient safety which may result in harm due to insufficient medical cover for service provision and long waits in the department	**5 x 4 = 20**	Continue to attempt to secure workforce as above. Provide regular monitoring to ensure basic observations and individual nursing and care needs are undertaken whilst waiting in the department
6	Short/medium term implications of workforce acting down or training diversion to sustain current model has now reached a point where the workforce are unable to continue offering this as a mitigation	**5 x 5 = 25**	Risk assessment required on a daily basis.

7	Sustainable model not deliverable	**5 x 5 = 25**	Risk assessment required on a daily basis.
	TOTAL SCORE	**150**	

Figure 20

Option 2

Reduce the opening hours of the Emergency Department at Princess Royal Hospital as follows:

- Open: 08:00 – 20:00 Closed: 20:00 – 08:00.
- Retain full 24/7 ED at The Royal Shrewsbury Hospital.
- Divert ambulances that would have gone to PRH to neighbouring Trusts.

	Risks	Risk RAG	Mitigating Actions
1	Change in service for the local population	**5x3=15**	a) Analysis shows that for, approximately 13,000 patients per annum currently arriving in the ED between 8pm and 8am would not have access to Emergency Care at PRH and would need to access care in an alternative ED. b) 8,395 of these will be conveyed by ambulance to an alternative ED provider at a neighboring Trust. (New Cross, Stoke, Wrexham) c) 60% patients who self-attend would make their way to an alternative ED (RSH, New Cross, Wrexham, Stoke) d) evidence suggests that 40% of self-presenting patients will not make a trip to an alternate ED.
2	Impact on ambulance service	**3x5 =15**	WMAS and Welsh Ambulance service would make further journeys to neighbouring ED's. WMAS have advised that longer conveyance times does not necessarily equate to increased patient safety risks due to them having qualified paramedics on each ambulance. The Welsh ambulance service are more concerned about the increased conveyance times due to the rurality of the county and the already long conveyance times experienced by patients. There has been dialogue with both ambulance services and both understand the impact that the closure will have. Additional ambulances will be required to maintain the level of performance and access to paramedic ambulance crews in the local area whilst the crews are conveying patients to neighbouring Trusts.
3	Impact on other acute providers	**4x3=12**	Other acute providers have been contacted and are aware of the impact of additional ED activity and potential admissions into their Trust. Royal Wolverhampton Trust have already modelled the impact and have made some provision in their winter plan for such an event happening. However they have highlighted that a repatriation process will be required in order for them to manage the level of activity that has been modelled.

4	Impact on community, primary & social care providers	**4x3=12**	Social Care will not have the capacity to support all patients remaining at Royal Wolverhampton Trust for the duration of their stay as this will require additional social work input on a new hospital site.
5	Impact on activity & workload at Royal Shrewsbury Hospital and potential patient safety risk due to increased attendances and admissions	**4x3 =12**	Ambulance patients would not be seen at RSH ED. These patients will have to travel further to another ED in a neighbouring Trust. 60% of the self-presenting patients would be expected to attend either RSH or an alternative ED. The staffing model developed could absorb this level of activity. There will be a requirement to transport patients between sites in order to facilitate the patient being seen rapidly the following morning by the most appropriate senior decision maker. The main group that will require transfer if PRH close will be children who self-present if they require admission (approx. 1 per night)
6	Impact on estate at RSH	**3x3=9**	There is more opportunity to flex accommodation at RSH than at PRH. Whilst there will be a requirement to review the ED estate and determine how this can be expanded, there are more opportunities for this to happen at RSH than at PRH.
7	Impact on radiology	**2x3=6**	There is adequate radiology support at RSH to manage the radiology requirements through the night.
6	There may be people attending ED at PRH that are not aware that it is closed	**4 x 4 = 16**	A clear escalation response will need to be developed to support a person in crisis who turns up at a closed site. Clear communications with all stakeholders will be critical regarding service provision on offer at PRH site to mitigate inappropriate attendances. Public engagement
7	Availability of workforce to deliver this service	**3x3=9**	The medical workforce situation should improve by relocating medical workforce that would have been working in the PRH ED, over to the RSH at a point when patients have either left ED or have a clear plan for leaving ED (discharge or admission) The nursing workforce initially will need to remain as current to ensure adequate safety and support for patients that are in ED awaiting a bed, being monitored before discharge or awaiting transport home.
8	Specific service impact - The Paediatric service is currently located at PRH and there is currently only an off-site on-call Paediatric response at RSH overnight.	**5x4 =20**	With additional children expected at RSH there is a requirement to have an on-site presence of Paediatric trained APLS competent medics. A revised Paediatric pathway will be agreed to mitigate these risks. Pediatricians have been engaged in this work should option 2 be approved by the Board.
	TOTAL RISK SCORE	**126**	

Figure 21

OPTION 3

Reduce the opening hours of the Emergency Department at Royal Shrewsbury as follows:

- Open: 08:00 – 20:00 Closed: 20:00 – 08:00.
- Retain full 24/7 ED at The Princess Royal Hospital

	Risks	Risk RAG	Mitigating Actions
1	Change in service for the local	**5x3=15**	Analysis shows that approximately 7,300 patients per annum currently arriving in the ED between 8pm and 8am by ambulance and would have to be taken to an alternative ED in neighbouring Trusts.
2	Impact on ambulance service	**5x3=15**	WMAS and Welsh Ambulance service would make further journeys to neighbouring ED's. WMAS are unwilling to convey to Wrexham due to the increased handover delays that are experienced at this hospital. Therefore, alternative ED's would be New Cross or Royal Stoke. WMAS have advised that longer conveyance times does not necessarily equate to increased patient safety risks due to them having qualified paramedics on each
3	Impact on other local acute providers	**4x4=16**	Other acute providers have been contacted and are aware of the impact of additional ED activity and potential admissions into their Trust. Wrexham as the nearest ED would be concerned about the additional demand attending their ED and have no additional provision available.
4	Impact on community, primary & social care providers	**4x4 =16**	Patients that require a length of stay of more than 72 hours will be repatriated back to SaTH to enable their discharge planning to be carried out in the local area. This will minimize the impact of complex discharge planning for ShropComm and social care providers.
5	Impact on activity & workload on the PRH hospital site and potential patient safety risk due to increased attendances and admissions	4 x 3 = 12	The PRH site has less opportunity to expand a bed base or flex capacity to manage increased demand. The workforce at RSH are not skilled in acute surgical or acute trauma responses and as such patients would have to be conveyed by ambulance from PRH to RSH if surgical input is required.
6	There may be people attending ED at RSH that are not aware that it is closed	4 x 3 = 12	A clear escalation response will need to be developed to support a person in crisis who turns up at a closed site.
6	Impact on estate at PRH	**5x4=20**	There is more opportunity to flex accommodation at RSH than at PRH. Whilst there will be a requirement to review the ED estate and determine how this can be expanded, there are more opportunities for this to happen at RSH than at PRH. There is no SAU at PRH and no opportunity to create an SAU within the current accommodation.
7	Impact on radiology	**5x4=20**	There is not adequate radiology at PRH to support a single Trust ED at night. There is one MRI and one CT – the CT scanner is due for procurement as it is reaching the end of it useful life.

7	Availability of workforce to deliver this service	**3x3=9**	The medical workforce situation should improve by relocating medical workforce that would have been working in the RSH ED, over to the PRH at a point when patients have either left ED or have a clear plan for leaving ED (discharge or admission) The nursing workforce initially may need to remain as current to ensure adequate safety and support for patients that are in ED awaiting a bed, being monitored before discharge or awaiting transport home. There will be no direct on-site access to surgical specialty's at PRH and therefore this could cause anxiety in the ED workforce that they haven't got the support that they need to manage the patient that are likely to attend.
8	Specific service impact - There is not the space, equipment or enough staff with specific skills to develop a surgical theatre or create a second SAU on the PRH site to be able to manage surgically compromised patients. RSH is the designated trauma unit for the area – if this is closed overnight then the organisation will lose trauma unit status	**5 x 4= 20**	Patients requiring emergency surgical intervention would require a blue light transfer across to RSH following attendance at PRH ED as there is no feasibility of creating a surgical unit at PRH due to the accommodation, workforce and equipment limitations. There is no flexibility in creating additional bed capacity to manage additional admissions at PRH and therefore patients are likely to be waiting longer in ED and require transfer across to RSH through the night.

Appendix 7

Risk analysis

A risk analysis has been undertaken, figure 20, with regard to the impact of an ED closure for services, if their non-preferred option was agreed, and the mitigation plan that would be enacted to reduce the risk identified.

Service	Option 2	Option 3	Risk Description should the non preferred option be agreed	Risk Score (if the preferred option is NOT approved (likelihood and impact)			Mitigation	Risk Score post mitigation (likelihood and impact)		
	PRH Overnight Closure	RSH Overnight Closure		L	I	Score		L	I	Score
ED	X		If RSH is closed, the PRH will be too small to accommodate additional patients. There is limited bed escalation capacity on site	5	4	20	The PRH close option is the most appropriate a there are potentially more options in terms of expanding into Head and Neck theatres on the PRH site.	2	2	4
Acute Medicine	X		If RSH is closed, the PRH will be too small to accommodate additional patients. There is limited bed escalation capacity on site	5	4	20	The PRH close option is the most appropriate a there is a new ward currently being developed and additional escalation capacity available	2	2	4
Cardiology		X	If PRH closes and ambulance patients are diverted, patients requiring cardiology interventions would need these at alternative hospitals following their admission.	3	3	9	If new pathways can be created to direct access into AMU the risk can be mitigated	2	3	6
Stroke		X	If PRH closes patients conveyed by ambulance will have to be taken to RSH or nearby Trusts. Walk in patients at RSH will have to be conveyed under blue light to PRH, significantly affecting the thrombolysis window for treatment	5	4	20	If new pathways can be created to direct access into AMU the risk can be mitigated	2	3	6
Theatres	X		If RSH closes Surgical kit and skills not available to manage emergency surgical cases. New kit aquision is not financially viable.	4	3	12	Maintain services at RSH and Blue light patients from PRH	3	3	9
Critical Care			ITU capacity is insufficient if ambulances are not diverted	4	5	20	Ambulance diverts to neighbouring Trusts reducing the demand on critical care	2	3	6

Paediatrics		X	If PRH closes there is no on-site Paediatric support at RSH overnight	5	4	20	Revised Paediatric Pathway	4	3	12
Gynaecology		X	If PRH closes, patients will have to be conveyed to RSH	3	3	9	Direct access pathway to be developed at PRH	2	2	4
Obstetrics		X	Patients rarely present at ED currently as most women are aware of the maternity pathway. There will be some women who don't know they are pregnant, or have a concealed pregnancy that could attend RSH – just as they do now.	2	3	6	No change to pathway required.	2	2	4
Head & Neck		X	If PRH closes critically ill patients with compromised airways will not have access to relevant specialist care. Higher conversion of day case to inpatients to mitigate post-operative bleed risk	5	4	20	Patients will be conveyed to neighbouring Trust via Paramedic emergency ambulance. A review of the risks associated with day case v in-patient procedures will be undertaken by the service and any more risky patient will be required to convert to in-patient	4	3	12
General Surgery & Urology	X		If RSH closes patients requiring admission will need to be conveyed via ambulance to SAU at RSH	4	4	16	Patients arriving by ambulance will be diverted out of area. Walk in patients will need to be conveyed via ambulance to SAU at RSH.	3	4	12
Trauma & Orthopaedics		X	If PRH closes there is concern that more paediatric orthopaedic cases will need to be seen at RSH.	5	3	15	Paediatric support will be provided as required at RSH. Transfers to PRH will be provided as happens now	3	3	9
Vascular Surgery	X		If RSH closes the trauma site status is not viable. If RSH closes the equipment, accommodation, skills and competencies are not available currently at PRH. The vascular service will be at risk if no overnight service can be provided.	5	4	20	Patients arriving by ambulance will be diverted out of area. Mitigation will be for patients who arrive at PRH and require SAU will need a further transfer across to RSH.	4	4	20
Radiology	X		If RSH closes, there will be significant reliance on a single, fragile CT scanner at PRH	4	5	20	New scanner is being procured currently, however not in place until mid 2019	4	5	20

Using this methodology overnight closure at RSH has the highest risk score reflecting a predicted higher risk to a number of acute and emergency pathways.

Site Closure	Total red rated based on risk score post mitigation
PRH	0
RSH	2

Financial Appraisal of Income & Expenditure In Relation to Impact of Emergency Department Overnight Closure

					PRH Overnight Closure				RSH Overnight Closure			
					Average Change per	Change per Annum	Income Change Per Annum		Average Change per	Change per Annum	Income Change Per Annum	
		Direct Changes in Activity and Income										
a		Reduction in Ambulance Attendances (Adults)	Attendances		(18)	(6,570)	(1,104)		(20)	(7,300)	(1,226)	
		RSH	Attendances									
		PRH	Attendances									
		Increase in AMU Direct Admissions (Adults)	Spells		5	1,825	1,501		0	0	0	
		Stroke direct pathway to AMU then to 1.5 to stroke; 1.5 mimics & 2 leave AMU										
		Cardiology - potentially 3.5										
		Reduction in Inpatient Spell following ED Attendance via Ambulance (Adults)	Spells		(9)	(3,285)	(4,668)		(10)	(3,650)	(5,187)	
		Reduction in Inpatient Spell following ED Attendance via Ambulance (Children)	Spells		(3)	(1,095)	(694)		0	0	0	
b		Reduction in Walkin Attendances (Adult)	Attendances		(24)	(8,760)	(1,104)		(20)	(7,300)	(920)	
		Increase at RSH	Attendances		14	5,256	662					
		Increase at PRH	Attendances						15	5,475	690	
		Reduction in Inpatient Spell following ED Attendance (Adults)	Spells		(3)	(1,095)	(901)		(3)	(1,095)	(901)	
		Increase in Inpatient Spell following ED Attendance (Adults)	Spells		1	365	300		1	365	300	
c		Change in ENT Pathway reduction in Tonsillectomy related activity	Spells		(0)	(50)	(34)		0	0	0	
		Summary Impact on Income										
		Change in attendances			(28)	(10,074)	(1,545)		(25)	(9,125)	(1,456)	
		Change in Spells			(9)	(3,335)	(4,496)		(12)	(4,380)	(5,787)	
		Total					(6,041)				(7,243)	
		Direct Changes in Expenditure										
d		Increased Paediatric Medical Cover					7				0	
e		Reduction in Overnight ED RN Nursing					(630)				(630)	
f		Overnight ED Medical Staffing					(380)	*			(380)	*
g		Reduction in Bed Base (16 beds)					(1,610)	*				
h		Reduction in Bed Base (28 beds)									(2,956)	*
		Total					(2,613)				(3,966)	
		Net Recurrent Change				net change	(3,429)			net change	(3,277)	
				Plus contingent costs for 2 months			154	Plus contingent costs for 2 months			154	
		Worst Case Model										
		Income loss					(6,041)				(7,243)	
		Cost Reduction					(623)				(630)	
		Net Recurrent Change					(5,419)				(6,613)	
		* In the worst model these costs may not be realised										
				Plus contingent costs for 2 months			154	Plus contingent costs for 2 months			154	
		Note that it is expected that there will be an increased cost for the Ambulance Service, but this has not been quantified at this stage.										

The Shrewsbury and Telford Hospital NHS Trust

Full Equality Analysis Template

Delivering Safe, Effective & Sustainable Accident & Emergency Services at Shrewsbury & Telford Hospital NHS Trust

Currently, Shrewsbury & Telford Hospitals NHS Trust (SaTH) provides a full Emergency Department offer 24/7 at both Shrewsbury Royal Hospital and at Princes Royal Hospital, Telford.

SaTH currently provides the following services across the organisation:-

At Princess Royal Hospital, Telford there is currently a 24 hour Emergency Department with 8 major cubicles, 4 minor cubicles and a 4 space resusc bay. There is a CDU (with 6 spaces) that operates between the hours of 10am and 10pm. Medical patients that require admission are admitted to a 17 bedded Medical Admissions Unit prior to transfer to a base ward if their stay is longer than 24-48 hours.

Princess Royal Hospital is the site providing a 24 hour women's and children's centre which includes day case, emergency and outpatients services. Paediatric consultants are available for general paediatric referrals. There is a 23 bedded paediatric in-patient ward and a children's assessment unit that is open between 24 hours a day with 8 spaces. Gynaecology and Obstetric services are provided mainly from Princess Royal Hospital, there is a 13 bedded gynaecology ward, obstetric theatres and 19 bedded antenatal, 18 bedded delivery suite and 23 bedded post-natal ward along with a 23 bedded neonatal unit.

Princess Royal Hospital has a 7 bedded Hyper-Acute Stroke Unit and all patients that have been assessed as potentially having had a stroke by the ambulance service, are conveyed directly to this site. Patients are currently conveyed to the emergency department where they are met by a Stroke trained team who will immediately assess and determine if the patient would benefit from thrombolysis. If they are then the patient is transferred to the Stroke unit where they will receive thrombolysis and be admitted to the HASU.

Princess Royal Hospital is also the hub for the Head and Neck services. The ENT and Maxillo-Facial team provides elective day-case and in-patient surgery, outpatient and emergency services from the Princess Royal site. The team utilise 10 beds on ward 17, along with T&O that occupy 18 beds on the same ward. There is a 11 bedded intensive care on the PRH site

Royal Shrewsbury Hospital is the identified Trauma Unit site for Shropshire. The site provides a 24 hour Emergency Department with 12 major cubicles, 3 minor cubicles (open until 11;30pm) and a resuscitation bay with 4 spaces. There is a CDU (with 9 spaces) available 24 hours a day. Medical patients that require admission are admitted to a 16 bedded Medical Admissions Unit prior to transfer to a base ward if their stay is longer than 24-48 hours. Often the CDU spaces are utilised by the AMU, particularly overnight.

Royal Shrewsbury Hospital is the main site for surgical patients Surgical patients that require admission are admitted to a 17 bedded Surgical Assessment Unit prior to transfer to a base ward if their stay is longer than 24-48 hours. Vascular, general and urology surgical services are provided from this site

Royal Shrewsbury Hospital hosts most of the orthopaedic surgery, both elective and trauma occurs at this site. The orthopaedic bed base at Royal Shrewsbury is 29, the surgical bed base at RSH is 34, with a further 18 beds for gastroenterology and 18 beds for urology. There is also a 23 bedded short stay surgical unit at RSH. There is an 8 bedded intensive care unit with a 6 bedded high dependency unit attached.

Since 2014 the Trust Board has been updated to the significant workforce challenges that have met the Emergency Department at Royal Shrewsbury and Princess Royal Hospitals NHS Trust. In March 2016 the public meeting of the Trust Board received a paper outlining a number of options to maintain safe and effective urgent and emergency care services. This paper followed on from an earlier paper received at the public meeting of the Trust Board in December 2015 which outlined the risks and challenges being faced at that time in relation to maintaining two emergency departments at the PRH and RSH sites. This original paper was in response to the challenge facing the Trust around the continued availability of sufficient medical workforce to provide two 24-hour emergency departments and associated clinical services.

This risk was, and remains, the greatest risk on the Trust Board Assurance Framework and Trust Risk Register. It has previously also formed part of the programme of review and scrutiny by the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin.

The outcome of the Board discussion in March 2016 was that of the three potential Plans contained within the contingency plan, which had been developed with key stakeholders and patient representation, the preferred Plan at that time was to seek mutual aid from other Trusts across the region, in order to maintain adequate consultant staffing levels to sustain the safe effective functioning of two 24 hour A&E services.

Plan A – seek mutual aid from Trusts across the region to maintain adequate staffing levels to sustain two 24 hour A&E services;

Plan B – sustain services until agreement is reached on the NHS Future Fit Programme and agree an accelerated implementation of the agreed vision;

Plan C – maintain focus on recruitment whilst developing a detailed plan to implement an overnight closure of the PRH Emergency Department.

This position was consistent with the Trust's primary focus to avoid the need for emergency measures and to agree the medium and long-term vision for local health services for the NHS Future Fit and associated programmes.

In 2016 the Board approved that Plan A was the preferred plan, at that time; it would require minimal investment and cause least disruption to patients and the service delivery of a number of specialties and would continue to deliver a safe, effective and dignified urgent and emergency care service for Shropshire, Telford & Wrekin and Powys patients. Whilst there have been a number of discussions with neighbouring Trusts, no provision of additional workforce has been provided by other organisations. The last meeting with neighbouring Trusts, supported by NHSI and NHSE colleagues occurred in July 2018. Again no additional support was secured.

In February 2018 the Emergency Department Contingency Plan was received and approved at Trust Board. This document described the process of closure of ED at PRH overnight for a short period of time (up to two weeks) should the workforce position be that no middle grade doctor is available to be on site for both PRH and RSH.

The Emergency Department, however, has struggled to achieve a level of medical workforce to provide a robust consultant and senior medical rota to routinely cover both emergency departments without significantly relying on agency support. This situation in recent months has become steadily more fragile both from a medical and nurse staffing and as such SaTH have been further developing the business continuity options such that if the level of workforce was at a point that both ED's could not be staffed safely, they may be enacted over a longer period of time than the initial 2 weeks.
In August 2018, a risk summit was held, chaired by the Medical Director of NHS England and

attended by both Shropshire and Telford & Wrekin CCG's, WMAS, Healthwatch, both local authorities, HEE and NHSI. The conclusion of the meeting was that there was a further request to neighbouring organisations for additional resource to support the ED's and a requirement to review all of the options available. An options appraisal session was held on 27th August 2018, attended by all of the organisations above where 7 potential options moving forward were presented:

Option A: Maintain both ED's and maintain status quo
Option B: Closure of one ED overnight and provide access to a UCC overnight at the closed site
Option C: Closure of one ED fully overnight with no access to UCC at the closed site
Option D: Close PRH ED overnight and divert ambulances to RSH
Option E: Close PRH and divert ambulances to neighbouring Trusts
Option F: Close RSH and divert ambulance to PRH
Option G: Close RSH and divert ambulances to neighbouring Trusts

The general consensus at the system wide risk summit was that unless an additional 5-7 senior doctors could be found to support the rota, the status quo was not an option.

During the option appraisal Option 2 was discounted as there was a concern that the UCC model has not been fully worked up and currently would not be adequately staffed to provide a safe level of care for any patient that walked in without an adjacent Emergency Department to provide senior level of care should it be required. In addition, the risks associated with moving all emergency demand to the alternate site without additional staff or accommodation available would not mitigate the risks sufficiently.

Therefore the updated options refined as follows:for future consideration:-

Option 1: Maintain both ED's and maintain status quo
Option 2: Close PRH ED overnight and divert some specialist ambulances to neighbouring Trusts
Option 3: Close RSH ED overnight and divert some specialist ambulances to neighbouring Trusts

The updated options are shown in the table below.

Option One	**Maintain existing dual site ED service** – Continue to request additional support from other organisations – Consultants maintain rota by acting down as Middle Grade support – however they are not able to continue to offer this due to the impact this is having on their health and wellbeing. – Measure and respond to risks on a shift by shift basis – Continue to work up short and long term business continuity and service development plans – Maintain workforce recruitment strategy
Option Two	**Close PRH ED from 20:00 – 08:00** – Last ambulance @ 20:00, walk-in patient accepted at 20:00 (divert plan thereafter) – UCC will accept patients via CCC until 22:00 – Some patients may remain in ED into the night until pathway for discharge or admission available – On-call ED consultant support RSH only from 23:00. Any patient remaining in ED transferred to acute medical consultant team – Middle grade on site at RSH through the night, and at PRH until 23:00 – SHO on site at RSH through the night and at PRH until 12:00 midnight

	– PRH will continue to accept GP referred admissions in those specialities managed at PRH – Ambulance divert to neighbouring Trusts for paediatric, Gynaecology, ENT, Maxillo-facial patients and medical patients so as to not over stretch RSH ED and create additional risk – Direct admission to PRH AMU for Stroke patients and cardiology patients identified through clinical criteria conveyed by ambulance. – Surgical patients will maintain the pathway of admission via RSH and to the SAU
Option Three	**Close RSH ED from 20:00 – 08:00** – Last ambulance @ 20:00, walk-in patient accepted at 20:00 (divert plan thereafter) – UCC will see patients via CCC until 22:00 but last patient accepted will be 20:00 – Some patients may remain in ED into the night as currently admitted under ED until pathway for discharge or admission available – On-call ED consultant support RSH only from 23:00. Any patient remaining in ED transferred to acute medical consultant team – Middle grade on site at RSH through the night, and at PRH until 23:00 – SHO on site at RSH through the night and at PRH until 12:00 midnight – Ambulance divert to neighbouring Trusts for all ambulance patients so as to not over stretch PRH ED and create additional risk. – Paediatric patients continue to be direct admission to PRH – Revoke the Trauma unit status with the Trauma Network and all trauma patients diverted to neighbouring organisations

Who will be affected?

Staff:
SaTH Clinical staff working in Accident and Emergency, Paediatrics, ENT, MaxFax, Acute medicine, respiratory, cardiology, stroke, trauma and orthopaedics, obstetrics and gynaecology, general surgery, vascular surgery, urology, theatres & anaesthetics, critical care, clinical site
Operational management teams supporting the services above
West Midlands Ambulance Team
Welsh Ambulance Service
General Practitioners
Urgent Care Centre staff
Telford, Shropshire & Powys Social Care staff
ShropComm staff
Midlands Partnership NHS Foundation Trust Staff
Clinical and non-clinical staff at UNHM, New Cross Hospital, Wrexham Maelor Hospital

Patients:
Patients of all ages and conditions will be impacted as a result of any decision made
People requiring access to an Accident & Emergency Department in Shropshire, Telford and Wrekin and mid Wales

People requiring follow up care after an attendance at an Accident & Emergency Department

Young Carers and Carers of patients who require attendance and admission following an emergency episode

Families, relatives and friends of people requiring admission to hospital following an emergency attendance at an accident & emergency department

The affect population:
The acute services at PRH and RSH currently serve Telford and Wrekin, Shropshire, and parts of the neighbouring Welsh county of Powys. The total population of the area is over half a million people; nearly half live in dispersed rural areas. Household income is slightly below average, although this is
partly skewed by the large proportion of the population that is retired. Minority populations are below national averages.

Telford and Wrekin has a significantly more urban population than the other two localities. Its age profile is also notably younger and it is has the largest BAME population. The Shropshire population largely matches that of the combined catchment area. Powys is the most rural of the three localities and also the oldest. There are some differences within these areas and this assessment takes account of these where possible.

Three age groups are potentiality more sensitive to changes in local acute hospital services than others: pre-school age children; young adults; and older people. Data is not routinely reported on the proportion of A&E attendances that are made by people with a disability. However the wider evidence-base strongly suggests that disability is associated with higher levels of need for emergency services – particularly mental health and learning disabilities. Similarly data is not available for transsexual people but wider evidence suggest they are at greater risk of mental health problems than the general population.

No evidence was identified to indicate that pregnant women and mothers of new-born children have disproportionate or differential needs in relation to acute hospital services, however one of the options will impact on the co-location of emergency and women's and children's services overnight.

Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission, with BAME groups being more likely to access emergency services than white groups (although there are differences within this). In addition, cultural factors can mediate access.

No evidence was identified to indicate that religion or belief affects access to or use of hospital services. Although males account for more A&E attendance than females, the difference is small.

Research into gay, lesbian and bisexual people's experiences of accessing healthcare indicates that they have more negative experiences, on average, than heterosexual patients and may also face specific challenges associated with disclosing their sexuality and being visited by friends and same-sex partners in healthcare settings.

Deprived groups account for a disproportionately high number of A&E attendances. Despite the low overall levels of deprivation in the catchment area, Telford and Wrekin and Shropshire contain certain areas that are amongst the 20% most deprived in England. There are also areas that are amongst the 40% most deprived nationally. The affected parts of Powys contain two areas that are amongst the 20%, and others amongst the 30%, most deprived in Wales.

Travel times to access urgent and emergency care: It is significantly more challenging to reach Princess Royal hospital by public transport, particularly for those in outlying areas.

Option 2 has an adverse travel impact on patients from Telford, The Wrekin and Hadley Chase and for children requiring emergency services across the whole patch

Option 3 will have an adverse travel impact for people in, North Shropshire, Bridgnorth, South

Shropshire Shrewsbury and Atcham, Powys and Oswestry

Evidence

- Public Health – Finger Tips Reports
- IIA – 11/02/2016
- ONS (2015) 2014-based subnational population projections for local authorities in England; Welsh Government (2012) 2011-based household projections for local authorities in Wales.
- Joint Strategic Needs Assessment (JSNA)
- SuS Activity Data for 2017/2018
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- Working together to safeguard children, 2015
- Children's and Families Act, 2014
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- World Health Organisation (2015) Disability and health. Fact sheet N°352.
- Royal College of Nursing (2011) Learning from the past – setting out the future: developing learning disability nursing in the United Kingdom.
- De Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, et al. (2011) Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care
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- Public Health England (2016) A&E attendance rate for children (0-4 years) 2014/15.
- Downing A, Rudge G (2006) A study of childhood attendance at emergency departments in the West Midlands. Emergency Medicine Journal 23 5: 391–393.
- Citizens Advice Bureau (2014) Evolving expectations of GP services: Gaining insight from the perspectives of younger adults.
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- Care Quality Commission (2014) Key findings from the National Accident and Emergency Patient Survey.
- SAND (2015) Researching the hopes, fears, experiences, expectations of health & social care by older – and old - lesbian, gay, bisexual and trans people in Shropshire.
- Stonewall (2013) Gay and Bisexual Men's Health Survey.

Demographics

Telford and Wrekin has a significantly more urban population than the other two areas, with only a minority living in rural areas. Its age profile is also notably younger and it is has the largest BAME population. Income levels are broadly in line with the other two areas, as are levels of deprivation. However life expectancies are lower and a higher proportion of its population have a disability. Car access is lower than in the other two localities (although still above the national average).

The profile of the **Shropshire** population largely matches that of the combined catchment area. It is older and more rural than Telford and Wrekin, with a smaller BAME population, and lower levels of deprivation. Life expectancies are also higher, a smaller proportion of the population have a disability, and there are high levels of car access.

Powys is the most rural of the three areas and also the oldest. Similar to Shropshire it has a small BAME population, above average life expectancies and high rates of car ownership. However, in terms of deprivation it is more in line with Telford and Wrekin, while the proportion of its population that is disabled is close to the average for the catchment area combined.

Population size

	Population size (2016)	Proportion aged 70 and over (2016)
Telford & Wrekin	171,000	11.35%
Shropshire	312,400	16.58%
Affected parts of Powys	70,216	18.27%
Combined catchment area	553,616	15.12%

ONS (2015) 2014-based subnational population projections for local authorities in England; Welsh Government (2012) 2011-based household projections for local authorities in Wales.

Disability

Data is not routinely reported on the proportion of A&E attendances that are made by people with a disability. However the wider evidence-base strongly suggests that disability is associated with higher levels of need for emergency services – particularly mental health and learning disabilities. People with these disabilities are at risk of developing secondary conditions that may precipitate the need for emergency care. For example, the prevalence of diabetes in people with schizophrenia is around 15% compared to a rate of 2-3% for the general population20. Those with learning disabilities are at an increased risk of respiratory tract infections21. Those with mental health disabilities are more likely than the general population to suffer from coronary heart disease before the age of 5522. These conditions can, in the short or long term, precipitate the need for emergency care

The distribution of people with a disability or long-term condition similar to that of older people, with the highest concentrations being in Powys and South Shropshire, although there are also parts of Oswestry, North Shropshire and Shrewsbury and Atcham with high concentrations too.

Physically disabled people are more likely to call 999 in an emergency than self-convey and they are more likely to be admitted, particularly if attendance is at night time, due to limited access to increased care at home during these hours.

It is also recognised that as disabled people are more likely to require emergency services that messaging and communication to this group needs to be explicit, widely available and accessible.

Therefore either option 2 or 3 will impact on disabled people as they are more likely to be conveyed out of the county to alternate ED's.

Sex

Males account for a higher proportion of all A&E attendances than females – both nationally and in the catchment area. However the scale of this difference is relatively small. In 2014/15, males accounted for 52.1% (56,944) of all A&E attendances at RSH and PRH combined, while 47.9% (52,425) were female. There is also little evidence to suggest that access to, and experiences of, acute hospital care differs solely on account of an individuals' sex. In addition, the split of males and females is consistent across the catchment area with no notable geographical differences.

The women's and children's centre is based at PRH, and as such the impact on women overnight who require gynaecological input overnight may be delayed if they attend RSH in the first instance and require transfer to PRH for admission. If patients with a gynaecological problem attend RSH now they are admitted to a surgical ward overnight and then transferred

across to PRH the following morning.
The obstetric pathway is not impacted as patients have direct access to PRH maternity unit and will continue to have this available, whichever option is decided.

Race

The BAME population in the catchment area predominantly live in Telford and Wrekin, and within it are most heavily concentrated within The Wrekin and Hadley Castle. The BAME population in Shropshire is more concentrated in Shrewsbury and Atcham, while other areas of Shropshire and Powys have similarly small proportions of BAME residents.

Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission, with BAME groups overall being more likely to access emergency services than white groups. However there are variations between different BAME groups within this. The Department of Health reports that some conditions and diseases are also particularly prevalent among certain ethnic groups, for example coronary heart disease among South Asians, and diabetes among South Asians (prevalence five times higher than the general population) and people from African and Caribbean backgrounds (three times higher). Asthma admission rates for South Asian patients have been double those of white patients, and are also high for black patients.

There is a significant Polish and Eastern European community in Telford & Wrekin and therefore more likely to access PRH. These patients do tend to self-present at ED rather than calling 111 or 999.

The Welsh community are more likely to access RSH than PRH; people that are predominantly Welsh speaking are also generally in the older age bracket and therefore more likely to require access to Emergency Care. There are more Welsh speaking staff at RSH than PRH

There is therefore a requirement to ensure that wide communication and engagement is undertaken within the Community centres of this population to ensure that people are clear about how to access Emergency services should either option be decided.

Age

Children aged 0-4 have amongst the highest rates of A&E attendance of any age group. In 2014/15 this was 310.2 per 1,000 head of population in Shropshire and 353.4 Telford. Although this is below the national average of 540.5 it is still higher than for any other age group in the catchment area. The most common factors that precipitate attendance at A&E amongst this age group are head injuries, lacerations, respiratory conditions and infections. Overall Telford and Wrekin has a higher proportion of 0-4 year olds than Shropshire and Powys, with the highest concentrations in Lakeside South and The Wrekin. Within Shropshire, the proportion in this age group is highest in Shrewsbury & Atcham and parts of North Shropshire.

The children's centre is based at PRH and as such any ambulances are currently diverted to PRH to ensure that the appropriate skills are available once a patient arrives in ED. There are approximately 3 ambulances per night between 20:00-08:00 that convey a child to PRH. Very sick children who require paediatric intensive care are taken directly to Birmingham Children's hospital without attending PRH.

In Option 2 the ambulances would divert to New Cross, Birmingham Children's or Wrexham where there are skilled paediatric doctors on site. Each ambulance has a trained paramedic on board and the WMAS have indicated that longer transfer times would not compromise patient safety. If Option 2 is decided there will be a piece of work undertaken to develop repatriation process of children that require admission to hospital so that they can be nearer home as soon as possible.

If option 2 is decided, children who are brought to ED by an adult will be seen by an ED doctor who can contact the on-call paediatric doctors if required. If admission is then required

direct transfer to PRH children's ward will be undertaken.

If option 3 is decided then there will be no change for paediatric patients.

Young adults
Per head of population, young adults are disproportionately more likely to use emergencies services than any other pre-retirement adult age groups. In 2014/15 the 20-29 age group represented 14.6% of all A&E attendances at RSH and PRH combined despite representing less than 11% of the total population in the catchment area. Young adult males in particular are more likely than other sections of the population to be in road traffic accidents, accidents at work, and accidents while practicing sports.

Recent research also suggests that male and female young adults (aged 18-24) are more likely to access acute care services (including walk-in centres and A&E) when they can't see a GP than other age groups. The geographical distribution of young adults is similar to that of young children. The highest concentrations are in Telford and Wrekin, and within this in Lakeside South and Hadley Castle. There are also relatively high concentrations in parts of Shrewsbury and Atcham and Oswestry.

Trauma patients are currently take predominantly to the Trauma centre at RSH. If Option 3 is decided then these patients will be diverted to alternate ED's.

Young adults are also are a significant proportion of the patients that attend ED following a self-harm episode. Both ED's have an agreed joint pathway with mental health services to support these young people.

Older people
People aged 60 and over account for more than a quarter (27.5%) of all A&E attendances in the catchment area, and those over 75 are the most likely of any adult age group to attend A&E. Older people who attend A&E are also more likely to have an underlying long-term health condition, experience a longer stay in A&E, and be referred on to further care provision rather than return home, in comparison to other age groups. On average, older people report higher levels of satisfaction with A&E and other health services than other age groups. However, a notable potential issue for this age group identified by local stakeholders interviewed for the IIA is their ability to access to hospital provision.

The geographical distribution of older people is largely the inverse of that of young children and young adults. The represent the highest proportion of the population in the most rural parts of the catchment area, namely Powys, South Shropshire and Bridgnorth

Patients that require admission following ED attendance would be repatriated back to PRH or RSH if their hospital stay is likely to be longer than 72 hours. This will then enable social and support services to develop an appropriate discharge pathway in the local area.

More ambulance diverts will occur if option 3 is decided; there is an anticipated 20 ambulances per night that will be diverted to neighbouring Trusts in option 3; and 10 adult ambulances per night will be diverted to neighbouring Trusts if option 2 is decided.

In option 2, a cardiology and stroke direct access pathway into PRH specialist beds can be developed to minimise the disruption for this population.

Deprivation
Deprived groups are not protected under the 2010 Equality Act but have been considered in this eQIA because they account for a disproportionately high number of A&E attendances. Nationally the proportion of A&E attendances made by people living in the most deprived 10% of areas is double that made by people in the least deprived 10%.

This disparity has been linked to the poorer housing, diet, lifestyle, and mental health that deprived groups may experience in comparison to more affluent ones45.

Despite the low overall levels of deprivation in the catchment area, Telford and Wrekin and Shropshire contain certain areas that are amongst the 20% most deprived in England. This includes wards within and immediately around Telford plus two wards within Shrewsbury. This equates to a total of 14,093 people in Shropshire, and 45,326 people in Telford and Wrekin, who live in areas that are amongst the 20% most deprived nationally. There are also areas that are amongst the 40% most deprived nationally in other parts of Telford; The Wrekin; Shrewsbury and Atcham; South Shropshire; Oswestry; and North Shropshire.

The affected parts of Powys contain two areas that are amongst the 20% most deprived in Wales (Welshpool Castle; and Newtown South), with a combined population of 3,448. There are other areas amongst the 30% most deprived (Newtown Central; Newtown East; Welshpool Gungrog; and Llandrindod).

There will be an impact for people in deprived groups with either option 2 or option 3 as there will be further travel involved for either option. Public transport links into PRH is more challenging, particularly for outlying areas. It takes 3 hours to get to PRH from Whitchurch for example.

Gender reassignment (including transgender) Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.

Data is not available, either locally or nationally, on current levels of usage of acute hospital services by transsexual people. Wider evidence indicates they may be more likely to come into contact with these services than other groups in the population. On average they are at a greater risk of mental health problems and more than 1 in 3 have attempted suicide at some point in their lives.

In either option 2 or 3 the Emergency Department at the alternate site will be accepting patients who self-present. As now, there may be times when the emergency department is very busy and staff will need to, as they do now, be cognisant of privacy and dignity for all patients.

There is no specific impact for transgender and transsexual people

Sexual orientation Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.

No data is available on the size or geographical distribution of this group in the catchment area. Nationally, it has been estimated that there are 3.7 million LGB people in the UK, representing 5.85% of the population.

Research into this group's experiences of accessing healthcare indicates that they have more negative experiences, on average, than heterosexual patients and may also face specific challenges associated with disclosing their sexuality and being visited by friends and same-sex partners in healthcare settings. One of the few studies to have included findings specifically on this group's experiences of acute hospital services highlighted instances of discrimination and reported that 70% of gay and bi men felt they were treated with respect and dignity in A&E compared to 78% of the general population.

There is no specific impact on any option in relation to sexual orientation.

Religion or belief Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.

No evidence has been identified to indicate that this group has significant disproportionate or differential needs in relation to acute hospital services. Data is also not readily available on the geographical distribution of people holding different regions or beliefs across the catchment area.

All hospitals have access to chaplaincy and faith services and as such there is no specific impact on any option in relation to religion or belief.

Pregnancy and maternity
Any consolidation of medical staffing in paediatrics that leads to the deficit in the above standards then affects the viability of both the neonatal and obstetric service.

The highest concentrations of this group are in Telford and Wrekin, although Shropshire and Powys also contain some areas of high concentration.

No evidence has identified to indicate that pregnant women and mothers of newborn children have disproportionate or differential needs in relation to acute hospital services. However, it is important to note that should the PRH ED close overnight there will be more limited access to specialist paediatric and obstetric support on the RSH ED site. This option therefore has identified that all paediatric ambulances would be diverted away from RSH to neighbouring organisations, thus impacting on the distance travelled for patient and their families.

Marriage and Civil Partnership Consider and detail (including the source of any evidence) on same sex people who are in a civil partnership, and heterosexual people and same sex people who are married.

No evidence has been identified to indicate that this group has significant disproportionate or differential needs in relation to acute hospital services. The geographical distribution of people who are married is fairly even across the catchment area. The number of people in a civil partnership in the catchment area is small and their distribution is only known at a large-area scale. Between 2008 and 2014 a total of 189 civil partnerships were registered in Shropshire, 74 in Telford and Wrekin and 66 in Powys.

No impact for either option in relation to marriage and civil partnership

Carers Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.

Potential for people to feel more isolated whilst in hospital if families live further away either due to the journey times, the limitation of public transport and caring conflicts with other members of the family whether this is school runs or working. The repatriation process of people who need a stay in hospital will be a priority action for the service.

There may be an increased requirement for carers to stay with their loved one if services are further away which again impacts on the other caring responsibilities and work commitments.

Engagement and involvement

Board papers raising and escalating the risks to patient safety around the current ED position have been held on the following dates:

- December 2015
- March 2016
- February 2017
- February 2018
- August 2018

Multi-agency sessions have been held in developing business continuity plan(attended by Telford CCG, Shropshire Patient group, T&W Patient group, Shropcom, Shropdoc, WMAS)

- 15 December 2015
- 11 August 2017
- 13 October 2017

Multi Agency / external stakeholder risk summits have been held on the following dates:

- 9th July 2018
- 14th August 2018
- 13th September 2018

Business Continuity Scenario exercise (attended by WMAS, CCG's)

- 17th August 2018

System options appraisal (attended by NHSI, NHSE, CCG's, Healthwatch, WMAS, Shropcom)

- 28th August 2018

eQIA appraisal (attended by Healthwatch Telford & Wrekin, Healthwatch Shropshire, Powys Community health Council, Shropshire Patients Group, Telford Patient First)

- 18th September 2018

eQIA and QIA review (attended by Telford & Wrekin Council)

- 20th September 2018

Weekly clinical summit meetings held since July 2018 – some attended by external stakeholders

Weekly Business continuity meetings held

Eliminate discrimination, harassment and victimisation Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

No protected group will suffer discrimination, harassment or victimisation as a result of the changes

Advance equality of opportunity Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

We will work with community groups representing protected groups who will be adversely affected to develop an action plan to promote equality.

Promote good relations between groups Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

As above.

What is the overall impact?

Option 2 (PRH ED overnight closure)	Option 3 (RSH ED overnight closure)
Disability – negative impact Age- negative impact Sex – negative impact Gender reassignment – neutral impact Sexual orientation – neutral impact Race – negative impact Pregnancy and maternity – negative impact Religion – neutral impact Marriage and civil partnership – neutral impact Carers – negative impact	Disability – negative impact Age- negative impact Sex – neutral impact Gender reassignment – neutral impact Sexual orientation – neutral impact Race – negative impact Pregnancy and maternity – neutral impact Religion – neutral impact Marriage and civil partnership – neutral impact Carers – negative impact

Addressing the impact on equalities Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.

We will work with community groups representing protected groups who will be adversely affected.
We will ensure communication is provided widely and accessible on any change in provision of Emergency care overnight.

Action planning for improvement

This will be developed following Trust board meeting on 27 September 2018.

Name of persons who led this assessment:

Karen Barnett, Assistant Director Unscheduled Care, Shrewsbury & Telford Hospitals NHS Trust

Date assessment completed
20 September 2018

Name of responsible Director/ General Manager:

Edwin Borman , Medical Director

Date assessment was signed: