**PRESS RELEASE**
**For immediate release, 4 October 2016**

**Review recommends reopening 12-hour A&E at Chorley**

Chorley and South Ribble Hospital's Emergency Department could reopen on a part-time basis, a team of expert reviewers has found. Although a definite date for this is still being finalised, in order to ensure safe and high quality patient care, reopening is likely to be in mid-January.

The independent review panel, jointly commissioned by NHS England and NHS Improvement, looked at the current arrangements at both Preston and Chorley hospitals, to ascertain whether the department at Chorley could reopen, within the current medical staffing available.

The review was requested by both local Clinical Commissioning Groups (CCGs), Lancashire Teaching Hospitals NHS Foundation Trust and Lindsay Hoyle MP, supported by a broad range of other stakeholders.

Following detailed and intensive work, supported by staff at the department, the Trust's executive team and the two CCGs, the panel has today published its final report.
The report details the key finding that the Trust will be able to reopen a 12-hour emergency department and recommends this option.

The report found, however, that it isn't feasible to reopen the department on a 24-hour-a-day basis.

Having the emergency department reopened at the same time as the opening of the new 24-hour urgent care centre, integrating the two services, will provide additional resilience. This is an opportunity to enable the service to reopen without compromising patient safety.

It has been agreed that it would not be practical or safe to open the department before then, because it would require staff to work excessive hours, and would compromise the major trauma centre at Preston.

Full implementation of the recommendations will only be possible when the urgent care centre is fully operational and is in place to provide additional resource where required.

With those necessary arrangements in place the emergency department at Chorley would reopen, between the hours of 8am and 8pm , likely in mid-January.

Karen Partington, Chief Executive of Lancashire Teaching Hospitals NHS Foundation Trust said: "The new provider taking over the urgent care centre from January gives us the opportunity to redeploy our staff and work in a different way so that we can safely reinstate the emergency department part time.

"We have just successfully appointed a middle grade doctor, and will be continuing to try to recruit more, as well as extra consultants and nurses to ensure the service is sustainable. Until we can make these further appointments, our staff have agreed to work extra hours to keep the service running and we thank them for their continued support and commitment.

"Temporarily replacing the emergency department with an urgent care centre was one of the most difficult decisions we ever had to make, however it was the best possible option to provide safe care in the circumstances.

“We know this has been a matter of great concern for local people and are deeply sorry for the anxiety this has caused.

“We thank NHS Improvement and NHS England for commissioning the independent review, and the review team for carrying out the work so quickly.”

In a joint statement, Lyn Simpson, Executive Regional Managing Director, for NHS Improvement in the North and Richard Barker, NHS England Regional Director for the North, said: “We welcome the findings of the report and are committed to working closely with the Trust and CCGs to implement the recommendations in such a way that ensures the continued provision of safe and effective services to the people of Chorley, Preston and the surrounding areas.

“We would like to take this opportunity to thank the independent panel for their detailed and thorough work, and for taking the time necessary to approach this review in a comprehensive and rigorous manner. That would not have been possible, either, without the commitment shown by the Trust, CCGs and local system to reaching a solution that meets the needs of its patient population, and is safe and sustainable in the way in which it will be delivered.

“In addition, we would like to acknowledge the views and concerns expressed by other stakeholders including Members of Parliament, local councillors and members of Lancashire County Council’s Health Scrutiny Committee, and members of the public, who have voiced support for their health services.

“It is important that we see the publication of this report as a milestone and take the opportunity to move forward, working together to implement the recommendations in such a way that the Trust can continue delivering the care that its population deserves.”

Jan Ledward, Chief Officer of Chorley and South Ribble CCG and Greater Preston CCG and Chair of the system resilience group, said: “We welcome the outcome of the review into the temporary closure of the emergency department at Chorley Hospital.

“Along with the other system resilience group partners, we will support Lancashire Teaching Hospitals in moving forwards to open the emergency department on a 12-hour basis, as recommended by the reviewers.”

3 October 2016

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In welcoming the findings of the independent report into options for reopening the Emergency Department at Chorley and South Ribble Hospital, I would like to take this opportunity to thank the reviewers, and all who have joined in discussions and debate about what is best for patients in this part of Lancashire.

NHS Improvement and NHS England endorse the findings of the Report, and we are committed to working closely with the trust and health partners to implement the recommendations in a way that ensures the continued provision of safe and effective services.

In setting out their conclusions, the reviewers felt that more could be done to reopen the department sooner. However, the trust has expressed strongly to us that this is not practical given pressures at its Preston site. In addition, this would require unrealistic requirements of the current medical staff and could, potentially, weaken the major trauma service on the Preston site. These are very real risks and the Trust is best placed to weigh up the risks involved in their decision making.

As a result, we have said that we will accept a position whereby the Department reopens when a newly-agreed contract to provide more GPs in the co-located urgent care centre is implemented. This will give the extra support the trust needs at the Chorley site and is scheduled for January 2017.

We believe that this meets the spirit of what the reviewers have recommended and, therefore, the A&E department is expected to reopen in January 2017 from 08:00 – 20:00. NHS Improvement and NHS England will work with the Trust and local health patrons to deliver this.

Once again, my thanks go to everyone who has contributed to this review, and for their patience.

Yours sincerely

**JIM MACKEY**
**Chief Executive**

# External Review of Options for Reopening the Emergency Department at Chorley and South Ribble Hospital

**Commissioned by NHS Improvement and NHS England**

**Date of commissioning: w/c 15 August 2016**

**Dates of site visit: 22-23 August 2016**

**Date of report: first draft: 8 September 2016**

**Date of final submission: 21 September 2016**

# Contents

## Executive summary

Following sustained difficulties in ensuring sufficient medical staff to cover the on call rota, to ensure patient safety and quality of care, the decision was made to temporarily downgrade the Emergency Department (ED) at Chorley and South Ribble Hospitals (CSRH) in April 2016.

This independent review was undertaken by a team of senior clinicians at the request of NHS Improvement and NHS England to determine the feasibility of reopening an ED service at CSRH and other options for service provision. In doing so it was important that in addition to reviewing performance data, consideration was given as to the configuration of the units, impact on neighbouring trusts, wider staffing complements and to also seek feedback from multi-disciplinary teams.

This review includes an appraisal of the possible options for configuring local urgent and emergency care services for the next 12-18 months. The longer term solution for the local urgent and emergency care system will be the remit of the Lancashire and South Cumbria Sustainability and Transformation Plan (STP).

## Summary recommendations

The review team considered three options:

### OPTION 1 - ED Opening 08.00hrs – 20.00hrs (last patient 20:00hrs closing at 22:00hrs)

The conclusion of the review is that current provision of medical and nursing staffing levels at CSRH provides an opportunity to enable reopening of the ED. We recognise that the staffing levels across both EDs would not meet Royal Colleges' best practice guidelines but this is not an unusual situation and many organisations are unable to do so.

Weekend consultant cover needs to be addressed. As the trust moves to a 24/7 consultant led service in the major trauma centre (MTC), there is opportunity through current and further recruitment to release consultant time to cover CSRH at the weekends. This will require review of the consultant rota and roles at Royal Preston Hospital (RPH). In the short term this may require the current senior clinicians to perform additional sessions.

Re-opening CSRH ED will require an increase in nurse staffing with a similar allocation to previous numbers (prior to April 2016) based on early and late shifts. The current increased nurse staffing numbers at RPH ED should be maintained despite the re-opening of CSRH ED. The relocation of emergency nurse practitioners (ENPs) from RPH to CSRH should be reviewed in order to ensure support to RPH ED. Minor presentations to ED can be assessed, treated and discharged by experienced NPs. Within the current establishment there is scope to staff both RPH CSRH EDs with ENP cover and this needs exploring to support an ENP rota across the two sites.

If CSRH ED were to reopen to the same standard as previously, then the only ambulance patients who would be brought there are those with minor injuries and acute medical presentations. As there are 24/7 resident middle-grade doctors from both medicine and intensive care on site, this allows for further support to more junior ED staff if there were times when an ED senior decision maker was not immediately available. Note the ED senior decision maker could be an ED consultant, Associate Specialist, ST6, suitable locum middle-grade or GP. In addition to this, clarity over the GP provision to the Urgent Care Centre would also allow concentration of ED staff to the Emergency Department provision.

**OPTION 2 - Re-open a full 24/7 ED at CSRH**

The team do not feel this is achievable in a safe or sustainable manner due to concerns with respect to medical staffing levels out of hours and also the impact this will have on nurse staffing with current establishments and in covering both sites.

**OPTION 3 - Continue with the present arrangement**

There is now a very well-performing UCC at CSRH with positive patient feedback and achievement of the ED performance, along with an ED at RPH which is better staffed both within the medical and nursing workforce. However the diversion of ambulance patients from CSRH adds further pressure to an already stretched regional healthcare system and adds inconvenience to some patients and families who now are no longer admitted to their local hospital (both CSRH patients brought by ambulance to RPH, and RPH patients admitted to CSRH via the GP emergency admissions system).

The current staffing provision at CSRH, whilst a temporary measure to support transition, is excessive from an urgent care service perspective although the hospital as a whole benefits from having the expertise of the ED practitioners and consultant on site.

**External Review of Options for Reopening the Emergency Department at Chorley and South Ribble Hospital**

**Terms of Reference**

- Determine what options may be available to reopen a limited hours ED (08.00hrs -20.00hrs or similar) at CSRH within the existing and near-term medical staffing constraints locally. This will also require specific reference to the staffing requirements of the MTC RPH.
- Determine the resilience of any such options, and how those options could be made more resilient to short notice reductions in the ED middle-grade workforce.
- Determine the patient and clinical risks, and available mitigations, associated with any such options and how these compare to the risks inherent in the current arrangements.
- Determine whether such options to reopen a limited hours ED at CSRH are likely to provide a consistently safe and acceptable level of service to the local patient population.
- Determine whether any options to reopen a limited hours ED at CSRH are likely to contribute to a safer clinical service and better patient experience for the Trust's patient population overall than the current arrangements.

This review will focus on the optimum configuration of urgent and emergency care services in this local health economy for the next 12-18 months. The longer term solution for the local urgent and emergency care system will be the remit of the Lancashire and South Cumbria STP.

Also out of scope of the review is the process, and associated governance, underpinning the decision to downgrade urgent and emergency services at CSRH. This review focuses on potential solutions for re-opening the ED rather than providing a forensic review of how this situation arose.

## Context

Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) provides an ED on two hospital sites, RPH and CSRH; and provides an MTC at RPH. These urgent and emergency care services are commissioned by Chorley and South Ribble, and Greater Preston Clinical Commissioning Groups (CCGs).

In early 2016 it became increasingly difficult to staff the middle grade doctor rotas across the two EDs at LTHTR. At an emergency system resilience group (SRG) meeting in April 2016 the trust shared an option appraisal of potential interim solutions. The supported option, agreed jointly by the trust and both CCGs, was to temporarily downgrade the ED at CSRH to an urgent care centre (UCC) service operating between the hours of 08:00- 20:00hrs. The decision was made on the 13 April 2016 and the ED was temporarily downgraded on 18 April 2016.

The UCC remains in place at CSRH, but many local stakeholders are calling for a reinstatement of a full, or limited hours ED at CSRH instead.

The trust and CCGs consider that they lack the medical staffing to be able to deliver this consistently, but have agreed that they would welcome an expert, independent review of this decision and their underlying assumptions.

## Review Team

The review was commissioned by NHS Improvement and NHS England with site visits planned and delivered within one working week of receipt of terms of reference.

The review team was convened in the week prior to visiting and comprised of three clinical members

## Approach

In advance of the review the team were provided with a number of trust policies and performance data including the following; vacancy management (recruitment strategy, sample job descriptions, specialty doctor and senior clinical fellow), board assurance report (ED middle grade recruitment) and ED performance.

The team had the opportunity over two days to visit;

RPH

- Emergency department (ED)
- Emergency decisions unit (EDU)
- Acute Medical Unit now Medical Short Stay Ward (19)

CSRH

- Emergency Department (presently closed and functioning as an UCC 08:00-20:00)
- Medical Assessment Unit (MAU)

The team met with members of the trust executive and non-executive directors including the chair and CEO, director of operations and service managers, matron for ED, urgent care and acute admissions units. In addition, the review team met the finance director, trust governor representative and spoke with the medical director by telephone.

During visits to clinical areas the team met with ED consultants on both sites, MAU consultants at RPH, a middle grade doctor in MAU (CSRH) and matrons and senior nurse practitioners on both acute sites. The team also met with the sector manager for North West Ambulance Service (NWAS).

The review team asked to meet with external representatives from the CCGs and Chorley Protest Action Group and were requested to meet with the local MP (RH Lindsay Hoyle). External representation was provided through meetings with the GP

commissioning lead for the STP and the chief officer for Chorley and South Ribble and Greater Preston CCGs.

Additional information requested and reviewed included:

- Trauma Audit and Research Network (TARN) data for ED
- ED performance data
- NWAS performance and compliance data
- Length of stay data for EDU, MAUs (both sites) – preceding the closure and following
- Datix reports for ED/MAU and the trust pre and post ED closure including any underlying themes
- Current and projected staffing levels (medical and nursing) for the ED
- Copy of the medical director report shared with external parties as described by NWAS
- Copy of a letter submitted by the consultant body prior to closure of CSRH ED
- Winter initiative schemes
- Sample job plans for consultants in ED at RPH

## Review findings

### Service Changes following Closure of ED

The A&E department at CSRH was expanded and remodelled to accommodate the primary care front end of the A&E department 18 months ago. It is a spacious purpose built building housing spaces for majors, minors and resuscitation with a co-located urgent care facility serving an expanding population of approximately 220,000. In comparison RPH serves a local population of 170,000.

Following emergency closure of CSRH emergency department, all ambulance and ED attends were transferred to RPH leaving only an urgent care service at CSRH. In order to staff this, all ENPs (10.21 WTE) were transferred from PRH to deliver an urgent care service at CSRH. The service at CSRH is open 08:00hrs -22:00 hrs. (last attendance 20:00hrs) and is staffed with ENPs (minimum of 2 throughout core opening hours) GPs (2), one junior doctor and one consultant (one shift 9 hours Monday - Friday). The consultant, associate specialist and junior were left in place as a safety net following introduction of the new UC service.

Prior to closure, the CSRH ED department saw an average of 130 attendances per 24 hour period. July 2015 saw an average of 139 attendances per 24 hours compared with July 2016 where an average of 108 attendances was seen per 12 hours. With a reduction in opening hours, the CSRH UCC presently sees a similar number of patients over 12 hours equating to around 10 patients per hour. At the time of visiting there were 5 patients in the department.

For every 130 A&E attendances at CSRH ED, about 25 patients required inpatient admission to hospital, with the rest being discharged home from the ED.

The ED at CSRH has never provided a full range of emergency services and as a result there has always been a dependency upon RPH for the following:

- Emergency surgical admissions: These have always been transferred directly to RPH there being no surgical on call at CSRH and no emergency theatre provision.
- Critical care provision at CSRH comprises 4 beds; 4 level 2 beds with the ability to ‘flex’ 2 of these beds for short-term level 3 care or to provide stabilisation for transfer to RPH for on-going specialist care (e.g. renal dialysis, neurosurgical intervention). Whilst the review team were informed that there are problems staffing the resident anaesthetics rota the review found this is not the case and there may be an issue with perception or communication between sites.

- The unit is staffed 24/7 by resident middle grade doctors with intensive care medicine experience and currently has a fully staffed rota. There is a dedicated consultant available to attend patients on the critical care unit at CSRH on a 24/7 basis within 30 minutes of request. Importantly, there is equitable provision of critical care outreach services across both hospital sites There is dedicated 24/7 consultant cover, middle grade cover and post op ASA 3. Paediatric emergencies, trauma and maternity emergencies are all managed at RPH. Orthopaedic emergencies including fractured neck of femur pathways are all managed at RPH.
- Stroke patients have always been admitted direct to RPH where thrombolysis takes place in the ED department.

Whilst staff at CSRH and RPH described historical inconsistencies in the level of general medicine support provided to ED at CSRH and reliance upon the middle grade medical rota which was often locum or trust grade doctor dependent, the review team were subsequently advised that this rota is presently fully staffed.

Out of hours cover to ED at CSRH was previously provided by the on-call ED consultant who provided cover to both the RPH and the CSRH units. The consultants described seldom being called out of hours; however there was a general feeling of increased pressure on them to support CSRH out of hours. There was concern regarding the over reliance on locum middle grade doctors and their range of competences.

The board representatives advised that they were aware of the limitations in specialty support to ED at CSRH and its limited provision as an ED department. It was indicated that the paediatric cover to the hospital had been on the risk register for many years. They did not think the paediatric provision at CSRH could be addressed because of staffing pressures or that it needed to be from a patient safety perspective as this is permanently risk assessed and there have been no significant incidents reported.

Core to any future full re-opening of CSRH would be re-establishing a 14 doctor middle grade rota with appropriate quality criteria for locums including minimum 3 month appointments.

Prior to the temporary changes the board agreed an improvement trajectory with CCGs that demonstrated a return to delivery of the 4 hour target by end of March 2017. CSRH 4 hour performance since ED closure has averaged 99% and RPH 82-88%, with some days in the 60-70% range.

Following plans to close the emergency department, the physicians at CSRH proposed and have implemented a direct to Medical Assessment Unit (MAU) service for all direct GP medical admissions from all GPs. Surgical GP referrals are accepted

onto the RPH site through the emergency decisions unit and the surgical hot clinic. The CSRH MAU receives 22 admissions per day with an increasing proportion of these being ambulant and discharged the same day (approx. 60%). A trust grade registrar is developing ambulatory care pathways but these are still in discussion.

Staff considered it probable that more acutely unwell patients and those from the RPH catchment area will increasingly self-present to ED at RPH or will be directed there by GPs who recognise the benefits afforded by an ED department and the range of co-located speciality services at RPH. Service management advised that they are observing a reduction in RPH GP admissions to CSRH combined with a greater tendency to repatriate CSRH patients from RPH. Clinicians confirmed this, noting that they are now seeing GP medical referrals attending RPH ED despite the receiving unit now being at CSRH.

Prior to the closure of CSRH ED, both sites had seen a significant deterioration in 4-hour target data from November 2015. It was striking that since opening the UCC, CSRH has consistently delivered 4-hour target performance at 98-100%, despite seeing similar numbers of patients in just a 12-hour period as opposed to 24-hours.

However RPH continues to be challenged. This reflects the type and acuity of patients presenting to the UCC, and the staffing levels there, along with the increasing volume, acuity and complexity of the patients presenting to RPH. Although RPH attendances are steadily increasing; on the whole, this is in keeping with the national trends in ED data. When a system is under this much pressure, even relatively small numbers of additional patients diverted from CSRH may have a significant impact upon workload and efficiency. Royal College of Emergency Medicine data suggests an F2 doctor will see one patient per hour in the ED; as such an extra three patients may represent an extra three hours' work.

This is also represented in the surrounding EDs, which are seeing small increases in attendances from patients who would have previously gone to CSRH, which will continue to add to their already limited capacity. Wigan has an increase of 6.1 patients per day - an increase of 4.6% from CSR CCG. These numbers require interpretation against the continuing increase in demand for emergency services nationally and as such will not all be as direct consequence of the service changes. NWAS advised that the net effect to date of CSRH ED closure has been an increase of 2-3 transfers per day to neighbouring ED departments at Wigan, RPH and Bolton. It was evident during the review that neighbouring hospitals were under considerable pressure thus emphasising the need for health economy wide solutions.

Following closure of the CSRH ED it was necessary to make urgent changes to the estate at RPH to accommodate the additional CSRH staff and patients. The ED at RPH has always had very limited space. The day case unit (10 beds) has been converted into the emergency decisions unit (EDU) (20 beds) which functions as an

admitting area from ED and for surgical GP referrals (planned length of stay 12 hours). This unit is constantly under pressure with length of stay at times exceeding the target and is now being monitored daily in capacity management meetings. The area is cramped and difficult for staff to work in and unlikely to be conducive to future recruitment and retention. It was felt by the review team that there was a possible duplication of service with the EDU and acute medical unit (now medical short stay ward) and there was a lack of demarcation of service provision in these two areas. For example, there were a number of the same types of medical patients on different care pathways exceeding LOS. It was a concern that the same cohort of patients were being treated and cared for in very different environments, and how operationally, the team could address the challenges in dealing with this.

The RPH ED has benefitted from consolidating the middle grade workforce onto the RPH site. The team were advised that there are no problems recruiting ED consultants. There are presently 12.6 WTE consultants with an expected increase to 12.8 by March 2017. Although there is some churn expected within the senior medical workforce, there will be an overall small net increase throughout this period. The consultants work shifts (10 hours) and there are usually 3 consultants per shift supported by a middle grade tier and juniors. Cover presently formally extends to midnight although invariably goes beyond as clinical need dictates. Consultant job plans provide for 7.5-8 direct clinical sessions. It was understood that the typical allocation of ED consultants during weekdays was 2 starting in the morning, one of whom would staff the daily ED clinic and then review pathology and radiology reports and one who would provide clinical care and supervision of the ED. When a further third consultant started, one would take on the non-clinical role of department coordination in order to manage patient flow. This overlap of 3 consultants presently occurs for 3 hours Monday to Friday.

In the current arrangement, a further senior decision maker (associate specialist in emergency medicine) is based at CSRH UCC to provide clinical care and support for ENP and GP medical staff. This work is in addition to his contractual commitment to ED and for another employer.

Although RPH is a designated MTC the standards mandated for ED medical staffing only require that “there should be a medical consultant trauma team leader with an agreed list of responsibilities who should be leading the trauma team and available 24/7. The trauma team leader should be available within 5 minutes on arrival of the patient.” (*Standard T16-2B-101*). The team were advised that the trust is currently working towards 24/7 resident ED consultant presence.

It is also a requirement for MTCs that 24/7 access to consultant specialists from different disciplines are available within 30 minutes including surgery, cardiothoracic surgery, neurosurgery etc. (*Standard T16-2B-113*). The ability to provide this was not investigated but should feature in the annual major trauma peer review process. In

addition to the consultant staff and 27 junior training grade doctors (FY1 – ST2, 2 of whom are LTHTR, and 2 are rotational posts not in place all year); the current staffing list provided demonstrated 9 middle-grade doctors (ST3+, SAS and associate specialist) including one at 80% WTE currently in post. The trust currently employs two physician assistants one already employed in the ED with a further 10 in training.

RPH ED is supported by a nursing establishment of 51.27 WTE registered nurses (RNs), with 3 WTE nurse clinicians and 2 in training. Prior to the closure of CSRH ED, the registered nurse numbers per early shift was 7 maximum, late shift 8 maximum and night shift 7 maximum. In addition there was a maximum of 2 ENPs per early and late shift. CSRH ED nursing establishment for RNs was 31.68 WTE and with comparable numbers of 6 RNs on early and late shifts reducing to 3-4 RNs on the night shift. Within the registered nurse establishment at Nurse Band 6 and 7, 10.21 WTE ENPs are included.

Since the closure of CSRH ED the RN numbers on shift a have increased significantly to support the ED at RPH. This has been a very positive move both in supporting the service and delivery of patient care at RPH ED, and it has also been a positive move for staff who feel more supported and engaged in their work and the experience they are gaining therein. This increase in RNs has supported a nurse co-ordinator role to work with the medical co-ordinator role in managing the ED. The team are also working to establishment consistently in delivering the rapid access & treatment service (RATS) model, which the increase in RNs is assisting with.

The nursing workforce at CSRH UCC has reduced in line with opening hours and service provision. Presently there are 3 RNs throughout the day with the addition of 2 ENPs throughout until 10pm. This appears to be adequate for the safe running of the current service and it is noted that there has been a significant decrease in reportable incidents in the months of June and July when compared to previous months. The temporary move of the RPH ENP workforce to CSRH UCC has meant that the ENP support at RPH is infrequent and there is a concern that this may have or will impact on the minor injury presentations that could be seen by dedicated ENPs for this “stream” of patients at RPH ED.

Recruitment for RNs is presenting challenges throughout the region and LTHTR is no different in this regard. Internally they have “boosted” the RN workforce at RPH ED however the success of current recruitment drives for nurses to the EDU and AMU areas is unpredictable.

The ED consultants described working at RPH under considerable pressures with patients often waiting in A&E for an inpatient bed to become available. They described difficulties getting timely surgical review in the EDU (review usually limited to beginning or end of the day when surgeons are not in theatre). Pathways for

medical patients create further bed capacity problems; there are only 3.5 WTE acute physicians who cover both the EDU and the AMU (which is remote to the ED). Due to the fact that the ED does not have a CDU, on occasions ED assessment patients are held within EDU and remain under the care of the ED team until discharge or onward referral.

The Trust is fully aware of the limitation of space on the RPH site and has been actively addressing the issues of bed capacity and timely discharge from hospital through collaborative work with the Emergency Care Intensive Support Team (ECIST) and an external company specialising in capacity and demand planning (Four Eyes).

**Patient Feedback**

Patient experience from the friends and family test feedback has generally been very positive for CSRH. At RPH when considering the number of responses and numbers who responded extremely unlikely the figures are as follows:

- January – 27 negative comments – rate 3% (n=774)
- February – 70 negative comments – rate 8% (n=808)
- March – 94 negative comments – rate 10.3% (n=910)
- April – 73 negative comments – rate 7% (n=1043)
- May – 68 negative comments – rate 6.2% (n=1091)
- June – 53 negative comments – rate 5.3% (n=987)
- July – 70 negative comments – rate 5.6% (n=1236)
- August – 43 negative comments – rate 4.1% (n=1046)

Most respondents reply by text message or telephone survey once at home.

**Interpretation**

The current 12 hour urgent care provision at CSRH is in effect medically staffed to ED levels Monday to Friday with a consultant (9 hours) FY1 / GPST 1, 2 GPs (employed by the trust to cover the urgent care centre), 2 ENPs, 3 RNs and one healthcare assistant. At the time of visiting one of the associate specialists was also working in the urgent care service. The team were assured that the equipment stocks in the CSRH UCC were unchanged from when it was an ED, and that in particular the resuscitation room was checked daily.

The provision of other clinical specialties at CSRH has not changed as a result of the changes to emergency care provision, although the hospital is now receiving all direct GP medical admissions to help minimise the pressure at RPH. The overall

number of medical admissions to CSRH has not changed significantly since closure of ED, despite admission of all GP direct medical referrals. This is because the increased numbers of GP-referred admissions is offset by the reduction of other patients being admitted from A&E. The nature of this workload is continually changing (increased ambulatory care need and reduction in RPH patients).

Services at CSRH are supported by CT scanning (available 24 hours) and pathology services.

The CSRH ED had an extension and refit 18 months ago to support the urgent care service development. It comprises a 3 bedded resuscitation room including one bed for paediatrics, 11 assessment cubicles (split between 2 areas), adult and paediatric waiting area, triage, 2 primary care assessment cubicles and a reception area. At RPH there are 4 resuscitation beds, one of which doubles as the trauma bay, 6 trolley areas and 8 cubicles. There is a separate paediatric waiting area and fracture clinic is co-located with ED. It is a very cramped ED, with minimal working space or space to manoeuvre patients on trolleys or in wheelchairs.

There have been considerable reductions in the in complexity of medical conditions that patients are presenting with at CSRH UCC, which some staff find frustrating and limiting in terms of gaining experience and maintenance of professional skills

**Commissioning Intentions**

Due to an ongoing procurement there is a limit to what the trust and CCGs can comment on at this stage. There is however a longstanding intention to co-locate urgent care with ED at RPH.

The trust, CCGs and local MPs are supportive of a system wide transformation plan which will ultimately impact upon all hospital services across Lancashire.

**Future Options**

The terms of reference for this review are forward looking and do not seek to explore the reasons and justification for closing CSRH ED. Whilst an understanding of the precipitants that led to this is important in contextualising decisions that were made, the reviewers have sought to make independent recommendations for a way forward in line with the objective of the review. During the course of the review observations were made and comments received with respect to the organisation and delivery of wider services in the trust which are considered important to inform any recommendations and assist the trust in future service planning.

It is important to state that there are no concerns regarding the provision of estate for ED and urgent care at CSRH. The facilities at CSRH are exceptional and have been

maintained as a working ED department with fully equipped areas for resuscitation, including children, in addition to on site radiology including CT co-located next to urgent care. The options proposed do not represent a detailed project plan, are challenging to implement and are contingent upon the trust pursuing engagement, negotiation and compromise; not just with the staff in the ED but beyond and into supporting clinical specialities and services.

In the time available for the review and compilation of this report, it has not been possible to conduct a detailed review of performance data and it is recognised that workforce numbers may change quickly. The acceptability of the proposed options is not within the scope of the review and has not been tested with staff, trust, CCGs or the public.

**Options and recommendations:**

**OPTION 1 - ED Opening 08.00hrs – 20.00hrs (last patient 20:00hrs closing at 22:00hrs)**

The conclusion of the review is that the current provision at CSRH i.e. consultant 9 hours, associate specialist supporting UCC and trust employee, 2 GPs, 2 ENPs and 3 RNs provides a *basis* to enable reopening of the ED. We recognise that the staffing levels across both EDs would not meet Royal Colleges best practice guidelines but this is not an unusual situation and many organisations are unable to do so.

Consultant provision on site throughout is a pre-requisite to minimising concerns with regard to capacity and capability on any middle grade rota and would enable reconfiguration of medical and nurse staffing support to reduce dependency upon middle grade doctors at CSRH and prioritise their training and development at RPH. A consultant based service by day would also create a supportive environment for training of specialty trainees and trust doctors.

Future medical staffing at CSRH should be based upon trained doctor support that is not defined by MTC requirements and could also include core trainees and GP registrars.

ED consultants presently rotate daily to CSRH where their skills are underutilised in an urgent care environment however training in and delivery of care to ‘minors’ is core to their role. They are all trained in paediatric and adult resuscitation and the 12 hour provision could be accommodated by a staggered start and finish between trained associate specialists, senior speciality trainees and consultants. The general pattern of referral and attendance at ED is for increasing numbers and activity over the course of the morning. This would enable several options for senior cover; full 12 hour shift, 8 to 10 hour shift rotating from RPH and potentially accommodate less than full time work for a designated individual for one to 5 sessions per week.

The review team accept that weekend cover is a challenge and would require an additional 18hrs time of a senior decision maker. There was enthusiasm to maintain ED at CSR amongst some staff and interim solutions could include; redistribution of consultant sessions, additional sessions for consultants, redistribution of SPA time, redistribution and/or additional sessions to AS doctors. Accepting the department has no problems recruiting additional consultants and has adopted a very positive approach to flexible working further consultant recruitment should be pursued in the meantime.

A consultant/senior decision maker led 12 hour day time service would be an excellent training environment for GP specialty trainees and help foster relationships

with the new providers, (whoever may be successful in the commissioning arrangement) of urgent care at Chorley. The Trust currently employs 2 GPs via contracts for service to support the current urgent care service and internal rotations between CSRH and RPH for GP specialty trainees could encompass both ED and medicine at CSRH. Training recognition should be sought via the training programme to enable this. Any reduction in junior cover at RPH potentially created by this is offset by the transfer of juniors that took place on closure of the ED.

Weekend consultant cover needs to be addressed. The reviewers are cognisant of the need not to compromise RPH as the MTC. As the trust moves to a 24/7 consultant led service in the MTC, there is opportunity through current and further recruitment to release a consultant to cover CSRH at the weekend (10-12 hours). This will require review of the consultant rota and roles at RPH. Whilst acknowledging the pressures under which they are working, the presence of 3 consultants during weekdays (staggered shifts for 3 hours per day) reflects the unplanned admissions system as numbers of ED attendances are not excessive when compared to other units.

It may for example be appropriate to re-allocate *some* parts of the co-ordinator role to a senior member of the nursing or bed management team, or engage more with the medical specialty physicians in order to improve flow and provide the on-going care required for patients in the ED awaiting medical beds building on a medical “in reach” model of care into ED.

As for weekday working, there is the opportunity to flex the start time for senior cover in line with peak activity times noting that, out of hours/after midnight neither site has or had consultant presence, albeit consultants commented that they invariably work beyond midnight to support the services.

In line with the TORs, ‘this review will focus on the optimum configuration of urgent and Emergency Care services in this local health economy for the next 12–18 months’. It is envisaged that as consultant recruitment increases to the planned 24 to deliver a full out of hours service at RPH a definitive region wide solution should be agreed.

The nursing workforce at RPH ED has been increased due to the downgrading of CSRH ED. This has increased nursing numbers per shift and supports safer staffing in the ED. Prior to this the staffing at RPH ED was notably understaffed in the review team’s opinion, e.g., one RN to 4 resuscitation cubicles given the increasing number of attendances and the status of RPH as the MTC.

The increase in beds on the EDU will require increased nurse staffing on a permanent basis should this model continue. It will require review of the nursing

establishment to ensure an already pressured ED at RPH is not reallocating staff to cover a shortfall in EDU.

Re-opening CSRH ED will require an increase in nurse staffing with a similar allocation to previous numbers based on early and late shifts. The increased staffing numbers at RPH ED should be maintained despite the re-opening of CSRH ED and this should be achievable within current establishment across the units with closure of CSRH ED at night. Any future strategy to reopen CSRH ED 24/7 would require review and possible investment in the nursing workforce. Nurse staffing guidance for EDs is not available, but draft NICE guidance did indicate a ratio of one RN to 2 resus bays, 2 RNs to one major trauma, one RN to 4 cubicles. This is worth consideration when reviewing nurse staffing in ED.

The use of ENP and NP resource across both sites should be considered. Based upon previous, current and likely future attendances, it is important to retain cover from ENPs at CSRH. With the current establishment there is scope to staff both RPH and CSRH with ENP cover and this needs exploring to support an ENP rota across the two sites.

As for medical staff, deployment of ENPs on both sites could be staggered over the course of the day to reflect activity trajectories and medical cover. A minimum of 2 ENPs during peak times would provide adequate capacity and reduce dependency upon junior medical staff but it is acknowledged that on the current establishment this will not be achievable 7 days a week. Nevertheless ENP cover on both sites is achievable and a nursing model that should be invested in future workforce planning.

Nurse clinician rotas should support the doctors' rota and can provide further capacity to deal with COPD, chest pain and delirium patients. Not only will this reduce further dependency on the clinicians it will release the consultants to address the problems of flow on the RPH site. In addition to this, security over the GP provision to the Urgent Care Centre would also allow concentration of ED staff to the Emergency Department provision.

Although repeated concerns and representations were made to the effect that a part time ED would be unsafe and attract patients out of hours - thus creating unnecessary delays in their care; this has been a longstanding and tolerated risk by the board (diverts of children, orthopaedics, stroke, acute surgery, trauma). The board representatives advised that there has never been a problem as a result of the limited range of services provided at CSRH. It is assumed that there were detailed transfer policies and protocols for the above patients and that these have been reviewed and revised following closure of ED. There continues to be signposting on major access roads to CSRH promoting the presence of hospital ED services. To date there has not been a problem with 'walk in' attends that the service cannot cope

with. NWAS has supplied additional ambulance cover 24/7 to reduce the risk of any attenders who need urgent assistance.
Re-opening the ED department at CSRH will be challenging for clinical staff who have at times felt vulnerable working in a limited provision ED department.

Addressing these concerns with the senior medical and nursing staff at this juncture would help facilitate the future regional reconfiguration that is being explored and envisaged.

**OPTION 2 Re-open a full 24/7 ED at CSRH**

The team do not feel this is achievable in a safe or sustainable manner due to the concerns described above. In particular, concerns raised about the level and availability of on-site support from acute medicine out of hours. This along with the inability to have one consultant safely covering 2 sites overnight (one being a MTC), and the nurse staffing at RPH preclude this as a viable option currently.

**OPTION 3 Continue with the present arrangement - UCC**

There is now a very well-performing UCC at CSRH with positive patient feedback, along with an ED at RPH which is better staffed both within the medical and nursing workforce.

In closing CSRH ED, the movement of staff to RPH has provided safer staffing numbers to manage on average 220–250 attendances a day, plus any trauma. The decision to close CSRH ED was based on lack of provision of out of hours medical cover. This has perhaps indirectly strengthened the nursing numbers at RPH ED to a safer staffing level than previously.

RPH is a challenged ED with performance consistently not meeting 95% from October 2015. Evidence shows that generally patients who remain longer in the ED continue to require care and treatment and have poorer outcomes - deterioration of patients will also occur in ED the longer their stay. RPH needs adequate nursing numbers to deliver care safely and manage risk appropriately and the increase in nursing numbers within the present arrangement has been welcomed by the team and should continue.

There are significant concerns about the ability of RPH to safely manage the additional anticipated winter pressures with the current situation; it is an overcrowded ED and under constant pressure. ED service provision across both sites would create additional capacity to help address this risk.

***Determine the resilience of any such options, and how those options could be made more resilient to short notice reductions in the ED middle-grade workforce.***

The proposed option is based upon permanent staff, is consultant and senior nurse led and the resilience could be enhanced by creating rotations through CSRH for junior doctors including GPSTRs, foundation and speciality trainees. This would enhance cover but is not a pre-requisite. The attraction of CSRH ED as a 12 hour day unit with senior medical and nursing staff supervision is an ideal model in which to place physician associates and could also benefit the new pathway for medical admissions.

Future urgent care provision in the trust/commissioning locality is uncertain and by opening the ED department again the trust can help develop this service and patient referral pathways with any new provider as opposed to being forced to react to change. Furthermore, partial re-opening of CSRH is likely to offer some reduction in the pressure placed on RPH, and allow better relations and engagement with the local population.

The focus of resolution must move away from the need to have 14 middle grade doctors to a trained doctor (GP, associate specialist, and trust doctor) and nurse based solution.

***Determine the patient and clinical risks, and available mitigations, associated with any such options and how these compare to the risks inherent in the current arrangements.***

It is important that the trust addresses the clinical and professional concerns of their staff with respect to the previously limited speciality service provision at CSRH. If partial reopening of CSRH is to be considered then the absence of manifest or known harm to date is not a reason not to put in place additional support that would provide both clinical and public reassurance. It would also enable the trust to further develop CSRH as a safe site for the increasing general medical workload and pathways for escalation in the event of a major incident.

The reviewers recognise that there are staffing pressures in paediatrics. Accepting the role of the MTCs in supporting trauma units and smaller ED providers, there is the potential to initially rotate senior paediatric staff to CSRH, to provide training in order to support both the elective service (surgery, out patients) and the ED/UCC provision.

Whilst the existing pathways for surgery and orthopaedics are longstanding, consideration should be given to using telemedicine links from CSRH to RPH for immediate surgical and orthopaedic consultation in the rare event of an emergency

requiring stabilisation prior to transfer. The review team heard that specialty response times to ED at RPH were often delayed and this could be an opportunity to address both longstanding issues.

The review team did not have the opportunity to meet and discuss with representatives of the anaesthetics department but an alternative and successful option implemented elsewhere is the combination of simple telemedicine and an intensivist patient retrieval service.

The trust needs to review how general medical services are provided at CSRH and how specific acute pathways e.g. major GI bleeds can be managed optimally. These are current challenges and would not preclude change in the interim. There is an opportunity to bring acute medicine closer to ED with responsive specialty referrals (push and pull) and the focus on ambulatory care on the acute medical unit. The current lead for ambulatory care at CSRH is a trust grade doctor and any future service requires senior buy in and delivery (if not already planned).

Appreciating these pathways will require change and investment, the trust faces a challenging winter delivering emergency care and optimising safety and services at CSRH would increase opportunity for change.

***Determine whether such options to reopen a limited hours A&E at CSRH are likely to provide a consistently safe and acceptable level of service to the local patient population.***

Reopening ED on a temporary 18 months basis is less than ideal in any circumstances and reversing decisions which came with consultant and nursing support is challenging. Nevertheless, the review team believes that the EDs are well staffed and the reopening of CSRH ED has to be part of a better and safer strategy that will enable the MTC to network in a more effective manner in any new hospital/arrangement. In turn this will provide better career opportunity for a wider range of staff and a service based upon ‘permanent’ trained staff solutions rather than the traditional medical rota model.

The trust should enter in to joint communications with all stakeholders including the local population when making changes to the provision at CSRH to ensure that there is a good understanding of what services are being offered and when.

A system has been put in place whereby GP-referred patients should be directed to CSRH, to reduce the pressure on RPH. However, at present the CSRH population and their GPs may not always be using this new system and this has the potential to further destabilise the RPH site.

***Determine whether any options to reopen a limited hours A&E at CSRH are likely to contribute to a safer clinical service and better patient experience for the Trust's patient population overall than the current arrangements.***

The current reactive arrangements have managed risk by centralising services at RPH which may ultimately be the correct direction of travel depending upon the longer term strategy for the health economy and outcome of consultation. The urgency of change has meant that RPH has not been able to develop the ED estate, the associated medical and surgical pathways are not fully developed (push or pulling patients) and ownership of patients was not clear to the reviewers or staff.

The trust like everywhere else faces a difficult winter and the decision to close CSRH has and will impact upon other providers at a time when capacity is extremely stretched and even one extra admission can have an impact on patient flow and experience. Everyone with whom the team spoke emphasised their concerns regarding the capacity and functionality of the ED and EDU departments at RPH. Opening CSRH on an interim basis would reduce some pressures on RPH whilst the trust under took some remedial actions to develop the ED footprint and embed urgent care.

The current staffing provision at CSRH, whilst a temporary measure to support transition, is excessive from an urgent care service perspective although the hospital as a whole benefits from having the expertise of the ED practitioners and consultant on site. The potential of CSRH in the interim can be maximised to support the local population and the wider trust service if the longstanding issues are in part addressed and a part time ED function is reopened.

**Acknowledgements**

The review team are grateful to the trust management for accommodating and supporting the review with day to day logistics and to all the staff and stakeholders who spoke with the team in such an honest and open way.

## Appendix 1 – WTE ED Medical Staff

| Directorate | Reporting Title | Posts | Vacant |
|---|---|---|---|
| ED | FY1 | 3.0 | |
| ED | FY2 | 7.0 | |
| ED | ST1-2 | 14.2 | 1 |
| ED | Junior Clinical Fellow | 1.0 | |
| ED | ST3+ | 7.8 | 1 |
| ED | SAS (speciality doctors) | 5.0 | 3 |
| ED | SAS (associate specialists) | 2.0 | |
| ED | Consultant | 12.6 | |
| **Total** | | **52.6** | **5** |