Reporting to:	**Trust Board, 3 December 2015**
Title	Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services **-** Developing our service continuity plan
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Previously considered by	
Executive Summary	The medium and long term vision for health services in the county is being developed through the NHS Future Fit programme. This programme envisages a new model of sustainable safe care including a network of urgent care centres supporting a single Emergency Centre. Work is continuing, with ongoing public engagement over the coming months followed by public consultation in 2016/17 on the proposed site for local services including the single Emergency Centre. In the meantime, the challenges that prompted the initiation of this work are growing, and the scenarios available to us to respond if an emergency arose are reducing. The most significant of these challenges is the continued availability of sufficient workforce to continue to provide two 24-hour emergency departments and associated clinical services. This risk features as one of the principal risks in our Board Assurance Framework (ref 859) and is therefore subject to ongoing Board scrutiny and review. It is also forms part of the progamme of review and scrutiny by the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin. The Trust aims to maintain 24-hour emergency departments whilst the plans for the medium and long term are developed through NHS Future Fit. However, we are mindful that there continues to be a risk that a situation could be reached where maintaining two 24-hour emergency departments is unsafe and emergency measures must be taken. As a responsible public authority the Trust must ensure effective business and service continuity plans for our emergency departments and wider clinical services so that these measures, if required, could be implemented safely. Any emergency measures categorically do not pre-judge the essential work through the NHS Future Fit programme to develop an agreed vision for the future of health services for patients and communities across Shropshire, Telford & Wrekin and mid Wales. Instead, they would be taken to mitigate clear and present risks to the safety of the services we provide. In addition, the presentation of this paper does not signal any plan or intent to implement emergency measures; instead it signals the commitment of this Trust to continue to put patients at the heart of everything we do by being prepared for actions to protect their safety. It also reinforces that our primary focus as a Trust remains (a) to prevent the need for emergency measures and (b) to agree the medium and long term vision for local health services through NHS Future Fit and associated programmes. The attached discussion document "Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services: Developing our service continuity plan" therefore provides an overview of the risks and challenges, outlines the process to define "tipping points" that would prompt

	emergency measures to be initiated, and sets out the work to develop and test those emergency contingency measures. It invites comment from staff, communities, partners and wider stakeholders. The main focus for this work over the coming months includes: - developing clear contingency measures where we have confidence that the measures would satisfactorily reduce the overall risk to the Trust and our patients, and that potential adverse consequences have been considered and mitigated. - ensuring that there are clear timelines for implementation so that "tipping points" can be defined sufficiently to allow sufficient lead-in time for safe implementation of contingency measures. The next steps include: December 2015: Stakeholder workshop to consider potential scenarios and undertake desktop exercise to develop outline implementation options; work to identify "Tipping Points" to enable timely decisions; continue to develop workforce profile and risk assessment to prevent tipping points being reached. January/February 2016: Further stakeholder workshop to confirm tipping points and desktop test of contingency measures; develop quality impact assessment for review through Quality & Safety Committee; develop communications plan. February to April 2016: Agreement of Tipping Points; continue monitoring process led by executive team; consider "live test" to further test contingency measures. April/May 2016: Quarterly stakeholder workshop to review Tipping Points and contingency measures, and recommend updates based on changing environment and context. Ongoing: Monthly stakeholder bulletin to keep staff, communities and partners informed and engaged. This work will be overseen on behalf of the Trust Board by the Hospital Executive Committee, with quality review and assurance through the Quality and Safety Committee.
Strategic Priorities 1. Quality and Safety 2. People	☒ Reduce harm, deliver best clinical outcomes and improve patient experience. ☐ Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards ☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☐ To undertake a review of all current services at specialty level to inform future service and business decisions ☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme ☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation 4 Community and Partnership 5 Financial Strength: Sustainable Future	☐ Support service transformation and increased productivity through technology and continuous improvement strategies ☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies ☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☐ If the local health and social care economy does not reduce the **Fit To**

	Transfer (FTT) waiting list from its current unacceptable levels then patients may suffer serious harm ☒ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☐ 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 ☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we are unable to resolve our structural inbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☒ Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well led
☒ **Receive** ☐ **Review** ☒ **Note** ☐ **Approve**	**Recommendation** The Trust Board is asked to RECEIVE and NOTE the update on the development of the service continuity plan for the Trust's urgent and emergency care services.

The Shrewsbury and Telford Hospital NHS
NHS Trust

Paper 7

Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services

Developing our service continuity plan

Version 1, 25 November 2015

Summary

- The sustainability of safe urgent and emergency care services in Shropshire and Telford & Wrekin has been subject to continuing debate over many years without resolution.

- These services face a range of challenges, including:
  - Ensuring sustainable rotas of skilled and experienced clinical professionals to provide 24-7 care
  - Bringing the latest life-saving technologies to the county.
  - Meeting the changing needs and expectations of patients and communities, particularly as more of us live longer with long term conditions.

- There are a number of constraints to addressing these challenges, including:
  - Workforce issues including availability, and changes in clinical training and accreditation.
  - The continued environment of financial austerity across the entire public sector.
  - Estate issues, including size and quality of current healthcare estate and scope for investment.

- One impact of the prolonged debate without resolution is that the need to address these challenges becomes more critical, and the options for addressing them reduce. For example, some options involving the development of new skills and roles have a long lead-in time, and those requiring capital developments need to be planned and delivered.

- As a Trust we are focused on three explicit phases of work:
  - Long Term: Creating a shared vision for the future of health and care services with our clinicians and communities. This should set out a future state for safe and sustainable urgent and emergency care services as part of a wider vision for health and healthcare.
  - Short to Medium Term: Taking steps in the medium term that help us maintain safety and continuity until the long term vision is achieved.
  - Immediate Service Continuity: Addressing immediate risks to the safety and continuity of services, and preventing the need for emergency measures to be taken.

- The sooner we are able to reach a shared agreement on a long term vision, the less likely that emergency measures would be needed and the more likely that medium term action can be delivered in the form of interim steps towards a long term vision.

- The Long Term vision is being developed through the NHS Future Fit Programme and options for the Short to Medium Term options are being developed in parallel with this work. Further information is included in the NHS Future Fit update to Trust Board on 3 December 2015. Our work to ensure immediate business continuity is described in this report, particularly in Section 7.

1. The main features of urgent and emergency care services for people in Shropshire, Telford & Wrekin and mid Wales

The majority of urgent care takes place outside hospitals in people's homes, in GP surgeries, through pharmacies and other local services. Treatment and care for the most serious and life-threatening injuries and illnesses is provided outside the area in major tertiary centres such as Birmingham and Stoke. Both Princess Royal Hospital and Royal Shrewsbury Hospital provide 24-hour Accident and Emergency Departments, but the challenges of maintaining these services are increasing.

1.1 Providing urgent care as close to home as possible

The significant majority of urgent care takes place outside hospitals:

- in people's homes (including residential and nursing homes) through self-care
- via web and telephone support (e.g. NHS Choices, NHS 111 and NHS Direct in Wales)
- in community pharmacies
- in GP practices or walk-in centres, and out-of-hours primary care services
- in the community through first responders and paramedics
- in Minor Injury Units and Urgent Care Centres.

Our goal is to maintain and increase the way in which urgent care needs can be met as close to home as possible, whilst ensuring that we are giving the best life chances for people with the most serious illnesses and injuries that need the specialist range of services that can only be provided in hospitals.

1.2 Providing specialist care for the most serious illness and injuries

Treatment and care for people from Shropshire, Telford & Wrekin and mid Wales with the most serious and life-threatening illnesses and injuries takes place outside the area in major tertiary centres that bring together the full range of expertise and technology that is not available in the county's district general hospitals. This expertise includes:

- Major trauma centre services
- Heart and chest surgery
- Neurosurgery
- Specialist burns
- Children's trauma and critical care services

Emergency care pathways take patients to a range of specialist hospitals outside the area. These include Queen Elizabeth Hospital in Birmingham, Royal Stoke University Hospital, Birmingham Children's Hospital and New Cross Hospital (e.g. following heart attack) as well as specialist hospitals in Merseyside or south Wales.

The majority of these specialist services are likely to continue to be provided in regional specialist hospitals that bring together this full range of expertise and technology. However, we need to protect and build the services provided within the county:

- We should seek to maintain our full range of services in the county rather than see them move to specialist centres elsewhere (e.g. hyper-acute and acute stroke services, cancer unit)

- We should take opportunities to repatriate services where it is safe and feasible to do so (for example, where technology, skills and pathway development enable more care to be provided within local hospitals).

1.3 Urgent and emergency care at Princess Royal Hospital and Royal Shrewsbury Hospital

Both the Princess Royal Hospital and Royal Shrewsbury Hospital provide 24-hour Accident and Emergency departments supported by a range of clinical services including acute medicine, radiology, critical care, pathology.

Royal Shrewsbury Hospital provides a 24-hour Accident and Emergency Department with the back-up of acute surgery and is a Trauma Unit as part of the region-wide Major Trauma Network. The hospital also provides inpatient and ambulatory cancer services and has the support of a daytime Children's Assessment Service. There is a daytime primary-care led Urgent Care Centre co-located with the A&E Department. There is an Acute Medical Unit for the assessment of urgent medical referrals and an Acute Surgical Unit (Surgical Assessment Unit) for the assessment of urgent surgical referrals, and ambulatory models of care are increasingly being developed in these departments.

Princess Royal Hospital provides a 24-hour Accident and Emergency also provides the county's main hyper-acute and acute stroke service on a temporary basis pending the outcome of the NHS Future Fit review. It is the county's main centre for inpatient women and children's services including a 24-hour children's assessment unit. There is a daytime primary-care led Urgent Care Centre within the hospital grounds. There is an Acute Medical Unit for the assessment of urgent medical referrals and ambulatory models of care are increasingly being developed in the department.

The sustainability of safe emergency care services at the Princess Royal Hospital and Royal Shrewsbury Hospital has been the subject of ongoing debate without resolution for many years. A solution is needed as, whilst the challenges are increasing, the options for addressing them are reducing.

2. The national vision for transforming urgent and emergency care services

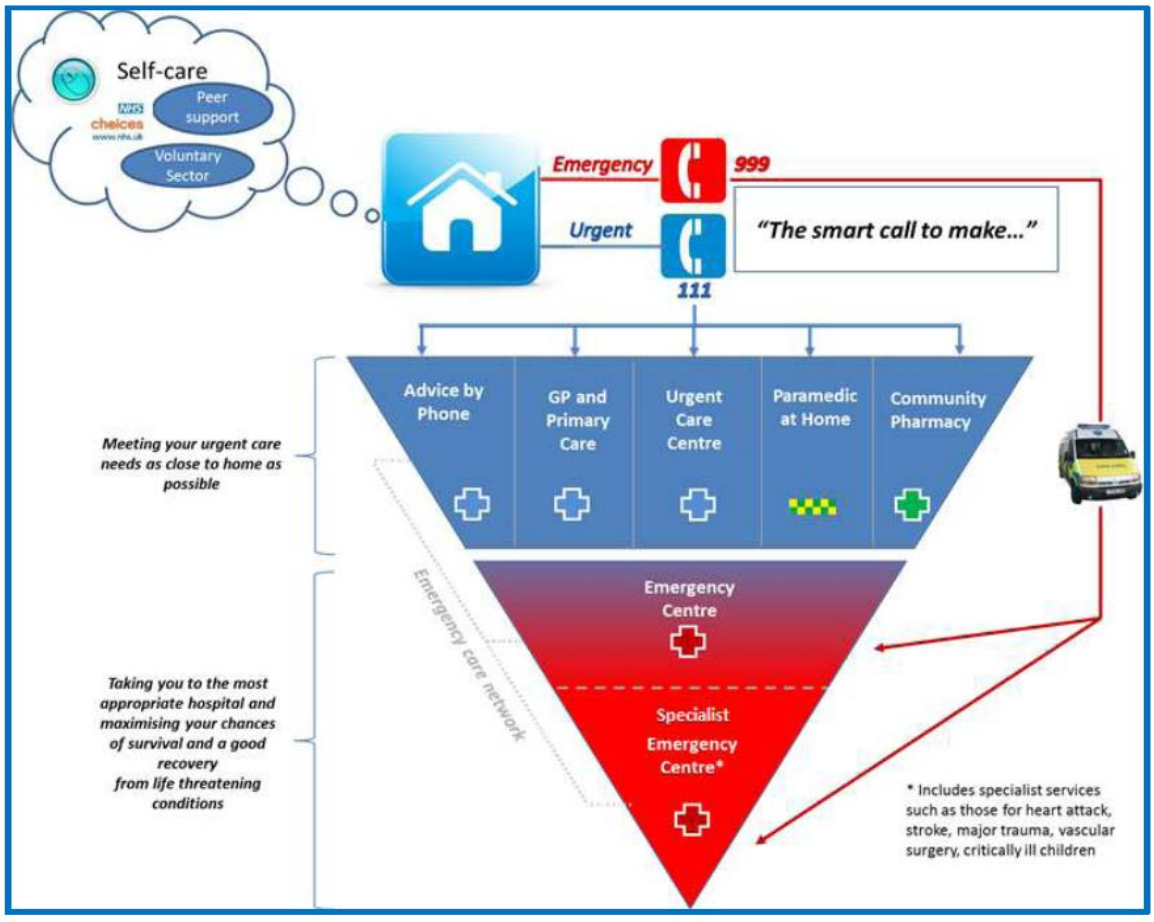
A national vision for Urgent and Emergency Care is being set out through NHS England's national Urgent and Emergency Care Review led by Sir Bruce Keogh. The review has set out a vision for urgent and emergency care services and establishing Urgent and Emergency Care Networks (including the North West Midlands Urgent and Emergency Care Network encompassing Shropshire, Telford & Wrekin, Stoke and Staffordshire) to oversee the delivery of the national vision at a local level.

2.1 National Vision

NHS England is setting out a national vision for urgent and emergency care services in England through the Urgent and Emergency Care Review led by Sir Bruce Keogh[1,2]. This envisages:

- Firstly, for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised care services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families.
- Secondly, for those people with more serious or life-threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities, in order to maximise their chances of survival and a good recovery.

This vision is summarised in the diagram below:



[1] NHS England (November 2013) "Transforming urgent & emergency care services in England: Urgent and Emergency Care Review End of Phase 1 Report"
[2] NHS England (August 2014) "Transforming urgent and emergency care services in England: Update on the Urgent and Emergency Care Review"

2.2 National Delivery

The national review proposes that five key changes need to take place to help create the conditions for establishing the new vision[3]:

- Providing better support for people and their families to self-care or care for their dependants.
- Helping people who need urgent care to get the right advice in the right place, first time.
- Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.
- Ensuring that adults and children with more serious or life-threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and good recovery.
- Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

2.3 Urgent and Emergency Care Networks

Health and care organisations are asked to work together through regional Urgent and Emergency Care Networks to develop and oversee the regional strategy for achieving this vision[4]. These networks will be based on "the geographies required to give strategic oversight of urgent and emergency care on a regional footprint … of 1 to 5 million (depending on population density, rurality and local factors)".

Their purpose is to improve the consistency and quality of Urgent and Emergency Care by bringing together System Resilience Groups (SRGs)[5] and other stakeholders to address challenges in the urgent and emergency care system that are difficult for single SRGs to address in isolation. This will include coordinating, integrating and overseeing care and setting shared objectives for the Network where there is clear advantage in achieving commonality for delivery of efficient patient care (e.g. ambulance protocols, NHS 111 services, clinical decision support and access protocols to specialist services such as those for heart attack, stroke, major trauma, vascular surgery and critically ill children).

Objectives for Networks include:

- Creating and agreeing an overarching, medium to long term plan to deliver the objectives of the Urgent and Emergency Care Review;
- Designating urgent care facilities within the network, setting and monitoring standards, and defining consistent pathways of care and equitable access to diagnostics and services for both physical and mental health;
- Making arrangements to ensure effective patient flow through the whole urgent care system (including access to specialist facilities and repatriation to local hospitals);
- Maintaining oversight and enabling benchmarking of outcomes across the whole urgent care system, including primary, community, social, mental health and hospital services, the interfaces between these services and at network boundaries;
- Achieving resilience and efficiency in the urgent care system through coordination, consistency and economies of scale (e.g. agreeing common pathways and services across SRG boundaries);

[3] NHS England (August 2015) "Safer, Faster, Better: good practice in delivering urgent and emergency care: A guide for local health and social care communities"

[4] NHS England (June 2015) "Role and establishment of Urgent and Emergency Care Networks"

[5] System Resilience Groups (SRGs) are forums that bring together local health and care stakeholders to plan the delivery of local services. More information can be found in "Operational resilience and capacity planning for 2014/15" (Monitor, NHS England, NHS Trust Development Authority, ADASS; June 2014)

- Coordinating workforce and training needs: establishing adequate workforce provision and sharing of resources across the network;
- Ensuring the building of trust and collaboration throughout the network;
- Spreading good and best practice and demonstrating positive impact and value, with a focus on relationships rather than structures.

The geographical footprint for our System Resilience Group is Shropshire and Telford & Wrekin. The area covered by our Urgent and Emergency Care Network is North West Midlands Urgent encompassing Shropshire, Telford & Wrekin, Stoke and Staffordshire.

3. The local vision for transforming urgent and emergency care services

A vision for the future of the county's health services is being developed through the NHS Future Fit programme. The safety and sustainability of services needs to be maintained in the short and medium term until that vision is realised.

Considerable work has taken place through the NHS Future Fit programme to:

- Understand local needs and expectations (e.g. through the Call To Action).
- Review local clinical challenges.
- Assess national and international evidence and strategic direction.
- Translate this into a local model of care that is fit for future generations.

A key output from the NHS Future Fit programme has been the development of a Clinical Model for future services. This model outlines a future vision for:

- Planned Care
- Urgent and Emergency Care
- Long Term Conditions

More information about the NHS Future Fit programme and the proposed clinical model is available from the NHS Future Fit website at www.nhsfuturefit.org

In relation to Urgent and Emergency Care, the key features of the NHS Future Fit clinical model mirror the national strategic approach. This includes:

- A network of urgent care centres treating people who don't have life-threatening illnesses or injuries but can't wait to see their GP.
- A single emergency centre treating the most serious illnesses and injuries that are treated in the county.
- Effective assessment, stabilisation and transfer to regional specialist centres for those illnesses and injuries that are not treated in the county's hospitals (e.g. neurosurgery, heart and chest surgery).

Whilst work continues through the NHS Future Fit programme to establish and agree the future vision, and develop detailed plans for putting it into practice, as a Trust we also need to ensure we maintain safe services in the short to medium term.

4. Opportunities and Challenges

National policy sets out opportunities for the NHS to transform healthcare, which in turn will save lives and reduce long-term ill health. However, our health system faces a number of challenges. Our two-site model contributes to the fragility of several clinical services including A&E, critical care and acute medicine. We struggle to recruit and retain the workforce needed to maintain services across two small hospital sites. We also face difficulties investing in duplicated equipment and infrastructure, whilst at the same time meeting the changing needs of our patients and communities. Whilst much of the debate has focused on "A&E", this department relies on a wide range of other clinical services, all of which need to be safe and viable for the A&E service to be maintained.

4.1 Opportunities

There is clear evidence that early access to senior clinical decision-makers can save lives and reduce long-term ill-health for the most seriously ill and injured patients. Studies have shown both a direct patient benefit through rapid access to definitive diagnosis and treatment, as well as indirect benefit (e.g. reducing unnecessary admissions, improving hospital flow).

The local NHS has a significant opportunity to transform urgent and emergency care to deliver the vision emerging from NHS England's national Urgent and Emergency Care Review. The national vision is built on patient and clinical evidence from the UK and abroad[6]. As outlined in the End of Phase 1 report for the Urgent and Emergency Care Review[7]:

> *The reasons for the growing pressures our A&E departments are experiencing have been well rehearsed. Two things in particular are often cited. Firstly, an ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care. Secondly, we know that many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E. While both these things are true, they arguably underplay the fact that A&E departments have become victims of their own success. The A&E brand is trusted by the public and, despite increasing pressure, continues to provide a very responsive service with an average wait for treatment of only 50 minutes and the overwhelming majority of patients being treated within 4 hours. So, we should not be surprised that people choose to go to A&E.*
>
> *But, the reality is that millions of patients every year seek or receive help for their urgent care needs in hospital who could have been helped much closer to home. The opportunities for bringing about a shift from hospital to home are enormous. For example, we know that 40% of patients attending A&E are discharged requiring no treatment at all; there were over 1 million avoidable emergency hospital admissions last year; and up to 50 per cent of 999 calls requiring an ambulance to be dispatched could be managed at the scene. To seize the opportunities these numbers present, we will need to greatly enhance urgent care services provided outside of hospital. This forms a key part of our proposals.*
>
> *The second part of our vision relates to those people with the most serious or life threatening emergency care needs who do require treatment in hospital. In the 1970s most A&Es and their hospitals could offer people the best treatment of the day for most conditions. Clinical practice has taken great strides forward in the last four decades, and this is no longer the case.*

[6] NHS England (November 2013) Transforming urgent and emergency care services in England: Urgent and Emergency Care Review End of Phase 1 Report. Appendix 1 – Revised Evidence Base from the Urgent and Emergency Care Review

[7] NHS England (November 2013) Transforming urgent and emergency care services in England: Urgent and Emergency Care Review End of Phase 1 Report

Take heart attacks for example. In the 1970s, heart attacks were treated with bed rest. The hospital mortality rate was about 25 per cent. Today, as a result of advances in medical science, we now mechanically unblock the culprit coronary artery which was causing the heart attack. This treatment has seen mortality rates fall to just 5 per cent. But this improvement has required very expensive diagnostic equipment and cardiologists with special skills. This highly effective, advanced treatment of serious heart attacks cannot be provided by every hospital; it is currently delivered by half the hospitals in England, with about a third providing a comprehensive 24/7 service. We have very good results by international standards because the diagnosis can be made in the ambulance and the right patients are taken to the right hospitals for the most advanced treatment. This means that for paramedics to get patients to the best and most appropriate services, they will sometimes drive past the nearest A&E to get the patient to the right place. This is a good thing. The recent national reorganisation of major trauma services which resulted in the designation of 25 major trauma centres has produced, in its first year, a 20% increase in survival despite increased travel time for patients who now bypass A&Es that previously treated only a handful of these very serious and complicated cases.

Similarly, the treatment of strokes which occur when the blood supply to part of the brain is blocked, has evolved. Effective treatment requires rapid transfer to a highly specialised unit with expensive diagnostic scanners and clinical expertise so that drugs can be given to minimise the brain damage that occurs. Stroke services in London have been reorganised to offer this high level treatment, but this required redirecting patients with suspected strokes from 32 admitting hospitals to only 8. The end result is that London has the best stroke services of any capital city in the world, saving more lives and returning more patients to independent living.

We have made good progress on treating heart attacks and strokes, although there is still more to do in these and other areas in order to reduce risks and improve outcomes. Advancing science has directed the way we deliver services to achieve the best results, but it also exposes the illusion that all A&Es are equally able to deal with anything that comes through their doors. We now find ourselves in a place where, unwittingly, patients have gained false assurance that all A&Es are equally effective. This is simply not the case.

We also know that the likelihood of recovering from a particular illness or injury varies considerably between hospitals. Despite the best efforts of the staff who work there, many hospitals and their A&E departments do not have consistent consultant presence overnight or at weekends. The support services available also vary considerably, with 1 in 7 lacking at least one "essential" on-site service, such as critical care, acute medicine, acute surgery or trauma and orthopaedics.

So, A&E departments up and down the country offer very different types and levels of service, yet they all carry the same name. We need to ensure that there is absolute clarity and transparency about what services different facilities offer and direct or convey patients to the service that can best treat their problem. Most importantly, we need to ensure that anywhere that displays a red and white sign is a place that will provide access to the very best care for the most seriously ill and injured patients, 24 hours a day and 7 days a week. A place that can resuscitate, make a diagnosis, start treatment and ensure rapid transfer to the right place if it can't offer the very best care.

Professor Sir Bruce Keogh in the introduction to the End of Phase 1 Report for the Urgent and Emergency Care Review

Locally there are opportunities, therefore, to:

- Provide more care closer to home, particularly for illnesses and conditions that do not need the specialist expertise provided in an A&E department.
- Use new treatments and technologies to ensure earlier, definitive diagnosis and treatment to reduce mortality, morbidity and long-term disability.

- Strengthen care pathways to ensure that more patients reach the point of definitive treatment more quickly.

4.2 Challenges

Patients and communities across Shropshire, Telford & Wrekin and mid Wales expect and deserve the highest standards of urgent and emergency care that increases survival rates, improve quality by reducing disability and shortening recovery times, and improves patient experience.

The Shrewsbury and Telford Hospital NHS Trust strives for the highest standards of urgent and emergency care, and working with patients and partner organisations through the NHS Future Fit programme we have already begun to develop a vision for the future of health and healthcare in the county.

However, the services we provide for our patients face some challenges which continue to increase:

- Providing a sustainably safe clinical model that brings the patient and clinician together as quickly as possible – reducing the need for patients to travel between our hospitals or elsewhere for specialist care, and ensuring that when such travel is needed it is safe and timely (see 4.2.1).
- Ensuring sustainable rotas of skilled and experienced clinical professionals to provide 24-7 care, and continuing to fulfil training requirements so that we continue to attract doctors in training (see 4.2.2).
- The duplicated costs of bringing the latest life-saving technologies to both hospitals (see 4.2.3).
- Meeting the changing needs and expectations of patients and communities, particularly as more of us live longer with long term conditions (see 4.2.4).

At the heart of the challenge is a vicious circle:

- We have a historic model of care spread across two small hospital sites. This is associated with a significant degree of civic and community pride.
- Clinical roles in smaller hospitals face a number of challenges in terms of recruitment and retention: small departments are less likely to see a wide and changing case-mix, which would make the role more attractive and support the maintenance of clinical skills; on-call rotas may be more onerous; fewer on-site clinical adjacencies create greater complexity in the care pathway.
- Our Trust receives the same income is if services were provided from a single site. Double-running of services across hospital sites also does not attract additional income but does incur additional costs. This means that departments have dated equipment and IT infrastructure, and are less able to adopt the latest technologies and techniques.
- Overall, we need more staff, equipment and infrastructure than if the same services were provided from a single site. This alongside our rural location creates challenges in recruiting and retaining our permanent workforce. This in turn leads to additional costs through agency and locum expenditure to sustain safe staffing.
- There are also limited opportunities to flex capacity to meet changing demand, requiring implementation of inefficient measures during times of escalation that reduce the staffing and resources available for other hospital services.
- The duplication of costs of staffing, equipment and infrastructure contributes to a deficit financial position. This reduces the availability of working capital to invest in new ways of working that will drive efficiency. This means that our service model is not responding fast enough to our changing environment, and our challenges continue to grow faster than our scope to address them.

4.2.1 Clinical Model

A&E services have very strong public recognition, but understanding of the services that need to sit alongside an effective 24-7 A&E department is much less widespread. Whilst A&E teams have specialist expertise in immediate assessment and stabilisation, the degree to which hospital emergency departments can save lives and ensure a good recovery is critically dependent on the links between A&E and other clinical specialties:

- Acute surgery (e.g. colorectal, upper gastro-intestinal, vascular) and Trauma & Orthopaedic Surgeons to provide life-saving operations.
- Critical Care & Anaesthetic teams to stabilise and support the most critically ill and injured patients, and provide 24-7 support in the operating theatre.
- Acute Medical teams to assess and treat medical conditions.
- Diagnostic specialists providing imaging and blood tests so that the best clinical decisions can be made, and life-saving treatment can start without delay.
- Effective pathways to regional specialist services (e.g. heart, chest, neurosurgery, burns, major trauma, critically ill children).
- Obstetric, gynaecology and paediatric services to assess and treat women and children.
- Oncology services to provide intervention and support for acutely ill cancer patients.
- Therapy support, for example to ensure immediate initiation of programmes that will accelerate recovery.
- A wide range of clinical support services that enable the delivery of front line care.

Each element of the service is subject to its own clinical and governance standards that aim to maintain and improve clinical outcomes, safety, patient experience and working lives. Where standards are not met within any one of these services this can have a number of effects including:

- Poor outcomes, safety and experience for patients.
- Service closure, or compliance or regulatory action requiring service improvement.
- Removal of education and training status (e.g. whereby hospitals no longer attract doctors in training – this has a direct impact on the available workforce, as well as on wider recruitment and retention).
- Staff dissatisfaction and low morale.

If one vital clinical adjacency is lost then this can result in the “closure” of an A&E department in its current form.

There is no single model for A&E care in England. Indeed the service model will be different at every hospital, typically emerging organically from the needs, the opportunities and the politics of the local area. The current national review aims to enable local solutions within a framework of national clarity and transparency.

If too few of these services are clinical adjacent to the A&E department then more patients will face delays or need to be transferred elsewhere, more ambulances will need to bypass the hospital to access these specialist skills elsewhere. This requires effective assessment and triage with clear emergency pathways in place.

Conversely, the greater consolidation of these services on a single site means that patients are able to have quicker access to specialist opinion, but it does mean that fewer sites provide the service that we have traditionally understood as “A&E”.

This understandably creates a level of tension in debates within communities:

- The overall goal may be to reduce the overall time from emergency call to definitive consultant-led treatment, through better assessment and triage, improved 24-hour availability of specialist clinicians, and fewer delays from the hospital door to multi-disciplinary assessment and initiation of treatment.
- The perception often focus on the element of the emergency care pathway from home to hospital, rather than the critical steps that take place both before and after this[8]. Whilst generally people recognise the need for the most critical injuries to be transferred out of the county to regional specialist centres, a level of reassurance is gained from having "a local A&E" with understandable anxiety if these services may move further from home.

So, the challenges do not solely relate to the A&E department, but to maintaining safe services across a range of clinical adjacencies.

4.2.2 Workforce

The NHS nationally faces significant workforce challenges, and SATH is no exception. We do not currently meet recommended staffing levels for the emergency department, critical care or acute medicine – each of which are vital clinical adjacencies for our A&E departments at both PRH and RSH.

The "Keeping It In The County" consultation in 2010/11 was driven by similar workforce challenges in both acute surgery and paediatrics; consolidation of inpatient services onto a single site (acute surgery at RSH and paediatrics and PRH) has significantly improved recruitment and retention in these areas, helping to sustain vital services in the county rather than see them move to specialist centres elsewhere. However, the split-site model of care between PRH and RSH still presents challenges for these specialties.

Medical Staffing: Emergency Department, Critical Care and Acute Medicine

The main areas of medical workforce fragility are emergency department, critical care and acute medicine.

Between these three areas we estimate that substantive consultant-level staffing is less than half required levels (this is based on national standards & requirements, clinical caseload and our two-site operating model – the adoption of single-site models would significantly reduce the staffing challenges).

This presents a number of challenges, including:

- Small teams have **onerous on-call responsibilities** – in some cases this is twice the levels in neighbouring hospitals, making roles in SATH much less attractive in a competitive employment market.
- **Workforce resilience** is significantly affected if the workforce is thinly spread. Vacancies or illness have a more significant impact on the workload for the remaining team and can lead to services reaching a tipping point[9].
- Vacancies need to be managed through short-term and unsustainable measures such as **locum & agency staff and "acting down"**.

[8] The overall emergency care pathway typically includes (a) identification of symptoms (b) decision to call for help [e.g. GP, NHS111, 999] (c) pre-hospital care [e.g. GP or paramedic attendance, assessment, stabilisation and/or treatment] (d) transfer [e.g. conveyance to hospital] (e) arrival at hospital (f) multi-disciplinary assessment and diagnostics (g) senior decision-making on intervention and treatment (h) ongoing care, rehabilitation and recovery. For some conditions, the overall period from (a) to (g) has a significant impact on outcomes and recovery, and the travel time is just one element of a pathway where significant and compensatory gains can be made in other steps.

[9] This was experienced in stroke services in 2013 where workforce gaps led to the hyper-acute and acute stroke service being temporarily consolidated onto the PRH site. As a result of the clinical benefits observed during this temporary consolidation, a further review was undertaken leading to this service model being retained on an interim basis pending the outcome of the NHS Future Fit review. Hyper-acute and acute stroke services therefore remain temporarily consolidated at PRH.

- Providing “on call” cover **reduces availability** of senior clinicians during the day at the busiest times for our clinical services.

Despite ongoing recruitment efforts, departments continue to rely on high levels of unsustainable agency staffing. There is significant competition within the NHS – and internationally – for these roles and our onerous on-call rotas, small size and limited facilities of our hospitals, and limited range and case-mix of presentations at each site, impact adversely on our ability to recruit and retain new consultants.

We also face challenges in other medical roles– middle grade and junior doctors. The development of roles such as Advanced Care Practitioners offers excellent potential as an alternative workforce to medical staff. However, currently it is difficult to support the development of advancing and extending practice for non-medical staff as the capacity for medical staff to mentor, support and supervise training is compromised by the workforce pressures outlined above.

Nursing and Support Roles

In addition to these three specialties, we face recruitment difficulties across a number of other skills and specialties including nursing, operating department practitioners, diagnostic radiographers and healthcare scientists. The double-running of services across two small hospital sites means that more staff are needed to provide 24-7 cover than if the services were provided on a single site and/or they require onerous on-call duties from our workforce.

NHS funding models anticipate that hospital services across the country will achieve the efficiency levels of the best and do not provide financial flexibility to fund duplicated rotas.

These challenges will increase with the growing requirements for seven-day services in the NHS.

Way Forward

Based on (a) discussions with our clinical teams, (b) our assessment of the future medical and nursing workforce market, and (c) the potential for extended and advanced non-medical roles, a combination of recruitment/retention and role development will not solve our workforce sustainability issues. Instead, the Trust needs to consider options for consolidation of further services onto a single site, which in turn will provide (a) a more attractive recruitment offer, (b) less onerous on-call responsibilities, (c) greater potential to sub-specialise for the benefit of our patients and (d) greater potential to invest once in life-saving new technologies (rather than requiring duplicated investment).

Our plans must address the immediate risks whilst ensuring a realistic workforce plan for the future.

4.2.3 Technology and models of care

Healthcare is changing. Every day, new technologies provide new opportunities to save lives and reduce long term ill health.

However, providing services across two small hospitals presents two main challenges:

- Either, it requires duplication of equipment (and indeed will often require more equipment overall than if the service was provided at a single site). The majority of equipment purchase, maintenance and replacement within the NHS is funded from organisational capital and revenue budgets. In other words, we need to fund this from the income we receive for patient care services, and from any working capital that we are able to generate.
- Or, the catchment of our small hospitals means either that the equipment is not viable at hospital population-level or that we are not able to compete with larger centres elsewhere as part of national deployment programmes.

The financial settlement for the NHS over the next five years anticipates levels of efficiency that cannot be delivered by maintaining the current levels of duplication of equipment and services.

Investing in the equipment needed for future healthcare requires us to develop new models of care.

4.2.4 Changing needs

The welcome improvement in the life expectancy of older people experienced across the UK in recent years is particularly pronounced in Shropshire. The population over 65 has increased by 25% in just 10 years. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted, with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

Long-term conditions are increasing due to changing lifestyles. This means health services need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community with consistent support for self-management and care.

Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push nationally towards 7-day provision or extended hours of some services and both of these require a redesign of how health services work given the inevitability of resource constraints.

Changing needs and expectations require is to think differently about how best we use finite NHS resources.

5. Constraints

The challenges we face are primarily clinical: reaching our full potential to save lives and reduce long term ill health, through a range of steps including earlier access to senior clinical decision makers. However, our constraints in responding to these challenges encompass a wide range of factors including financial, workforce, estate and local expectations. Achieving the national efficiency programme for the NHS requires bold decision-making so that we leave a legacy of safe and sustainable health services for future generations.

There are a number of key constraints that impact on the potential solutions to these challenges, including:

- **Financial resources: Plans to address these challenges must be affordable to the local NHS and offer value for money for taxpayers.**
  The NHS funding model for acute hospitals in England is based on a Payment By Results system, where providers of health care services receive a payment for an episode of care. One of the most significant effects for this Trust is that there is minimal recognition within the funding model for multi-site services. Trusts that provide services dispersed across multiple sites receive the same income as if these services were provided from a single site, and therefore need to ensure high levels of efficiency to accommodate the costs of double-running (e.g. staffing rotas, medical equipment, estates and facilities services and infrastructure).
  The impact of this on SATH has been well documented and we estimate the costs of duplication to be in the region of £12m a year – funding that this therefore not available for direct care.
  The government's plans for the NHS anticipate the most far-reaching efficiency savings ever achieved since the establishment of the NHS. Therefore, all organisations, and the health & care systems within which they operate, must identify and deliver challenging cost improvement plans to ensure that the NHS can meet growing demand whilst also attending to the expectations of our patients and communities.
  Whilst the drivers for change in urgent and emergency care services are clinical and needs-led, finance is a constraint to the options available.
- **Scope for capital developments: Plans to address these challenges must be based on a realistic assessment of the potential both from the current estate and for future development, whilst not tying the NHS unnecessary into costly buildings-based care.**
- **Workforce: Plans to address these challenges must be based on achievable plans for workforce development and recruitment**
  We need to be realistic about the future workforce market locally, nationally and internationally. Our workforce represents our most valuable asset – and the most significant proportion of NHS expenditure. Future service models have to take account of the expected workforce availability as well as our potential to develop new roles (and the time frame needed to achieve this).
- **Technological infrastructure: Plans to address these challenges need to take advantage of potential from technological advancement whilst also recognising the current capacity and capability.**
- **Community and political expectations: Plans to address these challenges must take account of community expectations, and must fulfil statutory requirements for engagement and consultation.**

6. Responding to these challenges and constraints

We and our patients face challenges to immediate service & business continuity, as well as in the medium and long term. We need to ensure that we have plans to sustain safe services right now whilst planning for a healthy future.

Phase	Timeframe	Goal	Activities
Immediate Business Continuity (see Section 7)	Immediate action to address risks and fragility	Maintaining services until a clear plan for the medium-to-long term has been agreed	• Understanding the risks and potential tipping points for emergency care services. • Delivering plans that address these risks and prevent these tipping points being reached, so that emergency measures do not need to be implemented. • Understanding the scenarios in which emergency measures may be unavoidable and having robust service continuity in place
Short to Medium Term (see NHS Future Fit update to Trust Board on 3 December 2015)	Action within the next 18 months to maintain safety and continuity of services.	Agreeing and delivering any interim steps and transition that supports us to move towards the long term vision.	• Develop two OBC options for the emergency site - one at Telford and one at Shrewsbury.
Long Term (see NHS Future Fit update to Trust Board on 3 December 2015)	Action within the next five years to create and deliver the shape of health and care services fit for future generations	Agreeing a long term vision for the future of safe and sustainable health and care	• Continuing the work through the NHS Future Fit Programme to establish a future vision for safe and sustainable health and care

7. Immediate Service Continuity

This section sets out emerging ideas to ensure immediate service continuity for Emergency Care in the county's main hospitals. It outlines possible tipping points, measures to prevent those tipping points being reached, scenarios that could be implemented if those tipping points were reached, and suggested next steps. It sets out a series of questions for discussion and feedback by staff and communities.

The workforce challenges in some clinical departments mean that there is ongoing risk that these departments will reach a "tipping point" beyond which those services cannot be maintained in their current form. This is because, to put it bluntly, there will not be enough staff to provide a safe service 24-hours a day in two A&E departments.

These risks are particularly acute in the emergency department. We have great teams in our emergency departments – and in the wider hospitals – who work tremendously hard 24-7-365 to provide the highest standards of care and treatment. But, we have to recognise that the pressures on those teams may reach levels where urgent change is needed in order to protect us as patients, and protect them as staff.

These risks are real. If they were not, then we would not have embarked on the NHS Future Fit programme to develop a strategic vision for the shape of health services fit for generations to come.

Whilst the NHS Future Fit programme continues, our primary focus as a Trust is on **actions to prevent a tipping point being reached**. We do not want to make emergency changes and we have no plans to do so. Instead, we believe that any changes should be made in a planned way based on agreements through the NHS Future Fit programme following widespread public consultation.

But, as a responsible public body we must also ensure that we have:

- **Considered what emergency contingency measures could be taken, and developed and tested plans for their implementation, including understanding how long these would take to implement.**
- **Considered the tipping points that may lead us to consider implementing these emergency measures, and ensuring that systems are in place to keep these under review so that action can be initiated with sufficient lead in time to deliver changes safely.**
- **Assessed the risks and consequences, assuring ourselves that the emergency measures represent an overall reduction in risk to our patients.**
- **Considered the staff, community and wider stakeholder engagement in developing and testing these measures.**

This can be summarised as follows:

Current position *Ensure a detailed understanding of the current position and risks*	⇨ *Continue to take action to reduce risk that tipping points are reached*	**Tipping Point** *Ensure that tipping points are defined and kept under review*	⇨ *Ensure a detailed and tested plan is in place to enact contingency measures safely and swiftly, with clear timescales*	**Contingency measures in place** *Keep contingency measures under review include benefit/impact and triggers for returning to current position*

⇨ **Ongoing engagement with staff, partners, communities and wider stakeholders to review risks and tipping points and develop contingency measures** ⇨

7.1 What situations might constitute a tipping point within an Emergency Department?

A range of factors may constitute a "tipping point" for our emergency departments:

- Irretrievable gaps in staffing that would lead the service to become unsafe (e.g. sustained non-availability of medical staffing)
- Irretrievable failure of estate or infrastructure (e.g. department no longer fit for use)
- Irretrievable failure of essential clinical adjacency (e.g. critical care, diagnostics)

A fortnightly meeting takes place in the Trust to review service continuity for the emergency department and related services in the hospital. This provides an opportunity to review the workforce profile and other issues and risks within the hospital and wider health system.

The next steps will ensure a more systematic approach by:

- Defining potential tipping points in more detail and particularly ensuring that these are defined in a way that enables sufficient lead-in time to enable us to put in place contingency measures – in other words, how do we spot problems sufficiently early that we can take effective action?

Q	**What "tipping points" can you identify that might prompt the need for emergency changes to A&E services in the county? How likely are they to occur? How should these "tipping points" be kept under review? What is the best way to make decisions on whether "tipping points" have been reached and emergency action is needed?**

7.2 What steps are being taken to prevent tipping points being reached?

The main current risk relates to Emergency Department staffing. As outlined in Section 4, substantive medical staffing levels fall below required levels. The Trust continues to seek to mitigate this risk through a range of steps including:

- Continued focus on recruitment of permanent medical staffing
- Continued focus on recruitment of locum medical staffing
- Exploring opportunities for partnership working with other clinical departments (e.g. new models of consultant appointment) and with neighbouring organisations
- Developing extended and advanced workforce roles, such as Advanced Care Practitioners and Emergency Nurse Practitioners

The next steps include:

- Refreshing our workforce profile and establishing a risk assessment linked to the "tipping points" that includes mitigation plans that aim to sustain staffing levels and prevent "tipping points" being reached.

Our primary focus continues to be the management of these risks in order to maintain the current service model pending the agreements to be made through the NHS Future Fit programme.

Q	**What further steps could be taken to attract more permanent and locum staff in the short term (i.e. within the next six to twelve months)? Are there new workforce roles that we are not taking advantage of – if so, what could we do to bring these about quickly? Do you have insights into the likely workforce market that you can share – are there factors that we might not be aware of that could help us to recruit and retain?**

7.3 If a tipping point was reached, what scenarios could be considered?

A range of scenarios could be considered if a tipping point was reached, which are set out below.

These have been considered at a high level and will continue to be reviewed based on our emerging understanding of (a) the "tipping points" and (b) the workforce profile and risks.

The main criteria for initial assessment of these scenarios include:

- Sufficiency and risk – the degree to which the scenario sufficiently address the service risks and to which it creates new risks
- Quality – impact on patient experience, patient safety and clinical outcomes (including the impact of access on these factors)
- Feasibility and deliverability – the ease and speed of implementation, impact on other services and sectors
- Cost – the direct costs of implementing any changes (revenue, capital) and opportunity costs (e.g. impact of things we are no longer able to do)
- Impact – the wider impact on other services and pathways

	Site 1	Site 2	Description	Assessment	Priority
A	Close	Close	All A&E services in the county's hospitals would close. Establish 24-hour pathways from both Sites to neighbouring hospitals.	This would have a significant impact and this option is not required as other scenarios could be achieved safely and effectively.	Discounted
B	24-hour	Close	Establish 24-hour pathways from Site 2 to Site 1 (or to other neighbouring hospitals if required). Walk-In Centre (if Site 2 is PRH) or Urgent Care Centre (if Site 2 is RSH) continues.	Full closure of A&E at one site can be avoided as other scenarios are achievable. Neither of the current sites would have the capacity to accommodate consolidated 24-hour A&E activity from both sites without significant capital development.	Discounted
C	Daytime	Daytime	Establish overnight pathways to neighbouring hospitals.	This option is not required as overnight services can be maintained in the county.	Discounted
D	24-hour	Daytime	Establish overnight pathways from Site 2 to Site 1.	This scenario is feasible and should be assessed further.	Priority 1

E	24-hour	Daytime A&E service with GP / OOH-led service overnight	Establish overnight pathways from Site 2 to Site 1. Develop GP-led service overnight in Site 2.	This scenario would require strengthening of speciality support (e.g. acute medicine which is also a challenged specialty) to the GP-led service. It also relies on 24-7 GP cover (there are significant GP workforce challenges nationally and locally), and may lead to a misperception that A&E remains open overnight.	Priority 2
F	Single Emergency Centre	Urgent Care Centre	Accelerate the proposed NHS Future Fit Clinical Model to establish a Single Emergency Centre on one site.	This prejudges the decisions to be made through the NHS Future Fit programme. It could also not be achieved quickly as a business continuity measure due to the significant changes needed in critical care and bed capacity, and in wider hospital services.	Priority 3
G	24-hour	24-hour	Maintain both departments 24 hours a day.	If the "tipping point" had been reached then, by definition, we have reached a point where it is no longer possible to maintain both A&E departments 24-hours a day	*
	* It remains our goal to sustain the current service model until the future vision is agreed through NHS Future Fit. However, the risks and challenges are real and the service continuity scenarios listed above do require active consideration and planning in the event that they need to be implemented.				

Our current assessment is that Scenario D is the most feasible contingency scenario.

It is important to note that no scenario is simple to implement. Contingency action would only be taken where it was clear that the current risks could not be managed and tipping points had been reached beyond which the current service model could not be retained.

Key considerations in the further development of Scenario D would include:

- The potential for other hospital admissions to remain open even if A&E is closed (e.g. direct medical or surgical admissions)
- Options for creating the additional ward, theatre and wider clinical capacity required at the "overnight site", for example through linked service moves
- Clinical and pathway relationships with other services on each of the hospital sites such as Women and Children's Centre, Trauma Unit, Acute Surgery etc.
- Impact on wider hospital services, both clinical and non-clinical (e.g. pharmacy, phlebotomy, facilities etc.)

- Impact on wider services beyond the hospital, such as ambulance services primary care OOH services, Urgent Care Centre / Walk-In Centre etc.
- Understanding the potential impact on patient behaviour and choice of service.

The next steps include:

- Assessing Scenario D in more detail, including at a stakeholder workshop in December where the pros and cons of overnight closure of (a) PRH and (b) RSH will be reviewed and more detailed contingency measures developed. These contingency measures will need to be tested further to consider the impact on quality (experience, safety and outcomes including access), the feasibility and deliverability, the cost of implementation and the wider impact.
- Continuing to review potential scenarios, drawing on the views of our staff, communities and other stakeholders.

Q	**Are there other scenarios that we could consider? What are they and how feasible are they? What are their "pros and cons" against the criteria listed above? Are there other significant criteria that should be considered as part of this assessment?**

8. Next Steps

The next steps will include:

December 2015	Stakeholder workshop arranged for mid December: • Consider Scenario D in more detail, and specifically to consider the relative pros and cons of overnight closure of (a) PRH and (b) RSH taking account of factors such as: quality (experience, safety and outcomes including access), feasibility and deliverability; cost of implementation; and, wider impact. • Desktop exercise to develop outline implementation options. Continue work to develop agreed "Tipping Points" – need to ensure these are defined in such a way that a decision to implement contingency measures is taken in sufficient time to enable those contingency measures to be put in place. Continue to update workforce profile and risk assessment, maintaining actions that will reduce the likelihood that a "Tipping Point" is reached.
January/ February 2016	Further stakeholder workshop to: • Review and agree "Tipping Points" • Undertake desktop exercise to test contingency measures and identify further actions to support service continuity Develop Quality Impact Assessment for review by Quality and Safety Committee on behalf of the Trust Board. Ensure communication plan is in place that can be implemented if "Tipping Points" are reached to inform patients and communities across Shropshire, Telford & Wrekin and mid Wales of the contingency measures being enacted.
February to April 2016	"Tipping Points" and contingency measures agreed by Hospital Executive Committee. Keep "Tipping Points" and contingency measures under executive review on an ongoing basis (at least fortnightly, and by exception if required). Progress and exception reports to Trust Board via Hospital Executive Committee and executive members. Consider "live" test exercise to ensure that contingency measures and their wider impact is understood more deeply.
April/May 2016	Quarterly stakeholder workshop to review "Tipping Points" and contingency measures, and recommend updates based on changing context and environment.
Ongoing	Publish monthly stakeholder bulletin providing an update on service continuity planning. Continue to seek staff, community and wider stakeholder feedback to inform and refine service continuity plans.

Key outputs will include:

- Defined trigger points
- Service continuity plan
- Quality Impact Assessment
- Communications Plan

Sharing Your Views

Comment is invited on this document on an ongoing basis via the email address or postal address below. We are particularly grateful for your feedback on the questions in Section 7 of this report.

Please also check for the latest updates which will be available from our website at www.sath.nhs.uk/bcp (please note that this page will be published by 10 December 2015).

We welcome your feedback and input to help us ensure that patients and communities across Shropshire, Telford & Wrekin and mid Wales continue to receive the highest standards of urgent and emergency care that increase survival rates, improve quality by reducing disability and shortening recovery times, and improve patient experience.

Contact details for feedback:

- In writing to the Chief Operating Officer at the addresses at the bottom of the page.

- By email to consultation@sath.nhs.uk

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