Lincolnshire COUNTY COUNCIL Working for a better future		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of
Dr Suneil Kapadia, Medical Director, United Lincolnshire Hospitals NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 September 2016**
Subject:	**United Lincolnshire Hospitals NHS Trust: Emergency Care Service**

Summary:

The purpose of this report is to provide an update to the Committee relating to the provision of emergency care at United Lincolnshire Hospitals NHS Trust and the next steps to ensure continued patient safety and public engagement.

The briefing provides:

- A timeline of actions leading up to and following the temporary closure of Grantham A&E.
- The full collection of documentation associated with this change.
- An early indication on the impact of this change.
- Next steps.

Actions Required:

The Health Scrutiny Committee is requested to consider and comment on the actions taken to date and the proposed next steps.

1. Background

During July 2016 Lincoln and Pilgrim emergency departments expressed increasing concern as to their ability to fill their middle grade medical rotas. Due to the increasing reliance locally, and demand nationally for locum doctors the fill rate of our A&E shifts was reducing, thus leaving the departments at Lincoln and Pilgrim significantly understaffed.

Between 31 July and 6 August a further three middle grade doctors at Lincoln and 0.6 at Pilgrim had left. As a result of only having 2.6 whole time equivalent (wte) middle grade doctors in Lincoln against an establishment of 11; and 4 wte middle grade doctors at Pilgrim against an establishment of 11, despite extreme mitigation and planning, the rota could not be safely staffed on a prospective basis.

The Trust Board was appraised of the situation on 2 August and the potential options. The Trust Board was in agreement that the level of additional risk to patients as indicated by deterioration in ambulance handover times (particularly at Lincoln County Hospital); delays in first assessment (although the sickest patients are always prioritised); and a significant reduction in the number of patients assessed, treated, admitted or discharged within four hours (causing overcrowding within the emergency departments) is too great to continue without action. Approval was given to work through the possibility of a temporary service closure at Grantham in order to support staffing at Lincoln and Pilgrim A&E departments.

A significant volume of discussion and work was conducted following the Trust Board to consider the implications and impact on patients, staff and partner organisations.

Throughout the intervening period the Trust Board as well as key stakeholders have been kept informed where possible. Support to proceed with the temporary change to the opening hours at Grantham was provided on the morning of the 9 August with the change taking effect on Wednesday 17 August.

The purpose of this report is to provide:

- A timeline of actions leading up to and following the temporary closure of Grantham A&E
- The full collection of documentation associated with this change
- Provide an early indication on the impact of this change
- To outline the next steps

The full detail of the case for change, options considered and full actions are attached as appendices to this report.

2. Timeline

Date	Action
1.8.16	Email sent to all Clinical Commissioning Groups and Lincolnshire providers (including East Midlands Ambulance Service) accountable officers providing an update of the staffing issues and request for help
1.8.16	Briefed chair of System Resilience Group and Accountable Officer of the lead Clinical Commissioning Group regarding Trust Board paper
2.8.16	Trust Board appraised of the situation, potential options and gave approval to work through the possibility of a temporary service closure at Grantham
2.8.16	NHS Improvement and Chair of System Resilience Group and Accountable Officer of the lead Clinical Commissioning Group appraised of the Trust Board decision

Date	Action
2.8.16	Chief Executive of Healthwatch briefed of the current A&E challenges
3.8.16	Briefed Chief Executive of East Midlands Ambulance Service and South West Lincolnshire Clinical Commissioning Group Accountable Officer
3.8.16	Further communications regarding staffing support released. Crisis report for further medical staff
4.8.16	NHS Improvement checklist for temporary closure submitted (Appendix A)
5.8.16	Updated Chief Operating Officer at East Midlands Ambulance Service
5.8.16	Finalised Emergency Care Service Case for Urgent Service Reconfiguration on Grounds of Patient safety submitted to NHS Improvement (Appendix B)
8.8.16	Finalised Case for change shared with the Trust Board
8.8.16	Briefed Mr Dilip Mathur, Clinical Director Grantham
9.8.16	Authorisation from NHS Improvement provided to enact temporary service closure on grounds of patient safety
9.8.16	Enacted the communications plan (Appendix C) • Briefed local staff side, all affected staff, Healthwatch, local councillors, MPs, and stakeholders • Telephone briefing with Care Quality Commission • Face to face staff briefings at Lincoln, Pilgrim and Grantham • Face to face media briefing to ensure public and patients would be aware • 1 to 1 staff briefings with affected staff • All user email message to all staff • All ULHT stakeholders emailed • UHLT members emailed (which included over 1000 members of the public) • Grantham MAC attended
9.8.16	Briefed Chief Executives of University Hospitals of Leicester NHS Trust, Nottingham University Hospitals NHS Trust, and Peterborough and Stamford Hospitals NHS Foundation Trust
9.8.16	System Resilience Group Briefed
10.8.16	Publish press release on website, including Frequently Asked Questions and post on social media
10.8.16	Media interviews to ensure public and patients aware and engaged
10.8.16	1:1 with consultants
10.8.16	1:1 with middle grades
10.8.16	1:1 with juniors

Date	Action
10.8.16	1:1 with nursing and departmental staff commenced
10.8.16	Teleconference held to discuss possible service models which included Lincolnshire Community Health Services NHS Trust, South West Lincolnshire Clinical Commissioning Group and Lincolnshire Partnership NHS Foundation Trust. East Midlands Ambulance Service consulted.
11.8.16	Agreed final operating model for Grantham during temporary closure. Opening 09:00 and closing at 18.30 (staffed to 21.00 to assess, treat, admit or discharge patients who have presented prior to closing at 18.30)
11.8.16	Briefed stakeholders on decision to close A&E overnight
11.8.16	All user email message to all staff on new opening hours
11.8.16	All user email message to all stakeholders including Healthwatch, local councillors, Mid-Kesteven District Council, Lincolnshire County Council. Begin considering and responding to public enquiries and questions
11.8.16	Press release on new opening hours
11.8.16	Published press release on website, including updated Frequently Asked Questions and post on social media
11.8.16	Sent out email message to all staff and Non-Executive Directors
11.8.16	Grantham, Lincoln and Pilgrim staff briefing
15.8.16	Implementation plan further developed and implemented
15.8.16	Quality Impact Assessment Finalised (Appendix D)
15.8.16	Equality Impact Assessment Commenced (Appendix E)
15.8.16	Displayed posters at Grantham and District Hospital and distributed to GP surgeries, other community areas
16.8.16	Full Briefing and update to the Trust Board (Trust Board Development session)
16.8.16	Out of Hours service worked from new location at Grantham
16.8.16	Standard Operating Procedure agreed for the process of overnight closure
17.8.16	Media and continued dialogue with public and stakeholders over details
17.8.16	**New departmental hours implemented**
17.8.16	Published press release on alternatives to A&E
18.8.16	Reviewed time staff available post closure and extended from 21:00 to 21.30
18.8.16	Daily reviews initiated with NHS partners. Continued dialogue with public and stakeholders
19.8.16	Monitoring process agreed to review impact

Date	Action
19.8.16	Lead Clinical Commissioning Group and NHS Improvement undertook a quality visit of Grantham A&E following changes and reported no concerns (awaiting written feedback)
22.8.16	Reviewed time staff available post closure and extended from 21:30 to 22.00
23.8.16	Meetings held with Lincolnshire Community Health Services NHS Trust and South West Lincolnshire Clinical Commissioning Group to explore possibility of a minor injury service being provided by Lincolnshire Community Health Services NHS Trust to supplement the out of hours service
23.8.16	Met with Police and Crime Commissioner
23.8.16	Received letter before action instructed from Councillor Morgan as a representative of SOS Grantham Hospital
26.8.16	Potentially impacted on groups communication plan further refined (Appendix F)
30.8.16	Received letter of support from NHS Improvement
30.8.16	Provided an update to Care Quality Commission
31.8.16	Continued dialogue with staff, public and stakeholders

3. Impact of the changes

The impact of these changes cannot be underestimated upon patients, stakeholders and our staff. The decision to reduce the opening hours at Grantham was not taken lightly but on the grounds of patient safety due to a lack of a viable alternative option.

Throughout this process our staff have worked hard to make the new arrangements work and their support is recognised.

A monitoring process has been agreed and is in place. The early monitoring between 17 August and 29 August is showing:

- Daily average attendances at Grantham are approximately 60. This demonstrates a reduction of 20 attendances a day on the average attendances (80) seen between 1 August and 16 August. This is less than 25 reduction predicted. The daily peak in attendances is now being seen earlier in the afternoon suggesting a change in presenting behaviour. There has been no increase in attendances at Lincoln or Pilgrim.
- Daily average admissions at Grantham are 12 compared to a previous average admission rate of 14. This suggests a daily reduction of 2 admissions a day. This is less than the 6 predicted. There has been no increase in admissions at Lincoln or Pilgrim.
- No material change in Out of Hours presentations.
- No change in ambulance conveyance rates at Lincoln or Pilgrim. Awaiting further data from EMAS to analyse potential impact.

Early indications suggest that the expected impact is lower than originally thought. However this will remain under close scrutiny as the above data is only for a 13 day period and therefore needs to be viewed with caution.

During these early stages releasing staff and orientating them to the department 120 hours of middle grade support from Grantham staff have provided cover at Lincoln A&E. This equates to 16.5% (1:6) of the Lincoln Middle grade rota. This is expected to increase over the coming weeks as the rotas settle.

4. Recruitment activity

Significant recruitment activity has been underway for a considerable amount of time to increase the number of middle grade staff. Additional actions have included:

1. All adverts have been reviewed and refreshed.
2. A new agency has approached us who suggest they can help us to recruit consultants and middle grades across hard to recruit to posts, which is being explored.
3. CESR (Certificate of Eligibility for Specialist Registration) posts re-advertised
4. A&E speciality doctor posts advertised with up to 2 sessions a week, together with funding, to support the completion of an appropriate part time MSc or PhD. This ULHT funded initiative has been developed in partnership with the Community and Health Research Unit, based in the University of Lincoln.
5. ULHT to have a recruitment stand at the Royal College of Emergency Medicine (RCEM) conference 20th-22nd of September.
6. RCEM agreed to tweet all of their members with details of our vacancies to support our ED recruitment drive.
7. Launch of Masters programme for middle grades planned

At the time of writing our middle grade establishment is as follows:

Site	Establishment	In Post
Lincoln	11	2.6
Pilgrim	11	5
Grantham	6	5

As can be seen from above Lincoln have not been able to recruit as yet, Pilgrim have managed to increase their establishment by 1 (from 4 wte) and Grantham have interviewed a suitable candidate in Egypt and are awaiting the individuals status and requirements to enter into the UK and practice as a middle grade.

5. Conclusion

Timeline going forward

- ULHT will consider and respond to the legal letter before action
- Continue to review temporary arrangement with staff and partners
- Continue the implementation of the public and stakeholder engagement plan
- Discuss at Member Locality Forums

- Regular system calls will continue to monitor the impact of these temporary changes
- Further quality assurance visit by NHSI and lead CCG will be completed
- Brief Trust Board in October and November
- Continue to seek suitable middle grade medical staff in line with recruitment activities
- Review temporary arrangements for Grantham A&E at Lincolnshire A&E Delivery Board 6 September 2016 and 11 October 2016
- NHSI and NHSE to set the date, prior to the 17 November, to review whether the temporary changes in place at Grantham A&E can be lifted

6. Consultation

This is not a consultation item.

7. Appendices

These are listed below and attached at the back of the report	
Appendix A	ULHT Hospital Services
Appendix B	Emergency Care Service - Case for Urgent Service Reconfiguration on Grounds of Patient Safety
Appendix C	Grantham A&E Changes – Communications Plan
Appendix D	Quality Impact Assessment Tool
Appendix E	Equality Impact Assessment
Appendix F	Grantham A&E Equality Analysis Communications and Engagement Plan

8. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Dr Suneil Kapadia, Medical Director, United Lincolnshire Hospitals NHS Trust, who can be contacted on 01522 573850 or suneil.kapadia@ulh.nhs.uk.

ULHT Acute Hospital Services

There is an imminent risk to A&E services provided at Lincoln County Hospital/ Pilgrim Hospital by United Lincolnshire Hospitals NHS Trust. This report summarises the key issues and outlines the Trust proposed response, against the NHSI Emergency Change Checklist.

Fast-Track Emergency Changes to Services Checklist

Service Area: A&E at United Lincolnshire Hospitals NHS Trust (ULHT)

Medical Director: Suneil Kapadia
COO: Mark Brassington

<table>
<tr><th>Document reference and summary</th><th>Status</th><th>Timescale</th><th>Lead</th></tr>
<tr><td>1. Service safety issues:
On 02/08/16 the Trust Board received in private a draft report that outlined a significant increase in risk to patients as a result of the current level of staffing within our Emergency Departments at Lincoln County Hospital and Pilgrim Hospital which has recently deteriorated further within the middle grade rota. The staffing position is as outlined below:
<table>
<tr><th></th><th>Grantham</th><th>Lincoln</th><th>Pilgrim</th><th>TOTAL</th><th>% ULHT</th></tr>
<tr><td>Consultant</td><td>0/2 ULHT
2 locums</td><td>3/7 ULHT
4 locums</td><td>1/6 ULHT
4 locums
1 gap</td><td>4/15 ULHT
10/15 locums
1/15 gap</td><td>26.6%</td></tr>
<tr><td>Middle Grade</td><td>5/6 ULHT
0 locums
1 gap</td><td>2.6/11 ULHT
0 locums
8.4 gaps</td><td>4/11 ULHT
0 locums
7 gaps</td><td>11.6/28 ULHT
0/28 locums
16.4/28 gaps</td><td>41.4%</td></tr>
<tr><td>Junior</td><td>5/7 ULHT
2 gaps</td><td>9/9 ULHT
0 gaps</td><td>6/8 ULHT
2 gaps</td><td>20/24 ULHT
4 gaps</td><td>83.3%</td></tr>
</table>
Utilising the recommendations as set out by the Royal College of Emergency Medicine (Service design & delivery committee 2015) it would suggest that in order to provide adequate clinical cover, supervision and training, we would require a minimum of 24 consultants and between 27-36 middle grades. Therefore it should be noted that our consultant compliment is below expected and the middle grades are within the lower end of expected. Therefore it is important additional context when reviewing ULHT employed staff against our expected number.

The current emergency situation relates to:
- A further reduction of 2 wte middle grades in post. Therefore we only have 11.6 wte compared to an expected number of 28
- Only 41% of the middle grade rota can now be covered by ULHT directly employed staff</td><td>Trust Board Approved the need for service configuration in private</td><td>Service change to be implemented by 17th August 2016</td><td>MD and COO</td></tr>
</table>

- More junior middle grades currently on the middle grade rota
- Increased reliance on agency locums to fill the vacant 59% of the A&E middle grade rotas which is not sustainable
- Reduction in fill rate of the vacant shifts resulting in an increased number of shifts not filled

The result of the above is an inability to maintain safely populated A&E rotas. As an example as at 09:00 on 1st August 2016 for the full week 15-30% of the medical rotas each day in A&E at Pilgrim and Lincoln were not covered.

This is placing additional stress upon the existing consultants and middle grades to provide cover and to stretch shifts with fewer bodies within the Lincoln and Pilgrim A&Es. This is a particular concern as they receive the full remit of presentations with the exception of poly trauma which is taken to the major trauma centre at Nottingham. Furthermore, the supervision of trainees delivering care is becoming increasingly more difficult.

This has been a deteriorating position despite significant efforts to recruit permanent members of staff.

Due to the above the Trust Board are in agreement that the level of additional risk to patients as indicated by; deterioration in ambulance handover times (particularly at Lincoln County Hospital), delays in first assessment although the sickest patients are always prioritised and a significant reduction in the number of patients assessed, treated, admitted or discharged within 4 hours (causing overcrowding within the emergency departments) is too great to continue without action.

As a result the Trust Board considered a range of options. The preferred option in the first instance is to reduce the opening hours of Grantham A&E. The reason for this is that Grantham currently has a significantly reduced specialty take, has underutilised doctors out of hours (average of 7 patients attending between 23:00 and 07:00) and that the recently completed Commissioner Requested Services identified the need for a 24/7 presence at Lincoln and Pilgrim.

The proposed model is to:

- Maintain an A&E at Lincoln and at Pilgrim 24/7
- Maintain an A&E at Grantham 08:00 to 18:00 (to be confirmed)
- Ambulances would be received 08:00 to 17:00 (TBC)
- The department would be staffed until 20:00 to ensure all patients in the department, from ambulance conveyance up until 17:00 and self-presenters until 18:00, have been

assessed, admitted or discharged by 20:00.

This model would minimise the impact upon EMAS and surrounding acute providers. It would also enable the continuation of a medical take at Grantham.

Confidential conversations are ongoing with a small group of clinical leaders across ULHT and SWLCCG to confirm the final model and operational policy. This is expected to be completed by 10/8/16.

It is anticipated that the change in service provision would be required for a minimum of 3 months. A review will be completed by the SRG after 3 months and then on monthly intervals to determine if the required threshold has been reached to re-establish a 24/7 A&E at Grantham.

This threshold has been set as:
-No deterioration in the current consultant position
-Fill rate of at least 75% (21) of the Middle Grade establishment (28) on an 8 week prospective basis.

It must be noted that this will not mitigate the full risks nor provide the full solution. It is an interim measure to improve the significant safety concerns. A more radical solution could not be implemented quickly and requires significant work.

Initial confidential conversations have occurred with CEO EMAS, Accountable officer of SWLCCG and Accountable officer of LECCG (Chair of SRG) where unanimous support has been provided. Clinical support for this change across the hospital is expected. Although this remains as a potential risk that will be actively managed.

We are working on the assumption that the above model will release 4 wte middle grades and 1 FY2 in the initial phase who can be deployed to Lincoln (and / or Pilgrim). At this stage conversations with affected staff have not been conducted. The contractual arrangements have been explored and there is provision to move staff between sites as long as the travel time is not ‘unreasonable’. A suite of incentives are being developed to increase the likelihood of staff agreeing to move. Whilst this predominantly affects medical staff this is also being explored for the affected nursing staff.

A significant amount of debate has occurred with the public and local stakeholders over the recent years, months and weeks associated to the future direction of the Grantham site. However

the current reduction in the available workforce has resulted in us not being able to maintain three staffing rotas 24/7.

It is anticipated that the proposed change would contribute towards the achievement of agreed STF 4 hour trajectory.

2. Mitigation of risks

The risk has been mitigated on a daily basis over recent months. This has been achieved through stretching shifts, utilising ULHT staff out of hours and backfilling core hours, skill mixing rotas utilising medical and surgical middle grades, utilising consultant nurse, ACPs and ENPs where possible to provide additional support and stretching out of hours support into core hours where possible. These have not always been possible to consistently apply and nor are they sustainable.

Agencies have been filling vacant middle grade shifts without long term arrangements being possible. Since April 1st 1582 shifts have breached the agency price cap across our A&Es at ULHT. As stated during June, July and into August we are seeing a reduction in our fill rate and an escalation in costs at a time where we have become increasingly dependent upon locum support.

The health system primary care and community services have been approached to support rota gaps where possible.

This risk has been on the strategic / corporate risk register since November 2015.

3. Proposals for change

Case for change document will be finalised and available 5/8/16

4. Impact assessment

Reference QIA to be finalised and available 05/08/16	Insert	Insert

Between 18:00 and 08:00 Grantham receives on average 30 attendances (85th centile = 35 attendances). Of these 24 self present (85th Centile = 28) and 6 (85th centile = 7) are conveyed by EMAS.

Analysis suggests that based upon the Self presenters home postcode their next nearest A&E would be as follows (based on 28 [85th centile]):

Lincoln 50% (14)
Pilgrim 25% (7)

Peterborough 8% (2)
Others 17% (5)

The above assumes:

1) Patients do not change their self-presenting behaviours which they may do to access a local service. This would limit the impact of the other providers. The staffing model will be able to absorb some increases in hourly presentations above the current levels.
2) Out of hours services at Grantham does not expand its presence onsite
3) Additional patients are not absorbed within urgent care services within the SWLCCG footprint

Analysis suggests that based upon the Patients conveyed by EMAS by their pick up postcode their next nearest A&E would be as follows (based on 7 – 85th centile):

Lincoln 50% (3)
Nottingham 25% (2)
Leicester 25% (2)

5. Communication Plan

Please refer to the Draft Communications plan 4/8/16. Headlines are as follows:

- SRG Chair confidential briefing 2nd August
- EMAS CEO confidential briefing 3rd August
- SWLCCG AO confidential briefing 3rd August
- NHSI and NHSE approval to proceed required by 5th August '16
- CEO to CEO briefings to NUH, Peterborough and UHL
- Stakeholder briefings 9th August
- Media briefings 9th August
- Staff briefings 9th August
- SRG review 9th August
- Public communications and engagement begins 10th August
- Stakeholder, Media and Staff briefings regarding final model and operational policy 11th August
- Go Live date Wednesday 17th August 2016

In discussion with NHSI on the timing and sequence

Insert

Insert

6. Audit trail

1/8/16 All AO briefed by email of current issues and request for help
1/8/16 Chair of SRG briefed by ULHT COO
2/8/16 Consideration in private by ULHT Trust Board
2/8/16 NHSI informed of outcome of the TB
2/8/16 Chair of SRG informed of outcome of TB

3/8/16 AO of SWLCCG briefed
3/8/16 First draft emergency checklist submitted to NHSI
3/8/16 First draft comms plan submitted to NHSI
3/8/16 Further comms requesting staffing support released
3/8/16 V2 checklist reviewed internally
4/8/16 V3 checklist submitted to NHSI

United Lincolnshire Hospitals NHS
NHS Trust

EMERGENCY CARE SERVICE
Case for Urgent Service Reconfiguration on Grounds of Patient safety

August 5th 2016

Executive Summary

This report is the culimination of a series of circumstances that have led to a crisis situation within our Emergency Departments. This is not a situation that any health economy wants to find itself in. However, patient safety is and must always be our first and foremost concern and that is why we are recommending unprecedented action to protect the safe care that we need to provide.

At the time of writing, we do not have sufficent doctors in total, to staff the Emergency Department rotas on three ULHT sites to ensure the safe provision of emergency clinical services.

This report contains our response to the emergency care crisis. In section one, it provides the background. In section two, it sets out and analyses the issues that we are facing in our current service provision. In section three, it considers the options avaliable to the Trust Board. In section four, there is an impact assessment.

This report has been developed as a response to the emergency care difficulties at United Lincolnshire Hospitals NHS Trust. It has been developed by the Chief Operating Officer and Medical Director.

The objectives of the report are;

- To provide the current situation with regards to emergency care at Lincoln Hospital, Pilgrim Hospital and Grantham Hospital

- To develop, analyse and appraise the options for resolving the emergency care crisis

- To outline the recommended option that is being proposed for implementation with effect from Wednesday 17th August.

THE EMERGENCY CARE SERVICE – CURRENT SITUATION

Background context
Hospital emergency departments are staffed by consultants, doctors, doctors in training, nurse practitioners and nursing staff. In recent months it has become increasingly difficult to staff our middle grade doctor rota for our emergency departments. This issue has arisen for a number of reasons – there is a national shortage of emergency medicine doctors; there are insufficient doctors in training who choose to come to ULHT creating gaps in the rotas; our reliance on locums has increased and despite breaking the national agency cap, we continue to have difficulty securing locums in the required volume to consistently fill rota gaps.

We have taken a significant number of actions to recruit a sustainable workforce including continuous international and national recruitment activities, changing how our service works and adapting some job roles to maintain services. We have approached our GP's and they too have worked some shifts to provide additional support to the emergency departments. However at present we do not have a sustainable or consistent solution to the staffing crises.

Current staffing crisis
We currently have just 4 substantive consultants in post out of the funded 15 wte posts across the three 24/7 Emergency Departments (one of which has been on an extended period of leave and recently returned); we use NHS and agency Locum doctors to cover the 11 consultant posts that we have not been able to recruit to. Our consultants have been working extra shifts to cover the middle grade doctor rota and where required have been resident at night. However this isn't sustainable and this approach is beginning to affect our ability to provide consultant supervision and clinical input.

Due to a recent deterioration of a further 2 wte middle grade vacancies we have just 11.6 of the 28 funded middle grade doctors. This means we can currently only staff 41% of the required weekly hours on the middle grade rota across three emergency departments. In addition to this our level of experience and skill mix within the 11.6 wte staff across our 3 departments has reduced due to experience individuals moving on or gaining promotion being replaced by more junior members of staff. This has placed additional pressures upon our 4 permanent and 10 locum consultants to provide departmental leadership.

Where are we now?
Despite the commitment from our consultant team, and ongoing recruitment drive, we can no longer staff our three emergency department rotas consistently. Lincoln Hospital and Pilgrim Hospital are significantly affected by the shortage of middle grade doctors. This creates significant uncertainty about the availability of medical staff resulting in increased and unacceptable stress placed upon our workforce.

Whilst efforts are continuing to secure the staff we need to provide a safe working environment for staff and a safe clinical environment for patients. Unfortunately due to the staffing crises we have now reached a level which compromises patient safety as can be seen by extending ambulance handovers, delays in first assessment and a deterioration in the number of patients who are assessed, treated, admitted or discharged within 4 hours.

As a consequence of the deterioration and following the most recent decline in staffing numbers prospective rotas can no longer be staffed with confidence. Therefore it is believed that a 'tipping point' has been reached where the level of risk is not acceptable and cannot be mitigated any further. Therefore it is with regret that further action is required to ameliorate the unacceptable risks to patient care created by a significant middle grade doctor shortage.

What have we done?

- During the recent past significant actions have been taken to ensure a compliant and safe rota. This has included continuous recruitment including the use of CESR to attract staff and develop consultants. Where recruitment has become more difficult mitigations have been taken which have included: utilising agency staff, requesting consultants to act down and fill middle grade shifts, stretch shifts of existing staff to cover vacant shifts resulting in fewer clinicians on the shop floor, filling middle grade rotas with non-middle grade staff such as junior doctors, nurse consultant and Advanced Nurse Practitioners. This has the impact of having less clinical leadership and support for trainees which increases the clinical risks to patients and places staff at additional risk. However due to the numbers of gaps on the rotas these actions are no longer sufficient. Nor are we able to attract long term or a sufficient quantity of short term (shift by shift) locums to ensure the rotas can be filled prospectively with confidence.
- The risks have been escalated to the Trust Board, our Commissioners and to NHSI.
- We have considered the options available to mitigate the risks
- We describe the preferred option that we have requested support from NHSI to enable planned implementation from 17th August 2016. However the model must remain open to development as the plans are discussed more widely with our staff, partners, stakeholders and regulators.
- A conversation will occur at SRG on Tuesday 9th August

1. Introduction

1.1 Context and Background

An overview of United Lincolnshire Hospitals NHS Trust

- **Lincolnshire is the second largest county in the UK and is characterised by dispersed centres of population in large towns and the city of Lincoln, and otherwise largely rural communities.**
- **Transport networks are underdeveloped resulting in transport times of around 1 hour between the respective hospital sites.**
- **Lincolnshire has one of the fastest growing populations in England projected to rise to 838,200 by 2033.**
- **We provide acute hospital care, to around 757,000 residents of Lincolnshire.**
- **Indicated levels of health care need are relatively high due to an accelerating population (above the national average) and the trend towards an ageing population profile will continue, with the proportion of people over 75 years of age predicted to increase by 101% between 2012 and 2037.**
- **These factors combine to increase pressure on hospital services, particularly urgent care (COPD, diabetes, CHD, and elderly frailty) and referral for cancer treatment, and it is widely acknowledged and understood that the way health and care services in the county are provided needs to change.**
- **In an average year, we treat more than 150,000 accident and emergency patients, over 600,000 outpatients and over 140,000 inpatients, and deliver over 5,000 babies.**

ULHT is one of the largest acute trusts in the country. The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health and Care Services or local GP clusters. These include: Louth County Hospital, John Coupland Hospital, Gainsborough, Johnson Community Hospital, Spalding and Skegness and District General Hospital

We deliver services across the following specialities:

Audiology	Dermatology	Haematology	Ophthalmology	Respiratory Physiology
Breast Services	Diabetic Medicine	Hepatobiliary and Pancreatic Surgery	Oral and Maxillofacial Surgery	Specialist Rehabilitation Medicine
Cardiology	Diagnostic Services	Maternity and Obstetrics	Orthodontics	Rheumatology
Chemotherapy	Dietetics	Medical Physics	Pain Management	

Children's Community Services	Ear, nose and Throat	Medical Oncology	Palliative Care	Therapies
Clinical Immunology	Endocrinology	Neonatology	Pharmacy	Trauma and Orthopaedics
Clinical Oncology	Gastroenterology	Nephrology	Radiotherapy	Urology
Colorectal Surgery	General Medicine	Neurology	Rehab Medicine	Vascular Surgery
Community Paediatrics	General Surgery	Neurophysiology	Research and Development	
Critical Care	Gynaecology	Nuclear Medicine	Respiratory Medicine	

Whilst ULHT is the leading provider of elective care across all four CCGs in Lincolnshire, Northern Lincolnshire and Goole NHS Foundation Trust and Peterborough and Stamford NHS Foundation Trust achieve a significant share of elective care in Lincolnshire East and South Lincolnshire respectively. It is of note that South Lincolnshire CCG commissioners have more than 70% of its elective care from hospitals outside Lincolnshire.

An overview of the services provided at our hospitals
The Lincoln and Pilgrim Hospitals provide a full range of clinical services, with only the following exclusions:

- Neurosurgery
- Cardiothoracic surgery
- Spinal surgery

Specialised services are provided at ULHT either at Pilgrim Hospital or at Lincoln Hospital, and in the case of some services, both hospital sites. The specialised services include: Critical Care level 3 and Stroke Medicine at both Pilgrim and Lincoln hospitals, Cardiology (Cardiac Centre at Lincoln), Specialised Rehabilitation Medicine level 2a at Lincoln and Vascular services at Pilgrim Hospital.

Grantham & District Hospital does not provide any in patient specialised services; there is currently a restricted medical take at Grantham, together with a range of elective surgery and outpatient services. Grantham hosts the Trust's main Cardiac Diagnostic services, including Cardiac MRI and Cardiac Echo both of which see more patients than our neighbouring hospitals in Nottingham and Leicester.

Our hospitals have the following number of beds:

- Grantham: 100 beds
- Lincoln: 540 beds
- Pilgrim 350 beds

An overview of the current Emergency Department service
ULHT currently provide three Emergency Service Departments running 24 hours per day, 7 days per week. The regional major trauma centre is located at Nottingham University Hospitals NHS Trust; this is where patients needing the services of a major trauma service are directed. The Emergency Departments at Lincoln and Pilgrim hospitals provide a full A&E service 24 hours per day 7 days per week, and can both receive patients via air ambulance.

Lincoln County Hospital

The Emergency Department at Lincoln provides unrestricted access to A&E services 24/7 with an in-patient infrastructure to support most clinical emergencies. It can receive patients by air ambulance. Seven Consultants (3 ULHT and 4 locums) provide on-site presence from 08:00 to 22:00 in week and 08:00 to 20:00 at weekends, and thereafter offsite on call.

Cardiac emergencies are sent to the Cardiac centre at Lincoln Hospital. Both hospitals take hyper acute stroke patients.

Pilgrim Hospital, Boston

The Emergency Department at Pilgrim provides unrestricted access to A&E services 24/7 with an in-patient infrastructure to support a range of clinical emergencies. It can receive patients by ambulance. Six Consultants (1 ULHT and 5 locums) provide on-site presence in the A&E Department from 08:00 to 21:00 in week and 09:00 to 16:00 at weekends, and thereafter offsite on call.

Vascular emergencies are sent to the Pilgrim Hospital. Both hospitals take hyper acute stroke patients.

Grantham & District Hospital

The Grantham & District hospital provides unrestricted access to A&E services 24/7 for a very limited range of conditions. The Emergency Department and in-patient infrastructure is unable to support the range of emergencies that could be expected to be treated in an ED. Two locum Consultants provide on-site presence between 09:00 and 17:00 weekdays only, with off-site on call between 17:00 and 09:00. Consultants are off-site oncall between Friday 17:00 and Monday 09:00.

The health community (EMAS and GPs) are aware that patients with the following conditions should not be taken to Grantham & District hospital:

- Cardiology patients (heart attacks (inc. suspected), abnormal heart rhythms)
- Surgical issues

- Multiple trauma
- Suspected stroke
- Paediatric emergencies
- Maternity
- GI bleeds
- Patients requiring ICU

Only patients with limited medical conditions and single limb orthopaedic injuries are admitted to Grantham Hospital via the A&E department or via GP referral. Any patient who presents as a self-referral/walk in to the Grantham Hospital A&E department and requires a specialist review beyond that available at Grantham Hospital, is transferred to Lincoln, Pilgrim or Nottingham Hospital.

Approximate number of patients presenting to the ULHT Emergency Departments on an annual basis are as follows:

- Grantham A&E: 29,000 (80 per 24 hours)
- Lincoln A&E: 71,000 (191 per 24 hours)
- Pilgrim A&E: 55,000 (148 per 24 hours)

The average number of patients who present to the emergency department between the hours of 23:00 and 07:00 are as follows:

- Grantham: 11 patients
- Lincoln: 34 patients
- Pilgrim: 25 patients

1.2 Current activity levels in the A&E Departments

The analysis below demonstrates the numbers of patients attending the Emergency Departments at all three hospital sites. Whilst the current emergency care crisis is about safe staffing levels, it is useful context to understand the levels of activity within the emergency departments to demonstrate the wider context.

The tables below shows a summary of attendance data for each hospital site (over the recent 12 month period, April 15 – March 16, and for the first quarter of 2016/17).

Period: 2015/16 full year

Average numbers per day	Site	Number	%
Attendances	GDH	80	
	LCH	190	
	PHB	147	
Admissions from ED	GDH	14	17.5%
	LCH	50	26.3%
	PHB	47	32.0%

In 2015/16 when compared to 2104/15:
- 4.3% growth in attendances [National growth 2.3% and Midlands and East 6.5%]
- 1% growth in admissions [National growth 2.6% and Midlands and East 4.5%]

Period: 2016/17 first quarter

Average numbers per day	Site	Number	%

Attendances	LCH	199	
	PHB	158	
	GDH	85	
Admissions from ED	LCH	54	27.1%
	PHB	49	31.1%
	GDH	14	16.4%

In Q1 of 2016/17 when compared to Q1 2105/16:

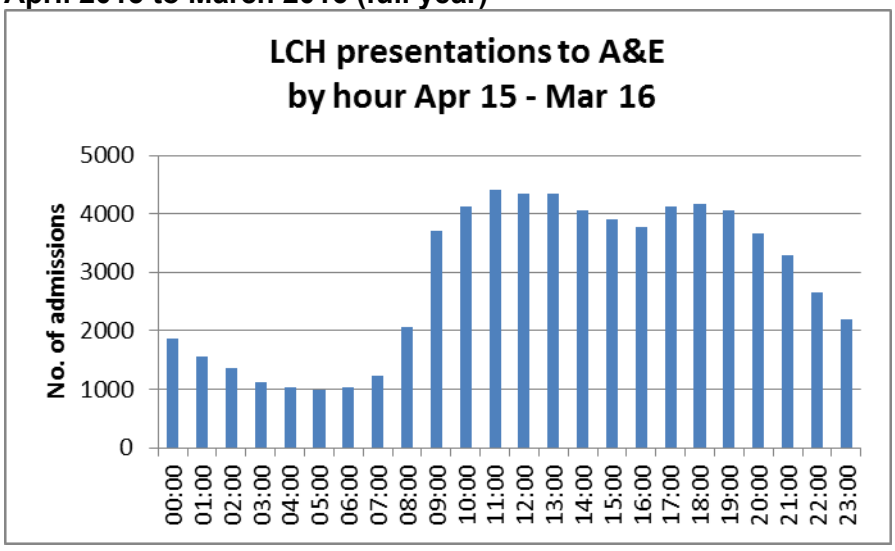
- 4.9% growth in attendances
- 4.2% growth in admissions

The Q1 position of significant attendance and admission growth is contributing to the increase in clinical risk at a time of less clinical staff availability.

Flow of activity through the Hospital Emergency Departments

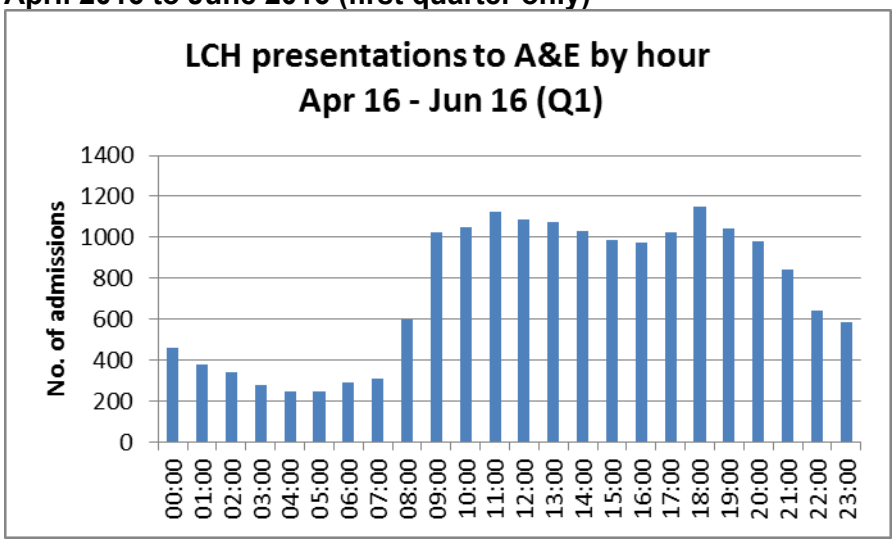
By the hour at Lincoln Hospital
The bar charts below demonstrate the flow through the Emergency Department at Lincoln Hospital by hour of the day, demonstrating the peak in attendances between the hours of 09:00 and 20:00. The other hours of the day experience relatively low attendances in comparison.

April 2015 to March 2016 (full year)



The trend for this current year is following the same pattern as for 2015/16.

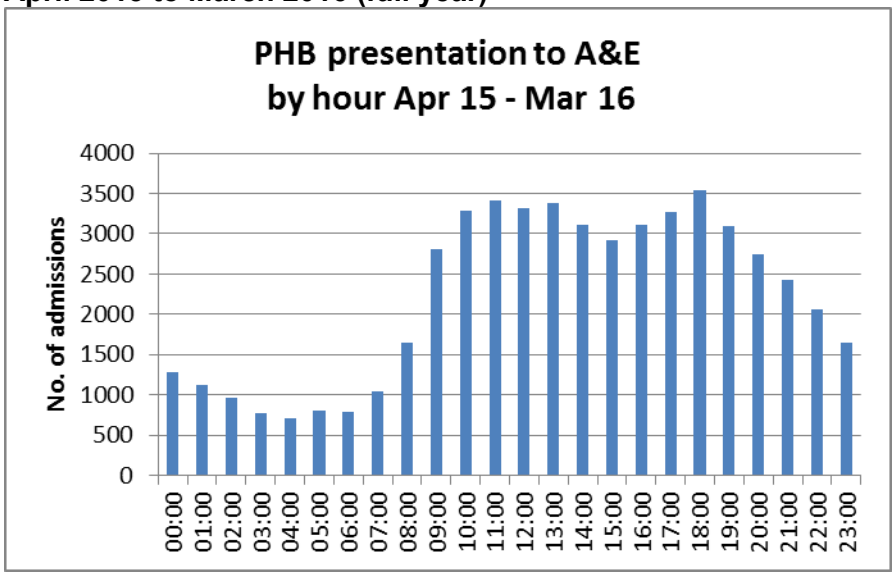
April 2016 to June 2016 (first quarter only)



By the hour at Pilgrim Hospital

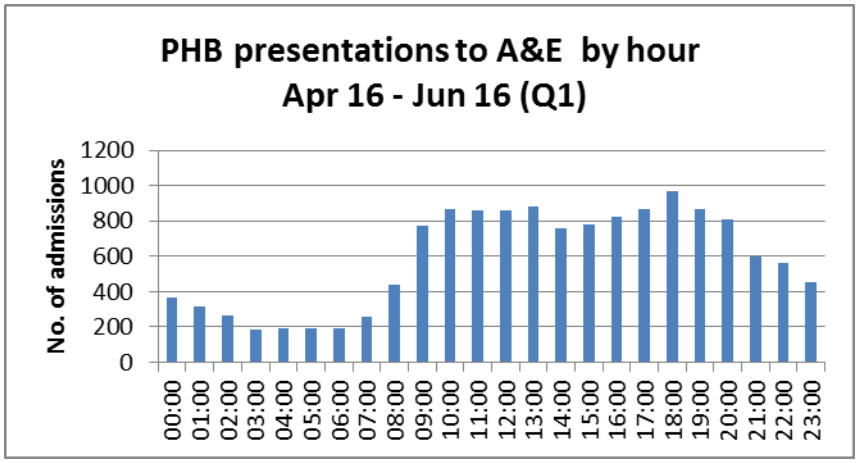
The bar charts below demonstrate the flow through the Emergency Department at Pilgrim Hospital by hour of the day, demonstrating the peak in attendances between the hours of 09:00 and 20:00. The other hours of the day experience relatively low attendances in comparison.

April 2015 to March 2016 (full year)



Once again, the flow for the first quarter of the current year is showing the same trend as for 2015/16.

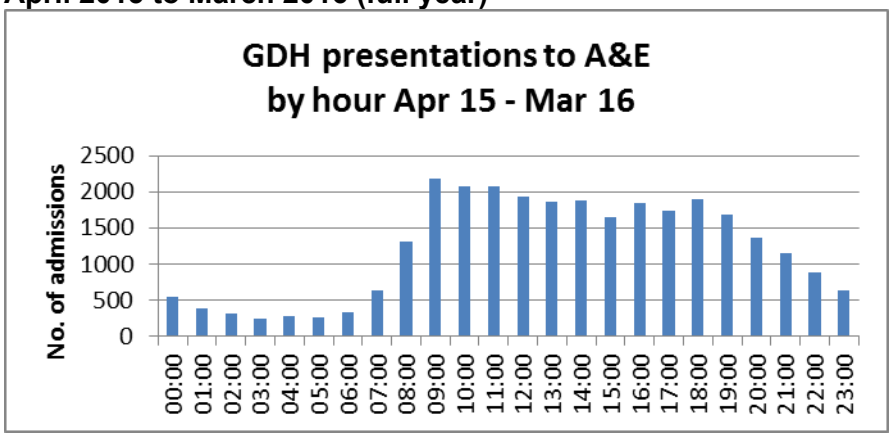
April to June 2016 (First Quarter)



By the hour at Grantham Hospital

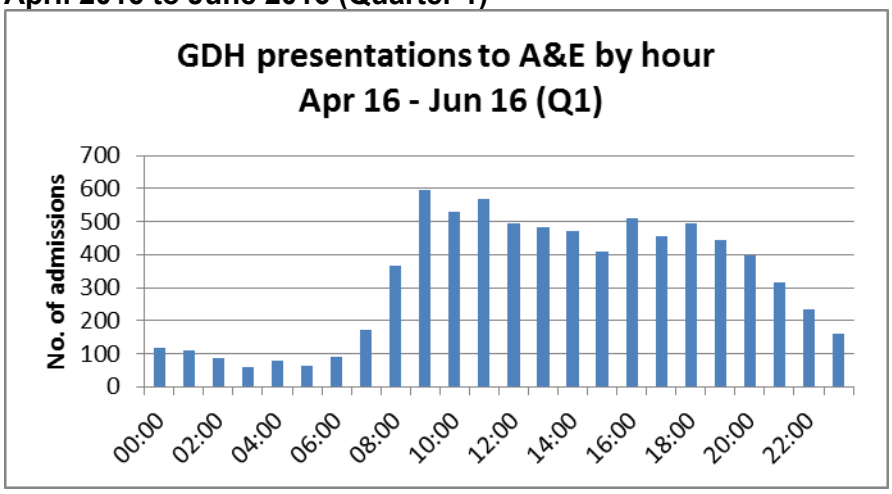
The bar charts below demonstrate the flow through the Emergency Department at Grantham & District Hospital by hour of the day, demonstrating the peak in attendances between the hours of 09:00 and 18:00. The other hours of the day experience relatively low attendances in comparison.

April 2015 to March 2016 (full year)



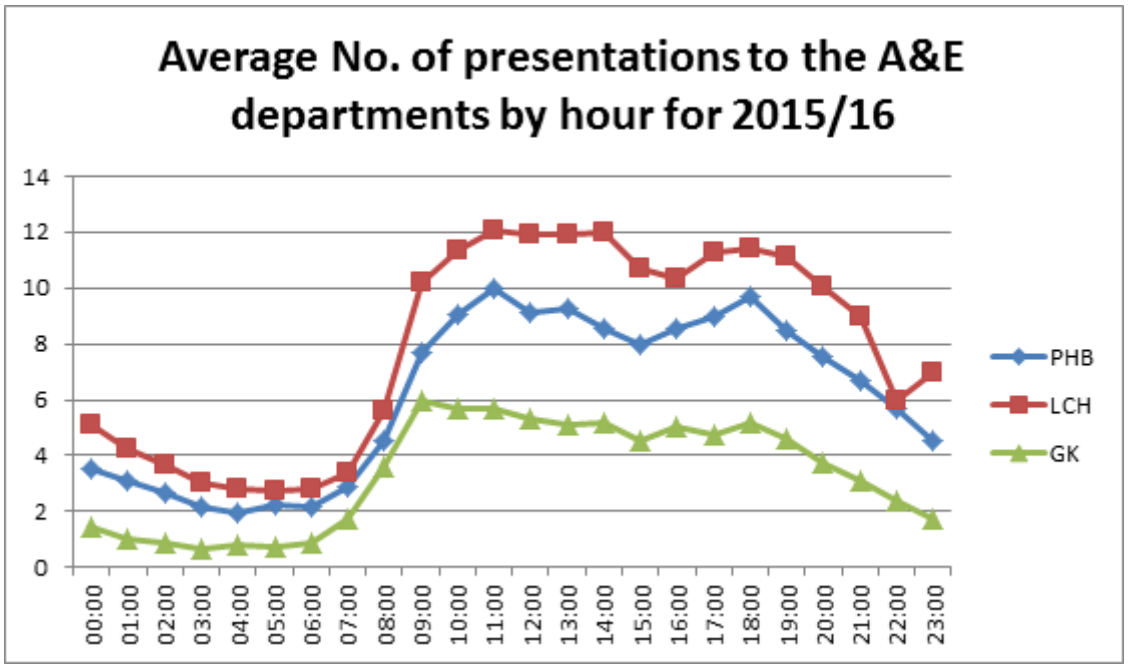
The flow for the first quarter of the current year 2016/17 is following a similar trend to that of 2015/16.

April 2016 to June 2016 (Quarter 1)



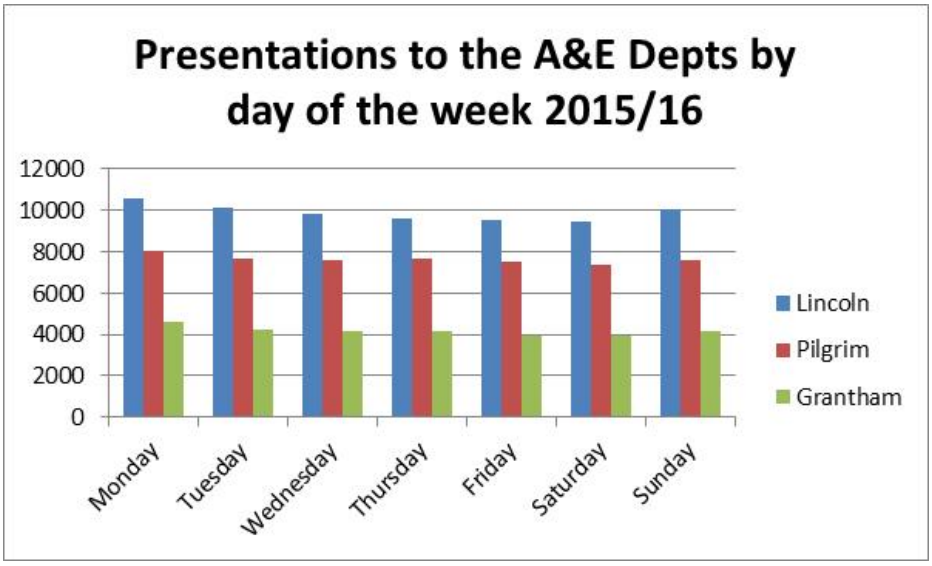
Summary of presentations to A&E by hour

The graph below summarises the presentations to each of the A&E departments. It shows the average number of presentations to all three A&E departments by hour, for the period April 2015 to March 2016.



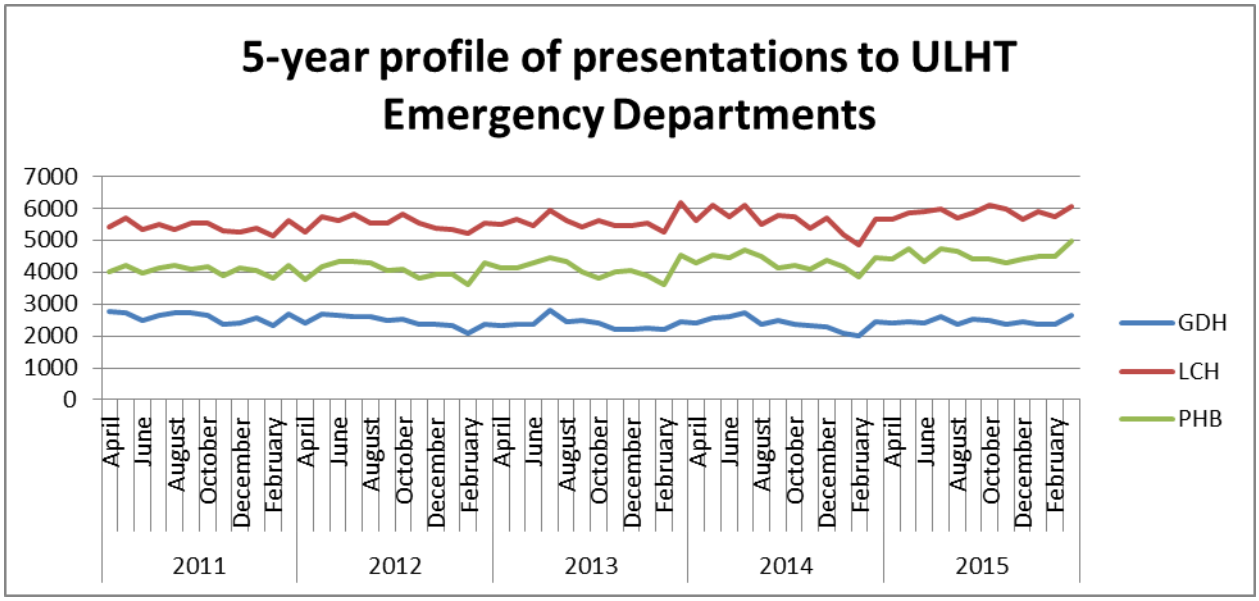
Summary of presentations to the A&E departments by day of the week

The bar chart below demonstrates the flow through the Emergency Department at Lincoln Hospital by the day of the week, demonstrating that the peak in attendances occurs on Mondays of each week followed by Sundays.



Overall ED Attendance Profile over the Last 5 Years (2011 - 2016)

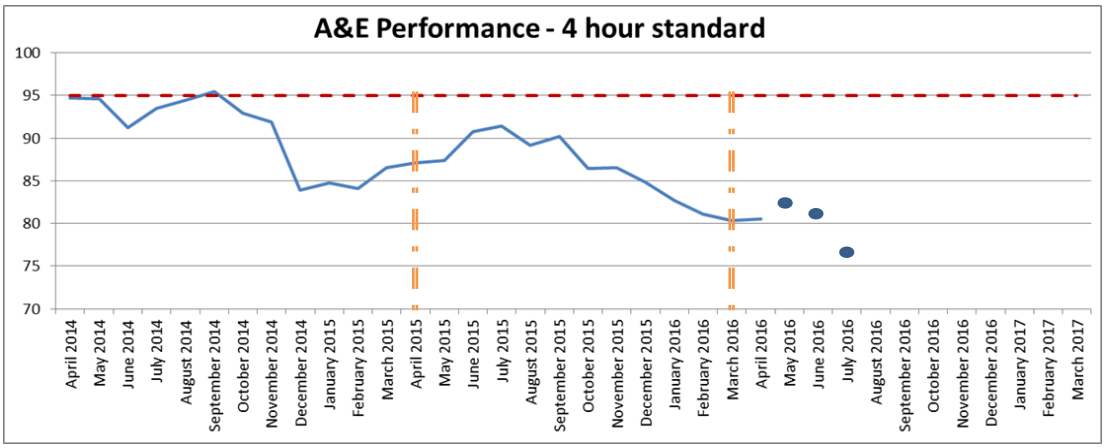
The chart below shows the profile of presentations to the emergency departments since 2011. This demonstrates an increase in presentations to both Lincoln (13.2%) and Pilgrim (25%) over the five year period. Grantham has remained relatively static.



1.4 Our current performance against national standards

The national 4-hour target has historically been challenging to achieve at all three hospital A&E departments. The graph below shows the performance for ULHT against the 4 hour standard since April 2014. As the workforce pressures have increased and demand has continued to rise performance has dropped significantly. This particularly stark in July 2016.

Our ability to assess, treat, admit or discharge patients within 4 hours is a significant concern to the organisation and action is required to improve this important access standard.



Ambulance handovers in June 2016

During June 13.5% of ambualnce handovers at Lincoln County Hospital were taking in excess of 60 minutes which is not acceptable for patients or for EMAS.

	2hrs+	1-2hrs	30mins -1hrs	0-30	**Total**
Lincoln	**55 (2.3%)**	**269 (11.2%)**	563	1517	**2404**
Pilgrim	2	29	221	1764	**2016**
Grantham	0	21	93	316	**430**

2. Current Service Provision & the Emergency Care Crisis

Previous sections of this report have provided context regarding the current levels of service provided and activity within our emergency departments. Whilst we have indicated that our emergency departments are experiencing consistently high demand, and that we are struggling to meet the four-hour A&E standard, our current crisis is derived from concerns as a result of a continued reduction in staffing. This section sets this out in detail.

2.1 What levels of staff do we need to run our A&E Departments

Hospital emergency departments are staffed by a combination of consultants, middle grade doctors and doctors in training. In addition, emergency care practitioners may also contribute to the workforce and of course, nurses are a key element of the team.

Utilising the recommendations as set out by the Royal College of Emergency Medicine (Service design & delivery committee 2015) it would suggest that in order to provide adequate clinical cover, supervision and training, we would require a minimum of 24 consultants and between 27-36 middle grades across ULHT.

Whilst we are working towards complying with the Royal College of Emergency Medicine (Service design & delivery committee 2015) our current establishments for consultants are significantly below those as expected via the aforementioned report. Therefore the importance of a robust middle grade rota is of paramount importance.

Grade	RCEM recommended Whole time equivalents	ULHT current establishment Whole time equivalents
Consultants	24	15.0
Middle grades	27-36	28.0

Our current establishment, when at a full complement, enables us to deliver the following service. It can be seen that the consultant presence is lower than would be ideal. This again supports the need for a robust middle grade rota.

Site	Grade	Cover/Hours	Days per week
Lincoln	Consultant	14 hours per day 08:00-22.00 with on call cover after 22.00	5 days (Mon-Fri)
	Consultant	12 hours per day 08:00-20:00 with on call after 20:00	2 days
	Middle Grade	24 hour per day	7 days
Pilgrim	Consultant	13 hours per day 08:00-21.00 with on call cover after 21.00	5 days (Mon-Fri)
	Consultant	7 hours per day 09:00-16.00 with on call cover after 16.00	2 days
	Middle Grade	24 hour per day	7 days
Grantham	Consultant	09:00 – 17.00 with on call cover after 17:00	5 days (Mon-Fri)
	Middle Grade	24 hour per day	7 days

This shows that Lincoln and Pilgrim hospitals provide a 24 hour, 7 days per week emergency department service, with consultant cover at both hospitals until 22.00 hrs and 21.00 respectively (on call thereafter). There is no consultant presence at Grantham Hospital after 5pm during the week and there is no consultant onsite presence routinely on Saturdays and Sundays.

2.2 What levels of staff do we currently have in our A&E Departments

The previous section has explained the shortfall in consultant posts within our A&E departments, and to deliver the consultant rota as set out in hours we provide consultant cover, it is necessary to recruit locum or agency consultants to fill the vacant posts.

As the issues regarding staffing are primarily associated with the availability of middle grade doctors, the rest of this section will focus on those issues.

Gaps in provision

The table below shows the extent of the problem relating to staffing the gaps in middle grade posts at each of the hospital sites, with the two most busiest A&E departments, which also take the higher acuity of patients suffering the biggest gaps in middle grade doctors with 8.4 wte at Lincoln and 7.0 wte at Pilgrim.

	Grantham	Lincoln	Pilgrim	TOTAL	% ULHT
Consultant	0/2 ULHT 2 locums	3/7 ULHT 4 locums	1/6 ULHT 4 locums 1 gap	**4/15 ULHT** 10/15 locums 1/15 gap	**26.6%**
Middle Grade	5/6 ULHT 0 locums 1 gap	2.6/11 ULHT 0 locums 8.4 gaps	4/11 ULHT 0 locums 7 gaps	**11.6/28 ULHT** 0/28 locums **16.4/28 gaps**	**41.4%**
Junior	5/7 ULHT 2 gaps	9/9 ULHT 0 gaps	6/8 ULHT 2 gaps	**20/24 ULHT** 4 gaps	**83.3%**

Grade	RCEM recommended Whole time equivalents	ULHT current establishment Whole time equivalents	ULHT Only staff in post (Wte)	ULHT and long term locums in post (wte)
Consultants	**24**	15.0	**4.0**	14.0
Middle grades	**27-36**	28.0	**11.6**	11.6

The above demonstrates how far we are with staff in post from the required staffing as recommended by the Royal College of Emergency Medicine. As a consequence of the deterioration and following the most recent decline in staffing numbers, prospective rotas can no longer be staffed with confidence. Therefore it is believed that a 'tipping point' has been reached where the level of risk is not acceptable and cannot be mitigated any further. It is with regret that further action is required to ameliorate the unacceptable risks to patient care created by a significant middle grade doctor shortage.

2.3 Why has this become an issue, and why now?

The current emergency situation relates to:

- A further reduction of 2 wte middle grades in post. Therefore we only have 11.6 wte compared to an established number of 28 (RCEM recommends 27-36)
- Only 41% of the middle grade rota can now be covered by ULHT directly employed staff
- More junior middle grades currently on the middle grade rota
- Increased reliance on agency locums to fill the vacant 59% of the A&E middle grade rotas which is not sustainable
- Reduction in fill rate of the vacant shifts resulting in more shifts not filled

The result of the above is an inability to maintain safely populated A&E rotas. As an example as at 09:00 on 1st August 2016 for the full week 15-30% of the medical rotas each day in A&E at Pilgrim and Lincoln were not covered.

This is placing additional stress upon the existing consultants and middle grades to provide cover and to stretch shifts with fewer bodies within the Lincoln and Pilgrim A&E departments. This is a particular concern as they receive the full remit of presentations with the exception of poly trauma which is taken to the major trauma centre at Nottingham. Furthermore, the supervision of trainees delivering care is becoming increasingly more difficult to provide.

Due to the above the Trust Board are in agreement that the level of additional risk to patients as indicated by; deterioration in ambulance handover times (particularly at Lincoln County Hospital), delays in first assessment although the sickest patients are always prioritised and a significant reduction in the number of patients assessed, treated, admitted or discharged within 4 hours (causing overcrowding within the emergency departments) is too great to continue without action.

As a result of the recent deterioration in staffing across our Emergency Departments the following risks are now increased:

- Longer waits for initial assessment, treatment and disposition leads to:
  - Increased mortality, particularly at 10 days
  - Increased Length of stay (LoS) of admitted patients.
  - Delayed time critical intervention
  - Less frequent and less adequate pain relief
  - Delayed antibiotic administration with adverse effect for treatment of sepsis
  - Associated with increased risk of adverse events which doubles LoS
- Decreased departmental function – 'under triage', inferior care in terms of standard performance measures, increased Left without Treatment rates, delays to ambulance handovers.
- Poor patient satisfaction and experience
- Staff stress and burnout
- Inadequate supervision for doctors in training leading to errors and patient safety issues
- Poor experience for doctors and other clinicians in training
- Risk of trainees being removed from the department, thereby exacerbating the risks
- Difficulty retaining and recruiting ED staff
- Lost opportunities for system efficiency (care isn't delivered right-first-time)
- Cost arising from high staff turnover, locums, mistakes, and performance failure
- Failure to innovate, develop practice, or invest time in basic departmental management and quality improvement
- Significant risk of not being able to respond to declared major emergencies

3. Our Response to the Crisis: Actions

3.1 What mitigation actions have we already taken?

Over the previous few months, we have managed to safely staff our emergency departments by asking our consultants to work extra shifts, to cover the gaps in the middle grade doctor rota, together with securing as many agency doctors as possible. During this period, we have been developing plans to mitigate the issue in the short, medium and longer term.

Utilising our current workforce

- An agreement with the consultant workforce to undertake additional shifts and to act down into middle grade slots with enhanced pay on an "as required" bases
- Stretched shifts of existing staff to cover vacant shifts resulting in fewer clinicians on the shop floor
- Supported the middle grade rotas with non-middle grade staff such as junior doctors, nurse consultant and Advanced Nurse Practitioners. This has the impact of having less clinical leadership and support for trainees which increases the clinical risks to patients and places staff at additional risk

- Specialities of respiratory, stroke, acute medicine, gastro, elderly and orthopaedics asked to support the emergency department with middle grade / consultants at all sites
- Approached our system colleagues across primary and community care to help out in the ED, who have come into the ED to help clinically where possible. This has not had a material impact.

Use of Agency staff
Over the last 6 months we have managed to safely staff our emergency department service by asking our consultants to work extra shifts, to cover the gaps in the doctor rota, and securing as many agency doctors as we can. Whilst we were aware that this was not a long term solution, we were able to safely staff the departments whilst we undertook other short, medium and long term actions to improve patient flow and ensure that the service was a productive and efficient as possible, including ongoing recruitment activities.

As an organisation we have worked with the agencies to ensure that we can fill our rotas. This has included breaching the national price caps to ensure service continuation. The total number of shifts that have breached the price cap between 1st April 2016 and 18th July 2016 is 1,582 shifts. There has been an upward trend over the last four months for consultant and registrar agency shifts at Lincoln Hospital breaching the cap.

The table below shows the total expenditure on agency cover and additional duties from existing staff to support the A&E departments for 2015/16:

	Agency spend 2015/16	Extra duty 2015/16	Total spend 2015/16
A&E Lincoln	1,888,772	140,489	2,029,261
A&E Pilgrim	1,826,510	610,000	2,436,510
A&E Grantham	287,514	215,799	503,313

Unfortnatelty the sheer number of shifts that now require filling via agency staff (59% of the rota), the fill rate has dropped. Despite the commitment from our consultant team and ongoing recruitment drive, we have identified that we are now not able to consistently staff our emergency department rotas. The pressure of Consultants covering extra shifts is now starting to take its toll on the consultants with two having been referred to occupational health for stress related issues, and this is no longer a sustainable option for covering the gaps in the middle grade rotas.

Actions to recruit to establishment
We have taken a number of actions with regards to recruiting to establishment. We are on continual active recruitment for all posts, and permanently have vacancies out for agency doctors. We are working with HEE to look at reallocation of training posts across the region
Proactive national recruitment actions including;

- Exhibited at national recruitment conference
- Released promotional DVD to attract doctors to the trust
- Advertised through networks such as Doctors.net
- Proactive international recruitment actions including ;
    - Skype interviews undertaken to support international recruitment
    - Developed a Trust wide vacancy management strategy
    - Role substitution through nurse clinicians, physicians associates and emergency nurse practitioners

Other actions to improve flow and performance within the Emergency Departments

Whilst the issue is the shortage of staff to fill the required rotas, and the ongoing recruitment actions described above have been delivered to mitigate that staff shortage, we have also been proactive to consider what ways we can make our services more productive and efficient, to improve patient flow and work across the health economy including a number of areas of investment.

Some of the areas include:

- Introduction of team based working with the Emergency Departments to ensure there are named doctors and nurses looking after a cohort of patients and that the leadership can focus their limited time on appropriate support.
- Revised the ambulance handover process and escalation
- Strengthened where possible RAT to mitigate delays for patients to receive their full assessment and treatment to manage any potential clinical risk as best as possible
- Introduced a 'majors lounge' to utilise the footprint best as possible to assist handovers and manage as best as possible overcrowding
- Invested £1m into Lincoln and Pilgrim Emergency Departments to ensure appropriate nurses on duty to care for the current demand, introduce new roles to assist in departmental leadership and additional capacity to manage the minors stream
- Invested into uplifting the consultant workforce at Pilgrim by 2 wte
- Working with KM&T at Lincoln to maximise minors flow and departmental leadership
- Establish onsite Access and Flow Improvement Groups
- Maximising use of AEC participating in cohort 8 of AEC collaboration
- Introducing some frailty support across Pilgrim and Lincoln
- Strengthening streaming and short stay pathways
- Increasing onsite bed compliment permanently by 66 from October '16
- Trialling proof of concept across Pilgrim LoS reduction approach with a hypothesis it can be reduced by up to 20% releasing 60 beds worth of bed days.

The above schemes whilst not exhaustive provide an indication of the range of activities currently underway to improve systems and processes within emergency departments and across the hospital sites.

There is also a system wide improvement programme to reduce attendances through the implementation of the (CAS) Clinical Assessment Service and increased transition pathways out of hospital including more robust social care support.

4. Our Response to the Crisis: Options

4.1 Options development

The ED consultants raised a significant concern about both patient and staff safety, and both clinical and management teams have been concerned about the performance against the 4-hour waiting time standard for a number of months, and have been trying to improve the performance as described earlier in the document.

Due to the Lincoln and Pilgrim sites being the sites where complex emergency patients are seen and treated, priority has to be given to ensuring these departments are fully staffed where possible, and therefore the options have to be focussed taking this into consideration. This approach also supports the output from the CRS (Commissioner Requested Services).

Commissioner Requested Services / Location Specific Services
Under the terms of the Health and Social Care Act 2012 (the Act), commissioners supported by Monitor, have a responsibility to ensure that local populations continue to have access to key NHS services even in the unlikely event of provider failure. In order to encourage innovation the Act requires that Monitor only apply its regime to a subset of NHS services called LSS (Location Specific Services). These services should continue to be provided locally if any individual provider is at risk of failing financially. The responsibility of identifying LSS is given to commissioners; the process for identifying which services meets the threshold of being a LSS requires commissioners to consider what would happen to a patient if a service was no longer provided at a specific NHS Hospital site from both a travel times and health inequalities perspective.

The 2012 Health and Social Care Act (The Act) requires all CCGs to identify CRS at Foundation Trusts by April 2016. Although ULHT is not a Foundation Trust, the LSS approach has been adopted in Lincolnshire by the Commissioners as part of the Lincolnshire Health and Care Programme. The result of the subsequent LSS analysis is summarised below from an extract taken from the document "Identifying Essential Services at ULHT sites":

- If major A&E services were no longer accessible at Lincoln and Pilgrim Hospitals, or a Hybrid model were implemented, patient travel times would increase; we therefore conclude that at least an Emergency Centre must be provided at both sites
- Any change to major A&E services would force many patients to travel beyond the 45 minute travel time set by commissioners. Patients from Pilgrim hospital, particularly the most deprived (identified through the indices of multiple deprivation), would face the greatest increase in travel times if one of these options were pursued. Creating capacity (for example by diverting people away from ULHT's sites as part of a Lincolnshire out-of-hospital strategy) will not remove the overarching challenge around travel times or health inequalities. From an access perspective, a full range of A&E services (equivalent to an Emergency Centre) should therefore be maintained at Lincoln and Pilgrim Hospitals
- Our analysis at Grantham suggests that the patient accessibility criteria should not limit the range of options for this site going forwards. Given that sufficient physical capacity already exists within the system, the vast majority of patients are able to reach alternative provider sites within the maximum travel time thresholds set for major A&E / inpatient services

"Identifying Essential Services at ULHT sites", 28th May, 2015, Lincolnshire Health and Care Programme led by the Lincolnshire West CCG, Lincolnshire East CCG, Lincolnshire South-West CCG and Lincolnshire South CCG

Taking into account the output from the LSS, we are unable to put forward a temporary change to the existing A&E services delivered at the Lincoln and Pilgrim Hospitals, and therefore, this leaves two possible options for consideration, as temporary proposals, until a longer term solution can be determined. The two options for addressing the immediate crisis are shown in the table below:

Option One	**Sustain three sites with ED departments 24/7 by securing additional ED specific resource (status quo)**
Option Two	• **Maintain an A&E at Lincoln and at Pilgrim 24/7** • **Maintain an A&E at Grantham 08:00 to 18:00 (to be confirmed)** • **The Grantham A&E department would be staffed until 20:00 to ensure all patients in the department, from ambulance conveyance up until 17:00 and self-presenters until 18:00, have**

	been assessed, admitted or discharged. **N.B an out of hours and minor injury / illness service is being explored with primary care and community services as an adjunct**

This model would minimise the impact upon EMAS and surrounding acute providers. It would also enable the continuation of a medical take at Grantham.

Confidential conversations are ongoing with a small group of clinical leaders across ULHT, LCHS and SWLCCG to confirm the final model and operational policy. This is expected to be completed by 10/8/16.

It is anticipated that the change in service provision would be required for a minimum of 3 months. A review will be completed by the SRG after 3 months and then on monthly intervals to determine if the required threshold has been reached to re-establish a 24/7 A&E at Grantham. This will be discussed in more detail later in the document.

4.2 Risk assessment and decision

The next section contains the risk assessment that has been developed internally within the Trust to consider the impact of these options.

The risk assessment has been undertaken using the Trust risk assessment framework and matrix method, and the formulae have been based upon: consequence multiplied by the likelihood, which in return gives the overall risk rating.

RISK ASSESSMENT OF OPTIONS

Options		Risks	Risk RAG	Mitigating Actions	Responsible Person
OPTION 1 Sustain all three sites as full A&E service 24/7 (Status Quo)	1	Not able to safely fill the middle grade rota due to a national recruitment shortage	**5 x 5 = 25**	• Continual active recruitment for all posts • Meeting with the deanery to discuss reallocation of training posts • Implemented local recovery plans • Developing a promotional DVD to attract doctor to the trust • Permanently had vacancies out for locums • Developed a Trust wide vacancy management strategy • Role substitution through nurse clinicians, physicians associates and emergency nurse practitioners • International recruitment opportunities • Skype interviews undertaken to support international recruitment • Offered trust contracts and contracts for service • Advertised on Doctors.net •Consultant grades acting down to middle grade level to cover rotas • Mobilisation of GPs in the Emergency Departments	Mark Brassington/ Tina White
	2	Unable to deliver training requirements to medical workforce as stipulated by HEE	**4 x 5 = 20**		
	3	Potential for substantive staff to become ill due to pressure	**4 x 5 = 20**		
	4	Potential further reductions in workforce due to increased demands	**4 x 5 = 20**		
	5	Significant risk to patient safety which may result in harm due to insufficient medical cover for service provision.	**5 x 5 = 25**	Continue to attempt to secure workforce as above. Analysis of geographical & service demand requirements to understand potential impact on any changes to service provision	Executive team
	6	Short/medium term implications of workforce acting down or training diversion to sustain current model.	**5 x 5 = 25**	Risk assessment required on a daily basis.	Tina White
	7	Sustainable model not deliverable	**5 x 5 = 25**	Risk assessment required on a daily basis.	Tina White
OPTION 2 Reduce the	1	Change in service for the local population	**3 x 4 = 12**	Approximately 11,881 patients arrive at Grantham A&E department between the hours of 18:00 and 08:00, these	

opening hours of the Emergency Department at Grantham Hospital to open between 08:00 and 18:00 **Retaining 24/7 A&E services at Pilgrim and Lincoln**					patients would need to be taken to an alternative A&E dept by ambulance, or would need to self –refer to another ED or Urgent Care Centre. Analysis shows that around 13 patients per day (4,745 per annum) are taken to the Grantham ED by ambulance between the hours of 18:00 and 08:00. This demonstrates that around 7,136 people per annum, self-refer to the ED between the hours of 18:00 and 08:00, and therefore would need to refer themselves to another ED or perhaps more appropriately in some cases, but not all, to an UCC.	
		2	Impact on ambulance service and local acute, community, primary & social care providers	**3 x 4 = 12**	Approximately 13 ambulance conveyances per day between the hours of 18:00 and 08:00 would need to be diverted to another A&E department	
		3	Impact on activity & workload at Pilgrim and Grantham Hospitals and potential patient safety risk due to increased attendances and admissions	**3 x 4 = 12**	The following distribution of patients may present to alternative ED's: • Lincoln 6178= 17 additional patients per day • Pilgrim 2851 = 8 additional patients per day • Peterborough 891 = 2 additional patients per day • Grimsby & Leicester 166 each = 0.5 additional patients per day • Leicester, Lincoln or Nottingham 1545 = 4 additional patients per day	
		4	Availability of workforce to deliver this service	**4x4 = 16**	Still remains a significant risk, but medical and nursing staff could relocate from the Grantham ED to support Pilgrim and Lincoln ED's to help mitigate the staffing related risk	

4.3 Impact assessment

This section considers the impact of the options on the emergency departments at ULHT other two hospital sites, Pilgrim and Lincoln hospitals, together with other providers outside of Lincolnshire.

Emergency Department attendances

As a result of the Commissioners Required Services review, we are proposing one option only at the current time to mitigate the risk to safety of the patients attending ULHT emergency departments, described as option 2 in section 4.1 above. The impact assessment for option 2 is shown in the table below:

Between 18:00 and 08:00 Grantham receives:

- on average 30 attendances (85th centile = 35 attendances)
  - 24 self present (85th Centile = 28)
  - 6 are conveyed by EMAS (85th centile = 7)

Analysis suggests that based upon the Self presenters home postcode their next nearest A&E would be as follows (based on 28 [85th centile]):

Lincoln	50%	(14)
Pilgrim	25%	(7)
Peterborough	8%	(2)
Others	17%	(5)

The above assumes:

- Patients do not change their self-presenting behaviours which they may do to access a local service. This would limit the impact of the other providers. The staffing model will be able to absorb some increases in hourly presentations above the current levels.
- There is no local service in addition to the out of hours services
- Additional patients are not absorbed within closest urgent care services within the Lincolnshire footprint (Sleaford / Stamford)

Analysis suggests that based upon the Patients conveyed by EMAS by their pick up postcode their next nearest A&E would be as follows (based on 7 – 85th centile):

Lincoln	50%	(3)
Nottingham	25%	(2)
Leicester	25%	(2)

5. Recommended Option & implementation date

All options have been considered, following the risk assessment and impact analysis, and with an aim to deliver a safe service which optimises the service provision at Grantham

hospital, whilst having the least impact on other organisations outside of Lincolnshire, with the staffing resources available. It has therefore concluded with the risk assessment and analysis shared that the supported option is:

- Option Two: The Grantham A&E Department open between 08:00 and 18:00

Model of Service

The opening hours of the emergency department at Grantham hospital will be reduced from the existing 24/7 model to the following:

- Open between 08:00 and 18:00
- The Grantham hospital will maintain a medical admissions take
- Will accept ambulance conveyances in line with the current inclusions and exclusions between the hours of 08:00 and 17:00
- Will accept self-presenters until 18:00

It is important to note that 82% of people who currently attend the emergency department at Grantham Hospital are discharged from the emergency department with conditions that can be treated safely and appropriately by an urgent care service, or by another service such as a GP, pharmacist, or self-care at home.

This model would minimise the impact upon EMAS and surrounding acute providers. It would also enable the continuation of a medical take at Grantham.

Confidential conversations are ongoing with a small group of clinical leaders across ULHT and SWLCCG to confirm the final model and operational policy. This is expected to be completed by 10/8/16.

Workforce Model

Implementing this service model will not reduce the level of medical and nursing cover provided at Grantham. Where possible we will look to enhance it.

This model will allow the release of 4 Middle Grade doctors and 1 FY2. Further shifts may be able to be released in due course but until the model settles and the patient behaviours are known it would not be prudent to plan to release further medical cover. At this stage conversations with affected staff have not been conducted. The contractual arrangements have been explored and there is provision to move staff between sites as long as the travel time is not ‘unreasonable’. A suite of incentives are being developed to increase the likelihood of staff agreeing to move. Whilst this predominantly affects medical staff this is also being explored for the affected nursing staff.

Introducing this model will not mitigate the full risks nor provide the full solution. It is an interim measure to improve the significant safety concerns. A more radical solution could not be implemented quickly and requires significant work. This will increase the middle grade cover at Lincoln from 2.6 to 6.6 wte.

System Support

Initial confidential conversations have occurred with CEO EMAS, Accountable officer of SWLCCG, Accountable officer of LECCG (Chair of SRG), Chair of SWLCCG and Medical Director of LCHS where unanimous support has been provided. Clinical support for this change across the hospital is expected. Although this remains as a potential risk that will be actively managed.

6. Reversing the decision to reduce the hours for Grantham A&E

It is anticipated that the change in service provision would be required for a minimum of 3 months. A review will be completed by the Systems Resilience Group after 3 months and then on monthly intervals to determine if the required threshold has been reached to re-establish a 24/7 A&E at Grantham.

This threshold has been set as:
-No deterioration in the current consultant position
-Fill rate of at least 75% (21) of the Middle Grade establishment (28) on an 8 week prospective basis.

7. The Communication Plan

A draft communications plan is available in the embedded document below:

DRAFT A&E comms plan August 16 v7.do

The headlines are as follows:

- SRG Chair confidential briefing — 2nd August
- EMAS CEO confidential briefing — 3rd August and 5th August
- SWLCCG AO confidential briefing — 3rd August and 5th August
- SWLCCG Chair confidential Briefing — 5th August
- LCHS Medical Director confidential briefing — 5th August
- NHSI and NHSE approval to proceed required by — 5th August
- CEO to CEO briefings to NUH, Peterborough and UHL — 8th August
- Stakeholder briefings — 9th August
- Media briefings — 9th August
- Staff briefings — 9th August
- SRG review — 9th August
- Public communications and engagement begins — 10th August
- Stakeholder, Media and Staff briefings regarding final model and operational policy — 11th August
- Go Live date Wednesday — 17th August 2016

Grantham A&E changes comms plan

1. Objectives

Aims of the communications plan are to:

- Raise awareness of what stays the same, what will be different and what the public should do between 6.30pm to 9am for those who live within the GDH catchment area
- Raise awareness of why A&E needs to change
- Raise awareness that the changes are temporary
- Ensure balanced media coverage and reduce the likelihood of adverse publicity
- Ensure staff, stakeholders and public are aware of the planned actions to stabilise all A&Es in the medium term
- Ensure that staff and key stakeholders are briefed immediately before or alongside media briefing
- Encourage key stakeholders and staff to publically support the changes, albeit temporarily

2. Key audiences

Primary audiences

- ULHT affected staff
- Local staff side (including BMA)
- Regional staff side
- ULHT staff including NEDs
- Chairs, CEOs and quality leads from Lincolnshire CCGs
- Postgraduate dean at HEEM
- Health OSC chair
- Nick Boles
- Other MPs
- Health and Wellbeing Board chair
- Healthwatch Lincolnshire
- ULHT members
- General public
- LMC chair
- South Kesteven leader and CEO
- Sleaford Town Council leader and CEO
- Newark and Sherwood District Council CEO and leader
- CEOs for EMAS NUH, UHL and Peterborough
- Leader and CEO Lincolnshire County Council, and other district councils
- NHS England (area team including comms team)
- NHS Improvement (including comms team)
- CQC
- Media
- Campaigners
- Fire and police authorities
- Silvers on call

3. Key messages

To ensure the information is read, heard and understood by each target audience, it will be necessary to tailor the key messages for some groups. The following key messages are relevant to all audiences and will be incorporated in all communications.

Core messages

The quality and safety of patient care is the Trust's number one priority.

There is a national shortage of appropriately trained doctors to work in emergency departments and ULHT is particularly challenged by this. To ensure the provision of safe care for patients, in three emergency department open 24/7 it is recommended that we should have 30 consultants and at least 28 registrars, as known as middle grade doctors. The ULHT emergency departments normally work on the basis of having 15 consultants and 28 middle grade doctors. At present, we are now down to 14 consultants of whom 10 are locums and just 12 middle grades. We have reached a tipping point.

We will put patients at risk if we continue as we are. We are looking at a number of options to keep patients safe. These include reducing the opening hours of our A&Es. We have ruled out reducing the opening hours at Lincoln and Pilgrim as they both take patients with life threatening injuries and have a higher number of patients attending A&E and being admitted. Our only option is to look at reducing the opening hours at Grantham A&E.

We haven't yet made a final decision, and we hope to avoid this but the reality is we may need to temporary close A&E at Grantham overnight in the next few days.

We haven't rested on our laurels. We have tried to recruit in the UK and abroad, and we have offered premium rates to attract agency doctors. ULHT board has recently approved £1 million investment into nursing in Lincoln and Pilgrim A&Es, increased funding for two consultants at Pilgrim, and have invested money to improve how quickly patients with minor injuries and illnesses are seen. Despite this, we have reached crisis point.

For announcement on decision made:

We will put patients at risk if we continue as we are. To ensure that we run safe services, we have looked at a number of options and the safest one means that we have had to make temporary changes to the opening hours of Grantham A&E.

From 17 August, A&E at Grantham will be closed from 6:30pm to 9am.

The decision has been taken due to a severe reduction in the availability of doctors at the same time as an increase in the demand for emergency care services.

We haven't made this decision lightly but the reality is we do not have enough doctors to safely staff all three of our A&Es 24 hours a day 7 days a week.

This has placed exceptional additional pressures on the remaining doctors and nurses providing care to patients. We are now unable to recruit locum or agency doctors to provide a standard of care expected by all, thereby putting patients at risk.

Lincoln and Pilgrim A&Es are considerably busier than Grantham, both during the day and night. By reducing the opening hours at Grantham means, we can move the medical staff to where they are most needed.

I know people will be concerned about travelling further for treatment but it isn't about how far you have to travel, it's about what happens to you when you get there. This can be demonstrated by our experience with the Lincoln heart centre, where the provision of specialised care in fewer places has saved many lives.

ULHT and the CCGs are committed to fully reopening the Grantham A&E as soon as we have enough doctors in place to provide safe care. It is envisaged that this revised service at Grantham will be in place for a minimum of 3 months. The reduction in opening hours improves the problem but it doesn't solve it.

The decision to reinstate services will ultimately rest with ULHT Board, however the System Resilience Group which is a collection of senior people from the 4 clinical commissioning groups, Lincolnshire County Council, providers (such as ULHT, LCHS, LPFT, EMAS) and regulators (such as NHS England and NHS Improvement) will provide important advice and a recommendation whether to open or not. If it is not possible to reinstate 24/7 service to Grantham Emergency Department after this time, it will be reviewed again after a further three months.

This decision is not driven by financial considerations.

4. Plan

The comms plan will be delivered in 4 phases:

Phase	When
1.Call to action for clinical staff to work shifts or additional shifts in Pilgrim and Lincoln A&Es	Monday 1 August ongoing
2. Raise awareness of impending crisis and actions we are taking and options we are looking at	Tuesday 9 August
3. Announce action we are taking and public information	Thursday 11 August
4.Big public awareness campaign on where to go for what and when	Monday 15 August

It is proposed that affected staff, key stakeholders (opinion formers), and key media are briefed on the same day – eight days before the changes come into effect. This coordination will minimise the risk of the changes being leaked before we have the chance to brief the media otherwise we will be on the back foot and lose control of the messaging.

The plan will be to brief key audiences in the following order:

- Local staff side
- Affected staff
- Christine Talbot/ MPs, and other key stakeholders
- Media (under embargo)
- All staff
- All stakeholders

We will also prepare a holding statement in case the plans are leaked before the embargoed media briefings.

It is proposed there will be three main ULHT public spokespeople – all clinical. Suneil Kapadia will be the lead spokesperson, giving TV and radio interviews. Ben Loryman and Penny Snowden will help with other media where necessary. Mark Brassington, Jan Sobieraj, and Kevin Turner will give stakeholder briefings, and support Suneil in face to face staff briefings, as well as Louise Ludgrove. Other execs and senior clinicians may be needed to brief stakeholders.

To meet our objectives and best support the media to meet their production deadlines and formats, we will proactively invite all key media to a briefing on Tuesday 9 August under embargo until 00:01 Wednesday 10 August).

Led by Suneil, we will give a 10 minute presentation clearly outlining the current issues, actions taken thus far and the plan to change A&E. We will provide a media pack (see appendix A) including a press release, key facts and FAQs. We will then offer the media present the opportunity to interview Suneil, Ben or Penny for their own content. We will invite South West CCG and EMAS to take part in the briefing.

Where possible, we will include a supportive statement from the CCG, EMAS, Royal College of Emergency Medicine, Healthwatch Lincolnshire or NHS Improvement in our press release, particularly when we announce what the changes will be.

When we know what the plan will be, after talking to affected staff, (estimated to be 11 August), we will send out a press release to all local and regional media with the decision and listing alternatives to A&E for affected patients and to promote the 111 service.

We will give interviews to support the media's coverage and to ensure we reach as many affected people as possible.

Outside of the actions in this plan, CEOs of Peterborough, NUH, UHL, EMAS and CCGs will be briefed by Jan, and follow up meetings will take where as appropriate.

Draft holding statement quoting Suneil Kapadia:
"No decision has been made about the long-term future of Grantham A&E. However, due to shortages in the availability of emergency care doctors, ULHT is looking into all possible options to provide safe emergency services across all our hospitals."

Scenario: changes come into effect on Wednesday 17 August 2016.

Pre-change plan and timeline

Action	Who	When	Where
Monday 1 August			
Brief Gary James (chair of SRG)	Mark		
Wednesday 3 August			
Brief CEO of EMAS	Mark		
Brief Allan Kitt (Lincs South West CCG)	Mark		
Friday 5 August			
Update COO at EMAS	Mark		
Monday 8 August			
Send Communication timeline to Execs and NEDs	Lucy	11am	
Brief CEO of ULH, NUH and Peterborough	Jan		
Brief Dilip Mathur, CD Grantham	Mark		
Tuesday 9 August			
Telephone briefing with Nick Boles	Jan	9am	Nick will call Jan's mobile
Telephone briefing with Cllr Sue Woolley	Kevin	9am	Kevin to call Sue Woolley
Briefing for chairman of HOSC (will be exec cllr Trisha Bradwell	Mark	9.30am	
Telephone briefing with South Kesteven Leader/ CEO	Kevin	9.30am	Kevin to call Cllr Bob Adams 9
Telephone briefing with Stephen Philips	Jan	9.30am	Jan to call
Telephone briefings with Healthwatch – Sarah Fletcher	Jan	10.00 a.m	Jan to call Sarah on
Telephone briefings with Karl McCartney	Jan	10.30am	Jan to call
Telephone briefings with Matt Warman	Jan	11.30am	Jan to call Matt on
Telephone briefing with Ian Fytche, CEO North Kesteven DC	Kevin, Jan or Mark	Morning	TBC
Telephone briefing with Lincolnshire County Council Leader and CEO. Cllr Trisha Bradwell will advise Martin Hill, Leader Lincs LCC			n/a
Brief Ray Wooten	Jan	11am	
Victoria Atkins MP – Louth & Horncastle			By email
Edward Leigh MP – Gainsborough			By email
John Hayes MP – South Holland and The Deeping			By email
Brief local staff side	Suneil, Louise and Penny	9.00am GDH	TBC
Briefing for all affected staff	Suneil, Louise and Penny	10am	A&E
Telephone briefing CQC	Penny	11am	
F2F media briefing	Suneil, Ben and Penny	12pm	Meeting Room 3
F2F staff briefings at Lincoln, Pilgrim and Grantham	Mark and Debra LCH Mark and Jennie PHB Suneil at Grantham	1 to 2pm 11-12 am 1.30 - 2.30	Boardroom TBC Meeting Room 3
121 staff briefings	Louise, Suneil, Penny and Ben	From 2.30	
Send out email message to all staff and NEDS	Lucy	4.30pm	
Send out email message to all stakeholders including ULHT members	Lucy	4.30pm	
Brief and get support of SRG	Mark	2.30- 4.30pm	

Action	Who	When	Where
Publish A&E doctor job ads on homepage.	Lucy	AM	
Grantham MAC	Mark, Jan and Suneil	5pm to 7pm	Meeting Room 3
Grantham staff briefing	Suneil, Mark and Penny	8pm	
Inform Lincolnshire Police	Lucy	PM	
Wednesday 10 August			
Publish press release on website, including FAQs and post on social media	Lucy	00:01	
Media interviews (Look North will want a live or down the line with Peter Levy)	Suneil, Ben and Penny	As requested	Grantham
Grantham Staff Briefing – drop in session	Suneil, Mark, Penny and Louise	9am	
1:1 with Consultants	Louise and Suneil	10am	TBC
1:1 with Middle Grades	Louise and Suneil	11am	
1:1 with Juniors	Louise and Suneil	12pm	
1:1 with nursing and departmental staff	Penny, Jade and Karen	10am-1pm	
Thursday 11 August			
Brief stakeholders as sequence for 9 August	Jan, Kevin, Mark and Suneil		
Publish new press release (not under embargo)	Lucy	PM	
Send out email message to all staff and NEDS	Lucy	Just before press release	
Give media interviews	Suneil, Ben and Penny	As requested	Grantham
Grantham staff briefing	Suneil and Penny	AM	
Grantham staff briefing	Mark and Louise	PM	
Send out email message to all stakeholders including ULHT members	Lucy	Same time as staff	
Display posters at GDH and distribute to GP surgeries, other community areas	Lucy	Afternoon onwards	

Post-announcement plan and timeline

Action	Who	When
Monday 15 August		
Sign off printer's signage proofs	Lucy	
Schedule tweets and FB posts including for Suneil and Jan	Lucy	
Organise live twitter Q&A with Suneil/ Ben and promote time and date	Suneil	
Write draft letter from consultant body/ CEC. On hold.	Suneil	
Tuesday 16 – Friday 19 August		
Publish new press release on website with case studies	Lucy	Wednesday am
Live twitter Q&A with Suneil or Ben	Suneil	Wednesday pm
Publish supportive letter from consultants. On hold until MAC issues resolved.		TBC
Publish Grantham A&E changes go live today press release	Suneil	17.8.16
Schedule tweets and FB posts including for Suneil and Jan.	Lucy	
Boost FB posts	Lucy	
Monitor twitter and Fighting for GDH FB groups	Lucy	
Give media interviews	Suneil, Ben, Penny	As requested
Display posters at GDH and distribute poster and leaflets to GP surgeries (via CCG), other community areas	Lucy	By Wednesday pm
Display posters in community areas	Lucy	By Wednesday pm
Put up signs around A&E	Lucy	
Brief for affected providers to share with staff	Lucy	Tuesday
Write and send daily updates to GDH staff	Kevin, Mark/ Suneil	Starting 15.8.16
Update FAQs answering the concerns being raised on FB	Kevin, Mark/ Suneil	
Support writing of EIA to inform comms and engagement	Mark/ Suneil	

The following media will be invited to the briefing on Tuesday 9 August.

- BBC Look North
- BBC Radio Lincolnshire
- BBC East Midlands
- Lincs FM
- ITV Calendar
- Grantham Journal
- Lincolnshire Echo
- Sleaford Standard
- Lincolnite/ Lincolnshire Reporter
- Grantham Matters

Appendix A – Media pack

1. Press release

RELEASED UNDER EMBARGO TO 00.01 WEDNESDAY 10 AUGUST 2016

Lincolnshire's A&Es at crisis point

Today United Lincolnshire Hospitals NHS Trust has announced that due to a severe shortage of doctors in our three A&Es we are looking at reducing the opening hours of emergency departments.

There is a national shortage of appropriately trained doctors to work in A&Es and along with other Trusts in the east midlands ULHT is seriously affected by this. We don't have enough doctors to fill shifts in three departments 24 hours a day, seven days a week.

ULHT emergency departments normally work based on having 15 consultants and 28 registrar or middle grade doctors. At present, we are now down to 14 consultants, of whom 10 are locums, and just 12 middle grades. This means we have 43% of middle grades we need. We have reached a crisis point and we may put patients at risk if we don't act.

We are now in a situation where we are unable to recruit locums, so our consultant doctors have filled the gaps by doing extra shifts. Our staff are under enormous pressure and the situation is now unsustainable.

Our A&E staff are concerned that if we don't act, patients could be put at risk if we continue as we are. To ensure that we run safe services, we have looked at a number of options. These include reducing the opening hours of our A&Es. We have ruled out reducing the opening hours at Lincoln County Hospital and Pilgrim Hospital, Boston. This is because they both take patients more seriously ill patients and have a higher number of patients attending A&E and being admitted than Grantham and District Hospital does. Our safest option for the people of Lincolnshire is to look at reducing the opening hours at Grantham A&E.

Dr Suneil Kapadia, medical director at ULHT, said: "We haven't made a final decision yet, and we hope to avoid this, but the reality is we will need to temporarily reduce the opening hours of A&E at Grantham.

"The quality and safety of patient care is the Trust's number one priority and we haven't rested on our laurels. We have tried to recruit in the UK and internationally, and we have offered premium rates to attract agency doctors whilst investing £4 million in urgent care services. Despite this, we have reached crisis point."

We are working with other A&E providers, East Midlands Ambulance Service and the CCGs to find a solution to this crisis to avoid changing A&E services.

Allan Kitt, Chief Officer, south West Lincolnshire CCG said:

“Any temporary emergency closure is very concerning, whilst we are disappointed that we may be forced to take this action, we do believe that closing A&E at Grantham overnight is the best way to ensure that services for our patients remain as safe as possible.

We will be working closely with ULHT, local GPs and our community services to develop a range of services to ensure that those people who have less serious illnesses but might currently use A&E can get a service locally during the temporary closure. We will be sharing these plans with the public in the next week.”

To help our hospitals, we would always urge everyone to think twice before they go to A&E – if it’s not serious or life threatening you shouldn’t be there. Many illnesses can be better treated by visiting your local pharmacy, calling 111, visiting your local GP, GP out of hours services, or attending a walk in centre or a minor injuries unit. If you are concerned and need medical advice please contact NHS 111.

ENDS

For further information contact:
The communications team on 01522 573986

Notes to editors

United Lincolnshire Hospitals Trust runs three A&Es in Lincolnshire based at Lincoln County Hospital, Pilgrim Hospital, Boston, and at Grantham and District Hospital.

A&E departments are staffed by consultants, registrars, or middle grades, doctors in training, nurse practitioners and nurses.

Middle grades are experienced A&E doctors that can work unsupervised for many clinical conditions.

See Royal College of Emergency Medicine’s campaign calling for action to address the significant challenges facing A&Es
http://rcem.ac.uk/Shop-Floor/Policy/Campaigns/STEP%20Campaign/

2. Data and facts

Current A&Es

Lincoln and Pilgrim A&Es are level 1 departments. This means they are open 24/7 and see all types of patients apart from major trauma and multiple trauma – these patients are taken by ambulance to Nottingham which is the region's major trauma centre.

Grantham is a level 3 A&E. Only patients with limited medical conditions and single limb orthopaedic injuries are admitted to Grantham hospital via the A&E department or via GP referral (see protocol on page 6).

Any patient who presents as a self-referral, or walks into the Grantham hospital A&E department and requires a specialist review beyond that available at Grantham hospital, is transferred to Lincoln, Pilgrim or Nottingham.

Consultants are on call between Friday 5pm and Monday 9am.

Three A&E attendance figures

Approximate number of patients attending ULHT A&Es per year are as follows:

- Grantham A&E: 29,000 (80 per 24 hours)
- Lincoln A&E: 71,000 (190 per 24 hours)
- Pilgrim A&E: 55,000 (147 per 24 hours)

In the first three months of the financial year (from 1 April to 30 June), attendances in the three A&Es increased by 4.3% (6,419 people):

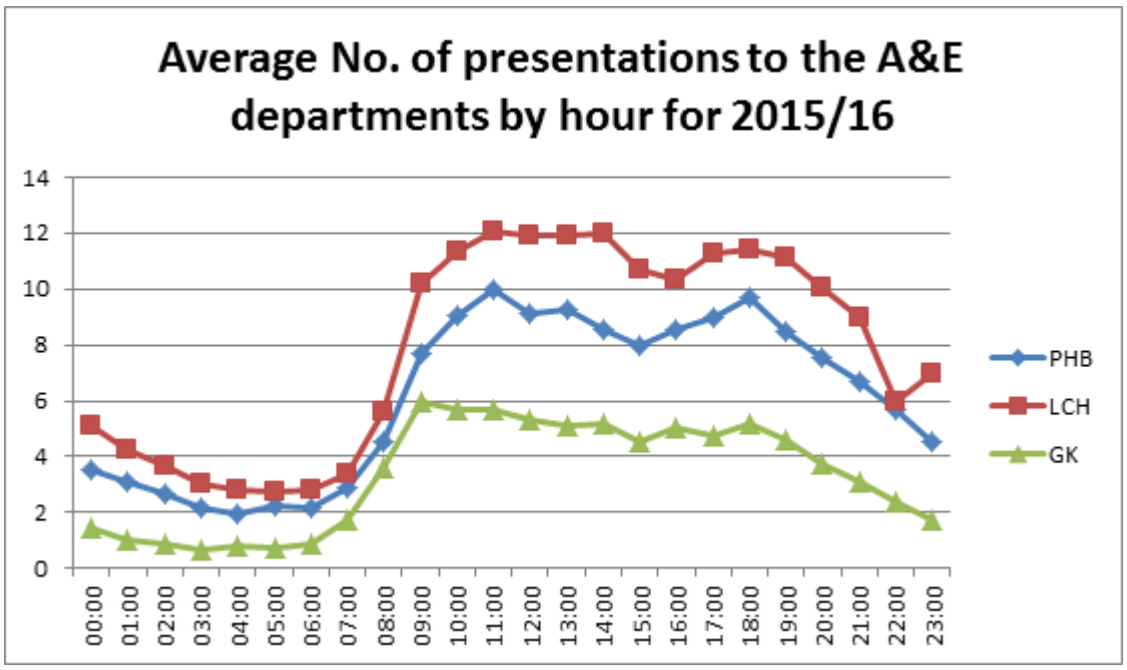
- Grantham A&E: 85 per 24 hours
- Lincoln A&E: 199 per 24 hours
- Pilgrim A&E: 158 per 24 hours

In the first three months of 2016/17, compared to the first three months of 2015/16, attendances have increased by 4.9% (1,800) which is 20 patients a day. This continued into July 2016, which is a 7.24% increase compared to July last year, or 957 people.

Summary of attendances at A&Es by hour

The graph overleaf summarises attendances at each of the A&E departments, showing the average number attending all three A&E departments by hour for the period April 2015 to March 2016.

The graph shows that the highest throughput of any hour is through Lincoln hospital, followed by Pilgrim hospital. The average number of presentations to Grantham hospital between 11pm and 7am is between one and four per hour.



As the graph shows, fewer people attend A&E overnight than during the day. The average number of patients who attended ULHT A&Es a year between the hours of 11pm and 7am are as follows:

- Grantham: 11 patients
- Lincoln: 34 patients
- Pilgrim: 25 patients

Emergency admissions

The number of people admitted to our hospitals in an emergency is also increasing.

Emergency admissions rose by 1% in 2015/16 compared to 2014/15. In quarter 1 (April to June) versus quarter 1 of 15/16 admissions rose by 4.2%. This is 600 patients - around seven patients per day needing an extra 16 beds.

In July 2016 admissions increased by 4.74% compared to July 2015, that's 165 people equating to 25 additional beds.

Current medical staffing at ULHT's three A&Es

	Grantham	Lincoln	Pilgrim	Total	% ULHT
Consultant	0/2 ULHT 2 locums	3/7 ULHT 4 locums	1/6 ULHT 4 locums 1 gap	4/15 ULHT 10/15 locums 1/15 gap	**26.6%**
Middle grades	5/6 ULHT 0 locums 1 gap	2.6/11 ULHT 0 locums 8.4 gaps	4/11 ULHT 0 locums 7 gaps	11.6/28 ULHT 0/28 locums 16.4/28 gaps	**41.4%**
Junior	5/7 ULHT 2 gaps	9/9 ULHT 0 gaps	6/8 ULHT 2 gaps	20/24 ULHT 4 gaps	**83.3%**

The biggest shortages of staff are middle grades at Lincoln (8.4 gap) and at Pilgrim (7 gap).

At Lincoln, two middle grade doctors left in early August making managing the shortage of doctors on a day to day basis unsustainable.

In order to maintain a safe rota over our three sites, there are minimum staff levels we must adhere to relating to both a consultant and middle grade presence of 15 consultants and 28 middle grades.

We rely on locum and agency doctors to cover the 11 consultant posts we cannot recruit to permanently.

Recommended number of doctors in an A&E
A&E departments are staffed by consultants, registrars or middle grades, doctors in training, nurse practitioners and nurses.

Our interpretation of the Royal College of Emergency Medicine guidelines is that they recommend in order to provide adequate clinical cover, supervision and training, we would require a minimum of 24 (10 each at Lincoln and Pilgrim, and four at Grantham) consultants and between 27-36 middle grades (registrars). If we could recruit to all of the posts, our consultant numbers would be below expected and the middle grades would be within the lower end of expected.

Only 41% of the middle grade rota can now be covered by ULHT directly employed staff, 59% posts are unfilled.

If all our doctor shifts are filled, we can provide the following services:

Site	Grade	Cover/hours	Days per week
Lincoln	Consultant	14 hours per day 8am to 10pm with on call cover after 10pm	5 days (Mon-Fri)
	Consultant	12 hours per day 8am to 8pm with on call after 20:00	2 days
	Middle grade	24 hour per day	7 days
Pilgrim	Consultant	13 hours per day 8am to 9pm with on call cover after 9pm	5 days (Mon-Fri)
	Consultant	7 hours per day 9am to 4pm with on call cover after 4pm	2 days
	Middle grade	24 hour per day	7 days
Grantham	Consultant	9am to 5pm	5 days (Mon-Fri)
	Middle grade	24 hour per day	7 days

Currently there is no consultant cover at Grantham after 5pm or at weekends, consultants are on-call off site.

Current Grantham A&E admission exclusion protocol used by ULHT, GPs and EMAS

Ambulances / GPs should not bring / send these patients to Grantham and District Hospital A&E department, and emergency assessment unit for the following specific patient groups:

- Acute surgical admission

- Acute stroke
- Gastro-intestinal haemorrhage (fresh blood or melaena).
- Severe abdominal pain and acute abdomen (refer patient directly to Lincoln County.)
- A female of childbearing age with lower abdominal pain.
- A male under 30 years of age with testicular pain.
- A patient with suspected AAA or ischaemic limb needs admission to the on-call
- Vascular Unit (Pilgrim Hospital)
- All obstetric and gynaecological conditions
- Head injury – Glasgow Coma Score < 15
- Neutropenic sepsis
- Patients requiring dialysis
- Patients with renal transplants
- Ophthalmological emergencies (e.g. acute glaucoma)
- Severe ENT emergencies (e.g. bleeding).

Patients with major injuries

- All major trauma involving head, cervical spine, chest, abdominal or pelvic injuries
- All suspected and actual spinal trauma and patients with abnormal spinal neurological examination
- Multiple peripheral injuries involving more than one long bone fracture above the knee or elbow.
- Head injuries with a Glasgow Coma Score < 15
- All gunshot wounds
- All penetrating injuries above the knee or elbow
- Scalds and burns covering >15% body surface area
- Burns to face, neck, eyes, ears or genitalia
- Electrical burns, significant inhalation injuries or significant chemical burns

Patients with significant mechanism of injury who need admission or assessment

- Ejection from vehicle
- Death in same passenger compartment
- Roll over RTA
- High speed /impact RTA (speed > 30mph, major vehicle deformity, passenger, compartment intrusion, extraction time > 20 mins)
- Motorcyclist RTA > 20mph or run over
- Pedestrian thrown, run over or > 5 mph impact
- Falls > 3m

Current admission protocol

A patient may be brought to Grantham and District Hospital if they require immediate airway and/or breathing resuscitation.

Trauma involving just the peripheral skeleton may still be brought to Grantham A&E. For example:

- All suspected shoulder, arm, wrist and hand fractures (including compound [open])
- All suspected hip fractures
- All suspected femoral, tibia, ankle and foot fractures (including compound [open])
- All suspected joint dislocations, shoulder, elbow, wrist, hip, knee, and ankle
- All suspected peripheral soft tissue injuries, sprains, strains, lacerations, haematomata

- All hand injuries (may require subsequent transfer after assessment)
- Children's suspected fractures. If confined to one area and are haemodynamically stable may be brought to Grantham. (May require subsequent transfer after assessment)

3. Frequently asked questions

1. Why did you let it get this stage?
We haven't rested on our laurels. We have tried to recruit in the UK and internationally, and we have offered premium rates to attract agency doctors whilst investing £4 million in urgent care services. Despite this, we have reached crisis point.

We have had shortages for months. The risk to patient safety has been managed daily. We have extended shifts, used ULHT staff out of hours and backfilled core hours and used medical and surgical middle grades in A&Es. We have also utilised consultant nurses and emergency nurse practitioners where possible to provide additional support and stretching out of hours support into core hours where possible. Consultants have also been working additional shifts and stepping down into the middle grade role. These have not always been possible to consistently apply, nor are they sustainable.

We have asked doctors and nurses working in the community or GP practices to work additional shifts.

Along with many other places were are trying to develop advance nurse practitioners (ANPs) with a MSc level education who can see many of the patients that middle grade doctors traditionally would have seen.

The University of Lincoln has been very supportive and we have two ANPs who have just finished their MScs. This is excellent but it will take several more years before they can work independently to the level of a middle grade doctor.

2. What have you been doing to recruit?
We have a rolling advert for emergency care doctors and we interview all suitable candidates. At Pilgrim, we have four international doctors going through the various stages of a recruitment process. The process takes time particularly with international doctors as they have to pass International English Language Testing System (IELTS) exams to prove their proficiency in English.

We have paid premium hourly rates to attract agency doctors. Since 1 April, 1,582 shifts have breached the agency price cap across our A&Es – this means we have paid higher rates than the government allows to attract staff to cover shifts. During June, July and into August we are seeing a reduction in the availability of agency doctors at a time where we have become increasingly dependent upon locum support.

3. When will A&E fully reopen?
The System Resilience Group (SRG) will review the situation in three months' time. The SRG is a collection of senior people from the four clinical commissioning groups, Lincolnshire County Council, providers (such as ULHT, LCHS, LPFT, EMAS) and regulators (such as NHS England and NHS Improvement). They will provide important advice and a recommendation whether to open or not.

If it is not possible to reinstate 24/7 services to Grantham A&E after this time, it will be reviewed again monthly.

4. What will happen after three months if you can't recruit?
If it is not possible to reinstate 24/7 services to Grantham A&E after three months, it will be reviewed again monthly.

5. Why is Grantham losing its service to help Lincoln and Pilgrim?
In order to concentrate our limited medical resource and support our busiest departments at Lincoln and Pilgrim we have had to reduce the opening hours at Grantham A&E. Reducing the opening hours at Grantham means we can move the medical staff to where they are most needed and continue to provide safe patient care across the three sites.

Grantham people with more serious conditions are taken by ambulance to neighbouring A&Es.

Doctors on shift out of hours at Grantham are currently underused. Between 6:30pm and 9am Grantham receives on average 31 attendances. Of these, 25 self-present and six arrive by ambulance. On average 11 patients attend A&E overnight between 11pm and 7am.

Based on the postcode of those who self-present, the next nearest A&Es are:
Lincoln 50% (14)
Pilgrim 25% (7)
Peterborough 8% (2)
Others 17% (5)

Of course, some of these patients may access alternatives to A&E such as GP, GP out of hours, urgent care centre, or a local pharmacy, or wait until the following day.

Looking at the postcodes of patients bought in by ambulance, their next nearest A&E would be:
Lincoln 50% (3)
Nottingham 25% (2)
Leicester 25% (2)

6. Can Lincoln and Pilgrim cope with the extra patients?
We don't predict many patients will attend the other A&Es. Between 6:30pm and 9am Grantham receives on average 31 attendances. Of these, 25 self-present and six arrive by ambulance. On average 11 patients attend A&E overnight between 11pm and 7am.

Based on the postcode of those who self-present, the next nearest A&Es are:
Lincoln 50% (14)
Pilgrim 25% (7)
Peterborough 8% (2)
Others 17% (5)

Of course, some of these patients may access alternatives to A&E such as a GP, GP out of hours, urgent care centre, or a local pharmacy, or wait until the following day.
Looking at the postcodes of patients bought in by ambulance, their next nearest A&E would be:
Lincoln 50% (3)

Nottingham 25% (2)
Leicester 25% (2)

On average we expect, between 6.30pm and 9am, 25 patients to attend alternative services. Most of these will be discharged back to their GP with little or no treatment required. We also expect that three patients will need to be transferred to alternative A&Es by ambulance.

7. Why doesn't Grantham A&E currently accept the type of patients Lincoln and Pilgrim does?

The infrastructure at Grantham only allows its A&E department to be able to deal with a very limited range of conditions. The hospital isn't busy enough, and doesn't have a "critical mass" of patients to have a broader range of services. Emergency and specialist services need to see a minimum number of patients to have the right skills to treat patients. They need to see those types of patients on a regular basis - so it's like a Formula One pit stop. The more they practice, the better the results. Grantham is a small hospital which services a small catchment population, and the hospital reflects this.

8. Did you consult with EMAS?

Yes we have met and discussed the issue with them over the last few days. They are supportive of our plans.

9. Can EMAS cope with the extra demands on their services?

Yes. On average we predict only three patients will need to be transferred by ambulance to alternative A&Es.

10. How will Lincoln and Pilgrim benefit?

Doctors from Grantham will be moved to Lincoln and to Pilgrim, on a shift by shift basis to where they are most needed. Both A&Es will remain 24 hours, seven days a week and see full range of patients (apart from major trauma).

11. You say this is about patient safety, but isn't it really about saving money?

No it's about putting patients first, and not putting them at risk. We won't save money by changing the opening hours at Grantham.

12. If this decision has been made due to safety, are you saying services are unsafe now?

No. Services are unsustainable they are not unsafe yet. They are at risk of falling over soon. If we don't act quickly, they will become unsafe and we will put patients at risk.

13. Aren't you putting Grantham patients at risk as they will have to travel further with life threatening conditions to receive care?

No. Currently Grantham people with life threatening conditions aren't treated at Grantham. They are taken by ambulance to Lincoln, Pilgrim or Nottingham. If a person who lives on Manthorpe Road has a heart attack today, the ambulance will take them straight to the Lincolnshire Heart Centre in Lincoln. And because of this they are more likely to survive than if they were taken to Grantham. This will continue.

On average we expect, between 6.30pm and 9am, 25 patients to attend alternative services. Most of these will be discharged back to their GP with little or no treatment required. We also expect that three patients will need to be transferred to alternative A&Es by ambulance.

14. Why is it so difficult to recruit doctors to Lincolnshire?
There's a national shortage of doctors, so all areas will struggle to recruit.

Historically Lincolnshire has struggled to attract people to work in the county including schools, social workers and private industry. The NHS is no exception, and emergency medicine is challenged most of all.

We don't run big teaching hospitals. Many big teaching hospitals at the centre of speciality training rotations, such as Queens Medical Centre, Nottingham and Leicester Royal Infirmary are relatively protected from the shortages, as they can keep the speciality trainees ('registrars') working with them for most of their rotations.

So, over the last few years Lincoln has had one trainee, or none at all, instead of the two that we're supposed to have.

A few years ago we tried to get registrars at Pilgrim, without any success, as the training programmes didn't have the funding to increase the numbers of A&E trainees, so currently they have none at all. This is a particularly challenging issue for ULHT as we are the largest acute trust that doesn't have its own medical school. A high proportion of medical students continue to live and work where they trained, which would benefit the full range of specialities.

The main group of people who apply for A&E middle grade posts outside a speciality training post are overseas graduates. Recruiting from the EU is an option but getting visas for non-EU doctors is extremely difficult and time consuming. Many of these will leave and get onto a speciality training programme as soon as they can, as they can earn more money as a GP or a consultant than they can as an specialty and associate specialist (SAS) doctor. Many other overseas doctors also leave and join locum agencies where they can earn a lot more money.

It's stressful and antisocial working in A&E, compared to other specialities, and many people are put off for these reasons.

15. Have you been affected by a reduction in the number of junior doctors?
No the problems are with what we call middle grades, and to a lesser extent consultants.

However, the shortage of doctors means they are overstretched and have less time to provide training and support to junior doctors.

16. Isn't this really about downgrading the A&E through the backdoor?
No, the changes are temporary, and the decision has not been made lightly. We will put patients at risk if we continue as we are. To ensure that we run safe services, we have looked at a number of options and the safest one means that we have had to make temporary changes to the opening hours of Grantham A&E.

We are committed to involving the public and patients in our plans and decisions, and are fully committed to the LHAC consultation.

17. Where should patients go if they need treatment if A&E isn't open?
Many illnesses can be better treated by people visiting their local pharmacy, calling 111, visiting a GP, GP out of hours services, or attending a walk in centre or a minor injuries

unit. During the hours of 6.30pm and 9am, if you are concerned and need medical advice please contact NHS 111, or in real emergency please call 999.

18. What will happen in an emergency if a patient needs A&E?
If you are concerned and need medical advice, please contact 111 for urgent care or 999 in an emergency.

New
Added 16.8.16

19. What will happen at 6.30pm?
Patients can walk into A&E, and arrive by ambulance until 6.30pm each day.

At 6.30pm the door will be locked, and will be used as an exit only.

An external phone is being fitted outside the A&E entrance. There will be a poster telling patients to call NHS 111 if they need urgent care or dial 999 in an emergency**.**

A&E doors will reopen at 9am each day.

20. How do I visit a patient on a ward if the A&E entrance is closed?
Please use the tower block entrance, as this will be open until 10pm each day.

United Lincolnshire Hospitals NHS Trust: Quality Impact Assessment Tool

Overview

This tool involves an initial assessment (stage 1) to quantify potential impacts (positive, neutral or adverse) on quality from any proposal to change the way services are delivered. Where potential adverse impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Quality is described in 6 areas, each of which must be assessed at stage 1. Where a potentially adverse risk score is identified and is greater than (>) 8 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring greater than 8 must go on to a detailed assessment at stage 2.

Scoring

A total score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are multiplied to reach a total score.

The following tables define the impact and likelihood scoring options and the resulting score: -

LIKELIHOOD		IMPACT	
1	RARE	1	MINOR
2	UNLIKELY	2	MODERATE / LOW
3	MODERATE / POSSIBLE	3	SERIOUS
4	LIKELY	4	MAJOR
5	ALMOST CERTAIN	5	FATAL / CATASTROPHIC

Risk score	Category
1 - 3	Low risk (green)
4 - 6	Moderate risk (yellow)
8 - 12	High risk (orange)
15 - 25	Extreme risk (red)

A fuller description of impact scores can be found at appendix 1.

		IMPACT				
		1	2	3	4	5
LIKELIHOOD	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Please take care with this assessment. A carefully completed assessment should safeguard against challenge at a later date.

Stage 1

The following assessment screening tool will require judgement against the 6 areas of risk in relation to Quality. Each proposal will need to be assessed whether it will impact positively, adversely or have a neutral impact on patients / staff / organisations. Where adverse impacts score greater than (>) 8 is identified in any area this will result in the need to then undertake a more detailed Quality Impact Assessment. This will be supported by the Clinical Quality team. **Where there are more than 3 negative impacts and all total scores are less than 8 the Chief Nurse following review will request a full assessment to be completed.**

Title of the scheme/project being assessed: Emergency Care reconfiguration of grounds of patient safety
Executive Director Leads: Dr Suneil Kapadia, Medical Director and Mark Brassington, Chief Operating Officer

Brief overview of the scheme:

Our proposal is to reconfigure our emergency care services on a temporary basis to address the imminent risk to patients brought about by the staffing crisis in our Emergency Departments. In summary we have just 11.6 of the 28 funded middle grade doctors. This means we can currently only staff 41% of the required weekly hours on the middle grade rota across three emergency departments. In addition to this our level of experience and skill mix within the 11.6 wte staff across our 3 departments has reduced due to experience individuals moving on or gaining promotion being replaced by more junior members of staff. This has placed additional pressures upon our 4 permanent and 10 locum consultants to provide departmental leadership

The temporary reconfiguration will involve reducing the opening hours of the Grantham A&E department from the current 24/7, to being open between the hours of 09:00 and 18:30. The timing reflects the peak in attendances, either via self-referral or by ambulance. Timings have also taken into consideration the timing of the OOH service, which commences when the A&E department closes. The decision to select Grantham for the reduction in hours is made on the basis that Lincoln and Pilgrim Hospitals A&E departments accept both the highest acuity, and the highest volume of patients, Grantham has a restricted medical take, with significantly lower acuity and lower number of attendances on a daily basis, and thus this proposal places the least amount of risk to the people of Lincolnshire.

The Medical Director has approved this QIA, and it will now go to the Quality Assurance Committee on 30th August in line internal governance processes

Answer positive, neutral or adverse (P/N/A) against each area. If A score the impact, likelihood and total in the appropriate box. If score > 8 insert Y for full assessment

Area of Quality	Impact question	P/N/A	Impact	Likeli-hood	Score	Full Assessment required
Duty of Quality	Could the proposal impact on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults	P	2	3	6	No

	and the duty to promote equality?					
Patient/Staff Experience	Could the proposal impact on any of the following - positive survey results from patients and staff, patient choice, personalised & compassionate care?	A	3	3	9	Yes
Patient Safety	Could the proposal impact on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections?	P	3	3	9	Yes
Clinical Effectiveness	Could the proposal impact on evidence based practice, clinical leadership, clinical engagement and high quality standards?	P	2	3	6	No
Prevention	Could the proposal impact on promotion of self-care and improving health equality?	N				
Productivity and Innovation	Could the proposal impact on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	P	2	3	6	No

Please describe your rationale for any positive impacts here:

Although the reduction in opening hours at the Grantham A&E department will be perceived as a negative step, the outcomes will:

- Reduce the risk of clinical harm to patients across all three of our emergency departments. The impact on the East Midlands Ambulance service is minimal, since between the hours of 18:30 and 08:00, an average of 6 ambulances convey patients to the Grantham Hospital, that will need to be taken to Pilgrim and Lincoln (50%) or other neighbouring (50%) Hospitals.
- Improve the opportunities for Consultants to provide clinical leadership by reducing the number of middle grade shifts that consultants are currently covering
- Improve the Trust's performance against the national standards for A&E departments, e.g. the 4 hour wait to see, diagnose, and subsequently treat, admit, or discharge. The Trainee Doctors will undertake their night duties at Lincoln Hospital or at Pilgrim Hospital, which will improve their educational experience by seeing a wider range of clinical conditions and acuity.
- It will improve the ability of the Lincoln and Pilgrim to be able to deal with any major declared incidents

The proposal will consolidate the precious medical resource we have in middle grade and consultants, and maximise their efficiency across the three emergency departments. It will focus the medical resource on areas where the need is most great without compromising patient safety.

PMO Trust wide Projects

Signature:	Designation:	Date:
	Director of Nursing	
	Medical Director	

	Director of Finance	

Stage 2

Area of quality	Indicators	Description of impact (Positive, Neutral or Adverse)	Risk (5 x5 risk matrix)			Mitigation strategy and monitoring arrangements
			Impact	Likelihood	Overall Score	
DUTY OF QUALITY	What is the impact on the organisation's duty to secure continuous improvement in the quality of the healthcare that it provides; in accordance with "Everyone Counts: Planning for Patients 2013-14"	**N**				
	Does it impact on the organisation's commitment to the public to continuously drive quality improvement as reflected in the rights and pledges of the NHS Constitution?	**N**				
	Does it impact on the organisation's commitment to high quality workplaces, with commissioners and providers aiming to be employers of choice as reflected in the rights and pledges of the NHS Constitution?	**A**	2	3	6	This will impact on staff working in the Grantham A&E departments who will be asked to work on a temporary basis at Lincoln or Pilgrim A&E departments. **Mitigation:** Support will be offered to the staff to facilitate. Future staffing appointments will be made as "Trust" appointments rather than site specific.
	What is the impact on strategic partnerships and shared risk?	**N**				This proposal has minimal or no effect on our neighbouring provider organisations.
	What is the equality impact on race, gender, age, disability, sexual orientation, religion and belief, gender reassignment, pregnancy and maternity for individual access to services and experience of using the NHS (Refer to ULHT Equality Impact Assessment Tool)?	**N**				

	Are core clinical quality indicators and metrics in place to review impact on quality improvements?	**P**	2	3	6	Quality indicators will include assessment of the number of patients taken to Lincoln or Pilgrim Hospitals, or to Hospitals out of county for their care during the hours of 18:30 and 08:00 who ordinarily have been taken to Grantham Hospital. Clinical outcomes will be measured
	Will this impact on the organisation's duty to protect children, young people and adults?	**N**				
PATIENT EXPERIENCE	What impact is it likely to have on self-reported experience of patients and service users? (Response to local surveys/complaints/PALS/incidents)	**A**	3	4	12	It is likely there will be a surge of patient complaints, together with complaints from the Local Councillors protesting against the reduction in opening hours for the A&E department **Mitigation** A robust communications plan that includes highlighting to the residents in the Grantham area that the Grantham A&E department is not a full A&E department, explain the restrictions on which emergencies cannot be taken to Grantham A&E. Raise awareness as to the small number of patients that will be affected by this proposal.
	How will it impact on patient choice? For example choice being influenced by wait times, access to services and clinical outcomes.	**A**	2	4	8	Due to patients being taken by ambulance to alternative A&E departments and patients seeking out self-referral to alternative sources of care e.g. Urgent Care Centres in Sleaford and Newark. **Mitigation** – keep patients, CCG's and GP's fully informed of future developments, and the key reason for the temporary change being to deliver safe and sustainable care across the three departments. Access to Out of Hours service remains accessible on site (different location within Grantham Hospital) and co-incides with closing times for the A&E department

	Does it support the compassionate and personalised care agenda?	**N**				
PATIENT/STAFF SAFETY	How will it impact on patient safety?	**P**	3	3	9	Through re-distribution of medical resources, and increasing efficiency of the resources available, A&E services at the two larger A&E departments will become safer and more robust. Current stresses on the consultant medical workforce in the A&E departments at Lincoln & Boston will reduce, providing more time for clinical leadership and supervision of junior doctors in training. **Mitigation** Keep patients, CCG's and GP's fully informed of future developments and the reasons why this temporary change is critical for patient safety.
	How will it impact on preventable harm?	**P**	3	3	9	It will support patients being seen in a timely manner at the two busier A&E departments which will enable patients to be treated sooner and help reduce crowding in the department which is know to have an adverse effect on patient harm
	Will it maximise reliability of safety systems?	**P**	2	3	6	Reasons: It will maximise the use of the Medical resources available to continue provision of Emergency Services at all three hospital sites.
	How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections is reduced?	**N**				
	What is the impact on clinical workforce capability care and skills?	**p**	2	3	6	The Reduced hours for staff to manage across three departments will maximised efficiency of the workforce available to deliver safe care. It will release consultant time for clinical leadership and supervision.
	How will it impact staff safety incidents?	**N**				

	How will it impact staff satisfaction?	**A**	2	4	8	Medical and Nursing staff at Grantham will feel vulnerable for their future employment position. Medical and Nursing staff at Lincoln and Pilgrim Hospitals may also feel unsettled in relation to the future service delivery. **Mitigation** – keep all staff informed of future service development; include them in discussions about any future changes.
CLINICAL EFFECTIVENESS	How does it impact on implementation of evidence based practice?	**N**				
	How will it impact on clinical leadership?	**P**	2	2	4	Reasons: It will reduce the current pressures on A&E consultants and allow more time to be given to clinical leadership rather than covering gaps in the middle grade rota.
	Does it reduce/impact on variations in care?	**P**	2	2	4	Increased senior presence will enable junior doctors to be better supervised at the Lincoln and Boston where the majotrity of patients are seen.
	Are systems for monitoring clinical quality supported by good information?	**N**				
	Does it impact on clinical engagement?	**N**				Reasons- Medical and Nursing staff in the Grantham A&E department will feel vulnerable, but this will be counteracted by the increase of engagement at the Pilgrim and Lincoln Hospital sites. Overall the Medical and Nursing staff understand the current constraints and that we can no longer sustain the medical rotas across the three hospital Emergency Departments.
PREVENTION	Does it support people to stay well?	**N**				
	Does it promote self-care for people with long term conditions?	**N**				
	Does it tackle health inequalities, focusing resources where they are needed most?	**N**				
PRO CTIV	Does it ensure care is delivered in the most clinically and cost effective way?		2	3	6	Reason: Through reducing the opening hours of the Grantham A&E

AND INNOVATION		**P**				department, it ensures that patient safety is not compromised, and maximises the efficient use of the limited medical resources across all three existing emergency departments
	Does it eliminate inefficiency and waste?	**P**	2	3	6	Reason: It supports us to utilise the limited medical staff available most efficiently.
	Does it support low carbon pathways?	**N**				
	Does it lead to improvements in care pathway(s)?	**N**				Care pathways will remain unchanged

Appendix 1.

Impact / Consequence score (severity levels) and examples of descriptors				
1	2	3	4	5
Negligible	**Minor (Green)**	**Moderate (Yellow)**	**Major (Orange)**	**Catastrophic (Red)**
Informal complaint/inquiry	Formal complaint (stage 1)	Formal complaint (stage 2) complaint	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
	Local resolution	Local resolution (with potential to go to independent review)	Low performance rating	Inquest/ombudsman inquiry
	Single failure to meet internal standards	Repeated failure to meet internal standards	Critical report	Gross failure to meet national standards
	Minor implications for patient safety if unresolved	Major patient safety implications if findings are not acted on		
	Reduced performance rating if unresolved			
Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
		Unsafe staffing level or competence (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
		Low staff morale	Loss of key staff	Loss of several key staff
		Poor staff attendance for mandatory/key training	Very low staff morale	No staff attending mandatory training /key training on an ongoing basis
			No staff attending mandatory/ key training	
No or minimal impact on breech of guidance/ statutory duty	Breech of statutory legislation	Single breech in statutory duty	Enforcement action	Multiple breeches in statutory duty
	Reduced performance rating if unresolved	Challenging external recommendations/ improvement notice	Multiple breeches in statutory duty	Prosecution
			Improvement notices	Complete systems change required
			Low performance rating	Zero performance rating
			Critical report	Severely critical report
Rumours	Local media coverage –	Local media coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
	short-term reduction in public confidence	long-term reduction in public confidence		
Potential for public concern	Elements of public expectation not being met			Total loss of public confidence

Insignificant cost increase/ schedule slippage	<5 per cent over project budget	5–10 per cent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
	Schedule slippage	Schedule slippage	Schedule slippage	Schedule slippage
			Key objectives not met	Key objectives not met
Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
	Claim less than £10,000	Claim(s) between £10,000 and £100,000	Claim(s) between £100,000 and £1 million	Failure to meet specification/ slippage
			Purchasers failing to pay on time	Loss of contract / payment by results
				Claim(s) >£1 million
Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

Likelihood score				
1	**2**	**3**	**4**	**5**
Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Caring for You

United Lincolnshire Hospitals NHS
NHS Trust

Equality Analysis

Please refer to the document 'Equality Analysis – An Overview'

Introduction

The **General Equality Duty** as set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help ULHT staff members to comply with the general duty.

Further, one of the **Specific Equality Duties,** with which the Trust must comply, requires that information evidencing compliance with the General Equality Duty is published. Together the general and specific equality duties form the Public Sector Equality Duty (PSED) with which the Trust must comply.

The form below is intended to offer a structured framework through which an Equality Analysis can be undertaken, and compliance and monitoring evidenced.

When undertaking an Equality Analysis, one question remains of paramount importance:

How have you evidenced that you have shown due regard to the Public Sector Equality Duty?

Please remember, the impact of a function could be positive, neutral or negative.

Title: *of the function to which this Equality Analysis applies*

Temporary night closure at A&E Grantham Hospital

What are the intended outcomes of this work? *Include outline of objectives and function aims*

To ensure and provide safe A&E services for the people of Lincolnshire

Who will be affected? *e.g. staff, patients, service users etc*

Residents of Grantham and surrounding areas and doctors from Grantham A&E, as they will have to travel further to work and access services.

A positive effect will be Lincoln and Pilgrim A&E departments will be more safely staffed and able to maintain safe services for patients of Lincolnshire. Staff in Pilgrim and Lincoln A&E departments are less likely to be over worked and stressed due to current staffing issues. Patients within these two areas are as a result of the change, more likely to be treated quickly in accordance with NHS Constitutional standards.

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment.*

What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.*

- Staffing rotas (consultant, middle grade and junior doctors by site)
- Attendance figures to A&E by hour and by sites – those that self-present and arrive by ambulance
- Emergency admission figures
- Performance against national standard figures
- Royal college of emergency medicine safe staffing guidance
- Agency use and availability
- Inability to recruit to doctors within all sites (middle grade and Consultants predominantly)
- Frequent attenders to A&E

Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.*

Negative – people with LD are less likely to hear of, and understand the public awareness campaigns on the new opening hours, therefore, may be more likely to arrive in A&E when it has closed

As above for people who are visually impaired or hard of hearing may not hear or read of the proposed changes

Those who have a mental health problem, are often heavy users of A&E services and may be disproportionately affected

Positive – the residents of Lincolnshire will be more safely staffed and able to maintain safe services for patients of Lincolnshire.

Sex *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).*

No negative impact.

Positive – the residents of Lincolnshire will be more safely staffed and able to maintain safe services for patients of Lincolnshire.

Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*

People whose language is not English may be less likely to hear of, and understand the public awareness campaigns on the new opening hours, therefore, may be more likely to arrive in A&E when it has closed

Positive – the residents of Lincolnshire will be more safely staffed and able to maintain safe services for patients of Lincolnshire.

Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*

Older people, particularly the frail elderly, and small children are more likely to use A&E service, so may be negatively impacted by the changes.

Positive – the residents of Lincolnshire will be more safely staffed and able to maintain safe services for patients of Lincolnshire.

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

No negative impact.

Positive – the residents of Lincolnshire will be more safely staffed and able to maintain safe services for patients of Lincolnshire.

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

No negative impact.

Positive – the residents of Lincolnshire will be more safely staffed and able to maintain safe services for patients of Lincolnshire.

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

No negative impact.

Positive – the residents of Lincolnshire will be more safely staffed and able to maintain safe services for patients of Lincolnshire.

Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*

Women who are pregnant may be more likely to access A&E services. Grantham hospital does not have maternity or paediatric services on site anyway, and clear protocols are in place should patients

self-present for treatment.

Positive – the residents of Lincolnshire will be more safely staffed and able to maintain safe services for patients of Lincolnshire.

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

Carers may be more likely to use A&E services both as a patient and to accompany the person they care so.

Positive – the residents of Lincolnshire will be more safely staffed and able to maintain safe services for patients of Lincolnshire.

Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*

People on a low income may be affected due to further travel or more expensive public transport/ taxi fares.

Positive – the residents of Lincolnshire will be more safely staffed and able to maintain safe services for patients of Lincolnshire.

Engagement and involvement

How have you engaged stakeholders in gathering evidence or testing the evidence available?

How have you engaged stakeholders in testing the function proposals?

Following Trust board on 2 August, we engaged staff and senior managers at ULHT, and EMAS, CCGs, GPs, and neighbouring providers to get support for our plans and agree actions to safely implement the changes, and put mitigations in place.

As part of LHAC and development of ULHT's clinical strategy there has been wide engagement with the public and patients on future of emergency care services in Grantham, including their views on impacts any potential changes may have of the public.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

ULHT has been engaging public and patients on our clinical strategy for the last 18 months. This includes on centralising specialist services, and options to change emergency care services at Grantham hospital.

We have engaged people from across Lincolnshire, including locality forums held in Grantham. We discussed our clinical strategy and emergency care at the following meetings.

- July 2016 locality forums, with a total of 30 people, 19 at Grantham.
- January 2016 locality forums with 39 people.
- Central forum 2016 with 16 people
- October 2015 locality forum with 27 people.

- July 2015 locality forum with 28 people.

Key themes were:

Centralising services

- It comes down to people knowing what is available and where (need for promotion)
- It comes down to individual circumstances – it is not only about the time of travel (15 – 20 miles for general appointment, 30 miles for specialist) but it depends what transport is available to them
- People would want to go to their most local hospitals for outpatients care, but might accept a further journey for the specialist care
- hospitals need to address the issue of patients travelling all around the county for appointments for pone condition
- A&E improvements need to account for large geographical area
- There needs to be a hub with the right people and networks, plenty of scope to reach out into the communities
- people always want the best care they can possibly get
- social care is the key to improving the situation- that needs to be sorted first of all. We need to create capacity in the social care system and community beds to remove some of the pressure from the hospitals.
- Could there be one specialist elective surgery site? We would travel there if it meant you were getting the best care and your family would do what they need to do to be there for you. You'd always travel for better care.

Travel

- It depends greatly upon availability of transport- and that needs to be factored into the decision-making about what services are where. You have to remember that patients are often delivered to hospital by ambulance, but have to get themselves home. That's when it really matters how far away you are.
- Also need to take into account difficulties for visitors if services are far away
- We need to consider carers in this. They are an important part of the care provided to many patients and they need to be nearby. If a patient has to travel we should explore providing a way for the carer to stay with them.
- The transport infrastructure in Lincolnshire is terrible so this needs addressing if people have to travel further for care
- Suggestion there could be local points of access for hospital transport, both for patients and visitors and carers.
- We need to make sure sufficient transport and transfer arrangements are in place for patients travelling for emergency surgery- perhaps with the financial savings made we could fund an ambucopter just for ULH, dedicated to transporting surgical emergencies?
- Need to invest in transport.

Summary of Analysis *Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.*

See above.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

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

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

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

We will work with community groups representing protected groups who will be adversely affected such as people with mental health problems, people with learning disabilities, people with visual impairments, those who are hard of hearing, people whose first language is not English and pregnant women to raise awareness of the changes. We will also produce leaflets, posters and other public information in easy to read formats, the most commonly spoken non-English languages spoken in the Grantham areas.

We will also work with other providers such as LPFT, CCGs, and GPs so they can get out information on protected groups.

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

As above. Plus, ULHT engagement team will continue engage ULHT members who represent all protected groups, patient experience will continue to engage with carers' groups.
We will engage mental health liaison nurses and maternity services, to reach these people.

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*
The overall impact will be positive for the majority of the people in Lincolnshire as Lincoln and Pilgrim A&Es will have safer staffing levels. However some people in South Kesteven area, and some groups mentioned above may be adversely affected but these will be small in number due to lower levels of attendances at Grantham A&E and the acuity of patients seen and treated there.

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

We will work with community groups representing protected groups who will be adversely affected such as people with mental health problems, people with learning disabilities, people with visual impairments, those who are hard of hearing, people whose first language is not English and pregnant women to raise awareness of the changes. We will also produce leaflets, posters and other public information in easy to read formats, the most commonly spoken non-English languages spoken in the Grantham areas.

We will also work with other providers such as LPFT, CCGs, and GPs so they can get out information to protected groups.

As above. Plus, ULHT engagement team will continue engage ULHT members who represent all protected groups, patient experience will continue to engage with carers' groups.
We will engage mental health liaison nurses and maternity services, to reach these people.

Action planning for improvement *Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*

We will work with community groups representing protected groups who will be adversely affected such as people with mental health problems, people with learning disabilities, people with visual

impairments, those who are hard of hearing, people whose first language is not English and pregnant women to raise awareness of the changes. We will also produce leaflets, posters and other public information in easy to read formats, the most commonly spoken non-English languages spoken in the Grantham areas.

We will also work with other providers such as LPFT, CCGs, and GPs so they can get out protected groups.

As above. Plus, the ULHT communications and engagement team will continue to engage ULHT members who represent all protected groups, and the patient experience team will continue to engage with carers' groups.
We will engage mental health liaison nurses and maternity services, to reach these people.

The Associate director of communications and engagement will produce a communications and engagement plan that covers the actions within the EIA. This will cover all groups potentially affected by the changes.

Please give an outline of your next steps based on the challenges and opportunities you have identified. Include here any or all of the following, based on your assessment

- Produce a communications and engagement plan covering protected groups that may be adversely affected by the change. to include as a minimum:
- Distribute leaflets and posters around health services and public places in Grantham including care and nursing homes.
- Translate A&E changes leaflet into Polish, the most common non-English language spoken in South Kesteven (0.5% of the population).
- Visit local health groups such as carers' groups.

For the record

Name of persons who carried out this assessment:
Linda Keddie and Lucy Ettridge

Date assessment commenced:
16 August 2016

Name of responsible Director/ General Manager:

Date assessment was signed:

Grantham A&E equality analysis comms and engagement plan

1. Introduction

The first communications plan (dated 8 August 2016) focused on three main areas:

1. All to action for clinical staff to work shifts or additional shifts in Pilgrim and Lincoln A&Es
2. Raise awareness of impending crisis and actions we are taking and options we are looking at
3. Announce action we are taking and public information.

The fourth area on a big public awareness campaign on where to go for what and when has started, but now needs to be targeted to key groups – those who may be adversely affected by the temporary changes – and to engage these groups to understand if or how people are being affected.

2. Context

There is a legal, and moral, duty on the NHS (providers as well as commissioners) to involve the public and patients in decision making. However, there is no legal duty to consult. The duty is on the organisation making the decision.

The definition of involvement covers a spectrum from giving information to consultation, and there is no precedent on engaging the public when making a temporary decision on the grounds of patient safety.

Legal duty

The legislation, section 242 under health and social care act, 2012 (carried over from the 2006 act) says providers should involve users of services in:

a) the planning and provision of services;
b) the development and consideration of proposals for changes in the way services are provided; and
c) decisions affecting the operation of services (change at the point they are received by patients)

(b) and (c) apply if the proposals impact on: the manner in which the services are delivered to users of those services; or the range of health services available to those users.

So this covers change in location including for example, the move of services from hospital to the community, or move from one ULHT hospital to another.

There are also four Gunning principles which should govern the process – ie involving at a formative stage. We need to be open about the process we used to reach our decision.

There is also the need to show due regard to the Public Sector Equality Duty (PSED). In meeting this duty, it's important the needs of people within the nine protected groups are considered and steps are taken to meet their needs, both in engagement and service delivery.

There is no legal duty to carry out a full 12 week consultation exercise.

Failure to involve can have legal implications. Individual service users, groups of service users and current providers who risk "losing out" when a service is changed, can all bring a judicial review. Judicial review considers the process taken, not the decision taken.

The NHS has to show regard to the duty, and needs a good reason not to involve. However informing the public and patients on the changes is covered by the definition of "involve".

3. Objectives

Our communication and engagement objectives are to:

1. Raise awareness of what stays the same, what will be different and what the public should do between 6.30pm and 9am for those who live within the GDH catchment area including groups most likely to be adversely affected by the change.
2. Continue to ensure balanced media coverage and reduce the likelihood of adverse publicity
3. Generate ideas to mitigate any impacts, particularly if the changes are in place for longer than 12 weeks.
4. Avoid legal challenge.

4. Plan

Following the comprehensive media and social campaign to raise awareness on the changes to A&E at Grantham, a more targeted communications and engagement is needed with key protected groups over the coming weeks.

The key audiences including stakeholders and staff in the plan dated 8 August will continued to be engaged and informed.

Key stakeholders will include:

- Health OSC
- Health and Wellbeing board
- Healthwatch Lincolnshire
- ULHT members

The following groups have been identified as part of the equality analysis (dated 16 August 2016) as groups that may be adversely affected by the change.

Patients groups

- People with learning disabilities
- People who are visually impaired or hard of hearing
- People with mental health problems
- People whose language is not English
- Older people, particularly the frail elderly
- Younger children
- Pregnant women
- Carers
- People on low incomes

Engagement plan

To target the right methods to the right audience, we will tailor methods according to the group. A general three-stage approach would be:

1. Formal presentations to statutory organisations such as Health Overview Scrutiny, Health and Wellbeing Board, council committees and Healthwatch Lincolnshire.

2. Face to face focus groups with:
   - ULHT members.
   - Patient groups and interested groups ie and disability forums (see table A)
   - Joint meeting with Beat It Grantham and faith leaders
   - Hard to reach groups.

3. Social media conversations
   - Monitor conversations by protected group
   - Seek views via ULHT accounts

Communications plan

To target the right communications and messaged to the right audience, we will tailor our communications according to the group. Communications will be face to face, leaflets and posters will be produced in alternative formats where necessary.

Action	When	Lead	Progress
Design leaflet on the changes based on "choose well"	16.8.16	Lucy	
Design posters on the changes on "choose well"	16.8.16	Lucy	
Promote choose well messages on social media	16.8.16	Lucy	ongoing
Distribute posters and leaflets around DGH	17.8.16	Lucy	
Distribute posters and leaflets around primary care in SWCCG area	19.8.16	Lucy	
Distribute leaflets to nursing and care homes	25.8.16	Lucy	
Distribute posters to key groups in SWLCCG area	25.8.16	Lucy	ongoing
Weekly PR on progress being made on recruitment	30.8.16	Lucy	ongoing
Organise PR on success of the Lincolnshire Heart Centre	30.8.16	Lucy	ongoing
Live Q&As on twitter	30.8.16	Lucy	ongoing
Publish regular vlogs and video chats on social media	30.8.16	Lucy	ongoing
Give regular media interviews to key broadcast media	30.8.16	Lucy	ongoing
Distribute posters and leaflets to groups in table A including translated materials	From 30.8.16	Lucy	
Attend meetings and groups in table A	From 30.8.16	Lucy	
Translate leaflets into Polish, Latvian, Lithuanian and Russian	31.8.16	Lucy	
Give briefing to Health OSC	21.9.16	SK/ JS	
Give briefing to Health and Wellbeing Board	TBC	SK/JS	
Give briefing to Healthwatch Lincolnshire	TBC	SK/JS	
Discussion with ULHT members at locality forums	27.10.16	Lucy	

Table A – community and patient groups to involve

Group	Protected characteristic	Action	Progress
Beat it Grantham and faith groups	Religion	Beat It Grantham organising an invite only meeting with local faith leaders for mid-September	
Disability – to make contact with:			
Grantham Hard of Hearing Club	Deaf		
Grantham & District Talking Newspaper for the Blind	Blind / communications impairment	Get message into weekly tape or CD for the blind of news	
Grantham Self Help Blind Group or Grantham Social	Blind / communications impairment	Contact to arrange meeting or to share information	

Group	Protected characteristic	Action	Progress
Lincolnshire Visual Impairment Services	Blind / communications impairment	Contact to arrange meeting or to share information	
Grantham Stroke Club	Stroke	Contact to arrange meeting or to share information	
Grantham & District Mencap Ltd (Cree Centre)	Learning disability	Contact to arrange meeting or to share information	
Mencap Mothers Group (Grantham)	Learning disability	Contact to arrange meeting or to share information	
Alzheimer's Society Support Group	Mental health	Contact to arrange meeting or to share information	
Bipolar support	Mental health	Contact to arrange meeting or to share information	
CANadda	Mental health	Contact to arrange meeting or to share information	
Grantham Mind	Mental health	Contact to arrange meeting or to share information	
Rethink (Grantham)	Mental health	Contact to arrange meeting or to share information	
Rethink (Sleaford)	Mental health	Contact to arrange meeting or to share information	
Breathe easy	Serious conditions	Contact to arrange meeting or to share information	
United Together	Serious health conditions	Contact to arrange meeting or to share information	
Addaction	Substance misuse	Contact to arrange meeting or to share information	
Age - to make contact with:			
Age UK Kesteven	Older people	Contact to arrange meeting or to share information	
Grantham Senior Citizens Club Ltd	Older people	Contact to arrange meeting or to share information	
Grantham U3A	Older people	Contact to arrange meeting or to share information	Provisional date 25.10.16
Sleaford Friendship Group	Older people	Contact to arrange meeting or to share information	
Sleaford U3A	Older people	Contact to arrange meeting or to share information	
Race - to make contact with:			
Grantham Polish Club	Polish people	Contact to arrange meeting or to share information	
Ethnic Minority & Traveller Education Team	Travelling community	Contact to arrange meeting or to share information	
Pregnancy and maternity to make contact with:			
Sleaford breastfeeding group	Pregnancy women and young families	Contact to arrange meeting or to share information	
NCT – Grantham and Sleaford	Pregnancy women and young families	Contact to arrange meeting or to share information	
Carers - to make contact with:			
Carers UK	Carers	Contact to arrange meeting or to share information	

Group	Protected characteristic	Action	Progress
Gifts Hospice	Carers	Contact to arrange meeting or to share information	
Glasshouse Project	Carers	Contact to arrange meeting or to share information	
Lincolnshire Carers and Young Carers Partnership	Carers	Contact to arrange meeting or to share information	
Red Cross Carer Service	Carers	Contact to arrange meeting or to share information	
S.N.A.P.	Carers	Contact to arrange meeting or to share information	
Grantham Carer Support Group	Carers	Contact to arrange meeting or to share information	
Sleaford Carer Support Group	Carers	Contact to arrange meeting or to share information	
Low income groups			
Bala House	Homelessness	Contact to arrange meeting or to share information	
British Red Cross - Grantham	All – those in crisis	Contact to arrange meeting or to share information	

Lucy Ettridge
AD communications and engagement, August 2016