Public Document Pack

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

Direct Dialling: 01522 553787

E-Mail: andrea.brown@lincolnshire.gov.uk

Democratic Services
Lincolnshire County Council
County Offices
Newland
Lincoln LN1 1YL

A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 21 September 2016 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: Mrs C A Talbot (Chairman), R C Kirk, S L W Palmer, Miss E L Ransome, Mrs S Ransome, Mrs J M Renshaw, T M Trollope-Bellew and Mrs S M Wray

District Councillors: G Gregory (Boston Borough Council), Mrs P F Watson (East Lindsey District Council), J Kirk (City of Lincoln Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and Mrs L A Rollings (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

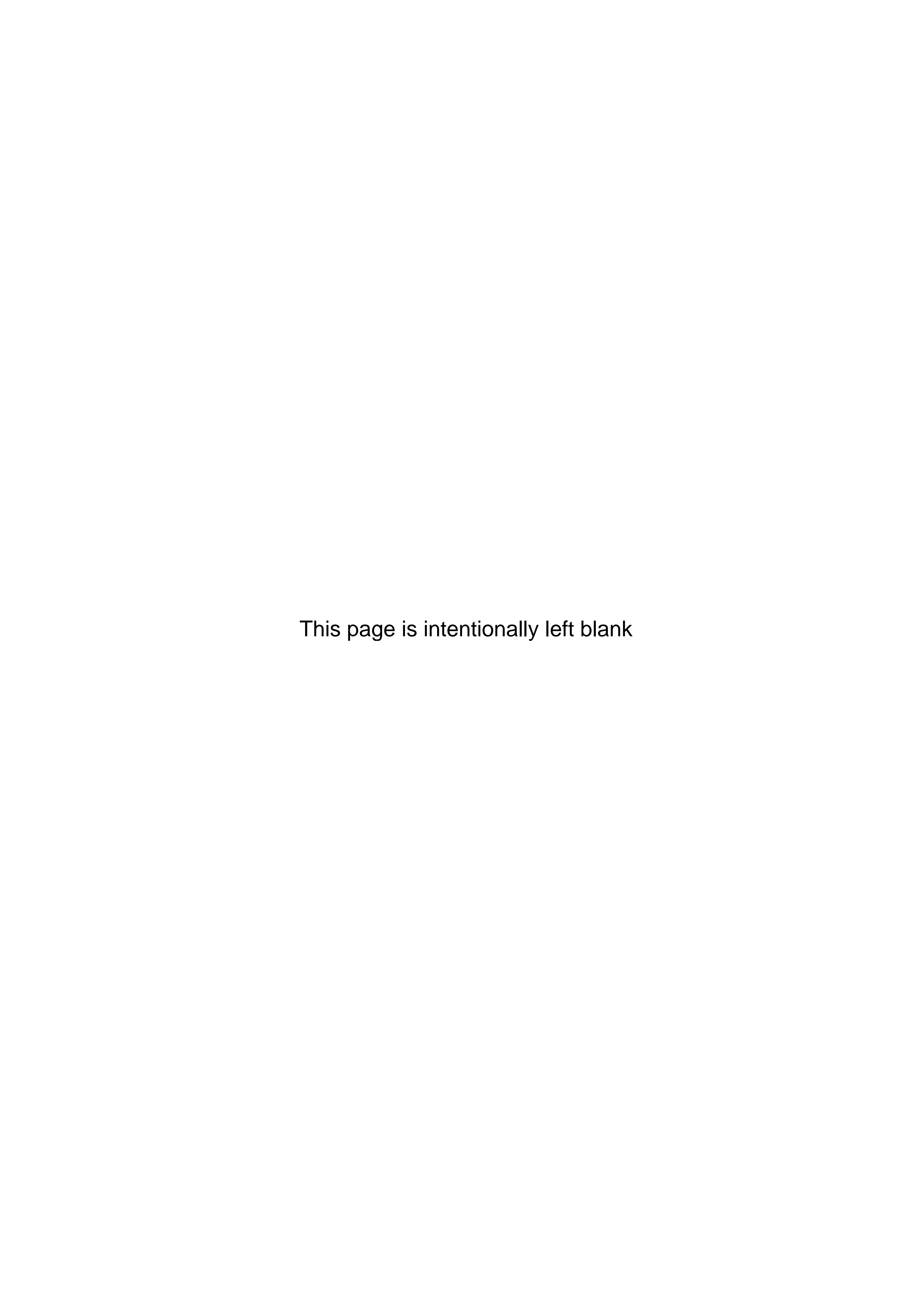
AGENDA

Item	Title	Pages
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interests**	
3	**Chairman's Announcements**	
4	**Minutes of the previous meeting of the Health Scrutiny Committee for Lincolnshire held on 20 July 2016**	5 - 24

Item	Title	Pages
5	**United Lincolnshire Hospitals NHS Trust: Emergency Care Service** In light of the recent announcement on A&E Services at Grantham and District Hospital, this item has been brought to the Committee as a matter of urgency by the Chairman, Councillor Mrs C A Talbot *(To receive a report from Dr Suneil Kapadia (Medical Director – United Lincolnshire Hospitals NHS Trust) which provides an update in relation to the provision of emergency care at United Lincolnshire Hospitals NHS Trust and the next steps to ensure continued patient safety and public engagement. Dr Suneil Kapadia (Medial Director – United Lincolnshire Hospitals NHS Trust) will be in attendance for this item)*	25 - 102
6	**Urgent Care Update** *(To receive a report from Gary James (Accountable Officer – Lincolnshire East Clinical Commissioning Group (CCG)) which provides the Committee with an update on urgent care services within Lincolnshire. Gary James (Accountable Officer – Lincolnshire East CCG) will be in attendance for this item)*	103 - 112
7	**Cancer Services in Lincolnshire** *(To receive a report from Sarah-Jane Mills (Director of Development and Service Delivery – Lincolnshire West Clinical Commissioning Group (CCG)) which provides an update on performance of cancer services across Lincolnshire and gives details of the progress made on specific improvement projects, previously described. Sarah-Jane Mills (Director of Development and Service Delivery – Lincolnshire West Clinical Commissioning Group CCG) will be in attendance for this item)*	113 - 126
	LUNCH 1.00pm – 2.00pm	
8	**East Midlands Ambulance Service Response to the Care Quality Commission Inspection Report** *(To receive a report from Richard Henderson (Acting Chief Executive – East Midlands Ambulance Service NHS Trust (EMAS) which provides the Committee with a copy of the Quality Improvement Plan produced in response to the inspection findings of the Care Quality Commission (CQC). Richard Henderson (Acting Chief Executive – East Midlands Ambulance Service NHS Trust and Blanche Lentz (Lincolnshire Divisional Manager – East Midlands Ambulance Service NHS Trust) will be in attendance for this item)*	127 - 168
9	**Congenital Heart Services - East Midlands Congenital Heart Centre** *(To receive a report from Simon Evans (Health Scrutiny Officer) which provides the Committee with the content of the Chairman's letter to NHS England, seeking a commitment to a full public consultation and the response received from NHS England)*	169 - 176

Item	Title	Pages
10	**APMS [Alternative Provider of Medical Services] GP Surgeries** *(To receive a report from Simon Evans (Health Scrutiny Officer) which provides the Committee with an update on the interim management arrangements introduced at four GP practices within Lincolnshire from 1 August 2016)*	177 - 180
11	**Quality Accounts 2015-16** *(To receive a report from Simon Evans (Health Scrutiny Officer) which gives the Committee an opportunity to consider the annual Quality Accounts of local providers during 2015-16)*	181 - 214
12	**Work Programme** *(To receive a report by Simon Evans (Health Scrutiny Officer) which invites the Committee to consider its work programme for the coming months)*	215 - 220

Tony McArdle
Chief Executive
13 September 2016



This page is intentionally left blank

**HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
20 JULY 2016**

PRESENT: COUNCILLOR MRS C A TALBOT (CHAIRMAN)

Lincolnshire County Council

Councillors R C Kirk, S L W Palmer, Miss E L Ransome, Mrs S Ransome, Mrs J M Renshaw, Mrs S M Wray and R L Foulkes

Lincolnshire District Councils

Councillors Mrs P F Watson (East Lindsey District Council), J Kirk (City of Lincoln Council), T Boston (North Kesteven District Council), C J T H Brewis (South Holland District Council (Vice-Chairman)), Mrs R Kaberry-Brown (South Kesteven District Council) and Mrs L A Rollings (West Lindsey District Council)

Healthwatch Lincolnshire

Dr B Wookey

Also in attendance

Liz Ball (Executive Nurse – South Lincolnshire CCG), Dr John Brewin (Chief Executive - Lincolnshire Partnership NHS Foundation Trust), Andrea Brown (Democratic Services Officer), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Stephen Graves (Chief Executive - Peterborough and Stamford Hospitals NHS Foundation Trust), Ian Hall (Senior Delivery and Development Manager - NHS Improvement), Mr Jim Heys (NHS England (Leicestershire and Lincolnshire Area)), Ian Jerams (Director of Operations - Lincolnshire Partnership NHS Foundation Trust), Tracy Johnson (Senior Scrutiny Officer), Sam Norton (Service User - Congenital Heart Centre), Anne-Maria Olphert (Director of Nursing and Quality - Lincolnshire Partnership NHS Foundation Trust), Caroline Walker (Deputy Chief Executive and Director of Finance - Peterborough and Stamford Hospitals NHS Foundation Trust) and Nigel West (Head of Democratic Services and Statutory Scrutiny Officer)

County Councillor B W Keimach attended the meeting as an observer.

9 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor T M Trollope-Bellew.

The Chief Executive reported that under the Local Government (Committee and Political Groups) Regulations 1990, he had appointed Councillor R L Foulkes to the Committee in place of Councillor T M Trollope-Bellew for this meeting only.

Apologies for absence were also received from Gary James, Accountable Officer – Lincolnshire East Clinical Commissioning Group.

10 DECLARATIONS OF MEMBERS' INTERESTS

The Chairman declared that, due to personal health reasons, she continued to be a private patient with Circle Nottingham, Nottingham NHS Treatment Centre in Nottingham and had also become a private patient with BMI Healthcare at The Park Hospital in Nottingham since the last meeting.

There were no other Declarations of Members' Interests at this stage of the proceedings.

11 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed everyone to the Committee and made the following announcements:-

i) Agenda Item 5 – Congenital Heart Disease Services – East Midlands Congenital Heart Centre

On 8 July 2016, NHS England made an announcement on the East Midlands Congenital Heart Centre. As a result of this, a report was prepared for inclusion on the Committee's agenda at short notice. This item was not on the Committee's work programme but a report had been prepared for the agenda and would be considered at Item 5 of the agenda.

ii) Item 8 – East Midlands Ambulance Service – Response to the Care Quality Commission (CQC) Comprehensive Inspection Report

The Chairman reported that a decision had been made to withdraw item 8 (East Midlands Ambulance Service – Response to the Care Quality Commission (CQC) Comprehensive Inspection Report) from the agenda. Mike Naylor (Finance Director – EMAS) and Steve Kennedy (Assistant Divisional Manager – EMAS), had been expected but, following the decision to withdraw the item, Richard Henderson (Acting Chief Executive – EMAS) and Blanche Lentz (newly appointed Lincolnshire Divisional Manager – EMAS) would attend the afternoon session of the Committee meeting scheduled for Wednesday 21 September 2016.

It was agreed, therefore, to consider item 9 immediately following the recess for lunch.

iii) Lincolnshire Health and Care – Case for Change Document

On 29 June 2016, Lincolnshire Health and Care published the *Case for Change* document, which identified the main challenges faced by the Lincolnshire Health and Care system, and led to the conclusion that the current system was not sustainable either clinically or financially.

The *Case for Change* committed to a full consultation on any reconfiguration of services but did not include any firm date for consultation. This would largely be dependent on the outcomes of the Sustainability and Transformation Plan submitted

to NHS England on 30 June 2016. A copy of the document would be circulated to the Committee with the Chairman's Announcements.

iv) Community Pharmacy 2016/17 and Beyond

As agreed at the last meeting, the Chairman wrote to the Rt Hon Alistair Burt MP, the Minister of State for Community and Social Care, on 21 June 2016 outlining the concerns about the absence of consultation with health overview and scrutiny committees. The Chairman reported that a reply had been received, dated 13 July 2016, in which Mr Burt reiterated the vision for a more efficient modern pharmacy system. The comments regarding consultation had also been noted although Mr Burt stated that many stakeholders had been consulted including patient groups and the Local Government Association.

v) Peterborough and Stamford Hospitals NHS Foundation Trust – Annual Public Meeting

The Chairman had received an invitation to attend the Annual Public Meeting of Peterborough and Stamford Hospitals NHS Foundation Trust, which would take place at Peterborough City Hospital between 5.15pm and 7.00pm on Thursday 28 July 2016. The Chairman was unable to attend the meeting and asked if any members could attend on behalf of the Committee. Councillor R L Foulkes advised that he would discuss this with Councillor D Brailsford and Councillor T M Trollope-Bellew, as divisional members for that area, to agree attendance. Councillor Foulkes would confirm the decision with the Health Scrutiny Officer once agreed.

vi) Lincolnshire East Clinical Commissioning Group Listening Event Report

A report had been received from Lincolnshire East Clinical Commissioning Group following a Listening Event held on 4 February 2016. A total of 85 people attended the event and the report made reference to several themes including access to services; communications between health professionals; and patient discharge from hospital. A copy of the report would be circulated to the Committee.

vii) Lincolnshire Special Care Dentistry Procurement Outcome

NHS England (Central Midlands) had issued a briefing paper on the outcome of the procurement exercise for the special care dentistry service. The Chairman explained that special care dentistry was dental care for those people with a physical, sensory, intellectual, mental, medical or emotional impairment or disability who required support beyond that available from the general dentist.

The contract was awarded to Community Dental Services and would begin on 1 December 2016 with services transferring from Lincolnshire Community Health Services NHS Trust. Community Dental Services was an employee-owned social enterprise and community interest company which had been in existence since 2011.

The briefing paper would be circulated to the Committee.

viii) Rural Services Network – Health Scrutiny Project

The Rural Services Network, which had a wide range of membership including local authorities, had initiated a project whereby it intended to gather evidence via local

authority health overview and scrutiny committees on health services in rural areas. The Committee had been asked to scrutinise its local clinical commissioning group to obtain answers to twelve questions, however as there were four clinical commissioning groups in Lincolnshire and the work programme was busy towards the end of the year, the Chairman proposed that this request be declined. The Committee agreed with this proposal for the reasons given by the Chairman.

ix) Meeting with Chief Executive of United Lincolnshire Hospitals NHS Trust (ULHT)

On 21 June 2016 the Chairman met with Jan Sobieraj (Chief Executive – United Lincolnshire Hospitals NHS Trust (ULHT) where discussion focussed on the impact of the junior doctor dispute on patient care; recruitment and retention at the Trust; and the Trust's overall financial position.

x) Adults Scrutiny Committee – Delayed Transfers of Care

At the last meeting of the Committee it was reported that the County Council's Adults Scrutiny Committee would be considering a paper on delayed transfers of care at its meeting on 7 September 2016. To enable Healthwatch Lincolnshire sufficient time to provide their input in to this topic, the Chairman advised that this item had now been rescheduled to be considered at the meeting of the Adults Scrutiny Committee on 19 October 2016.

The Committee expressed disappointment at the length of time taken for this item to be considered by the Adults Scrutiny Committee. It was explained, and acknowledged, that the reason for the delay was to enable a full report to be prepared for the Committee's consideration.

xi) Healthwatch Lincolnshire Annual Report

On 6 July 2016, Healthwatch Lincolnshire published its annual report for 2015/16, a copy of which would be circulated to the Committee.

xii) Training on Mental Health – 15 June 2016

The Chairman noted the Committee's thanks to Dr John Brewin, Chief Executive of Lincolnshire Partnership NHS Foundation Trust, for delivering a mental health training session to the Committee on 15 June 2016. Twelve members of the Committee had attended and the informal feedback received was that most members had found the session to be fascinating and helpful for the Committees future consideration of mental health topics. It was agreed to arrange a follow-up session in the Autumn.

12 MINUTES OF THE PREVIOUS MEETING OF THE HEALTH SCRUTINY COMMITTEE HELD ON 15 JUNE 2016

It was noted that Liz Ball (Executive Nurse – South Lincolnshire CCG) had been in attendance at the last meeting but omitted from the attendance list.

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee for Lincolnshire held on 15 June 2016, with the addition noted above, be approved and signed by the Chairman as a correct record.

13 CONGENITAL HEART SERVICES - EAST MIDLANDS CONGENITAL HEART CENTRE

A report by Richard Wills, the Director responsible for Democratic Services, was considered by the Committee which provided information following the announcement, on 8 July 2016 by NHS England, that *"subject to consultation with relevant Trusts and, if appropriate, the wider public"*, congenital heart disease surgery (Level 1 services) would be decommissioned from the East Midlands Congenital Heart Centre (formerly known as Glenfield Hospital).

The Chairman introduced the report which provided the historical background of the reviews undertaken of this service over the last eight years including two full public consultations, the most recent of which was held in September 2013. This review listed the following aims:-

- Securing the best outcomes for all patients;
- Tackling variation; and
- Improving patient experience.

The review also referred to three levels of service:-

- Level 1 – Specialist Surgical Centres;
- Level 2 – Specialist Cardiology Centres; and
- Level 3 – Local Cardiology Centre

In response to the consultation, on 14 December 2014, the Health Scrutiny Committee for Lincolnshire had provided three particular issues for consideration:-

- The number of surgeons at each centre – whether a one-in-three or a one-in-four was appropriate;
- The minimum number of operations undertaken by each surgeon each year, with 125 operations proposed in the consultation averaged over a three year period; and
- The co-location of congenital heart services with other paediatric services, which would mean Glenfield Hospital having to move its heart surgery services from Glenfield Hospital to Leicester Royal Infirmary.

The NHS England Board received the report from the review on 23 July 2015, where approximately two hundred new standards and service specifications were approved, which providers were expected to meet from April 2016, with a five-year trajectory to full compliance. The following excerpt was taken from the announcement issued by NHS England on 8 July 2016, pertinent to the University Hospitals of Leicester NHS Trust:-

"Subject to consultation with relevant Trusts and, if appropriate, the wider public, NHS England will also work with University Hospitals of Leicester NHS Trust and Royal Brompton & Harefield NHS Foundation Trust to safely transfer CHD surgical and interventional cardiology services to appropriate alternative hospitals. Neither University Hospitals Leicester or the Royal Brompton Trusts meet the standards and are extremely unlikely to be able to do so. Specialist medical services may be retained in Leicester."

Prior to this statement, NHS England had written to the Chief Executive of University Hospitals of Leicester NHS Trust advising that the East Midlands Congenital Heart Centre did not meet all the April 2016 requirements and was unlikely to do so. As a result, NHS England were minded to cease commissioning of Level 1 (Specialist Surgical Services - congenital heart disease) from the Trust. The Trust responded to NHS England on 5 July 2016, setting out the excellent progress made during the previous 18 months.

The Chairman further explained that there had been some developments since the agenda pack had been published and asked the Committee to note the following:-

- On 15 July 2016, NHS England published a series of documents on its website including the commissioning standards and specifications. A key document for consideration was entitled *"Paediatric Cardiac and Adult Congenital Heart Disease Standards Compliance Assessment: Report of the National Panel"* which provided NHS England's assessment of all surgical centres, including services provided at Leicester;
- In the *"What Happens Next?"* section of the document, it stated that *"The Specialised Services Commissioning Committee has determined that subject to appropriate public involvement and/or consultation, a change in service provision is appropriate and we expect that any such changes will be of a managed process and that continuity of care for patients will be a high priority"* however it remained unclear whether there would be a full public consultation;
- A number of examples were provided of those who had formally recorded their opposition to the proposals. These included the Chairman of the Leicester City Council Health and Wellbeing Board; the East Midlands Congenital Heart Centre Stakeholder Meeting; East Midlands Councils; and the Cabinet of Leicestershire County Council who requested that the Leicestershire Health Overview and Scrutiny Committee give consideration to the matter.

The Chairman went on to explain that whilst NHS England might argue that there had been a previous consultation in 2014, this consultation was limited to the standards and specifications and did not excuse NHS England from full consultation on the application of those standards and specifications to particular centres. Furthermore, Health Overview and Scrutiny Committees were in a unique position of having powers under the *Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013* including the ability to make a referral to the Secretary of State.

The amended actions were circulated to the Committee.

Members were given the opportunity to ask questions, during which the following points were noted:-

- It was reported that Leicestershire MPs had met with the Secretary of State to raise their concerns and that no MPs from Lincolnshire had attended. It was further noted that Parliament was now in Recess until September which would, potentially, be too late to act if waited until it reconvened;
- It was confirmed that local mediation was required before the Committee was able to approach the Secretary of State directly;
- The Committee was concerned about the additional expenditure for parents in attending the proposed centre in Birmingham and the impact on siblings;
- It was asked how this closure would affect Level 2 and Level 3 services and an additional concern raised that this may increase severity of illnesses and mortality due to the inability of parents to travel such distances for treatment;
- Dr B Wookey clarified the position of Healthwatch Lincolnshire and advised that the actions proposed for the Committee's approval were fully supported;
- Dr Wookey expressed disappointment that the views of Healthwatch Lincolnshire in relation to supporting the one-in-four rota for consultant surgeons had not been incorporated within the response of the Committee, at Appendix A of the report, found on page 18. Healthwatch Lincolnshire were also concerned that the report did not indicate when this position would be met or why it had not yet been met;

At this point of the proceedings, Councillor Mrs L A Rollings asked the Committee to note that her daughter was employed as a Junior Doctor at Birmingham.

At 10.45am, Councillor Mrs R Kaberry-Brown joined the meeting.

- It was confirmed that should NHS England respond advising that the proposals were not a substantial variation, it would be for the Committee to prove otherwise to therefore enforce a full consultation;
- An e-petition had been started by parents who had, or were using, the East Midlands Congenital Heart Centre and this had received over 20,000 signatures. This could be found at https://www.change.org/p/jeremy-hunt-mp-save-the-east-midlands-congenital-heart-centre-at-the-glenfield-hospital;

RESOLVED

1. That the view to decommission Level 1 Paediatric Cardiac and Adult Congenital Heart Disease Surgery Services from the East Midlands Congenital Heart Centre constituted a substantial variation, as defined by Regulation 23 of the *Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013,* which imposed on NHS England a duty to consult as the responsible commissioner of congenital heart disease services, be unanimously agreed;
2. That the request to authorise the Chairman to write to NHS England outlining the Committee's resolution in (1) above, seeking NHS England's commitment to full public consultation, be unanimously agreed;
3. That, in the event that NHS England decline to undertake consultation, the invoking of the procedures set out in Regulation 23 of the *Local Authority*

(Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, including the initiation of discussions with NHS England, be unanimously agreed; and
4. That delegation to the Chairman, should a simultaneous response be required, be unanimously agreed.

14 PROPOSED MERGER OF PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST WITH HINCHINGBROOKE HEALTH CARE NHS TRUST

Consideration was given to a report from Stephen Graves (Chief Executive – Peterborough and Stamford Hospitals NHS Foundation Trust) which provided information on the proposed merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust. The report included the engagement phase of the proposed merger programme as well as an update on the redevelopment work at Stamford and Rutland Hospital.

Stephen Graves (Chief Executive – Peterborough and Stamford Hospitals NHS Foundation Trust) and Caroline Walker (Deputy Chief Executive and Finance Officer – Peterborough and Stamford Hospitals NHS Foundation Trust) were in attendance for this item of business.

The Committee was advised that Councillor R L Foulkes was electronically recording the presentation and subsequent discussion. Councillor Foulkes confirmed that this was for his use only and would act as an aide memoir to brief fellow division members.

The background of the proposed merger was explained to the Committee. In October 2015 Monitor developed a strategic outline case which suggested that savings in the region of £10m may be achieved from closer collaboration between Peterborough and Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Health Care NHS Trust. In November 2015, both Trusts agreed to explore four levels of collaboration:-

- Option 1 – do nothing for now;
- Option 2 – shared back office function – leading an integrated back office;
- Option 3 – as per option 2, plus two boards, one executive team and one operational organisation;
- Option 4 – merger in to one organisation

A project management board had been established with engagement between both trust boards followed by the development of an Outline Business Case for the proposed merger of the two trusts. The boards agreed to the recommendations set out within the Outline Business Case in order to sustain and improve clinical services for patients and value for money for the taxpayer in Huntingdonshire, Greater Peterborough and South Lincolnshire and benefit both trusts by working as one organisation in the future.

Preparation of a Full Business Case commenced in June 2016 to be considered by both boards in September 2016 and final approved planned for November 2016 in readiness for a full merger on 1 April 2017.

Engagement of staff and members of the public had commenced in May 2016 during board meetings and would continue throughout July, August and September as part of a dedicated engagement plan. Views of residents, GPs, commissioners and service providers in South Lincolnshire would also be sought as key stakeholders within the engagement plan.

A further period of engagement would be held following a review of the Full Business Case by both boards prior to the final approval in November 2016.

Doctors and clinicians across the local health and social care economy had been engaged as part of the Cambridgeshire and Peterborough Sustainability Transformation Plan.

The Outline Business Case included details on the populations served by each trust, turnover and surplus figures, number of sites and beds, staffing levels, overall rating of the CQC and national performance standards for the year to-date.

Services were provided to a combined population of approximately 700,000 people living predominantly in Cambridgeshire, Peterborough and South Lincolnshire. The combined income for the 2016 financial year was £372 million with a combined forecast deficit of £54.8 million. Although the main commissioner of services was Cambridgeshire and Peterborough Clinical Commissioning Group, almost a quarter of the activity of Peterborough and Stamford Hospitals NHS Foundation Trust was commissioned by South Lincolnshire Clinical Commissioning Group.

It was proposed that with larger combined clinical teams that there would be greater opportunities for the sustainability of services across both sites. Activity forecasts had shown that activity demand would continue to rise in future years and the decision to merge was thought to reduce or eliminate the most barriers to flexible management of elective capacity thereby best supporting delivery of the Sustainability and Transformation Plan. The strategy to provide a specialist 'frail medical specialist centre' would be better supported by larger clinical teams offering recruitment and retention opportunities for community and acute geriatricians.

As a result of the merger it was suggested that £9m estimated savings could be made which were associated with reductions in Board cost and corporate pay and with the total elimination of agency spend in back office areas. The costs associated with the merger and transition into a new organisation was provided in detail within the report.

The Committee had specifically requested more detail on the current position of the Private Finance Initiative (PFI) and the impact of this on finances. The Outline Business Case included the following statement which gave context on the PFI:-

"Since the move to the new Peterborough City Hospital site in FY2011, Peterborough and Stamford Hospitals NHS Foundation Trust has been operating at a financial deficit of around £40 million. This is due to reliance on locum and agency staff, below tariff payments, penalties associated with the rise in emergency activity, and the national tariff not covering the premium cost of PFI buildings. Achievement of above average cost improvement as failed to deliver a surplus position over the past four years.

Peterborough and Stamford Hospitals NHS Foundation Trust is anticipating a reduction in its deficit largely through deliver of above average CIP [Cost Improvement Programme], and sustainability and transformation funding. This will reduce the forecast deficit to £17.2 million by FY21. Previous reports including the National Audit Office (2012) have identified that Peterborough and Stamford Hospitals NHS Trust also require an additional £15 million Department of Health permanent subsidy to meet the recognised gap between the tariff and the cost of the PFI. The benefit of this additional funding is not included in the financial plan. Including it would bring the deficit to £2 million. The benefits of merger would move the trust into a financial surplus position."

In regard to Stamford and Rutland Hospital, it was confirmed that Peterborough and Stamford Hospitals NHS Trust remained committed to delivering services from the site in Stamford and dialogue had been maintained with South Kesteven District Council and Stamford Town Council. Work had commenced in June 2016 to improve the infrastructure on the Stamford Hospital site and an application for planning permission for a new, permanent MRI scanner had been submitted. The work to refurbish the 'east' end of the site was awaiting the release of capital which was national issue across the NHS.

The Trust continued to liaise with Lakeside Health Care which ran the three GP practices within Stamford regarding their future plans and developments with the aim to ensure coherent services for patients in South Lincolnshire. The Lincolnshire Health and Care Team would be engaged following the release of the Case for Change Document on 29 June 2016.

In summing up, the Committee was reminded of the next steps of the proposed merger:-

- September 2016 – completion of a Full Business Case for decision by both Boards;
- September to November 2016 (six weeks) – further public engagement on Full Business Case;
- November 2016 – implementation to commence, only if all the necessary approvals received; and
- 1 April 2017 – subject to all necessary approvals being received, the merger would formally take place.

Members were given the opportunity to ask questions, during which the following points were noted:-

- It was reiterated that the PFI commitments of Peterborough and Stamford Hospitals NHS Foundation Trust were not financially viable;
- There was no expectation or intention to move services or patients to Huntingdon from Peterborough as part of the proposal;
- Hitchingbrooke Health Care NHS Trust were currently working to improve the CQC rating of "Requires Improvement" and feedback had been received that the trust had improved across the board;
- It was confirmed that acute services for the merged organisation would remain at all three sites;
- Further explanation was given about the deficit of both trusts. Peterborough and Stamford Hospitals NHS Foundation Trust had reduced a £40 million deficit to £20 million. Hinchingbrooke Health Care NHS Trust had a deficit of £10 million. It was expected that both deficits would be eliminated within five years;
- Subject to planning permission, it was expected that the planned refurbishment and installation of an MRI scanner at Stamford and Rutland Hospital would be completed within this financial year;
- Clarification was provided that, despite Lakeside Health Care being a private sector company, there was a requirement to offer the sale of excess land to public bodies in the first instance. Additionally, monies made from any sale made in Stamford by Lakeside Health Care should be put back in to the Stamford area;
- It was noted that other overview and scrutiny committees had noted the current position and agreed to consider the Full Business Case once prepared;
- At present there was representation on the Council of Governors from South Lincolnshire, however this was not a requirement. The Boards would be asking the view of relevant stakeholders during the process to formalise the appointment of governors in order to have representation proportionate to the populations served.

RESOLVED

1. That the report and comments, with particular focus on the following points be noted:-
    - Any impact of the merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust on services to patients from Lincolnshire; and
    - The latest position with regard to developments at Stamford and Rutland Hospital
2. That the merger proposals be noted and that the Committee reserve the right to make a full and formal response once in receipt of the Full Business Case.

15 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST - RESPONSE TO THE CARE QUALITY COMMISSION COMPREHENSIVE INSPECTION

Consideration was given to a report from Dr John Brewin (Chief Executive – Lincolnshire Partnership NHS Foundation Trust) which sought to provide assurance

to the Committee that Lincolnshire Partnership NHS Foundation Trust was making progress with the implementation of the action plan arising from the Care Quality Commission (CQC) Comprehensive Inspection which took place between 30 November and 4 December 2015.

Dr John Brewin (Chief Executive – Lincolnshire Partnership NHS Foundation Trust), Ian Jerams (Director of Operations – Lincolnshire Partnership NHS Foundation Trust) and Anne-Maria Olphert (Director of Nursing and Quality – Lincolnshire Partnership NHS Foundation Trust) were in attendance for this item.

The report provided background to the inspection by the Care Quality Commission (CQC) which looked at eleven service areas of Lincolnshire Partnership NHS Foundation Trust following which, on 23 April 2016, a detailed report was published giving the findings.

Overall the organisation had been rated as "Requires Improvement" with a "Good" rating for caring in all services inspected and an "Outstanding" rating for community based Child and Adolescent Mental Health Services (CAMHS). The rating for "safe" was "Inadequate" due to concerns raised about potential risk associated with Mixed Sex Accommodation and Points of Ligature.

It was reported that the vast majority of the findings were consistent with the Trust's own assessment of its areas for improvement, as presented to the CQC on the first day of the inspection. The Trust deemed that the concerns raised in relation to the "safe" key line of enquiry conflicted with the interpretation by the Trust regarding anti-ligature and same sex accommodation guidance. As such, the Trust had responded proactively to the assessment of the CQC in respect of these areas of risk and had also challenged the same sex accommodation assessment for the Ash Villa Child and Adolescent Mental Health inpatient unit to which a response was awaited.

Following the publication of the report, the Trust was required to submit an action plan covering the five CQC domains and to address the issues raised. This action plan was submitted to the CQC in early June 2016 in line with the deadline given. This was a key plan and could be found on the Trust's website at www.lpft.nhs.uk/get-involved/meeting-dates-and-minutes/board-of-directors-meetings/30-june-2016-bod-meeting-papers

The action plan was developed immediately following the inspection to address the initial feedback during the visit itself. This included the breaches in Mixed Sex Accommodation and Point of Ligature. A safety fence had been erected at the Ash Villa Unit to create a safe outside area due to the trees providing possible ligature points.

The action plan was updated further following the publication of the CQC report and included a list of the immediate actions identified. The action plan included approximately 100 actions and noted against each an accountable person along with the evidence of progress made and key milestones for each. This action plan formed part of the overall Quality Improvement Plan. Internal monitoring of the plan was led by the Director of Operations who liaised on a regular basis with Clinical Division

leaders and through the internal Operations Governance meetings. Factual evidence of progress was done through the Compliance Team and the Chief Executive had a further oversight of progress via regular updates to the Executive Team.

The following work was also being undertaken to strengthen the action plan further following feedback received from the Quality Summit and NHS Improvement:-

- Incorporation of the CQC Well Led key line of enquiry into the action plan (complete);
- Completion of the Assurance and Evidence columns (will be complete end of July 2016);
- Description of the monitoring process (complete); and
- Consideration, by the Board of Directors, of the Well Led Domain.

Risks to delivery were described and monitored as part of the Trust Board Assurance Framework on a monthly basis and would be included in the Clinical Divisional Risk Registers and escalated to the Operational Risk Register accordingly.

Assurance on progress was overseen by the Health Scrutiny Committee for Lincolnshire, NHS Improvement, NHS England and South West Lincolnshire Clinical Commissioning Group through regular contact and quarterly meetings.

The Committee was assured that this was not just a bureaucratic exercise for the Trust and had been given due attention and action.

Members were given the opportunity to ask questions, during which the following points were noted:-

- When asked why the standard health and safety assessments undertaken by the Trust had not picked up the concerns, it was explained that the Trust was aware of the guidance for same sex accommodation but was confident that they were compliant. The CQC had not noted these concerns during previous visits. Nevertheless the Trust was in disagreement with the CQC on the judgement of this issue as the interpretation of the guidance by the two organisations was clearly different. As a result, and with support from commissioners, a challenge to the CQC had been submitted;
- The Trust did undertake regular health and safety ligature assessments but, admittedly, one or two had been missed however the process for these assessments had been amended to ensure further robustness;
- In relation to Ash Villa, the ligatures highlighted were in the garden area and, as a children's facility, patients would not be in that area without supervision. However, all play facilities had been removed as a result of the report until a response to the challenge had been received;
- Each of the 97 actions had sub-actions therefore it was reported that 400-500 actions were required and these were currently being worked through successfully;
- Following feedback received at the last meeting of the Committee, it was reported that the bedding at Ash Villa had been reassessed and would be changed although would remain in line with stringent infection control guidelines. Young people in the facility had been consulted, via a focus group,

on what type of bedding they wanted and that feedback had also been taken on board. The Committee was thanked for their input;
- During a 12 month study, it had been found that of 105 ligature incidents, only six were to a fixed point. Of those six, only two were not to a collapsible fixed point. It was reported that the highest proportion of suicide attempts was by ligature;
- The cost to make the required changes, following the publication of the report, was in the region of £500k. The most expensive being the changes to bathrooms and to make the outer area of Ash Villa secure;
- In the event that the CQC did not accept the challenge, an estates business case was being prepared giving consideration on how to separate the areas in anticipation of the required changes;

At 12.30pm, Councillor Mrs S M Wray left the meeting and did not return.

- It would be difficult to turn each room at Ash Villa in to an ensuite facility without considerable expense. NHS England, as commissioners of this service, fully supported the challenge to the CQC for this decision;
- It was confirmed that no patients or families had raised any concerns regarding the same sex accommodation or the arrangements for use of facilities during the night;
- The Quality Network for Inpatient CAMHS (QNIC) (Royal College of Psychiatrists) had inspected the facility one week prior to the CQC and had given an "Outstanding" rating with no concerns raised. This report had also been referred to in the challenge submitted;
- It was thought that the amendments could be met within six months as this was not only physical changes but cultural changes. A programme for staff had been developed to incorporate the visions and values and was also included within the Trust's induction programme, 1:1s and appraisals;
- The Trust had developed a detailed plan which had overall actions required with evidence attached as and when completed. This was thought to be the most robust way of monitoring the requirements and was linked to the report from the CQC.

The Committee requested that this item be added to the work programme for the meeting on Wednesday 26 October 2016 but that more detailed and concise information be included. This was to assure the Committee of the progress made and to give a better understanding of the process.

The Committee was invited to visit Ash Villa in Sleaford and it was agreed to ask the Health Scrutiny Officer to liaise with the Director of Nursing & Quality – Lincolnshire Partnership NHS Foundation Trust.

The Chairman took the opportunity to reiterate the comments made during the Chairman's Announcements and thanked Dr Brewin for facilitating the mental health training session provided to the Committee on 15 June 2016.

RESOLVED

1. That the report and comments be noted;
2. That the assurance given to the Committee on the process by which the plan was monitored be accepted;
3. That a further update, including detailed and concise information on progress, be considered by the Committee on 26 October 2016

NOTE: At 12.55pm, the Committee adjourned for lunch and reconvened at 2.00pm. On return, the following Members and Officers were in attendance:-

County Councillors

Councillors Mrs C A Talbot (Chairman), R L Foulkes, R C Kirk, Mrs J M Renshaw and S L W Palmer

District Councillors

Councillors C J T H Brewis (Vice-Chairman) (South Holland District Council), J Kirk (City of Lincoln Council), Mrs P F Watson (East Lindsey District Council) and Mrs R Kaberry-Brown (South Kesteven District Council)

Officers in attendance

Liz Ball (Executive Nurse – South Lincolnshire CCG), Andrea Brown (Democratic Services Officer), Dr Kakoli Choudhury (Consultant in Public Health), Ian Hall (Senior Delivery and Development Manager – NHS Improvement), Jim Heys (Locality Director – Midlands and East (Central Midlands) NHS England) and Tracy Johnson (Senior Scrutiny Officer)

Apologies for Absence/Replacement Members (Councillors who attended the morning session)

Councillors Miss E L Ransome, Mrs S Ransome, Mrs S M Wray, T Boston (North Kesteven District Council), Mrs L A Rollings (West Lindsey District Council) and Healthwatch Lincolnshire representative, Dr B Wookey. The Executive Support Councillor for NHS Liaison and Community Engagement, Councillor B W Keimach, also submitted apologies.

16 EAST MIDLANDS AMBULANCE SERVICE - RESPONSE TO CARE QUALITY COMMISSION COMPREHENSIVE INSPECTION REPORT

Further to the announcement made by the Chairman at the start of the meeting, it was confirmed that this item had been withdrawn from the agenda and would be considered at the meeting of the Health Scrutiny Committee for Lincolnshire scheduled for Wednesday 21 September 2016.

17 LINCOLNSHIRE RECOVERY PROGRAMME BOARD

Consideration was given to a joint report by NHS England and NHS Improvement which provided an update on the Lincolnshire Recovery Programme, the purpose of which was to oversee the delivery of the NHS Constitutional Standards; improvements in quality of care; and actions to address financial balance within the Lincolnshire health economy. The report included outcomes from the Programme over the last year.

Jim Heys (Locality Director – Midlands and East (Central Midlands) NHS England) and Ian Hall (Senior Delivery and Development Manager – NHS Improvement) were in attendance for this item.

The context of the Lincolnshire Recovery Board, jointly chaired by NHS England and NHS Improvement, was explained for the benefit of the Committee by providing the background. The Lincolnshire Recovery Programme (LRP) had been developed to provide a senior level coordinating programme structure which supported performance improvement and further development of a clinically safe and financially sustainable health and care model across Lincolnshire.

The aims of the Lincolnshire Recovery Programme were noted:-

- Improve United Lincolnshire Hospitals NHS Trust's (ULHT's) performance against the NHS Constitutional standards so that all required targets were achieved;
- Continue to improve quality within ULHT and across the health community;
- Develop a financial strategy and plan to deliver improvements to the financial position across Lincolnshire; and
- Design an underpinning workforce/organisational development strategy and plan.

It was reported that no regulatory action had been necessary over the last 12 months and that the relationship and dialogue between commissioners and providers was much improved. The group membership had also evolved and included only accountable officers and Chief Executives. Although it had been agreed that the Lincolnshire Recovery Board would oversee the Lincolnshire Health and Care (LHAC) plan, this had now expanded to include the Sustainability and Transformation Plan (STP).

The current view was to continue with the Lincolnshire Recovery Board and consider strategic operational progress in addition to financial performance.

NHS England led the National Health Service (NHS) in England, setting the priorities and direction including strategies such as the *Five Year Forward View*. NHS England was organised into four regional teams, each providing support to Clinical Commissioning Groups (CCGs) in areas such as healthcare commissioning and delivery. Additionally, they provided professional leadership on finance, specialised commissioning, human resources and organisational development and worked closely with local authorities, health and wellbeing boards and GP practices.

Since the last meeting it was explained that the Trust Development Agency and Monitor had integrated to become one operational model known as NHS Improvement. NHS Improvement also included Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams. NHS Improvement was responsible for overseeing foundation trusts, NHS trusts and independent providers.

Chief Executives from the seven NHS organisations had undergone a Lincolnshire Leadership Programme facilitated by an external body. The benefit of the programme was to gain a sense of joint ownership and understanding of the issues and had been successful in the cessation of silo working.

The purpose of the Lincolnshire Recovery Programme Board was noted:-

1. To oversee achievement of the programme aims for an initial period of twelve months from July 2015, after which time those responsible for health and care system delivery would be in a position to no longer require this level of intervention;
2. To agree a programme structure that holds senior leadership from all represented organisations to account and oversee high level intervention and support;
3. To ensure that the boards of each organisation represented were signed up to the LRP aims and programme structure;
4. To accept recommendations from the Operational Programme Group with regards to the scope and expected outcomes from the programme work streams;
5. To act upon exception reports and items for escalation from the Operational Programme Group, in order to ensure the programme aims were achieved;
6. To ensure that dependency issues between the LRP and the Lincolnshire Health and Care (LHAC) Programme were managed in a manner that avoids duplication between the programmes or adverse impacts on either programme; and
7. To identify the need for additional support to facilitate achievement of the Programme aims and agree approaches for securing support.

The outcomes for the programme to-date included:-

- Outcome 1 – Improved working relationships between the constituent NHS organisations, and a new focus on joint action, led by new Lincolnshire Leaders working group. Evidenced by prompt signature of the 2016/17 contract between ULHT and its lead commissioner;
- Outcome 2 – Consistent delivery of the Referral to Treatment (RTT) incomplete standard of 92%;
- Outcome 3 – Consistent delivery of the national target for diagnostic waiting times;
- Outcome 4 – ULHT was currently off track against the Quarter 1 trajectory for the 62 day cancer standard. Improvement progress was monitored on a weekly call between NHS Improvement, NHS England, ULHT and Lincolnshire CCGs and an improvement trajectory agreed;

- Outcome 5 – The A&E standard (95% within 4 hours) varied by site and was the subject of intense support from all parties. A revised trajectory for delivery had been agreed by NHS Improvement and NHS England. Performance in April 2016 was better than the agreed monthly trajectory and performance in May and June was likely to be on or around the trajectory agreed. Current year to date delivery was 81.4% (at 17 June 2016);
- Outcome 6 – ULHT delivered its revised deficit target for 2015/16, recording a year end deficit of £57 million, (original planned deficit was £40 million). The Trust's control total for 2016/17 was a deficit of £48 million. Year to date (April and May 2016), ULHT had delivered a deficit of £8 million, a position that was £0.4 million better than plan. The STP included a section on "closing the finance" and efficiency gap", describing in outline the approach being developed to address the current circa £60 million deficit and the financial gap forecast for 2020/21, if no remedial actions were taken;
- Outcome 7 – The Lincolnshire Health and Care (LHAC) Programme also reported on progress to the Lincolnshire Recover Programme Board, although LHAC was subject to a separate governance and decision making structure.

Members were invited to ask questions, during which the following points were noted:-

- Outcome 4 (cancer standards) had not been met since January 2016 and there was a number of ways in which these concerns could be escalated. There had been a significant increase in referrals within recent months and the Trust had also reported significant referrals for spot check cancer. Further impact had been a significant turnover in consultant oncologists which had caused some disruption to clinics. The Cancer Committee was scheduled to meet where a trajectory would be agreed that the Trust was expected to meet over the next few months;
- Although it was acknowledged that 50% of people who presented at A&E did so inappropriately, it was reported that this was a national issue. There had been a significant decrease in performance in this area but those inappropriately presenting at A&E were generally found to be complex cases. Lincolnshire had significant gaps in the workforce and the inability to secure locum cover was a continued problem. Consideration was to be given to other options to fill the gaps as this was a mitigating factor in not meeting performance targets;
- The Ambulatory Care Clinic had improved performance in some areas but it was noted that unless the channels for release or transfer of patients from A&E improved, clinics such as ambulatory care were not the whole solution. National work was underway to discuss these areas;
- Presentation to A&E between April and June 2016 was greater than January to March 2016 and it was unclear as to why the "winter" period was quieter than subsequent months;
- Other Trusts across the country were also in a similar position in relation to Outcome 6 (financial sustainability). Commissioners and providers were developing an understanding of each other's position;
- In relation to Outcome 7 (workforce development), workforce was key to the working of the system and the Lincolnshire Recovery Programme was to

devise a workforce model which was fit for purpose. In doing so, a stocktake had been undertaken across all providers to understand the workforce including numbers, skills and experience. Services required were then considered and the competencies required for those services listed, following which an exercise was undertaken to see if the current workforce matched that;

- It was highlighted during the process that A&E did not have the required workforce and model to sufficiently support the service. Consideration was being given to patients being seen by other professionals rather than the requirement for doctors to treat everyone, for example nurses, pharmacists or paramedics;
- Although it had been anticipated that the workforce modelling would be completed by June 2016, it was accepted that the increased presentation to A&E between April and June had delayed this process and further identified the fragility of the service;
- The concept of Neighbourhood Teams had been changed slightly but had been rolled out with the associated workforce in place;
- The report indicated that the Lincolnshire Recovery Programme would continue beyond the initial twelve months, although this had not yet been agreed. It was anticipated this decision would be made on 12 August 2016;

At 2.37pm, Councillor C J T H Brewis, Vice-Chairman, left the meeting and did not return.

- A&E performance was monitored by the provider and based on the population however it was acknowledged that it was difficult to work out performance in each District Council area by population;
- Work was ongoing to understand why people presented to A&E as part of the workforce modelling as it may be found that by having a senior doctor on shift to undertake first triage, this would signpost people more quickly to the most appropriate care;
- In relation to Outcome 5 (A&E standards), it was noted that one of the main reasons for delays was the requirement for diagnostic work in other departments and waiting for results to be provided;
- Clarification was given that the £64 million deficit referred to in Outcome 6 incorporated £16 million allocated for the Sustainability and Transformation Plan (STP), and the actual deficit was £47.9 million;
- A suggestion was made to change road signs when services changed in hospitals as this may contribute to patients presenting inappropriately. This was acknowledged and would be given further consideration;
- Workforce modelling across Adult Social Care in addition to NHS partners was also underway as part of the stocktake. This included the extraction of data from Lincolnshire County Council (LCC) systems followed by individual providers;

The Committee was **not** reassured following the presentation of the report and requested that an update be presented in January 2017 when it was thought more progress would have been made.

RESOLVED

1. That the report and comments be noted; and
2. That a further update be presented to the Health Scrutiny Committee for Lincolnshire at its meeting in January 2017.

18 WORK PROGRAMME

The Committee considered its work programme for forthcoming meetings.

Tracy Johnson (Senior Scrutiny Officer) confirmed that there had been four changes to the work programme:-

1. 21 September 2016 – to add an item entitled *East Midlands Ambulance Service (EMAS) – Response to the Care Quality Commission (CQC) Report*
2. 26 October 2016 – to add an item entitled *Lincolnshire Partnership NHS Foundation Trust – Response to the Care Quality Commission (CQC) Comprehensive Inspection - Update*
3. 23 November 2016 – to add an item entitled *Joint Health and Wellbeing Strategy – Annual Assurance Report*
4. 18 January 2017 – to add an item entitled *Lincolnshire Recovery Programme - Update*

The Chairman urged the Committee to ensure that they allocate a full day in their calendars for these meetings. The work programme was particularly busy over the coming months and the Chairman stressed that full, regular, attendance was essential to ensure consistency of discussions.

RESOLVED

That the contents of the work programme, with the amendments noted above, be approved.

The meeting closed at 3.27 pm

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.

APPENDIX A

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

Document reference and summary	Status	Timescale	Lead
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:	Trust Board Approved the need for service configuration in private	Service change to be implemented by 17th August 2016	MD and COO

	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%

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

- 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

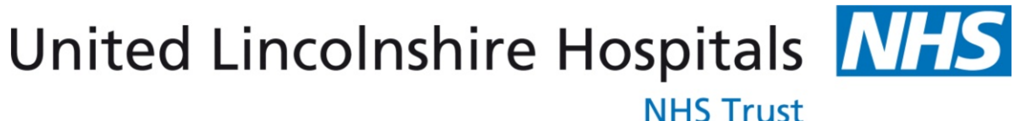
Analysis suggests that based upon the Patients conveyed by EMAS by their pick up postcode their next nearest A&E would be as follows (based on 7 – 85th centile):
Lincoln 50% (3)
Nottingham 25% (2)
Leicester 25% (2)

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



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:

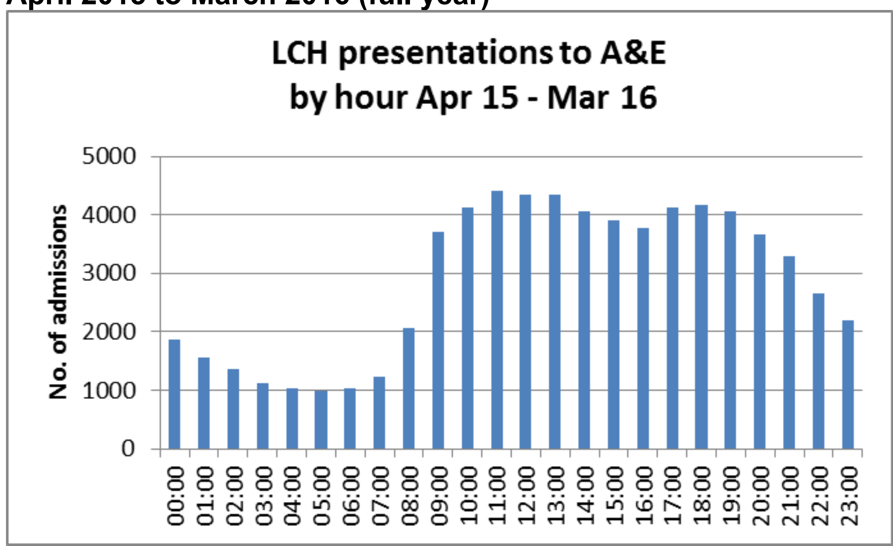
- 4.9% growth in attendances
- 4.2% growth in admissions

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

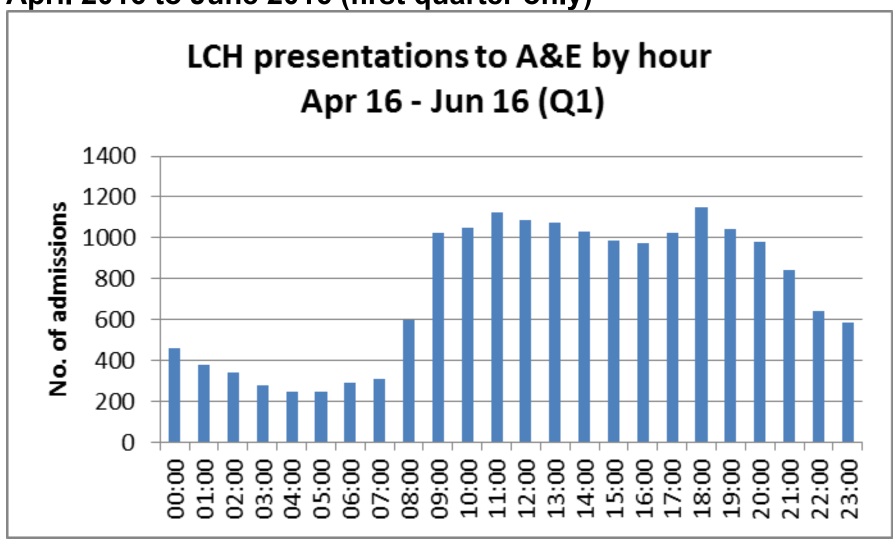
By the hour at Lincoln Hospital

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.



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

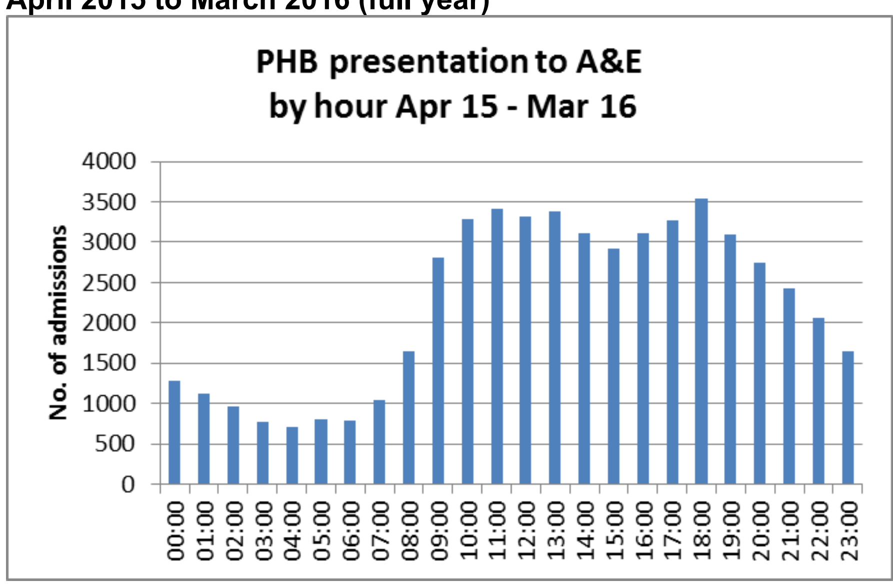
April 2016 to June 2016 (first quarter only)



By the hour at Pilgrim Hospital

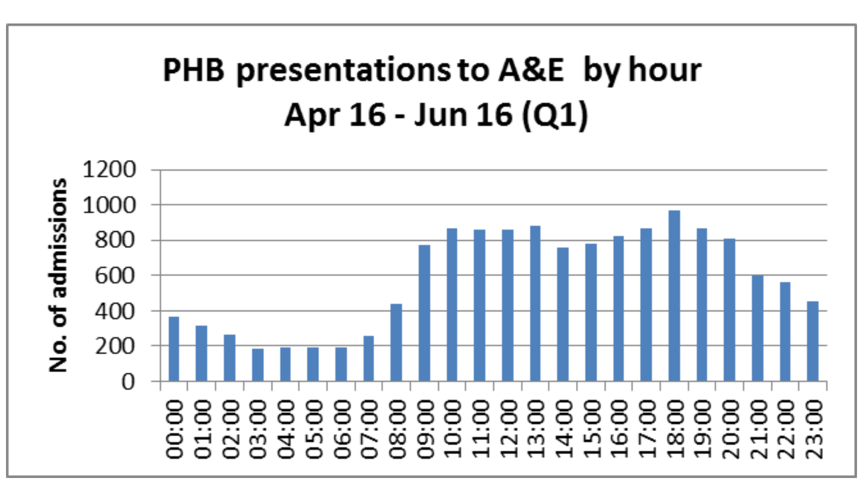
The bar charts below demonstrate the flow through the Emergency Department at Pilgrim Hospital by hour of the day, demonstrating the peak in attendances between the hours of 09:00 and 20:00. The other hours of the day experience relatively low attendances in comparison.

April 2015 to March 2016 (full year)



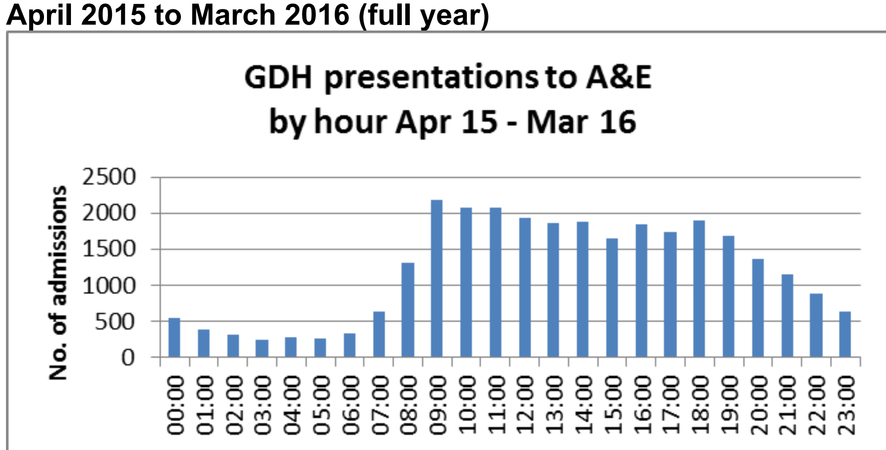
Once again, the flow for the first quarter of the current year is showing the same trend as for 2015/16.

April to June 2016 (First Quarter)



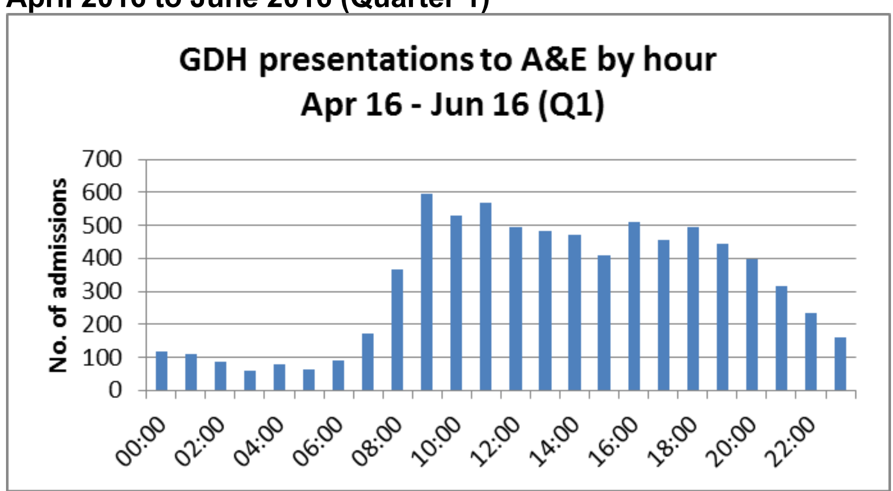
By the hour at Grantham Hospital
The bar charts below demonstrate the flow through the Emergency Department at Grantham & District Hospital by hour of the day, demonstrating the peak in attendances between the hours of 09:00 and 18:00. The other hours of the day experience relatively low attendances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

April 2015 to March 2016 (full year)



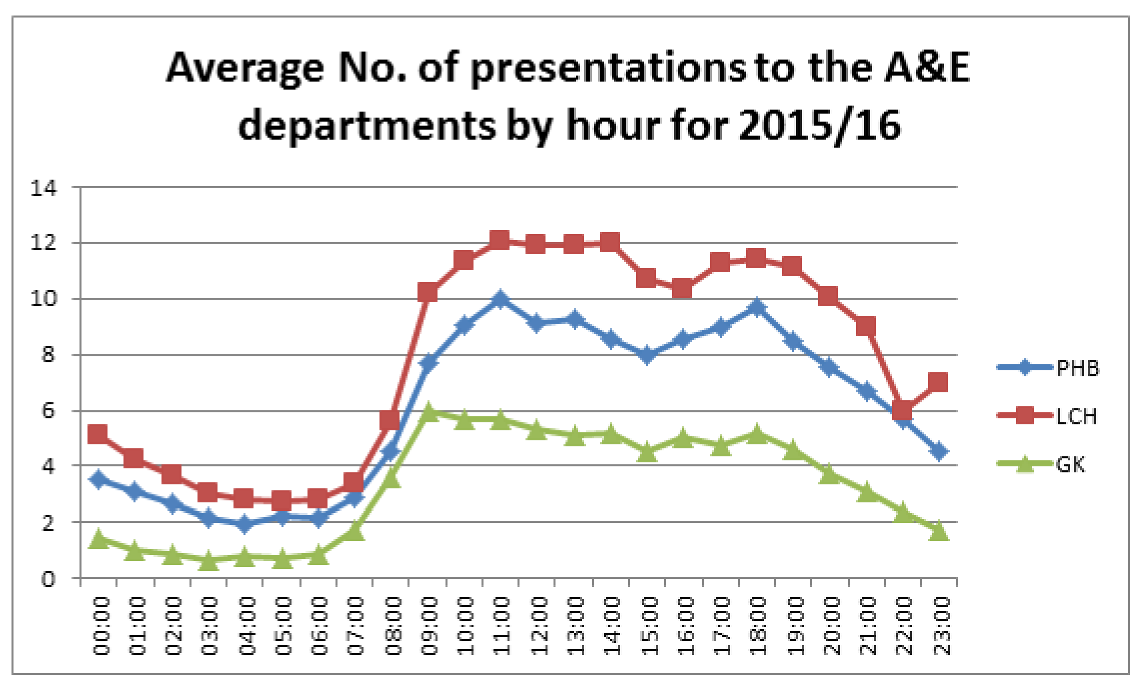
The flow for the first quarter of the current year 2016/17 is following a similar trend to that of 2015/16.

April 2016 to June 2016 (Quarter 1)

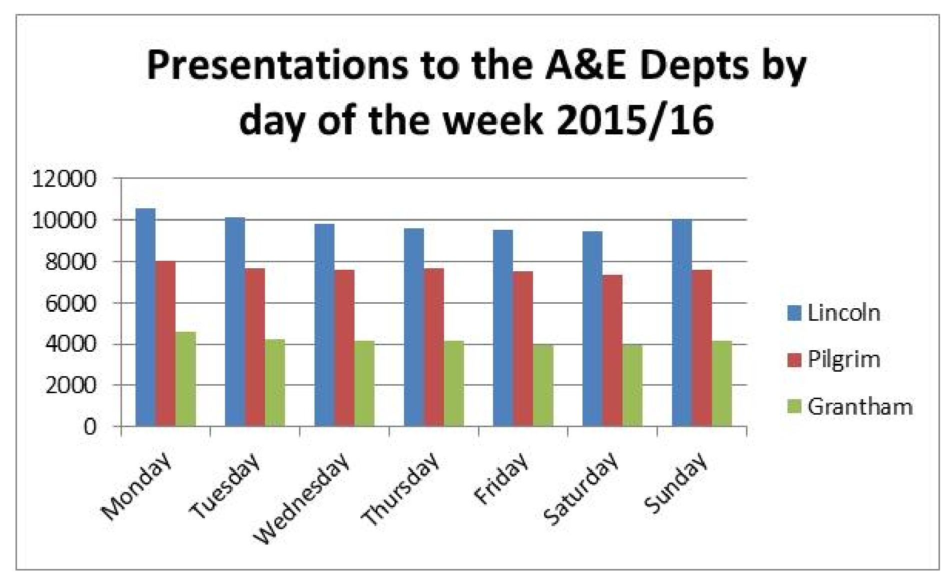


Summary of presentations to A&E by hour

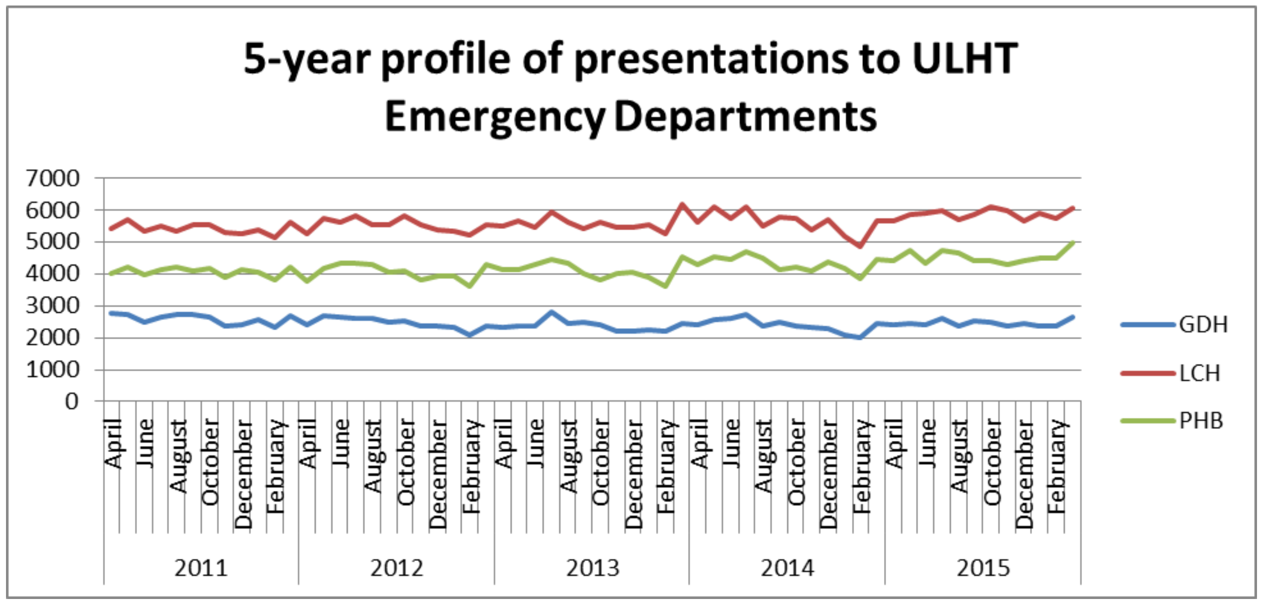
The graph below summarises the presentations to each of the A&E departments. It shows the average number of presentations to all three A&E departments by hour, for the period April 2015 to March 2016.



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.



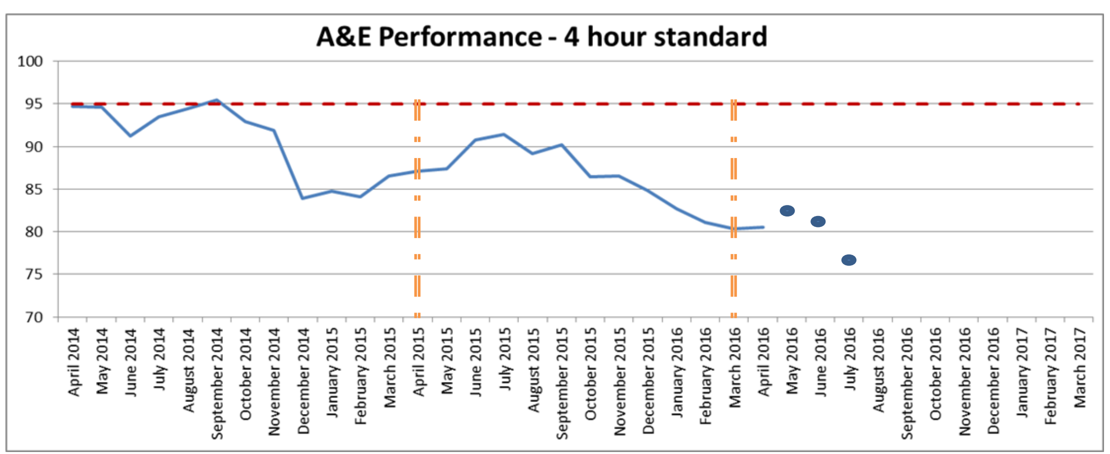
Overall ED Attendance Profile over the Last 5 Years (2011 - 2016)
The chart below shows the profile of presentations to the emergency departments since 2011. This demonstrates an increase in presentations to both Lincoln (13.2%) and Pilgrim (25%) over the five year period. Grantham has remained relatively 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.

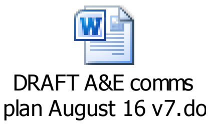
6. Reversing the decision to reduce the hours for Grantham A&E

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):

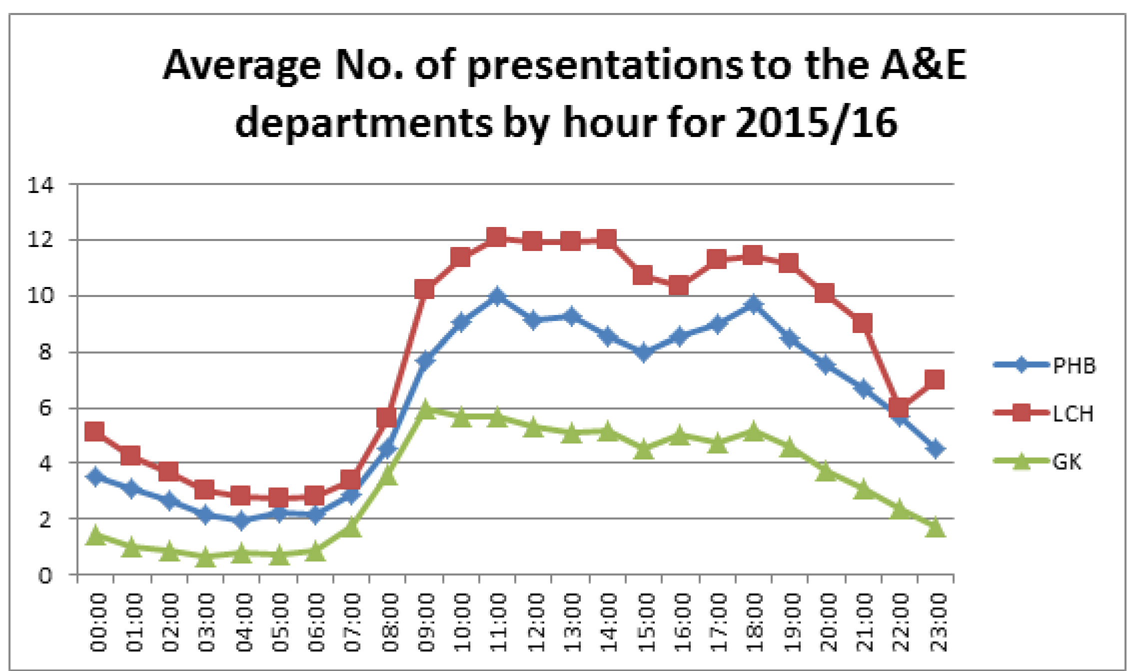
- Grantham A&E: 85 per 24 hours
- Lincoln A&E: 199 per 24 hours
- Pilgrim A&E: 158 per 24 hours

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.

LIKELIHOOD \ IMPACT	1	2	3	4	5
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 INNOVA TION		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

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:

APPENDIX F

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

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 Lincolnshire East Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 September 2016**
Subject:	**Urgent Care update**

Summary:

The purpose of this item is to update the Health Scrutiny Committee on urgent care in Lincolnshire.

Actions Required:

To consider and comment as necessary on the current position with regard to urgent care.

1. Background

The NHS constitution sets out that a minimum of 95% of patients attending an A&E department in England must be seen, treated and admitted or discharged in under four hours (the four hour A&E standard).

The target was originally introduced in 2004 and set at 98% when nationally the number of A&E attendances rose by almost 18% to 16.5 million. The increase in numbers reflects a decision at the time to incorporate data relating to Walk in Centres and Minor Injuries Units; the introduction of which was intended to improve patient access to primary care, modernise the NHS and be more responsive to patients' lifestyles.

More recently all types of department have seen the number of attendances increase however for many hospitals the number of people who show up at A&E is not primarily the problem affecting performance and the four hour standard is only a

rudimentary measure of how well the urgent care system performs in delivering care to patients.

1.1 National context

In 2015/16 attendances were slightly down nationally whilst overall performance worsened, although attendances tend to be higher in summer than winter; performance is worse in winter. *(NHS Digital 2016).*

Impacting on winter performance is the increase in older patients attending A&E who then need to be admitted in an emergency. Older people and those waiting for admission tend to wait longer in A&E than other patients, increasing the chance of the four hour target being breached. These are usually people with complex needs and multiple illnesses who need specialist assessment or to be admitted into hospital.

The real challenge in A&E is the flow of patients into and out of the hospital. More than two thirds of all hospital beds are occupied by people admitted in an emergency. When wards are full people who need to be admitted to hospital end up waiting in A&E; once people are admitted, they can sometimes get stuck in hospital when they are fit to leave. This is sometimes because the social care they need cannot be put in place quickly enough or there is often a shortage of care home beds and limited home care services in some areas however, two-thirds of patients waiting to go home are stuck because of delays within the hospital and between NHS services. For example patients may need tests or scans which might not be available late at night or at weekends.

If patients do not get the NHS and social care support they need in the community, they may have an avoidable health crisis and a cycle of emergency readmissions occurs.

1.2 Local context

A&E attendances and performance

In Lincolnshire, performance against the four hour A&E standard has been falling since the winter of 2014/15. At the end of 2015/16 the overall performance delivered 86.0% compared with 90.2% in 2014/15.

As part of the 2016/17 planning and contracting round, local systems were expected by regulators (NHS England and NHS Improvement) to agree sensible trajectories to move from the then current level of performance to the agreed Q4 performance at year end (March 2017). This regulatory decision reflected the number of systems failing to meet the 95% target across the country.

The trajectories were built into contracts and trusts were advised to document the capacity and growth assumptions upon which the trajectory was based.

In Lincolnshire the agreed Q4 position for 2016/17 is 89.0%. To put this in context, of the nine systems within the Central Midlands locality, three have a trajectory which delivers 95%. Regulators are satisfied 89% represents a sustainable position within the local system despite being 6% below the constitutional standard. Underpinning

the recovery trajectory is a Recovery Plan based on the recommendations made by ECIP [Emergency Care Improvement Programme] in March 2016.

The agreed trajectory is outlined below and demonstrates the target was achieved overall in Q1.

	Q1 80% Actual 81.8%			Q2 84%			Q3 85%			Q4 89%		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Planned	76.6%	82%	82%	84%	84%	84%	85%	85%	85%	89%	89%	89%
Actual	80.5%	83.5%	81.2%									

National performance for July and August is yet to be published however local (un-validated) data suggests a decline in performance during July.

The table below provides a comparison against both the regional and national performance.

Four Hour Standard 95%	April	May	June
England	90.0%	90.2%	90.5%
Midlands and East Region	88.7%	88.9%	88.8%
Peterborough and Stamford Hospitals NHS Foundation Trust	76.1%	79.2%	83.5%

In order to give context for this performance, the following table gives the number of people who used A&E services during the month of June 2016 and the numbers of people who were admitted.

In first three months of the 2016/17, compared to first three months of 2015/15 Q1 attendances have grown by 4.9% (1,800) which is 20 patients a day.

June 2016	Total A&E Attendances	Admissions via A&E	Other Emergency Admissions
England	1,950,754	350,960	129,250
United Lincolnshire Hospitals NHS Trust	13,704	3,539	1,246
Peterborough and Stamford Hospitals NHS Foundation Trust	8,931	2,215	778

Emergency admissions

Admissions via A&E at ULHT have increased by 959 compared to the same period in 2015/16.

Bed Occupancy

Bed occupancy rates for hospitals are context-dependent and vary between organisations, but the National Audit Office has suggested that hospitals with bed occupancy levels above 85% have regular bed shortages, periodic bed crisis and the risk of health care acquired infections increases.

In recent years there has been a national increase in the intensity with which beds are being used (measured by bed occupancy). Occupancy rates for acute beds have increased from 87.7% in 2010/11 to 89.5% in 2015/16. Year to date United Lincolnshire Hospital NHS Trust bed occupancy rate is 91.7% compared with 92.5%. During 2015/16, however, the number of weekly acute beds open is falling from 1,005 in 2015/16 to a current average of 994 which demonstrates an improving position overall.

Delayed Transfers of Care (DTOC)

Delayed transfers of care, occur when a patient is ready to depart from care and is still occupying a bed. According to NHS England, a patient is ready to depart when:

a. A clinical decision has been made that patient is ready for transfer
AND

b. A multi-disciplinary team decision has been made that patient is ready for transfer
AND

c. The patient is safe to discharge/transfer.

Longer stays in hospital can have a negative impact on older patients' health, as they quickly lose mobility and the ability to do everyday tasks. Keeping older people in hospital longer than necessary is also an additional and avoidable pressure on the financial sustainability of the NHS and local government. NHS guidance is that patients are moved out of acute hospital as soon as it is clinically safe to do so. It is important to achieve the correct balance between minimising delays and not discharging a patient from hospital before they are clinically ready.

Caring for older people who no longer need to be in hospital in more appropriate settings at home or in their community instead could result in additional annual costs of around £180 million for other parts of the health and social care system.

According to the National Audit Office, this would reduce the potential savings of £820 million arising from discharging patients earlier from hospitals. Over the past two years the official data shows there has been an increase of 270,000 (31%) in days in acute hospitals when beds have been occupied by patients who have had their discharge delayed unnecessarily, to the current figure of 1.15 million days.

Within Lincolnshire DTOC rates have fallen over the first quarter of 2016/17 with performance in June delivering 3.6% of bed days lost. The system is on track to achieve the target of 3.2% by the required date of October 2016.

	Number of Available Bed Days Lost Due to Delays				% of Delays, i.e. Number of Available Bed Days Lost Due to Delays			
July 2016	NHS	Social Care	Both NHS & Social Care	**Total Bed Days Lost**	NHS	Social Care	Both NHS & Social Care	**Total % of Delays**
Midlands and East Region	36,787	18,782	4,160	59,819	61.5%	31.5%	7.0%	5.6%
United Lincolnshire Hospitals NHS Trust	919	101	149	1,243	80.0%	8.8%	11.2%	3.6%
Peterborough and Stamford Hospitals NHS Foundation Trust	1,311	33	0	1,344	97.5%	2.5%	0	7.9%

Lincolnshire Community Health Services (LCHS) NHS Trust has experienced significant DToCs reported through the first quarter of 2016/17. Historical DToC reports have been consistently below 4%. The main outliers influencing the increase are improved reporting by Rehabilitation Services of patients, requiring onward placements appropriate to their needs, and increased demand upon Older Adult Division, where the primary reasons for delay are "awaiting residential or nursing home placement or availability". The average demand for residential care is 65% of total DToC.

Across the Older Adult inpatient areas eleven patients are DToC over 90+ days and four at 60+ days, prime pathology specific to dementia.

The notable increase in Adult Acute Inpatient area DToC is for ward 12a at Pilgrim Hospital, with three patients for May and June attributing to 14% of the total increase. Within Connolly Ward, at Lincoln County, the male acute ward, there has been a consistent DToC across the period with two patients at 90+ days and three patients at 60+ days with prime delay due to housing.

NHS 111 performance

Over the past 12 months 154,998 calls were made to Lincolnshire 111. During the first quarter of 2016/17 37,895 calls were received. The majority (63%) of calls result in patients being signposted to attend a primary or community care facility and 10% of calls result in no recommendation for service provision.

The national standard for NHS 111 is that 95% of all calls will be answered within 60 seconds. The table below gives the performance of NHS 111 so a comparison can be made.

NHS 111	April 2016	May 2016	June 2016
England	87.1%	88.2%	90.6%
Midlands and East Region	90.3%	90.0%	91.4%
Lincolnshire NHS 111	88.7%	94.0%	95.2%
Cambridgeshire and Peterborough NHS 111	96.5%	96.4%	97.9%

1.3 Lincolnshire's Constitutional Standards Recovery Plan

Since last reporting to the Committee, the urgent care recovery plan has now been focused on two distinct areas: a 30 day rolling programme of actions for Pilgrim Hospital; and five priority areas agreed with the Emergency Care Improvement Programme (ECIP). In February, a concordat was agreed by leaders from each part of the Lincolnshire system and the regional tripartite to demonstrate the overall commitment to the five priorities which are:

1. Emergency Care Flow
   - Development of "front door" services and early Comprehensive Geriatric Assessment
   - Early senior assessment in the Emergency Department
   - Review of pathways/criteria specifically short stay
   - Development of default to ambulatory care
   - Development of surgical ambulatory processes
   - Access to rapid access clinics

2. Safer Care Bundle & 'No Waits' process implemented on 5 wards per month (including community)
   - Senior Review
   - All patients have a Predicted Date of Discharge
   - Flow
   - Early discharge before 10am

3. Therapy Review/ Improvement
   - Assessment of current provision/ skills/ competencies
   - Review safe thresholds for transfer to non-acute environments/ home
   - Further development Early Supported Discharge

4. Amalgamation of existing discharge portals into a home first/ Discharge to Assess model (Transitional Care)
   - Ensure pathways developed and widely communicated with thresholds that accept patients
   - Ensure enablement resources are packaged around the patient
   - Patients must be managed actively through pathways

- Goals set and managed
- Ensure mental health support available

5. Perfect Week Programme
   - Ensure whole system engagement and response
   - Ensure metrics are clear from beginning
   - Staff engagement a priority encouraged by social movement approach
   - Executive Leadership and visibility required

Delivery of the trajectory and Recovery and Improvement Action Plan is managed via several multi-agency stakeholder groups, which include:

- Within ULHT, there is an Urgent Care Delivery Group meeting weekly, reporting into a fortnightly Operations Group chaired by Mark Brassington (Chief Operating Officer).
- Within LCHS, there is an Operational Delivery Group delivering internal transformation change chaired by Craig McLean (Deputy Director of Operations).

These meetings manage the specific Acute and Community Trust trajectory projects.

- The Lincolnshire Urgent Care Working Group was established in May is chaired by Ruth Cumbers (Urgent Care Programme Director). This group meets fortnightly to agree four to six week actions that support the recovery of the four hour emergency department standard and tracks recovery of the overarching Recovery and Improvement Plan. The Chairman reports directly into the A&E Delivery Board chaired by Jan Sobieraj (ULHT Chief Executive) which is attended by Executive Directors from across the system responsible for urgent care including local authority counterparts.

The introduction of A&E Delivery Boards was made by NHS England, NHS Improvement and ADASS (Association of Directors of Adult Social Services) in August 2016. The Boards replace local System Resilience Groups and are designed to focus primarily on A&E.

Alongside local system improvement, the Board is mandated to oversee five improvement initiatives. These initiatives are based on actions which the best health systems have already implemented and include a focus on outcomes and processes:

1. **Streaming at the front door to ambulatory and primary care**. This will reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.

2. **NHS 111 – increasing clinical call handler capacity in advance of winter.** This will decrease call transfers to ambulance services and reduce A&E attendances.

3. **Ambulances – Dispatch on Disposition and code review pilots.** This will help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive an appropriate and timely clinician and transport response. The aim is for a decrease in conveyance

and an increase In ‘Hear and Treat’ and ‘See and Treat' to divert patients away from the Emergency Department.

4. **Improved flow – "must do’s" that each Trust should implement to enhance patient flow.** This will reduce inpatient bed occupancy, reduce length of stay, and implementation of the Safer bundle will facilitate clinicians working collaboratively in the best interests of patients.

5. **Discharge – mandating ‘discharge to assess’ and ‘trusted assessor’ type models.** All systems moving to a ‘Discharge to Assess’ model will greatly reduce delays in discharging and points to home as the first port of call if clinically appropriate. This will require close working with local authorities on social care to ensure successful implementation for the whole health and care system.

* Call staff are allowed up to an additional 120 seconds to clinically assess all calls bar the most serious (Red 1) before a resource is dispatched.

Grantham Hospital A&E

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 leaving the departments at Lincoln and Pilgrim significantly understaffed.

Between the 31st July and the 6th August a further three middle grades 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 impact of these changes cannot be underestimated upon patients, stakeholders and 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.

A monitoring process has been agreed and is in place. The early monitoring undertaken by the Trust suggests:

- Daily average attendances at Grantham are c.60. This demonstrates a reduction of 20 attendances a day on the average attendances (80) seen between 1st August and 16th August. This is less than the 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.

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.

2. Conclusion

This paper has aimed to describe the current state of the Lincolnshire urgent care system. It focuses solely on the acute hospital four hour A&E standard of 95% and thus “masks” good performance in other services and does not acknowledge the interdependencies which impact on the acute trust's ability to deliver the four hour A&E standard of 95%, e.g. DTOC.

Urgent care is a complex system that “flexes” to accommodate surges in demand as it should but this also means that it requires dynamic solutions to meet ever changing problems.

All the performance measures detailed above and national performance (as a benchmark) have been considered when identifying a recovery trajectory for the Lincolnshire acute hospital four hour A&E standard of 95%. The trajectory was achieved in quarter 1 and a significant improvement in DTOC demonstrates a whole system response to performance management is impacting positively on patient care.

It remains the aspiration of Lincolnshire clinicians and leaders to improve beyond this trajectory.

3. Consultation

This is not a direct consultation item.

4. Background Papers

The following background papers were used in the preparation of this report:

Report to the Health Scrutiny Committee for Lincolnshire, March 2016 -
Urgent Care – Constitutional Standards Recovery and Winter Resilience

This report was written by Ruth Cumbers, Urgent Care Programme Director who can be contacted on 01522 513355 ext. 5424 or
Ruth.Cumbers@lincolnshireeastccg.nh.uk

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 Sarah-Jane Mills, Director of Development and service Delivery, Lincolnshire West Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 September 2016**
Subject:	**Cancer Services in Lincolnshire**

Summary

Improving cancer services for the people of Lincolnshire remains a top priority

There is a well-established Cancer Improvement Team, with representatives from all partner organisations. This team are responsible for leading the development of Cancer services across Lincolnshire and implementing local plans which reflect local challenges and the National Cancer Strategy.

During the last six months, performance has not sustained the level of improvement reported in January 2016. Key constraints are access to diagnostic services and workforce availability. Short terms priority plans are in place to mitigate these risks.

Significant progress has been made on the specific improvement projects described in January, with arrangements in place to support early detection and improvement, *Find Out Faster* and development of community support.

Actions Required:

To consider and comment on the progress in relation to the development of cancer services throughout Lincolnshire**.**

1. Background

Cancer remains one of the national priorities for the NHS. In 2015 an updated cancer strategy "Achieving World – Class cancer Outcomes" was published by the Independent Cancer Taskforce. The strategy sets out a vision for what cancer patients should expect from the health service. The 6 overarching objectives of the national strategy are:

- Spearhead a radical upgrade in prevention and public health
- Drive a national ambition to achieve earlier diagnosis
- Establish patient experience as being on a par with clinical effectiveness and safety
- Transform our approach to support people living with and beyond cancer
- Make the necessary investments required to deliver a modern high-quality service
- Overhaul processes for commissioning, accountability and provision.

The Lincolnshire Health and Care System remains committed to driving the continued improvement of cancer services and has established a network with key stakeholders, co-ordinated by Lincolnshire West CCG, to further promote the development of services for local people.

This report provides an update on the Lincolnshire Cancer Improvement Plan

2. Cancer Profile for Lincolnshire (information source Public Health Intelligence Team)

2.1 Incidence summary

- New cases of cancer (all cancers) are highest in South and South West Lincolnshire CCG's, with rates greater than the national average.
- New diagnosis of breast cancer amongst women is greatest in South Lincolnshire.
- New cases of lung cancer are comparably low across Lincolnshire compared to England, and lowest in South Lincolnshire.
- Colorectal cancer incidence is higher across all CCG's compared to England, with South and South West Lincolnshire having the highest rates.
- Trends over time show that new diagnosis of all cancers has seen a steady increase nationally since 2009.
- A similar increase can be seen in South Lincolnshire while rates have fallen in other areas of Lincolnshire over the same period.

Table 1: All-age, cancer incidence rate in Lincolnshire, by type of disease and CCG, 2012-14 (Source: National Cancer Registration and Analysis Service, Public Health England)

CCG	Incidence rate per 100,000				
	All cancers	Prostate	Breast	Lung	Colorectal
Lincolnshire East	622.2	184.2	172.7	72.4	76.3
Lincolnshire West	595.5	172.6	170.0	67.1	73.2
South Lincolnshire	599.7	210.2	164.3	63.2	78.2
South West Lincolnshire	626.3	207.9	171.0	71.6	75.5
Lincolnshire	610.3	189.9	169.7	68.9	75.5
England	**615.3**	**181.8**	**169.9**	**79.7**	**72.9**

2.2. Early detection

Early detection of cancer greatly increases the chances for successful treatment. There are two major components of early detection of cancer: education to promote early diagnosis and screening. Screening refers to the use of simple tests across a healthy population in order to identify individuals who have disease, but do not yet have symptoms. Examples include breast cancer screening using mammography and cervical cancer screening using cytology screening methods, including Pap smears.
(Source: WHO, Early detection of cancer, 2016)

Screening summary

- Invitation and uptake for breast cancer screening for females aged 50-70 in Lincolnshire is higher than the national average. South and South West Lincolnshire have seen a noticeably higher uptake compared to East and West Lincolnshire CCG's.
- 3-year coverage of breast screening is also high in Lincolnshire, compared to England. Again coverage is highest in South Lincolnshire.
- Cervical screening covers around three quarters of all females aged 25-64 living in Lincolnshire, looking over a 3.5 to 5.5 year period.
- Invitation and uptake for bowel cancer screening for all persons aged 60-69 is higher than the national average. South Lincolnshire has the highest uptake across Lincolnshire.
- Rates of bowel cancer screening in the past 30 months are also high in Lincolnshire, with South Lincolnshire having the highest uptake.
- Early diagnosis of cancer across Lincolnshire is poor in comparison to national averages.
- In 2014, half of all new cases nationally were diagnosed at stage 1 or 2, while in Lincolnshire West only a third were diagnosed at the same stage.
- South Lincolnshire has the highest early diagnosis rate across Lincolnshire, at 48.3% and is statistically comparable with England.
- Although lower than the national equivalent, early diagnosis rates for Lincolnshire East, West and South West have improved since 2012.

2.3 Survival

Survival statistics for cancer are usually written as 1 year survival, 5 year survival or 10 year survival. They mean the percentage of all adults (aged 15 to 99) who are alive 1, or 5, or 10 years after their initial diagnosis. (Source: Cancer Research UK, Understanding cancer stats, 2016)

Survival summary

- One year survival rates for all cancers across Lincolnshire are comparable to the national average. South Lincolnshire is the only CCG area where survival rates exceed the national equivalent.
- Of the defined types of cancer, survival rates are highest for breast cancer, with rates comparable to England.
- Around three quarters of adults across Lincolnshire initially diagnosed with colorectal cancer survive at one year.

- One year survival rates for lung cancer are much lower across Lincolnshire, at between 30.5% and 39.4%.
- Over time, survival rates for all cancers have seen the greatest increase in South Lincolnshire of 13.4% between 2004 and 2013. South West Lincolnshire has the slowest increase of 10.8%.

Table 2: Cancer survival rates at one year in Lincolnshire, by type of disease and CCG, 2013

CCG	One year survival rate			
	All cancers	Breast	Lung	Colorectal
Lincolnshire East	68.8	95.8	30.5	74.5
Lincolnshire West	69.9	96.5	37.3	73.9
South Lincolnshire	71.1	96.1	39.4	76.6
South West Lincolnshire	69.3	96.9	33.9	75.9
England	**70.2**	**96.7**	**35.4**	**77.7**

3. **The results of the National Cancer Patient Experience Survey**, published in July 2016, are presented in the table below

Extract from National Cancer Patient Experience Survey 2015 Results:

	LINCOLNSHIRE CCGs				NHS TRUSTS providing treatment for Lincolnshire people			
	EAST	WEST	SOUTH WEST	SOUTH LINCS	ULHT	PSFHT	NLAG	NUH
Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating	8.5	8.4	8.6	8.9	8.5	8.9	8.7	8.7
% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment.	76	77	78	82	77	81	74	79
% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment.	85	87	89	88	85	91	90	89
When asked how easy or difficult it had been to contact their Clinical Nurse Specialist % of respondents said that it had been 'quite easy' or 'very easy'.	86	82	86	89	86	86	87	89
% of respondents said that, overall, they were always treated with dignity and respect whilst they were in hospital.	87	86	91	92	88	91	90	86
% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.	92	92	92	95	92	96	93	92
% of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.	58	63	66	71	63	67	60	62

4. Lincolnshire Cancer Improvement Plan - Progress

4.1. Support for Continued Improved Performance against the National Waiting Time Standards.

The following table shows the performance during Quarter 1 2016/17 (April – June)

	2 week wait – percentage of patients seen by a specialist within 14 days of referrals	62 days – percentage of patients receiving treatment within 62 days
United Lincolnshire Hospitals Trust	90.83%	71.4%
Peterborough & Stamford Foundation Trust	97.2%	83.12%
Norther Lincolnshire & Goole	96.73%	82.32%
Nottingham University Hospitals	92.75%	79.02%

Towards the end of 2015, the trajectory for cancer performance at ULHT was improving month on month. Whilst nationally performance is expected to dip slightly in January and February, ULHT performance did not recover to the pre-Christmas level. The ULHT team along with colleagues from the CCG, NHS Improvement, NHS England, Cancer Network and National Intensive Cancer Support Team have worked together to understand why recovery was not in line with forecast. This review noted that:

- The Lincolnshire Improvement Plan is comprehensive and actions are being progressed in accordance with the plan.
- The primary constraint is at the early part of the cancer pathway. Increased demand for diagnostic tests is largely due to a positive response to the *Be Clear on Cancer* Campaign and the change to NICE guidance to encourage GPs to refer promptly if there is a possibility that the symptoms a patient is describing may be as a result of a cancer.
- During this period the Trust, along with other acute providers, have joined together to enable images to be shared and as such reported across the East Midlands. Whilst ultimately this will reduce the reporting time, during the implementation of the new software there have been a number of problems which have resulted in a delay in reporting.
- Workforce availability has also resulted in reduced capacity in a number of areas including :
    - Vacancies within the Oncology team which led to delays in patients receiving their radiotherapy (performance during the period January 2016 – July 2016 was 88% compared with the normal average of 95.8%) – all posts are now filled.

- Staff vacancy and maternity leave in chemotherapy (performance during the period December 2015 to May 2016 was 92% compared with the normal average of 99.1%. During this period the Trust were unable to support the Chemotherapy bus) – Issues are now resolved.
- Over the last 2 months, the 2 week wait performance deteriorated further as radiologist capacity in the breast service was drastically reduced following staff changes. – Issues are temporarily resolved but the service remains fragile and there is an urgent need to review the options with regards service configuration to ensure that these support a sustainable service model.
- Workforce availability remains one of the high risks with regards to the provision of cancer services.

- Although the CCG and ULHT have a comprehensive Improvement Plan which is being progressed in accordance with the agreed time line additional actions have been agreed to mitigate the current problems that are directly impacting on the Trust's performance today. These include :

  - An operational risk summit was arranged to review the actions that could be taken to manage the reduced capacity in the breast team. At all times the team had full knowledge of the length of time a person was waiting for their first appointment. All patients were actively tracked and managed to ensure that treatment needed was not delayed, i.e. that if a person was diagnosed as having cancer their treatment was completed within the 62 days and as such there would be no adverse impact on the prognosis for the patient. The team have also provided additional weekend clinics and this week's waiting time is now reported at 10 days.
  - Implementing a rapid improvement programme to review and stream line access arrangements to diagnostics.
  - Planning a rapid improvement programme, to follow the access improvement initiative, to reduce the time taken from test to report.
  - Submitted an application for national funding to increase the capacity in CT and support straight to test for suspected Lower Gastro-intestinal cancers.
  - Reinstating the 7 day horizon for booking 2 week wait referrals for all tumour sites other than skin and breast.
  - Securing additional support from the IST to explore the opportunity to review systems and processes within teams to proactively manage patients through their cancer treatment pathway.
  - Progress of these priority actions are monitored by all parties through a weekly teleconference and reviewed every six weeks so that we are assured that the priority actions are aligned to the identified constraints at any point in time.

4.2 Progress against the improvement actions discussed in January 2016

- Direct access to diagnostic investigations

  ULHT have piloted the development of a Clinical Nurse Specialist led telephone triage for patients with suspected Lower Gastrointestinal (Gi) cancer. The details of this project are outlined in appendix 1 and have led to a reduction in the time taken from GP referral to diagnostic test from 23 days to 10. The project has also improved

patient experience and costs less than the previous pathway. The plan is to roll out the new way of working to all sites.

- Work with colleagues in Public Health to gather information that will further support our understanding of issues for the local population.

  Cancer prevention and early presentation interventions are essential for addressing the health and wellbeing gap in the Lincolnshire Sustainability and Transformation Plan (STP). As a key workstream in the Lincolnshire Cancer Improvement Plan, colleagues in Public Health are leading the development of an integrated plan to support the co-ordination of plans to facilitate early detection and prevention. This group includes representatives from Clinical Commissioning Groups, Public Health England , the Local Authority and Cancer Research UK.

  The group will ensure that the Lincolnshire Improvement Plan considers the range of strategies and programmes that show the importance of cancer prevention and early presentation. Some of these include:

  National

  - The 5 Year Forward View includes how the NHS will take the lead for improving health and wellbeing and includes the need for incentivising and supporting healthier behaviours.
  - Improving Outcomes: A Strategy for Cancer 2015-2020 sets out the approach that health and care services will take to improve outcomes for cancer patients which includes the role of prevention and public health.
  - The NHS Mandate for 2016/17 includes actions on cancer to address poor outcomes and inequalities.
  - Public Health England's plan 'From Evidence into Action: Opportunities to Protect and Improve the Nation's Health' identifies seven priorities, which includes risk factors for cancer, for example, tackling obesity, reducing smoking and reducing harmful drinking.
  - There are a number of other national strategies that are relevant to cancer. For example, 'Healthy Lives, Healthy People: A Tobacco Control Plan for England' and 'Healthy Lives, Healthy People. A Call to Action on Obesity in England'.

  Local

  - Cancer is one of the topics in the Lincolnshire Joint Strategic Needs Assessment which relates to a number of core themes (for example, ill health and inequalities).
  - A number of the themes of the Joint Health and Wellbeing Strategy for Lincolnshire, such as Promoting Healthier Lifestyles and Delivering Care for Major Causes of ill Health and Disability, are very relevant to cancer.
  - There are a number of other local strategies that are relevant to cancer, for example, the Lincolnshire Tobacco Control Strategy 2013-2018 and the Lincolnshire Alcohol and Drug Strategy.

Actions plans are being developed to support continuous improvement in:

- Cancer prevention

- Cancer screening
- Promoting symptom awareness.

- Secure funding to support the appointment of a Project manager to lead the development of community based cancer support services.

  A dedicated project manager has been appointed to lead the development of community based services. The key objectives of the programme include:

  - Identifying patients who may need additional support prior to diagnosis and to ensure that this support is available
  - Improve the management of patients transferring from acute treatment to a recovery programme
  - Develop the network of services to support patients adjusting to the new norm of life after cancer treatment
  - Ensuring that patients who have a palliative condition are connected with palliative care services

- Develop links with tertiary centres to facilitate the review of clinical pathways and where appropriate explore the development of formal alliances.

  ULHT are working with colleagues to develop systems and processes that ensure that patients who need to go out of area for some aspects of their treatment are supported and are not lost to local clinical teams. Discussions with colleagues in Nottingham have supported the development of the 'Next steps' framework – which is aimed at ensuring that when a patient leaves an appointment they are clear about what will happen next, this joint management of patients is critical to both ensuring they are well supported but also in ensuring that there are no delays in their treatment.

- Review & consider the Danish model with respect to utilising different diagnostic strategies to facilitate access for patients at high risk of cancer.

  A project manager has been appointed to lead the *Find Out Faster* initiative.

  The *Find Out Faster* project aims to offer rapid access to diagnostic testing for patients who present to their GP with vague symptoms of cancer. GPs currently have two options for patients where there is a suspicion of cancer, refer on a two week wait pathway or send for routine diagnostics (this can take up to 6 weeks for results), the *Find Out Faster* pathway offers a third option, for patients who present with vague symptoms of cancer the GP will use a risk stratification tool (QCancer) to accurately predict the patients current risk of having a cancer, patients receiving a score of between 2% & 5% will be referred on the *Find Out Faster* pathway. It is hoped that the outcomes of the project will be:

  - A shift to early stage diagnosis of cancer (Stage 1&2 rather than stages 3&4) where it is more treatable.
  - A reduction in the number of emergency presentations of cancer
  - A reduction in the number of 2 week wait referrals
  - Improved access to diagnostics for patients classed as medium risk

- To work with key stakeholders to develop sustained improved access to breast services.

  Although there is general agreement of the need to review the breast services for Lincolnshire the recent focus has been on managing the impact of the current workforce pressures within the team. These discussions have though generated a greater understanding of the short term improvements that would improve the current service arrangements prior to a more comprehensive review. These include :

  - Review of the referral pathways to develop alternatives to provide advice / guidance / support to GPs
  - Review of the Clinical Nurse Specialist role
  - Collaboration with other breast teams.

  A review meeting is scheduled for the end of September. At this meeting the team will review progress on the short term actions to mitigate current risks and agreed the Project brief for the wider service review.

4.3 Update on issues raised at the meeting in January

At the meeting in January colleagues raised concern about feedback they had received from a local resident. This feedback was followed up and a face to face meeting arranged. As a result of this & similar feedback from a local patient support group the Lead Cancer Nurse is working with the Clinical Nurse Specialists to review their role and the time they have available to support individual patients. Further feedback was provided to the team involved in the patient care who acknowledge that a lack of information and shared decision making had led to the patient experiencing an apparently chaotic system and feeling un-supported.

The issue raised by councillors with regards to supporting patients, who are no longer routinely called for screening, to make a note in the diary, was raised with the team. Currently the template for letters is generated centrally, but through the Early Detection / Prevention Group, the team agreed that they will consider how to address the issue raised. It is hope that the principles of the successful Pink Pants Programme, which was led by EPOC [Early Presentation of Cancer] programme, who worked closely with practices to send personalised letters on pink paper might be adapted to address the highlighted concern

5. The objectives of our improvement plan are:

- To work with local communities to increase the number of people who attend the screening programme.
- To develop community services to support people affected by cancer so that they may be partners in their care and treatment, both during and beyond treatment.
- To improve access to diagnostic services in order to support referral to diagnosis in 4 weeks.
- To work with the East Midlands Clinical Network and other partners to support the development and implementation of best practice clinical pathways

- To continually improve the systems, processes and policies so as to facilitate the proactive management of patients on their cancer pathway.
- To support the continued development of palliative and end of life care services.

6. During the next six months our key actions are:

- Support continued improved performance against the national waiting time standards.
- Roll out the Nurse Led triage of referrals for suspected Lower Gi cancers
- Agree the action plan to support early detection and prevention
- Agree the key priorities for the development of Community services and the action plan to progress these
- Continue to develop the links with tertiary centres to facilitate the review of clinical pathways and work with the East Midlands Network to develop the Cancer Alliance framework
- Implement the *Find Out Faster* programme
- Agree the service design for the future provision of breast services
- ULHT will implement a new data base that will enable them to improve visibility of individual patient treatment pathways and as such minimise delays and provide richer information to support ongoing improvement
- Review the detail of the Patient Experience Survey in order to ensure that we are addressing concerns as a core part of our Improvement Plan

7. Conclusion

Improving cancer services for the people of Lincolnshire remains a top priority

There is a well-established Cancer Improvement Team, with representatives from all partner organisations. This team are responsible for leading the development of Cancer services across Lincolnshire and implementing local plans which reflect local challenges and the National Cancer Strategy.

The key areas of focus are:

- Ensuring access to services is in accordance with the constitutional standards
- Raising awareness.
- Encouraging people to take up the opportunity of screening.
- Improving access to local services
- Supporting the continuous improvement of acute cancer treatments at ULHT and other hospitals used by Lincolnshire people, and tertiary centres.
- Promoting the development of services to support people living with and beyond cancer
- Reinforcing and enabling the continued development of palliative and end of life care services.

During the last six months, performance in ULHT has not sustained the level of improvement reported in January. Key constraints are access to diagnostic services and workforce availability. Short terms priority plans are in place to mitigate these risks.

Significant progress has been made on the specific improvement projects described in January with arrangements in place to support early detection and improvement, *Find Out Faster* and development of community support.

Individual initiatives such as the introduction of the Clinical Nurse Specialist led triage have dramatically reduced the time between referral and diagnostic test, improved patient experience and reduced costs. The team have agreed a robust framework for the next six months and look forward to providing a progress report to the Health Scrutiny Committee for Lincolnshire.

8. Appendices

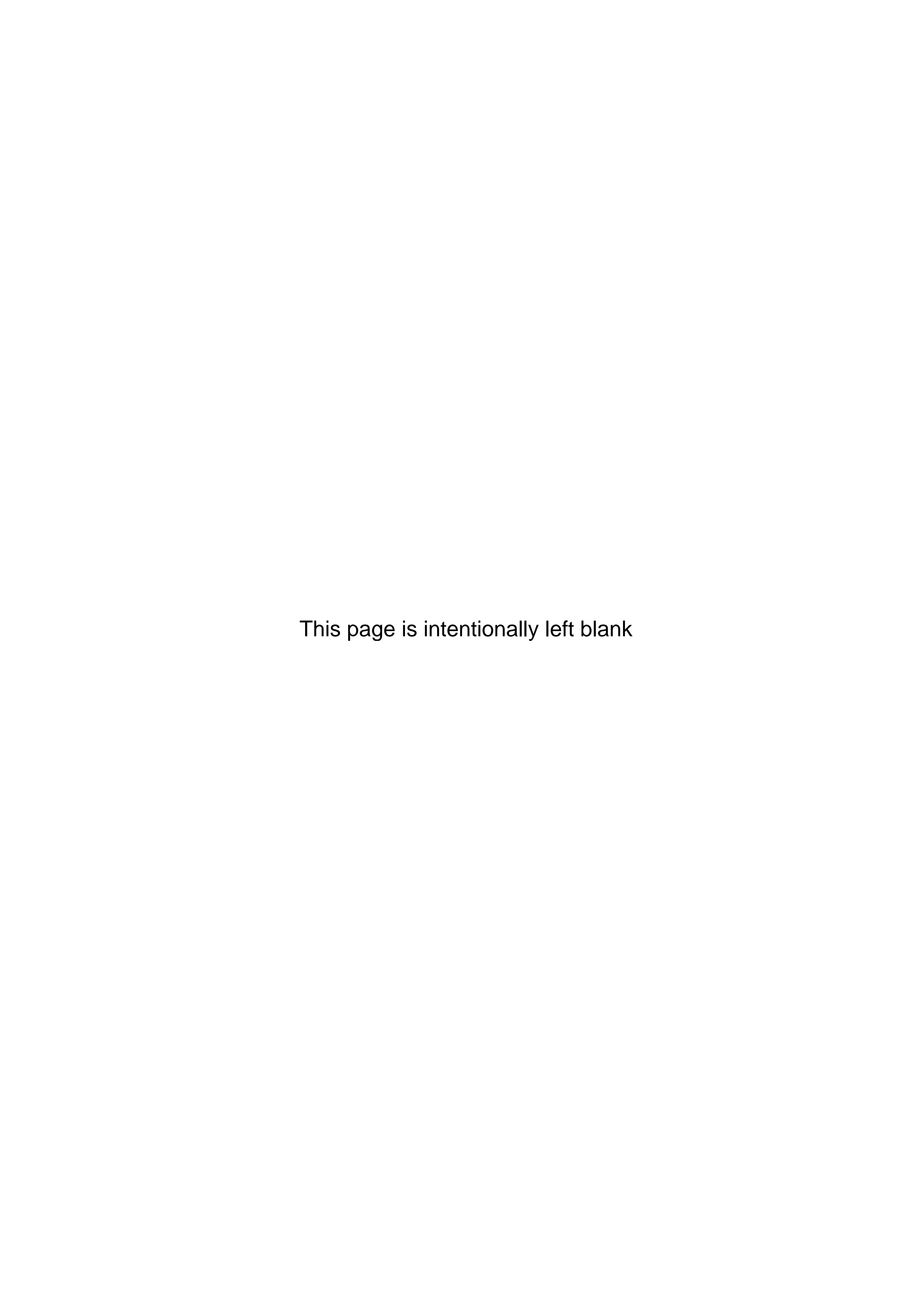
Appendix A	Lower Gastrointestinal Cancer Pathway: Piloting Clinical Nurse Specialist-led telephone triage

9. Background Papers

The following background papers were used in the preparation of this report:

- Cancer Profile for Lincolnshire (information source Public Health Intelligence Team)

This report was written by Sarah-Jane Mills, Director of Development & Service Delivery, who can be contacted on 01522 515330 or Sarah-Jane.Mills@Lincolnshirewestccg.nhs.uk


This page is intentionally left blank

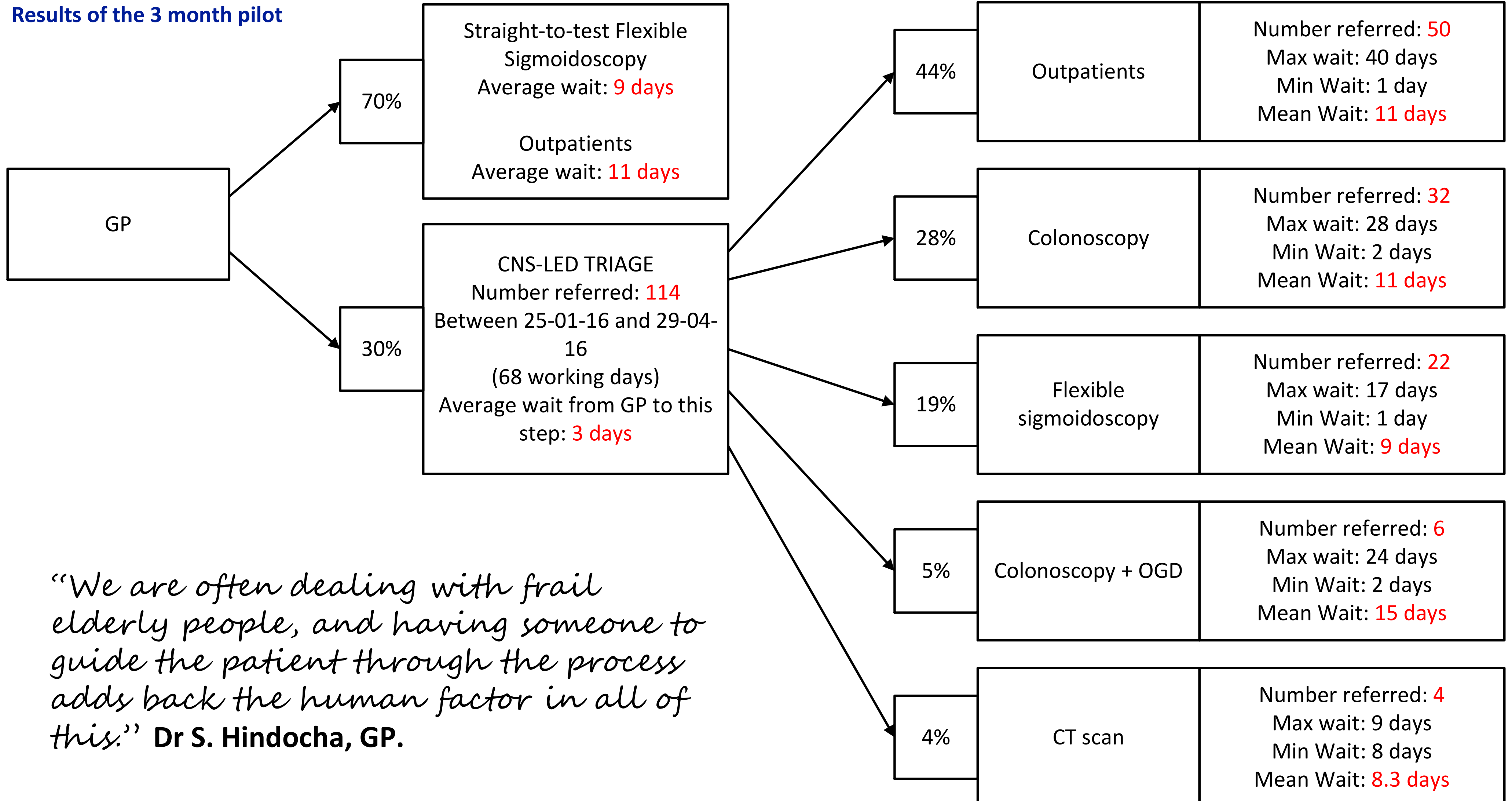
Lower Gi Cancer Pathway: Piloting CNS-led telephone triage

Key Achievements
- **Provisional cancer diagnosis at day 10**
- **16 hours of consultant-led clinical time saved**

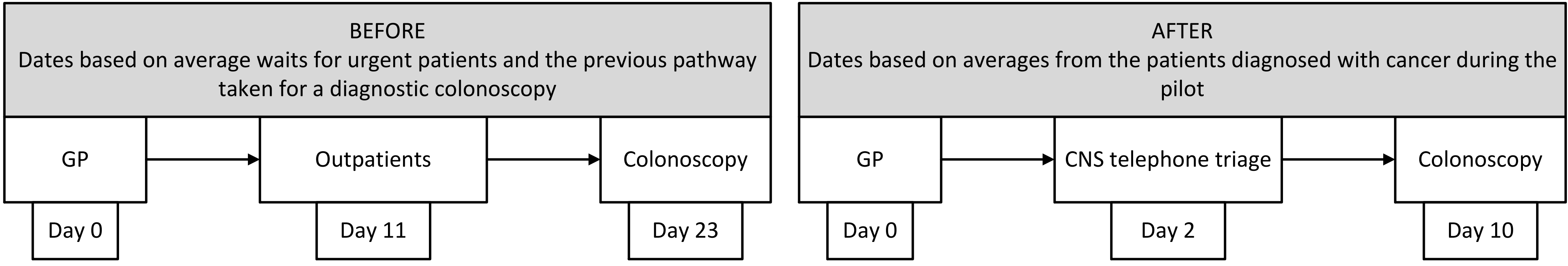
The Problem
- Patients frequently attend a two-week-wait outpatient appointment to be assessed, only to have a further two weeks to wait for a diagnostic test
- In some patient groups, this assessment before a diagnostic test could be safely completed over the phone as a 'triage' signposting the patient to the next stage of their pathway
- The Lower GI service at Lincoln deals with high patient numbers, urgent appointments and diagnostics are achieved within 14 days where possible, but demand sometimes outstrips capacity

Actions Taken
- Patients who are suspected of having colorectal cancer and fulfil certain criteria on the referral form can now be triaged over the phone by a Clinical Nurse Specialist (CNS), and be signposted on to the next clinically appropriate step.
- The CNS team are experienced members of the General Surgery team, qualified in assessing the patients and prescribing. Up until now their role in Outpatients is to work with patients who have had a cancer diagnosis and/or stoma fitted, this pilot extended their role to include patients who have not yet had a diagnosis.

Results of the 3 month pilot



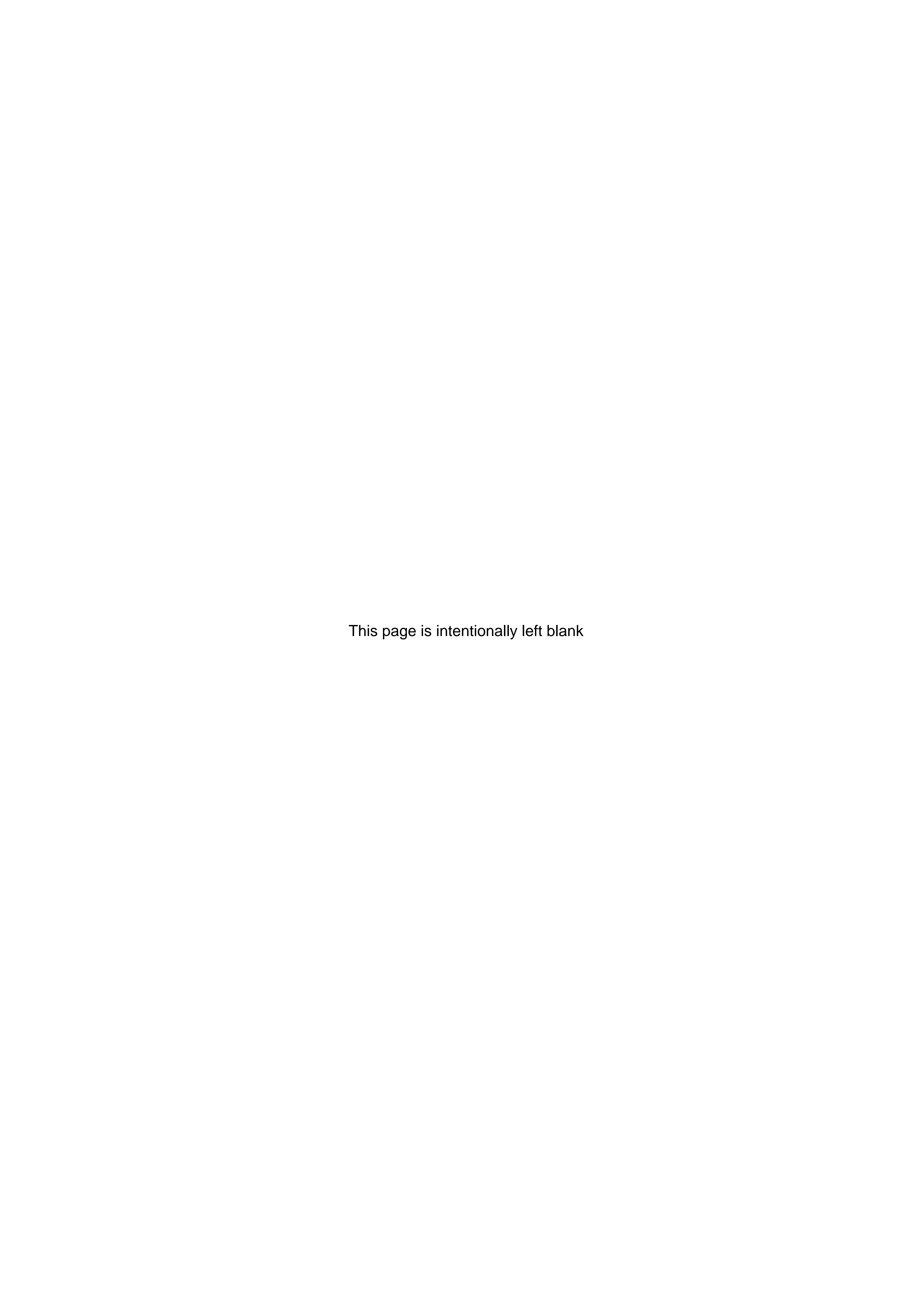
Benefits:
- Patients diagnosed with cancer in the pilot receive a provisional diagnosis 13 days sooner than before, see below.
- Patients who do not have cancer are taken off the pathway sooner, and are able to access treatment sooner.
- Triaging over the phone has saved 56 new two-week-wait slots in Outpatients, this equates to 4 sessions of clinical time, freeing up space in the system for patients who need a consultant appointment.



What's next?
We are working to roll this out to every Trust site by September 2016

Partners: Lincoln West CCG (Louise Jeanes)
Clinical Network (Atiya Chaudhry-Green)

Contacts: Polly Hyde – Clinical Improvement Facilitator
Jocelyn Fitzgerald – Senior Clinical Nurse Specialist
Amit Shukla – General Surgery Consultant


This page is intentionally left blank

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 East Midlands Ambulance Service NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 September 2016**
Subject:	**East Midlands Ambulance Service Response to the Care Quality Commission Inspection Report**

Summary:

As reported to the Health Scrutiny Committee on 25 May 2016, the Care Quality Commission (CQC) published on 10 May 2016 its inspection report on the East Midlands Ambulance Service NHS Trust (EMAS), which found that the Trust overall requires improvement. EMAS is developing a Quality Improvement Plan in response to the inspection, which was considered by the EMAS Board on 5 July 2016.

Richard Henderson, the Acting Chief Executive, East Midlands Ambulance Service NHS Trust, and Blanche Lentz, Divisional Manager, Lincolnshire Division of EMAS are due to attend.

Actions Required:

(1) To seek assurance on the response of the East Midlands Ambulance Service NHS Trust to the Care Quality Commission's Inspection Report, including consideration of the Trust's Quality Improvement Plan.

(2) To identify whether any additional information is required on any part of the information in the report.

1. Care Quality Commission Report – Summary of Findings

On 10 May 2016, the Care Quality Commission (CQC) published its inspection report on the East Midlands Ambulance Service NHS Trust, following an inspection undertaken between 16 and 20 November 2015 and on 3 December 2015. The CQC Report included the following summary of its findings: -

Introduction

"The East Midlands Ambulance Service NHS Trust (EMAS) is one of 10 ambulance trusts in England providing emergency medical services to Derbyshire, Nottinghamshire, Lincolnshire, Leicestershire, Rutland and Northamptonshire, an area which has a population of around 4.8 million people. The trust employs around 2,900 staff who are based at more than 70 locations including ambulance stations, an air ambulance station, emergency operations centres (EOCS) and support offices across the East Midlands.

The main role of EMAS is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received by the emergency operation centres (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. Other services provided by EMAS include patient transport services (PTS) for non-emergency patients between community provider locations or their home address and resilience services which includes the Hazardous Area Response Team (HART).

Every day EMAS receives around 2,000 calls from members of the public dialling 999. In 2014-15 they provided a face to face response to 649,625 emergency calls. The service provided by EMAS is commissioned by 22 separate Clinical Commissioning Groups with one of these taking the role as co-ordinating commissioner.

Our announced inspection of EMAS took place between 16 to 20 November 2015 with unannounced inspections on 3 December 2015. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected three core services:

- *Emergency Operations Centres*
- *Urgent and Emergency Care including the Hazardous Area Response Team (HART) and the air ambulance.*
- *Patient Transport Services* [Note: EMAS does not provide Patient Transport Services (PTS) in Lincolnshire, but in the North Lincolnshire and North East Lincolnshire areas. PTS are provided by NSL in the Lincolnshire area.]

Inspection Findings Overall

Overall, the trust was rated as requires improvement. Caring and Responsive were rated as good. Effective and Well Led were rated as requires improvement and Safety as inadequate. We have taken enforcement action against the provider in this respect.

Our key findings were as follows:

- *The trust was working hard to improve response times for emergency calls but these were consistently below the national target.*
- *There were insufficient staff and a lack of appropriate skill mix to meet the needs of patients in a timely manner.*
- *Standards of cleanliness and infection control, although inconsistent in some trust buildings were generally good on ambulances.*
- *All staff, especially those at the frontline were passionate about and committed to providing high quality, safe care for patients. At the same time they were open and honest about the challenges they were facing.*
- *Whilst the trust were working hard to recruit staff, they were finding it a challenge to retain staff and overall numbers were only increasing minimally.*
- *Staff morale was low and they often did not feel valued. There was an unrelenting demand for emergency services combined with a lack of staff and resources to meet the need.*
- *Frontline leaders did not have the capacity or in some cases the skills to support teams and individuals and fulfil the requirements of their roles.*
- *Many staff were not receiving performance development reviews (appraisals), clinical supervision (where appropriate) or mandatory training.*
- *There was a clear statement of vision and values driven by quality and safety. The trust board functioned effectively.*
- *Without exception the Chief Executive was held in high regard by staff for her visible, open approach.*

Areas of Outstanding Practice

We saw several areas of outstanding practice including:

- *We observed many examples of non-clinical staff supporting patients and saving lives in what were extremely difficult and stressful situations. Staff remained calm and gave callers confidence to deliver life-saving treatment.*
- *The trust had introduced 'change Wednesdays' in the emergency operations centre (EOC) to avoid daily contact with staff about minor changes to policies and systems. Staff were confident any changes to policies or procedures would take place on the same day every week.*
- *The trust were the best performing ambulance trust in England for the number of calls abandoned before answered.*

- *A mental health triage car was available in Lincolnshire between 4pm and midnight, staffed by a paramedic and a registered mental health nurse from a mental health trust. They could assess the needs of the patient and provide appropriate care which in some cases avoided hospital admission or the use of a Section 136 detention under the Mental Health Act 1983.*
- *The trust had a joint ambulance conveyance project working with six fire and rescue services in their region. This was the first service of its kind for an ambulance service nationally.*
- *The trust, in partnership with six fire and rescue services across the region, had introduced a regional emergency first responder (EFR) scheme. This was the first regional service of its kind of an ambulance service nationally.*
- *A project was in place to improve treatment for patients in acute heart failure. Crews had been issued with continuous positive airway pressure (CPAP) machines. The CPAP machine improves oxygen saturation levels in these patients.*
- *Staff in patient transport services (PTS) had direct access to electronic information held by community services including GPs. This meant they could access up to date information about patients including their current medication.*
- *The patient advice and liaison service had recruited existing patients to report to them about their planned journeys and experiences of patient transport services (PTS). They called this a 'secret shopper' programme.*
- *Staff name badges included their name in braille to assist patients with visual impairment. Guide dogs were allowed to accompany visually impaired patients.*
- *The Chief Executive was praised by all staff for her visible, open approach and her commitment to engaging staff face to face.*

<u>Areas for Improvement</u>

However, there were also areas of poor practice where the trust needs to make improvements. Importantly, the trust must:

- *Ensure staff report all appropriate incidents which are then appropriately and consistently investigated.*
- *Ensure learning from incidents, investigations and complaints is shared with all staff.*
- *Ensure all staff receive statutory and mandatory training.*
- *Ensure all domestic, clinical and hazardous materials are managed in line with current legislation and guidance.*
- *Ensure vehicle and equipment checks are carried out to the determined frequency.*
- *Ensure there are sufficient emergency vehicles to safely meet demand.*
- *Ensure medicines, including controlled drugs are stored and managed safely.*

- *Ensure paper patient report forms are stored appropriately and securely in trust premises and in such a way on trust vehicles as to maintain patient confidentiality*
- *Ensure there are sufficient numbers of staff with an appropriate skill mix to meet safety standards and national response targets.*
- *Ensure arrangements to respond to emergencies and major incidents are practised and reviewed in line with current guidance and legislation.*
- *Ensure response times meet the needs of patients by reaching national target times.*
- *Ensure all staff receive appropriate non-mandatory training to enable them to carry out the duties they are employed for.*
- *Ensure all staff receive an annual appraisal.*
- *Ensure service level agreements are in place to monitor the quality of taxi service provision for patient transport services."*

The full CQC inspection report is available at the following link:

www.cqc.org.uk/location/RX901

2. Response of the East Midlands Ambulance Service to the Report

The EMAS Board considered its response to the CQC inspection on 5 July 2016. The Trust has developed an action plan to respond to the issues identified in the CQC's report. The action plan forms part of the Trust's overall Quality Improvement Plan, which is attached at Appendix A to this report. The other strands of the Improvement Plan are the Financial Improvement Plan and the Performance Improvement Plan.

Progress on the implementation of the actions will be monitored by the EMAS Improvement Board which meets fortnightly and will report to the Trust Board at each meeting.

In addition to EMAS's internal monitoring arrangements, assurance that the EMAS Board is delivering the Quality Improvement Plan is undertaken by the Oversight Group, with the following representatives from the following organisations: -

- EMAS
- CCGs – Directors of Nursing from county lead CCGs (Lincolnshire West CCG is the lead CCG for Lincolnshire)
- NHS England – North Midlands
- NHS Improvement
- Quality Lead Co-ordinating Commissioner

The Oversight Group is chaired by Chief Nurse for Hardwick CCG (as co-ordinating commissioner). This Group will work with Healthwatch organisations to ensure the local population views are shared.

The themes from the inspection report are identified as:

- frontline staffing, support, leadership and training;
- vehicles and equipment;
- medicines management and record keeping;
- serious incident reporting and learning;
- complaints reporting and learning; and
- hospital handover delays.

The Committee is requested to consider Appendix A, which sets out EMAS Improvement Plan to address the above mentioned themes.

3. Regional Scrutiny Briefing - 6 July 2016

On 6 July 2016, a briefing session was held in Nottingham, to which representatives from all eleven health overview and scrutiny committees in the EMAS had been invited. Pauline Tagg, the Chairman, and Richard Henderson, the Acting Chief Executive of EMAS were in attendance, together with representatives from the lead commissioners Hardwick Clinical Commissioning Group: Jackie Jones, Director of Ambulance Commissioning and Jim Connolly, Chief Nurse.

The main points arising from the discussion were as follows: -

- The contract between the 22 CCGs in the East Midlands and EMAS for 2016-17 does not include a requirement for EMAS to deliver the national response time standards. Instead there is a requirement for EMAS to make improvements on agreed trajectories. At this stage it is unlikely the contract for 2017-18 will require EMAS to deliver national response time standards.
- Agreement between the 22 CCGs in the East Midlands on the content of the contract with EMAS is reached by overall consensus (no majority voting). Within the five counties of the EMAS region, there is a CCG lead in each county *(Note: Lincolnshire has two lead CCGs: Lincolnshire West CCG for the administrative county of Lincolnshire; with another CCG leading for the North and North East Lincolnshire areas.)*
- Only one ambulance service in England (West Midlands Ambulance Service) is currently meeting national response time standards.
- All the CCGs are committed to the *Strategic Demand, Capacity and Price Review*, a detailed and independent review of the level of demand in the EMAS region, and the level of staff and vehicles needed, along with finance, to be able to respond. This review is expected to start October and conclude December 2016, with an expected implementation timetable of 2-3 years.
- Whilst health overview and scrutiny committees in the region may receive response time performance information at county and CCG level, EMAS is not required contractually to deliver national standards at county or CCG level, and no such requirements are in place anywhere in England for any other ambulance service.

- The current salary grading of paramedic ambulance personnel under national conditions of service is a key staff retention issue, as it means that ambulance paramedics can easily transfer their skills to other health service roles at a higher salary.
- Handover times at certain hospitals have deteriorated in recent months. It has been calculated that the lost time waiting at hospitals would be equivalent to eight ambulances across the region being out of action for 24 hours per day.
- Where a referral is made from 111, there is a requirement to send an ambulance to the patient. However, 50% of the referrals from 111 to EMAS do not lead to a conveyance to hospital. Work is being undertaken by local system resilience groups with their 111 providers to ensure that 111 referrals to a 999 response are made only when genuinely required.
- Ambulance services need to be considered in the context of the overall emergency and urgent care system, with local system resilience groups playing an important role. In the medium to longer term, each local health area's Sustainability and Transformation Plan (STP) would be expected to seek improvements to primary care and accident and emergency services.

In the light of the absence of a requirement for EMAS to deliver national response time standards as part of its contract for 2016-17 (including the absence of any requirement for EMAS to deliver these standards at Clinical Commissioning Group level), the Committee is requested to consider how best to scrutinise the response time performance of EMAS at future meetings. For example, the provision of response time information at Divisional or CCG level would be indicative.

2. Conclusion

The Committee is requested to seek assurance on how East Midlands Ambulance Service NHS Trust is responding to the Care Quality Commission's Inspection Report. The Committee is also requested to identify whether any additional information is required on any part of the information in the report.

3. Consultation

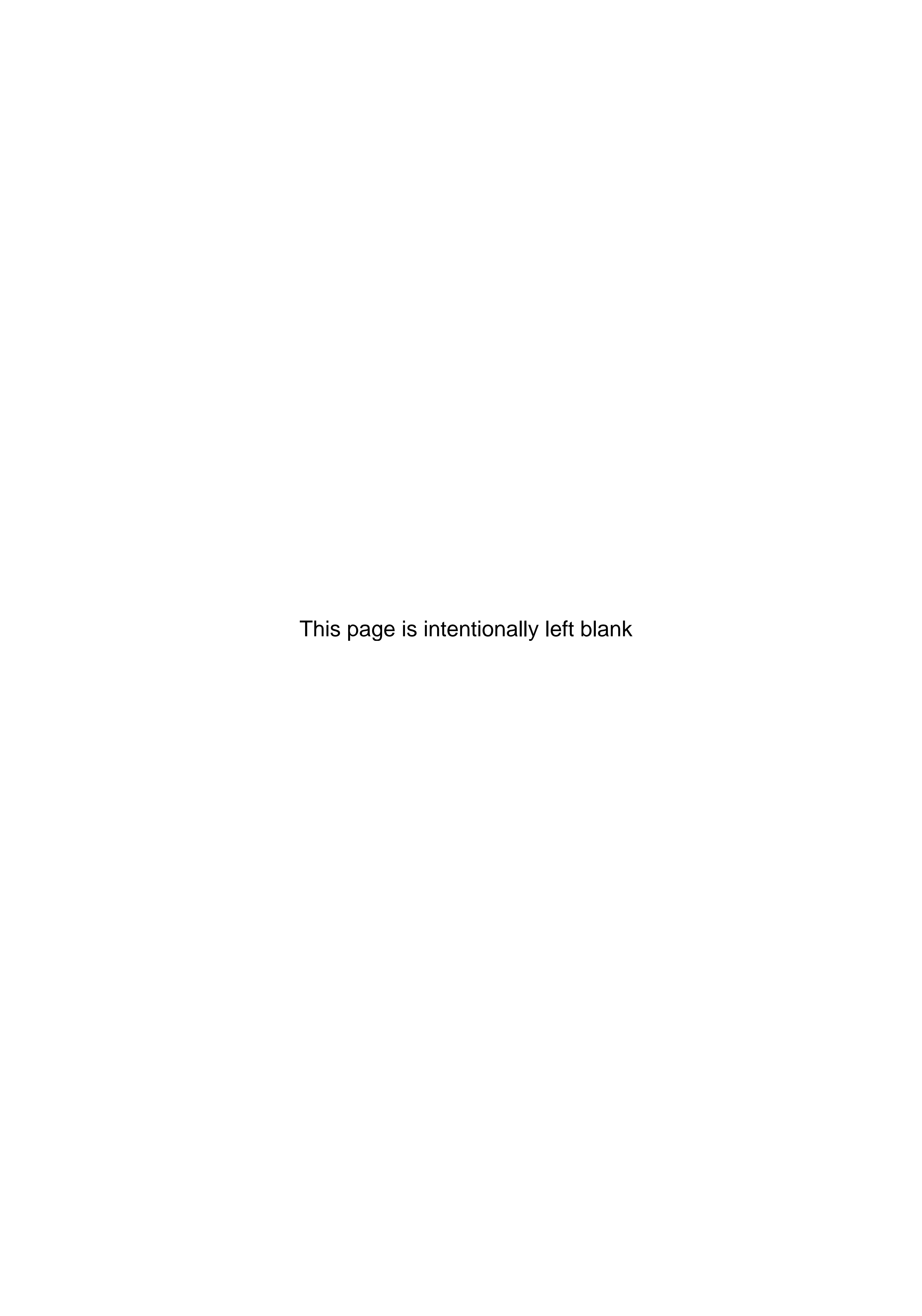
This is not a consultation report.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	East Midlands Ambulance Service – Our Quality Improvement Plan

5. 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 the East Midlands Ambulance Service NHS Trust.



This page is intentionally left blank

East Midlands Ambulance Service **NHS**

NHS Trust

Emergency Care | Urgent Care | We Care

Our Quality Improvement Plan

July 2016

Contents

Context/Background	2
What the Care Quality Commission found when they inspected EMAS	4
Outstanding practice and areas for improvement	5
Improvements we have made since the Inspection	7
Themes	11
Ensuring we have appropriate Staff Resources	11
Meeting National Standards and Regulatory Requirements	14
Ensuring we have the Vehicles and Equipment we need	19
Learning from Incidents	21
Developing and Supporting our Staff	23
Providing a Patient Transport Service	27
Ensuring the Safety of our Patients and Staff	30
Meeting the Needs of our Patients	32
Programme Governance	33

Context/Background

East Midlands Ambulance Service NHS Trust (EMAS) provides emergency and urgent care, patient transport, call handling and clinical assessment services for the 4.8 million people in the East Midlands, an area covering approximately 6,425 square miles across the six counties of Derbyshire, Leicestershire, Lincolnshire (including North and North East Lincolnshire), Northamptonshire, Nottinghamshire and Rutland.

EMAS employs more than 2,900 staff across the region, based at more than 60 locations, including two Emergency Operations Centres at Nottingham and Lincoln. Our largest staff group is made up of our accident and emergency 999 crews and we operate a fleet in excess of 500 vehicles, including emergency ambulances, fast response cars, specialised vehicles and patient transport vehicles.

Each day we receive around 2,000 calls from members of the public who have phoned 999 –the equivalent of receiving an emergency call every 45 seconds. Our frontline accident and emergency (A&E) teams of community paramedics, technicians, nurse triage advisors, emergency care practitioners, community first responders and volunteer lifesavers are ready day or night to respond to an emergency.

Our Patient Transport Services (PTS) take patients to and from hospital or clinics for routine appointments.

In addition our services include:

- 999 emergency care and transport of patients
- paramedic services at incidents and medical emergencies
- diagnosis and treatment or referral for minor illnesses and injuries
- responding to major incidents and emergencies with our specialist Hazardous Area Response Team (HART) and with our Air Ambulance colleagues
- medical cover at major sporting, music and social events.

Our vision: *To play a bigger part in the community through enhanced emergency and urgent care services delivered by proud, respected, highly skilled and compassionate staff.*

This vision is supported by a ‘strapline’, which in just a few words will help to describe what it is that we are about, and what we want to achieve.

Our strapline is Emergency Care | Urgent Care | We care.

What is also important is our continued commitment to living the EMAS values:

Value	Description
Respect	Respect for our patients and each other
Teamwork	Working together and supporting each other
Integrity	Acting with integrity by doing the right thing for the right reasons
Competence	Continually developing and improving our individual competence
Contribution	Respecting and valuing the contribution of every member of staff

This Quality Improvement Plan describes how we intend to improve the quality of the services we deliver, providing our patients and their families with the best possible care we can offer. Our plan will help us to become a better place to work, and will enable us to achieve our vision.

What the Care Quality Commission found when they inspected EMAS

East Midlands Ambulance Service NHS Trust received an announced inspection by the Care Quality Commission (CQC) Chief Inspector of Hospitals from 16 to 20 November 2015. As part of the inspection the CQC also carried out an unannounced visit on 3 December 2015. The inspection was carried out as a part of the CQC's comprehensive inspection programme.

The CQC inspected three core services here at EMAS, these were our:

- Emergency Operations Centres (EOCs)
- Urgent and Emergency Care including HART and the air ambulance
- PTS.

The inspection report was published on 10 May 2016. The table below shows the ratings we were given for each of the five key questions asked by the CQC when inspecting services.

Overall rating	Requires improvement
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Requires improvement

The core services were rated by the CQC as follows:

EOC	Good
Urgent and Emergency Care	Requires Improvement
PTS	Requires Improvement

Outstanding practice and areas for improvement

Through their inspection the CQC recognised several areas of outstanding practice at EMAS:

- The mental health triage car in Lincolnshire.
- The joint ambulance conveyance project in which we work with the fire and rescue service.
- The introduction of a regional emergency first responder scheme in partnership with six fire and rescue services.
- Our project to improve treatment for patients in acute heart failure using continuous positive airway pressure machines.
- Staff in our EOCs supporting patients and saving lives in what were extremely difficult and stressful situations.
- Our introduction of 'change Wednesdays' in the EOC so that staff are clear when changes are made.
- EMAS was the best performing ambulance trust in England in responding to calls promptly before the caller rang off.
- Access to electronic information held by community services for PTS staff which allowed them to view up to date information including current medication.
- The 'Secret Shopper' programme put in place by the Patient Advice and Liaison Service.
- Staff name badges with braille and the permitting of guide dogs to accompany visually impaired patients.

There were also areas where we need to take action to improve. The key areas were as:

- We must ensure we have sufficient staff who are appropriately trained and qualified to meet safety standards and meet national response targets.
- We must support our staff through ensuring they receive appropriate training and an annual appraisal.
- We must ensure there are sufficient emergency vehicles to safely meet demand.
- We must ensure staff report all appropriate incidents and they are appropriately and consistently investigated and learning from incidents is shared with all staff.
- We must ensure all waste is managed in line with current legislation and guidance.
- We must ensure medicines, including controlled drugs are stored and managed safely.
- We must ensure vehicle and equipment checks are carried out daily and equipment is serviced regularly.
- We must ensure patient records are stored appropriately to maintain patient confidentiality.

- We must ensure all staff are fitted for and trained in the use of filtered face pieces (face masks).
- We must ensure our arrangements for responding to major incidents are in line with current guidance and legislation and that we practise these arrangements.
- We must ensure we have arrangements in place to monitor organisations who support us in providing PTS and for checking the vehicle documentation of volunteer drivers.

The purpose of this Quality Improvement Plan is to address the areas for improvement the CQC has raised.

Improvements we have made since the inspection

EMAS has made a number of improvements between the inspection in November 2015 and publication of the inspection report in May 2016. In particular we have undertaken the following:

Ensuring we have appropriate staff resources

We have continued to progress our programme of recruitment resulting in 2,108 whole time equivalents being in post at the end of May 2016 against a projection for that date of 2,105. The recruitment programme includes direct entry technicians and paramedics to improve the ratio of qualified to non-qualified staff. As at May 2016 we have achieved our qualified to unqualified staff ratio of 80:20 which is an improvement on the previous position.

As at 1 June 2016, we are on track with our recruitment plan with recruitment and selection continuing to meet our annual contracted requirement. Also ten qualified Paramedics have been recruited and commenced work with the Trust in the first quarter of 2016/17. In addition we have 45 qualified paramedics who have been offered roles and are due to commence work with EMAS in the second quarter of the year.

As part of our contract negotiations with commissioners we have secured a commitment to an independent Strategic Demand, Capacity and Price Review which will determine the workforce requirements and associated funding for the next three years.

We have improved the management of our abstraction rates which are times when staff are unavailable due to sickness, training and other absences. In May 2016 the abstraction rate was 29.72% against a target of 28%. Since January 2016 we have reduced sickness absence and at May 2016 the absence rates was 4.79%, the lowest level we have seen in a number of years.

Meeting national standards and regulatory requirements

We have re-focussed our operational workforce on responding to patients requiring a more time critical response and in particular those patients who are very ill and fall into the Red 1 response category of response. Consequently we have seen patients in this category being attended to much sooner than previously.

We have agreed trajectories with our commissioners as part of the 2016/17 contract to improve performance against the national response standards. To further improve on this we have also developed internal trajectories for each county. We have achieved the contracted trajectory for the first quarter of 2016/17, although we recognise this has been

challenging and acknowledge that we did not meet two of the three response rate targets in June 2016.

We have continued to work with our partners in acute trusts to find ways of reducing the time taken to accept patients from us when we arrive at Emergency Departments. This includes formally meeting on a regular basis with our commissioners and with NHS Improvement to emphasise the impact of handover delays on the Trust's ability to respond to patients. We have seen some improvement in certain areas, although this is still one of our significant concerns in responding to our patients in a timely manner.

We have revised our procedures which explain how patient records should be stored and transported to clarify the arrangements we have in place for keeping patient information safe and have reminded staff of the requirements.

The Strategic Demand, Capacity and Price Review referred to above will assist us in ensuring we have the resources we need to respond promptly to our patients and meet national response standards.

We have addressed the issues identified by the CQC at certain stations regarding the storage of medicines including ensuring drugs cabinets are appropriately locked and secured to the wall.

We have implemented arrangements for regular collection of Patient Report Forms from all stations to ensure that all patient information is treated confidentially and transferred promptly to the Clinical Audit Team for safe storage.

We have ensured that all frontline staff receive emergency planning training as part of the basic training for new staff and our existing staff receive a refresher through the annual training programme.

Ensuring we have the necessary vehicles and equipment

Since the inspection with the assistance of a loan from NHS Improvement we have been able to increase the number of vehicles we have. We have added 31 Double Crewed Ambulances to our fleet since the inspection. We have also replaced 12 Fast Response Vehicles with new vehicles.

We have updated our fleet management system Fleetwave so that it is able to record the details of our medical devices. We have recruited additional staff to maintain the system and ensure that all equipment is serviced regularly and the servicing records maintained and are now in the process of transferring the information to Fleetwave. All information will be held on the Fleetwave system by November 2016.

Learning from incidents

We have restructured our investigation team to ensure consistency of approach and to provide appropriate support to team members. This also ensures that incidents are investigated appropriately, regardless of the manner in which they are reported to the Trust.

We have revised our Serious Incident Policy to ensure that it meets national guidance in terms of the reporting of incidents. We have also introduced a quality assurance process to ensure that all incidents are appropriately reported and investigated.

We have introduced divisional incident reporting showing numbers and trends of reporting in particular areas and making comparisons with other divisions. This allows divisional managers to monitor whether staff are reporting incidents.

Our computerised incidents system has been amended to ensure that managers have to feed back from the investigation of an incident to the member of staff who reported the incident before the investigation can be closed.

We have improved the process for learning from incidents and complaints to ensure this information is shared with staff and actions to make improvements are monitored to ensure implementation through the establishment of the Lessons Learnt group.

Developing and supporting our staff

We have continued to monitor training and appraisal completion rates to ensure as many staff as possible receive an annual appraisal and receive the training and development they need to carry out their role. We have developed a statutory and mandatory training and essential education plan for 2016/17 which provides sufficient capacity for all staff to receive the training they need to undertake their role.

We have introduced a new appraisal system which will improve the monitoring of appraisal completion rates and assist managers in ensuring the quality of the appraisals undertaken.

We have strengthened arrangements for monitoring completion of training and appraisals through the divisional performance reviews as part of our new service line management arrangements.

We have revised our escalation levels for Accident and Emergency Team Leaders to reduce the response requirements for this tier of leaders. This group are operating the Red 1 response cars, further reducing response commitments. This provides additional hours for managers to carry our supervisory duties and support their teams.

We have developed a workbook for frontline staff to provide guidance on the care of patients with mental health illness. This was issued to all staff in January 2016. In addition we now have two mental health leads who will continue to provide training and advice to staff.

Providing a Patient Transport Service

Since the inspection we have entered into a contract with commissioners to provide Patient Transport Services in Derbyshire. The service will start on 1 August 2016. As part of the mobilisation plan we have ensured that the issues identified by the CQC in relation to PTS have been addressed. This includes implementing a framework for ensuring there are adequate governance arrangements in place in relation to third party providers supporting us in delivering the service and annual inspections of these providers.

Ensuring the safety of our patients and staff

We have continued to issue regular guidance to staff on waste management to ensure the cases of non-compliance identified by the CQC are addressed. We have simplified our environmental assurance audit template used to check compliance with waste management regulations.

Meeting the Needs of our Patients

Executive Lead: Director of Quality and Nursing

We recently wrote to our high volume service users offering support. This has resulted in a reduction in frequent calls.

We have established a mental health steering group and through this are working with commissioners and other stakeholders including the Police and mental health services. This work includes the establishment of triage schemes in each county. We have an arrangement in place with the Samaritans for assisting patients and our staff with suicide cases. We are working with the British Transport Police in dealing with suicides on the transport network.

We have secured funding for two vehicles to transfer patients to mental health units.

Themes

This section describes the key themes within the CQC report and the actions which we intend to take to address each of the issues identified by the CQC. Each theme has an Executive Lead who is responsible for overseeing that theme and the actions within it.

Ensuring we have appropriate staff resources

Executive Lead: Acting Director of Workforce and Engagement

The CQC said EMAS must:

- ensure there are sufficient frontline paramedic and other staff with an appropriate skill mix to meet patient safety and operational standards and national target levels for Red 1 and Red 2 calls.
- ensure there are sufficient staff in the EOCs to meet planned staffing levels and demand, including at weekends.

The CQC said EMAS should:

- consider the effectiveness of processes for approval of annual leave for staff.

The following actions will address these issues.

- We will implement our revised workforce plan to increase the number of frontline staff and staff in our EOC to meet the demands of the service. This will take account of staff turnover and ensure a sustainable workforce. The workforce plan will be supported by a revised recruitment campaign for 2016/17 which will emphasise career progression routes and flexible working options to attract more applicants. We will also accelerate the timescale for training new staff so that they are operational earlier. By 30 September 2016 we expect to have achieved our revised workforce target of 2,193 whole time equivalent (wte) frontline staff, although a number of these staff will be in training. At this stage we expect 2,050 wte will be operational, whereas by 1 January 2017 2,125 wte are expected to be operational. Our current plans indicate that all 2,193 wte will be operational by July 2017, however through our recruitment campaign we are aiming to recruit an increased number of qualified staff which will ensure we will have all 2,193 wte operational by the earlier date of 31 March 2017.

  Responsibility: Acting Director of People and Engagement
  Timescale: target of 2,193 wte to be met by 30 September 2016 with all staff operational by 31 March 2017 subject to sufficient qualified staff being recruited

- We will accelerate the timescales between staff qualifying and becoming fully operational by reducing the number of preceptorship hours required. This will be within safe standards of working and in line with other ambulance trusts.

  Responsibility: Interim Chief Operating Officer
  Timescale: 1 October 2016

- We will recruit to the increased EOC establishment figure of 334 wte by 1 November 2016 and maintain a minimum 1% vacancy gap.

  Responsibility: Acting Director of People and Engagement
  Timescale: target of 334 wte to be met by 1 November 2016

- We will strengthen the application of the flexible working policy to enable staff to work fixed shift patterns and so reduce staff turnover. We will also clarify career progression routes and opportunities for existing staff. In addition we will also implement a talent management process to ensure succession planning for leadership roles.

  Responsibility: Acting Director of People and Engagement
  Timescale: promote the opportunity for flexible working arrangements by 1 August 2016
  introduction of talent management process by 1 September 2016

- We will work with commissioners to commission an independent Strategic Demand, Capacity and Price Review to determine the number of staff required to fulfil the requirements of our patients and the associated funding needs. We will base our future workforce plan for the next three years on this review.

  Responsibility: Interim Chief Operating Officer
  Timescale: Review to be completed by 31 October 2016 subject to NHS England providing commissioners with approval for the tendering process

- Our internal auditors are currently reviewing our arrangements for workforce planning. We will consider the outcome of their report and take appropriate action to make improvements.

  Responsibility: Acting Director of People and Engagement
  Timescale: review to be completed by 1 October 2016

- Through further embedding Service Line Management and strengthening monitoring through the divisional performance management reviews we will control our abstraction rates, including sickness absence and ensure that planned and unplanned absence is managed appropriately and reduced to target levels so that it does not impact on our resourcing levels.

  Responsibility: Interim Chief Operating Officer
  Timescale: abstraction rate 28% by 31 March 2017

We will measure success against the following indicators:

Staffing/Skill Mix:

- Front line workforce establishment against funded target of 2,193 wte and month by month recruitment trajectory
- EOC workforce establishment against funded target of 334 wte and month by month recruitment trajectory
- Numbers of direct entry staff in training against Workforce Plan
- Skill Mix ratio
- Staff turnover rate
- Abstractions levels, including sickness absence, against target

Meeting National Standards and Regulatory Requirements

Executive Lead: Interim Chief Operating Officer

The CQC said EMAS must:

- ensure response times meet the needs of patients by reaching national target times.
- ensure paper patient report forms are stored appropriately and securely in trust premises and in such a way on trust vehicles as to maintain patient confidentiality.
- ensure medicines including controlled drugs are always stored and managed safely and securely and audited effectively from the distribution of drugs to ambulance personnel, to their destruction or return.
- ensure staff follow the trust's policy in relation to countersignatures for controlled drugs.
- ensure arrangements to respond to emergencies and major incidents are practised and reviewed in line with current guidance and legislation.

The following actions will address these issues.

- We will monitor our response times against the monthly plan agreed with commissioners in the 2016/17 contract to ensure we meet the contractual targets. The plan indicates that by 1 November 2016 we will be achieving 67.5% for Red 1 calls, 61.6% for Red 2 calls and 86.6% for Red 19 calls. While recognising that our 2016/17 contract does not fund us to deliver national response targets, this will be an improvement on our performance against response rates at the time of the inspection. We will continue to strive to improve our performance by also monitoring performance against the internally set stretch targets for each county.

  Responsibility: Associate Director of Operations (Field Operations)
  Timescale: Expected performance by 1 November 2016:
  67.5% for Red 1 calls
  61.6% for Red 2 calls
  86.6% for Red 19 calls
  Expected performance by 31 March 2017:
  75% for Red 1 calls (aspirational target which is higher than contracted target)
  62.5% for Red 2 calls
  87.9% for Red 19 calls

- Improved response times will be achieved by increasing the size of our Clinical Assessment Team to 42 wte so that it can deal with a greater number of calls over the telephone where this is more appropriate for the patient than sending a vehicle to them.

  Responsibility: Associate Director of Operations (Field Operations)
  Timescale: to achieve target of 42 wte by 15 July 2016

- We will devolve our resource planning function to divisional management teams to provide greater flexibility in resourcing.

  Responsibility: Associate Director of Operations (Field Operations)
  Timescale: 30 September 2016

- We are running a pilot of a revised model of operation in Leicester, Leicestershire and Rutland to improve efficiency and address operational performance. Where this generates improvements the learning will be implemented in other divisions.

  Responsibility: Associate Director of Operational Improvement
  Timescale: 1 September 2016 (end of pilot phase)

- We will ensure our staff are appropriately trained to deal with major incidents by providing training to all new staff as part of the induction process and through the inclusion of emergency preparedness refresher training for existing staff in the annual education plan.

  Responsibility: Associate Director of Operations (Operational Support)
  Timescale: 95% of relevant staff to be trained by 31 March 2017

- Our command training strategy will determine the key roles in the organisation where commander training is required. An audit will be undertaken to determine those managers requiring commander training and completion of command and operational manager training will be closely monitored to ensure all relevant staff complete the training.

  Responsibility: Associate Director of Operations (Operational Support)
  Timescale: strategy to be completed by 31 August 2016
  all relevant managers to be trained by 31 March 2017

- Our on-call arrangements will be reviewed to ensure we have the necessary staff available to deal with major incidents and that they are adequately trained.

  Responsibility: Associate Director of Operations (Operational Support)
  Timescale: 31 August 2016

- We will introduce a schedule of emergency planning exercises and record details including lessons learnt.

  Responsibility: Associate Director of Operations (Operational Support)
  Timescale: 30 September 2016

- We will strengthen our arrangements for storing patient information and transferring it between locations by providing secure storage boxes for all stations, ensuring staff receive training in information governance as part of the statutory and mandatory training programme and provide further written guidance to staff.

  Responsibility: Head of Information Management
  Timescale: Storage boxes to be available by1 October 2016
  inclusion of training in statutory and mandatory training programme to be completed by 31 July 2016
  guidance to be provided by 1 September 2016

- Spotchecks will be undertaken at stations to ensure that information governance requirements are being complied with and the Records Manager will undertake a programme of independent confidentiality audits to ensure patient information is held appropriately.

  Responsibility: Head of Information Management
  Timescale: spotchecks to be introduced by 1 August 2016
  programme of audits to be completed by 1 January 2017

- We will review our audit process for medicine stocks and carry out regular audits to ensure our medicines management procedures are followed and stocks are held securely and issued appropriately. We will also continue to reinforce the procedures with staff to ensure compliance.

  Responsibility: Consultant Paramedic
  Timescale: review audit process by 31 August 2016

- We will undertake a post implementation review of the implementation of the new medicines management procedures to identify any learning and improvements required.

  Responsibility: Consultant Paramedic
  Timescale: post implementation review by 31 August 2016

- We will undertake regular checks on the issue of controlled drugs to reinforce the requirement for two signatures.

  Responsibility: Consultant Paramedic
  Timescale: by 31 August 2016

- We will review our medicines management security arrangements and make improvements where necessary to meet legal requirements.

  Responsibility: Consultant Paramedic
  Timescale: initial review by 30 November 2016

- We will use the lessons learned in Leicestershire in relation to hospital handover delays to address similar concerns in other parts of the region. We will continue to influence the System Resilience Groups and commissioners to take action in addressing this wider health economy issue. We intend to hold a second Turnaround Summit to work with partners in further considering the issues and identifying appropriate solutions.

  Responsibility: Director of Quality and Nursing
  Timescale: 31 March 2017

We will measure success against the following indicators:

Response times:

- Red 1 performance against trajectory
- Red 2 performance against trajectory
- Red 19 performance against trajectory
- Divisional abstraction rates
- Divisional resourcing levels against plan
- Call activity and acuity levels
- Lost hours due to hospital handover delays
- Prolonged waits
- Number of cases of harm due to prolonged waits

Emergency Planning:

- Training completion rates
- Number of emergency planning exercises completed

Patient Records:

- Number of information governance incidents
- Audit and spotcheck compliance rates

Medicines Management:

- Drug audit results
- Number of drug related incidents

Ensuring we have the necessary vehicles and equipment

Executive Lead: Interim Chief Operating Officer

The CQC said EMAS must:

- ensure vehicle and equipment checks are carried out to the determined frequency.
- ensure there are sufficient ambulances and other vehicles to respond to emergency calls in a manner that meets patient safety and operational standards and national response targets for Red 1 and Red 2 calls.
- ensure ambulances, rapid response vehicles and their equipment are checked on a daily basis as per trust policy to ensure patient and staff safety.
- ensure the servicing of all equipment is undertaken at the correct intervals stipulated by manufacturers to ensure the safety of patients.

The CQC said EMAS should:

- consider how to ensure staff have sufficient time to clean vehicles before being allocated to another call.

The following actions will address these issues.

- We will continue to implement our fleet management programme. In July we will receive seven new double crewed ambulances and by 31 March 2017 we will receive an additional 30 double crewed ambulances. We will also replace 15 fast response vehicles with newer vehicles this financial year.

Responsibility:	Head of Fleet
Timescale:	seven double crewed ambulances in July 2016 additional 30 double crewed ambulances by 31 March 2017 (to be phased in from September 2016 onwards) replacement of 15 fast response vehicles by 31 March 2017

- We are currently developing our computerised fleet system Fleetwave to record items of equipment held on vehicles and when that equipment was last serviced. This will improve our management of the servicing process and allow us to easily locate specific equipment. This will be in place by 30 November 2016 and also by that time regular scanning of all equipment will be carried out to determine the location of individual pieces of equipment.

  Responsibility: Head of Fleet
  Timescale: 30 November 2016

- We will purchase 292 new defibrillators during 2016/17 and 2017/18 to replace old equipment. This will ensure that equipment is reliable and staff have the equipment they need to respond to patients.

  Responsibility: Head of Fleet
  Timescale: 31 July 2017 (to be phased receiving a number each week)

- As part of the Strategic Demand, Capacity and Price Review referred to above we will identify the number and type of vehicles required to meet the demands of the service.

  Responsibility: Interim Chief Operating Officer
  Timescale: 31 October 2016 subject to NHS England providing commissioners with approval for the tendering process

We will measure success against the following indicators:

Vehicles and Equipment:

- Number of vehicles compared to Fleet Programme
- Equipment servicing rates
- Receipt of defibrillators against plan
- Number of vehicles compared to resourcing requirements

Learning from Incidents

Executive Director: Director of Quality and Nursing

The CQC said EMAS must:

- ensure staff report all appropriate incidents and they are appropriately and consistently investigated in line with Trust policy.
- ensure learning from incidents, investigations and complaints is shared with all staff.
- put systems in place to promote sharing and learning in PTS following a reported concern or incident.
- ensure all staff in EOC understand what an untoward incident is and report them consistently in line the trust policy.

The CQC said EMAS should:

- consider how feedback from incidents is supplied to individual staff raising the issues in a timely manner
- consider how lessons learnt from incidents can be effectively shared across the trust and how resulting actions can be consistently implemented.

The following actions will address these issues.

- We have arranged for independent reviews of our incident management arrangements to assist us in improving existing arrangements. NHS Improvement has reviewed our process for reporting and investing Serious Incidents and our internal auditors are looking at our arrangements for learning lessons from incidents and complaints.

  Responsibility: Director of Quality and Nursing
  Timescale: NHS Improvement review – report due by 31 July 2016
  Internal Audit review – report due November 2016

- We will implement a programme of education and awareness raising so that all staff are able to identify and report an incident and those responsible for investigations undertake these appropriately.

  Responsibility: Director of Quality and Nursing
  Timescale: 31 July 2016

- We will complete the incorporation of the Patient Advice and Liaison Service and Complaints Team into the Patient Safety Team to ensure consistency in reporting and investigation of incidents and appropriate support for the staff in the team.

  Responsibility: Director of Quality and Nursing
  Timescale: 31 July 2016

- We will check staff understanding of the incident process as part of our Quality Everyday Programme.

  Responsibility: Director of Quality and Nursing
  Timescale: programme restarted June 2016

We will measure success against the following indicators:

Incident reporting:

- Number of incidents reported
- Number of Serious Incidents

Developing and supporting our staff

Executive Lead: Acting Director of People and Engagement

The CQC said EMAS must:

- ensure all staff receive statutory and mandatory training.
- ensure all staff receive appropriate non-mandatory training to enable them to carry out the duties they are employed for.
- ensure statutory and mandatory training updates are delivered to PTS staff.
- ensure that staff mandatory training achieves the trust target of 95%.
- ensure all staff receive an annual appraisal.
- ensure all staff in EOC receive annual appraisals, which are accurately recorded by managers.

The CQC said EMAS should:

- consider how all frontline staff receive on-going training relating to the care of patients with mental health illnesses.
- consider how to ensure staff in EOC have adequate training in mental health awareness to be able to support patients calling with mental illness.
- consider how to ensure staff in EOC have adequate training in dementia awareness to be able to support patients calling who are living with dementia.
- consider how to ensure staff in EOC have adequate training in awareness of learning disabilities to enable them to support patients calling who have a learning disability.
- consider whether EOC staff have received sufficient training in the Mental Capacity Act 2005 to be able to support callers appropriately.
- ensure EOC staff receive training to enable them to support and work with child callers.
- consider how all staff understand the Duty of Candour and their responsibilities under it.
- consider how line managers can have sufficient allocated time to manage their teams effectively.

- consider how to provide an effective system of regular clinical supervision for paramedic and other clinical staff.
- consider appropriate career development opportunities for staff.
- consider communication with and support to EOC staff, which would enable them to understand changes to services, which support the ongoing strategy.
- consider the provision of an appropriate space for EOC staff to use following a distressing call.
- The trust should evaluate the effectiveness of single piece ear sets issued to staff at the Lincolnshire EOC.

The following actions will address these issues.

- We will introduce plans for each Division to ensure that training targets are met and staff will be allocated to specific course dates by divisional managers. .

  Responsibility: Deputy Director of Workforce
  Timescale: 95% of relevant staff to have completed statutory and mandatory training requirements by 31 March 2017

- Each division will produce a plan for completion of staff performance appraisals to ensure that sufficient time is allowed for each member of staff to have an annual appraisal.

  Responsibility: Deputy Director of Workforce
  Timescale: target 95% completion by 31 March 2017

- We are developing a Duty of Candour e-learning package which all relevant staff will complete as part of their essential education.

  Responsibility: Director of Quality and Nursing
  Timescale: 31 July 2016

- We are in the process of reviewing our frontline management arrangements which will assist in ensuring staff members receive appropriate clinical supervision.

  Responsibility: Interim Chief Operating Officer
  Timescale: 30 September 2016

- We will provide clarity for our staff on career progression opportunities within EMAS.

  Responsibility: Deputy Director of Workforce
  Timescale: 31 July 2016

- We will work with staff, trade union colleagues and line managers to identify an effective forum to communicate the Trust's strategies to EOC staff.

  Responsibility: General Manager EOC
  Timescale: 30 September 2016

- We will undertake an option appraisal for the most appropriate technical solution to the suggestion for single piece ear sets in EOC.

  Responsibility: General Manager EOC
  Timescale: 30 September 2016

- We will develop a workshop for EOC staff which will include guidance on supporting and working with child callers.

  Responsibility: General Manager EOC
  Timescale: 31 March 2017

- We have identified a room for use by EOC staff following distressing calls. This will be equipped with appropriate furniture.

  Responsibility: General Manager EOC
  Timescale: 31 August 2016

- We will provide training to EOC staff on dementia awareness and learning disabilities through the Safeguarding training module.

  Responsibility: Director of Quality and Nursing
  Timescale: 95% of staff to receive training by 31 March 2017

We will measure success against the following indicators:

Training and Appraisals:

- Appraisal rates by division
- Monthly Statutory and mandatory compliance rates against each subject at a divisional and Trust level

Providing a Patient Transport Service

Executive Lead: Interim Chief Operating Officer

The CQC said EMAS must:

- ensure service level agreements are in place to monitor the quality of taxi service provision for PTS.
- ensure there is an effective governance process in place to manage the quality of third party provision for PTS such as taxi services.
- ensure checks of PTS volunteer driver's documentation including MOT and insurance certification are performed and recorded annually.
- put systems in place to promote sharing and learning in PTS following a reported concern or incident.

The CQC said EMAS should:

- consider how all risks associated with PTS can be captured and reviewed on the risk register.
- consider providing PTS staff with protected time to access work related emails and other communication.

The following actions will address these issues.

- As part of our plans to take on the PTS in Derbyshire we have established a framework for provision of support from third party providers where additional resource is required at peak times. This will exclude the need for taxis. As part of this arrangement we will undertake annual inspections of the providers.

  Responsibility: General Manager PTS
  Timescale: 1 August 2016

- We will establish a register of checks on volunteers' vehicle documentation. Work will not be allocated to volunteers until these checks have been completed.

  Responsibility: General Manager PTS
  Timescale: 1 August 2016

- Each member of Patient Transport Service staff will have a named supervisor who will ensure that staff receive an annual appraisal. We will also ensure sufficient time is allocated for staff to receive an appraisal. Completion of appraisals will be monitored monthly to ensure that all members of staff receive an annual appraisal.

  Responsibility: General Manager PTS
  Timescale: 1 August 2016

- We will establish a robust monitoring system to ensure that all PTS staff receive the necessary training to undertake their role. We will also ensure sufficient time is allocated for staff to complete the training.

  Responsibility: General Manager PTS
  Timescale: 1 August 2016

- We have a risk register in place for the mobilisation of PTS in Derbyshire. This will be transformed into a risk register for the service once operational.

  Responsibility: General Manager PTS
  Timescale: 15 July 2016

- We will review options for PTS staff to access work-related emails and other communications.

  Responsibility: General Manager PTS
  Timescale: 30 September 2016

- We will ensure the incident reporting process is included in the induction training and mandatory training for PTS staff. We will also establish a Quality and Risk Review group which will consider reviews of PTS incidents. In addition we will establish a process of providing feedback to PTS staff on lessons learnt from incidents.

  Responsibility: General Manager PTS
  Timescale: Quality and Risk Review group 1 August 2016
  Feedback process 31 August 2016
  Training 31 October 2016

We will measure success against the following indicators:

Patient Transport Service:

- Training rates
- Appraisal rates
- Proportion of volunteers where documentation checks have been undertaken

Ensuring the Safety of our Patients and Staff

Executive Lead: Director of Quality and Nursing

The CQC said EMAS must:

- ensure all domestic, clinical and hazardous materials are managed in line with current legislation and guidance.
- ensure all staff are fitted for and trained in the use of filtered face pieces (face masks) according to the Health and Safety Executive requirement in Operational Circular 282/28.

The following actions will address these issues.

- We will carry out regular audits to ensure compliance with our waste management procedures. We will also continue to promote good waste management practices throughout EMAS. This will ensure that clinical waste is stored appropriately and safely.

  Responsibility: Environmental Manager
  Timescale: first quarterly audit 30 June 2016

- We will put in place a plan within each division to ensure that all staff are fitted for and trained in the use of face masks required for infection prevention and control purposes and we will monitor progress against this plan. This will include training managers within division so they can provide training and fit testing at a location more accessible for frontline staff. A requirement to confirm completion of fit testing will also be part of the annual appraisal.

  Responsibility: Director of Quality and Nursing
  Timescale: 31 October 2016

We will measure success against the following indicators:

Waste Management:

- Number of incidents
- Waste management audit compliance rates.

Face Masks:

- Proportion of staff having received fit testing.

(HART staff will be fit tested every six months in conjunction with their FM12 testing and other staff every 12 months).

Meeting the Needs of our Patients

Executive Lead: Director of Quality and Nursing

The CQC said EMAS should:

- consider how mental health pathways could be improved by working with other partners across the whole of the region.
- consider working with partners to develop 24-hour mental health pathways.
- work towards having Care Plans in place for all frequent callers that require them.

The following actions will address these issues.

- We are in discussions with our commissioners with regard to the feasibility of funding care plans for a larger number of our frequent callers. A pilot in Nottinghamshire was successful in reducing the number of referrals and commissioners have indicated that that they wish to continue funding this. A similar scheme will be run in Leicestershire using Commissioning for Quality and Innovation funding.

  Responsibility: Director of Quality and Nursing
  Timescale: 31 March 2017

- Through the Mental Health Steering Group and the triage schemes we will work with partners to develop mental health pathways in the region.

  Responsibility: Director of Quality and Nursing
  Timescale: 31 March 2017

We will measure success against the following indicators:

- Proportion of frequent callers with care plans in place

Programme Governance

Strong programme governance has been established to ensure delivery and accountability of the improvement plan supported by the Programme Management Office. An Improvement Board has been established to monitor delivery of the Quality Improvement Plan. This will report to the Trust Board and will be supported by the Improvement Plan Delivery Group. The latter will ensure the delivery of the plan, whereas the Improvement Board will have an assurance role and will provide assurance to the Trust Board that this plan is being implemented and the actions contained within the plan are effective in addressing the issues raised in the CQC inspection report.

Agenda Item 9

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 Richard Wills the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 September 2016**
Subject:	**Congenital Heart Services – East Midlands Congenital Heart Centre**

Summary

On 20 July 2016, the Committee considered an announcement by NHS England that "subject to consultation with relevant trusts and, if appropriate the wider public" it was decommissioning congenital heart disease surgery ("Level 1 services") from the East Midlands Congenital Heart Centre (formerly known as Glenfield Hospital). The Committee concluded that the decommissioning of Level 1 services would constitute a substantial variation in health care provision for Lincolnshire residents and authorised the Chairman to write to NHS England to seek a commitment to full public consultation. This paper sets outs the contents of the Chairman's letter and NHS England's response.

Actions Required:

(1) To determine if any further action is required at this stage.

1. Background

Announcement by NHS England - 8 July 2016

As reported to the Health Scrutiny Committee on 20 July 2016, NHS England issued an announcement on 8 July 2016, which included the following statement:

> *"Subject to consultation with relevant Trusts and, if appropriate, the wider public, NHS England will also work with* ***University Hospitals of Leicester NHS Trust*** *and Royal Brompton & Harefield NHS Foundation Trust to safely transfer CHD surgical and interventional cardiology services to appropriate*

alternative hospitals. Neither ***University Hospitals Leicester*** *or the Royal Brompton Trusts meet the standards and are extremely unlikely to be able to do so. Specialist medical services may be retained in Leicester."*

Decision of the Health Scrutiny Committee for Lincolnshire

The Committee unanimously agreed that to decommission Level 1 Paediatric Cardiac and Adult Congenital Heart Disease Services from the East Midlands Congenital Heart Centre would constitute a substantial variation, as defined by Regulation 23 of the *Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.* These regulations imposed on NHS England a duty to consult as the responsible commissioner of congenital heart disease services.

The Committee also unanimously agreed that the Chairman would write to NHS England outlining the Committee's view in the paragraph above, and seeking NHS England's commitment to full public consultation.

The Committee also agreed further provisions enabling the Chairman to take further action, if NHS England declined to undertake public consultation.

Letter from the Chairman, Councillor Mrs Christine Talbot

On 22 July 2016, the Chairman wrote to NHS England (Simon Stevens, Chief Executive of NHS England and Will Huxter, Senior Responsible Officer for the CHD Programme, as follows: -

"I refer to the NHS England announcement on 8 July 2016 that subject to consultation with relevant Trusts and, if appropriate, the wider public, NHS England would work with University Hospitals of Leicester NHS Trust to safely transfer CHD surgical and interventional cardiology services to appropriate alternative hospitals.

"In the first instance, I would like to put on record the disappointment of the Health Scrutiny Committee for Lincolnshire that NHS England did not provide any detailed information supporting this statement until 15 July 2016, when a report entitled Paediatric Cardiac and Adult Congenital Heart Disease Standards Compliance Assessment: Report of the National Panel was published, together with the CHD standards and specifications. This delay in publication raises issues of transparency and trust at a time when NHS England should be seeking to engage and involve the wider public in its proposals.

"Most importantly, I refer to the specific matter of consultation and the phrase in the NHS England statement: "subject to consultation with relevant Trusts and, if appropriate, the wider public". Aside from the uncertainty and ambiguity of this statement, I would draw your attention to Regulation 23 of the Local Authority [Public Health, Health and Wellbeing Boards and Health Scrutiny] Regulations 2013. This regulation places an obligation on NHS England as the responsible commissioner of CHD services to consult with local authority health overview and scrutiny committees. Failure to consult by NHS England would enable these committees to make a referral to the Secretary of State, on the basis of Regulation 23(9)(a).

Whilst there have been reports of NHS England's intention to consult, on behalf of the Health Scrutiny Committee for Lincolnshire I seek a full and unequivocal assurance from NHS England that it will fulfil its obligations under Regulation 23 of the Local Authority [Public Health, Health and Wellbeing Boards and Health Scrutiny] Regulations 2013 and engage in consultation with local authority overview and scrutiny committees.

On the matter of consultation I would also add that whilst NHS England might argue that consultation took place in 2014, the 2014 consultation was limited to the standards and specifications for CHD services and did not make any reference to the decommissioning of any particular Level 1 centre and any impact such a decommissioning would have on the local population. In fact none of the centres in England performing CHD surgery were named throughout the 56 page 2014 consultation document.

I also inform you that on 20 July 2016, the Health Scrutiny Committee for Lincolnshire resolved that the proposed decommissioning of Level 1 Paediatric Cardiac and Adult Congenital Heart Disease Services from the East Midlands Congenital Heart Centre [University Hospitals of Leicester NHS Trust] would constitute a substantial development or variation in health service provision for the residents of Lincolnshire, as it would clearly affect the ability of Lincolnshire residents to access to Level 1 Centres.

Furthermore, in the event of NHS England declining to perform its duties in accordance with Regulation 23 of the Local Authority [Public Health, Health and Wellbeing Boards and Health Scrutiny] Regulations 2013, the Health Scrutiny Committee for Lincolnshire has resolved that it will invoke the procedures in Regulation 23.

Finally, I would like to raise the issue of governance. The report entitled: Paediatric Cardiac and Adult Congenital Heart Disease Standards Compliance Assessment: Report of the National Panel refers to decisions being made by the "Specialised Services Commissioning Committee (SSCC), a sub-committee of the NHS England Board". The NHS England website refers to the role of the SSCC as one where it: -

> *"advises the Board on development and implementation of strategy for specialised commissioning, agreeing specialised commissioning priorities and work programmes, and receiving assurance that these are delivered."*

The website does not make reference to any powers of the SSCC to make decisions on the decommissioning of services in accordance with any agreed specialised commissioning priorities. I would therefore like you to confirm the terms of reference of the SSCC and provide information on the specific decision-making authority delegated to it by the NHS England Board. I would be grateful if you confirm whether meetings of the SSCC are open to the public and whether its papers are available to the public. If your response to these two questions is negative, I would be grateful if you could outline the legal basis for operating in this way. This again raises issues of trust and transparency.

"In the spirit of co-operation and transparency the resolution of the Health Scrutiny Committee for Lincolnshire on 20 July 2016 is set out below: -

(1) The decommissioning of Level 1 Paediatric Cardiac and Adult Congenital Heart Disease Services from the East Midlands Congenital Heart Centre [University Hospitals of Leicester NHS Trust] constitutes a substantial development or variation in health service provision, as defined by Regulation 23 of the Local Authority [Public Health, Health and Wellbeing Boards and Health Scrutiny] Regulations 2013, which imposes on NHS England a duty to consult as the responsible commissioner of congenital heart disease services.

(2) To authorise the Chairman to write to NHS England outlining the Committee's resolution in (1) above, seeking NHS England's commitment to full public consultation.

(3) In the event that NHS England decline to undertake consultation, the procedures set out in Regulation 23 of the Local Authority [Public Health, Health and Wellbeing Boards and Health Scrutiny] Regulations 2013 be invoked, including the initiation of discussions with NHS England."

Response of NHS England

Will Huxter, Senior Officer Response for the CHD Programme at NHS England, replied to the Chairman as follows on 9 August 2016: -

"Thank you for your letter of 22 July 2016, addressed to Simon Stevens and myself. I welcome the opportunity to clarify the position in relation to NHS England's proposals on congenital heart disease services.

"The first thing to say is that no final decisions have been taken about the future of University Hospitals of Leicester NHS Trust or any of the other congenital heart diseases services in England. NHS England has set out proposals, based on the findings of the recent assessment exercise. Whether or not these proposals are taken forward will be subject to further stakeholder engagement and the outcome of public consultation, which will begin later this year.

"I recognise the strength of feeling of the Health Scrutiny Committee in relation to these proposals and their potential consequences. We wish to discuss with Lincolnshire and other relevant Overview and Scrutiny Committees the approach to consultation.

"NHS England published its new standards for CHD services in July 2015. These standards – almost 200 of them – were collaboratively developed over a two-year period, by patients and their families/carers; clinicians; commissioners, and other experts. They were the subject of extensive public consultation, and all the views put forward were considered before the standards were finalised.

"Information regarding consultation about our proposals will be communicated as widely as possible, well in advance of consultation starting. NHS England will make sure that the consultation takes account of those services which could be impacted by changes to CHD services, including paediatric intensive care and ECMO.

"NHS England is now in the pre-consultation engagement stage.

"You raise in your letter questions about the governance relating to NHS England's proposals. There are four main elements to this:

- *The adoption of the standards for congenital heart disease was a decision of the NHS England Board.*
- *The outcome of the assessment of each centre against those standards was a decision of the Specialised Services Commissioning Committee (SSCC), under delegated authority of the Board.*
- *Any revision to a provider's assessment following consideration of its further submissions was a decision of the national Director of Specialised Commissioning.*
- *The final decisions at the end of the service change process will be taken by the NHS England Board.*

"Although meetings of the SSCC are not open to the public, a report from each of its meetings is provided to the full NHS England Board (which is held in public) and is published.

"NHS England, through its regional specialised commissioning team and the national congenital heart disease programme team, will follow up on your letter to discuss the detail of the approach to public consultation in relation to these important services."

Assessment of NHS England Response

Whilst NHS England has indicated that consultation will begin "later this year" there is no indication on the NHS England website to this effect, and there are no details of the precise timing of this consultation. As of 12 September 2016, the website still included the following statement: -

> "The proposals in the National Panel's report remain subject to the outcome of service change processes in relation to each of the proposed changes. Over the summer of 2016, NHS England will be working with the Trusts concerned, and other stakeholders as necessary, to draw up plans to make the changes proposed."

Given the above statement and that NHS England's announcement on 8 July referred to "if-appropriate" consultation with the wider public, the Committee may wish to reflect on the extent to which NHS England is fully committed to wide public consultation. NHS England refers to discussions on "the detail of the approach to public consultation". Since the receipt of the letter, no further approach has been received from NHS England on any discussions.

In terms of the governance and transparency issues raised in the correspondence, NHS England held a Board meeting on 26 July 2016. The agenda included a report from the Specialised Services Commissioning Committee (SSCC) in relation to its meetings on 31 May and 27 June 2016. This three-page report referred to several issues. Congenital Heart Disease was covered by a single paragraph: -

"The national and regional panel assessments of Congenital Heart Disease (CHD) centres against key standards in the new service specification, which came into effect on 1 April 2016, were completed in June 2016. Following these assessments, the Committee agreed with the recommendation that centres assessed as 'not satisfactory and highly unlikely to meet service standards' should be served notice that NHS England was minded to cease to contract their services. Providers were informed of these assessments at the end of June 2016. Any necessary public involvement would be undertaken before service changes were implemented."

The NHS England Board also revised new terms of reference for the SSCC, which are as follows: -

"Purpose

1. The Specialised Services Commissioning Committee purpose is to assure the Board that allocation for specialised commissioning in 2016/7 is utilised to maximise value, improve patient and population outcomes and ensure sustainability and transformation as part of wider programmes across the NHS.

2. The Committee's work programme should align with implementation of the required changes in how specialised services are to be commissioned and provided, specifically: delivery of place and population based systems of care, reforms at the national level to enable local flexibility, and ensuring financial sustainability

Delegated Responsibilities

3. The Committee operates on behalf of and reports to the Board. The following summarises the scope of responsibilities of the Committee:

   - Agree NHS England's work programme for specialised services and receive assurance about its delivery, with associated risks identified and mitigated

   - Promote the development and implementation of the strategic framework for specialised commissioning, being led by the Director of Specialised Commissioning

   - Ensure alignment of Specialised Commissioning strategy development with wider sustainability and transformation work across the overall commissioning system

   - Assure in-year and end-of-year financial balance, and to ensure necessary action – internally and with external bodies – is taken to ensure financial sustainability

   - Assure the work of the Specialised Commissioning Oversight Group and the Cancer Drugs Fund Investment Group."

Other Health Scrutiny Committees in the East Midlands

The Health Scrutiny Committee for Lincolnshire was the first health overview and scrutiny committee in the East Midlands to consider this matter on 20 July. Other health scrutiny committees are also considering this matter during September: -

13 Sept	Nottingham City and Nottinghamshire Joint Health Scrutiny Committee
19 Sept	Derbyshire County Council's Health Scrutiny Committee

The outcomes of these meetings will be reported. In addition, a date is also due to be arranged for the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee, which is likely to be after 21 September.

2. Conclusion

The Committee is requested to consider the information presented and to determine if any further action is required at this stage

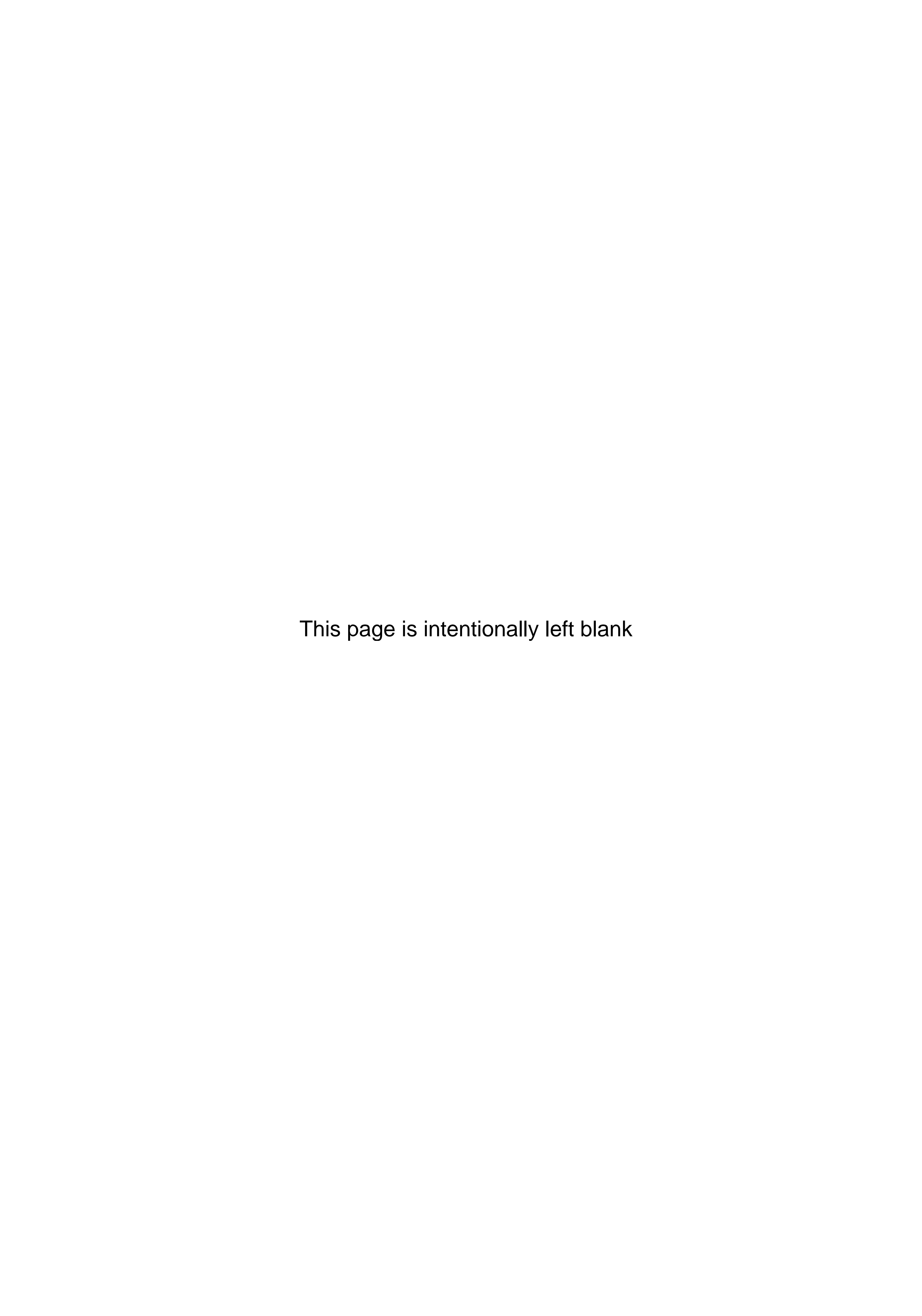
3. Consultation

The issue of consultation is pertinent to this item, as the initial announcement by NHS England on 8 July 2016 failed to acknowledge NHS England's obligations in relation to public consultation, as set out in the regulations.

4. 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 Simon Evans, Health Scrutiny Officer, Lincolnshire County Council, 01522 553607 Simon.Evans@lincolnshire.gov.uk


This page is intentionally left blank

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 Richard Wills the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 September 2016**
Subject:	**APMS [Alternative Provider of Medical Services] GP Surgeries**

Summary

On 21 July 2016, Lincolnshire West Clinical Commissioning Group announced that interim management arrangements would be introduced in four GP practices in Lincolnshire from 1 August 2016. The four GP practices are:

- Arboretum, Lincoln;
- Burton Road, Lincoln;
- Metheringham Surgery; and
- Pottergate, Gainsborough.

The interim management arrangements at the four surgeries would be provided by Lincolnshire Community Health Services NHS Trust. Between them the four surgeries have over 11,100 registered patients. Lincolnshire West Clinical Commissioning Group, which has responsibility for the budgets relating to these four surgeries, has been consulting with the registered patients on what they want from their GP surgeries.

Actions Required:

To consider the information in the report, and await further information from Lincolnshire West Clinical Commissioning Group on the outcomes of the consultation.

1. Background

APMS GP Contracts

Most GP surgeries in Lincolnshire operate under either a *General Medical Services* (GMS) or a *Personal Medical Services* (PMS) contract. Both GMS and PMS contracts are 'in-perpetuity' contracts without a time limit. Five GP practices in Lincolnshire West for historical reasons area operate under *Alternative Provider of Medical Services* (APMS) contracts, which are fixed term contracts, where an open procurement exercise is undertaken periodically. Four of the five APMS GP practices are the subject of this report and the practices (with the number of registered patients for April 2016) are:

- Arboretum, Lincoln (3,160);
- Burton Road, Lincoln (2,444);
- Metheringham Surgery (1,703); and
- Pottergate, Gainsborough (3,858).

NHS England previously had full responsibility for all contracts with GP practices, but the management of GP contracts transferred to the Clinical Commissioning Groups (CCGs) in Lincolnshire with full delegated responsibility from April 2015. CCGs operate decision making arrangements to avoid conflicts of interest for the GPs in management positions within the CCG governing bodies. Lincolnshire West CCG, for example, operates a Primary Care Commissioning Committee, which has decision making powers and does not include any GPs.

Announcement on 21 July 2016

On 21 July 2016, Lincolnshire West CCG announced that interim management arrangements would be introduced in four APMS GP practices in Lincolnshire from 1 August 2016. This was because the previous provider at these four practices, Universal Health Ltd, had run into financial difficulties and had asked Lincolnshire West CCG to terminate the contracts. Lincolnshire West CCG announced that Lincolnshire Community Health Services (LCHS) NHS Trust would run the surgeries at least until 15 December 2016 on a caretaker basis.

The four APMS contracts had previously been awarded by NHS England to Universal Health Ltd. (The contracts for Arboretum, Metheringham and Pottergate were effective from 1 April 2015, and the contract for Burton Road surgery was effective from 1 July 2015.)

Engagement and Consultation with Patients

Lincolnshire West Clinical Commissioning Group has undertaken a survey of the patients, seeking their views on the services they currently receive and what they would like in the future. Patients have been asked to complete the surveys by 9 September 2016. In addition drop-in sessions were held in each area in the last week of July.

The questionnaires sent to patients contained the following questions: -

1) What do you like about your GP practice?
2) Is there anything that can be improved at your GP practice?
3) When choosing your GP, what is the most important factor for you in making that decision?
4) How far do you currently travel from your home to access your GP services?
5) How do you currently travel to your practice? Please tick all that apply.
6) On average, how often do you use your GP practice?
7) Who do you prefer to see?
8) How do you prefer to make your GP and nurse appointments?
9) What would you consider to be the most important areas for improvement at your GP surgery?
10) If you are willing to share your postcode, please do so below:
11) Please use the box below for any additional information you would like to include:

Procurement Exercise

Lincolnshire West CCG has launched a procurement exercise, which would require any provider to operate both morning and afternoon sessions at the surgeries on a Monday to Friday basis. The surgeries could not operate as a branch surgery to an existing GP Practice. Interested providers are required to return their bids by 14 October 2016. Where bids are received, there would be an evaluation process, and decisions made on whether to award the contract to an alternative provider. If necessary, the interim management arrangements could be extended beyond mid-December.

If no bids are received to run any or all of the GP surgeries, the CCG would need to look at dispersing the patient lists of these surgeries to alternative GP surgeries, as the interim management arrangements cannot continue on a permanent basis.

2. Conclusion

The Committee is requested to consider the information in the report, and await further information from Lincolnshire West Clinical Commissioning Group on the outcomes of the consultation.

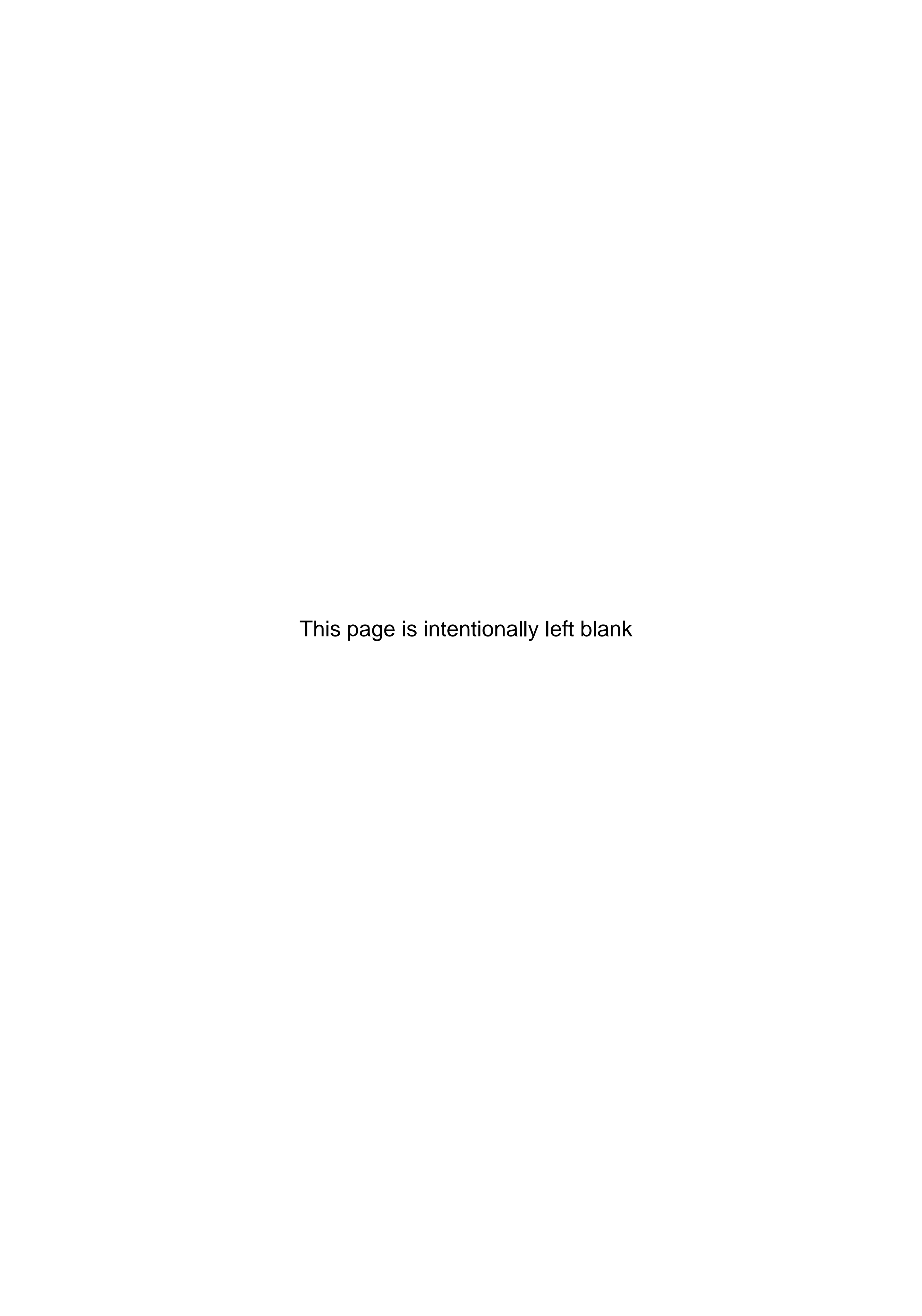
3. Consultation

This is not a direct consultation item with the Health Scrutiny Committee, but refers to a consultation that has been undertaken by Lincolnshire West Clinical Commissioning Group with patients registered at four GP surgeries.

4. 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 Simon Evans, Health Scrutiny Officer, Lincolnshire County Council, 01522 553607 Simon.Evans@lincolnshire.gov.uk


This page is intentionally left blank

Agenda Item 11

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 Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 September 2016**
Subject:	**Quality Accounts 2015-16**

Summary:

Each provider of NHS-funded services has to prepare an annual *Quality Account*, which includes priorities for improvement for the coming year and progress with previous priorities. The Committee may submit a statement on the *Quality Account* of each local provider. This report sets out how the 2015-16 *Quality Accounts* may be accessed*;* summarises the priorities of each provider for 2016-17; and includes the statements on the *Quality Accounts*. In three instances, joint statements were prepared with Healthwatch Lincolnshire; and six statements prepared on behalf of the Health Scrutiny Committee alone.

Actions Required:

(1) To consider the Quality Account priorities for 2016-17 of the following providers, together with the statement prepared on behalf of the Health Scrutiny Committee:

- Lincolnshire Community Health Services NHS Trust (Appendix A)
- Lincolnshire Partnership NHS Foundation Trust (Appendix B)
- United Lincolnshire Hospitals NHS Trust (Appendix C)
- Boston West Hospital (Appendix D)
- East Midlands Ambulance Service NHS Trust (Appendix E)
- Marie Curie (Appendix F)
- Northern Lincolnshire and Goole NHS Foundation Trust (Appendix G)
- Peterborough and Stamford Hospitals NHS Foundation Trust (Appendix H)
- St Barnabas Hospice (Appendix I).

(2) To consider whether the Committee's work programme should be informed by any aspect of the content of this report.

1. QUALITY ACCOUNTS 2016 - OVERVIEW

Legislative Requirements

Since 2010, each provider of NHS-funded services has been required to prepare an annual document entitled the *Quality Account*, which has to include three or more priorities for improvement for the coming year; and an account of the progress with the priorities for improvement in the previous year. Each provider also has to share their draft *Quality Account* with their local Health Overview and Scrutiny Committee; their local Healthwatch Organisation; and their relevant Clinical Commissioning Group. Each one of the above is entitled to prepare a statement of up to 1,000 words, which has to be included in the final published version of the *Quality Account*.

Arrangements for Making Statements on Quality Accounts 2016

The Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire have prepared a joint statement on the following draft quality accounts: Lincolnshire Community Health Services NHS Trust; Lincolnshire Partnership NHS Foundation Trust; and United Lincolnshire Hospitals NHS Trust.

Information on the Quality Accounts, including the priorities for improvement 2016/17 and the statements are set out in the attached appendices:

- Lincolnshire Community Health Services NHS Trust (Appendix A)
- Lincolnshire Partnership NHS Foundation Trust (Appendix B)
- United Lincolnshire Hospitals NHS Trust (Appendix C)
- Boston West Hospital (Appendix D)
- East Midlands Ambulance Service NHS Trust (Appendix E)
- Marie Curie (Appendix F)
- Northern Lincolnshire and Goole NHS Foundation Trust (Appendix G)
- Peterborough and Stamford Hospitals NHS Foundation Trust (Appendix H)
- St Barnabas Hospice (Appendix I)

2. CONCLUSION

This report outlines the key elements of the 2016 *Quality Account* process, and the Committee is invited to consider whether any additions are required to the Committee's work programme in the coming months.

3. CONSULTATION

The Health Scrutiny Committee is one of the three statutory entities (as cited in the *National Health Service (Quality Accounts) Regulations 2010*, as amended), to whom providers of NHS-funded services are required to submit their draft *Quality Account*. This is in effect a consultation process.

4. **Appendices** – These are listed below and attached at the end of the report.

Appendix A	**Lincolnshire Community Health Services NHS Trust** • Quality Account Access Information • Quality Account Priorities for 2016/17 • Joint Statement by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire
Appendix B	**Lincolnshire Partnership NHS Foundation Trust** • Quality Account Access Information • Quality Account Priorities for 2016/17 • Joint Statement by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire
Appendix C	**United Lincolnshire Hospitals NHS Trust** • Quality Account Access Information • Quality Account Priorities for 2016/17 • Joint Statement by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire
Appendix D	**Boston West Hospital** • Quality Account Access Information • Quality Account Priorities for 2016/17 • Statement by the Health Scrutiny Committee for Lincolnshire
Appendix E	**East Midlands Ambulance Service NHS Trust** • Quality Account Access Information • Quality Account Priorities for 2016/17 • Statement by the Health Scrutiny Committee for Lincolnshire
Appendix F	**Marie Curie** • Quality Account Access Information • Quality Account Priorities for 2016/17 • Statement by the Health Scrutiny Committee for Lincolnshire
Appendix G	**Northern Lincolnshire and Goole NHS Foundation Trust** • Quality Account Access Information • Quality Account Priorities for 2016/17 • Statement by the Health Scrutiny Committee for Lincolnshire
Appendix H	**Peterborough and Stamford Hospitals NHS Foundation Trust** • Quality Account Access Information • Quality Account Priorities for 2016/17 • Statement by the Health Scrutiny Committee for Lincolnshire
Appendix I	**St Barnabas Hospice Trust** • Quality Account Access Information • Quality Account Priorities for 2016/17 • Statement by the Health Scrutiny Committee for Lincolnshire

5. **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 Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST

QUALITY ACCOUNT

The 2015-16 Quality Account of the Lincolnshire Community Health Services NHS Trust (LCHS) is available at the following link:

http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=29671

LCHS QUALITY ACCOUNT PRIORITIES

The Quality Account includes the following priorities for 2016/17:

Priority 1: Introduction and Implementation of the Edmonton Tool [a clinical assessment tool] Delivering Improved Patient Outcomes.

The introduction of the Edmonton Tool will be applied to patients over the age of 75 years on our Caseloads with long term and frail conditions - we will implement at the following quarterly rate achieving a total of 500 assessments at Quarter 4.

Quarter 1 (April to June 2016) - 50
Quarter 2 (July to September 2016) - 150
Quarter 3 (October to December 2016) - 300
Quarter 4 (January to March 2017) - 500

Priority 2: Great Care Close to Home

Using a 2015 / 2016 baseline of 2359 patients with cardiovascular disease in receipt of our services - we will develop self-management plans in 2016/2017 at the following quarterly rate achieving a total of 95% at Quarter 4.

Quarter 1 (April to June 2016) – 25%
Quarter 2 (July to September 2016) – 50%
Quarter 3 (October to December 2016) – 75%
Quarter 4 (January to March 2017) - 95%

Priority 3: How safe are you? Falls prevention

There will be a reduction in all falls in Community Hospitals of 10%, this will result in a target annual rate of 7.5 falls per 1000 occupied bed days (against the baseline of 8.39 in 2015/16).

Priority 4: Enhancing therapeutic relationships, ‘Hello my name is…..’

We will introduce an additional question to the Friends and Family Test to ask patients whether staff introduced themselves. The target will be an increase in the percentage of patients and carers who reported that the person they spoke to introduced themselves, compared to the baseline determined in quarter one.

Priority 5: End of Life Care, Preferred Place of Care

During 2015 / 2016 we received 2745 referrals for 'Palliative' or 'End of Life Care' The number of patients who had a clearly identified 'advance care plan' was 1275. Using these baselines we will increase the number of patients who develop self management plans in 2016 / 2017 to achieve the following quarterly rate achieving a total of 1475 at Quarter 4.

Quarter 1 (April to June 2016) - 1325
Quarter 2 (July to September 2016) - 1375
Quarter 3 (October to December 2016) - 1425
Quarter 4 (January to March 2017) - 1475

STATEMENT ON LCHS QUALITY ACCOUNT FOR 2015/16

This statement has been prepared jointly by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire.

Review of Priorities for 2015-16

We note that the Trust's progress on its priority targets for 2015-16.

- *Increase in Clinical Supervision* – We accept that there were IT problems during the year that led to the data for this priority being incomplete. In terms of what was recorded, the level of achievement appears to be low, but this may be that not all examples of supervision have been captured. We urge the Trust to try to make recording supervision easier, by reinstating IT rather relying on manual recording.
- *Patient Facing Time* – We understand the definition of "patient facing time" may need to be revisited and a clearer alternative adopted. As this priority was not achieved, we look forward to the Trust implementing the IT, so that staff can enter patient details directly onto IT systems in real time, rather than needing to return to their office base to do so.
- *Reduction of Pressure Ulcers* – We are pleased that this priority has been achieved, with a 40% reduction in pressure ulcers.
- *Patient Assessment and Individual Plans of Care* – We note that the Trust has not achieved this priority, but it will continue as part of the Edmonton Tool priority for 2016/17.
- *Medication Errors* – We are pleased that the target for this priority has been achieved, but urge the Trust to continue with its efforts to reduce medication omissions and errors.
- *Safe Staffing Levels* – We note that the target for this priority has been achieved in most instances. We look forward to the Trust continuing its work to achieve safe staffing across its in-patient facilities.

Priorities for 2016-17

We support the Trust's selection of priorities for 2016-17 and would like to make the following comments:

- *Introduction and Implementation of the Edmonton Tool* – We note that this priority will be focused on those aged over 75 whose health has failed them, rather than embracing everyone over this age threshold. We acknowledge that IT systems to

support the delivery of this priority, which has been introduced on the basis of national evidence to confirm the success of the Edmonton Tool. We suggest that the role of any family carers is taken into account to complement the use of the Edmonton Tool.

- *Great Care Closer to Home* – We note the reasons for the Trust focusing on patients with cardio-vascular disease, with a view to reducing the need for the unnecessary admission into hospital. We acknowledge that the key worker role is essential to the success of this priority.
- *How Safe Are You?* – We note the Trust's plans for an overall reduction of 10% in the number of falls in community hospitals. The Trust has indicated that this is an achievable target and we look forward to this reduction being achieved.
- *Hello, My Name is…* – We note that this priority has been included as a result of comments by patients and we observe that an increasing number of trusts are adopting this national campaign. We believe that an introduction is a matter of common sense and courtesy. We note that the Trust will seek to measure this by seeking a ten per cent reduction in the number of relevant complaints.
- *End of Life Care, Preferred Place of Care* – We accept the rationale for this priority is that too many patients die in acute hospitals, when their preference would be to spend their final days at home. We understand initiatives are already being introduced to prevent end-of-life patients being admitted to acute hospitals. We recognise the contribution that community hospitals could make, if each hospital could undertake more complex procedures, for example the administration of intravenous antibiotics. We note the Trust will be employing an End-of-Life Pathway Lead to work with acute hospitals meeting patients' needs and wishes.

We urge the Trust to have regard to the need of carers, as required by the Care Act 2014, as 'partners in care' in the implementation of each of its priorities in the coming year.

We are assured that the Trust's priorities for 2016/17 will be monitored by the Quality and Risk Committee, which reports regularly to the Trust Board. We look forward to the Trust making progress during the course of the year on all these priorities.

Engaging the Public

We are pleased that the Trust has explained how it has engaged patients and the public over the last twelve months in various ways to develop the priorities for the coming year.

Engagement with the Health Scrutiny Committee

The Health Scrutiny Committee has continued to engage directly with the Trust, and in the last year reviewed the content of the Trust's clinical strategy. The Committee has also been updated on the progress with the Trust's application for foundation trust status, and looks forward to the Trust achieving this in the coming year.

Engagement with Healthwatch Lincolnshire

In September 2015, Healthwatch Lincolnshire published its enter and view report on Lincolnshire's out-of-hours services. Healthwatch made a total of 35 recommendations and observations. This included a conclusion that patients had found that the out-of-hours staff at Lincoln were caring and patients felt involved in their care and received with good explanations and support. Each out-of-hours service recorded high patient satisfaction scores. With regard to the Trust's response to the report, Healthwatch Lincolnshire feel

that the key issues have been embedded within the Trust's overall and workforce priorities. Healthwatch Lincolnshire will continue to seek assurance from the Trust on these areas during the coming year.

Compliments and Examples of Outstanding Practice

We urge the Trust to make sure that it is easy for patients and their families to record their compliments for the services provided. We commend the Trust on its successes and achievements highlighted in the *Examples of Outstanding Practice* section of the report, in particular a further 13 nurses being recognised by the Queen's Nurse Award.

Conclusion

We are grateful for the opportunity to make a statement on the Trust's draft Quality Account. Both the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire will be seeking more engagement with the Trust during the coming year on the progress with its priorities.

APPENDIX B

LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST

LPFT QUALITY ACCOUNT

The 2015-16 Quality Account of the Lincolnshire Partnership NHS Foundation Trust (LPFT) is available at the following link:

http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=2730

LPFT QUALITY ACCOUNT PRIORITIES

The LPFT Quality Account includes the following priorities for improvement for 2016-17:

Priority 1 – Evidence Improvement in Patient Safety

- Achieve quarterly targets set within the LPFT Safety Improvement Plan (Sign Up to Safety National Initiative). LPFT's identified target areas are: - 7 day follow-up, risk assessment in CRHT; and reduction in medication issues with harm and incidents in inpatient areas.
- Audit sample of closed serious incidents reports (1-2 years' post closure), evidencing that actions remain embedded in practice.
- Case records audits evidence service user/patient and/or carer involvement in a minimum of 85% of cases (evidenced through audit of clinical risk assessments).

Priority 2 - Evidence Improvement in Inpatient Experience

- Improvement in divisional survey results drawing from locally and nationally collected data (friends and family test, ward questionnaires, inpatient and community mental health surveys)
- Minimum 85% recruitment panels evidence service user/patient and/or carer involvement (direct or indirect)
- You Said We Did: Evidence of responsiveness to service user/patient and carer feedback displayed in a minimum of 85% of ward/unit/service user/patient community waiting areas inspected as part of the 15 Steps/quality governance visits
- A local quality priority metric to be selected and implemented by each division in each domain

Priority 3 – Evidence Improvement in Clinical Effectiveness

- AIMS accreditation (or equivalent) achieved and maintained within all inpatient areas and increase in AIMS accreditation (or equivalent) within community services (as compared to previous year)
- Evidence of continued active participation in service-focused research and audit (internally and externally led)
- Evidence of active staff engagement in LPFT leadership and development programmes
- LPFT maintain/improve upon previous years achievement in the Stonewall Workplace Equality Index (links to Equality Delivery system 2)

STATEMENT ON LPFT QUALITY ACCOUNT FOR 2015/16

This statement has been prepared jointly by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire.

Progress with Priorities for 2015-16

We acknowledge the Trust's progress with its priorities for 2015/16. We commend the Trust for increasing its external accreditations and participation in research studies and national audit programmes, as well as all the other targets which the Trust has met.

We note the reasons given for those negative results from the 2015 staff survey and support the actions proposed to address, in particular introducing staff suggestion schemes and forums.

The Trust states that there has been a response to 100% of the patient feedback from Healthwatch Lincolnshire. Healthwatch notes the evidence provided by the *You Said, We Did* initiative, but would like to explore further with the Trust the extent to which the Trust's responses to their feedback have led to positive improvements for patients across all services.

We note that the Trust has partially achieved the targets for the *Sign Up To Safety* national initiative and would like to see further improvements in the engagement of service users and carers within individual focus groups in the future.

Priorities for 2016-17

The Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire support the Trust's three priorities for 2016/17 and note that the Council of Governors and patient groups have been consulted on the draft priorities, with opportunities for members of the public to put forward their views via the Trust's website. We also accept the rationale for the nationally mandated elements of the indicators, as well as the selection of the local indicators.

We would like to stress the importance of achieving the following priority measures in the coming year:

- a minimum of 85% of recruitment panels will show evidence of service user/ patient and / or carer involvement (direct or indirect); and
- a minimum of 85% of the feedback as part of the *You Said, We Did* should be displayed for patients.

We are satisfied that the Trust will continue to monitor progress on these priorities via its Quality and Safety Team and reported three times a year to the Quality Committee, which in turn reports to the Trust Board.

Care Quality Commission Inspection Report

We note the overall rating for the Trust, following the publication of the Care Quality Commission's reports, published on 21 April 2016, together with eleven further reports on the Trust's range of services. We commend the Trust for achieving an *Outstanding* rating for community mental health services for children and young people.

We understand that the Care Quality Commission was most concerned about the *Are Services Safe?* domain. Essentially these concerns focussed on the child and adolescent in-patient unit, which was classed by the Care Quality Commission as mixed-sex accommodation; and about ligature points and other risks in some in-patient facilities.

We note the Trust will be bringing forward its action plans in response to the above concerns. We understand that these action plans will address topics such as improving patient engagement and involvement, as well as improving engagement with staff, and these are reflected in the Trust's priorities for the coming year.

Engagement with the Health Scrutiny Committee for Lincolnshire

The Trust has regularly engaged with the Health Scrutiny Committee during the year. In particular, the Committee has been involved in the development of the Trust's clinical strategy. The Trust has also reassured the Committee that has taken forward actions in response to the report on *Review of Suicides and Deliberate Self-Harm with Intent to Die*. We also note that the Trust has developed a *Suicide Prevention Strategy 2016-2019*, which includes a number of actions to reduce suicide.

We look forward to this engagement continuing in the coming year, in particular considering how the Trust is responding to the Care Quality Commission.

Engagement with Healthwatch Lincolnshire

Healthwatch Lincolnshire published its report on *Service User, Patient and Carer Views on Mental Health Services* in November 2015 and several issues in this report have also been highlighted by the Care Quality Commission. Healthwatch Lincolnshire also published an 'enter and view' report on the *Drug and Alcohol Recovery Team* in November 2015. Healthwatch Lincolnshire will continue to engage with the Trust on these reports. It will specifically seek action plans to address the following issues:

- waiting times for patients to access services;
- discharge planning and subsequent support;
- out-of-hours services and support for patients;
- liaison with and the involvement of GPs, including raising awareness of mental health issues with GPs;
- transition arrangements from children and young people services to adult services;
- patient safety issues; and
- the equity of service provision throughout the county.

Healthwatch Lincolnshire's report on *Service User, Patient and Carer Views on Mental Health Services* (November 2015) found that some patients and carers were not satisfied with the way in which complaints were handled. Healthwatch does not consider a rate of over 50% complaints upheld fully or partially upheld is good. Healthwatch is keen to know what work the Trust is planning that provides better support for complainants.

Other Items

We support the Trust's plans for introducing a no-smoking policy across all its premises from June 2016.

Accreditations and Achievements

We commend the Trust on its achievements, as identified in the Quality Account. We would like to highlight the patient improvement rates achieved by Steps2Change, particularly in Grantham and Sleaford.

Conclusion

We are grateful for representatives from the Trust taking the time to present the draft Quality Account to us. This provided us with an opportunity to provide immediate feedback on certain aspects of clarity and presentation of the document. This also enabled us to seek clarification of particular points, which was welcome.

We recognise that the year ahead will be a challenge for the Trust, as it seeks to balance the required improvements set by the Care Quality Commission, with the increasing emphasis on financial rigour within the Sustainability and Transformation Plan regime. The Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire look forward to continuing engagement with the Trust, and its continued improvement in the services provided to patients.

UNITED LINCOLNSHIRE HOSPITALS NHS TRUST

ULHT QUALITY ACCOUNT

The 2015-16 Quality Account of the United Lincolnshire Hospitals Partnership NHS Trust (ULHT) is available at the following link:

http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1990

ULHT QUALITY ACCOUNT PRIORITIES 2016-17

The ULHT Quality Account includes the following priorities for improvement for 2016-17:

Priority 1 – Reducing Hospital Mortality with a Key Focus on Septicaemia

Though HSMR and crude mortality are within expected limits, the Trust wishes to continue to reduce mortality levels. Our goals to support this in the coming year include:

- Aiming to review all deaths in specialities by independent clinicians. We now use a detailed and standardised review process and we are able to aggregate lessons learned.
- Carry out detailed Retrospective Case Record Reviews where we find indications that quality of care can be improved.
- Ensuring through our monthly Trust Mortality Report that the Board is fully sighted on mortality data, lessons learned, areas to focus on and what this means for the care of our patients.

During the coming year, our work on sepsis will be managed through a multi-disciplinary clinical team chaired by a senior clinician. Our focus will be on:

- Improving the early identification of Sepsis in patients in Hospital
- Raising sepsis awareness throughout the Trust through education and training
- Continue to deploy the Sepsis Six care bundle
- Use the *Red Flag Sepsis* methodology to identify those patients most at risk of Severe Sepsis and Septic Shock.

During 2016/17 we expect to raise sepsis early assessment to 90% and antibiotics within one hour to 90%.

Priority 2 – Reducing Harmful Falls

Our overarching goal is to reduce falls by 30%. This will be measured by reported incidents on Datix and per 1000 occupied bed days. The Trust's Falls Group are leading the improvement work and the key objectives for 2016/2017 are: to develop education programme on falls prevention, to review different models of one to one care and to undertake falls prevention improvements on pilot wards using PDSA methodology (a quality improvement cycle built around Plan-Do-Study-Act). Using this methodology enables local improvement to implemented and then shared widely across other areas.

Priority 3 – Increasing the Reliability of Checking and Charting

During the coming year, we aim to:

- Improve the reliability of patient observations to above 90% on all wards
- See all wards rise through a ward accreditation and evaluation programme
- Continue to roll-out and utilise an electronic observation system to manage patient care and identify deterioration

Priority 4 – Reducing Harmful Infections

The Trust has a comprehensive programme in place to prevent infections, including the following key initiatives.

Undertaking an NHS Improvement 90 day collaborative improvement programme.
Focusing on the management of GDH+ve patients (C.difficile carriers)

- The Infection Control Team regularly undertake ward compliance assessment visits and the results are fed back at the time to the ward manager/ shift coordinator. The results are also formally fed back by email to the ward manager, Matron and Head of Nursing, with a requirement to develop action plans and feedback progress at site Infection Control Meetings

- Saving Lives audits are undertaken monthly. The audits are based on validated toolkits which assess compliance with peripheral cannulas, urinary catheters and cleaning of patient equipment.

- Our infection prevention and control (IPC) strategy is to achieve front line ownership. Clinical teams are supported by IPC to develop improvements in their areas.

Priority 5 – Improving the Patient Experience in Out-Patients

The 2016/17 Outpatient Transformation Programme has five work streams focused upon:

(1) Environment – addressing clinical facilities that not fit for purpose / do not provide a good patient experience.
(2) Workforce – focused upon: (a) establishing a well led, single point of accountability and single management team for outpatients; (b) providing a fit for purpose workforce
(3) Management of Follow-Up (FU) Patients – focused on reduction of overdue FU patients and risk mitigation of delayed appointments.
(4) Outpatient Department (OPD) Systems and Process – focused upon delivery and establishment of responsive, effective and efficient systems and processes to address objectives associated with quality of service and activity data/ income capture.
(5) OPD Utilisation – addressing capacity and scheduling issues to support the delivery of clinically safe and responsive services and the efficient provision of timely outpatient appointments.

Priority 6 – Achieve our Constitutional Standards in Cancer, Referral to Treatment and Emergency Access

4 Hour Emergency Access Standard

- Increasing availability of beds at Lincoln and Pilgrim sites
- Implementation of 7 day therapies and pharmacy
- Mainstream an integrated discharge hub to work year-round as opposed to just winter months
- Review the frailty pathway and future ways of working in partnership with community and commissioning colleagues
- Implement the SAFER bundle to increase discharges
- Work with community and commissioning colleagues to implement new schemes to reduce length of stay and attendances (including the Clinical Assessment Service)

18 Week Referral to Treatment Standard

- Speciality recovery plans in place to meet expected levels of demand
- Service redesign in specialities where problems have been identified with meeting the expected levels of demand
- Extensive activity modelling and monitoring throughout the year to ensure capacity and demand levels are managed and are transparent
- Increase levels of support for the operational business units to provide realistic and achievable trajectories and remedial action
- Increase levels of support for clinicians and business managers in identifying issues outside of their control, and facilitating the dialogue with commissioners to rectify issues in a proactive manner
- Ongoing data quality improvement, training and validation

National Cancer Waiting Times

- Utilise capacity and more effective activity planning to mitigate demand increases.
- Clearer escalation and breach analysis
- Dedicated pathway work in areas with most challenge – lower GI, Urology and Skin

STATEMENT ON ULHT QUALITY ACCOUNT FOR 2015/16

This statement has been jointly prepared by the Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire.

Review of Progress on Priorities for 2015-16

We note that there has been some progress on the six priorities for last year, for example Priority 1 (Reducing Hospital Mortality) and Priority 3 (Improving the response to Complaints) have led to improvements in patient experience. We are pleased that some of the progress on Priority 4 (Improving Outpatient Services) will be consolidated by a priority in the coming year seeking further improvements to the patient experience in outpatient services. Similarly the progress with the constitutional standards (Priority 6) relating to cancer and urgent care has been mixed, and we are pleased that the priority to achieve these constitutional standards is being carried forward into the coming year.

Priorities for 2016-17

We strongly support the selection of the Trust's six priorities for the 2016/17. We would like to make the following specific comments: -

- Priority 1 *(Reducing Hospital Mortality and Reducing Septicaemia)* – We hope the Trust will seek to work with other providers so that end-of-life patients are able to receive intravenous antibiotics in an appropriate setting rather than being moved to an acute hospital, as this is better patient care. As a secondary consideration, we hope that the Trust's mortality figures are not skewed by the inclusion of end-of-life patients. With regard to reducing septicaemia, we strongly support the target that 90% of patients requiring intravenous antibiotics receive these within the hour.
- Priority 2 *(Reducing Harmful Falls)* – We note that a number of harmful falls occur with patients who are medically fit for discharge. Improving discharge arrangements is clearly a challenge for the wider health system, where the options available in the community need to be increased. We support the aim for a target of 0.19 falls per thousand bed days. We note the Trust's progress in making its hospitals dementia-friendly, but we would also comment that falls for patients with dementia are particularly distressing and we would urge that all staff are trained on how to meet the particular needs of patients with dementia.
- Priority 3 *(Increasing the Reliability of Checking and Charting)* – We note that a pilot that has taken place at Pilgrim Hospital introducing electronic recording of observations, which we welcome. Patient records remain a concern, and the move away from paper-based records is overdue. We strongly urge that there is co-ordination between departments so that patient information is always available, as appointments should not be cancelled, because information on a patient is held somewhere else within the Trust, but is not available to the clinician.
- Priority 4 *(Reducing Harmful Infections)* – We support the retention of a priority reducing infections. Increasing the rates of hand washing is important on entry and exit to patient areas. We also feel that the dress policy is important too, as staff should be appropriately dressed in clinical settings. Similarly, we also strongly urge that uniforms are not worn outside the hospital, as this is an infection risk.
- Priority 5 *(Improving the Patient Experience in Outpatient Services)* – We are pleased to see the inclusion of this priority, which will build on progress in the last year. We look forward to improvements in communications with patients in the way appointments are made: too often appointments are cancelled at short notice, which does not lead to a good patient experience. Services to patients should be integrated throughout the Trust's three main sites.
- Priority 6 (*Achieving Constitutional Standards in Cancer, Referral to Treatment and Emergency Access)* - We are pleased to see the retention of this priority. We understand that the Trust is one of the main providers of cancer care in the country in terms of the number of patients treated, and achieving higher standards should be explicit.

We understand that the Trust's Quality Governance Assurance Committee, which meets monthly, will monitor progress with these priorities and submit its minutes each month to the Trust Board.

Engagement with the Health Scrutiny Committee and Healthwatch Lincolnshire

The Health Scrutiny Committee for Lincolnshire and Healthwatch Lincolnshire are grateful to the Trust for being provided an opportunity to provide direct feedback on the Trust's proposed priorities for 2016-17. We are pleased that our comments have led to two additional priorities being included.

During 2015-16, representatives from the Trust attended the Health Scrutiny Committee for Lincolnshire on five occasions, including presentations on the Trust's improvement programmes.

Healthwatch Lincolnshire believes they and the Trust have continued to have a mutually respectful working relationship during the year. The Trust's timely and where relevant comprehensive responses to the monthly requests made by Healthwatch, which relate to patient and carer experiences, demonstrate this. In addition to the various joint meetings, in which Healthwatch has already been involved, Healthwatch was also pleased during the year to take up a non-voting observer seat at the Trust's monthly board meetings. This also demonstrates a more positive and open relationship between the two organisations.

Lincolnshire Sustainability and Transformation Plan

The development and implementation of the Lincolnshire Sustainability and Transformation Plan (STP) is likely to see significant changes in health service provision by the Trust, as part of the overall delivery of services within Lincolnshire. We look forward to the full participation of the Trust in the STP. We stress the importance of maintaining high standards of patient care during periods of change.

Carers

As a general theme, we urge that there is recognition of the role of carers and respect for their dedication supporting a close relative or friend. The importance of carers is being recognised in national policy and we would like this reflected in the Trust's policies and approaches.

Care Quality Commission

We note that the Quality Account includes the most recent ratings from the Care Quality Commission (CQC), which are based on evaluations undertaken in 2015. We understand a further full inspection is programmed for October 2016. We look forward to the Trust improving its ratings, in particular for outpatient services at Lincoln County Hospital, although we note the progress made in this area.

Conclusion

The Health Scrutiny Committee for Lincolnshire and Lincolnshire Healthwatch are pleased for their opportunity to make a statement on the draft Quality Account. We are particularly impressed by the opportunity to provide direct feedback on the content of the priorities. Both the Health Scrutiny Committee and Healthwatch Lincolnshire look forward to continued engagement with the Trust in the coming year.

APPENDIX D

BOSTON WEST HOSPITAL

BOSTON WEST QUALITY ACCOUNT

The 2015-16 Quality Account of Boston West Hospital (Ramsay Healthcare) is available at the following link:

http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Documents/2015/boston-west-hospital-ramsey-qa-2015.pdf

BOSTON WEST QUALITY ACCOUNT PRIORITIES FOR 2016/17

Boston West Hospital's *Quality Account* sets out its priorities for improvement for 2016-17:

Patient Experience Priority

We would like to further develop our Patient and Public Involvement Group (PPIG). We aim to continue to foster a healthy relationship whereby feedback can be used to provide the best possible patient experience.

Clinical Effectiveness Priorities

We aim to introduce Patient Recorded Outcome Measures forms, allowing further measurement of the intended outcomes of the procedures undertaken.

We will introduce display boards in each department to highlight key governance activity and performance. The boards will be regularly updated to encourage continuous learning and improvement.

We also hope to set up some shared learning sessions for all staff to raise awareness of the themes and trends of complaints and incidents at the Hospital.

Patient Safety Priorities

We will continue to audit theatre safety culture. The average compliance rate for these audits during 2015/16 was 99.25% and we would like to build on this.

We will use a national tool to measure medication errors and harm from medication errors in order to review current process and make changes where necessary if appropriate.

STATEMENT ON BOSTON WEST HOSPITAL QUALITY ACCOUNT 2015/16

This statement has been prepared by the Health Scrutiny Committee for Lincolnshire.

Progress on Priorities for 2015-16

We are pleased with the progress by Boston West Hospital on its priorities for 2015-16. In particular we would like to highlight the reductions to waiting times for patients by aiming to

avoid 'wasted' slots, as well as improvements to advice to patients on their pain management, following their operations.

We are pleased that the organisation is committed to the learning and development of all staff and we also welcome the Hospital's commitment to respond to feedback from patients received via the friends and family test.

Priorities for 2016-17

We support Boston West Hospital's priorities for 2016-17, and look forward to progress on these priorities leading to improvements in clinical effectiveness and patient safety. We reiterate our support for the continuous development and training of all staff. We encourage Boston West Hospital to undertake the shared learning sessions for staff, as part of its clinical effectiveness priority.

We look forward to Boston West Hospital delivering these priorities, but we would seek clarity on how progress with priorities is going to be monitored in the coming year.

Performance and Achievements

We congratulate Boston West Hospital on the following achievements during the last year:

- the Hospital's achievement a 'good' rating overall following its inspection by the Care Quality Commission (CQC) in 2015;
- the expansion of orthopaedic services to provide in-house ultra-sonography;
- the achievement of patient satisfaction scores of 97.4 per cent; and
- keeping infection rates lower than the national average (despite a small increase in 2015-16 compared to 2014-15).

We also strongly support the development of a dementia-friendly environment, as a result of the Patient-Led Assessments of Care Environment (PLACE).

Presentation of Information

The Quality Account includes information on Patient-Led Assessments of Care Environment (PLACE), which enables comparisons to be made between 2014 and 2015 as well the national average for 2014. We suggest that the Quality Account in future is clearer on the presentation of PLACE information. We note that the PLACE information for food in 2015 was 33.33%, but it was not clear in the draft Quality Account whether this refers to the level of patient satisfaction with food or simply refers to the collection of data from patients on their food. If it is the former, this would be a concern, although we acknowledge that as a day-case hospital, the provision of food would not be a significant priority.

Aside from the above concern, we are satisfied that the Quality Account is presented clearly so that the casual reader can develop an understanding of key services provided by Boston West Hospital.

Engagement with the Health Scrutiny Committee for Lincolnshire

We were pleased that a representative from Boston West Hospital presented to the Health Scrutiny Committee for Lincolnshire during the last year. This has helped the Committee develop its understanding of the operation of the Hospital. The Committee confirmed the following: the level of NHS-funded patients using the Hospital; the application of the NHS

tariff arrangements; the limited use of agency staffing and high levels of staff retention; and the focus on patients who were suitable for a day-case approach.

Conclusion

We are grateful for the opportunity to make a statement on Boston West Hospital's Quality Account. We congratulate the Hospital on its improvements and achievements during the last year. The Committee would like to continue maintaining links with the Hospital during the coming year.

EAST MIDLANDS AMBULANCE SERVICE NHS TRUST

EMAS QUALITY ACCOUNT

The 2015-16 Quality Account of the East Midlands Ambulance Service NHS Trust (EMAS) is available at the following link:

http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=29233

EMAS QUALITY ACCOUNT PRIORITIES 2016/17

The EMAS Quality Account includes the following five priorities for improvement for 2016-17:

Priority 1: Cardiac Arrest – Return of Spontaneous Circulation (ROSC) and Survival Outcomes. EMAS has continued to focus its attention upon the improvement of successful ROSC rates in cardiac arrest. During 2016/17 we will:

- Continue to develop and improve our cardiac arrest outcomes.
- Continue to see our Ambulance Quality Indicators and outcomes around stroke, COPD and asthma improve.
- Also see an increase in the presence of frontline clinical supervision to all active resuscitation attempts.

Priority 2: Sepsis is a worldwide public health issue. In developing nations, Sepsis is the leading cause of mortality, accounting for nearly 80% of deaths. Sepsis kills far more citizens than AIDS, prostate cancer and breast cancer combined. During 2016/17 particular focus will be to:

- Identify and treat Sepsis within our patients.
- Ensure the formalisation of the EMAS Sepsis Lead, including documented objectives and performance measures.
- Appoint divisional Sepsis champions (one per division) on a volunteer basis.
- Develop a robust action plan to ensure the availability of waveform capnography on a minimum of 95% of frontline operational resources (double crewed ambulance & fast response vehicle).
- Work with a partner acute trust to explore the increased prehospital use of IV antibiotics in the treatment of Sepsis.

Priority 3: To identify the common themes of all maternity related incidents, and to reduce patient related incidents:

- We will aim to see a reduction in severity of all maternity related incidents within our care.
- Receive an improvement on aspects of clinical care from maternity units.
- Educate all operational workforces in maternity related training.

Priority 4: To explore the use of alternative pathways in each division by using the pathfinder leads to develop the pathways in each EMAS commissioning area.

Priority 5: Having signed up to the Mental Health Crisis Care Concordat, we will work collaboratively with local commissioners and relevant stakeholders to implement the agreed priorities within the mental health steering group. We will:

- Continue to build mental health pathways in all divisions
- Embed parity of esteem in EMAS for all patients presenting with mental health issues.
- Ensure that these patient groups receive an appropriate response and are signposted to the appropriate receiving facility.
- Improve the awareness of mental health conditions with our staff.

STATEMENT ON EMAS QUALITY ACCOUNT FOR 2015/16

Introduction

This statement has been made by the Health Scrutiny Committee for Lincolnshire, which scrutinises NHS-funded health services in the administrative county of Lincolnshire. This county forms a large part, but not all, of the Trust's Lincolnshire Division.

The Lincolnshire Division is a key part of the Trust's region, but it is unfortunate that the draft Quality Account makes a statement on the importance of the M1 motorway to the region's 'county towns'. Lincoln, as the 'county town' of Lincolnshire, is at least one hour's drive to the nearest point on the M1. On this theme, we would like to see more information on each Division, as this would give the document more local flavour.

Progress on Priorities for 2015-16

Whilst progress and activities are described on each priority, there is no clear statement in the draft Quality Account on whether each priority has been achieved. We urge that this is done in future years, for the sake of simplicity and the casual reader. Taking priority 1 as an example, we would like to have seen more information on how in practice patients have benefited from the development of the paramedic pathways.

Selection of Priorities for 2016-17

The Health Scrutiny Committee for Lincolnshire acknowledges that it was given an opportunity to comment on the draft priorities early in 2016 and recognises this early engagement across the East Midlands on the content of the priorities is best practice. After giving the priorities further consideration we would urge that the Trust does not lose sight of its core activities: responding to and stabilising patients in need of an emergency response and them conveying them to hospital for treatment. Other initiatives should be secondary to and supportive of this core aim. Elsewhere in the document there is reference to the Trust's participation in 17 research studies. We would like to have seen more information on how these research studies have led to improvements for patients.

The Health Scrutiny Committee for Lincolnshire has been concerned about responses to life-threatening and serious emergency calls for many years. Whilst the Committee acknowledges that certain initiatives lead to the freeing up of emergency ambulances to deal with these calls, we would like to have seen the national requirements for response times reflected in some way in the Quality Account priorities.

We understand that the Board's Quality and Governance Committee has a role in monitoring the detailed performance with these priorities, with the Board also receiving reports at each meeting.

Contribution of First Responders

We acknowledge that the Quality Account by necessity refers to the services provided by the Trust, rather than any other organisation. However, we would like to record the valuable contribution of volunteers: Lincolnshire Integrated Voluntary Emergency Service, operating throughout the Lincolnshire Division, with over 700 volunteers; and Lincolnshire Emergency Medical Response, comprising 30 serving and former military personnel acting as volunteers. Similarly, Lincolnshire Fire and Rescue also provides first responder services. All these services complement those of the East Midlands Ambulance Service and contribute to certain response time measures.

Engagement with the Health Scrutiny Committee for Lincolnshire

We are pleased that managers from the Trust's Lincolnshire Division have regularly attended meetings of the Health Scrutiny Committee for Lincolnshire over the last year. As stated above, the Committee's main focus has been the response times for life-threatening and serious emergency calls in Lincolnshire. The Committee has reviewed detailed information on response times and welcomes improvements in this performance, which have largely resulted from direct engagement between the Lincolnshire Division and the clinical commissioning groups in the county. The introduction of the mental health triage cars is cited as a key development improving outcomes for patients.

Other Initiatives in Lincolnshire

We would like it recorded that the joint ambulance conveyance project, involving Lincolnshire Fire and Rescue, had proved a success in the three towns selected for the pilot: Long Sutton; Stamford and Woodhall Spa. The pilot has won innovation awards and we look forward to the continuation of this service.

Care Quality Commission Inspection

At the time of our review of the draft Quality Account, the Care Quality Commission had not published its report on the outcomes of its inspection, which took place in November 2015. Whatever the findings, the Committee looks forward the Trust to be making improvements to meet the Care Quality Commission's requirements.

Leadership and Management

At the time of consideration of the draft Quality Account, the Trust was without a permanent chief executive. We would like to stress the importance of the Trust making a permanent appointment to this role as soon as possible.

Presentation of Information

We are grateful for the opportunity to review the draft Quality Account. We understand that the final document will have numbered pages. To ease our review of the draft, we would request that pages are numbered in the draft documents circulated for comment.

We understand that owing to timescales a draft Quality Account cannot contain all the required information, as data is still being collected. We suggest in future years that the

draft contains the latest available information, for example up to the end of Quarter 3, to enable us to make comments on items such as complaints and compliments.

Conclusion

We recognise that the Trust has made considerable progress in the last few years in Lincolnshire, introducing initiatives to improve response times to life-threatening and serious calls and we acknowledge more work is required in this area, which will require due support from commissioners. We look forward to continued engagement with the Trust in the coming year and expect to see further improvements.

MARIE CURIE

MARIE CURIE QUALITY ACCOUNT

The Marie Curie Quality Account for 2015/16 is available at the following link:

http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Documents/2016/marie-curie-quality-account-june-2016.pdf

MARIE CURIE QUALITY ACCOUNT PRIORITIES FOR 2016-17

Priority 1 – Patient Experience

We will continue to monitor incidents that are considered a 'notifiable safety incident' – any incident that results in or appears to have resulted in death, severe harm, moderate harm or prolonged psychological harm of the patient.

We will record and report on those incidents that fall into the 'notifiable safety incident' category and ensure we have been open and honest with our patients and their families.

Priority 2 – Patient Safety

We will implement and embed a tissue viability link nurse framework.
We will implement an embed an infection prevention and control link nurse framework.
We will improve our understanding of grade 2 pressure ulcers.
We will develop community of practice to promote safeguarding and best practice.

Priority 3 – Clinical Effectiveness

We will ensure all services participate in the annual data for National Council for Palliative Care (NCPC) minimum data set. The date set is collected by the NCPC each year to provide an accurate picture of hospice and specialist palliative care services.

STATEMENT ON MARIE CURIE QUALITY ACCOUNT FOR 2015/16

Introduction

The context for this statement is that whilst Marie Curie is a national organisation providing services throughout the United Kingdom, including nine hospices, more people in Lincolnshire receive care from Marie Curie's community nursing service than in any other local authority area. The Health Scrutiny Committee for Lincolnshire recognises that none of Marie Curie's hospices are located in the county.

Progress on Priorities for 2015-16

The Quality Account clearly sets out the progress and achievements on each priority, which is clear to the casual reader. We would in particular highlight the following:

- We welcome the success of the volunteer helper service, which supported 979 people affected by terminal illness during 2015/16.
- The in-depth semi-structured interviews with patients should continue.

Priorities for 2016-17

The Health Scrutiny Committee for Lincolnshire supports Marie Curie's chosen priorities for the coming year. The Committee is always keen to see reductions in pressure ulcers, so any activity aiming to reduce pressure ulcers is particularly supported. The Committee notes that some of the inpatient units have recorded high numbers of pressure ulcers during 2015-16, but accepts that Marie Curie will be seeking to reduce this in the coming year.

The Health Scrutiny Committee for Lincolnshire suggests that in future years Marie Curie might consider performance measures to support its chosen priorities. For example, the priority on pressure ulcers could be supported by a target to reduce the number of such ulcers.

The Health Scrutiny Committee for Lincolnshire notes references in the Quality Account to Marie Curie's Clinical Governance and Executive Committee and assumes this Committee will undertake the required monitoring of progress with the priorities during the course of the coming year. On the basis of the information submitted, all the priorities will support improvements to patients.

Presentation

The information throughout the document is clearly presented and the priorities are well-presented for the casual reader.

Conclusion

We acknowledge that Marie Curie perform a considerable amount of their work within Lincolnshire, which is widely appreciated. We welcome the opportunity to comment briefly on the draft Quality Account of an organisation which is a key element in the health services in our county. We would like to engage further with Marie Curie in the coming year.

NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST

NLAG QUALITY ACCCOUNT

The 2015-16 Quality Account of Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) is available at the following link:

http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1726

NLAG QUALITY ACCOUNT PRIORITIES FOR 2016/17

The NLAG Quality Account contains the following priorities for improvement for 2016-17, which are grouped under three headings:

Priority 1 – Clinical Effectiveness

- Deliver mortality performance within 'expected range' and improving quarter on quarter, until reported SHMI is 95 or better.
- 90% of patients are screened for sepsis on admission/attendance
- 90% of patients with sepsis receive antibiotics within 1 hour of attendance
- Dementia – 90 per cent of patients aged 75 and over admitted as an emergency to be asked the dementia case finding question.
- 100% of Technology Appraisal Guidelines to be fully compliant within 3 months of publication
- 90% of Clinical Guidelines/NICE Guidelines to be fully compliant within 3 years of publication
- Transfer of patients for non-clinical reasons (capacity) to not exceed 10% of the total.

Priority 2 – Patient Safety

- MRSA - 0 MRSA bacteraemia developing after 48 hours into the inpatient stay (hospital acquired.
- C. Difficile - achieve a level of no more than 10 hospital acquired C. Difficile cases due to a ‘lapse in care’ over the financial year 2016/17.
- Community Safety Thermometer - provide harm free community care to 95 per cent or more patients - as measured by the Safety Thermometer.
- Hospital acquired pressure ulcers, specific targets for higher incidence/reporting ward areas to enable further reductions of ‘avoidable’ pressure ulcers over time. The specific target wording and areas of focus are to be agreed during the early part of 16/17 financial year, as part of the monthly quality report.
- Patient falls - Eliminate all avoidable repeat falls (as measured via the root cause analysis undertaken for every repeat faller).
- Pressure ulcers - a 50 per cent reduction in avoidable grades 2, 3 and 4 pressure ulcers (as measured via the root cause analysis undertaken for every grade 2, 3 and 4 pressure ulcer).
- Nutrition – 100 per cent of patients the care pathway was followed.
- Nutrition – 100 per cent of patients identified as requiring it will have their food record chart completed accurately and fully in line with the care pathway.
- Hydration – 100 per cent of patients identified as requiring it will have their fluid management chart completed accurately and fully in line with the care pathway.

Priority 3 – Patient Experience

- 98% of feedback from the Friends and Family Test is positive (this will be supported with, for context, response rate information)
- Re-opened complaints to not exceed 20% of total closed complaints.
- Complaints: Reduction of complaints relating to communication.
- 90% of patients feel that medical and nursing staff did everything they could to help control pain.
- 90% of patients received pain relief when they needed it in a timely manner.
- Patients should not have more than 2 omitted doses of medications.
- 90% of patients should have appropriate action taken in relation to any medication omissions.

STATEMENT ON NLAG QUALITY ACCOUNT 2015-16

Introduction

The context for this statement is that the Health Scrutiny Committee for Lincolnshire acknowledges that the Trust provides significant services to patients from Lincolnshire East and Lincolnshire West Clinical Commissioning Group areas, particularly with people from the Louth and surrounding area attending Diana Princess of Wales Hospital in Grimsby. Lincolnshire East and Lincolnshire West Clinical Commissioning Groups between them invested over £38 million in the services provided by the Trust during 2015-16.

Presentation and Content

There is comprehensive information throughout the Quality Account and the graphs are clear and easy to understand. The document is cross-referenced and allows readers to take an overview of services or, if they wish, to focus on specific details.

Progress on Priorities for 2015-16

We commend the Trust for clearly indicating whether it has met its targets and for providing this information for each of its three hospital sites. Of particular note is the Trust's progress reducing avoidable pressure ulcers and the number of patients who fall repeatedly and the achievements in significantly reducing MRSA and clostridium difficile. There has also been progress in implementing the NICE guidelines.

We note that the Trust has seen a reduction in the number of complaints that have been reopened, but we would like to see as many complaints as possible resolved in the first instance.

Priorities for 2016-17

We support the Trust's 23 priorities for improvement in 2016-17, and recognise that in most instances these priorities are continuation of previous priorities. This approach is welcomed, particularly in areas where the Trust has not met the previously set targets. We compliment the Trust on its wide consultation that took place prior to the identification of the priorities. This included the public, the Council of Governor and the commissioners.

We believe that the target to screen 90% of patient on admission for sepsis is ambitious, but we look forward to the Trust making progress in this area.

As highlighted above, the continuation of targets to reduce pressure ulcers and prevent patients from falling repeatedly is welcome, as the continued targets for elimination MRSA and clostridium difficile.

We are satisfied that the progress against the priority indicators will be monitored by the Quality and Patient Experience Committee and the Trust Board on a monthly basis.

Never Events

There have been four never events in 2015-16 (there were none in 2014-15). We note the statement by the Trust on its learning from these never events and how this learning is shared with the wider organisation and elsewhere.

Care Quality Commission

We acknowledge that the report by the Care Quality Commission was published at the same time as the draft Quality Account was being prepared. Their specific findings, for example on Scunthorpe General Hospital, will motivate the Trust to pursue further actions in this regard.

Engagement with the Health Scrutiny Committee for Lincolnshire

We note that there has been no direct engagement by the Trust at meetings of the Health Scrutiny Committee for Lincolnshire, and accept that the Trust by necessity has more focus on the health overview and scrutiny committees in North Lincolnshire, North East Lincolnshire and the East Riding of Yorkshire. However, we are grateful for the information updates provided by the Trust. The Health Scrutiny Committee for Lincolnshire would like to explore the possibility of direct engagement in the coming year.

Conclusion

Owing to the timetable set for the receipt of this statement, we were not able to meet a representative of the Trust to provide direct feedback on the content of this Quality Account.

The Health Scrutiny Committee for Lincolnshire looks forward to the Trust making progress across all its priorities, as well as meeting the requirements of the Care Quality Commission, so that services to patients in Lincolnshire continue to improve.

PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST

QUALITY ACCOUNT

The Quality Peterborough and Stamford Hospitals NHS Foundation Trust is available at the following link:

http://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=2008

QUALITY ACCOUNT PRIORITIES FOR 2016/17

The Peterborough and Stamford NHS Foundation Trust's *Quality Account* sets out the following priorities for improvement for 2016-17:

Trust Wide Priority - To develop the CREWS ward accreditation scheme to assess/ monitor wards aligned to the CQC domains.

Patient Safety Priorities

- Documentation Compliance: 90% compliance with documentation audit by all Directorates
- Safe Discharge: Introduce monitoring of patients with a safe discharge / transfer from Peterborough City Hospital - Q1 - Agree measure with Matrons/ Ward Managers re discharge checklist and monitoring; Q2 – Benchmark to define level of improvement in Q3 and Q4; Monitor details during Q1 to benchmark improvements by year end.
- MUST / Nutrition Assessment Compliance: Achieve 95% completed accurate MUST assessments within 24 hours of admission. 100% of completed assessments with MUST components accurately calculated 100% of completed assessments with correct MUST care plan in place.
- E Observations: 100% roll out of the e-observation programme.

Clinical Effectiveness Priorities

- Upper Quartile HSMR for all Trusts nationally: (1) Consultant led review of at least 50% of all hospital deaths; (2) Respond to Dr Foster alerts within 45 days of them being raised.
- Safe Staffing Levels with Reduced Reliance on Agency and Locum Cover: (1) 85% of adult inpatient wards have a minimum 90% registered nurse fill rate on days and nights; (2) Paediatric inpatient areas have a minimum 90% registered nurse fill rate per month; (3) Implement Healthroster SafeCare Live module; (4) 70% retention of nursing students commissioned through Health Education East of England.
- Increase involvement in clinical trials: Year on year increase in the number of patients in clinical trials by 10%.

Patient Experience Priorities

- Improve Responsiveness to Complaints: (10 Increase the response rate to a minimum of 90% of complaints being responded to within the 30 day timescale or agreed timeframe with complainant ; (2) Ensure that all complainants (100%) receive an acknowledgement letter within 3 days of receipt of the complaint; (3) 80% of complainants ‘extremely satisfied’ or ‘satisfied’ with their complainant response
- National Patient Survey: Increase the responses to questions in the inpatient National Patient Survey (NPS) in the ‘best performing category’.

STATEMENT ON THE PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST QUALITY ACCOUNT

Introduction

This statement has been prepared by the Health Scrutiny Committee for Lincolnshire. The context for the Committee's statement is that the Trust is the main provider of acute hospital services to patients from the South Lincolnshire Clinical Commissioning Group area. The Trust also provides services to patients in other parts of the county. During 2015-16, over £50 million of acute hospital services were provided by the Trust to South Lincolnshire residents.

Review of Priorities for 2015-16

The Health Scrutiny Committee for Lincolnshire welcomes the fact that the Trust has met 21 of the 27 targets which have supported its priorities for 2015-16. Whilst the Trust did not achieve all its targets on pressure ulcers, there has been progress, with reductions overall, as a result of the 'six steps' campaign.

We are also supportive of the Trust's programme of providing foundation degree programmes, flexible nursing opportunities and its work with Health Education England and other partners to develop the Trust's own workforce. We are pleased that the Trust has achieved high 'nurse-fill' rates, which is an outcome of the Trust's efforts to retain nursing staff recruited from overseas.

We also commend the Trust as it has achieved all its targets in relation to the handling of complaints. The Quality Account also sets out how the Trust has responded to and learned from the investigations and follow-up to complaints.

All the performance information is well-presented, whether graphically or lexically, clearly indicating whether the Trust has met each target. This makes the report easier to understand for all types of reader. Setting out the progress on 2015-16 priorities sets the context for the selection of the priorities for 2016-17.

Priorities for 2016-17

We support all the Trust's priorities for 2016-17 and note that in many instances the priorities are continuation of the priorities from 2015-16. We are also assured that the priorities have been developed with input from appropriate stakeholders.

We note that the Trust Board's Quality Assurance Committee will continue with its in-depth monitoring of performance against the targets to deliver these priorities and each month a detailed performance report is submitted to the Board.

Other Quality Improvements

We are pleased that the Trust has made changes to wards and departments to make them dementia-friendly. Similarly we welcome the introduction of children and young people friendly areas.

The involvement of patients in clinical trials is noted, and the Trust's commitment to increasing the number of patients involved in such trials is also welcome.

Care Quality Commission Rating

We note the Trust's current rating of 'good' from the Care Quality Commission and we are pleased with all the Trust's work in securing this. We congratulate the Trust on its active approach in seeking an 'outstanding' rating from its next inspection.

Challenges for the Future

We understand that the Trust will be exploring options on how it can work with a neighbouring acute hospital trust in Cambridgeshire, for example by sharing back office functions or even a merger. Whatever the outcome of this initiative, it is important that the focus remains on maintaining high levels of patient care and treatment. We would not wish to see the treatment and the services provided to Lincolnshire residents being adversely affected.

Stamford and Rutland Hospital

We would also like to reiterate our support for Stamford and Rutland Hospital and the services it provides for Lincolnshire patients. The Committee looks forward to exploring with the Trust in the coming year how it will be developing its plans for the Hospital.

Engagement with the Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire acknowledges that most of the Trust's engagement with the health overview and scrutiny function will be with Peterborough City Council's Scrutiny Commission for Health Issues. However, given the extent of services provided to Lincolnshire residents, it is important that there is engagement in the coming year.

Whilst we accept the short timescales for drafting and finalising the Quality Account, we would request that in future years there is more time available to consider the draft document.

ST BARNABAS HOSPICE TRUST

ST BARNABAS QUALITY ACCOUNT

The 2015-16 Quality Account of St Barnabas Hospice Trust is available at the following link:

http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Documents/2016/St-Barnabas-Hospice-Quality-Account-June-2016.pdf

ST BARNABAS QUALITY ACCOUNT PRIORITIES 2016/17

The St Barnabas Quality Account includes the following three priorities for 2016-17:

Priority 1: Clinical Effectiveness - All Staff are Prepared to Care

Every professional needs to be competent and up to date in the knowledge and practice that enables them to play their part in good end of life care. It is vital that every locality and every profession has a framework for their education, training and continuing professional development to achieve and maintain this competence. The framework must allow expertise and professionalism to flourish in the culture of every organisation and every caring contact. This priority will be achieved by: (a) training and support for external healthcare providers; and (b) sustaining a skilled and competent workforce.

Priority 2: Patient Safety

(a) Falls Prevention - The aim of the falls prevention strategy will be the prevention of, and the reduction in, the number of patient falls whilst as far as possible maintaining patient independence. The work will include designation of a falls prevention link nurse within the Inpatient unit to be a point of advice and support for staff. The link nurse role will be adapted to include community and day therapy services once the role has been developed in the inpatient unit.

(b) Pressure Damage - The complexity of our patient group heightens the risk of skin damage. However the organisation is committed to reducing the incidences of pressure damage as far as possible with a plan to undertake an in-depth audit to identify any trends or further measures that may be required to maintain skin integrity for dying patients.

Priority 3: Information Management and Technology Systems Review - This priority will be achieved by: (1) electronic clinical record keeping system; (2) electronic reporting system; and (3) review of information management technology resources.

STATEMENT ON ST BARNABAS QUALITY ACCOUNT

This statement has been prepared by the Health Scrutiny Committee for Lincolnshire.

Priorities for 2015-16

We welcome the progress by St Barnabas Hospice on its improvement priorities for 2015-16. In relation to Priority One *(Cognitive Behavioural Therapy Training for Hospice Nursing Staff)*, we are pleased that the staff who have been trained are already using their skills, with the result that there is evidence that patient anxiety levels are being reduced.

We are pleased that there has been progress with Priority Two *(Advance Care Planning in Other Settings)* to further support palliative care provision for prisoners.

On Priority Three *(Developing a Resource Pack to Support the Care of Patients with Learning Disabilities),* we note that the resource pack is due to be launched during July 2016.

Priorities for 2016-17

We support St Barnabas's four priorities for 2016-17 and make the following comment on each: -

- We note that Priority One (*Clinical Effectiveness – Continuing Professional Development*) applies both to St Barnabas's own staff and to the staff of other health care providers. We particularly welcome the initiative whereby three end-of-life care facilitators will be located in the three main hospitals. We look forward to this leading to improvements in patient care in all settings for Lincolnshire patients.
- We strongly support Priority Two *(Falls Prevention and Reducing Pressure Damage)*. Any progress in these areas will be of benefit to end of life patients.
- We accept that Priority Three *(Information Management and Technology Systems Review)* will lead to improved data and reporting, improving the clinical effectiveness of the organisation.
- We strongly support Priority Four (*Implementation of a Dementia Strategy*). Addressing the particular needs of patients with dementia at the end of their life is welcome and we welcome any progress in this area.

Achievements During 2015-16

We note that the Care Quality Commission (CQC) inspected the in-patient palliative care unit in Lincoln on 29 March 2016. We are pleased that the CQC found that the unit in Lincoln was rated good overall and we are particularly impressed by the summary in the CQC's report, which recorded people being unanimously positive about the care they have received; high levels of respect for people's dignity and privacy; and the high level of care provided by staff, as well as their expertise. We congratulate St Barnabas on this CQC report.

We would also like to congratulate St Barnabas's Welfare Benefits Service on supporting over 3,800 people to claim benefits of over £7.7 million in the last year, which represents an average monetary gain per patient of just over £2,000. The importance of ensuring patients do not suffer undue financial hardship cannot be stressed enough.

Engagement with the Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee has continued to engage with St Barnabas Hospice during the last year and looks forward to further engagement in the coming year. The Committee continues to recognise the contribution of St Barnabas to innovation in palliative care.

Presentation and Accessibility of Information to the Public

We believe that the Quality Account includes clear statements on progress with each of last year's priorities; and a clear rationale for the selection of priorities for 2016/17. We understand that the final version of the Quality Account will clearly separate its chapters, so it is clear for all readers.

We also note that St Barnabas has put in place arrangements for monitoring progress with priorities in the Quality Account in the coming year.

Conclusion

We would like to congratulate St Barnabas Hospice on its achievements over the last year and the outstanding work undertaken by the organisation.

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 Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 September 2016**
Subject:	**Work Programme**

Summary:

This item invites the Committee to consider and comment on its work programme.

Actions Required:

To consider and comment on the content of the work programme.

1. The Committee's Work Programme

The work programme for the Committee's meetings over the next few months is attached at Appendix A to this report, which includes a list of items to be programmed.

Set out below are the definitions used to describe the types of scrutiny, relating to the proposed items in the work programme:

Budget Scrutiny - The Committee is scrutinising the previous year's budget, the current year's budget or proposals for the future year's budget.

Pre-Decision Scrutiny - The Committee is scrutinising a proposal, prior to a decision on the proposal by the Executive, the Executive Councillor or a senior officer.

Performance Scrutiny - The Committee is scrutinising periodic performance, issue specific performance or external inspection reports.

Policy Development - The Committee is involved in the development of policy, usually at an early stage, where a range of options are being considered.

Consultation - The Committee is responding to (or making arrangements to respond to) a consultation, either formally or informally. This includes pre-consultation engagement.

Status Report - The Committee is considering a topic for the first time where a specific issue has been raised or members wish to gain a greater understanding.

Update Report - The Committee is scrutinising an item following earlier consideration.

Scrutiny Review Activity - This includes discussion on possible scrutiny review items; finalising the scoping for the review; monitoring or interim reports; approval of the final report; and the response to the report.

In considering items for inclusion in the Committee's work programme, Members of the Committee are advised that it is not the Committee's role to investigate individual complaints or each matter of local concern.

2. Conclusion

The Committee is invited to consider and comment on the content of the work programme.

3. Consultation

There is no consultation required as part of this item.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Health Scrutiny Committee Work Programme

5. 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 Simon Evans, who can be contacted on 01522 553607 or simon.evans@lincolnshire.gov.uk

APPENDIX A

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE

Chairman: Councillor Mrs Christine Talbot
Vice Chairman: Councillor Chris Brewis

21 September 2016		
Item	**Contributor**	**Purpose**
United Lincolnshire Hospitals NHS Trust – Temporary Closure of Accident and Emergency at Grantham Hospital	Jan Sobieraj, Chief Executive, United Lincolnshire Hospitals NHS Trust and/ or Suneil Kapadia, Medical Director, United Lincolnshire Hospitals NHS Trust	Position Statement
Urgent Care Update	Gary James, Accountable Officer, Lincolnshire East Clinical Commissioning Group Ruth Cumbers, Director of Urgent Care, Lincolnshire East Clinical Commissioning Group	Update Report
Lincolnshire Cancer Strategy	Sarah-Jane Mills, Director of Delivery and Development, Lincolnshire West Clinical Commissioning Group	Update Report
East Midlands Ambulance Service NHS Trust – Response to the Care Quality Commission Report	Richard Henderson, Acting Chief Executive, East Midlands Ambulance Service NHS Trust Blanche Lentz, Lincolnshire Divisional Manager, East Midlands Ambulance Service NHS Trust	Update Report
Congenital Heart Disease – East Midlands Congenital Heart Centre	Simon Evans, Health Scrutiny Officer	Update Report
APMS Surgeries in Lincolnshire West Clinical Commissioning Group Area	Simon Evans, Health Scrutiny Officer	Position Statement

21 September 2016		
Item	**Contributor**	**Purpose**
Quality Accounts 2015-16 – Priorities and Comments of the Health Scrutiny Committee	Simon Evans, Health Scrutiny Officer	Status Report

26 October 2016		
Item	**Contributor**	**Purpose**
Lincolnshire Partnership NHS Foundation Trust – Update on Response to Care Quality Commission Report	John Brewin, Chief Executive, Lincolnshire Partnership NHS Foundation Trust	Update Report
Lincolnshire East Clinical Commissioning Group - Update	To be confirmed.	Update Report
Making Arrangements for Winter Resilience 2016/17	To be confirmed	Update Report
Dental Services Contracts in Lincolnshire	Jane Green, Assistant Contract Manager, Dental and Optometry, NHS England – Midlands and East (Central Midlands)	Status Report

23 November 2016		
Item	**Contributor**	**Purpose**
Joint Health and Wellbeing Strategy – Annual Assurance Report	David Stacey, Programme Manager – Strategy and Performance, Lincolnshire County Council Alison Christie, Programme Manager – Health and Wellbeing, Lincolnshire County Council	Update Report

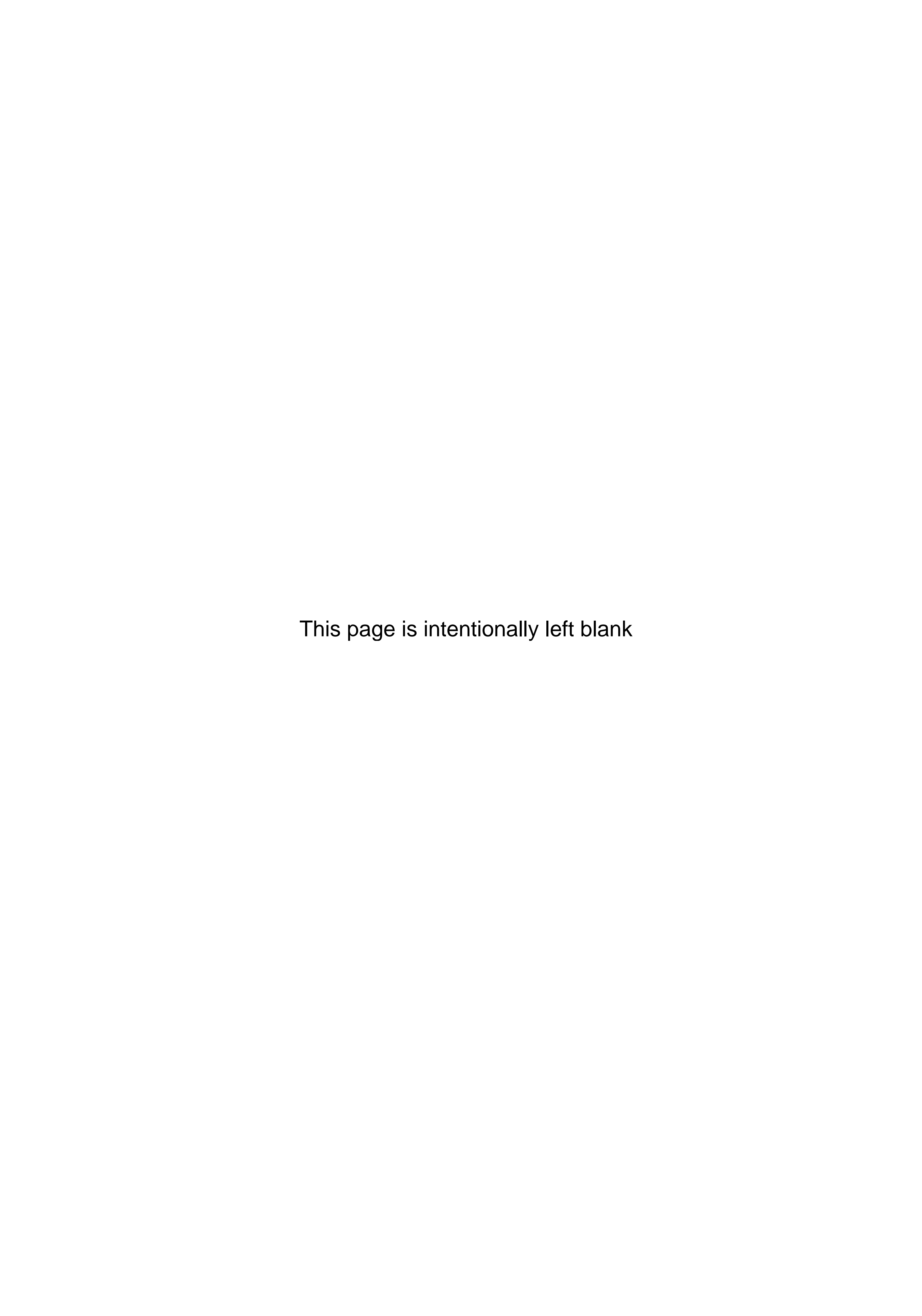
23 November 2016		
Item	**Contributor**	**Purpose**
United Lincolnshire Hospitals NHS Trust - Pharmacy Services	Colin Costello, Director of Pharmacy and Medicines Optimisation, United Lincolnshire NHS Trust	Update Report
Queen Elizabeth Hospital, King's Lynn, General Status Report	To be confirmed	Status Report

21 December 2016		
Item	**Contributor**	**Purpose**
Lincolnshire West Clinical Commissioning Group Update	Sarah Newton, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group	Status Report
Lincolnshire Sustainability and Transformation Plan / Lincolnshire Health and Care – Consultation	To be confirmed	Consultation

Items to be programmed

- Reducing Obesity in Adults and Children
- Dementia and Neurological Services
- Lincolnshire East CCG Update
- South West Lincolnshire CCG Update
- South Lincolnshire CCG Update
- Reducing Alcohol Harm in Lincolnshire - Update on Services Report *(No earlier than January 2017)*
- St Barnabas Hospice *(Feb 2017)*
- Butterfly Hospice

For more information about the work of the Health Scrutiny Committee for Lincolnshire please contact Simon Evans, Health Scrutiny Officer, on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk


This page is intentionally left blank