| Lincolnshire COUNTY COUNCIL *Working for a better future* | | **THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE** | |
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| 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 |

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**A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 13 September 2017 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL**

**MEMBERS OF THE COMMITTEE**

County Councillors: C S Macey (Chairman), Mrs K Cook, M T Fido, R J Kendrick, R A Renshaw, Dr M E Thompson, M A Whittington and R H Woolley

District Councillors: P Gleeson (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 P Howitt-Cowan (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

## AGENDA

| Item | Title | Pages |
|---|---|---|
| 5 | **Grantham Hospital Accident and Emergency Department: Outcome of Referral to the Secretary of State for Health**<br>*(To receive a report from Simon Evans (Health Scrutiny Officer), which asks the Committee to consider the determination of the Secretary of State for Health on the overnight closure of the Grantham Accident and Emergency Department; and the latest information from United Lincolnshire Hospitals NHS Trust regarding their staffing levels for emergency care. Jan Sobieraj (Chief Executive of United Lincolnshire Hospitals NHS Trust) and Dr Neill Hepburn (Trust's Medical Director) will be in attendance for this item)* | 21 - 52 |
| 6 | **Emergency Ambulance Commissioning**<br>*(To receive a report from the Lincolnshire West Clinical Commissioning Group, Lead Commissioner of Emergency Ambulance Services in Lincolnshire, which provides the Committee with an overview on how emergency ambulances are commissioned from the East Midlands Ambulance Service. Martin Kay (Head of Commissioning, Lincolnshire West Clinical Commissioning Group) will be in attendance for this item)* | 53 - 56 |
| 7 | **East Midlands Ambulance Service: Outcomes of Care Quality Commission Inspection and Ambulance Response Programme**<br>*(To receive a report from Simon Evans (Health Scrutiny Officer), which invites the Committee to consider information from the East Midlands Ambulance Service, following the publication of the Inspection report by the Care Quality Commission; and to also consider information relating to the Ambulance Response Programme. Richard Henderson (Chief Executive of the East Midlands Ambulance Service) and David Williams (General Manager of the East Midlands Ambulance Service will be in attendance for this item)* | 57 - 92 |
| 8 | **Health Scrutiny Committee for Lincolnshire - Work Programme**<br>*(To receive a report from Simon Evans (Health Scrutiny Officer), which invites the Committee to consider and comment on its work programme).* | 93 - 98 |

Tony McArdle
Chief Executive
5 September 2017

**HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**
**19 JULY 2017**

**PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)**

Lincolnshire County Council

Councillors Mrs K Cook, M T Fido, R J Kendrick, R A Renshaw, Dr M E Thompson and M A Whittington.

Lincolnshire District Councils

Councillors P Gleeson (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)) and Mrs R Kaberry-Brown (South Kesteven District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

John Brewin (Chief Executive, Lincolnshire Partnership NHS Foundation Trust), Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Dr Sunil Hindocha (Chief Clinical Officer, Lincolnshire West Clinical Commissioning Group (LWCCG)), Gary James (Accountable Officer, Lincolnshire East CCG), Ian Jerams (Director of Operations, Lincolnshire Partnership NHS Foundation Trust), Jan Sobieraj (Chief Executive, United Lincolnshire Hospitals NHS Trust), Chris Weston (Consultant in Public Health (Wider Determinants)), Wendy Martin (Executive Lead Nurse and Midwife Quality and Governance, Lincolnshire West CCG) and Michelle Rhodes (Director of Nursing, United Lincolnshire Hospitals NHS Trust).

11 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors R H Woolley (Lincolnshire County Council) and P Howitt-Cowan (West Lindsey District Council).

An apology for absence was also received from Councillor Mrs S Woolley (Executive Councillor NHS Liaison and Community Engagement).

12 DECLARATIONS OF MEMBERS' INTEREST

Councillor Mrs P F Watson advised the Committee that she was currently a patient of United Lincolnshire Hospitals NHS Trust.

Councillor Mrs K Cook also advised the Committee that she was currently a patient of Lincolnshire Partnership NHS Foundation Trust.

13 MINUTES OF THE MEETING OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE HELD ON 14 JUNE 2017

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 14 June 2017 be approved and signed by the Chairman as a correct record.

14 CHAIRMAN'S ANNOUNCEMENTS

The Chairman welcomed to the Committee, advisors Gary James, Accountable Lincolnshire East Clinical Commissioning Officer and Chris Weston, Consultant in Public Health (Wider Health Determinants).

The Chairman advised the Committee that there were no further updates to those already circulated. The Committee was however invited to consider whether they wished to respond to any of the proposed GP mergers (Items 2, 3 and 4 of the Chairman's Announcements documents circulated as part of the agenda).

Following a short discussion, it was agreed that a response should be made to Item 2 - The Proposed Merger of GP Surgeries in Coningsby, Louth and Tetford; and that a working group should be established to formulate a response.

Some reference was also made to the additional A & E funding for United Lincolnshire Hospitals NHS Trust. Confirmation was received that the funding was capital funding for buildings to NHS providers for the provision of Primary Care Streaming Services. The Committee was also advised that as Grantham Hospital already had primary care provision, they were not eligible for the funding.

RESOLVED

1. That the Chairman's Announcements presented be noted.

2. That a small working group be established to formulate a response to the formal consultation of the proposed merger of GP Surgeries in Coningsby, Louth and Tetford.

15 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST - CARE QUALITY COMMISSIONING REPORT APRIL 2017

The Committee gave consideration to a report from Jan Sobieraj, Chief Executive, United Lincolnshire Hospitals NHS Trust, which advised on the progress made since the Care Quality Commission (CQC) had published their findings on 11 April 2017; following a partial inspection at Lincoln County Hospital, Pilgrim Hospital Boston and Grantham Hospital in October 2016; and an unannounced inspection in December 2016 at Pilgrim Hospital Boston.

Details of the CQC ratings for each site were detailed in Appendix A to the report.

The key concerns highlighted by the CQC had related to:-

- governance, which included serious incident management;
- medicines management;
- failure to meet national access standards for A & E; cancer and referral for treatment;
- identifying vulnerable adults and responding to their care needs;
- staff morale and managerial supervision; and
- board level oversight.

It was noted that the Trust had been asked to respond to a number of concerns in a prompt manner. It was noted further that substantial progress had been made against these issues; and as a result the issues had been incorporated into the Trust's forward plan. Details of the issues raised and progress made against each issue was contained within the report presented.

Trust representatives expressed their disappointment to the outcomes of the CQC report; but also recognised that the Trust could do better. It was highlighted that staff shortages within the Trust had resulted in some issues taking longer to resolve. Despite operational issues, the Trust was making good progress and reassurance was given that if CQC inspectors conducted an inspection now, they would be looking at a different organisation. Working with partners, the Trust would continue to make progress to improve quality and safety.

During discussion, members of the Committee raised the following points:-

- Some members felt that the Trust should promote its good working achievements more. Particular reference was made to 'Surgery', which had achieved good CQC ratings in each category. Good news stories reflected on Lincolnshire as a whole; and better promotion might help with recruitment going forward. One member stressed that there was a need to communicate in Plain English to the residents of Lincolnshire.

  It was also highlighted that the Trust needed to keep residents aware of what was going on to improve the Trust's CQC ratings; and that this should be conveyed in Plain English also, this would then ensure community buy in. It was highlighted further that awareness of the CQC's rating evaluation method

needed to be defined and communicated better. Clarification was given that the CQC's 'N/A' in this context meant 'Not Available';

- The non-inclusion of Delayed Transfers of Care (DTOC). It was reported that the CQC inspection did not focus on DTOCs; in any event, overall DTOCs were not an issue at the moment. The percentage was at 4.1%, but had been as low as 3.6%;
- An explanation of the CQC rating pertaining to 'Maternity and Gynaecology' in relation to Pilgrim Hospital Boston, when the Sustainability & Transformation Plan (STP) had included a reference to consideration of the discontinuation of such services on safety grounds, yet the CQC report had given Maternity and Gynaecology a good rating in the 'Safe' domain. The Director of Nursing United Lincolnshire Hospitals NHS Trust explained that this was due to a shortage of paediatric nurses at Pilgrim Hospital Boston, but that Pilgrim Hospital Boston had systems and processes in place to mitigate the situation, i.e. being able to close beds and cots down better than the Lincoln County Hospital site. The Director of Nursing advised that the Trust currently needed 375 nursing staff. Details of the Trust vacancies had been reported to the Trust Board in the previous month; and the Trust was happy to share this information with members of the Committee. Confirmation was given that there was not a shortage of midwifes, it was a lack of paediatric nurses that was the issue. The Committee noted that the Trust worked closely with the University to help fill some of the vacancies. The Committee noted further that work was being carried out with regard to a 'talent academy' and that there were open days with schools encouraging young people to come into the health profession.

  It was noted further that the Trust would be looking at the team around the patient, which would involve all disciplines providing care;

- One member expressed disappointed that the Trust was back in special measures; and felt for the Trust to improve it needed to be well led and operate in safe manner; a question was asked as to whether the management team would be able to succeed in this task; and when was it hoped the turnaround would be achieved. The Chief Executive explained that for the first time since his arrival in December 2015, he was now heading a team of substantive (rather than interim) Directors, who would be supporting him to reduce the overspend; improve the quality and safety of patient care; and improve support to staff. The Committee noted that a structural shift was planned to provide better care in the community; and the need for the STP to work effectively. With regard to when the Trust would be out of special measures, this was up to the CQC; and at the moment the Trust was unsure when this would be. An estimated timescale quoted was 2018 and beyond;
- Some concern was expressed as to whether the hospital was safe; due to the number of CQC ratings provided being 'Inadequate' or 'Requires Improvement'. It was highlighted that it was the level of detail behind the CQC rating; some were specific to a particular ward. These specifics were now being tracked. An example given was that as a piece of equipment was found to be out of date at Lincoln County Hospital, this had then resulted in a score of 'Inadequate' the Committee was advised that the Trust was working with

others outside of Lincolnshire; an example of Morecambe Bay was cited as they had achieved 'Outstanding Status' and the Trust was looking at their working practices, with a mind to introducing similar practices in Lincolnshire;

- Progress of the STP - It was noted that wider considerations for Lincolnshire were dependent on the STP. It was reported that health and social care staff were working closer together to reduce the need for patients to be admitted to hospital; and that a shift was being made to Neighbourhood Teams with more care being provided in the community. Reference was also made to the supported housing trials. The Trust had expressed support for the use of technology which would assist someone being looked after in their own home;
- Culture and Development – The Committee noted that work was in progress to improve staff culture and development; confirmation was given that any member of staff wishing to raise a concern was able to do it through the Freedom to Speak up Guardian (this was a neutral person outside of the management team). The Trust was also monitoring awareness and usage of this route;
- Some reference was made to fact that the Pilgrim Hospital Boston was struggling in relation to its 'Medical Care'. The Committee was advised that Boston Hospital Boston had the largest number of vacancies and most of them were in medicine. It was noted that since the CQC inspection there had been a lot of changes in these areas; and
- Walk-in-Centre Consultation – The Committee noted that the Trust was working together with Lincolnshire West Clinical Commissioning Group concerning the detail of what was involved, particularly with regard to A & E provision at Lincoln County Hospital. The Trust was still to make its response.

In conclusion, the Committee enquired as to how areas of improvement would be reviewed. The Trust agreed to send a copy of the full plan to all members of the Committee. The Committee agreed that an update report should be received twice a year where appropriate.

The Chairman extended thanks to the Chief Executive and the Director of Nursing for their report and attendance.

RESOLVED

1. That the findings of the Care Quality Commission in relation to United Lincolnshire Hospitals NHS Trust be noted.

2. That the Committee's assurance be recorded in relation to United Lincolnshire Hospitals NHS Trust and its progress since the inspection in October 2016, and its future plans for improving quality and safety.

3. That updates on the progress from United Lincolnshire Hospitals NHS Trust be presented to the Health Scrutiny Committee for Lincolnshire twice a year where appropriate.

16 LINCOLN WALK IN CENTRE - CONSULTATION BY LINCOLNSHIRE WEST CLINICAL COMMISSIONING GROUP

The Chairman on behalf of the Committee welcome to the meeting Dr Sunil Hindocha, Chief Clinical Officer, Lincolnshire West Clinical Commissioning (LWCCG) Group and Wendy Martin, Executive Lead Nurse and Midwife Quality and Governance, LWCCG.

The Committee received a short joint presentation from the Chief Clinical Officer LWCCG and the Executive Lead Nurse and Midwife Quality and Governance LWCCG, which provided some background information to the Walk-in-Centre; the alternative services available for urgent and routine primary care requirements; provided information of user groups of the Walk-in-Centre; and provided confirmation concerning the communications campaign.

During discussion, the Committee raised the following comments:-

- Contract expiry date – The Committee was advised that the contract had already been extended several times previously. The current contract was due to expire on 30 September 2017. From the feedback received so far, it had become apparent that very few people were aware of the alternative provision available. The Committee was advised that urgent access to health services was already available through GP surgeries and NHS 111. For less urgent health issues, these could be addressed by a routine appointment with a GP, or health advice from a Pharmacy. If assistance was needed 'Out of Hours' patients would be able to access urgent GP services through calling 111; it was also highlighted that many GP surgeries also ran minor illness clinics which were run by Advanced Nurse Practitioners. For parents with children, GPs would be providing a separate phone line for them to use.

  It was also reported that 25 GPs had been recruited to Lincolnshire from GP International Recruitment Scheme; seven of whom were now based in practices in the Lincoln area;
- The financial viability of the proposal and the impact on A & E – Some concern was expressed as to the financial viability of the proposal, as it was suggested that the financial appraisal would follow the consultation. The Committee was advised if the Walk-in-Centre were to close, national survey data indicated that 20% - 30% of patients stated that in such circumstances they would present themselves to A & E; however evidence from elsewhere, where walk-in-centres had closed, suggested that the actual number presenting to A & E was much lower. It was highlighted that the LWCCG had realised that there was more to do to educate people not to attend to A & E unless it was an emergency. The Committee was advised further that actual figures of patients diverting to A & E were estimated as being between 2% – 3%. It was confirmed that a modelling exercise had been conducted;
- What happened following the consultation – It was reported that the consultation would now conclude on 18 August 2017. All comments received

would be reviewed and taken in to account for a final recommendation to the Governing Body. A final decision would be made in September 2017;

- What alternative provisions would be made if a decision was made to close the Walk-in-Centre – It was highlighted that promotional work of alternative provisions had already been included on BBC Radio Lincolnshire. Irrespective of the outcome of the Walk-in-Centre consultation, a campaign had already started to advise the public of the different routes to routine primary care, urgent primary care, emergency care and self-care. Also, educational information was being provided at GP practices and public places.

  Some concern was expressed to patients seeking advice from pharmacists for minor ailments, as some pharmacists were under threat.

  Reassurance was given that the CCG worked very closely with the pharmacists, and confirmation was given that clinical pharmacists were expected to support general practice in the future.

  Further concern was expressed with regard to encouraging more self-care. Some members felt this was satisfactory for minor ailments, but for those patients with more serious conditions, patients should be given the time and care needed. The Committee was advised that self-care was available through a support network; in conjunction with information on the website. Some members felt that the use of any website offering health advice in some instances could cause patients more anguish.

  Reassurance was sought from members of the Committee that if the Walk-in-Centre was to close, that alternative services would be able to cope with the extra workload, some of the points raised included:-

  - That there needed to be improved access for patients having to explain their personal information to receptionists face to face. The Committee noted that all practices had a confidential area that patients could request to use to discuss matters of a personal nature;
  - That a period of transition should be maintained to allow patients to become fully aware of the alternative options available;
  - The Committee welcomed the installation of a children's line;
  - Transferring patient's records. The Committee noted that most were now done electronically;
  - Clarification was sought as to the arrangements for patient registration. It was reported that a patient would register once at their main GP practice; and that registration elsewhere would only be temporary;
  - More awareness for service users of the alternative services available. Reassurance was given that support would be given to support people to meet their needs;
  - Clarification was sought as to who the main user group was. The Committee was advised that students comprised the main user group of the Walk-in-Centre;

- The potential increased use of A & E;
- The lack of confidence in the NHS 111 option due to some members of the Committee's personal experiences; and

- Some concern was also expressed relating to the inadequacy of the consultation, due to the lack of information relating to models of alternatives; that no firm costs had been made available relating to the proposed changes. The Committee felt that it was very hard to make a measured decision on the information provided. It also felt that the whole process had not been planned sufficiently.

In conclusion, the Committee was not satisfied firstly with the inadequacy of the consultation, in terms of the overall information provided and its availability; secondly that that there would not be suitable alternative arrangements in place, if the Walk-in-Centre were to close, as what was proposed currently would not create a back to back replacement of the service currently provided, or provide an enhanced service. The Committee also felt that the closure of the Walk-in-Centre would in all probability add pressure on to the A & E Department at Lincoln County Hospital.

At the conclusion of this item, two documents were circulated: *Lincoln Walk-in-Centre Data Summary for 2015-2017;* and a revised version of the *Frequently Asked Questions.*

RESOLVED

1. That the Committee's concern be recorded that the alternative arrangements suggested in the event of the Lincoln Walk-in-Centre's closure would not be acceptable as suitable alternative arrangements, as they would not provide a seamless replacement or alternative service; or an enhancement of the service currently provided.

2. That the Committee's concern with the adequacy of the Lincoln Walk-in-Centre Consultation be recorded; and that the Committee record the view that the matter might need to be referred to the Secretary of State for Health.

3. That a further meeting of the Working Group be arranged to formulate a response on behalf of the Committee to the Lincoln Walk-in-Centre Consultation.

17 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST - UPDATE

Consideration was given to a report from John Brewin, Chief Executive of Lincolnshire Partnership NHS Foundation Trust, which provided the Committee with an overview of the current issues within the Trust, and an update on recent feedback from the Care Quality Commission (CQC) re-inspection. Ian Jerams, Director of Operations Lincolnshire Partnership NHS Foundation Trust and Jane Marshall, Director of Strategy & Performance Lincolnshire Partnership NHS Foundation Trust were also in attendance at the meeting.

The Committee was advised that the Trust had undergone a full CQC re-inspection in April 2017; and had been rated overall as 'good'. Details of the particular areas of progress since the initial inspection in 2015 were that:-

- Services in the 'safe' domain had improved from inadequate;
- The 'well led' domain had improved to good;
- The Community Children and Adolescent Services (CAMHS) had continued to be rated as outstanding; and
- The CQC had noted the transformation across the Trust in a short period of time; resulting in a positively engaged workforce; and good staff morale.

Further information relating to the achievements of the Trust and the measures that contributed to the Trust's improvement were contained in Appendix A to the report.

It was reported that the Service Developments going forward included:-

- Proposals to address the out of area bed use. The Committee noted that approximately 300 patients were receiving treatment out of county in 2015/16;
- That a Psychiatric Intensive Care Unit (PICU) unit had opened earlier in July. The facility provided ten beds for men with acute and severe illness. It was highlighted that an equivalent women's unit was proposed to be opened by the end of 2018; and
- Other developments included a Clinical Decisions Unit, investment in more intensive crisis and home treatment services; and the creation of a community based rehabilitation service.

The report also provided the Committee with details of the Five Year Forward View for Mental Health and Learning Disability, which was a national document that contained key objectives that needed to be in place by 2020/21. Particular reference was made to the expansion of psychological services, improving access to psychological therapies for both people with long term conditions and children and young people.

It was highlighted that for 2016/17 the Trust had met all its financial targets and the majority of the other performance and quality indicators. It was highlighted further that as the Trust had recorded a small surplus above the Control Total set by NHS Improvement of c£700k on a budget of £100m, the Trust would receive an additional bonus from the national Sustainability and Transformation Fund, and that this could be used to support on-going capital programmes.

The Committee was advised the most significant target that had not been met related to Delayed Transfers of Care. It was noted that these had reduced, but remain challenging in older adult services, due to a lack of appropriate placements.

The Chairman on behalf of the Committee congratulated the Trust on its achievements.

During discussion, the Committee raised the following points:-

- The Committee welcomed the report and the positive comments contained within;
- One member enquired as to why the male Psychiatric Intensive Care Unit (PICU) had been completed first. The Committee was advised that this was due to a higher number of men out of County requiring this secure facility compared to women and to the fact that the Trust only had limited resources available. It was hoped that the successful opening of the male unit would provide impetus for the development of the female unit;
- The Committee received a short explanation as to how the Trust had re-designed Ash Villa to comply with the 'same-sex' accommodation requirements;
- Staff issues at the new PICU. The Trust advised that staff had been employed in advance of the PICU opening were now working in other wards; however, a significant number of new qualified staff would be in place in August and that currently the unit was bridging the gap by using bank staff;
- Staff Morale, how did the Trust know that it was continually improving – The Committee noted that 60% of staff had responded to the staff survey; and the Trust had achieved the most improved Mental Health Trust rating;
- Support for Volunteers – The Trust advised that this area had been recently reviewed; and the previous Volunteer Manager post had been reviewed and bench marked against other Trusts;
- One member enquired as to whether the Council received income from out of Lincolnshire residents using Lincolnshire services. The Committee was advised that there were very few out of County patients in Lincolnshire. If there was an acute emergency admission required, this would be commissioned through NHS England on a regional basis. It was confirmed that Clinical Commissioning Groups bore the financial cost for out of County beds. It was confirmed that as Lincolnshire did not have some specialist services as there was not the volume of cases. An example given was a mother and baby unit, the Committee noted that there was good working relationship in place with Nottingham to use their facilities in these instances;
- Vacancy rates – The Trust confirmed that this was an issue in Lincolnshire, particularly with an ageing workforce. The Committee was advised that focus was being made on recruitment and retention;
- Provision of Supported Housing Outreach Workers – It was reported that the Trust would like to expand the service where there was a case; and that the Trust would only be able to do this if they got extra resources; and
- The Trust confirmed they worked very closely across the County with Neighbourhood Teams, the Community Trust; and GPs.

RESOLVED

That the Lincolnshire Partnership NHS Foundation Trust – Update be noted.

18 JOINT HEALTH AND WELLBEING STRATEGY PRIORITISATION

Consideration was given to a report from Simon Evans (Health Scrutiny Officer), which provided the Committee with a draft statement from the Working Group established at the 14 June 2017 meeting to select which themes merited prioritisation for the purposes of drafting the revised Joint Health and Wellbeing Strategy.

Attached at Appendix A to the report was a copy of the Working Groups Draft Statement of Prioritisation of the Themes in the Joint Strategic Needs Assessment for Inclusion in the Joint Health and Wellbeing Strategy for the Committee's consideration.

During a short discussion, the Committee agreed to a minor change being made to Appendix A under the heading of Road Traffic Collisions, last sentence being amended to read "They also highlighted the importance of maintenance of road signs to ensure all signage is clearly visible on rural roads in the County"

A request was also made from the Committee for the Joint Health and Wellbeing Strategy to be included in the Committee's future work programme.

RESOLVED

1. That the statement attached at Appendix A be approved subject to the last sentence under the heading Road Traffic Collisions being amended to read "They also highlighted the importance of maintenance of road signs to ensure all signage is clearly visible on rural roads in the county."

2. That the Joint Health and Wellbeing Strategy be included as a future item in the Committee's work programme.

19 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

Consideration was given to a report from Simon Evans (Health Scrutiny Officer), which enabled the Committee to consider and comment on the content of its work programme to ensure that scrutiny activity was focussed where it could be of greatest benefit.

Appendix A to the report provided the work programme from July 2017 to April 2018 for the Committee's consideration.

The Committee was invited to highlight any additional scrutiny activity which could be included for consideration in the work programme.

Items suggested for inclusion by members of the Committee were as follows:-

- Grantham A & E Department – Overnight Closure – Outcome of Referral to the Secretary of State for Health;

- North West Anglia NHS Foundation Trust – Update on Peterborough City Hospital and Stamford & Rutland Hospital;
- Immunisation and Screening;
- Joint Strategic Needs Assessment;
- Lincoln Walk-in-Centre – Report on decision made by Lincolnshire West Clinical Commissioning Group;
- Update on the progress from Lincolnshire Hospitals NHS Trust to be presented to the Committee twice a year (Minute number 15(3) refers); and
- Update on the Joint Health and Wellbeing Strategy (Minute number 18(2) refers).

RESOLVED

1. That the items as detailed above be included as future items for consideration in the work programme.

The meeting closed at 1.45 p.m.

| Lincolnshire COUNTY COUNCIL Working for a better future | | THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE | |
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| 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 |

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| Report to | **Health Scrutiny Committee for Lincolnshire** |
| Date: | **13 September 2017** |
| Subject: | **Chairman's Announcements** |

**1. Decision by Secretary of State for Health on Grantham Accident and Emergency Department**

On 2 August 2017, the Secretary of State for Health issued his decision on the referral by the Committee of the overnight closure of Grantham Accident and Emergency Department. This is the subject of a full report on this agenda.

**2. Lincoln Walk-in-Centre – Consultation on Future Arrangements**

Following consideration by the Committee on 19 July and a further meeting of the Committee's working group on 1 August, the response of the Health Scrutiny Committee for Lincolnshire to the consultation on the future of the Lincoln Walk-in-Centre was submitted to Lincolnshire West Clinical Commissioning Group on 17 August 2017.

It is understood that Lincolnshire West Clinical Commissioning Group will be making a decision on the consultation at its governing body meeting on 27 September. This decision will be reported to the Health Scrutiny Committee on 11 October 2017. A meeting of the Committee's working group has been programmed for Thursday 5 October 2017.

**3. GP Mergers – Louth and Surrounding Area - Consultation**

On 19 July 2017, the Health Scrutiny Committee was advised of consultations on several proposed mergers of GP surgeries throughout Lincolnshire. In relation to two of the proposals, the Committee expressed an interest in submitting a response to the consultations and agreed to form a working group to do so. The first of these consultations relates to the proposed merger of New Coningsby Surgery, Coningsby; Newmarket Medical Practice, Louth; and the Wolds Practice,

Tetford. The second consultation relates to the proposed merger of James Street Family Practice, Louth; and the Kidgate Surgery, Louth.

On 19 July, one member of the Committee expressed an interest in joining the working group and for this reason a working group has not progressed. If the Committee wishes to confirm that it would like to make a response to these two consultations, an option is for the Chairman to do so on the Committee's behalf. Members of the Committee could provide their suggestions to the Chairman prior to the response.

The first consultation closes on 25 September and the second closes on 9 October 2017.

**4. Northern Lincolnshire and Goole NHS Foundation Trust – Urology and Ear, Nose and Throat Service**

On 25 July 2017, Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) Board made a decision on two services, which affect a small number of Lincolnshire patients: Urology and ENT (ear, nose and throat). It was reported to the NLAG Board that both of these services were facing critical workforce challenges. Despite repeated and continual focused efforts to recruit to vacant consultant posts in these services the Trust has been unsuccessful.

In relation to Urology, to deliver are safely on a 24/7 basis NLAG needs six consultants to provide emergency and planned care at Both Scunthorpe and Grimsby. The service has seen a significant turnover in consultants and has been reliant on long term locums who have now moved on. Safe emergency care could not be maintained across two hospital sites on a 24/7 basis with just three consultants. The NLAG Board decided that a 24-hour, seven day a week emergency urology service will now be provided at Scunthorpe General Hospital only.

In relation to ENT, to deliver care safely 24/7 the Trust needs five consultants. The service is operating safely with extra capacity provided by another Trust. Due to the capacity issues the service is already alternating on-call cover between the two main hospital sites resulting in patients being transferred between sites out of hours. From September, all inpatient ENT services have been provided from Grimsby hospital (adult and paediatric, elective and non-elective).

**5. NHS England Consultation on "Wasteful and Ineffective" Drug Treatments**

On 21 July 2017, NHS England published detailed plans to cut out prescriptions for 'ineffective, over-priced and low value' treatments. A formal public consultation is being launched on new national guidelines which state that 18 treatments - including homeopathy and herbal treatments - which together cost taxpayers £141 million a year should generally not be prescribed.

In addition the consultation also covers a further 3,200 prescription items, many of which are readily available and sold ‘over the counter’ in pharmacies, supermarkets, petrol stations, corner shops and other retailers, often at a

significantly lower price than the cost to the NHS.

The consultation proposes initial action to limit prescribing of products for minor self-limiting conditions which currently cost taxpayers £50-£100 million a year. The products include cough mixture and cold treatments, eye drops, laxatives and sun cream lotions.

NHS England has stated that the consultation is being nationally co-ordinated but also encompasses a local element, is addressed to all CCGs, the public and patients, and any relevant interest group or body. It will be open for three months from 21 July until 21 October 2017.

## 6. Annual General Meetings / Annual Public Meetings

Set out below is a table showing the annual general meetings / annual public meetings of the Lincolnshire-based NHS organisations:

| Date / Time | Venue | Organisation |
|---|---|---|
| Thu 14 Sept<br><br>1.30 – 4 pm | Learning and Development Centre, Unit 3, The Reservation, East Road, Sleaford NG34 7BY | Lincolnshire Partnership NHS Foundation Trust |
| Tues 19 Sept<br>5 pm | Jubilee Church Life Centre, 1-5 London Road, Grantham, NG31 6EY | South West Lincolnshire CCG |
| Tues 19 Sept<br>4.00 – 6.00 pm | Maple Seminar Room, Beech House, Witham Park, Waterside South, Lincoln, LN5 7JH | Lincolnshire Community Health Services NHS Trust |
| Fri 22 Sept<br>3pm – 5pm | Travis Perkins Suite, Lincoln City Football Club, Sincil Bank, Lincoln, LN5 8LD | United Lincolnshire Hospitals NHS Trust |
| Thu 28 Sept<br>2.00 – 4.30 pm | The Dower House Hotel, Woodhall Spa, LN10 6PY. | Lincolnshire East CCG |
| Thu 28 Sept<br><br>5pm | Springfield Events Centre, Camelgate, Spalding PE12 6ET. | South Lincolnshire CCG |
| Wed 25 Oct<br>3.30 pm | Showroom, Tritton Road, Lincoln, LN6 7QY | Lincolnshire West CCG |

## 7. Expansion of the International GP Recruitment Programme

The *General Practice Forward View*, published by NHS England in April 2016, included a commitment for 5,000 more doctors and 5,000 other health professionals like clinical pharmacists, nurses, and physician associates in general practice by 2020.

On 22 August 2017, NHS England announced that while GP training places are increasing year-on-year and many GPs are returning to practice, many practices continue to face recruitment issues, and newly qualified GPs often prefer to work as a locum rather than joining a practice as a permanent GP. As a result of this, NHS England is working with partners to increase targeted international recruitment to a total of 2,000 overseas doctors over the next three years.

NHS England has stated that it will follow the World Health Organisation Global Code of Practice on the International Recruitment of Health Personnel and all doctors will need to meet the highest standards of practice and speak good English. NHS England will be seeking look to attract UK-trained doctors back to the UK wherever possible and target those countries where there is likely to be the best chance of affordable supply.

## 8. Expansion of Undergraduate Medical Education

On 9 August 2017, the Department of Health announced the outcome of its consultation on the *Expansion of Undergraduate Medical Education*, which had taken place between 14 March and 2 June 2017. In the consultation document, the Department for Health had set out the case for increasing the number of domestic students entering medical schools in England, with plans for an immediate increase of approximately 500 undergraduate places across existing medical schools; and an increase of a further approximately 1,000 places via a competitive bidding process. The focus of the consultation was the process for allocating the additional 1,000 places.

The Department for Health received over 3,500 responses to its consultation. This included a response from Councillor Sue Woolley, the County Council's Executive Councillor for NHS Liaison and Community Engagement.

In its response, the Department of Health has stated that it is committed to expanding undergraduate medical places by 1,500, as announced in October 2016. The intention is that in the academic year 2018-19 the number of places available at established providers will increase by approximately 500. The remaining 1,000 places will be allocated through a competitive process with the expectation for delivery in 2019-20. There will be some flexibility to consider phased starts in 2018-19 or 2020-21 where bids that are best able to meet the Government's policy objectives provide strong evidence of the need to provide places to a different timescale.

Details of the competitive bidding process for the allocation of the further 1,000 places will be set out later in 2017. The bidding criteria will be determined jointly by the Higher Education Funding Council for England and Health Education England, and will be prioritised to address the following:

- widening participation and improving access so that the medical workforce is more representative of the population it serves;
- aligning expansion to local NHS workforce need with an emphasis on priority geographical areas, including rural and coastal areas;
- supporting general practice and other shortage specialties so that the NHS can deliver services required to meet patient need;
- ensuring sufficient provision of high quality training and clinical placements (with funding provided to Higher Education Funding Council for England for the additional teaching costs and funding to Health Education England to support additional high quality placements); and
- encouraging innovation and market liberalisation.

One of the issues in the consultation was whether the taxpayer should have a return on the investment made, for example, by seeking a minimum number of years of service in the NHS from doctors who have been trained. The Department of Health has stated that there was some agreement on the principle of ensuring that the significant taxpayer investment in medical education is maximised, but no general consensus on the mechanism to achieve this. The Government has asked Health Education England to consider this matter further.

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| 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: | **13 September 2017** |
| Subject: | **Grantham Hospital Accident and Emergency Department: Outcome of Referral to the Secretary of State for Health** |

**Summary:**

On 2 August, the Secretary of State for Health issued his decision on the referral of the overnight closure of Grantham Accident and Emergency Department, which had been submitted by this Committee in December 2016. The Secretary of State has accepted the advice of the Independent Reconfiguration Panel (IRP) that the referral does not merit a full review and should be resolved locally. The advice of the IRP is set out in Appendix A and the Secretary of State's determination letter is set out at Appendix B to this report.

Jan Sobieraj, the Chief Executive of United Lincolnshire Hospitals NHS Trust, and Dr Neill Hepburn, the Trust's Medical Director, are due to attend to provide an update on the staffing position for emergency care.

**Actions Required:**

The Health Scrutiny Committee is recommended to:

(1) note the determination of the Secretary of State for Health on the referral of the overnight closure of Accident and Emergency Department at Grantham A&E, and the content of the advice from Independent Reconfiguration Panel;

(2) consider the next steps, in terms of the advice from the Independent Reconfiguration Panel that 'further local action by the NHS with the Council can address the issues raised'; and

(3) consider the latest information from United Lincolnshire Hospitals NHS Trust, regarding their staffing levels for emergency care.

## 1. Background to Referral to the Secretary of State for Health

Decision on Overnight Closure of Grantham Hospital Accident and Emergency Department

On 2 August 2016, United Lincolnshire Hospitals NHS Trust Board decided that with effect from 17 August 2016 the Accident and Emergency Department at Grantham and District Hospital would be closed between 6.30 pm and 9.00 am for a period of three months, on the grounds of patient safety. The difficulties recruiting and retaining Accident and Emergency consultant and middle grade doctors were cited by United Lincolnshire Hospitals NHS Trust as reasons for the closure and the effects these difficulties would have on patient safety. The decision by the Trust was supported by NHS Improvement and local commissioners.

On 1 November 2016, United Lincolnshire Hospitals NHS Trust Board decided to extend the period of the closure to 17 February 2017 and stated that the position remained under review. Further extensions of the period of the closure were not ruled out at this time.

Health Scrutiny Committee Consideration and Referral

On 23 November 2016, the Health Scrutiny Committee considered the continuation of the period of closure and decided the refer the matter to the Secretary of State for Health, in accordance with Regulation 23(9)(c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. This followed earlier consideration of the temporary closure by the Committee on 21 September 2016.

The Committee's referral statement and supporting documentation were submitted to the Secretary of State for Health on 15 December 2016.

## 2. Consideration and Determination by the Secretary of State for Health

Initial Response by the Secretary of State for Health

On 23 February 2017, the Secretary of State for Health advised the Chairman of the Health Scrutiny Committee that he would be seeking initial advice on the referral from the Independent Reconfiguration Panel (IRP). The IRP is an advisory non-departmental public body, sponsored by the Department of Health and aims to provide independent expert advice on NHS service change. The IRP is made up of clinical, managerial and lay members. The IRP states that these members offer wide-ranging experience in clinical healthcare, NHS management and public and patient involvement.

Seeking initial advice from the IRP on health overview and scrutiny committee referrals is the usual practice for the Secretary of State, although

it is not understood to be automatic. Also in accordance with usual practice, the Secretary of State requested that he receive initial advice from the IRP within one month, in this case by 23 March 2017.

There were expectations that the Secretary of State for Health would consider and make a decision on the referral shortly after his receipt of the IRP's initial advice on 23 March 2017, but the evidence from the IRP's website suggests that the Secretary of State may take a longer period to consider the IRP's initial advice and make a determination.

IRP Advice and Decision by the Secretary of State for Health

The advice of the IRP was submitted to the Secretary of State in a letter dated 22 March 2017. This is set out in Appendix A to this report. The IRP concluded that this referral was not suitable for full review because further local action by the NHS with the Council could address the issues raised.

On 2 August 2017, the Secretary of State for Health issued his decision – Appendix B to this report. He accepted the advice of the IRP in full.

Analysis of the IRP Letter

The IRP letter refers to several issues: -

- Status of Grantham A&E – The IRP states that "considering the limitations that have long been in place, it occurs to the Panel that the level of emergency service provided from Grantham and District Hospital prior to August 2016 was already more akin to that of an urgent care centre. Yet description of the service as an A&E or ED by both NHS and the HSC continues today. The point here is not merely one of the appropriate use of terminology or signage but that unrealistic expectations and misunderstanding may have been allowed to develop about the level of service that can and should be provided at Grantham and District Hospital. level of emergency service provided Early Engagement between ULHT and the Committee.
- Exchange of Information Between the Committee and ULHT – The IRP finds that the crisis that arose did not happen overnight yet it appeared the HSC was only advised of circumstances once decisions had been made and action taken. The Panel would have expected that, as part of the exchange of information that should be taking place regularly, the HSC would have been advised of the situation earlier.
- Closure no Longer Temporary – The IRP agreed with the Committee that after six months the closure can no longer be regarded as temporary.
- Future Consultation - The Panel stated that "the time has come for an open and honest appraisal, both of the options for future emergency care delivery at Grantham and more widely across Lincolnshire. An alternative to the current approach is needed that reflects the

prospective staffing position for emergency care provided by the Trust." Commissioners must as a matter of urgency work with the local providers (including mental health care and community providers as well as ULHT) and the HSC to engage and consult the public across Lincolnshire on current services and what might be achievable and sustainable in the future. "Drawing on the work already done for the sustainability and transformation plan for the area, a plan of action for the whole health economy is required that will implement safe and sustainable urgent and emergency services and bring about an early end to the current uncertainty."

The IRP Process

The IRP can make one of two recommendations to the Secretary of State at the initial review stage: **either** the referral is suitable for a full review **or** the referral is not suitable for a full review.

Since the implementation of the new health scrutiny regulations in 2013, all thirteen initial assessments undertaken by the IRP have concluded with a recommendation that the referral is not suitable for a full review and in each case the Secretary of State has accepted the IRP's advice. It is only following a full review, which includes wider evidence gathering and hearings that detailed recommendations can be made by the IRP to the Secretary of State.

## 3. Action by United Lincolnshire Hospitals NHS Trust and Latest Position

Further Consideration by United Lincolnshire Hospitals NHS Trust

Since the Committee made the referral on 23 November 2016, United Lincolnshire Hospitals NHS Trust (ULHT) Board has continued to review the closure decision at its Board meetings, in particular focusing on the recruitment and retention position of A&E consultant and middle grade doctors and the impact of the overnight closure on other public services. The main elements are as follows:

- 7 February 2017 – The ULHT Board made a decision to reduce the period of overnight closure from 6.30 pm to 8 am, and extended the temporary closure for a further three months.
- 7 March 2017 – The ULHT Board confirmed the decision to reduce the period of overnight closure, with the new closure hours of 6.30 pm to 8 am becoming effective from 27 March. The report to the Board included the statement that 'the provision of emergency services, particularly at Lincoln County Hospital, remains fragile.'
- 9 May 2017 – The ULHT Board extended the temporary closure for a further three months.
- 1 August 2017 – The ULHT Board supported the continued overnight closure of the Grantham A&E department and decided to continue with the new current opening hours of 08.00 - 18.30 hours implemented 27 March 2017. The Board agreed to review the

overnight closure in 3 months. The Board also agreed to work with the Clinical Commissioning Groups to explore an interim service model for a 24 hour emergency/ out of hours service.

Latest Position on Recruitment and Retention of Accident and Emergency Staff

The most recent report to the ULHT Board on 1 August 2017 is available at the following link:

https://www.ulh.nhs.uk/content/uploads/2017/07/EMERGENCY-CARE-SERVICE-July-17-v5.pdf

The relevant extracts of the report are set out in Appendix C to this report.

## 4. Conclusion

The Health Scrutiny Committee is requested to note the determination of the Secretary of State for Health on the referral of the overnight closure of Accident and Emergency Department at Grantham A&E, and the content of the advice from Independent Reconfiguration Panel. The Committee is also asked to consider the next steps, in terms of the advice from the Independent Reconfiguration Panel that 'further local action by the NHS with the Council can address the issues raised'.

The Committee is also requested to consider the latest information from United Lincolnshire Hospitals NHS Trust, regarding their staffing levels for emergency care.

## 5. Appendices

| These are listed below and attached at the back of the report | |
|---|---|
| Appendix A | Initial Advice from the Independent Reconfiguration Panel, dated 22 March 2017 |
| Appendix B | Letter from the Secretary of State for Health to the Chairman of the Health Scrutiny Committee for Lincolnshire, 2 August 2017 |

## 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, Health Scrutiny Officer, who can be contacted on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk

*6th Floor*
*157 – 197 Buckingham Palace Road*
*London*
*SW1W 9SP*

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

22 March 2017

Dear Secretary of State

**REFERRAL TO SECRETARY OF STATE FOR HEALTH**
**Report by Health Scrutiny Committee for Lincolnshire**
**Grantham and District Hospital**

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Christine Talbot, Chairman of the Health Scrutiny Committee for Lincolnshire (HSC). NHS England and United Lincolnshire Hospitals NHS Trust (ULHT) provided initial assessment information. A list of all the documents received is at Appendix One.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State for Health may be made. The IRP provides the advice below on the basis that the Department of Health is satisfied the referral meets the requirements of the regulations.

The Panel considers each referral on its merits and concludes that **this referral is not suitable for full review because further local action by the NHS with the Council can address the issues raised.**

**Background**
Grantham and District Hospital is part of United Lincolnshire Hospitals NHS Trust (UHLT) and, along with Lincoln County Hospital and Pilgrim Hospital Boston, has an Accident and Emergency department (A&E)[1] staffed by consultants, doctors, doctors in training, nurse practitioners and nursing staff. Grantham A&E sees approximately 29,000 patients per year compared to 71,000 at Lincoln A&E and 55,000 at Pilgrim A&E. Grantham is around 36 miles from Lincoln and 32 miles from Boston. The major trauma centre in Nottingham is around 28 miles away. Only patients with a limited range of medical conditions and single limb orthopaedic injuries are admitted to Grantham and District Hospital via the A&E department or GP referral. Patients

[1] Also know n as Emergency Department (ED)

requiring a specialist review beyond that available at Grantham are transferred to Lincoln, Pilgrim or Nottingham hospitals.

During July 2016, concern was expressed by the emergency departments at Lincoln County Hospital and Pilgrim Hospital about their ability to fill middle grade medical rotas. A report to the ULHT Board on 2 August 2016 described a number of reasons for this – a national shortage of emergency medicine doctors, insufficient doctors in training choosing to work at ULHT, an increasing reliance on locums and difficulty in securing the number of locums required to fill rota gaps consistently. The report stated that across the Trust (at the time of the report's writing) there were four substantive consultants in post out of 15 funded whole time equivalent (wte) posts, vacancies being filled by locums. Further, there were 11.6 wte middle grade doctors against the 28 funded posts. The reduced emergency staffing levels, combined with a reduction in skill mix of substantive staff, compromised the on-going provision of safe, 24 hours, seven days per week A&E care across three sites. Although efforts were continuing to recruit additional staff, and various steps had been taken to mitigate staff shortages, it was felt that further action was required *"to ameliorate the unacceptable risks to patient care created by a significant middle grade doctor shortage".*

The Trust Board considered potential options:

| | |
|---|---|
| Option One | Sustain three sites with ED departments24/7 by securing additional ED specific resource (status quo) |
| Option Two | Change the service provision at Lincoln County hospital by reducing the opening hours of the emergency department as follows:<br>2a. Emergency Department is open 24/7<br>2b. Emergency Department is open 8am – Midnight<br>2c. Emergency Department is open 8am – 8pm<br>2d. Emergency Department is open 9am – 4pm<br>Retain a 24/7 Emergency Department at Pilgrim and a 24/7 Emergency Department at Grantham Hospital with a restricted clinical take |
| Option Three | Change the service provision at Pilgrim Hospital by reducing the opening hours of the emergency department as follows:<br>3a. Emergency Department is open 24/7<br>3b. Emergency Department is open 8am – Midnight<br>3c. Emergency Department is open 8am – 8pm<br>3d. Emergency Department is open 9am – 4pm<br>Retain a 24/7 Emergency Department at Lincoln hospital and a 24/7 emergency department at Grantham Hospital with a restricted clinical take |

Option Four Change the service provision at Grantham and District Hospital by closing the emergency department and by opening an urgent care centre as follows:
4a. Urgent Care Centre is open 24/7
4b. Urgent Care Centre is open 8am – Midnight
4c. Urgent Care Centre is open 8am – 8pm
4d. Urgent Care Centre is open 9am – 4pm
Retain a 24/7 emergency department at Lincoln Hospital and at Pilgrim Hospital

The recommended option was Option 4c.

The Trust Board accepted that the additional risk to patients was too great to continue without further action. The Board agreed to implement a temporary service closure at Grantham and District Hospital to support staffing at the Lincoln and Pilgrim A&E departments, as releasing middle grade doctors to work at the two main A&E sites would provide safer services for the Lincolnshire population (around 750,000) as a whole.

The accountable officer of South West Lincolnshire Clinical Commissioning Group (CCG) (in which Grantham is located) was briefed on the closure on 3 August 2016. An initial three month closure of the A&E department at Grantham Hospital between 18.30 and 09.00 was introduced on 17 August 2016, to be reviewed monthly with an agreed threshold and plan to meet that threshold for recommencing services. The Lincolnshire A&E Delivery Board would assume responsibility for undertaking the monthly reviews with effect from September 2016 against a threshold of:

- No deterioration in the current consultant position
- Fill rate of at least 75 per cent (21) of the middle grade establishment (28) on an eight week prospective basis

Stakeholders including the local Healthwatch, the County Council and local councillors, Care Quality Commission, neighbouring hospital trusts and East Midlands Ambulance Service were briefed during August 2016 and a county-wide communications plan advising the public and staff was implemented. On 19 August 2016, representatives of Lincolnshire East CCG (the lead commissioner of services from UHLT) and NHS Improvement undertook a quality visit of Grantham and District Hospital A&E and reported no concerns. Quality impact and equality impact assessments were undertaken. The Trust's decision was supported by NHS Improvement and NHS England in a letter of 30 August 2016.

The UHLT chief executive and medical director attended a meeting of the HSC on 21 September 2016. The HSC considered a report and information presented showing that daily average attendances at Grantham and District Hospital A&E had reduced from 80 between 1 and 16 August 2016 to around 60 subsequently. Releasing staff from

Grantham had initially enabled an additional 120 hours per week of middle grade cover to be provided at Lincoln County Hospital. It was noted that significant recruitment activity had been undertaken. The Committee recorded its support for the permanent reinstatement of overnight A&E services at Grantham and District Hospital. The Committee also concluded that it was not reassured that overnight A&E services would be reinstated by 17 November 2016 owing to the difficulty of recruiting suitably qualified A&E staff. A further report was requested for the HSC meeting on 23 November 2016 covering A&E staff recruitment across the Trust and the impact of the temporary overnight closure at Grantham and District Hospital on other NHS services.

The UHLT Board met on 1 November 2016 and considered an updated report from the medical director on the latest position regarding emergency care services. A number of expressions of interest in vacancies had been received but no appointments made while a further two middle grade doctors were leaving the Trust. The Board considered options on how to proceed and decided to extend the period of closure of A&E services between 18.30 and 09.00 at Grantham and District Hospital to the end of February 2017.

The UHLT chief executive and medical director attended the HSC meeting on 23 November 2016. It was reported that reducing the A&E department opening hours at Grantham and District Hospital had enabled the A&E department at Lincoln County Hospital to be supported by up to an additional 85 hours per week by middle grade and consultant staff from Grantham. No serious issues had been reported. A recruitment drive had indicated the potential to reach the necessary threshold but it was unlikely that sufficient new doctors would be in employment before January or February 2017. The Committee concluded that the closure of A&E services between 18.30 and 09.00 at Grantham and District Hospital represented a substantial variation in the provision of health services for the area. It recorded that it was not reassured that the required threshold of consultant and middle grade doctors would be recruited by February 2017 and hence that A&E services would not be reinstated by this date. It concluded that, as a result, the closure of A&E services between 18.30 and 09.00 at Grantham and District Hospital would effectively be permanent. The HSC decided that the matter should be referred to the Secretary of State for Health and a letter of referral was sent on 15 December 2016.

Since the referral, UHLT has continued its efforts to recruit staff and the closure of A&E services between 18.30 and 09.00 at Grantham and District Hospital has been reviewed. A review in February 2017 concluded that the threshold to re-open the service full time had not been met but acknowledged that there had been an improvement in staffing levels. It was agreed to increase opening hours by one hour (08.00 – 18.30) with effect from 27 March 2017 and to introduce a direct to admission unit pathway for selected medical patients conveyed by the ambulance service from 3

April 2017. These changes aside, the closure would remain in place for a further three months. NHS Improvement confirmed, in a letter of 20 February 2017, that it had received assurance regarding the decision.

**Basis for referral**
The HSC's letter of 15 December 2016 states:

*"In accordance with Regulation 23(9) (c) of the Local Authority (Public Health, Health and Wellbeing Board's and Health Scrutiny) Regulations 2013, the Health Scrutiny Committee for Lincolnshire is making a report to the Secretary of State for Health in relation to the closure of Accident and Emergency Services at Grantham and District Hospital between 6.30pm and 9.00am. This referral is made on the basis that the closure is not in the interests of [the] health service in the Grantham and surrounding area."*

**IRP view**
With regard to the referral by the Health Scrutiny Committee for Lincolnshire, the Panel notes that:

- The HSC in its referral letter, asserts that, since the temporary closure of A&E services between 18.30 and 09.00 (to be 08.00) at Grantham and District Hospital has now been in place for several months, the change amounts to a substantial variation
- The HSC does not contest the conclusion reached on 2 August 2016 by the UHLT Board that, without action, A&E services across the three sites were unsafe
- Nor does the HSC contest the decision to transfer temporarily staff from Grantham and District Hospital A&E to other sites to ensure the safe continuation of services from those sites – by implication, the ULHT threshold for re-opening the A&E at Grantham and District Hospital 24/7 is also accepted
- The HSC accepts that consultation is not required when a decision is made because of a risk to safety or welfare of patients and staff in services but asserts that, in view of the length of time that the change has been in place, it cannot any longer be considered to be temporary and should be subject to consultation with the HSC
- Further, the HSC asserts that the overnight closure is adversely affecting patient care for Grantham and district residents with other A&E departments around 30 miles away and may also impact on the sustainability of other NHS and wider services
- UHLT has stated that no proposals for any permanent changes have been put forward
- The HSC is seeking a commitment that A&E services at Grantham and District Hospital will re-open between 18.30 and 09.00 and the level of service provided will be same as those in place prior to 17 August 2016

**Advice**
The IRP offers its advice on a case-by-case basis taking account of the specific circumstances and issues of each referral. **The Panel does not consider that a full review would add any value. Further local action by the NHS with the Council can address the issues raised.**

The Health Scrutiny Committee for Lincolnshire has concluded that the closure of A&E services at Grantham and District Hospital between 18.30 and 09.00 represents a substantial variation in health care provision, in accordance with regulation 23(1) of the 2013 Regulations. This does not appear to be disputed by the NHS and the IRP, in responding to the request for advice on this matter, does so on the assumption that the Department of Health is also content that the closure amounts to a substantial variation.

The changes agreed by the UHLT Board on 2 August 2016 and implemented on 17 August 2016 – including to introduce a temporary service closure at Grantham and District Hospital A&E – were done so on grounds of safety. The necessity to take action, that is, to release middle grade doctors from Grantham to support services at the Lincoln County and Pilgrim hospitals and thus provide a safer service overall for the population of Lincolnshire, is not contested. The HSC has also accepted that prior consultation with the Committee was not needed in view of the imminent risk to the safety and welfare of patients. Nevertheless, a number of questions arise in relation to the true nature of emergency care provision at Grantham and District Hospital past and present, the level of engagement with the HSC and other stakeholders prior to decisions being taken in August 2016 and understanding what is envisaged for the longer term development of emergency and urgent care services across the county.

The accident and emergency service at Grantham and District Hospital has for some time only dealt with a limited range of presenting emergency conditions. Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions have since 2007/08 been taken by the ambulance service straight to neighbouring hospitals (Lincoln County, Pilgrim or Nottingham) where more specialised services are located. Other patients receive stabilisation before being transferred. The report presented to the Trust Board on 2 August 2016 lists at Option Four *"Change the service provision at Grantham & District Hospital by closing the emergency department and by opening an urgent care centre as follows…".* Considering the limitations that have long been in place, it occurs to the Panel that the level of emergency service provided from Grantham and District Hospital prior to August 2016 was already more akin to that of an urgent care centre. Yet description of the service as an A&E or ED by both NHS and the HSC continues today. The point here is not merely one of the appropriate use of terminology or signage but that unrealistic expectations and misunderstanding may

have been allowed to develop about the level of service that can and should be provided at Grantham and District Hospital.

Patients, the public and stakeholders need to know what to expect from their local health services. Their elected representatives have a right to be kept advised of developments, including potential pressures that may affect the provision of services. The report presented to the Trust Board on 2 August 2016 emphasized that *"this report is a culmination of a series of circumstances that have led to a crisis situation within our Emergency Departments".* The report explains that over previous months, emergency departments were safely staffed by asking consultants to work extra shifts to cover gaps in the middle grade doctor rota and by securing as many agency doctors as possible. New ways of working were also piloted to improve performance. Clearly the crisis that arose did not happen overnight yet it appears the HSC was only advised of circumstances once decisions had been made and action taken. The Panel would have expected that, as part of the exchange of information that should be taking place regularly, the HSC would have been advised of the situation earlier. The absence of ongoing communication might have helped to fuel the view that the temporary closure was to be continued indefinitely until made permanent.

UHLT has stated that no proposals for any permanent changes have been put forward. In the meantime, genuine efforts to recruit and retain staff to work in the Trust's emergency departments continue but with, thus far, limited success. As the HSC has itself highlighted, the prospects of recruiting and retaining sufficient staff to meet the agreed threshold of 21 middle grade doctors across the Trust do not appear strong. Despite the original intent to close temporarily, the Panel agrees with the view of the HSC that, after six months (to date), the closure of the A&E service at Grantham and District Hospital between 18.30 and now 08.00 can no longer be regarded as a temporary measure and considers that it is not in the interests of patients that future discussions be conducted on this basis.

The Panel, in this advice, has already noted the limited nature of the A&E service provided at Grantham and District Hospital and is concerned that unrealistic expectations have built up about what the service actually provides – both before and after the night-time closure. The service is demonstrably the smallest of the three A&E services provided across Lincolnshire by UHLT and deals with a limited range of presenting conditions. Consequently, taking account of the low level of activity through the night, the actual numbers of patients affected in terms of accessing A&E elsewhere is relatively small. That said, the Panel accepts that the issues that gave rise to the current situation did not originate in Grantham and that there is considerable disquiet about the uncertainty among the residents of Grantham and the surrounding area.

The HSC is seeking a commitment that A&E services at Grantham and District Hospital will re-open between 18.30 and 09.00 (to be 08.00) and the level of service provided will be same as those in place prior to 17 August 2016. However, the Committee also accepts that this cannot happen without sufficient staff to operate the service. **The Panel agrees that in the interests of safety the A&E service at Grantham and District Hospital should not re-open 24/7 unless sufficient staff defined by the threshold can be recruited and retained.**

The future for A&E services at Grantham and District Hospital is currently, therefore, fundamentally unclear. Patients, the public and stakeholders at Grantham require a consistent picture of what is *on offer* at Grantham. The changes being made to the opening hours and the introduction of a direct to admission unit pathway for selected medical patients provide little reassurance that the A&E will be able to return to a 24/7 service. Even if that were possible, it has to be recognised that the service provided can never be (nor was it prior to the overnight closure) at the same level as that provided at Lincoln or Boston.

The Panel considers that the time has come for an open and honest appraisal, both of the options for future emergency care delivery at Grantham and more widely across Lincolnshire. An alternative to the current approach is needed that reflects the prospective staffing position for emergency care provided by the Trust. Recognising that the staffing threshold currently required to restore the service at Grantham is unlikely to be achieved in a sustainable way CCGs, as commissioners of these services, must as a matter of urgency work with the local providers (including mental health care and community providers as well as ULHT) and the HSC to engage and consult the public across Lincolnshire on current services and what might be achievable and sustainable in the future. Drawing on the work already done for the sustainability and transformation plan for the area, a plan of action for the whole health economy is required that will implement safe and sustainable urgent and emergency services and bring about an early end to the current uncertainty.

Yours sincerely

Lord Ribeiro CBE
Chairman, IRP

Independent Reconfiguration Panel

Tel: 020 7389 8045/6 *E Mail:* irpinfo@dh.gsi.gov.uk
*Website:* www.gov.uk/government/organisations/independent-reconfiguration-panel

**APPENDIX ONE**

## LIST OF DOCUMENTS RECEIVED

**Health Scrutiny Committee for Lincolnshire**

1 Letter from Cllr Christine Talbot, HSC Chairman, 15 December 2016
Attachments:
2 Statement in support of report to Secretary of State for Health by the Health Scrutiny Committee for Lincolnshire – Grantham and District Hospital Accident and Emergency Services
3 Enclosure 1 – Report to the Health Scrutiny Committee for Lincolnshire, 21 September 2016: United Lincolnshire Hospitals NHS Trust: Emergency Care
4 Enclosure 2 – Extracts from the minutes of the Health Scrutiny Committee for Lincolnshire, 21 September 2016
5 Enclosure 3 – Report to the Health Scrutiny Committee for Lincolnshire, 23 November 2016, United Lincolnshire Hospitals NHS Trust: Emergency Care Services at Grantham and District Hospital
6 Enclosure 4 – Extracts from the (unconfirmed) minutes of the Health Scrutiny Committee for Lincolnshire, 23 November 2016

**NHS**

1 IRP template for providing initial assessment information
Attachments:
2 Maps
3 ULHT private board minutes, 2 August 2016
4 ULHT private board meeting paper, 2 August 2016
5 ULHT public board minutes, 1 November 2016
6 ULHT Fast track emergency service change checklist, August 2016
7 NHS Improvement and NHS England letter to ULHT, 30 August 2016
8 NHS Improvement and NHS England letter to ULHT, 15 November 2016
9 ULHT equality impact assessment
10 ULHT emergency care service position, 6 September 2016
11 ULHT emergency care service position, 4 October 2016
12 ULHT public board meeting (current position), 1 November 2016
13 ULHT Grantham A&E changes communications plan
14 Letter, Mills and Reeve LLP to Leigh Day & Co, 1 September 2016
15 ULHT report to HSC, 21 September 2016
16 UHLT report to HSC, 23 November 2016
17 Health Scrutiny Committee for Lincolnshire referral letter 15 December 2016
18 Grantham A&E equality analysis communications and engagement plan
19 Grantham A&E engagement
20 ULHT equality impact assessment

Other evidence considered

1 Lincolnshire A&E Delivery Board terms of reference
2 Emergency care service – current position, UHLT, February 2017
3 Minutes of Public Trust Board meeting, UHLT, 7 February 2017
4 Exert from Clinical Management Board, UHLT, 2 February 2017
5 Presentation by UHLT medical director, A&E services at Grantham and District Hospital
6 System Executive Team paper, 8 February 2017
7 Letter from NHS Improvement to UHLT chief executive, 20 February 2017

Department of Health

*From the Rt Hon Jeremy Hunt MP*
*Secretary of State for Health*

*Richmond House*
*79 Whitehall*
*London*
*SW1A 2NS*

*020 7210 4850*

POC_1064502

Councillor Mrs Christine Talbot,
Chairman of the Health Scrutiny Committee for Lincolnshire
County Offices,
Newland,
Lincoln,
LN1 1YL

- 2 AUG 2017

Dear Cllr Talbot,

**Review of closure of Accident and Emergency Services at Grantham and District Hospital between 6.30pm and 9.00am: Formal referral under Regulation 23(9) of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013**

I am responding to your letter of 15 December 2016 referring the decision taken to closure accident and emergency services at Grantham and District Hospital between 6.30pm and 9.00am.

You referred this case on the basis that the closure is not in the interests of health services in Grantham and the surrounding area. As you know, I asked the Independent Reconfiguration Panel (IRP) for its initial advice on receipt of your referral.

The IRP has now completed its initial assessment and shared its advice with me. After careful consideration, the IRP is of the view that your referral does not warrant a full review and I accept the IRP's advice in full.

**IRP advice**

The IRP has considered the issues you raise in your letter. The IRP have concluded that a full review is not necessary in this case. The IRP state that, in the interests of safety, the A&E service at Grantham and District Hospital should not re-open 24/7 unless there is sufficient staff as defined by the threshold can be recruited and retained.

However, the IRP agreed that the closure amounts to a substantial variation. They recommend that as the staffing threshold currently required to restore the service at Grantham is unlikely to be achieved in a sustainable way CCGs and local commissioners must work with local providers and the HSC to engage and consult the public on future services.

A copy of the full advice is appended to this letter and will be published today on the IRP's website at www.irpanel.org.uk.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

Yours sincerely

Jeremy Hunt

**JEREMY HUNT**

# EXTRACTS OF REPORT TO UNITED LINCOLNSHIRE HOSPITALS TRUST BOARD ON 1 AUGUST 2017

## EMERGENCY CARE SERVICE CURRENT POSITION

### Executive Summary

In August 2016, a decision was made by United Lincolnshire Hospitals NHS Trust (ULHT), supported by NHS England, NHS Improvement and the local Clinical Commissioning Group, to temporarily close the Grantham Accident & Emergency (A&E) Department between the hours of 18:30 and 09:00. This decision was taken in response to a staffing crisis within our A&E departments, primarily at Lincoln County Hospital.

Following a detailed assessment of the effects of this by the Trust Board in November 2016 and February 2017, the overnight closure was to be continued until 17th May 2017. However, at the February Trust Board meeting it was agreed that the opening hours of Grantham A&E should be changed to 08.00 – 18.30, an increase of 1 hour. This was to be effective from 27th March provided middle grade staffing levels enabled this to take place safely.

The status of medical staff recruited and in post, as well as the numbers required to support three ULHT Accident & Emergency Departments were reviewed and noted by the Trust Board on 7th March 2017. No changes were made to the planned alteration to the overnight closure due to commence 27th March 2017.

This report provides a summary of the emergency department activity, performance, and capacity following the closure of Grantham A&E between the hours of 18:30 and 09:00 with effect from 17th August 2016 until 26th March 2017.

The increase in the opening hours to the current opening times of 08.00 – 18.30 hours since 27th March 2017 appears to have made little difference to the activity in A&E at Grantham.

The report indicates the current staffing levels to support the ULHT A&E departments. It also describes the impact on A&E by the recent changes to taxation rules for contracted medical staff. The report makes one recommendation to be considered for the Grantham A&E department after 17th May 2017. It takes into account the overall situation across all A&E departments and whether ULHT is now in a position to safely staff all three of them.

The objectives of the report are:

- To provide the current situation with regards to medical staffing in emergency care at Lincoln hospital, Pilgrim hospital and Grantham hospital following the decision taken to close the Grantham A&E department overnight from August 17th 2016.

- To evaluate the impact of this closure up to 30th June 2017 on each of the ULHT A&E departments since August 17th 2016.

- To enable a decision to be made for the operational hours at Grantham hospital following review of the staffing situation following the decision to temporarily close the Grantham A&E overnight.

## 1. Introduction

### 1.1. Context and background

**An overview of the emergency department services at ULHT**

ULHT currently provides three emergency service departments running 24 hours per day, 7 days per week (9am to 6.30pm at Grantham since 17.8.16 and increased to 8am since 27.03.17). The regional major trauma centre is located at Nottingham University Hospitals NHS Trust, Queens Medical Centre campus. This is where patients needing the services of a major trauma service are directed.

**Lincoln County Hospital**

The Emergency Department (ED) 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 provide on-site presence from 08:00 to 22:00 during the week and 08:00 to 20:00 at weekends. At other times they provide on call cover off site but are available to attend the hospital emergency department for emergencies. The department is funded for 11 middle grades specialising in emergency care.

**Pilgrim Hospital, Boston**

The ED 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 air ambulance. Six consultants provide on-site presence in the ED from 08:00 to 21:00 during the week and 09:00 to 16:00 at weekends. At other times they provide on call cover off site but are available to attend the hospital for emergencies. The department is funded for 11 middle grades specialising in emergency care.

**Grantham and District Hospital**

The ED at GDH provides unrestricted access to A&E services 24/7 (9am to 6.30pm since 17.8.16 and from 8am to 6.30pm since 27.03.17). However, because of the limited in-patient infrastructure, the ED is restricted in its ability to support a full range of emergencies that normally would be expected to be treated in an ED. It cannot receive patients by air ambulance.

The health community (East Midlands Ambulance Service and local general practitioners) are aware that patients with certain medical conditions should not be taken or sent GDH. The Exclusion Protocol and the Admission Protocol are set out below:

EXCLUSION PROTOCOL

*Ambulances / GPs SHOULD NOT bring / send these patients to Grantham and District Hospital A&E and Emergency Assessment Unit*

*The following Specific Patient Groups*

- *Acute surgical admission*
- *Acute stroke*
- *Gastro-intestinal haemorrhage (fresh blood or melena).*
- *Severe abdominal pain and acute abdomen (refer patient directly to LCH.)*
- *A female of childbearing age with lower abdominal pain.*
- *A male under 30 years of age with testicular pain.*
- *A patient with a suspected abdominal aortic aneurysm.*
- *Patients with an ischaemic limb needs admission to the on-call vascular team at PHB*
- *All Obstetric and Gynaecological patients*
- *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.*

*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).*

Patients who require treatment and management beyond that available at GDH are transferred to LCH, PHB or Nottingham University Hospitals.

Two consultants provide on-site presence in the ED from 09:00 to 17:00 during the week only. At weekends and at other times they provide on call cover off site but are available to attend the hospital for emergencies. The department is funded for 6 middle grades specialising in emergency care.

## 1.2. Medical staffing

Hospital emergency departments are staffed by a combination of consultants, middle grade doctors, doctors in training, A&E nurses and emergency care practitioners. Current guidance is for there to be on site presence, by a consultant, for 16 hours per day. Tables 3 and 4 show the number of funded medical posts, the numbers in place in August 2016 and the rostered presence of senior medical staff for the three A&Es.

Table 3: Funded medical posts for ULHT A&E departments and numbers in place August 2016

| Grade | Funded Whole Time Equivalents | August 2016 |
|---|---|---|
| **Consultants** | 15.0 | 14 |
| **Middle Grades** | 28.0 | 11.6 |

Table 4 below summarises the medical presence for each of the ULHT Emergency Departments

**Table 4: Medical Staff presence at UHT Emergency Departments**

| Site | Grade | Site Presence | Days per week |
|---|---|---|---|
| Lincoln | Consultant | 14 hours per day 08:00-22.00<br>On call off site after 22.00 | Mon-Fri |
| | Consultant | 12 hours per day 08:00-20:00<br>On call off site after 20:00 | Sat/Sun |
| | Middle Grade | 24 hour per day | Mon – Sun |
| Pilgrim | Consultant | 13 hours per day 08:00-21.00<br>on call cover off site after 21.00 | Mon-Fri |
| | Consultant | 7 hours per day 09:00-16.00<br>On call cover after 16.00 | Sat/Sun |
| | Middle Grade | 24 hour per day | Mon – Sun |
| Grantham | Consultant | 8 hours per day 09:00 – 17.00<br>On call off site after 17.00 | Mon-Fri |
| | Consultant | On call off site only | Sat – Sun |
| | Middle Grade | 24 hour per day | Mon - Sun |

### 1.4 Threshold to re-open the A&E department at GDH

It was agreed with commissioners, NHS Improvement and NHS England that the A&E department at GDH should return to 24/7 opening hours when the required middle grade establishment had been reached and that there had been no deterioration number of consultants. The middle grade threshold was set at 21 substantives and/ or long term locums, against an establishment of 28. This would enable three 24/7 rotas to be staffed consistently and prospectively but still requiring agency support to fulfil all duties within the rotas.

### The model of service for the provision of emergency care at GDH since 17th August 2016

- Emergency admission and exclusion criteria to GDH remains unchanged (See above)
- Out of hours (OOH) service and a new minor injuries service located in the Kingfisher unit at GDH and run by LCHS
- Single point of contact 17.00 – 09.00 for police, EMAS, LCHS and ULHT to access the crisis response team

- Direct line of access for police to the Grantham OOH services
- Dedicated telephone access outside A&E for 999 and 111 only when A&E is closed.
- 2 ring fenced in-patient beds for patients needing transfer from A&E to another hospital after A&E closed and staff not present
- Since 3rd April 2017 direct admission to EAU by EMAS against agreed protocols
- Since 27th March 2017 increased opening times to A&E; 08.00 – 18.30 hours.

**1.5 Outcomes of recruitment actions since August 2016**

**Actions and outcomes to recruit to establishment**

Significant recruitment activity has been underway for a considerable amount of time to increase the number of middle grade staff.
Two more middle grades have been appointed following the last advert but they will need 4 months on the junior rota before they can participate on the middle grade rota. This is not expected to be before the autumn 2017.

**Consultant Medical Staff**

The total number of substantive consultants in A&E remain at 4, but will increase to 5 in August with a new appointment. Ill health reduced the expected consultant staffing numbers for ULHT from 15wte to 14 wte during May – June but the consultant is now on a phased return to work.

**Trainees/Junior Medical Staff**

There has been a reduction from 10 to 5 in the number of junior medical and trainee staff from April 2017 to July at LCH. The 10 posts are made up of 8 deanery and 2 trust posts. One deanery post has been converted to a trust post and it is expected all 10 posts will be filled in August.

**Registered Nursing Staff**

The A&E department at Grantham have 2.5 registered nursing vacancies. At PHB there are 1.1wte nurse vacancies in A&E and 1 wte on maternity leave in March. At LCH there are 6.55 registered and 2.71unregistered wte nurse vacancies.
Table 5 below shows the number of middle grades at each of the hospital sites.

**Table 5: Summary of recruitment to medical middle grade posts**

| | Lincoln funded for 11.0 wte | | PHB funded for 11.0 wte | | GH funded for 6 .0wte | | ULHT funded for 28 wte |
|---|---|---|---|---|---|---|---|
| | Substantive | Long term locum | Substantive | Long term locum | Substantive | Long term locum | Total |
| **01.08.16** | 2.6 | 0 | 4.0 | 0 | 5.0 | 0 | 11.6 |
| **01.09.16** | 2.6 | 0 | 5.0 | 0 | 5.0 | 0 | 12.6 |
| **01.10.16** | 2.6 | 2.0 | 5.0 | 2.0 | 5.0 | 0 | 16.6 |
| **01.11.16** | 2.6 | 2.0 | 5.0 | 2.0 | 5.0 | 0 | 16.6 |
| **01.12.16** | 2.6 | 3.0(2.0) | 5.0 (4.0) | 2.0 | 5.0 | 0 | 17.6 (15.6) |
| **01.01.17** | 2.6 (3.6) | 3.0 | 6.0 | *2.*0 | 5.0 | 0 | 18.6 (19.6) |
| **01.02.17** | 2.6 (5.6) | 3.0 | 6.0 | 1.0(2.0) | 5.0 | 0 | 17.6 (21.6) |
| **01.03.17** | 3.6 | 3.0 | 6.0 | 1.0 | 5.0 | 0 | 18.6 |
| **01.04.17** | 3.6 | 3.0 | 6.0 | 1.0 | 5.0 | 0 | 18.6 |
| **01.05.17** | *3.6* | *3.0* | *6.0* | *1.0* | *5.0* | *0* | *18.6* |
| **01.06.17** | *3.6* | *3.0* | *6.0* | *1.0* | *5.0* | *0* | *18.6* |
| **01.07.17** | *3.6* | *3.0* | *6.0* | *1.0* | *5.0* | *0* | *18.6* |

Numbers in *italics* represent appointments subject to a number of actions beyond the control of ULHT. Numbers in ( ) represent what was predicted at the December Trust Board

**2.0 Impact of IR 35 taxation by HMRC**

From 6 April 2017, changes to the IR35 tax system has required public sector employers to deduct tax and national insurance contributions from contractors' pay at source, rather than allowing them to defer and claim expenses. These changes to the tax system affect many locum or agency medical staff who have previously chosen to contract their work through personal service companies.

Coincidently and perhaps as a consequence, many locums and agency medical staff have become "unavailable" for employment since early April. This has had a profound effect on many NHS organisations that employ locum medical staff. ULHT and in particular our A&E departments rely very heavily on these staff. Therefore, the change to the taxation rules has had a disproportionate effect on the running of our A&E departments.

At ULHT there was a reduction in agency hours covered by locums from 295 hours per week to 52 hours per week. Unfilled hours increased from 16 hours per week to 166 hours per week. Substantive medical staff increased their additional hours from 63 to 126 hours per week.

In order to be able provide a safe 24/7 emergency service to the population of Lincolnshire, ULHT had to declare a "Critical incident" (which was one stage below

major incident) with effect from 5th April 2017 until 19th April 2017. This resulted in having to take extraordinary measures to keep the A&E departments staffed appropriately and safe for patients. Actions taken included:

1. Seeking system wide support from NHSI and neighbouring Trusts less affected that ULHT.
2. Some A&E consultants being resident overnight in A&E, acting as middle grades
3. A physician, surgeon, orthopaedic surgeon and paediatrician were placed in the A&E department during the day and over the weekend before Easter at LCH and at LCH and PHB for Easter weekend.

Whilst the pressures eased for a time, three long term locums have been replaced by 3 new long term locums. However from August there do not appear to be locums available for Lincoln which will create a shortfall of 3. At present it remains unclear for how long the pressures on medical locum staffing will continue.

**3.0 Impact of reduced A&E opening hours at ULHT**
**Medical staff**

In the three months to 29th May 2017, the middle grade doctors and consultants from Grantham A&E have continued to provide up to 64 additional middle grade and 8 additional consultant hours per week respectively at LCH. This has decreased from the previous three month period when it had peaked at 75 hours of middle grade time reflecting the small increase in opening hours at GDH.

**Attendances to A&Es at ULHT**

The data for the number of patients attending the ULHT emergency departments is in summary:

- The average attendance over 24 hours to A&E at LCH 1st April 2016 to 16th August 2016 was 196 and since then to 30th June 2017 was 192.
- The average attendance over 24 hours to A&E at PHB 1st April 2016 to 16th August 2016 was 161and since then to 30th June 2017 was 156.
- The average attendance over 24 hours to A&E at GH 1st April 2016 to 16th August 2016 was 86 per day and since then to 30th June 2017 was 59.

**Summary**

There has been no significant change to the overall attendance to A&E departments at LCH and PHB since the reduced opening hours at GDH and since last reported to Trust Board.

**Attendance to A&E at LCH and PHB from the Grantham and Sleaford area**

The detail by patient postcode of attendances to the emergency departments at Lincoln and Pilgrim Hospitals, for patients living in the following postcode areas: NG31, NG32, NG33, and NG34

- The average 24/7 attendance to A&E at LCH from these post codes 1st April 2016 to 16th August was 13 and since then to 30th June 2017 was 17.4.
- The average 24/7 attendance to A&E at PHB from these post codes 1st April 2016 to 16th August was 5 and since then to 30th June 2017 was 6.6.

**Summary**

Following the change, 4 more patients are attending Lincoln A&E and 2 more attending Pilgrim each day from the Grantham and Sleaford area with the above post codes. This is marginally less since last reported to Trust Board.

**Patients conveyed to the emergency departments via 999**

The patients who were taken to the Lincoln and Pilgrim hospital emergency departments via 999 calls, in summary:

- The average 24/7 attendance to A&E at LCH 1st April 2016 to 16th August 2016 was 69, to 26th March 2017 was 70 and since then to 30th June 2017 was 69.
- The average 24/7 attendance to A&E at PHB 1st April 2016 to 16th August 2016 was 64, to 26th March 2017 was 62 and since then to 30th June 2017 was 62.

**Summary**

Overall there has been no significant change to 999 conveyances to A&E departments at LCH and PHB since the changes to the opening hours of the Grantham A&E were implemented. This has remained unchanged since last reported to Trust Board.

**Attendance to A&E by 999 at LCH and PHB from the Grantham and Sleaford area**

The number of patients who were brought to the Lincoln and Pilgrim emergency departments via 999 calls, and who lived in the following post code areas: NG31, NG32, NG33 and NG34.

- The average 24/7 attendance to A&E at LCH from these post codes 1st April 2016 to 16th August 2016 was 8 , to 26th March 2017 was 10 and since then to 30th June 2017 was 9.
- The average 24/7 attendance to A&E at PHB from these post codes 1st April 2016 to 16th August 2016 was 3, to 26th March 2017 was 3 and since then to 30th June 2017 was 3.

**Summary**

Following the changes in the opening hours of the Grantham A&E, 2 additional people are attending Lincoln A&E each day by 999 from NG31, 32, 33 and 34 post codes. There is no change to Pilgrim A&E. This data has remained unchanged since last reported to Trust Board.

**Total admissions to ULHT**
The total admissions to ULHT:

- The average number of patient admissions to LCH 1st April 2016 to 16th August was 208 and since then to 9th October 2016 - 204, to 8th December 2016 – 211, to 26th March 2017 - 209 and to 30 June 2017 – 208.
- The average number of patient admissions to PHB 1st April 2016 to 16th August was 151 and since then to 9th October 2016 – 145, to 8th December 2016 – 147, to 26th March 2017 – 144, and to 30 June 2017 – 144.
- The average number of patient admissions to GH 1st April 2016 to 16th August 2016 was 40 and since then to 9th October 2016 – 38, to 8th December 2016 - 39 to 26th March 2017 - 39 and to 30 June 2017 – 39.

**Summary**

Overall there has been a slight decrease in total admissions (8) to ULHT since the changes to the opening hours of the Grantham A&E were implemented. These changes are mostly due to a reduction in admissions at PHB.

**Admissions to ULHT from Grantham and Sleaford areas**

The average number of admissions for patients living in post code areas; NG31, NG32, NG33 & NG34:

- The average number of admissions to LCH prior to 16th August 2016 was 26 and since then to 8th December 2016 was 27, to 26th March 2017 was 25 and to 30th June 2017 was 24.
- The average number of admissions to PHB prior to 16th August 2016 was 9 and since then to 8th December 2016 was 9, to 26th March 2017 was 9 and to 30th June 2017 was 9.

**Summary**

Overall there has been no change in admissions to LCH or PHB from the Grantham and Sleaford post codes since 17th August 2016.

**Emergency admissions to ULHT**

The average number of emergency admissions to each of the ULHT hospitals: -

- The average number of emergency admissions to LCH prior to 16th August 2016 was 85 and since then to 9th October 2016 and to 8th December 2017 was unchanged. To 26th March 2017 the average number of emergency admissions was 86.
- The average number of emergency admissions to PHB prior to 16th August 2016 was 61 and since then to 9th October 2016 was 60, to 8th December 2016 was 60.5 and to 26th March 2017 was 59.

- The average number of emergency admissions to GDH prior to 16th August 2016 was 15 and since then to 8th December 2016 was 12 and to 26th March 2017 was 12.6.

**Summary**

There has been negligible change in emergency admissions since the 17th August.

**Emergency admissions to LCH and PHB from the Grantham and Sleaford area**

The number of emergency admissions to the Lincoln and Pilgrim Hospitals from 1st April 2016 to 8th December 2016 for patients living only in the following post code areas: NG31, NG32, NG33 and NG34:

- The average number of emergency admissions to LCH from these post codes 1st April 2016 to 16th August 2016 was 10. Since then to 9th October it was 12, to 8th December 2016 it was 11, to 26th March 2017 it was 10.5 and to 30 June 2017 it was 10.3.
- The average number of emergency admissions to PHB from these post codes 1st April 2016 to 16th August 2016 was 3.6. Since then to 9th October 2016 it was 3.2, to 8th December 2016 it was 3.5, to 26th March 2017 it was 3.5 and to 30th June 2017 it was 3.5.

**Summary**

There has been very little change in emergency admissions to LCH and PHB from the Grantham and Sleaford post codes since the 17th August. The previously reported slight increase in emergency admissions has not been sustained.

**Discharges from A&E at LCH to Grantham and Sleaford post codes NG31, 32, 33 & 34.**

The number of patients discharged by hour of the day from the Emergency Department at Lincoln Hospital to the Grantham and Sleaford post code areas; NG31, NG32, NG33 and NG34.

The previously documented increase in the number of patients discharged to Grantham and Sleaford post codes out of hours since August 17th has decreased a little. The most recent data to 10th July 2017 shows 7.04 patients were discharged. Data presented to the November 2016, February 2017 and May 2017 Trust Board meetings were 7.6, 7.42 and 7.0 respectively. This compares with 3.8 patients prior to 17th August 2016.

**Activity of Grantham Ring Fenced Department**

To facilitate transfer of patients from A&E requiring more specialised care after the department has closed there have been two beds on the Emergency Admissions Unit ring fenced specifically for this purpose. Between 18th August and 21st December there have been 13 patients placed here pending transfer. From December 5th 2016 to 30th March 2017 there were 23 patients admitted to the ring fenced beds awaiting

transfer to other sites. The average time awaiting transfer was 3 hours. The longest wait was 8.5 hours, the shortest wait was 45 minutes. These numbers have not been recorded since March 2017 but the bed managers and matron report the activity is low.

**Patients in A&E at GDH at 18.30**

There has been a marginal reduction in the number of patients in the department at 18.30 hours pre overnight closure from 14 to 11.7 following the closure.

**Call to 111 and 999 from Grantham A&E**

- From the 18th August to 2nd January 2017 there have been a total of 88 calls using the telephone outside A&E.
- From 1st January 2017 to 24th April 2017 there were 54 calls made including 5 to 999. A total of 35 calls were made over the weekend (Saturday & Sunday). There were 24 calls made whilst the department was open and 20 of these were made at the weekend.
- From 11 June to 2 July 2017 there were 102 call made including 1 to 999. Of those 30 were made over the weekend (Saturday and Sunday) and 71 were made whilst the department was open.

**7.0 Summary**

Since the overnight closure of A&E at GDH, the overall impact on ULHT remains more or less unchanged since last reviewed by the Trust Board in February 2017. To date it has not been possible to assess the impact of the new opening times from 27th March 2017.

Since the last reported to the Board (February 2017), a formal assessment of the quality impact in terms of length of stay, mortality, serious incidents and complaints has not been made because of insufficient data. However, there is no suggestion of any adverse events as a direct consequence of the overnight closure.

The significance of the impact on EMAS remains unclear but there have been no new developments since last reported to Trust board.

The impact on surrounding stakeholders, anecdotally, remains small for the most part. Attendance to the OOH service on site at Grantham decreased prior to the changes were made. The rate of decline has reduced

The public, particularly from the Grantham area continue to have concerns about the on-going closure of the A&E department. This concern is shared by some staff from Grantham hospital.

Reducing the A&E opening hours at GDH to 09.00 – 18.30, has enabled A&E at LCH to be supported up to an additional 85 hours per week by the middle grade and consultant staff from A&E at GDH. It is anticipated that this will decrease to 53 hours following the commencement of the new opening times.

Although nursing vacancies in A&E were not the primary reason for the overnight closure of Grantham A&E, there remains a significant vacancy factor in the A&E departments at both Grantham and Lincoln. The nursing shortage merely adds to the pressures faced in the Emergency departments.

To date the number of substantive or long term locum middle grades recruited has increased to 18.6 wte except during February. There is no expectation that this will change in the immediate future but has the potential to increase. Based on our experience, it is highly unlikely any doctors recruited in the next couple of months would be in a position to take up employment before autumn 2017. Although there remains the potential to recruit more middle grade doctors, this is subject to a number of actions beyond the influence of ULHT.

The number of substantive wte consultants and total wte consultants have remained static at 15 but temporary sickness absence has made staffing arrangements a challenge. There remains an expectation that junior medical staff recruitment will decrease significantly.

The recent introduction of IR 35 taxation has had a profound impact on our ability to recruit locum medical staff and maintain a safe level of service in A&E. This has led to ULHT declaring a time limited critical incident resulting in the implementation of exceptional but unsustainable actions in order to provide a safe 24/7 A&E service at LCH and PHB.

It is important for the Trust Board to be aware that the recruitment of trained medical staff of appropriate seniority and the provision of 24/7 A&E services remains very fragile. The recruitment of middle grade doctors to ULHT remains particularly challenging and volatile.

## 8.0 Recommendation

The Trust Board is asked to note the contents of this paper, including the views of all interested parties.

When the decision was taken in August to reduce the opening hours of the Grantham A&E, a threshold of a minimum of 21 wte middle grade doctors would be required to safely staff the three A&E departments (Lincoln, Pilgrim and Grantham). This report has demonstrated that although the recruitment drive has led to a gradually improving picture in medical staffing, it will not reach the minimum threshold to open 24/7 by 31 July 2017 and remains doubtful thereafter. The provision of emergency services, particularly at LCH, continues to remains fragile and requires the support of A&E medical staff, from GDH, on grounds of patient safety. The recent change to the taxation rules has had an additional deleterious and previously unforeseen effect on A&E staffing.

From the evidence provided in the report, the Trust Board is asked to support the following recommendations:

1. Based on the evidence provided in the report, the Trust Board is asked to support the overnight closure of the A&E department and to continue with the new current opening hours of 08.00 - 18.30 hours implemented 27th March 2017.
2. To work with the CCGs to explore an interim service model for a 24 hour emergency/ out of hours service.
3. To review the overnight closure in 3 months

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| 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 West Clinical Commissioning Group, Lead Commissioner of Emergency Ambulance Services in Lincolnshire

| | |
|---|---|
| Report to | **Health Scrutiny Committee for Lincolnshire** |
| Date: | **13 September 2017** |
| Subject: | **Emergency Ambulance Commissioning** |

**Summary:**

This report provides an overview on how emergency ambulances are commissioned from the East Midlands Ambulance Service.

**Actions Required:**

The Committee is invited to consider and comment on the information presented.

## 1. Background

### Commissioning Arrangements

The four Lincolnshire County Clinical Commissioning Groups (CCGs) (Lincolnshire East, Lincolnshire West, South Lincolnshire and South West Lincolnshire) commission emergency ambulances as part of a collaborative commissioning arrangement across the East Midlands, along with another 18 CCGs - 22 CCGs in total.

Emergency ambulances are commissioned from the East Midlands Ambulance Service (EMAS), which covers five counties Derbyshire, Leicestershire, Lincolnshire, Northamptonshire and Nottinghamshire.

Commissioning meetings are held at both (EMAS) Trust level, and at County (or divisional) level. For Lincolnshire this involves six CCGs, the four Lincolnshire

County CCGs and North and North East Lincolnshire CCGs. These six CCGs constitute the EMAS Lincolnshire Division.

The Trust level meetings include the contract lead commissioner team (Hardwick CCG), a lead commissioner from each County (two from Greater Lincolnshire) and EMAS management Board.

The local meetings include the contract lead commissioner team, local commissioning team from both the four Lincolnshire County CCGs and North/North East Lincolnshire CCGs and the EMAS Divisional management team.

The above arrangement provides a balanced approach to understanding and managing emergency ambulance services across all 22 CCGs and at a local level (Lincolnshire) .

Hardwick CCG provides lead commissioning with EMAS.

Lincolnshire West CCG provides lead commissioning across the four Lincolnshire County CCGs.

**Contracting**

There is a single contract across the 22 CCGs and EMAS, which is managed by Hardwick CCG. Additional local requirements can be added to the contract.

The contract currency with EMAS is activity-based using four counts: calls; hear & treat; see & treat; and see & convey. Contracted activity is based on a three-year rolling analysis and adjusted for system changes that would have impact on any of the four counts, e.g. Clinical Assessment Service, or 111 changes.

Activity is agreed between the 22 CCGs and Hardwick CCG, and further between Hardwick CCG and EMAS. Discrepancies are managed locally though Hardwick CCG and involving the local lead and EMAS contracting team.

EMAS as a Trust is currently (2017/18) contracted to deliver national performance standards at Trust level only. This also includes improvement at Divisional level compared to the previous year.

The contract value across the four Lincolnshire County CCGs is £25.5m.

**Commissioning Decision Making**

The majority of commissioning decisions are managed at Trust level as they are largely governed at national level. These are national "must be dones".

Regional (EMAS Trust level) application is determined through meetings between the commissioners (Hardwick CCG and the County Leads) and EMAS through negotiation. This requires negotiation between Hardwick CCG and the County Leads, who represent their specific CCGs.

Local commissioning, is managed at local level through the local lead commissioner with the involvement of Divisional General Manager.

In Lincolnshire County decisions usually involve all CCGs, but at times may be CCG specific. There is clear communication between Lincolnshire West CCG, as the lead commissioner and the other three CCGs. This communication is via the CCGs' own commissioners and includes attendance at CCG Boards etc.

Decision making involves the EMAS management, which is usually the Divisional Team and involve identifying issues, reasons and solutions.

Having a local approach is important in order to identify and meet local needs. This is particularly important now in view of the Lincolnshire Sustainability and Transformation Plan (STP) and system-wide changes to ensure that unintended consequences are mitigated.

In summary there is a myriad of influences on commissioning decisions including; performance, activity; 'local' issues/changes; STP; and the Urgent Care Board (A&E Delivery Board). It is critical that EMAS is committed to, and involved in these county-wide groups. There is also close working between lead commissioners and EMAS Lincolnshire Division which enables robust confirm and challenge on both parts.

Local working has delivered change which benefits the local population. One of the latest examples of this is EMAS being an alliance partner in the Lincolnshire Clinical Assessment Service (CAS). The CAS now provides additional clinical support to paramedics on-scene and has reduced the number of people previously taken to hospital, who are better cared for within other community-based services.

**Future Commissioning**

There has recently been a number of significant changes to ambulance services including a new response programme, review of how EMAS is commissioned and their use of their resources.

We are still in very early stages of assessing and understanding the impact of these, they do offer significant opportunities for the health system to work differently.

## 2. Consultation

This is not a consultation item.

## 3. Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

The emergency ambulance service supports the work of the Joint Strategic Needs Assessment by looking to ensure people who call 999 are directed to the most appropriate services, and not just automatically conveyed to an acute hospital. This includes looking to improve pathways for to enable people to access care and treatment more locally and to meet the interdependency of services that people's clinical conditions require.

This approach specifically supports people with long-term conditions, including frailty.

For these people it is important that they are only taken to, and admitted into an acute hospital if they require higher levels of treatment and care.

Unnecessary admissions can create problems in both admitting people who clinically need to be admitted, and contributes to those who experience delays in their discharge.

## 4. Conclusion

There is a robust commissioning process and system across the 22 CCGs which supports sustainable development of emergency ambulances services to meet national and, regional requirements. This approach also provides a local focus to analyse, identify and deliver service improvement for the people of 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 Martin Kay, Head of Commissioning, NHS Lincolnshire West CCG who can be contacted on 07972 194768 or martin.kay@lincolnshirewestccg.nhs.uk

| Lincolnshire COUNTY COUNCIL Working for a better future | | **THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE** | |
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| 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: | **13 September 2017** |
| Subject: | **East Midlands Ambulance Service: Outcomes of Care Quality Commission Inspection and Ambulance Response Programme** |

**Summary:**

The purpose of this item to consider information from the East Midlands Ambulance service, following the publication of the Inspection report by the Care Quality Commission.

The Committee is also requested to consider information on the Ambulance Response Programme, which has replaced the former response time arrangements for all ambulance trusts.

Richard Henderson, the Chief Executive, and David Williams, the General Manager, from the East Midlands Ambulance Service, are due to attend for this item.

**Actions Required:**

The Health Scrutiny Committee is recommended to consider and comment on: -

(1) the outcomes of the Care Quality Commission Report on the East Midlands Ambulance Service, and their response to the report;

(2) the information on the Ambulance Response Programme, in which the East Midlands Ambulance Service has been participating since 19 July 2017; and

(3) the other information submitted by the East Midland Ambulance Service.

## 1. Care Quality Commission Report

On 13 June 2017, the Care Quality Commission (CQC) published its report on the East Midlands Service NHS Trust, following an inspection visits on 21-23 February 2017 and on 3 March 2017.

The full report is available on the CQC website: -
http://www.cqc.org.uk/sites/default/files/new_reports/AAAG3548.pdf

The overall finding for the Trust was "Requires Improvement" for both emergency and urgent care services; and for the emergency operations centre. The CQC stated that its key findings were as follows:

- *"The trust had made significant improvements as required by the July 2016 warning notice. However we remained concerned about response times.*
- *Response times for Red 1, Red 2 and A 19 calls were consistently below the national target and patients were not receiving care in a timely manner.*
- *There were variable standards of incident investigation, limited recommendations, lack of learning at an organisational level and a lack of evidence that recommendations had been actioned.*
- *There was a lack of consistency in the management of risk due to trialling a revised risk register pro forma.*
- *Staff did not know about the Duty of Candour requirements or their responsibilities under it and the trust had not consistently fulfilled their responsibilities under the Regulation.*
- *We found pockets of concern about the potential bullying and harassment of staff who were not confident to report this. We found instances where policies and procedures relating to staff wellbeing were not followed in practice.*
- *Not all staff had been trained on the use of and supplied with filtered face piece masks (FFP3). Those that had been supplied with a mask did not always have them available for immediate use.*
- *The trust were not compliant with the requirements of the Fit and Proper Persons Regulation.*
- *Whilst the trust had a clear vision and strategy, frontline staff were not aware of these.*
- *Whilst training completion rates for statutory and mandatory training had significantly improved, mandatory training completion rates for equality and diversity and risk management modules were too low and there were challenges in two specific divisions around completion rates in general.*
- *The trust had taken appropriate actions which had been successful in increasing the number of front line staff.*
- *Standards of cleanliness had improved.*
- *The majority of equipment and vehicle checks were appropriately completed.*
- *There was an increased number of operational vehicles available to deliver emergency and urgent care services.*
- *Medicines were stored securely and the management of controlled drugs was in line with the trust's policy. However, we had some concerns about the lack of robust audit trail for access to controlled drugs on solo responder vehicles.*

- *There were notable improvements in the security of patient records.*
- *Potential risks to the service were anticipated and planned for in advance.*
- *The trust had taken action to provide frontline staff with the knowledge and information they needed to respond to a major incident.*
- *People's care and treatment was planned and delivered in line with current evidence-based guidance, standards and best practice.*
- *Patient outcomes were mainly above or equivalent to national average levels.*
- *Staff had received timely appraisals which had been perceived by most to be a meaningful process.*
- *Improvements in training and development opportunities were evident and staff told us about them.*
- *Where patients received care form a range of different staff, teams or services this was effectively coordinated.*
- *Staff were confident in their understanding of the principles for patient consent and the Mental Capacity Act 2005 and they followed them.*
- *There was a governance framework able to support the delivery of safe, high quality care.*
- *There was a high level of confidence in and respect for the leadership of the acting chief executive.*
- *There was increased confidence in the effectiveness of the board and frontline leaders were better equipped with skills and knowledge.*
- *The culture of the trust from board to frontline staff was overwhelmingly patient focussed. Our inspection team observed caring, professional staff delivering compassionate, patient focussed care in circumstances that were challenging due to the continued demand placed on the service.*
- *Staff engagement and satisfaction had improved since our last inspection.*

*"We saw several areas of outstanding practice including:*

- *The trust had run a highly effective recruitment campaign and received a national award for equality and diversity in recruitment.*
- *The trust were trialling a pre-hospital sepsis treatment in North and North East Lincolnshire. Where patients presented with the symptoms of sepsis, blood cultures were taken and a pre-hospital dose of intravenous antibiotic therapy administered to the patient. This saved valuable time and provided prompt lifesaving treatment. The results of the study had not been published at the time of our inspection but early indications showed positive outcomes for patients. The trust was the only ambulance trust in England providing pre-hospital care to this group of patients.*
- *The trust had extended the provision of a mental health triage car in Lincolnshire and also to include patients in Derbyshire increasing the provision of appropriate care and treatment for patients with mental health conditions.*
- *We observed caring, professional staff delivering compassionate, patient focussed care in circumstances that were challenging due to the continued demand placed on the service.*

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

- *The trust must ensure patients receive care and treatment in a safe way by meeting national and locally contracted response time targets for Red1, Red2 and A19 categorised calls.*
- *The trust must take steps to improve EOC call taking response times therefore reducing the number of calls abandoned and the length of time callers are waiting on the phone.*
- *The trust must ensure all staff know how to report incidents. The trust must ensure serious incidents are appropriately and consistently investigated with lessons learnt acted upon and shared widely.*
- *The trust must ensure all staff understand the Duty of Candour Regulation and their responsibilities under it.*
- The trust must ensure all staff access and attend mandatory training with particular focus on compliance rates for equality and diversity and risk management training.
- The trust must ensure all staff are fitted for and trained in the use of a filtered face piece mask to protect them from air borne infections.
- *The trust must increase the percentage of frequent callers who have a specific plan of care.*
- *The trust must ensure there are systems in place to ensure staff have received, read and understand information when there are updates to trust policies, procedures or clinical practice.*
- *The trust must ensure they comply with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014)."*

The detailed findings from the CQC in June 2017 are as follows: -

| CQC Findings – June 2017 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Safe | Effective | Caring | Responsive | Well Led | | Overall |
| Emergency and Urgent Care | Requires Improvement | Requires Improvement | Good | Good | Requires Improvement | | Requires Improvement |
| Emergency Operations Centre | Requires Improvement | Requires Improvement | Good | Good | Good | | Requires Improvement |
| OVERALL | Requires Improvement | Requires Improvement | Good | Good | Requires Improvement | | Requires Improvement |

This compares with the CQC findings of May 2016 (based on inspection visits in November and December 2015):

| CQC Findings – May 2016 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Safe | Effective | Caring | Responsive | Well Led | | Overall |
| Emergency and Urgent Care | Inadequate | Requires Improvement | Good | Good | Requires Improvement | | Requires Improvement |
| Emergency Operations Centre | Requires Improvement | Good | Good | Good | Good | | Good |
| OVERALL | Inadequate | Requires Improvement | Good | Good | Requires Improvement | | Requires Improvement |

Response of EMAS to the CQC Report

The response of EMAS is set out in the presentation in Appendix A.

EMAS Trust Board – 4 July and 5 September 2017

On 4 July 2017, the outcomes of the CQC inspection were reported to the EMAS Trust Board. On 5 September 2017, the Board is due to consider an action plan, which details the required actions to meet the CQC's requirements.

East Midlands Health Scrutiny Network

On 27 June 2017, the Chairman attended the East Midlands Health Scrutiny Network and received a presentation from EMAS, together with the lead commissioner, Hardwick Clinical Commissioning Group.

## 2. Ambulance Response Programme

On 13 July 2017, NHS England announced the introduction of a new set of performance targets for all ambulance services. The main elements were as follows:

- National response targets to apply to every single 999 patient for the first time
- Faster treatment for those needing it, to save 250 lives a year
- An end to “hidden waits” for millions of patients
- Up to 750,000 more calls a year to get an immediate response
- New standards to drive improved care for stroke and heart attack
- World’s largest clinical ambulance trial updates decades-old system

NHS England stated that the new system was supported by the Association of Ambulance Chief Executives, the Royal College of Emergency Medicine, the Stroke Association and the British Heart Foundation amongst others. The House of Commons Public Accounts Committee also issued a report in April 2017 recommending the introduction of the Ambulance Response Programme across all ambulance trusts.

NHS England has advised that call handlers would change the way they assessed cases and would have slightly more time to decide the most appropriate clinical response. As a result cardiac arrest patients would be identified more quickly, with evidence showing this could save up to 250 lives every year. The redesigned system would focus on ensuring patients get rapid life-changing care for conditions such as stroke rather than simply “stopping the clock”. Currently one in four patients who need hospital treatment – more than a million people each year – undergo a “hidden wait” after the existing eight minute target is met because the vehicle despatched, a bike or a car, cannot transport them to A&E.

Ambulances would now be expected to reach the most seriously ill patients in an average time of seven minutes. The ‘clock’ will only stop when the most appropriate response arrives on scene, rather than the first. This would release more vehicles and staff to respond to emergencies. Currently, three or even four vehicles may be

sent to the same 999 call to be sure of meeting the eight minute target, meaning that across the country one in four ambulances are stood down before reaching their destination.

The changes also introduce mandatory response time targets for all patients who dial 999. Currently half of all ambulance calls, around five million a year, are classed as “green” and not covered by any national target. Response times for these patients, who are often frail and elderly, have been under pressure, with some patients waiting 6 hours or more. It will also help to make patients in rural areas less disadvantaged than they can currently be.

Set out below in the two tables are the ambulance response time standards, which are due to be replaced, and the new standards (as set out in the letter from Professor Sir Bruce Keogh, the National Medical Director of NHS England to the Secretary of State for Health on 13 July 2017)

| **Ambulance Response Time Standards – Due To Be Replaced** | | | | |
|---|---|---|---|---|
| **Category** | **Percentage of calls in this category** | **National Standard** | **How long does the ambulance service have to make a decision?** | **What stops the clock?** |
| Red 1 | 3% | 75% within 8 minutes | The clock starts at the point the call is connected to the ambulance service | The first ambulance service-dispatched emergency responder arriving at the scene of the incident |
| Red 2 | 47% | 75% within 8 minutes | The earliest of:<br>• The problem being identified<br>• An ambulance being dispatched<br>• 60 seconds from the call being connected | The first ambulance service-dispatched emergency responder arriving at the scene of the incident |
| Green | 50% | No national standard | The earliest of:<br>• The problem being identified<br>• An ambulance being dispatched<br>• 60 seconds from the call being connected | The first ambulance service-dispatched emergency responder arriving at the scene of the incident |

| New Ambulance Response Time Standards | | | | |
|---|---|---|---|---|
| **Category** | **Percentage of calls in this category** | **National Standard** | **How long does the ambulance service have to make a decision?** | **What stops the clock?** |
| 1 | 8% | 7 minutes mean response time<br><br>15 minutes 90th centile response time | The earliest of:<br>• The problem being identified<br>• An ambulance response being dispatched<br>• 30 seconds from the call being connected | The first ambulance service dispatched emergency responder arriving at the scene of the incident<br><br>(There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation) |
| 2 | 48% | 18 minutes mean response time<br><br>40 minutes 90th centile response time | The earliest of:<br>• The problem being identified<br>• An ambulance response being dispatched<br>• 240 seconds from the call being connected | If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock. |
| 3 | 34% | 120 minutes 90th centile response time | The earliest of:<br>• The problem being identified<br>• An ambulance response being dispatched<br>• 240 seconds from the call being connected | If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock. |
| 4 | 10% | 180 minutes 90th centile response time | The earliest of:<br>• The problem being identified<br>• An ambulance response being dispatched<br>• 240 seconds from the call being connected | Category 4T:<br>If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. |

East Midlands Ambulance Service and the Ambulance Response Programme

A report to the EMAS Board on 5 September 2017 is set out at Appendix B and explains how EMAs is implementing the Ambulance Response Programme, since joining the programme on 19 July 2017.

The Integrated Performance Report submitted to the EMAS Board on 5 September includes the following: -

*"From 19 July, EMAS moved to the ARP to prioritise sending the right resource to the patient. Reporting under ARP means that there is no longer a performance 'hit' or a 'miss' based on the speed of response. Measures under ARP are based on a mean average, for Category 1 and Category 2 incidents and also a 90th percentile. The mean average relates to the average time it took the ambulance service to respond to a patient. The 90th percentile gives the time by which 90% of patients received a response, or sooner. Category 3 and Category 4 are also measured using a 90th percentile. The national move towards averages and percentile reporting are designed to report the spread of responses and highlight any length delays by using measures of the 90th percentile.*

*Due to 19 July being the changeover day for ARP at EMAS, a full accurate 24 hours performance data is not available (however complete incident recording was in place). Therefore information in the IBR using ARP reporting is based on 20 July onwards. With limited data on ARP reporting it is not possible at this stage to identify factors affecting performance, however as more data is collected over the coming months analysis will be undertaken to understand the interlinkages between different factors.*

*Reporting 20 July to 31 July*

*The percentage of calls split by Category was as follows:*

*Category 1: 7.65%*
*Category 2: 57.55%*
*Category 3: 27.14%*
*Category 4: 7.67%*

*Initial reporting is as follows:*

| | *Mean average Hours: minutes: seconds* | *90th percentile Hours: minutes: seconds* |
|---|---|---|
| *Category 1:* | *00:07:57* | *00:13:52* |
| *Category 2:* | *00:23:45* | *00:50:28* |
| *Category 3:* | *Not reported nationally* | *02:11:03* |
| *Category 4:* | *Not reported nationally* | *04:42:24* |

"

## 3. Update from EMAS

A briefing paper from EMAS is attached at Appendix C.

## 4. Conclusion

Health Scrutiny Committee is recommended to consider and comment on the outcomes of the Care Quality Commission Report on the East Midlands Ambulance Service, and the response to the report; and the information on the Ambulance Response Programme, in which the East Midlands Ambulance Service has been participating since 19 July 2017.

**5.** Appendices – These are listed below and set out at the end of this report

| | |
|---|---|
| Appendix A | EMAS Lincolnshire Division Update – Presentation from Richard Henderson, Chief Executive, and General Manager, David Williams |
| Appendix B | Ambulance Response Programme Pilot- Report to East Midlands Ambulance Service Board (Paper No PB/17/118) – 5 September 2017 |
| Appendix C | East Midlands Ambulance Service NHS Trust Lincolnshire Overview and Scrutiny Committee Briefing Paper |

**6.** Background Papers - None

This report was written by Simon Evans, Health Scrutiny Officer, Lincolnshire County Council: 01522 553607 – Simon.Evans@lincolnshire.gov.uk

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East Midlands Ambulance Service NHS Trust

# EMAS and Lincolnshire division update

Chief Executive Richard Henderson and General Manager David Williams

**Emergency care | Urgent care | We care**

# 2016/17 overview

- 2016/17 was a real challenge across NHS and Social Care services.

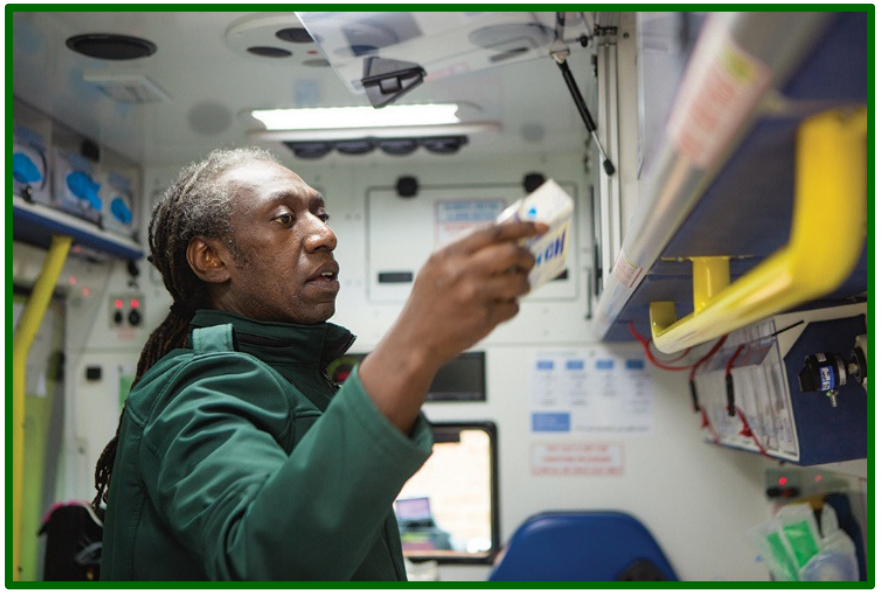
- Significant changes made to improve trust position;
  - clinical standards for our patients
  - response times to meet our contractual obligations
  - our finances
  - staff wellbeing

- Progress has allowed us to focus on our transformation plans, refresh our vision and our strategic objectives.



# 2016/17 overview

- Independent capacity and demand review.
- Findings of review influenced contract agreement for 2017/18 allowing for further investment in our service.
- We continue to progress our improvement plans, including proactively recruiting to our frontline and investing in new ambulances to expand our fleet.



# Care Quality Commission (CQC)

- CQC inspected EMAS November 2015 and published its report May 2016.

- We progressed our Quality Improvement Plan, and the CQC came back to EMAS February 2017. In March the CQC published its follow-up report:

  - **Overall CQC rating** 'requires improvement'

  - **Safe:** improved from 'inadequate' to 'requires improvement'

  - **Effective:** remained 'requires improvement'

  - **Well-led:** remained 'requires improvement'

  - **Caring** and **Responsive:** remained 'good'

# Safe

- Enhanced arrangements to ensure lessons learnt are captured and addressed (Quality Everyday programme).
- Integration of PALs, complaints and investigation teams.
- Effective leadership of the resolution of hospital handover delays, delivering system-wide changes and improvement.



# Effective

- Revised Capacity Management Plan focussing on patient safety and patient acuity.
- Continued improvement of Medicines Management.
- Further roll-out of pre-hospital antibiotics for Sepsis patients.
- Survival to discharge from cardiac arrest improved from 5.9% to 6.9%.
- Direct access to Primary Percutaneous Coronary Intervention (PPCI) laboratories for Stroke patients.

# Well-led

- Strengthened and stabilised leadership;
  - Board level roles and external support
  - Directors linked to geographical locations.
  - Operations management restructure

- Realigned our vision and strategic objectives

- Significantly improved financial position, and invested in frontline staffing and equipment.

- Long term activity, price and strategic reviews with Commissioners.

- Engagement with broader health community including:
  - A&E Delivery and Escalation Boards
  - Sustainability Transformation Partnership



# Caring

- Best practice in staff support and wellbeing
- Reduced sickness absence
- Improved appraisal rates
- Improved statutory and mandatory training rates
- Improved staff engagement
- Sector lead in mental health training

# Responsive

- Recruited 352 operational and EOC staff and 27 international Paramedics.
- Improved skill mix of frontline staff:
  - Maintained paramedic workforce
  - More technicians
- Reduced staff turnover from 11% to 9%.
- Career progression opportunities offered.
- National recruitment, equality and diversity award 2017.
- Reviewed and strengthened our emergency resilience, following the devastating and tragic attacks in Manchester and London.

# Responsive

- Financial stability and certainty allowing for long-term investment.
- 57 new double crewed ambulances.
- 164 new defibrillators on our vehicles during 2016/17, and 127 this year.
- New Electronic Patient Report Form solution (ePRF) – over £3million investment.
- Plans agreed with Commissioners for long-term strategic review to support greater patient care focus and Sustainability & Transformation Plans alignment.


# Ambulance Response Programme (ARP)

- After the largest clinical ambulance trials in the world, NHS England is implementing new standards for English services.

- Evidence shows the changes are safe; no safety issues identified in more than 14 million 999 calls handled over the 18 month trials.

- New system updates a decades old system, providing a strong foundation for the future:
  - prioritising the sickest patients to ensure they receive the fastest response, and
  - driving efficient behaviours to give greater opportunity for the patient to get a response in a clinically appropriate time.

- EMAS introduced ARP 2.3 on 19 July 2017.

# Local Developments

- Remodel management team for progression and staff access
- Co-locating with fire and rescue
- Turnaround teams liaising with NLAG and ULHT
- Summer swell plans:
  - Triage unit East coast
  - Push bikes East coast
  - Fresher's week unit
- Winter and Christmas planning underway

# In summary

- We have made substantial improvements.
- We continue to focus on and progress priority areas - we understand where there are further challenges and what we need to do.
- Along with all our staff we are confident and committed to continuously improve our services to meet the needs of the communities we serve.

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East Midlands Ambulance Service NHS Trust

| Paper No. | PB/17/118 |
|---|---|

**Report to: TRUST BOARD**

**Date: 5 September 2017**

| | |
|---|---|
| **Report Title:** | Ambulance Response Programme Pilot |
| **Author:** | Jayne Condon, Head of Programme Management Office |
| **Presented by:** | Dave Whiting, Chief Operating Officer |

**Purpose of Report**

The purpose of this report is to provide an update to Trust Board following migration to the Ambulance Response Programme (ARP) 2.3 pilot, and to provide assurance on the ARP governance and reporting arrangements.

| Type of Report | Decision-making | Assurance | Discussion |
|---|---|---|---|
| | | X | |

**Executive Summary**

- On Wednesday 19 July 2017 EMAS joined the national ARP 2.3 pilot.
- The ARP pilot is a fundamental change to the way ambulance services respond to patients, both in terms of the time to respond, and the categorisation of patient conditions.
- The migration to ARP on the 19 July was delivered smoothly without any staff or patient issues.
- North West Ambulance Service also joined the 2.3 pilot as the second trust in this wave.
- The rationale for the ARP pilot is to provide the most appropriate response and clinician to the patient, to reduce duplication and improve clinical outcomes.
- The governance and reporting structure for the programme was approved by the Trust Executive Team.
- An ARP Delivery Group was established to provide oversight and governance across the programme work streams.
- The ARP Delivery Group met on a weekly basis, providing weekly reports to the Executive Team and lead commissioner.
- The Chief Operating Officer is the sponsor of the programme and has authority to make key decisions while consulting with other member of the Executive Team
- Work is continuing to ensure effective and complete reporting platforms are in place.

- All relevant clinical policies and procedures have been updated to take into account changes due to ARP and have been presented to the relevant groups for approval.
- Early benefits of the migration to ARP have included:
  - A timely response to those patients with life-threatening conditions - Category 1 calls.
  - Ability to dispatch the right clinical resources to meet the needs of patients based on presenting conditions.
  - A reduction in multiple dispatches, and reduced stand down of resources, once allocated.
  - Increased opportunity and ability to support patients through Hear and Treat, and See and Treat (advice and support via the telephone and at scene).
  - An increase in allocation of crew 'rest breaks' at the correct time.
  - A reduction in late finishes for frontline crews.
- The first full month of ARP activity and delivery is reported in the Integrated Board Report (IBR) - reported to Trust Board on the 5 September 2017.
- The Executive Team on the 14 August 2017 agreed how ARP will be transitioned into 'business as usual'.
- To realise the opportunities and patient benefits arising out of ARP, the clinical operating model will be revised over the coming months.

**Strategic Fit:**

| Strategic Objective | Relevant |
|---|---|
| **Our Quality** - We will respond to our patients with a high quality service exceeding national ambulance target quality indicators. | **X** |
| **Our Reputation** - We will be recognised nationally as a reliable provider of high quality out of hospital and community based care across the East Midlands. | **X** |
| **Innovation ambition** - We will be recognised nationally as a leading innovator in community based and out of hospital care. | **X** |
| **Integration** - We will work in partnership with our local health care, social care, and voluntary sector partners to deliver and enable integrated patient services and care pathways across the East Midlands. | **X** |
| **Our People** - We will consistently develop and support our people to be highly skilled, highly motivated, caring and compassionate professionals. | **X** |
| **Efficiency** - We will make the most effective use of all our resources, delivering upper quartile performance on our indicators for money, staff, premises, and fleet. | **X** |

**Impact:**

| |
|---|
| **Quality**<br>• A quality impact assessment has been completed to determine the impact the pilot will have on patient outcomes |
| **Financial Position**<br>• Currently no material impact, but potential for improved efficiency |

| |
|---|
| **Operational Performance**<br>• National and local reporting has been amended to report on ARP |
| **Workforce including Equality Issues**<br>• An equality impact assessment has been completed to assess the impact on communities and staff of the way this service is provided |
| **Reputation of the Trust**<br>• A communications plan was produced to ensure the reputation of the trust is maintained |
| **Other**<br>• N/A |

**State in the box below the committees or groups which this report has already been presented to:**

| |
|---|
| None |

**Risk Management:**

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|---|
| **Board Assurance Framework:**<br><br>BAF Risk 12 |

| **Details of any new risk(s) identified which may result from the recommended decision or action:** | **Risk Assessment** | | |
|---|---|---|---|
| | **Consequence** (A) | **Likelihood** (B) | **Score** (A x B) |
| None | | | |
| **Details of mitigation of identified risk(s):** | Not applicable | | |

**Recommendation(s)**

**That the Trust Board:**

- **CONSIDERS** the update on the migration to the Ambulance Response Programme 2.3 pilot, including early findings; and
- **TAKES ASSURANCE** from the governance and reporting arrangements for the Ambulance Response Programme.

**Trust Board Meeting – 5 September 2017**

**Ambulance Response Programme (ARP)**

## 1. Introduction / Background

The Trust has been a key supporting partner to the development of the Ambulance Response Programme thus far, and had expressed an interest in becoming an additional trial site for the Phase 2 trial. The Trust was informed on the 30 May 2017 that it would participate in the trial commencing July 2017.

The national ARP pilot is a fundamental review of the way ambulance services respond to patients, both in terms of the time to respond (performance) and the categorisation (clinical coding) of patient conditions.

- Category 1 (8% of calls) for people with life-threatening injuries and illnesses.
- Category 2 (57% of calls) emergency calls.
- Category 3 (27% of calls) urgent calls. In some instances this may include treatment by an ambulance clinician in the patients own home.
- Category 4 (8%) for less urgent calls. In some instances this may include advice being given over the telephone or referral to another service such as a GP or pharmacist.

The rationale for the ARP pilot is to:

- Prioritise the sickest patients, to ensure they receive the fastest response.
- Drive clinically and operationally efficient behaviours, so the patient gets the response in a clinically appropriate timeframe.
- Put an end to unacceptably long waits by ensuring that resources are distributed more equitably amongst all patients contacting the ambulance service.

The planning and implementation phase lasted 6 weeks, during which time the governance and reporting arrangements were approved by the Trust Executive Team, and weekly reports provided to the Executive team / Turnaround Board as part of the governance process. The Executive Team on the 10 July 2017 received an update to understand the scope of the ARP 2.3 pilot and changes proposed, acknowledged the readiness process and agreed the go-live date of the 19 July 2017.

NHS England announced on the 13 July 2017 the new set of Ambulance Quality Indicators (AQIs) for English ambulance services; the announcement meant that EMAS would continue to introduce ARP on 19 July 2017.

At 03:00 hours on Wednesday 19 July 2017 EMAS went live with the new ARP 999 call categories.

## 2. Purpose

The purpose of this report is to provide an update to Trust Board following migration to the Ambulance Response Programme (ARP) 2.3 pilot, and to provide assurance on the ARP governance and reporting arrangements

## 3. Assurance

The governance and reporting structure for the programme was approved by the Trust Executive Team on the 12 June 2017.

An Ambulance Response Programme Delivery Group was established to provide oversight and governance across the following programme workstreams:

- Emergency Operations Centre (EOC) – responsible for the delivery of the required training packages to the different teams within EOC, updating the Standard Operating Procedures and upgrading and testing the systems used for the EOC and operational staff.
- Quality Governance – to ensure all the supporting policies and procedures relating to patient experience, patient engagement, and external letters are updated to reflect the national project.
- Reporting – responsible for ensuring national and contractual returns were made; information is available internally to support performance, and to ensure AQI compliance.
- Contracting – ensure that the terms of the Trust's 2017/18 Urgent and Emergency Ambulance contract was reviewed in the light of ARP.
- Community First Response – to assess, analyse and communicate the outcome of the ARP introduction to EMAS direct Community First Responders, and partner response agencies.
- Communications – responsible for ensuring key ARP messages and corporate briefings are shared in a structured, consistent, timely and accessible manner to staff, volunteers and stakeholders.

The ARP Delivery Group has met on a weekly basis and provided a weekly report to the Executive Team and lead commissioner; the Chief Operating Officer as sponsor of the programme had authority to make key decisions while consulting with other member of the Executive Team. To support the delivery of the programme the following work has been completed:

- A risk/issues log and decisions log has been maintained to record all risks/ issues and decisions identified by the workstreams, ARP Delivery Group and Executive Team
- A quality impact assessment and an equality impact assessment have been completed and approved
- In preparation for the go-live for the ARP Phase 2.3 pilot, NHE England nationally has coordinated the overall programme and associated governance with local project teams from EMAS reporting into the national team. The EMAS local project team,

which is multi-disciplinary, created a local project plan to determine the activities required for the ARP change to take place

- A go live plan and readiness status report was presented to the Executive Team to inform the decision to go live on the 19 July 2017
- A communication plan was developed for the ARP programme Phase 2.3
- A post project review will be undertaken and provided to the Trust ExecutiveTeam.
- The programme has been managed through the Trust Programme Management Office

## 4. Implementation

ARP has now been implemented across the trust and in both emergency operations centres with currently no technical and system issues to report. The migration on the 19 July was delivered smoothly without any staff or patient issues.

Work is continuing to ensure effective and complete reporting platforms are in place to enable in depth analysis of performance and areas where process needs further refinement to improve existing delivery.

All relevant clinical policies and procedures have been updated to take into account changes due to ARP and have been presented to the relevant groups for approval. Templates for incidents, complaints and serious incidents have also been amended to take into account the new indicators. The changes due to ARP have not negatively impacted on the clinical effectiveness, patient safety and quality of the service provided to our patients. There have been no concerns raised in relation to the new indicators.

Following the national announcement made via Ministerial Statement and NHSE media release introducing new ARP standards, the trust issued internal, stakeholder and media/social media posts based on 4 objectives, to:

1. Raise awareness internally, ensuring staff and volunteers could identify and relate to the key messages.
2. Raise awareness of East Midlands based healthcare professionals and to encourage appropriate behaviour change.
3. Manage expectations and change perceptions of the ambulance service.
4. Promote the importance of dialing 999 in an emergency and using alternative healthcare for minor illnesses and injuries.

The final AQIs for ARP version 2.3 were issued to the trust on the 4 August 2017. The trust is currently working to the draft version of the 2.3 AQI guidance, with a plan to implement the revised AQIs during August 2017.

## 5. Benefits

The high level benefits of ARP are summarised below; ARP has been live for approximately 4 weeks at the time of this report and early indications are that the following benefits are being reported:

Ensuring a timely response to those patients with life-threatening conditions category 1 calls:

- Some bespoke work has taken place internally to enable quicker identification of Category 1 calls relating to Haemorrhage and Fitting.
- Additionally the trust is also employing auto dispatch technology to speed up the dispatch of resources to Category 1 calls.

Providing the right clinical resources to meet the needs of patients based on presenting conditions:

- ARP provides the environment for dispatch to allocate a resource of the appropriate clinical skill mix to the right patient more often. This may include Paramedic deployment to a cardiac arrest, major trauma case, or heart attack.

Reducing multiple dispatches:

- ARP provides the opportunity for EOC dispatchers to have additional time to review the deployment to 999 calls that are not immediately life threatening. This enables them to identify patients' needs better and send the most appropriate response(s).
- The number of responses per incident (RPI) for Category 2, 3 and 4 calls has reduced to an average ratio of 1:1 (from 1:2).
- This is enabling EMAS to reduce the number of vehicles it sends to each incident and therefore improving efficiency making more resource unit hours available for deployment to higher categories of call.

Reducing the diversion of resources:

- ARP is providing the opportunity for dispatchers to send the most appropriate response on the first allocation rather than diverting and re-diverting resources.

Increasing the ability to support patients through hear and treat:

- This national objective was set to improve national Hear and Treat (HAT) levels. This is allowing the trust to maintain its already high level of Hear and Treat. The EMAS re-contact rate following self care / advice (HAT) remains below 1% which continues to provide assurance that hear and treat outcome was the most appropriate outcome for the patient, and the Trust will continue to use the re-contact rate as one quality assurance measure for Hear and Treat.

Increasing the ability to support patients through See and Treat:

- ARP provides the dispatchers with the appropriate amount of time to send the most appropriate resource and clinician to the patient. This will in turn support the Trust's objective of treating more patients at home, before either discharging them or referring them on to the right clinician or service for their continued care.

Early indications are that the following additional staff benefits are also being reported:

- Following the implementation of ARP an initial review of data indicates that there has been an improvement in the proportion of front line employees able to take their meal breaks during their planned break window. This in turn assists in reducing fatigue and therefore improves the safety of care provided.
- Improved compliance with End of Shift Deployment, meaning that more staff are able to finish their shift on time.
- EOC dispatchers are supportive of the new dispatch regimes, allowing them to more effectively assign the right clinician to the right patient, more often.
- EMAS has experienced a reduction in the levels of escalation experienced when there have been sudden increases in activity. The improved availability of resources is a key contributor to reducing escalation and delayed responses.

## 6. Delivery against the new Categories

The first full month of August is reported in the Integrated Board Report (IBR) - reported to Trust Board on the 5 September 2017.

## 7. Next Steps

The Executive Team on the 14 August 2017 approved how ARP will be transitioned into 'business as usual', including:

- The ARP Delivery Group will be replaced by an AQI Implementation and Reporting Group and this will accountable to the Executive Team in their roles of designated project board for ARP.
- The project will be formally closed with the transition into business as usual. Existing committees and sub groups will be utilised to monitor specific areas i.e. impact on quality through the Quality and Governance Committee (QGC).
- Assurance to commissioners will continue through the Partnership Board.
- ARP delivery data is now included in the IBR.

To realise the opportunities and patient benefits arising out of ARP, the clinical operating model will be revised over the coming months, creating more dual crewed ambulances through a reduction in the quantity of fast response vehicles. This will also include consideration of the staff resources required by the Trust in order to the deliver the model. This will involve changes to the core average frontline workforce requirement upon which the Workforce Plan was based. The Workforce Plan is incorporated into the Operational Plan previously approved by the Trust Board and therefore any changes in resourcing are likely to impact on the Operational Plan. Once clarification has been obtained the revisions will be presented to the Trust Board for approval.

## 8. Recommendation

That the Trust Board:

- **CONSIDERS** the update on the migration to the Ambulance Response Programme 2.3 pilot, including early findings; and
- **TAKES ASSURANCE** from the governance and reporting arrangements for the Ambulance Response Programme.

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**East Midlands Ambulance Service NHS Trust**
**Lincolnshire OSC Briefing Paper**

In addition to the areas identified within the presentation, the Lincolnshire Division is engaged in partnership working across the county both internally and externally with a number of key stakeholders in order to improve health services in partnership.

Some of the examples are stated below.

**Turnaround**

Hospital turnaround and ambulance handover continues to be challenging in Lincolnshire. We are working closely with our acute providers to improve our position, which if not addressed result in reduced availability of ambulance resources to respond to patients in the community. In conjunction with a bespoke Emergency Care Improvement Program (ECIP) review being under taken at United Lincolnshire Hospitals (ULHT) we are refining our staff and manager guidance accordingly. This work is in progress and focuses on key themes:

- Fit2Sit
- Staff led co-horting
- Streamlined handover process
- Primary care streaming once online (Autumn 2017)
- EPRF integration and engagement

While the ECIP work is based around ULHT we are using this as an opportunity to refresh our approach with colleagues in Northern Lincolnshire and Goole (NLAG) acute hospitals.

**Blue Light Collaboration**

As an organisation and as a division we are seeking to improve and modernise our estate position through collaborative working with Lincolnshire Blue light colleagues. The following sites are in advanced degree of planning with projected “move-in” dates:

Lincoln – Police, Fire & Ambulance shared site (Projected Go-Live 2019)
Louth – Ambulance & Fire shared site (Go-Live November 2017)
Sleaford – Ambulance & Fire shared site (Go-Live April 2018)

Other sites are being reviewed and will be fully appraised in the coming months.

**Surge Planning and Response**

During the peak 6 week school holiday period we have deployed an Emergency Care Practitioner (ECP) supplemented by cycle response to specific East Coast areas of high demand e.g. Skegness, Butlins etc. This has continued year on year to improve the management of increased

call demand and reduce pressure on our urgent care partners due to the significantly increased holiday population.

Our Winter plans are being finalised at present, however the expectation will be to support Lincoln City during peak pressures of festivities with our mobile assessment and triage facility based on Lincoln High St. This consists of additional ambulance resources including an ECP, a Double Crewed Ambulance and an operational commander. This facility provides a "buffer" area for assessment and management of low acuity patients who are visiting the city centre and assists with demand management for our colleagues at Lincoln Emergency Department through appropriate patient management, signposting and discharge.

For the first time this year we are supporting Lincoln City during University Fresher's week with a mobile assessment and triage facility. This will be based on the Christmas triage model initially subject to review of demand and utilisation levels.

**Recruitment and Skill Mix**

We continue to improve our skill mix of qualified ambulance staff through recruitment and internal training. Supplementing this route we have welcomed 11 International Paramedics into Lincolnshire over the past months and continue to support their learning and development as UK Paramedics. Additionally 6 graduate paramedics are joining us during the Autumn of 2017. We are also in talks with the Armed Forces (RAF & Army) to provide paramedics on a 1 day a week release basis to aid their emergency care development. Since April 2016 we have trained over 40 of our staff upskilling them from Emergency Care Assistant to qualified technician level. In line with the national pay review all of our paramedic staff have migrated to Band 6 which will hopefully enhance our recruitment and retention position.

**CAS & Care Home Callers**

The alliance with our partners in the Clinical Assessment Service is expanding to offer direct access for care homes seeking urgent care advice. Initially this will be a 3 month trial for selected care homes starting in October 2017. Care home staff will be able to expediently access and manage the correct level of care for this elderly patient co-hort. Additionally we are also engaged with a similar "Silverline" scheme at Peterborough Hospital which allows direct telephone access to a Care of the Elderly Consultant for admission avoidance and care planning.

**Sepsis Roll-out**

Following a successful trial in Northern Lincolnshire utilising pre-hospital antibiotics for sepsis we are now in the process of rolling this out to paramedics across greater Lincolnshire. This is being delivered in conjunction with NLAG and ULHT sepsis leads. The expectation is that this will be live during September 2017.

**David Williams**
**Interim General Manager**

| 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: | **13 September 2017** |
| Subject: | **Health Scrutiny Committee for Lincolnshire - Work Programme** |

**Summary:**

This item enables the Committee to consider and comment on the content of its work programme, which will be reviewed at each meeting of the Committee to ensure that its content is relevant and will add value to the work of the Council and its partners in the NHS. Members are encouraged to highlight items that could be included for consideration in the work programme.

**Actions Required:**

The Health Scrutiny Committee is invited to:

(1) review, consider and comment on the work programme as set out in Appendix A to this report; and

(2) highlight for discussion any additional scrutiny activity which could be included for consideration in the work programme.

## 1. Background

The overview and scrutiny of the health service and other areas within the remit of this Committee should be positive, constructive, independent, fair and open. The scrutiny process should be challenging, as its aim is to identify areas for improvement. Scrutiny activity should be targeted, focused and timely and include issues of corporate and local importance, where scrutiny activity can influence and add value.

Health overview and scrutiny committees should not involve themselves in relatively minor matters or individual cases, particularly where there are other processes (for example NHS complaints processes), which can handle these issues more effectively.

All members of overview and scrutiny committees are encouraged to bring forward important items of community interest to the committee whilst recognising that not all items will be taken up depending on available resource.

Purpose of Scrutiny Activity

Set out below are the definitions used to describe the types of scrutiny, which relate to the Health Scrutiny Committee's work programme:

Policy Development - The Committee is involved in the development of policy, usually at an early stage, where a range of options are being considered.

Policy Review - The Committee is reviewing the implementation of policy, to consider the success, impact, outcomes and performance.

Performance Scrutiny – This describes circumstances where the Health Scrutiny Committee is scrutinising periodic performance, issue specific performance or external inspection reports, for example from the Care Quality Commission.

Consultation - The Health Scrutiny Committee is responding to (or making arrangements to) respond to a consultation, either formally or informally. This includes pre-consultation engagement. This includes consultations on any proposals for a substantial variation or development in local health provision.

Budget Scrutiny - The Committee is scrutinising the previous year's budget, or the current year's budget or proposals for the future year's budget.

Requests for specific items for information should be dealt with by other means, for instance briefing papers to members.

Identifying Topics

Selecting the right topics where scrutiny can add value is essential in order for scrutiny to be a positive influence on the work of the local NHS. The Committee may wish to consider the following questions when highlighting potential topics for inclusion in the Committee's work programme: -

- Will scrutiny input add value?
  *Is there a clear objective for scrutinising the topic, what are the identifiable benefits and what is the likelihood of achieving a desired outcome?*

- Is the topic a concern to local residents?
  *Does the topic have a potential impact for one or more section(s) of the local population?*

- Is the topic a priority area?
  *Does the topic relate to Joint Health and Wellbeing Strategy or other strategy documents, such as the Sustainability and Transformation Plan?*

- Are there relevant external factors relating to the issue?
  *Is the topic a Department of Health or NHS England priority area or is it a result of new government guidance or legislation?*

Scrutiny Review Activity

Where a topic requires more in-depth consideration, the Committee may commission a scrutiny panel to undertake a scrutiny review, subject to the availability of resources and approval of the Overview and Scrutiny Management Board. The Committee may also establish a maximum of two working groups at any one time, comprising a group of members from the committee.

Work Programme items on scrutiny review activity can include discussion on possible scrutiny review items; finalising the scoping for the review; consideration and approval of the final report; the response to the report; and monitoring outcomes of previous reviews.

## 2. Conclusion

The Committee's work programme for the coming year is attached at Appendix A to this report.

The Committee is invited to review, consider and comment on the work programme as set out in Appendix A and highlight for discussion any additional scrutiny activity which could be included for consideration in the work programme.

## 3. Appendices

| These are listed below and attached at the back of the report | |
|---|---|
| Appendix A | Health Scrutiny Committee for Lincolnshire – Work Programme |

## 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, who can be contacted on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk

# HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
## Work Programme: September 2017 – May 2018

| ***13 September 2017 – 10 am*** |
|---|
| Grantham Hospital Accident and Emergency Department: Outcome of Referral to the Secretary of State for Health |
| Commissioning Arrangements for East Midlands Ambulance Service |
| East Midlands Ambulance Service – Outcomes of Care Quality Commission Inspection and National Ambulance Response Programme |

| ***11 October 2017 – 10 am*** |
|---|
| Lincoln Walk-in-Centre – Report of Decision Made by Lincolnshire West Clinical Commissioning Group |
| Sustainability and Transformation Plan Update, including Long Leys Court Consultation |
| Dental Services Procurement |
| Commissioning of Continuing Health Care *(to be confirmed)* |
| Outcomes of NHS England Consultation on Congenital Heart Disease |

| ***8 November – 10 am*** |
|---|
| Lincolnshire Pharmaceutical Needs Assessment – Introduction and Consultation Arrangements |
| NHS Immunisation and Screening for Patients in Lincolnshire – Response to Issues Raised in Report by Healthwatch Lincolnshire |
| Non-Emergency Patient Transport – Thames Ambulance Service *(To be confirmed.)* |
| North West Anglia Foundation Trust – Update on Peterborough City Hospital and Stamford and Rutland Hospital |

| ***13 December – 10 am*** |
|---|
| Lincolnshire West Clinical Commissioning Group Update |
| Joint Health and Wellbeing Strategy Update |
| Lincolnshire Pharmaceutical Needs Assessment – Pre-Consultation |

## Items to be Programmed

- Lincolnshire Sustainability and Transformation Plan Consultation Elements: -
  - Women's and Children's Services
  - Emergency and Urgent Care
  - Stroke Services
  - Cancer Care
- Specialised Commissioning
- Lincolnshire East Clinical Commissioning Group Update
- South Lincolnshire Clinical Commissioning Group Update
- South West Lincolnshire Clinical Commissioning Group Update

| *17 January 2018 – 10 am* |
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| *21 February 2018 – 10 am* |
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| *21 March 2018 – 10 am* |
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| Annual Report of the Director of Public Health |
| Arrangements for the Quality Accounts 2018-19 |

| *18 April 2018 – 10 am* |
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| *16 May 2018 – 10 am* |
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