Extraordinary System Resilience Group (SRG)

13 April 2016 | 9.00am | Seminar Room B
Education Centre 3, Chorley and South Ribble Hospital

Present:

Iain Crossley	Chief Finance and Contracting Officer, CCGs (in the Chair)
Gora Bangi	Chair of Chorley and South Ribble CCG
Graham Curry	North West Ambulance Service
Helen Curtis	Head of Quality and Performance, CCGs
Matt Gaunt	Chief Finance Officer, CCGs
Louise Giles	Director of Development, Lancashire Care
Suzanne Hargreaves	Operations Director, Lancashire Teaching Hospitals
Paul Havey	Finance Director, Lancashire Teaching Hospitals
Sam James	Head of Performance, CCGs
Jan Ledward	Chief Officer, CCGs *(joined by conference call)*
Clare Mattinson	Lancashire County Council
Jayne Mellor	Head of Planning and Delivery, CCGs
Sue Moore	Chief Operating Officer, Lancashire Care
Karen Partington	Chief Executive, Lancashire Teaching Hospitals
Dinesh Patel	Chair of Greater Preston CCG
Mark Pugh	Medical Director, Lancashire Teaching Hospitals
Mike Smith	Head of Assurance and Delivery (Lancashire), NHS England
Karen Swindley	Director of Workforce and Education, Lancashire Teaching Hospitals

In attendance:

Karen Brewin	Committee Secretary, Lancashire Teaching Hospitals (minutes)
Lorraine Kelly	Communications Manager, Lancashire Teaching Hospitals
????	Policy Engagement, CCGs

Apologies:

Kate Burgess	Commissioning Manager, Lancashire County Council
Emma Foster	Network Director (Adult Community Services), Lancashire Care
Mick Duffy	Social Services, Lancashire County Council
Bill Gregory	Director of Finance, Lancashire Care
Adrian Leather	Chief Executive, Lancashire Sport (voluntary sector lead)
Dominic McKenna	Financial Management Director, Lancashire Care
Max Marshall	Medical Director, Lancashire Care
Matthew Orr	GP Director, CCGs
Ahmad Qamar	Out of Hours Service
Sharon Ross	Adult Services, Lancashire County Council
Heather Tierney-Moore	Chief Executive, Lancashire Care
David Winters	General Manager, Ramsay Health Care UK

1/16 Welcome and introductions

The Chair opened the meeting by welcoming health economy representatives and round table introductions were made. Mr I Crossley explained the purpose of the meeting was to discuss the staffing crisis which was affecting both Preston and Chorley A&E services

at Lancashire Teaching Hospitals; all other items on the agenda would be carried forward.

2/16 Apologies for absence

Apologies for absence had been identified on the agenda and were noted above.

3/16 Emergency departments crisis

Mrs K Partington explained that urgent discussions were required regarding the current emergency departments staffing crisis and a decision would be required today, with the approval and support of the health economy, to agree the most appropriate way forward for provision of safe emergency services. Attention was drawn to the draft paper that had been circulated yesterday which provided a detailed outline of the current position with regard to emergency care at both Royal Preston and Chorley and South Ribble Hospitals and a risk assessed option appraisal on the emergency care crisis. Mrs S Hargreaves noted that further work was required on the paper and provided an outline of discussions held at the last SRG meeting on 8 April 2016 to ensure full understanding by those who had not been involved in previous discussions.

Mrs S Hargreaves explained that the Trust was currently unable to safely staff the middle grade rotas within the emergency departments. It was noted that this was due to a number of factors, including Deanery gaps from reduced training posts, a national shortage of middle grade doctors, and application of the national agency rate cap which had affected the Trust's ability to secure locum cover. The Trust had now reached a point where only 8 of the 14 middle grade doctors were available to cover the emergency department rota. The emergency department consultants had identified an immediate risk 2 weeks' ago with consultants agreeing to act down to junior level although it was recognised that this was not sustainable. Reference was made to mitigating actions that had been undertaken and these were outlined within the appendices of the draft report.

SRG members agreed that it was essential the emergency department at Royal Preston Hospital should remain open as it was the trauma centre for Lancashire and south Cumbria.

Attention was drawn to the three main options that had been identified as temporary arrangements for Chorley and South Ribble Hospital during the emergency care crisis, along with sub options, which were identified as:

- *Option 1*: Sustain both sites with 24/7 emergency department provision by securing additional emergency department resource (maintaining the status quo)

- *Option 2*: Change the service provision at Chorley and South Ribble Hospital by opening an urgent care centre, with sub options identified as:

    a) urgent care centre open 24 hours
    b) urgent care centre open 8am to midnight
    c) urgent care centre open 8am to 8pm
    d) urgent care centre open 9am to 4pm

- *Option 3*: Full closure of Chorley and South Ribble Hospital and no urgent care centre provision

Mrs K Partington referred to option 3 and confirmed that this should read 'Full closure of *the emergency department*…' and this would be amended.
Mrs S Hargreaves explained that the overriding principle when considering the options would be delivery of a safe service for patients. In response to a question regarding the provision of emergency department services at Chorley for parts of the day it was explained that the proposed rationalisation of services did not fit with the national definition for an emergency department. Mrs S Hargreaves explained that there was a national kitemark in relation to urgent care centre provision which would not include category 1 services which related specifically to life threatening emergency conditions. In response to a question from Dr G Bangi regarding how the Trust currently met the national definition, Professor M Pugh confirmed that currently the service was 24-hour consultant led. Mrs K Partington added that consultants were available 24 hours a day on-call and that the inability to meet the middle grade rota was the issue. It was clarified that on-call consultants provide cover from midnight across both hospital sites. Mr G Curry noted that NWAS currently recognised the emergency department at Chorley and South Ribble Hospital as a 24-hour full service.

Attention was drawn to section 4 on page 18 of the draft report which contained the risk assessment of options which had been jointly reviewed with colleagues from Lancashire Care and a detailed overview was provided on individual risks. During presentation of the information Mr I Crossley suggested there was a need to quantify the risks. It was also proposed that timelines for completion needed to be determined for each action when viewed as a whole plan, along with timescales for the short-term plan to plug the gaps. Mrs S Hargreaves acknowledged the additional information that would be required to be incorporated into the final report although it was recognised that the time available from previous discussions to today's meeting had not afforded the opportunity to include this information. It was also noted that the risk information within section 4 should be viewed as temporary arrangements as the Trust would continue to work towards full reintroduction of the emergency department at Chorley, however, the current reality meant that an immediate solution was required to ensure safe services. Mr P Havey noted that the paper would be a live document and would be reviewed weekly by the SRG and a statement would be included within the final paper to clarify this point.

Mrs S Hargreaves referred to a request that had been made to the Deanery around the potential for trainee doctors with emergency department experience to be utilised by the Trust although this request had been declined. Discussions had also been held earlier this week with senior officers from Fulwood Barracks to determine whether there was availability of military medical staff to support maintaining the emergency department. Unfortunately there were no appropriately qualified medics who could deliver or support sustainability of a 24-hour emergency department.

Attention was drawn to appendix 3 which outlined the risk assessment and impacts of the options on other providers, including NWAS and neighbouring hospitals, and these were described. An overview was provided on emergency department attendances and impact assumptions against the 3 proposed options; additional demand on local hospitals; and current data on NWAS conveyances into Chorley including potential redirection rates to local hospitals.

Mrs S Hargreaves provided a detailed overview of the sub options and noted that the out of hours service within each model would be provided overnight. It was confirmed that arrangements had been agreed for GP staff to cover at Chorley overnight to support patient walk-ins meeting the definition of urgent/emergency care and the draft report would be updated to include this risk mitigation. Consultants had also agreed to extend cover at Chorley across 7 days under sub option 2c (urgent care unit cover from 8am to 8pm) over the next 2 months working alongside GPs.

Mrs S Hargreaves explained that it was important to clarify and explain the assumptions and confirmed that work had been undertaken as a group with representation from LTH, LCFT and the CCGs on individual patient conditions and Mr S James had undertaken additional analysis which more or less met with the group assumptions. Reference was made to the map which provided current NWAS conveyance analysis into Chorley and South Ribble Hospital and NWAS had worked through a number of options for redistribution of patients to neighbouring hospitals and percentage transfers were included.

Mr S James confirmed that the original assumptions had been reviewed against first presentations for minor categories with assumptions showing that 90% of patients would remain at Chorley. However, a 50:50 split of attendances was analysed which showed that there would be increased pressure on patient attendances at Royal Preston Hospital.

Mr P Havey commented that neither model would provide a definitive position and a sensitivity analysis would need to be agreed with a plan developed for those expectations and assumptions and be vigilant in monitoring the actual effects and respond accordingly.

Mr G Curry referred to paediatric patients and indicated that kitemarked urgent care centres were able to accept children over the age of five which could potentially reduce the demand on Royal Preston Hospital. Mr G Curry noted that the national kitemark requirements were at a lesser level than those for an emergency department therefore there should be rapid progress in achieving kitemark status.

Mrs S Moore referred to the impact on mental health patients, for example if a patient was transferred to a hospital out of area social care officers would need to travel further and visits would need to be undertaken out of county which would place pressures on mental health services. Mrs S Moore confirmed that a standard had been developed to look at support with NWAS and how to delineate patients with no physical condition to reduce ambulance conveyance out of area and progress would be reported into the formal SRG meeting on this work which should also support the current crisis.

In response to a question from Mr I Crossley regarding whether discussions had been held with neighbouring Chief Executives regarding the crisis, Mrs K Partington confirmed that conversations had been held with Wigan and Bolton Chief Executives and similar contact had been made with the Chief Executives at Blackpool, East Lancashire, Morecambe Bay and Lancashire Care to determine whether support could be provided although all organisations had confirmed that support could not be provided as similar pressures were being experienced within each Trust.

Mr I Crossley asked whether the option of placing the urgent care centre provision at Royal Preston Hospital rather than Chorley had been considered. Mrs S Hargreaves

explained that the Trust had an obligation to deliver a Major Trauma Centre at Royal Preston Hospital and there was insufficient space.

Mrs H Curtis referred to the national middle grade shortage and asked how other organisations were coping with the risk. Mrs K Partington confirmed that organisations, particularly DevoManc were looking to reorganise services and whilst some organisations were recruiting, hospital location was a significant consideration for doctors.

Mr I Crossley commented that none of the options were ideal and bearing in mind safety for patients asked for clarification from the Trust as to what was considered the least worst option. Professor M Pugh explained that the options had been discussed internally with emergency department staff and outlined at today's meeting and the view from clinicians' was that option 2c (urgent care centre from 8am to 8pm) was the only viable option given the currently available staff.

Mrs K Partington referred to an earlier statement made by Mr P Havey regarding clarity around the reasons why a decision was required and asked, regardless of the options, whether SRG members were clear that the Trust could not continue to operate its current emergency services under the current circumstances and there was a need to make a temporary change. Dr G Bangi acknowledged that there was a crisis within the emergency department.

Professor M Pugh confirmed that the risks of maintaining two emergency departments would lead to unsafe emergency care provision within either one or both of the Trust's emergency departments and this was not acceptable. Mr P Havey asked if the Trust attempted to maintain two emergency departments what the potential outcome would be for the medical staff and proposed that this would need to be included as a risk within option 1 in the final report.

In response to Mrs K Partington's earlier question, SRG members agreed that they understood the risks within emergency services and recognised that the Trust could not continue to maintain the status quo.

In response to a question from Dr G Bangi on the impact of the Our Health, Our Care programme, Professor M Pugh confirmed that there should not be an impact as this is a temporary solution.

Dr G Bangi asked if the urgent care centre could mobilise, what percentage of the GPs could act as middle grade cover. Mrs L Giles and Mrs S Moore both confirmed that none of the doctors would be able to cover middle grade emergency care roles. Professor M Pugh clarified that GPs would need to be trained to emergency department middle grade standard. Mrs S Hargreaves acknowledged that Dr G Bangi had previously explored the potential for 24-hour GP support although it was explained that as there would be no consultant cover then the model would not be viable as the requirement was to support a 24-hour service. Mrs S Moore referred to the medium term solution to accelerate GP recruitment with emergency and urgent care skills although the market did not support this at the moment.

Dr G Bangi referred to the recent discussions with the military and Mrs K Partington explained that an approach had been made as requested by the local MP, Lindsay Hoyle. As mentioned earlier, discussions had been held this week with senior officers to

determine whether military medics are available to support a 24-hour emergency service on the Chorley site and it had been confirmed that the military did not have the appropriate level of staff.

Dr G Bangi asked if the locum rate cap was instrumental and what other factors were causing the underlying gap. Mr P Havey explained that the locum cap of itself had not created the current crisis rather the national shortage of middle grade doctors and that of the 14 middle grade doctors required to cover the middle grade rota only 8 doctors were in post despite prolonged attempts to recruit. Mrs K Partington added that the Deanery had an impact in respect of rotation and supply, and CVs from locum agencies were not being presented to the Trust as the organisation was known to have held the line in respect of the agency rate cap.

Mr I Crossley suggested there was a need to consider any new risks that would be created through introducing a different model for the Chorley emergency department and whether these had been considered by the trust; it was agreed these needed to be assessed.

Mrs S Hargreaves stated a huge communication strategy would need to be developed to clearly articulate the changes within the emergency service provision within the Trust. The Trust would need to provide communications to a wide range of stakeholders and ensure that local residents were aware of the position at the earliest opportunity, therefore a consensus was required on the option to be taken forward from Monday.

Dr G Bangi commented that there was no question there was a need for a decision today although consideration needed to be given to additional potential impacts caused by the proposals.

In response to a question from Mrs K Partington regarding whether SRG members felt that it was acceptable and safe to run the Chorley emergency department without doctors, it was agreed that option 1 would be discounted. It was also agreed that option 3 was not viable so this option would be discounted.

Discussion was held regarding the sub options within option 2. Mrs S Hargreaves explained that workforce and staffing levels was a key driver within the sub options. Professor M Pugh confirmed that under any option many patients would be seen at Chorley and only urgent patients would be redirected to the nearest emergency department. In response to a comment from Mr I Crossley that this would create an ambulance backlog at Preston and a potential void in the surrounding areas, Mr G Curry explained that arrangements could be made for an ambulance to be located on the Chorley site to transfer patients to other hospitals; Mrs S Hargreaves confirmed that this would assist with risk mitigation.

Mrs L Giles confirmed that a stabilisation area had been looked at within the Chorley site with access to a crash team and a procedure was being drafted to sustain the patient and maintain the airway until ambulance transport arrived to safely transfer patients. Professor M Pugh noted that discussions had also been held with emergency department consultants regarding increases in attendances at Royal Preston Hospital and discussions were ongoing with general medicine physicians regarding different ways of working. Mrs S Moore added that pathways were being developed for general conditions.

Mr M Gaunt felt there was a need to understand the additional activity expected at Royal Preston Hospital and asked whether resources would be sufficient to cover the impact of increased activity. Professor M Pugh explained that this had been discussed with the emergency department consultants and whilst no guarantee could be given on expected increased activity, the consultants had committed to change and adapt on a daily basis depending on the situation and this would form part of the weekly update to the CCGs.

In respect of sub option 2a (urgent care centre 24 hours), Professor M Pugh confirmed that there were insufficient staff to develop this model and this was supported by SRG members, although this would be the preferred interim solution. However, owing to the lack of staff this option was discounted.

Mrs J Ledward requested that separate risk assessments be carried out on the options for both hospitals which would provide clear comparative information. It was agreed that Mrs S Hargreaves would produce this information bearing in mind there would not be a full impact on the Royal Preston Hospital as some patients would be transferred to other hospitals, such as Wigan or Bolton.

In response to a query from Dr D Patel regarding in-reach consultant cover, Professor M Pugh confirmed that ongoing discussions had been held regarding new models of care to address a number of issues with consultants, including hot clinics and 7-day working as part of transformation discussions. It was noted that there was some interest in progressing this and further discussions would be held to explore the potential to bring forward this work at Royal Preston Hospital, however, this would not assist with addressing the immediate crisis.

In response to a query from Mr I Crossley regarding what the patient flow would look like between the local hospitals, Professor M Pugh confirmed that the position would be kept under review although there would be transfers between the Chorley and Preston hospital sites following appropriate clinical decisions. Mr M Smith suggested that discussions could be held with Trafford who had downgraded its emergency department to an urgent care centre regarding lessons learned. Mrs K Partington acknowledged that such conversations would be helpful and contact would be made to obtain further information, although the work undertaken at Trafford had been introduced over a significant time period.

Mrs J Ledward referred to the activity chart within the draft report and asked whether consideration had been given to running the urgent care centre from 7am to 10pm. Professor M Pugh explained that staffing levels could not be sustained during this period as an additional 2 hours would be required to see and treat patients presenting at the tail end of the opening hours. In response to a query from Mrs J Ledward regarding the significant increased activity during 7am to 8am, it was agreed that work would be undertaken to determine the category of patients presenting.

In summary, Mr I Crossley confirmed it was for the Trust to propose what they considered the most appropriate option and for the SRG to determine whether or not to support the proposal. In response, Professor M Pugh and Mrs K Partington confirmed that on the basis of risks and mitigations the Trust's proposed option was 2c, urgent care centre provision from 8am to 8pm as this was seen as the least worst solution and that, subject to obtaining SRG support, the Trust's proposal would be implemented from Monday 18 April 2016. Dr G Bangi confirmed from a clinical perspective that based on discussions this proposal was supported.

Mr I Crossley asked the SRG to support the Trust's proposal and this was accepted unanimously.

Resolutions:

- **Following consideration of the practicalities of running 2 established 24-hour emergency departments the SRG determined that this was not possible, therefore the next practical solution was discussed and at this moment in time option 2c was supported as the agreed option, with the intention of working towards the reinstatement of 2 accident and emergency departments as soon as possible.**
- **The SRG members unanimously supported the proposal to introduce option 2c, urgent care centre provision from 8am to 8pm as the least worst solution, with no dissentions.**

Mrs S Hargreaves confirmed that there was still a requirement to shape the final report and it was anticipated that this would be ready tomorrow. Once completed, the final report would be forwarded to NHS England and NHS Improvement.

4/16 Further actions

During discussion the following further actions were agreed:

- Mr I Crossley to speak to NHSE, Graham Urwin and Mrs K Partington to speak to NHSI Mr Paul Chandler to communicate the decisions reached.
- A weekly review would need to be undertaken on the action plan to determine progress towards reopening Chorley as an emergency department.
- Communications plan to be finalised jointly by the SRG communication leads as soon as possible following the meeting.
- Final report to be completed following the meeting.
- Organisations' governing bodies and boards to be briefed on the arrangements.
- There may be individual media discussions involving Mrs K Partington and Professor M Pugh although support would be required from SRG members and this was acknowledged and agreed.
- A detailed briefing to be developed for issuing to community and social care staff and this would be prepared and circulated as soon as possible.
- Staff availability and patient safety would be the drivers to inform the weekly update report on the action plan.
- Timeline to change risks would need to be included in the action plan.

Mrs L Kelly confirmed that a communication plan had been drafted and would be updated with the key decisions and a joint statement would be circulated for approval in the next hour for distribution later today. It was also confirmed that the communication leads for the CCGs and the Trust were liaising with the NWAS press office.

Further discussion was held regarding the scheduled teleconference tomorrow with the local MP, Lindsay Hoyle, and it was agreed that attempts would be made to arrange a face to face meeting tomorrow with representatives from the Trust and the CCGs.

5/16 Lead roles and responsibilities

Reference was made to the need to determine lead roles in respect of practical operational mobilisation and during discussion the following was agreed:

- Senior Responsible Officer – **Mr I Crossley**
- Practical mobilisation – **Mrs S Hargreaves**
- Moves into the Urgent Care Centres and PPCU – **Mrs S Moore**
- Direct queries regarding additional ambulance provision to **Mrs S Hargreaves**
- Social care link on operational issues through **Mrs S Hargreaves**
- Financial impact on changes to be produced – **Mr P Havey/M Gaunt**
- Weekly SRG update meetings to be arranged on Wednesday mornings 8am to 9am at Chorley House – **Mr I Crossley**
- SRG mobilisation group meetings to be co-ordinated by **Mrs S Hargreaves**

6/16 Date, time and venue of next meeting

The next meeting will be held on Wednesday, 20 March 2016, 8.00am, Boardroom 1, Chorley House, Lancashire Business Park, Centurion Way, Leyland, PR26 6TT.