Lancashire Health and Wellbeing Board

Minutes of the Meeting held on Monday, 13th June, 2016 at 10.00 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

Chair

County Councillor Jennifer Mein, Leader of the County Council

Committee Members

County Councillor Azhar Ali, Cabinet Member for Health And Wellbeing (LCC)
County Councillor Tony Martin, Cabinet Member for Adult and Community Services (LCC)
County Councillor David Whipp, Lancashire County Council
Dr Sakthi Karunanithi, Director of Public Health, Public Health Lancashire
Louise Taylor, Corporate Director Operations and Delivery (LCC)
Bob Stott, Director of Schools, Education and Care
Tony Pounder, Director of Adult Services
Councillor Bridget Hilton, Central Lancashire District Councils
Michael Wedgeworth, Healthwatch Lancashire Interim Chair
Karen Partington, Chief Executive of Lancashire Teaching Hospitals Foundation Trust
Sarah Swindley, Third Sector VCFS Rep
Jane Booth, Independent Chair, Lancashire Safeguarding Children's Board
Councillor Hasina Khan, Chorley Borough Council
Andrew Bennett, Lancashire North CCG
Cllr Viv Willder, Fylde Borough Council
Jan Ledward, Chief Officer - Chorley & South Ribble and Greater Preston CCG
Janet Thomas, Lancashire Care Foundation Trust
Sharon Martin, East Lancs Clinical Commissioning Group

Apologies

County Councillor Matthew Tomlinson	Cabinet Member for Children, Young People and Schools (LCC)
Dr Tony Naughton	Fylde & Wyre CCG
Graham Urwin	NHS England, Lancashire and Greater Manchester
David Tilleray	Chair West Lancs HWB Partnership

1. Appointment of Chair

Resolved: that in accordance with the Terms of Reference, County Councillor Jennifer Mein, as the Leader of the County Council, is appointed as the Chair for the remainder of the 2016/2017 municipal year.

2. Appointment of Deputy Chair

Resolved: that Dr Tony Naughton is appointed as the Deputy Chair of the Board for the remainder of the 2016/2017 municipal year.

3. Membership and Terms of Reference of the Board

A report was presented in connection with the membership and Terms of Reference of the Board.

Resolved: that the Board accept the current Terms of Reference and Membership.

4. Welcome, introductions and apologies

Apologies for absence were noted as above.

Replacements were as follows:

Janet Thomas for Dee Roach (Lancashire NHS Foundation Trust)
Sharon Martin for Mark Youlton – East Lancashire CCG
Jan Ledward for Dr Gora Banghi – Chorley and South Ribble CCG and Dr Dinesh Patel – Greater Preston CCG

5. Disclosure of Pecuniary and Non-Pecuniary Interests

There were no disclosures of interest in relation to items appearing on the agenda.

6. Minutes of the Last Meeting

The Chair informed the meeting that the Better Care Fund evaluation that was due to come to this meeting, be brought to the next meeting as Paul Robinson and Mark Youlton were unable to attend this meeting.

Resolved: i) that the minutes of the meeting held on 28 April 2016 are confirmed as an accurate record.

ii) that the BCF evaluation report is on the next agenda on 2 September 2016.

7. Director of Public Health Annual Report

Dr Sakthi Karunanithi gave a detailed account of the report Securing our Health and Wellbeing, highlighting key points.

The report is aimed at all partnerships and for them to raise awareness of it with the public.

The Board felt the report was excellent and it was clear that partnership working had to be effective in order to deliver the health outcomes needed. The report should also link in with the Sustainability Transformation Plan (STP).

It was noted that telecare/teleaccess to clinicians from the local hospital is available in parts of Lancashire.

Sakthi agreed to update the Board regularly on progress on the report.

Resolved: that the Board noted the Director of Public Health's Annual Report and agreed to support the recommendations within it.

8. Sustainability and Transformation Plan

Sam Nicol, Healthier Lancashire was welcomed to the meeting.

The purpose of the report was to provide the HWBB with an update on the development of the Lancashire and South Cumbria STP. The original NHS England guidance regarding the STP which was published in December 2015, advised that STPs are approved by the HWBB prior to 30 June 2016 submission deadline. However, on Friday 20 May 2016, NHS England issued new guidance as follows:

"The plans that you submit on 30 June will form the basis for a face to face personal conversation with the national leadership in the NHS throughout July, and will be a key part of a subsequent managerial process to inform decisions about the geographical targeting of growth in the intervening years to 2020. Your submissions will therefore be work in progress, and as such we do not anticipate the requirement for formal approval from your boards and/or consultation at this early stage. We will, however, wish to be assured that your plans reflect a shared view from your leadership team where possible, based upon the needs of patients and taxpayers, and a robust plan to engage more formally with boards and partners following the July conversations."

Sam also spoke about the meeting that had taken place recently with Councillors and County Councillors from Lancashire. One clear message that came from the session was that we cannot hold on to what we have – we have to have more joined up working and provide what works and what there is a demand for, within the resources available. The same message came from a session with Blackburn with Darwen also.

Local Delivery Plans (LDPs) have to be accountable to the delivery of local outcomes.

The public need to be aware of what is going on and it needs to be communicated in plain English.

The STP needs to focus on financial sustainability and get people's minds to look to the future and how it will work.

There needs to be a communication plan for the STP for County Councillors, Chief Executives and District HWB Partnerships so they can feed into other groups along with the LDPs.

It is now expected that the third, and final version of the STP will be required in October 2016. The Case for Change will be utilised at pace to agree a future system model and to mobilise the work required, with a strong focus on delivery of our ambitions set out in the STP, and the 10 priority areas.

Sounding Boards will be set up which will include politicians who will meet in September 2016.

Resolved: that the Board:

i) noted the contents of the report
ii) provided relevant comments on the Lancashire and South Cumbria STP

Sam was thanked for her report.

9. Closure of Chorley A & E

Karen Partington tabled and gave a detailed description to the attached Briefing Paper to the HWBB and brought attention to the fact that this item had been discussed as set out in the agenda papers at Health Scrutiny also on a number of occasions.

The Board felt that the public needs to be clearly aware of the position around locums and how that affects the department, when quick decisions are needed.

Karen also expressed her personal thanks for support from various members of the Board around this issue.

10. Lancashire CYP Emotional Wellbeing and Mental Health Transformation

Julie Haywood, Midlands and Lancashire Commissioning Support Unit (MLCSU) and Peter Tinson, Fylde and Wyre Clinical Commissioning Group (CCG) were welcomed to the meeting.

They took the Board through the presentation attached to these minutes.

If anybody wished to receive any district specific information which can be shared with the Children's Partnership Boards then please contact Julie Haywood, email: Julie julie.haywood1@nhs.net or Peter Tinson, email: Peter.Tinson@fyldeandwyreccg.nhs.uk.

The workstream proposals for 2016/2017 are as follows:

- Promoting Resilience
- Improving Access
- Care of the Most Vulnerable
- Accountability and Transparency
- Developing the Workforce

A digital concept called 'Thrive' is currently being scoped out for Lancashire which is a tool which provides:

i) a system overview
ii) integrated performance reporting
iii) enabling an interactive offer

It was noted that monthly newsletters and an expanded quarterly newsletter will expand on what is and what is not working. A quarterly report will come back to the Board.

Following on from the CQC Inspection and the issues raised, the Board needs to feel confident that everything that is planned in the transformation covers the concerns expressed by the CQC.

Resolved: that the Board receive a quarterly update on the transformation.

11. Development of Pan Lancashire Health and Wellbeing Board

Sakthi gave a brief insight into the development of a Pan Lancashire HWBB working across three Authorities, Lancashire, Blackburn with Darwen and Blackpool.

A workshop will be held to discuss further development. To include the Third Sector and Local HWB Partnerships in these discussions.

12. Urgent Business

CQC Inspection

The Authority has recently undergone a CQC Inspection. A final report will be available mid-August and will bring it to a future Board meeting.

Resolved: that an item on the CQC Inspection is put on the agenda for a future meeting.

13. Date of Next Meeting

The next scheduled meeting of the Board will be held at 10.00am on Friday, 2 September 2016 in the Henry Bollingbroke Room (formerly Cabinet Room 'D' at County Hall, Preston, PR1 8RJ.

I Young
Director of Governance,
Finance and Public Services

County Hall
Preston

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Emergency Care Staffing Challenge

B2B Briefing Paper

8th June 2016

Context

The decision to replace the emergency department at Chorley with an urgent care centre was, and remains, a temporary measure to address a critical staffing issue and maintain safe care for patients.

The Trust's critical staffing issue has arisen because of a combination of three factors:

1. There is a national shortage of emergency medicine doctors and indeed a shortage of clinical staff in many specialties. In part this is caused by an underinvestment in training places. In addition this has been exacerbated by continuously rising demand for healthcare as the population ages and more people live for longer with chronic conditions.
2. We have not been allocated enough doctors in training by the Deanery and so we have gaps in our rota.
3. The way in which the national agency cap has been applied by other trusts has affected our ability to attract locums.

Our emergency department staffing challenge has been on our risk register since 2010. We have taken a variety of actions to mitigate this risk which is reviewed regularly by our board and up until April 2016 we have managed the position and maintained service delivery. However, a number of additional factors created further pressure during February and March which necessitated the decision to temporarily replace the emergency department service with the urgent care service:

1. In February only three of the seven doctors in training who provide 50% of our emergency department middle grade workforce were allocated to the Trust by the Deanery and, whilst we were endeavouring to secure locum staff to fill the gaps in the rota that this created, our consultants 'acted down' to middle grade doctor posts. This situation was unsustainable because we do not have enough consultants to cover both consultant and middle grade doctor rotas.
2. In March two of our substantive middle grade doctors unexpectedly became unavailable for work. We require 14 middle grade doctors to run the emergency departments at Preston and Chorley and, at this point, we had 5 out of the 14 in post plus 3 locums; meaning there was a gap of 6 posts. The board took urgent action on 16th March to not implement the agency cap for emergency medicine locums on the grounds of patient safety (break glass).
3. However not implementing the agency cap for emergency medicine locums did not generate further CV applications and so we were unable to secure enough doctors to staff the rotas and hence had no other option but to review the services we provide so we could maintain safe care for patients. To be clear, we

did not need to 'break glass' sooner because we had up until that point managed the staffing position and patient safety was not compromised. We 'broke glass' at the point at which it was evident we were unable to maintain safe patient care.

Please see Appendix 1 for a timeline of reporting and decision-making in relation to the Trust's critical staffing issue and Appendix 2 for our 'Frequently Asked Questions' document.

Recruitment activity

In managing our workforce, we have undertaken a wide range of actions to ensure we can recruit and retain all the staff we need, including:

- Continuously trying to recruit all the staff we need, both substantively and on a temporary (locum) basis;
- Developing and implementing a vacancy management and recruitment strategy with a clear focus on improved marketing, role substitution and the use of alternative recruitment sources;
- Working with Health Education North West to look at increasing the number of doctors in training we are allocated, as we know that Lancashire and South Cumbria are allocated proportionately fewer doctors in training than other regions. Doctors in training are needed in order for us to staff the doctor rota in emergency departments;
- Raising the profile of our organisation to attract more candidates. To this end, we have promoted vacancies nationally through advertising posts on the NHS Jobs website and doctors.net which is where doctors would look for potential opportunities, exhibited at national recruitment conferences and developed a promotional DVD to highlight why this organisation is a good employer;
- Advertising emergency department vacancies in the national press including in The Guardian, Times and Telegraph however to date this has not generated any applications;
- Attending national recruitment fairs and have been working hard to promote our organisation as a good place to work via entering national awards to raise our profile, making a recruitment film, improving our website and promoting our staff and services in trade and national press;
- Undertaking proactive overseas recruitment. This has included undertaking skype interviews with doctors who are abroad, making links with an organisation that supports overseas doctors to gain GMC registration, working with the Royal College of Surgeons on an international recruitment project and supporting a number of medical training initiative schemes that provide junior doctors with opportunities to work and train in the United Kingdom;
- Implementing role substitution through nurse clinicians, physicians associates, advanced nurse practitioners and prescribing pharmacists to support the emergency department team and service;
- Changing conditions and contracts to include appointing GPs, offering hospital contracts to locum staff, enhancing the staff bank pay rate, enhancing terms and conditions for specialty doctors, introducing a recruitment premium for emergency medicine doctors and decided not to implement the final stage of the agency cap given the impact on our ability to fill our posts;
- Attempting to fill substantive posts on a temporary basis with locum doctors either through NHS contracts or through locum agencies;

- Raising our concerns about how the agency cap has been applied elsewhere with NHS Improvement;
- Developing and offering joint academic and/or research posts to attract a wider range of staff.
- Established the first self-funded nurse degree programme in the country which indicates that our recruitment practice is innovative and that we plan for our long-term future; and
- Using a managed service who help us to source locum doctors through a whole range of agencies who are registered on the procurement framework, this is in excess of 20 agencies; the arrangement is not exclusive and we approach other framework agencies directly.

Additionally, to manage the increasing staffing problems we have:

- Requested additional help from GP colleagues;
- Contacted other hospitals to determine whether anyone has any doctors who can provide support; however, we are advised that many other emergency departments are in a similar position and consequently, nobody is currently available;
- Attempted to recruit extra consultants to 'act down' into the middle grade doctor role; and
- Had conversations with colleagues at the local army barracks however they do not have the right kind of doctors available that we need.

We have also sought advice from NHS England (Stephen Groves, NHS England National Head of EPRR) about the feasibility and process for accessing national armed services support. NHS England advised that such an application for support would constitute a Military Aid to Civilian Authorities request, which is a last resort and would only be considered when all other options have been exhausted. NHS England advised that as plans are in place to maintain a safe and effective service, and discussions are continuing, such a request is therefore not currently appropriate. NHS England also advises that military medical personnel are now based in district general hospitals and no longer within military hospitals so mobilising them to support Chorley would leave other district general hospitals short of personnel.

Furthermore, on 12 April 2016 Dr Gora Bangi, Chair of NHS Chorley & South Ribble Clinical Commissioning Group and Dr Dinesh Patel, Chair of NHS Greater Preston CCG, wrote to all GP practices in Chorley, South Ribble and Greater Preston to see if they can help cover the staff shortfall in our Trust.

Until recently we have used agencies registered on the approved NHS framework to source locum staff as they undertake checks to ensure any doctors they offer are available, suitably registered, qualified and experienced. More recently we have also used agencies that are not on the NHS framework and have received more than 60 CVs; however in most cases these doctors are either unavailable, are not appropriately registered or qualified, or do not have sufficient experience of working in the emergency department. We are promptly reviewing and following up every single CV we receive. Any locum doctors who successfully complete a trial period will be offered fixed contracts or permanent posts.

Some potential candidates have provided feedback that the negative media coverage and criticism of the leadership team is adversely affecting our corporate reputation and making this a less attractive place to work.

Allocation of doctors in training

Doctors in training provide 50% of our emergency department middle grade doctor workforce. In the last rotation in February this year, of the seven doctors we are allocated only three came to work with us. We understand that the North West is allocated proportionally fewer doctors than the South and within the North West, Lancashire receives proportionally fewer doctors than Manchester, Liverpool and Cheshire. We have written to both Health Education England and Health Education North West to request that the allocation criteria is reviewed and the Chief Executive has personally discussed this directly with the Chief Executive of Health Education England, Professor Ian Cumming. Our understanding was that the trainee balance had been reviewed and would be enacted in August, which we understood may result in us being allocated more training placements. However we have recently been advised that this is not the case. Currently we have four unfilled HENW posts and it is not clear given the national shortage of doctors in training that these will be filled.

A safe and sustainable service

Delivering a safe and sustainable service is our main priority and therefore reinstating a service staffed primarily by locums is not an option as this is an unstable and vulnerable positon and very likely to result in similar staffing challenges in the future and a potential inability to safely deliver an ED service. We need to ensure that we have a balance of substantive (and therefore more reliable) doctors and locums. The SRG supported a risk assessment that indicated the requirement to have 10 out of the 14 posts being substantive appointment with 4 locum posts covering the gaps – to deliver a safe and sustainable service.

We will not apply the agency cap, however we have decided that we will not proactively advertise a message that we will pay whatever anyone asks as this will create inequity across our wider workforce that will destabilise other services. We will continue to try to recruit locums however our main focus as supported by the SRG must be to recruit permanent middle grade doctors and ensure we receive the full allocation of doctors in training as this will provide a more dependable workforce and enable the service to be reinstated in circumstances that can be sustained.

Assurance that current interim arrangements are delivering a safe service

There have been no patient safety issues attributed to temporarily replacing the Emergency Department at Chorley with an Urgent Care Centre.

The Trust has been undertaking daily monitoring of activity; performance; complaints; incidents; and friends and family test results, to provide assurance that the interim service arrangements are safe and provide a positive patient experience. A weekly review of this information is tracked and reviewed in the weekly SRG meeting.

We have worked with partner agencies to implement robust plans and procedures to ensure patients are swiftly transferred to the appropriate setting to meet their needs. Patients with the most serious illness or injury will be taken by North West Ambulance Service (NWAS) directly to their nearest appropriate emergency department. Any patient who self-presents in the urgent care centre, whose needs cannot be met, will be transferred promptly to the Royal Preston Hospital. The majority of people who previously attended the emergency department at Chorley did so between 8am and 8pm. These are the hours that the urgent care centre is open. The majority of patients who went to the Emergency Department at Chorley are now attending the Urgent Care Centre where they receive the appropriate treatment.

Impact on other services

The changes to Chorley has had minimal impact on the emergency departments of surrounding hospital trusts, as evidenced by NHS England monitoring, NWAS ambulance activity data and postcode analysis undertaken by surrounding hospital trusts.

The assessments made using NWAS data indicated that Wigan would receive an additional 9 patients via ambulance each day and that Blackburn would receive an additional 1 patient. On this basis both hospitals were advised of the potential impact. Daily monitoring of patient flow to Wigan and Blackburn is undertaken to assess impact. Wigan have confirmed they are able to manage this demand appropriately and are continuing to achieve the four hour accident and emergency standard. Other trusts in the area confirm there is no evidence that significant numbers of patients who would have otherwise attended the emergency department at Chorley are electing to attend an alternative hospital and those that are are not having an adverse impact. There has been an increase in the number of people attending Royal Preston Hospital, as we predicted, and we have extended the emergency department and assessment areas to accommodate additional patients and maintain a prompt service.

The North West Ambulance Service has confirmed both directly to us and to the media that the pathfinder process they have implemented is managing demand safely and effectively and patients are being conveyed to the appropriate setting for treatment. Overall proportionately more people are attending the urgent care centre at Chorley in 12 hours than attended the emergency department in 24 hours.

However, since the beginning of May all hospitals in Lancashire have experienced a significant increase in attendance and many are finding it challenging to achieve the four hour standard. This busy spell has been erroneously and anecdotally attributed to the Chorley emergency department issue – but actual analysis of the activity evidences that this increase is unrelated to the service change.

Ensuring the best possible working conditions for nursing and other staff

Prior to the decision to temporarily replace the Emergency Department at Chorley with an Urgent Care Centre, we held a series of meetings with staff and union representatives to discuss the position we found ourselves in and to explain the options that we were pursuing to try and mitigate the medical staffing shortages. At the point that we concluded that temporarily replacing the Emergency Department at Chorley with an Urgent Care Centre

was the only viable option, we informed the staff immediately and met with each employee individually to discuss the impact for their role. Their preferences for remaining in the Urgent Care Centre, moving to the Emergency Department at Preston, or another ward area at Chorley were sought and all of these preferences were accommodated.

There have been frequent communications with staff to keep them informed and the Operations Director has visited the UCC on a number of occasions, providing an opportunity for staff to ask questions or raise concerns. Staff have also been encouraged to speak with the Matron or other members of the management team at any time, should they have any concerns and informed of the wider sources of support available to them. Communications have also been maintained with the wider staff at Chorley & South Ribble General Hospital in relation to the Emergency Department situation and this has been through a variety of channels, including team meetings and briefing notes.

Ensuring the best possible working conditions for our staff is a high priority for us and we have recently held focus groups with staff to discuss the results of the last staff satisfaction survey and actions are already being implemented as a result of this. We provide support to our staff through a range of health and well-being initiatives, which includes a new programme around mindfulness. Our occupational health service provides individual support through a counselling service which is accessible to all staff via self-referral.

Informing stakeholders

We have kept the regulators and the System Resilience Group fully informed about this issue in recent months (see Appendix 1). As soon as it became apparent that no viable options to maintaining the service remained we immediately informed our other external stakeholders through face-to-face meetings to facilitate discussion and feedback. Since 18th April (when the service change was implemented) we have been regularly briefing all of our stakeholders through regular meetings and weekly email bulletins and we are committed to keeping our stakeholders fully informed and involved in this way. Details of the key stakeholder briefing events are as follows:

- 21 April 2016: briefing meetings with Trust Board, Governors and JNCC. Unions and Protect Chorley Hospital Group cancelled their meeting.
- 22 April 2016: briefing meetings with the Leaders and Chief Executives of the local authorities (Lancashire County Council, Preston City Council, South Ribble Borough Council and Chorley Council), the Chair of the LCC Health Scrutiny Committee, local MPs and HealthWatch. The 23 MPs for Lancashire and South Cumbria were also invited to a briefing meeting. We issued a report to the Chorley Council Special Meeting.
- 26 April 2016: Chief Executive provided a briefing at the Lancashire County Council Health Scrutiny Committee meeting and the Central Lancashire Health & Wellbeing Partnership meeting.
- 13 May 2016: briefing meetings with local MPs and Chorley Council.
- 16 May 2016: briefing meetings with Lancashire County Council, Preston City Council, South Ribble Borough Council and HealthWatch.
- 18 May 2016: briefing meeting with Protect Chorley Hospital Group.

Furthermore, we have organised open sessions every fortnight from 17 June 2016 for stakeholders to come along to hear the latest progress and a weekly drop in session for

MPs. To inform stakeholders about other matters affecting our hospitals we will be launching a new briefing in the summer and we will continue to meet regularly to maintain dialogue and relationships.

Karen Partington
CHIEF EXECUTIVE

APPENDIX ONE: TIMELINE OF REPORTING & DECISION-MAKING

April 2010: The risk of ED medical staffing was included on the Trust's risk register.

July 2011: The limited supply of doctors in training in specialised roles was included on the Trust's board assurance framework.

July 2011 onwards: Over the last five years the Chief Executive, Medical Director and Workforce Director have raised the need for rebalancing of trainees across the North West in several forums including SRG, LWEG, and in 1:1 meetings with the Dean.

June 2015: We raised the issue of staff shortages within ED with Monitor during the June PRM visit.

NB: *As previously stated, we require 14 middle grade doctors to run the emergency departments at Preston and Chorley. We consider it helpful to provide (in red text below) the pattern of increasing gaps in our substantive ED workforce between August 2015 and March 2016. By March 2016 we had only 5 substantive staff in post which created nine gaps in our substantive ED workforce, however, as we were able to secure 3 locum staff the overall gap in the rota was 6.*

August 2015: We were working with five gaps in our substantive ED workforce – we raised concerns regarding reliance on locums with Monitor during the August PRM visit.

September 2015: We were working with five gaps in our substantive ED workforce.

October 2015: We were working with four gaps in our substantive ED workforce - we raised the issue of staff shortages within ED with Monitor during the October PRM visit.

November 2015: We were working with four gaps in our substantive ED workforce.

December 2015: We were working with four gaps in our substantive ED workforce. A detailed risk assessment of the staffing issues was taken to the December Trust Board and the December SRG meeting (the SRG comprises Chorley & South Ribble CCG, Greater Preston CCG, Lancashire County Council, Lancashire Care and NWAS) due to our heavy reliance on locum cover and the impact of the locum agency rate caps. The issue was raised with NHS England and Monitor at the December Joint Financial Recovery Board meeting (with board members from the Trust and the CCG present).

January 2016: We were working with five gaps in our substantive ED workforce. The risks around ED (including staffing issues and the impact of the locum agency rate caps) was discussed further at the January SRG meeting.

February 2016: We saw an increase to eight gaps in our substantive ED workforce as only three of the seven doctors in training who provide 50% of our emergency department middle grade workforce were allocated to the Trust by the Deanery. This increased the risk to 25 (HIGH) and the risks around ED (including staffing issues and the impact of the locum agency rate caps) was discussed further at the February SRG meeting. We raised the issue with Monitor again during the February PRM visit.

March 2016: We saw an increase to nine gaps in our substantive ED workforce as two of our substantive middle grade doctors unexpectedly became unavailable for work. The risk assessment was updated and the ED recovery plan, staffing issues and the impact of the locum agency rate caps was discussed at the March SRG meeting.

We consider it would be helpful to provide a more detailed timeline of reporting and decision-making for March 2016 and April 2016 as follows:

11 March 2016: we formally wrote to Jim Mackey of NHS Improvement to express our support with respect to the agency cap but to raise our concerns regarding the consistent implementation of the cap; in particular, the impact the lack of consistency has on an organisation's ability to recruit and retain doctors when other organisations are paying higher rates and there is no agency cap in other parts of the UK.

14 March 2016: we received a letter from Jim Mackey of NHS Improvement stating "*I stress the importance of you continuing to hold the line*" and "*The coming weeks are crucial for us all to hold our nerve in order to realise the most significant benefits of the agency caps*" and "*compliance with the agency controls will be a condition for the release of the Sustainability and Transformation funds so there will be a very strong incentive on Trusts to reduce their overrides*".

16 March 2016: we held an emergency Trust board meeting to review the risks and the board took the decision to not implement the final phase of the agency cap for April where patient safety would be compromised. Later on that day the Trust's Chief Executive and the Operations Director met with Simon Stevens and Graham Urwin of NHS England as part of a wider meeting and showed them around our A&E department and our clinicians made them aware of the significant issues we are currently facing.

24 March 2016: the risks were raised with NHS England at the Joint Financial Recovery Board meeting (with board members from the Trust and the CCG present).

31 March 2016: we identified a significant risk to service delivery with immediate effect.

1 April 2016: we sought agreement from the ED Consultant team to cover and act down into the middle grade shifts. The consultants agreed a period of two weeks for the Executive team to seek additional staffing and plan contingency.

5 April 2016: an emergency SRG meeting was convened when the options were considered with an aim to deliver a safe service which optimised the service provision at Chorley and which had the least impact on other organisations with the staffing resources available.

8 April 2016: a second emergency SRG meeting was convened to further discuss the fragility of the Emergency Departments.

13 April 2016: a third crisis meeting of the SRG was held and the SRG supported the decision to temporarily change the service provision at Chorley to an urgent care service between the hours of 08:00-20:00; with a GP out of hours service overnight. The SRG decision was based on an agreed risk assessment, the principles of providing a safe service which optimised the service provision at Chorley with the staffing resources available and which had the least impact on other organisations. NHS Improvement were immediately notified of the decision. After this meeting it was agreed that a weekly meeting of the SRG would be convened to monitor implementation of the temporary change to service provision.

18 April 2016: the service changes were implemented. The SRG continue to meet on a weekly basis from this date to review the risk assessments and the minimum requirements for re-opening.

APPENDIX TWO: FREQUENTLY ASKED QUESTIONS

QUESTIONS AND ANSWERS

Temporary changes to Chorley Emergency Department

UPDATED 20/05/2016

Are you committed to reinstating the emergency department at Chorley Hospital?
Yes, our board is fully committed to reinstating the emergency department at Chorley Hospital as soon as we have sufficient staff to provide a safe and sustainable service, and we are continuing to do everything possible to achieve that position. The decision to replace the emergency department at Chorley with an urgent care centre was, and remains, a temporary measure to address a critical staffing issue and maintain safe care for patients. From the outset it has always been our firm intention to reinstate the emergency department service as soon as we had enough doctors to provide a safe and sustainable service, and we have been doing everything we possibly can to secure the staff we need.

What needs to happen for the emergency department to be reinstated?
The board and all our staff, along with partner agencies are fully committed to reinstating the emergency department at Chorley as soon as we have the sufficient staff to ensure we can provide a safe and sustainable service. We are all working to make this happen.

We need 14 doctors to safely staff the departments across both hospitals, and as of 19 May we have a gap of five. We are trialling locum doctors on a continuous basis and actively pursue each and every potential candidate for both temporary and permanent posts. The position changes every day as we receive and review CVs, arrange trials and continue our recruitment efforts.

Trainee doctors make up 50% of our emergency department middle grade doctor workforce. In the training rotation in February only three of the seven trainee doctors we were allocated actually reported for duty. Seven trainee doctors have again been allocated to us in the next training rotation in August. Our staffing position will be greatly improved if all seven trainee doctors actually report for duty. However in the meantime we are continuing all efforts to recruit the additional staff we need.

As soon as we have enough doctors to provide a safe and sustainable service we will reinstate the emergency department at Chorley, and we will provide regular updates about our progress.

Have you advertised in the national press?
Yes. In response to a suggestion from a local MP we took out adverts in the Telegraph (28 April 2016), Sunday Times (1 May 2016) and Guardian (4 May 2016). Unfortunately those adverts haven't generated any applications. However we do continuously advertise on doctors.net and jobs.nhs, which is where doctors tend to look for vacancies. We are also advertising our emergency department vacancies on the home page of our website, Facebook site and are regularly tweeting job opportunities. Our

other recruitment activities are also continuing, including international and national recruitment, creating different types of posts to make working in emergency medicine more attractive, offering recruitment premiums, and offering locums long term and permanent contracts.

Why have you decided to replace the emergency department with an urgent care service?

This issue has arisen because of a combination of factors :

1. There is a national shortage of emergency medicine doctors.
2. We haven't been allocated enough doctors in training, and so we have gaps in our rota.
3. The way in which the national agency cap has been applied elsewhere is affecting our ability to attract locums

These three things combined means that we don't have enough of the right type of doctors to safely staff the emergency department.

We should have 14 middle grade doctors to safely staff the department - but at the time the decision was made we had just 8 middle grade doctors in post (and have 9 doctors at the moment).

It would be negligent to attempt to provide a service when there are not enough doctors to staff it – this would be an unacceptable risk to patient safety.

What have you been doing to recruit the staff you need?

In managing our workforce, we have undertaken a wide range of actions to ensure we can recruit and retain all the staff we need. We have recently established the first self-funded nurse degree programme in the country which indicates that our recruitment practice is innovative, and that we plan for our long term future. We have developed and are implementing a recruitment and retention strategy, and advertise all vacancies on nhs.jobs and doctors.net (which is where the healthcare workforce searches for jobs) as well as our corporate website and social media. We have recently advertised emergency department vacancies in the national press including in the Guardian, Sunday Times and Telegraph; however to date this hasn't generated any applications. We attend national recruitment fairs, and have been working hard to promote our organisation as a good place to work via entering national awards to raise our profile, making a recruitment film, improving our website, and promoting our staff and services in trade and national press. We have created new types of roles such as clinical fellowships and research posts to broaden the appeal of working in the emergency department.

We have undertaken proactive overseas recruitment including skype interviews with doctors abroad; making links with an organisation that supports overseas doctors to gain GMC registration; working with the Royal College of Surgeons on an international recruitment project; and supporting a number of schemes that provide junior doctors with opportunities to work and train in the UK. We have changed conditions and contracts including appointing GPs; offered contracts to locum staff; enhanced the staff bank pay rate; enhanced terms and conditions for specialty doctors; and introduced a recruitment premium for emergency medicine doctors. We are also trying to recruit extra consultants to 'act down' into middle grade doctor posts to help us staff the rotas.

What have you done to prevent the recruitment issue reaching crisis point?
The emergency department staffing challenge has been on our risk register since 2012. We have taken a variety of actions to mitigate this risk, which is reviewed regularly by our board, and up until April 2016 we have managed the position and maintained service delivery. However since February 2016 a number of additional factors created further pressure which necessitated the decision to temporarily replace the emergency department service with the urgent care service : only three of the seven trainee doctors, who provide 50% of our emergency department middle grade workforce, actually reported for work. And in March two of our substantive middle grade doctors also became unavailable for work. Whilst we were endeavouring to secure locum staff to fill the gaps in the rota tehse two factors created, our consultants 'acted down' to middle grade doctor posts. That situation is unsustainable because we do not have enough consultants to cover both consultant and middle grade doctor rotas. Despite the board agreeing that we would 'break glass' and not implement the agency cap for emergency medicine locums, we were not able to secure enough doctors to staff the rotas, and hence had no other option but to review the services we provide so we could maintain safe care for patients. We did not need to 'break glass' sooner because up until that point we had managed the staffing position and patient safety was not compromised. We 'broke glass' at the point at which it was evident we were unable to maintain safe patient care.

Is it true that you've been sent CVs you're not acting on?
This is absolutely not true.

Until recently we have used agencies registered on the approved NHS framework to source locum staff as they undertake checks to ensure any doctors they offer are available, suitably registered and qualified, and experienced. More recently we have also used agencies that are not on the NHS framework and have received more than 60 CVs; however in most cases these doctors are either unavailable, are not appropriately registered or qualified, or do not have sufficient experience of working in the emergency department.

We are promptly reviewing and following up every single CV we receive. Any locum doctors who successfully complete a trial period will be offered fixed contracts or permanent posts. However we will not appoint any staff who are unsuitable, or unqualified, as we will not compromise patient safety.

Some people have suggested calling in the army, is that a good idea and have you considered this?
An emergency department needs to be staffed by appropriately qualified, trained and experienced staff to deliver safe patient care.

We've had conversations with colleagues at the local barracks because we already provide some training for their medics - however they do not have the kind of doctors that we need.

We have requested advice from NHS England about the feasibility and process for accessing national armed services support. NHS England advises that such an application for support would constitute a Military Aid to Civilian Authorities request,

which is a last resort and would only be considered when all other options have been exhausted. NHS England advises that as plans are in place to maintain a safe and effective service, and discussions are continuing, such a request is therefore currently not appropriate. NHS England also advises that military personnel are no longer based in military hospitals, but are reservists within NHS district general hospitals, so providing military support would involve taking medics from other hospitals around the country.

Who has made the decision to replace the emergency department with an urgent care service?
Based on the staffing available, the medical director of Lancashire Teaching Hospitals made a clinical recommendation to the trust's chief executive to move to an 8am to 8pm urgent care service in order to continue to provide a safe service.

The trust's chief executive then asked the system resilience group (SRG) to support the recommendation. The SRG includes the senior leadership and clinical leads of the Chorley and South Ribble Clinical Commissioning Group (CCG), and Greater Preston CCG, Lancashire Care NHS Foundation Trust, Lancashire County Council, Lancashire Teaching Hospitals NHS Foundation Trust, and the North West Ambulance Service.

The SRG considered the situation and supported the trust's recommendation to temporarily change the emergency department at Chorley Hospital to an urgent care service.

Why has there been no public consultation?
This is a temporary measure to deal with an urgent staffing crisis and maintain patient safety, so the System Resilience Group has the authority to agree such a decision without a public consultation. Any proposal to make a permanent and significant change to any hospital services would be subject to a formal process.

Preston is already busy, how will it cope with the extra patients?
The majority of patients who attended the emergency department at Chorley previously can be safely and appropriately treated at the urgent care centre based in Chorley Hospital.

We have temporarily expanded the assessment areas at Preston to accommodate additional patients, and staff from departments across the hospital are providing extra support. We have transferred some medical assessment services and some day case surgery to Chorley to free up space for extra beds so we can admit any additional patients.

We have also been working closely with the ambulance service whose staff are very experienced in assessing patients and transferring them quickly to the most appropriate setting.

People are saying that patients are now waiting many hours to be seen is this true?
In the first week or so following this change waiting times at both Royal Preston Hospital and Chorley hospital reduced. Hospitals across Lancashire have reported that the beginning of May has been busier than usual – but that this is due to an overall increase in the numbers of people attending rather than a redistribution of patients who would

have otherwise attended Chorley. The urgent care centre at Chorley is actually busier than the emergency department was.

People in Chorley are concerned that the extra travel time to Preston might affect them if they have a medical emergency?
For several years patients from Chorley with certain conditions have been transferred to Preston for treatment. Major trauma services were reorganised a few years ago, and evidence from that new way of working tells us that people's outcomes are affected by how they're treated by the paramedic crew, and how they're treated when they get to hospital, rather than how long they spend in an ambulance.

For several years patients from Chorley (and other areas in Lancashire and South Cumbria) have been transferred to Preston where a number of other specialist services are provided including neurosurgery, plastic surgery, and more recently vascular surgery. For some time children from the Chorley area have been taken directly to Preston by ambulance where the paediatric service is provided.

For several years patients from Chorley and surrounding areas who have a cardiac emergency have been taken to Blackpool.

Our ambulance service colleagues are very experienced in getting patients to the place they need to be as quickly as possible, and there are just a few miles between Chorley and other emergency departments in Preston and other areas.

Why has the emergency department at Chorley rather than Preston been affected?
The major trauma centre along with a number of other specialty services including neurosurgery, plastic surgery and vascular surgery are provided at Preston, and are a vital part of the pathway for patients from Lancashire and South Cumbria who may need to be admitted to hospital for emergency care and treatment. Patients who need any of these services, as well as children, are already transferred from Chorley to Preston to be admitted to hospital.

The area's helipad is at Royal Preston Hospital which enables patients with life and limb threatening injury to be transferred to hospital by air ambulance. And Preston is the busier department, with around 80 more people attending every day than Chorley.

What will the Urgent Care Centre provide?
Urgent care services will be provided at the urgent care centre, at Chorley & South Ribble Hospital. The service will be provided by a combination of emergency department consultants, nurse practitioners, GPs, nurses and healthcare assistants.

The majority of people who currently attend the emergency department at Chorley have conditions that can be treated safely and appropriately by an urgent care service. Most patients with minor injury or illness can be treated by an urgent care service.

The Urgent Care Centre will be open between 8am and 8pm. Outside these hours patients should phone 111 for advice or attend their nearest emergency department. From Monday, the Euxton GP out of hours service has been based at the Urgent Care Centre to provide additional support.

We have produced a detailed leaflet that explains exactly what treatment is available at the urgent care centre- you can find this on our website.

Implications for our staff

Will any emergency department staff lose their jobs?
No emergency department staff will lose their jobs. We will work with staff and the trade unions to transfer staff from Chorley to Preston to help us manage this current issue. Nursing and other staff will also have opportunities to work in the urgent care service at Chorley, and in other departments in both hospitals. We will do everything we can to accommodate our staff's preferences. Our staff have responded really constructively to this temporary change because maintaining patient safety is everyone's priority, so they're willing to work flexibly to make sure we're able to provide good care whilst we're dealing with this issue.

Will doctors in training be able to get the experience they need if there is no emergency department at Chorley?
This is a temporary measure to deal with an immediate staffing crisis. Some medical assessment services will be transferred from Preston to Chorley which means junior doctors can be assured they will still get the acute medical experience they need to complete that stage of their training.

Lancashire Children & Young People's Emotional Wellbeing & Mental Health

'Transformation Programme Update'

Health and Wellbeing Board

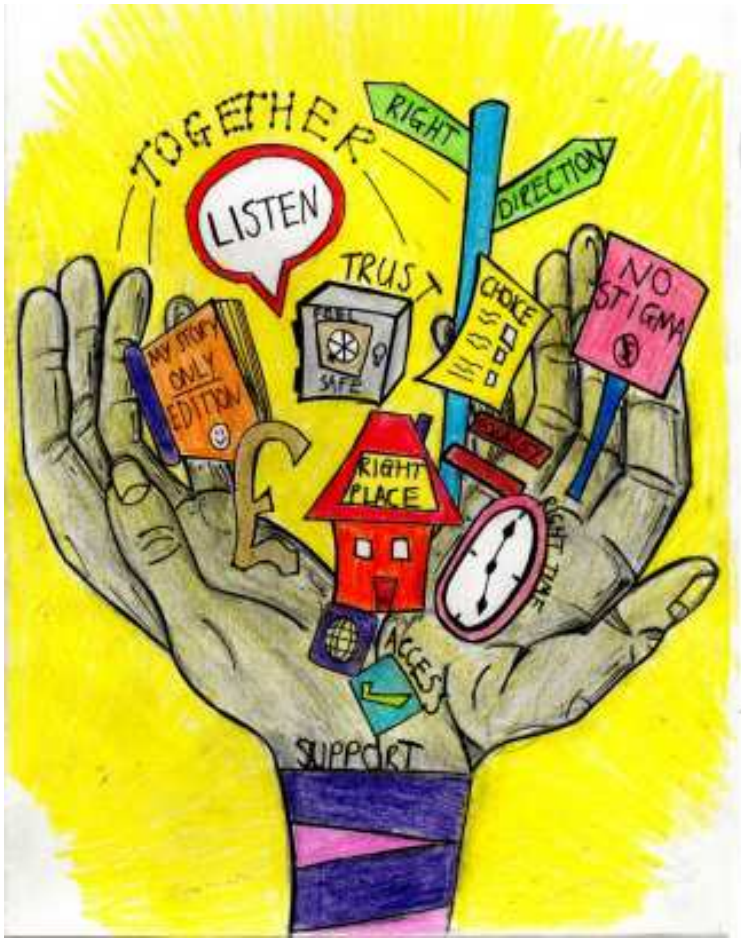
13th June 2016

Agenda for Today

- **Mobilising the Plan and Operationalising Delivery**: A recap on the Transformation Plan and how we've got our programme of work up and running.

- **Delivery in 15/16 and our plans for 16/17:** An overview of what we invested in during 15/16, what was delivered, and what we are investing in for 16/17 and what we expect to be delivered.

- **Future Goals and Next Steps**: How we want to move forward as a partnership and where we want to focus next.



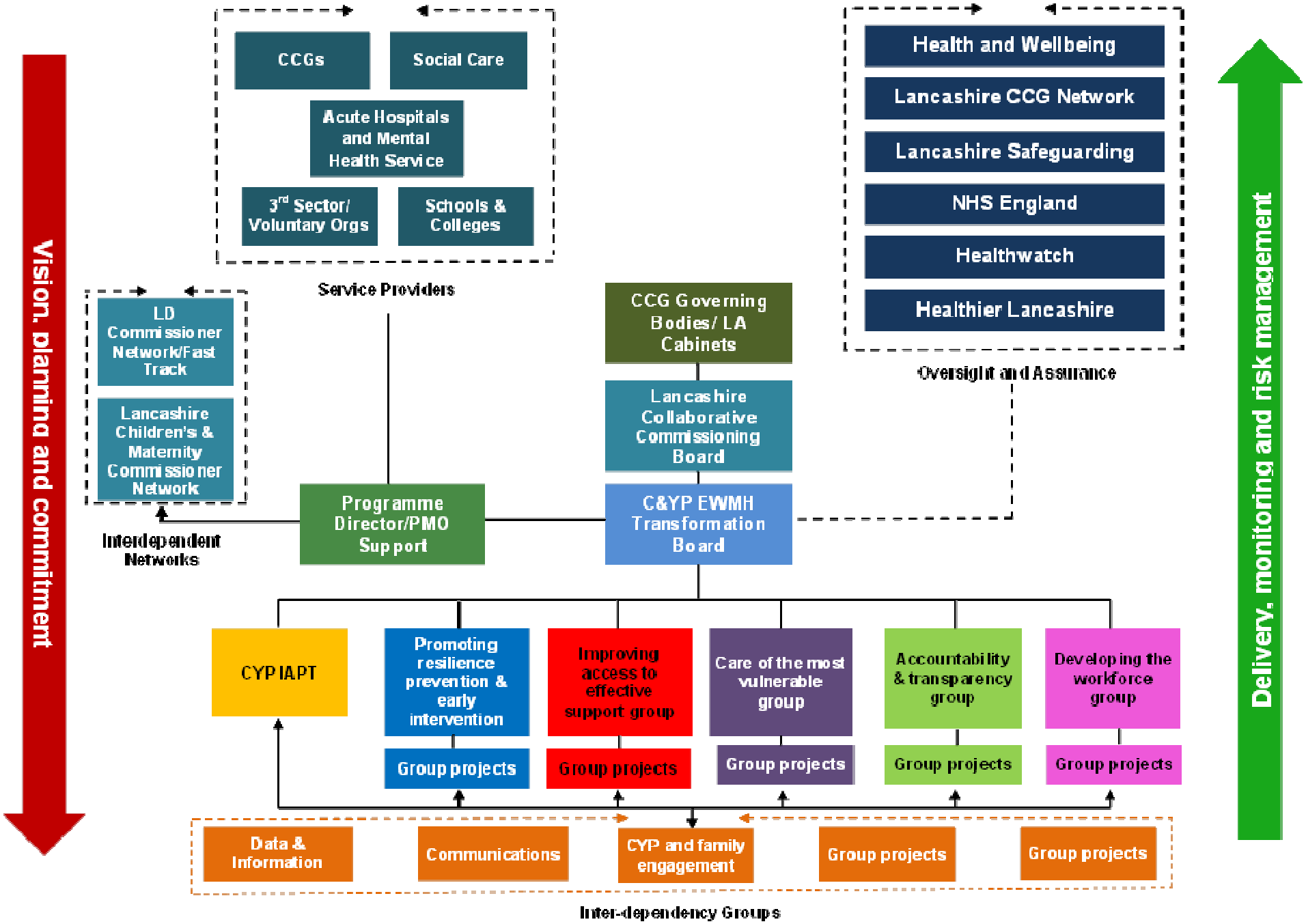
Recap on the Process

- **Lancashire Transformation Plan**
  - Developed in partnership
  - 8 CCG's, 3 LA's, multiple clinical and specialist service providers and the voluntary sector
  - Based on Future in Mind requirements
  - Included local input from children and young people's groups
  - Described 5 key areas of priority with 24 objectives and 200+ deliverables over 5 years
  - Signed off by HWBBs in Autumn 2015
  - Assured by NHSE 24th Dec 2015
  - Published in January 2016
  - Mobilised for 6 months

Recap on The Plan

- Some key differences to previous plans:

- 0-25 years of age
- An additional £3m+ a year for 5 years
- Greater focus on prevention, resilience and promoting positive mental health and wellbeing
- A commitment to improving access across the system and reducing waiting times
- Intentions to improve the quality of care for vulnerable children and young people
- Aims to set shared standards and outcomes across services, with greater system co-ordination
- Ambitions to ensure a ‘fit for purpose’ workforce


Vision, planning and commitment
CCGs
Social Care
Acute Hospitals and Mental Health Service
3rd Sector/ Voluntary Orgs
Schools & Colleges
Service Providers
Health and Wellbeing
Lancashire CCG Network
Lancashire Safeguarding
NHS England
Healthwatch
Healthier Lancashire
Oversight and Assurance
LD Commissioner Network/Fast Track
Lancashire Children's & Maternity Commissioner Network
Interdependent Networks
Programme Director/PMO Support
CCG Governing Bodies/ LA Cabinets
Lancashire Collaborative Commissioning Board
C&YP EWMH Transformation Board
CYP IAPT
Promoting resilience prevention & early intervention
Improving access to effective support group
Care of the most vulnerable group
Accountability & transparency group
Developing the workforce group
Group projects
Group projects
Group projects
Group projects
Group projects
Data & Information
Communications
CYP and family engagement
Group projects
Group projects
Inter-dependency Groups
Delivery, monitoring and risk management

Programme Work To Date

- **Functional Programme Board** (schools, LA's, providers, vol. sector, SCN, CCGs, NHSE).
- **Project Management Office supports**: PIDs, work plans, inter-dependencies, system relationships, risk management, comms and engagement, training and development.
- **Check and Balance**: stakeholder test on 14th March, feedback built into finalised plans and resource 'asks' for 16/17.
- **Decision Making Framework**: articulates principles of collaboration and joint commissioning among partners, approved by CCB.
- **Investment Plans and Pooled Resources** (12% 15/16 and 15% 16/17).
- **Alignment with STP and South Cumbria and Lancashire Transformation Programme :** a key programme with identified inter-dependencies and shared opportunities
- **Strong Provider Engagement**: Clinical Reference Group and exploration of models for provider collaboration and co-production.
- **iTHRIVE**: National 'Community of Practice'.
- **Continued Reporting:** On-going assurance process with NHSE and with all Lancashire partners, children, young people, families and accountable bodies.

Delivery in 15/16

- Spent additional £2.2 m
- Increased our spend on resilience
- Commissioned increased staff numbers and increased episodes of care
- Commissioned pilots to test new models of care
- Collaborated across Lancashire to invest in shared approaches to major service developments

Delivery in 15/16

Work streams	15/16 spend	%
Resilience	£703,241	31%
Improving Access (Not in ED)	£217,800	10%
Care of Vulnerable	£335,000	15%
Crisis	£605,266	27%
Workforce	£74,500	3%
Joint pot workstreams	£319,740	14%
Total	£2,256,035	100%

£865,990 for Eating Disorders and Self Harm

Outcomes by March 2017

Over 3,411 more children to be supported and treated per year

Over 51 wte more staff to be in post

Promoting Resilience

- Links established with the North West Coast Strategic Clinical Network which has influenced the wider thinking of the group on regional and national initiatives
- Establishment of a Public Health working group and links made to already established CAMHS Stakeholder Group
- Development of 'Lancashire Prevention and Resilience Workshop – Working Collaboratively' bringing together colleagues from the Prevention work stream for the Lancashire and South Cumbria Change programme with colleagues from the Resilience work stream
- Development of a service specification for Primary Care Mental Health resource with engagement with schools

Promoting Resilience

No. of objectives	No. of deliverables	Status
7	57	1 deliverable completed
		13 deliverables in progress
		7 deliverables not started
		36 deliverables not due to start

Improving Access

- Needs Assessment being undertaken for community eating disorder services to inform future commissioning arrangements to meet NHS England and NICE guidelines
- Joint working planned with Resilience workstream, North West Coast Strategic Clinical Network and providers for future peri-natal care to improve access

Improving Access

No. of objectives	No. of deliverables	Status
7	55	0 deliverables completed
		10 deliverables in progress
		0 deliverables not started
		45 deliverables not due to start

Care for the Most Vulnerable

- Liaison with interdependent programmes to produce all age service specifications for Learning Disabilities, unscheduled care and Crisis Care Concordat
- Development of a pan-Lancashire collaborative bid to the Department of Education Children's Social Care Innovation Programme to develop Place of Safety provision alongside wraparound care to support CYP
- Improving access to psychosocial assessment and improving telephone support for professionals service specifications developed
- Workshop held to co-design a 'good' crisis pathway

Care for the Most Vulnerable

No. of objectives	No. of deliverables	Status
3	33	1 deliverable completed
		15 deliverables in progress
		3 deliverables not started
		14 deliverables not due to start

Improving Accountability and Transparency

- Systems established to monitor finance and performance
- Development of a governance system for agreeing non recurrent and recurrent spend
- CCG commissioning intentions for 2016/17, identifying remaining amounts per CCG for collaborative work
- Initial consideration of developing outcomes against the Thrive model including a digital solution

Improving Accountability and Transparency

No. of objectives	No. of deliverables	Status
5	24	1 deliverables completed
		12 deliverables in progress
		0 deliverables not started
		11 deliverables not due to start

Developing the Workforce

- Support from Barry Nixon, National Lead for workforce
- Identification of the need to do a workforce audit
- Support for a gap analysis
- Development of a workforce plan

Developing the Workforce

No. of objectives	No. of deliverables	Status
1	15	0 deliverables completed
		0 deliverables in progress
		15 deliverables not started
		0 deliverables not due to start

Proposals in 16/17

Workstream	Schemes
Promoting Resilience	• More Primary Mental Health Workers • Increased provision for Peri-natal Mental Health • Pilot and evaluate different approaches to promoting resilience in schools • Resilience model and training plan pan Lancashire developed • Roll out of resilience therapy framework
Improving Access	• CAMHS Transition points reviewed and re-worked • Increased Access to Psychological Therapies for 16 – 18 years across Lancashire • Digital solutions • Engagement with children and families
Care of the most vulnerable	• ASD Pathways strengthened • ADHD Nurses recruited • Community specification for children with LD • Crisis pathway • Places of Safety
Accountability & Transparency	• Model for system oversight • Improved performance reporting
Developing the workforce	• Training Courses/Community Development

The Future

Future Focus ….

- **On going delivery:** the work streams, the work plans and the programme
- **Increasing the pool:** 17/18 and beyond.
- **Consolidating collaborative commissioning:** 16/17 joint commissioning schemes
- **Aligning with LA integration agenda:**

i) Closer integration at both an STP strategic level and also at a community level; securing efficiencies; ensuring that services are focussed better on individuals and communities with a significant emphasis on prevention

ii) Taking account of proposed investment by local authorities, particularly Prevention and Early Help Programmes, ensuring clear and appropriate interventions to prevent escalation to specialist services

- **On-going strategic alignment:** with wider and related programmes (Prevention, WBEH, LD, AMH)
- **Development of end state view:** metrics, measures and steps

Looking Ahead .....

Why	What	How
OUR CASE FOR CHANGE	**OUR 24 PROGRAMME OBJECTIVES**	**Our 200+ Deliverables**

Gap	Indicators	Programme objectives	KPIs	Outcomes
HWB	• Prevalence - CYP with a MH disorder (by age group), other conditions • Pop. need – no. of CYP who may experience mental health problems, self harm, suicides • Demographic, Social, Economic & Environmental Determinants driving need and poor MH outcomes • Lifestyle choices	• Objective #1- resilient communities • #3 public awareness • #5 &16 – prevention & early intervention • #7 early intervention during pregnancy	• Hospital admissions as a result of self harm / poisoning (10-24 years), rate per 100k / • Child admissions for Mental Health / conduct disorder / eating disorder • Children in care / children in need (abuse, neglect, family dysfunction) • Social exclusion • Maternal mental health (perinatal depression) • Maternal smoking rates	• Increase in early identification and treatment • Reduction in self harm and poisoning • Reduction in crisis care demand • Increased understanding of Mental Health services available amongst C&YP • Effective use of Digital services as part of Prevention and Early intervention pathway
C&Q	• Access to MH services • Referral times and waiting times • Effectiveness of treatments • Estate and locations • Integration of CAMHS and AMHS • Transparency & oversight	• #2 – improve access to: EBTs, • #6 support, • #12 eating disorders, • #14 psychosis services • #4 – availability of information, • #9 digital access • #10 single point of access • #17 equitable access (vulnerable) • #20 transparency / robust metrics • #22 user needs, co-design of services	• CYP IAPT reliable recovery • Access to EBTs • Referral times and waiting times e.g. GP referral to receiving MH service • Waiting times between services (police, community services, schools etc)	• Increase in reliable recovery rates • Measurable improvement in person centred care based on robust and auditable user feedback
F&E	• Service efficiency – duplication of services and delivery costs • Spend vs outcomes (above average spend, below average outcomes) • Workforce capacity and resilience • Supplier base and contracting models	• #21 – increased level of investment • #24 resourced, skilled and trained workforce	• Total contract value / annual contract value • Unit cost per patient (inpatient and care in the community) across providers • Fixed fee vs variable cost based on performance • Contingent labour	• Increased value for money measured by benchmark costs • Mixed economy of service providers, improving quality of services

Looking To The End …..

- **Totality View**: using Digital THRIVE for i) system overview, ii) integrated performance reporting iii) enabling an interactive offer.
- To understand the total investment (money and services) as mapped against

A potential tool….

Conceptual Lancashire Thrive