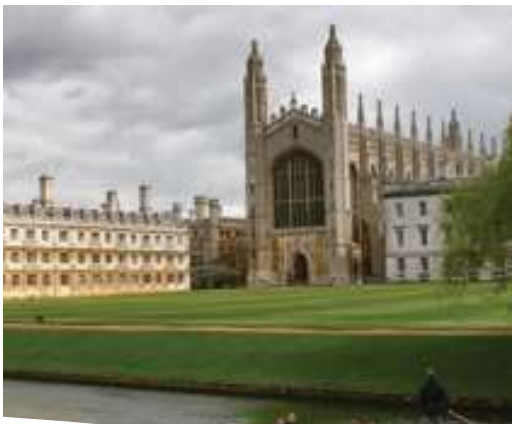
NHS
East of England
Clinical Senate



Review of Accident and Emergency Services at Grantham & District Hospital (United Lincolnshire Hospital NHS Trust). Review sponsored by NHS England and NHS Improvement

Report of the Independent Clinical Senate Review Panel – 22 November 2017

FINAL DRAFT 28/11/17

Glossary of abbreviations used in the report

A&E	Accident and Emergency (used interchangeably with ED – below)
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
ED	Emergency Department (used interchangeably with A&E – above)
GDH	Grantham and District Hospital
GP	General Practitioner
HSC	Health Scrutiny Committee
IRP	Independent Reconfiguration Panel (*Body which reviews proposals for changes to NHS services that are being contested, and advises the Secretary of State for Health)*
LCH	Lincoln County Hospital
NHSE	NHS England
NHSI	NHS Improvement
PHB	Pilgrim Hospital Boston
STP	Sustainability and Transformation Partnership
ULHT	United Lincolnshire Hospitals NHS Trust
24/7	Twenty four hours, seven days a week.

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1. FOREWORD BY DR BERNARD BRETT, CLINICAL SENATE REVIEW PANEL CHAIR

The East of England Clinical Senate, along with the other eleven Clinical Senates in England, has been established with a key function to conduct independent clinical review panels providing an expert clinical view on service reconfiguration options and decisions focussing on patient outcomes. The East of England Clinical Senate was approached by NHS England on behalf of NHS Improvement to undertake a safety review of proposals by the United Lincolnshire Hospitals NHS Trust (ULHT) to re-open the Accident and Emergency Department at Grantham and District Hospital, 24 hours seven days a week. It is currently open between the hours of 08.00 and 18.30 seven days a week.

The United Lincolnshire Hospitals NHS Trust, like many other NHS Acute Trusts, has been facing significant challenges in the provision of emergency services over the course of the last two years. This has included difficulties in recruiting key members of Emergency Department staff and high levels of demand leading to difficulties in meeting key performance indicators. Given the shortage, particularly of medical personnel, the Trust had to decide which one of a series of options to take in order to deploy its staff in the most appropriate way to ensure safe emergency care was delivered across its three Emergency Departments. With the appropriate involvement of NHS England and NHS Improvement, the option chosen was to reduce the hours of opening of the Emergency Department on the Grantham site from a 24/7 service to initially an 09.00-18.30 hours service which was then slightly extended to an 08.00-18.30 hours services. The Trust board agreed a target of 21 permanent or long-term middle-grade doctors across the three Emergency Departments to be reached before a 24/7service on the Grantham site could be reconsidered.

The Trust has engaged in a variety of recruitment initiatives to enhance their Emergency Department workforce and has achieved some success. The Trust has also reviewed its establishment in order to meet anticipated demand, with significant uplift in funded middle-grade and consultant posts. Over many months, the Trust has also been working with Sustainability and Transformation Partnership partners to

develop a longer term urgent and emergency care plan. A significant amount of work has been undertaken but there remains the need for some further development before these plans reach the stage appropriate for full public consultation.

We were tasked with undertaking an independent clinical review panel with a focus on patient safety with a very tight timescale. We were delighted with the range and experience of clinical staff who were able to offer their services and we thank them for their time, effort and thoughtful contribution.

We also thank the United Lincolnshire Hospitals NHS Trust and lead commissioning Clinical Commissioning Group for the provision of a range of information and the open and honest approach to questions from the panel. The previous Independent Reconfiguration Panel report was also a very useful document that the panel took into consideration.

The unanimous view of the panel was that it was not in the interests of short term or longer-term patient safety to re-open the Emergency Department on Grantham Hospital site on a 24/7 basis at this time. It was also the unanimous view that any changes to service provision on the Grantham site, should, if at all possible, be linked to the longer-term plans for urgent and emergency care across the Trust and that these plans should be developed with appropriate stakeholders and public consultation as soon as possible. Once a final decision has been reached there needs to be clear and sufficient communication with public, patients and staff.

Dr Bernard Brett

East of England Clinical Senate Chair and clinical review panel Chair

2. BACKGROUND AND ADVICE REQUEST

2.1 United Lincolnshire Hospital NHS Trust (ULHT) is one of the biggest acute hospital trusts in England, serving a population of over 720,000 people. It has three main acute hospitals; Lincoln County Hospital (LCH) serving the city of Lincoln and the North Lincolnshire area, Pilgrim Hospital Boston (PHB) serving South and South East Lincolnshire and Grantham and District Hospital (GDH) serving Grantham and the local area. Lincoln and Pilgrim Hospitals provide all major specialties and a 24-hour major accident and emergency service, Grantham and District Hospital provides accident and emergency services currently only during the hours of 08.00 to 18.30.

2.2 The East of England Clinical Senate was approached by NHS England on behalf of NHS Improvement to undertake a safety review of proposals by Untied Lincolnshire Hospitals NHS Trust (ULHT) to re-open the Accident and Emergency Department at Grantham and District Hospital, 24 hours, seven days a week (24/7). It is currently open between the hours of 08.00 and 18.30 seven days a week.

2.3 The East of England Clinical Senate was requested to take on this out of area review as the Chair of the East Midlands Clinical Senate, which covers the Grantham area, is the Medical Director of ULHT and would therefore have a conflict of interest.

2.4 The background to the evening and night time hours closure of Grantham and District Hospital Accident and Emergency Department is thoroughly detailed in the letter to the Secretary of State from the Independent Reconfiguration Panel (IRP), dated 22 March 2017. As that letter is available in full as Appendix A of this report, it would not serve any useful purpose to re-produce that information here. The IRP upheld the Trust board's decision to reduce Grantham Hospital's opening hours on the grounds of patient safety.

2.5 In November 2017, the ULHT board considered the recommendation of its Medical Director to re-open the Accident and Emergency Department on a 24/7 basis.

2.6 NHS Improvement requested that the Trust Board delay its final decision on whether to re-open the department for a period of one month to allow time for a safety review (i.e. this Clinical Senate Review Panel) to take place.

3. METHODOLOGY & GOVERNANCE

3.1 It was agreed that the most appropriate methodology would be a single panel to review the proposal to re-open Grantham and District Hospital Accident and Emergency Department 24 hours a day seven days a week.

3.2 The ULHT team was invited to send representatives to attend the panel to make a short presentation and respond to questions from the review panel. The invitation naturally included representation from the lead local Clinical Commissioning Group[1] (CCG). Unfortunately the date of the review panel clashed with a prior meeting for the CCG members. In order to ensure that the commissioner's view was heard, a teleconference was arranged for the day of the panel, prior to the panel (being the only mutually convenient time). The commissioners also provided for the panel a letter outlining the proposed longer term solution for Accident and Emergency provision at Grantham Hospital and a paper (undated) agreed between the CCG and ULHT that included the proposal for the longer term model for Grantham Hospital A&E.

3.3 That teleconference went ahead with two commissioner representatives and the majority of panel members (see Appendix C).

3.4 It was agreed that it would be inappropriate for NHS Improvement, although the sponsors of this review, to participate in the panel either as panel members or with the ULHT team.

3.5 Terms of Reference for the clinical review were agreed with NHS Improvement.

3.6 Normally Clinical Review Panel members would be asked to make their declarations of interest and sign confidentiality agreements once they had agreed to join the panel and then be provided with any available evidence for the review. On this occasion the turnaround was exceptionally short, with some panel members agreeing to join only a week before the panel and so declarations of interest (Appendix D) and confidentiality agreements were signed immediately prior to the panel.

[1] South West Lincolnshire CCG is the lead Commissioning CCG for the four Lincolnshire CCGs.

3.7 The clinical review panel was held in private on 22 November 2017.

3.8 A draft report was sent to the ULHT team and panel members to check for matters of accuracy.

3.9 This, final report, was submitted to the East of England Clinical Senate Council on 13 December 2017 for it to ensure that the clinical review panel met and fulfilled the Terms of Reference for the review. The report was then submitted to the sponsoring organisation and owner of the report.

3.10 East of England Clinical Senate Council will publish this report on its website at a time agreed with the sponsoring organisation in the Terms of Reference.

4 KEY FINDINGS

4.1 The United Lincolnshire Hospitals Trust operates three Accident and Emergency (A&E) Departments: Lincoln County Hospital (LCH) provides a full A&E including support for Air Ambulance. Six consultants provide on-site cover 08.00- 22.00hrs. LCH has recently been funded for nine consultants (previously seven) and 16 middle-grade doctors. Pilgrim Hospital Boston (PHB) is also a full A&E able to receive Air Ambulance with six consultants' 08.00-21.00 hrs Monday to Friday and 09.00-16.00 at weekends. PHB is funded for six consultants and (from April 2017) 16 middle-grade doctors, recently increased to 19. Major trauma cases go to Nottingham Queens Medical Centre. Grantham and District Hospital (GDH) has two consultants, currently both long-term locums, with consultant presence between 09.00-17.00hrs during week days only. It is funded for two consultants and six middle-grade doctors. There is an extensive list of exclusions that the panel were advised is well understood by the local healthcare system including primary care, community providers and the ambulance service. The panel heard that the exclusion protocol for GDH A&E currently in place would not be subject to any change should the decision to extend or change opening hours be implemented; this had been agreed with the East Midlands Ambulance Service NHS Trust (EMAS).

4.2 The Trust advised that over half of the consultant workforce were locums with most currently not on the GMC Specialist Register, and only a small proportion with specialist qualifications.

4.3 The temporary closure of Grantham and District Hospital (GDH) Accident and Emergency Department (A&E) in August 2016 from 24/7 to 09.00 to 18.30 hrs (extended in March 2017 to 08.00 to 18.30hrs), was made on the grounds of patient safety due to severe staff shortages across the Trust, particularly Lincoln County Hospital. This decision had been made with appropriate involvement of NHS England and NHS Improvement.

4.4 The panel heard that the decision to temporarily reduce the A&E opening hours was regularly reviewed by Trust board and was also supported by the Independent Reconfiguration Panel following appeal (see Appendix A).

4.5 Following the unplanned temporary change to GDH A&E opening hours, the Trust board set a threshold of 21 middle-grade medical staff in post across all three sites as the determinant for reconsidering 24/7 re-opening of GDH A&E. The threshold of 21 middle-grade included long term locums, defined as those in place for longer than 12 weeks, as well as substantive appointments. The Trust had not set any limit on the proportion of middle-grade doctors who were locums rather than substantive appointments.

4.6 The panel found that the target threshold had been derived by looking back at historical rotas, 21 being around 75 per cent of the required minimum number of medical staff across all three sites (at 28) that the Trust considered at that time could safely provide cover for a 24 hour period at that time.

4.7 Since then, the Trust has reviewed its workforce requirements resulting in a significant uplift in its target establishment; this has been supported with additional funding to increase the workforce to support the redesign of its departments and significant recruitment activity took place with some success. The panel commended the Trust on its innovative approach to recruitment and retention of medical staff. It heard that the Trust had reworked ED rotas and it was enabling part time working for doctors with funded study for PhD or Master's degrees.

4.8 The Trust acknowledged that if the same calculation (of around 75 per cent) was made now on the new establishment of 38 middle-grade doctors across all three sites rather than historical data, the required number would in fact now be around 30 middle-grade doctors (across all three sites). The Trust also had plans to increase to middle-grade staffing to 42 with effect from January 2018 and a further increase to 44 in April 2018, again across all three sites. The current middle-grade number of 22, including locums, therefore only meets 50 percent of the Trust's target establishment for April 2018. The Trust acknowledged that the heavy proportion of locums amongst the 22 middle-grade doctors meant that this was a relatively unstable position.

4.9 The panel advised that the Royal College of Emergency Medicine provided a 'rule of thumb' guide for 'Medical and Practitioner Staffing in Emergency Departments'[2]. Using that guide would indicate that ideally 36 middle-grade medical staff would be needed (i.e. 12 middle grades at each of the three sites) to maintain safe, sustainable 24/7 cover.

4.10 The panel learned that although there were currently around ten nursing vacancies across the three sites, an additional 20 nurses would be needed to reach the new uplift level, including 24/7 opening on the Grantham site. In addition not all senior nursing staff are Advanced Practitioner level and provision would need to be made for training and development. The Trust advised that all senior nursing staff had recently received training to deal with paediatric attendances.

4.11 Despite having reached the previously agreed threshold of 21 middle-grade doctors, the Trust acknowledged that there were still significant performance challenges across the Trusts' three A&Es, with particularly poor compliance to the four hour performance standard and Friends and Family results.

4.12 The panel heard that the Trust had made changes to some hospital specialist on-call arrangements to ensure that they provided enhanced support to A&E on two of the sites. The panel commended the Trust on this approach and were pleased to hear that this approach appeared to be easing workload pressures on the A&E staff.

4.13 The Trust confirmed that there had been no reported patient harm as a result of the closure; the CCG also confirmed that it was unaware of any harm resulting from the reduction in opening hours. The Trust also reported that there had not been any significant change in activity, nor had overall admissions increased. The data provided as evidence showed that since August 2016, there had been an average decrease in attendance to GDH

[2] https://www.rcem.ac.uk/docs/Workforce/RCEM%20Rules%20of%20Thumb%20for%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf

A&E of around 100attendances a week, with no correlating increase at either of the other two A&Es.

4.14 The panel heard that the Trust considered that having reached the 21 threshold across the three sites, it may be able to support three 24/7 rotas for A&E but had no certainty or confidence in how long that could be safely sustained. The Trust agreed that with the considerable vacancy gaps currently across the Trust, it was unlikely to be able to safely sustain three 24/7 rotas for longer than three to four months. The sustainability of three rotas had dependencies outside of the Trust's control including staff numbers being maintained - with the current level of staffing there was little resilience should further vacancies arise or high numbers of staff sickness occur.

4.15 The panel noted that, should the opening hours be extended, there was no clear guide or plan to indicate any trigger points that would determine the service became unsafe and would need to close again or how that decision would be made. The panel was concerned that relatively sudden changes to opening hours could lead to confusion amongst the public and patients, and indeed healthcare staff, with the potential to lead to significant harm.

4.16 The panel agreed that as middle-grade staff from GDH were currently covering some of the workload created by middle-grade vacancies at Lincoln and Pilgrim Hospitals; re-opening GDH A&E 24/7 would mean that this additional support to Lincoln and Pilgrim Hospitals would no longer be available. Given the activity levels of the A&E on these sites, most needed adequate medical workforce and any shortfall would put patients at risk at those hospitals.

4.17 The majority of patients presenting at GDH A&E were type 3[3] patients, the department did not support patients of higher acuity. Although the department did have a resuscitation area, any critical patients would always need to be transferred (note, not all sick patients are transferred). The department had two beds in the Emergency Admissions Unit 'ring fenced' for patients requiring transfer for more specialised care, or to another site, after the department had

[3] As defined in 'Emergency Care Weekly Situation Report Definitions ' NHS England 2014

closed. The panel heard that although formal recording of number of transfers ceased in March 2017, bed managers reported that the activity was low.

4.18 The panel heard that the Trust had a direct admission pathway for frail and elderly at GDH, the panel recommended that the Trust to promote this more widely, especially as this could relieve some pressure on other sites.

4.19 A paper provided to the panel from the CCG made reference to the potential to consider extending A&E opening hours at GDH to 21.00 (from 18.30hrs). The panel heard from the Trust that current staff rotas at GDH covered up to 21.00hrs, any extension to the current opening hours would require new staff rotas to extend to midnight or beyond which would be challenging to achieve on current staffing and rotas. The panel heard that the Trust was also concerned regarding potential safety risks if staff had to travel away from the site at midnight or later. The Trust advised that historically there were typically around 11 patients presenting between 23.00 and 07.00hrs at GDH.

4.20 Both the Trust and the CCG agreed that, having taken a year or more to adjust to the change in opening hours, to temporarily reinstate 24/7 opening would likely result in confusion among the public, patients and staff. There was agreement that there was insufficient patient demand for a full medically led overnight A&E service and that until there was a full establishment across ULHT, services were not stable on any of the three sites.

4.21 The Trust also made clear that, as a financially challenged Trust, extended hours would create an unwelcome affordability issue. Although finances were out of the scope of clinical review panels, the panel acknowledged the concern of the Trust.

4.22 The panel noted that there had been no mention or reference to any discussion with other parts of the system such as out of hours, community care providers, GPs and primary care on managing the impact of change in opening hours. The panel found that GDH hosted an Enhanced Out of Hours service (Kingfisher Suite) taking walk in minor injuries from 18.30 until 23.30hrs seven days a week and an Out of Hours service for minor illnesses with appointments accessed via 111 from 18.30 to 08.00hrs, although no mention had been made of this.

4.23 The panel agreed that there was insufficient evidence to form an opinion on whether the closure had had an impact on hospitals outside of the area e.g. Nottingham Queens Medical Centre, Leicester Hospitals and Peterborough City Hospital.

4.24 There was no evidence to demonstrate that by opening GDH 24/7 over winter, it would improve services at Lincoln and / or Pilgrim hospital. Given the A&E four hour performance, the panel was of the view that any additional medical availability could help ease workload pressures on the Lincoln and Pilgrim sites.

4.25 The panel heard that there were variations in clinical pathways across the sites and although some surgeons did work across the sites, the medical teams did not and were very much site based. The panel agreed that this was an opportunity to join up services and rotations could offer greater training and development opportunities for staff across the three sites.

4.26 The panel was advised that when GDH A&E closure was instigated in August 2016, the Trust and CCG were in discussion, as part of the STP, on a longer term solution for A&E services across the area. However, the preferred model was still being finalised with a plan to go to public consultation during 2018, although the panel was not provided with any clear timelines or plans.

4.27 The panel agreed there appeared to be a lack of clarity and consensus between the Trust and CCG about the future model. Whilst both agreed that there needed to be a joined up approach, there was not a clear vision or direction of travel or any apparent alignment with the Lincolnshire STP. The panel had been provided with a letter of agreement between the Trust and CCG/STP outlining services for Grantham Hospital, but this did not include the wider strategy for services across the patch.

4.28 The panel was clear that there was senior clinical leadership for development of the Trust A&E through the Medical Director and CCG Clinical Chair and an attempt to come to a single solution for the Trust. The panel was not presented with evidence to suggest there was strong clinical leadership below Medical Director level in relation to emergency services.

4.29 The panel heard that there had been ongoing engagement and discussion with the CCG and local stakeholders including community group leaders and that there was broad agreement that a 24/7 medically led A&E at GDH was not a sustainable model, nor a model that was justified in view of the small number of patients per hour that previously attended overnight. The panel agreed that there appeared to be a difference of opinion between the Trust and the CCG on the need for a seven day week overnight service at GDH and a difference regarding the degree to which medical cover was required.

4.30 The panel agreed that although it heard that there was broad agreement it had not seen any evidence of a clear plan or way forward. It heard that the STP was preparing the pre consultation business case for NHS England service change Assurance review, with a view to public consultation in spring 2018, although no evidence of a plan or clear timeline was provided for the panel.

4.31 The panel expressed concern that the CCG/STP and Trust were not using the opportunity to link the GDH A&E overnight closure issue with the medium and longer term objectives and vision for urgent and emergency care particularly. Whilst it understood the initial rationale for keeping separate the A&E overnight closure and possible medium and longer term planning, the panel agreed that the time had come to bring these together and be clear about the

short, medium and long term plan for urgent, emergency and planned health care across the entire STP patch. The panel further agreed that appropriate consultation with the public, patients, relevant stakeholders, neighbouring STPs and Health Scrutiny Committee needed to be planned as soon as possible.

4.32 The panel agreed that the terminology 'A&E Centre' could imply a full A&E facility and be confusing for patients. Common terminology, although not formally defined by NHS England, are 'Type 1 A&E department' (major A&E) providing a consultant-led 24 hour service with full resuscitation facilities, a 'Type 2' (single speciality A&E service such as ophthalmology, dentistry) and 'Type 3' (other A&E / minor injury / walk in centre / urgent care centre treating minor injuries and illnesses) .

4.33 The panel noted that in its letter of 22 March 2017 (Appendix A) the IRP had made comment 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*". It made reference to use of appropriate terminology and "*unrealistic expectations and misunderstanding about the level of service that can and should be provided at Grantham hospita*l". The panel reiterated those concerns, although it did agree that GDH did currently provide more than an Urgent Care Centre which tended to be Primary Care led, but significantly less than one would usually expect an A&E to provide.

4.34 The panel deliberated on a hypothetical case of parents visiting the area with an unwell child with sepsis, and the potential harm that could result from the child being taken to the GDH A&E. The discussion highlighted several areas of significant concern for patient safety.

4.35 The panel agreed that although it heard that there had been significant engagement with patients and public, there appeared to be less so with staff and no evidence of engagement with neighbouring STPs, primary care or GPs. The panel acknowledged that due to the lack of time, this had not been explored in any depth with the Trust and CCG team.

5 PANEL CONCLUSIONS

5.1 The panel agreed that there was no evidence that any extended opening, over and above the current level of provision of the Accident and Emergency department at Grantham and District Hospital would improve outcomes for patients. With the medical staffing vacancy gap across United Lincolnshire Hospitals Trust, and the heavy reliance on locum doctors who are likely to represent a less stable workforce, extended opening at GDH would clearly create additional pressure across the system and could potentially put patients at risk, particularly at the Lincoln and Pilgrim sites. The panel also agreed that extending the opening hours at GDH would put further pressure on the Trust's A&E nursing staff when there are already vacancies - this could further impact on the quality and safety of care provided.

5.2 Due to lack of detail available, the panel was unable to confirm whether the current medical staffing provided the required level of senior medical cover to supervise more junior staff. Clearly further recruitment of more senior medical staff that were on the Specialist Register would enhance the current situation. The panel recommended that the Trust engages with Health Education England on this matter

5.3 The panel considered that the best use of existing clinical staff, particularly during the coming winter period, would be to retain the current opening hours and exclusions for Grantham Hospital, and maintain the current arrangements for staff to support workloads across the three ULHT sites.

5.4 The panel recognised that the initial decision to close GDH A&E overnight was made on safety grounds; however it agreed that the time had come to link any changes to the longer term model for the whole of Lincolnshire and not just the Grantham area. The panel considered that it was imperative to refine the model rapidly and move to public consultation as quickly as possible.

6 RECOMMENDATIONS

6.1 Recommendation 1

6.1.1 The panel does not support the reopening of the 24/7 Accident and Emergency Department at Grantham Hospital on the grounds of potential adverse impact on patient safety at Accident and Emergency Departments at all three United Lincolnshire Hospitals.

6.1.2 The panel strongly recommends that, on the grounds of patient safety, United Lincolnshire Hospitals NHS Trust Board reconsider its proposal to extend the current Accident and Emergency service opening hours at Grantham and District Hospital.

6.1.3 The panel recommends that the Trust should continue to provide an Accident and Emergency Service at Grantham and District Hospital on the current opening hours of 08.00-18.30, seven days a week until a more definitive long term urgent and emergency care plan was developed and agreed.

Recommendation 2

6.2 The panel recommends that in order to make it clear for patients and the public the type of service available at GDH A&E, the Trust look to re-labelling or re-naming the department, and ensure that it communicates that widely. The panel further recommended that the terminology 'A&E Centre' is not applied to GDH in any future model.

Recommendation 3

6.3 The panel recommended that the Trust should look to move to a single A&E team with a focus on standardised clinical pathways and processes across the three sites, removing any unnecessary variation and providing enhanced training opportunities.

Recommendation 4

6.4 The panel recommended that the Trust and CCG have clear alignment with the Lincolnshire STP, developing a system approach to urgent and emergency care, and planned care, for patients and the public. The Trust and STP should move to public consultation on an agreed future model as quickly as possible.

Recommendation 5

6.5.1. The panel recommended that the United Lincolnshire Hospitals Trust works with the local CCG and STP to develop an enhanced communication and engagement strategy to ensure that all stakeholders, the public, patients and local elected representatives have an opportunity to input on the development and decision regarding the final model for urgent and emergency care across the Trust's three sites.

6.5.2 The panel recommended that the communication and engagement strategy develops plans to ensure that any changes to the designation, opening times and pathways related to emergency care provision are clearly communicated with the public, patients, stakeholders and staff both within the STP footprint and with surrounding STP footprints.

END.

APPENDIX A:

6th Floor
157 – 197 Buckingham Palace Road
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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)[4] 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 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"*.

[4] Also known as Emergency Department (ED)

The Trust Board considered potential options:

Option One	Sustain three sites with ED departments 24/7 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: 2a. Emergency Department is open 24/7 2b. Emergency Department is open 8am – Midnight 2c. Emergency Department is open 8am – 8pm 2d. Emergency Department is open 9am – 4pm 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: 3a. Emergency Department is open 24/7 3b. Emergency Department is open 8am – Midnight 3c. Emergency Department is open 8am – 8pm 3d. Emergency Department is open 9am – 4pm 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

(***NOTE SIGNATURE REMOVED FROM THIS APPENDIX COPY)***

Lord Ribeiro CBE
Chairman, IRP

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

East of England Clinical Senate

Independent clinical review panel on the current arrangements and proposals for 24 hour re-opening of Accident and Emergency Services at Grantham and District Hospital (United Lincolnshire Hospitals NHS Trust)

Date: 22 November 2017

Terms of Reference

CLINICAL REVIEW PANEL: TERMS OF REFERENCE

Title: Review of proposals to extend Grantham and District General Hospital Accident and Emergency Department opening hours

Sponsoring body: and NHS IMPROVEMENT for the United Lincolnshire Hospital NHS Trust (ULHT)

Terms of reference agreed by: (NB: AGREED BY PETER BURNETT for NHS Improvement BUT THIS COPY NOT SIGNED – S Edwards)

Name on behalf of NHS Improvement

Signature

Dr Bernard Brett, East of England Clinical Senate Chair

on behalf of East of England Clinical Senate and

Signature 

Date: 21 November 2017

Aims and objectives of the clinical review

In October 2017, the board of United Lincolnshire Hospitals NHS Trust considered the recommendation of the Medical Director to re-open the Accident and Emergency Department at Grantham Hospital 24 hours a day seven days a week; the A&E department is currently closed at night. NHS Improvement has requested the Clinical Senate provide an external clinical opinion of the proposal with a focus on patient safety.

The Clinical Senate has been asked to examine the current arrangements for Accident and Emergency Services in the three United Lincolnshire Hospitals NHS Trust, Lincoln Hospital, Pilgrim Hospital and Grantham Hospital, and advise whether:

a) the current medical staffing arrangements provide sufficient and appropriate cover for the three ULH NHS Trust Accident and Emergency Departments, including the required level of senior medical cover to supervise more junior staff; and
b) the current and medical staffing arrangements would support the re-opening of Grantham Accident and Emergency Department during the hours of 18.30 – 09.00 seven days a week, and would provide effective, resilient and safe care for patients, with particular reference to the additional pressures that may incur during the 2017/18 winter period.

Clinical Senate has also been asked to advise on:

c) the best use of existing clinical staff in mitigating the staff shortages across all three sites over the winter period December 2017 to March 2018; and
d) the likelihood of any re-opening of Grantham A&E being sustainable in the long term, taking into account the advice of the Independent Review Panel.

Scope of the review

Clinical Senate will review the current arrangements for the three United Lincolnshire Hospitals NHS Trust Accident and Emergency Departments - Lincoln Hospital, Pilgrim Hospital and Grantham Hospital. It may include arrangements for supporting services including diagnostics.

In considering its recommendations, the Clinical Senate will review the evidence provided by the Trust, the Clinical Commissioning Groups and NHS Improvement and will consider the report of the Independent Reconfiguration Panel of 22 March 2017.

Other Departments and services at United Lincolnshire Hospitals are out of scope of this review.

Clinical Senate Review Panel: The clinical review panel should assess the strength of the evidence base of the case for change and proposed models. Questions that may help the panel in assessing the benefit and risk of the proposals include (but are not limited to):

- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g., sustainability of cover, clinical expertise)
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Will the proposals reflect further the delivery of the NHS Outcomes Framework and Five Year Forward View?
- Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
- Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. five years)?
- Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?
- Do the proposals demonstrate good alignment with the development of other health and care services, including national policy and planning guidance?
- Do the proposals support better integration of services from the patient perspective?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

Timeline: The review panel will be held on the 22 November 2017.

Reporting arrangements: The clinical review panel will provide a report to the Clinical Senate Council which will ensure that the panel met the agreed terms of reference, agree the report and be accountable for the advice contained in the final report.

Methodology: The review will be undertaken by a review panel meeting to enable presentations and discussions to take place.

Report: A draft report will be made to the sponsoring organisation for fact checking prior to publication.

Comments/ correction must be received from the sponsoring organisation within **two working days**.

Final report will be submitted to Clinical Senate Council to ensure it has met the agreed terms of reference and to agree the report.

A final draft report will be submitted to the sponsoring organisation by Thursday 30 November 2017.

Communication and media handling: Communications will be managed by the sponsoring organisation. Clinical Senate will publish the report once the Trust papers have been released.

Resources: The East of England Clinical Senate will provide administrative support to the review panel, including setting up the meetings and other duties as appropriate.

The clinical review panel may request any additional existing documentary evidence from the sponsoring organisation. Any requests will be appropriate to the review, reasonable and manageable.

Accountability and Governance: The clinical review panel is part of the East of England Clinical Senate accountability and governance structure.

The East of England Clinical Senate is a non statutory advisory body.

The sponsoring organisation remains accountable for decision making but the review panel report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

i. provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Background information may include, but is not limited to:
    - relevant public health data including population projections, health inequalities, specific health needs
    - activity date (current and planned)
    - internal and external reviews and audits,
    - relevant impact assessments (e.g. equality, time assessments),
    - relevant workforce information (current and planned)
    - evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions).

   The sponsoring organisation will provide any other additional background information requested by the clinical review panel.

ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.

iii. undertake not to attempt to unduly influence any members of the clinical review panel during the review.

iv. Arrange and bear the cost of suitable accommodation (as advised by clinical senate support team) for the panel and panel members.

Clinical Senate Council and the sponsoring organisation will

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate Council will

i. appoint a clinical review panel, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a review panel chair
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the panel and
v. submit the final report to the sponsoring organisation.

Clinical review panel will

i. undertake its review in line with the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the final draft report to Clinical Senate Council for it to ensure that the panel met the Terms of Reference of the review.

Clinical review panel members will undertake to

i. declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information
ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc. that are part of the review (as defined in methodology).
iii. contribute fully to the process and review report where appropriate
iv. ensure that the report accurately represents the consensus of opinion of the clinical review panel
v. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the review panel chair and the Head of Clinical Senate, any conflict of interest that may materialise during the review.

APPENDIX C: Membership of the review panel

PANEL MEMBERS	
Dr Bernard Brett *	Consultant in Gastroenterology and General Internal Medicine Norfolk and Norwich University Hospitals NHS FT, Clinical Senate Chair & Review Panel Chair
Dr James Crawfurd*	Consultant in Emergency Medicine, James Paget University Hospital NHS FT Regional Chair of College of Emergency Medicine
Ruth Derrett*	Director of Transformation and Delivery: Urgent and Emergency Care, Cambridgeshire and Peterborough CCG
Dr Robert Florance*	Consultant in Emergency Medicine, Queen Elizabeth Hospital Kings Lynn
Dr Mohammad Ghaliaei	Consultant in Emergency Medicine, Princess Alexandra Hospital, Harlow
Jane Hubert*	Expert by Experience (former Senior A&E Nurse)
Dr Melanie Iles*	Consultant Paediatrician West Suffolk Hospital, Associate Regional Medical Director, NHS Improvement, Midlands & East. Clinical Senate Council member
John Martin*	Associate Director for the Older People's & Adult Community, Cambridgeshire & Peterborough NHS FT, Chair of the National College of Paramedics and a Consultant Paramedic & Clinical Senate Council member
Anna Morgan*	Director of Nursing & Quality at Norfolk Community Health & Care NHS Trust Clinical Senate Council member
Joanne Pope*	Senior Service Specialist & Acute Quality Lead Specialised Commissioning NHS England – Midlands and East (East of England)
Dr Celia Skinner	Chief Medical Officer, Southend Hospital NHS FT

*** Denotes member was present on the teleconference call with CCG**

In attendance at the panel:

United Lincolnshire Hospitals Trust Team:

1. **By teleconference at 12.15hours**,

John Turner Chief Officer, South West Lincolnshire CCG & South Lincolnshire CCG & Senior Responsible Officer Lincolnshire STP, and

Dr David Baker, Clinical Chair, South West Lincolnshire CCG.

2. **In attendance at the panel (*by teleconference)**

Mark Brassington, Chief Operating Officer, United Lincolnshire Hospitals Trust

Dr Neill Hepburn, Medical Officer United Lincolnshire Hospitals Trust

Michelle Rhodes, Director of Nursing, United Lincolnshire Hospitals Trust* and

Jan Sobieraj, Chief Executive Officer, United Lincolnshire Hospitals NHS Trust*.

* = by teleconference.

Clinical Senate Support Team:

Sue Edwards, Head of Clinical Senate East of England, NHS England

Brenda Allen, Project Officer, East of England Clinical Senate, NHS England

APPENDIX D: Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Dr Bernard Brett	None	None	None	None
Dr James Crawfurd	None	None	None	None
Ruth Derrett	None	None	None	None
Dr Robert Florance	None	None	None	Declared
Dr Mohammad Ghaliaei	None	None	None	None
Jane Hubert	None	None	None	None
Dr Melanie Iles	None	None	None	Declared
John Martin	None	None	None	None
Anna Morgan	None	None	None	None
Joanne Pope	None	None	None	None
Dr Celia Skinner	None	None	None	None

Dr Robert Florence declared a personal non-pecuniary interest as an employee of a neighbouring Trust (Queen Elizabeth Hospital Kings Lynn).

Dr Melanie Iles declared a personl non-pecuniary interest as an employee of NHS Improvement (commissioners of this review). Dr Iles has had no involvement in any decisions or review on A&E in United Lincolnshire Hospitals Trust.

APPENDIX E: Agenda

INDEPENDENT CLINICAL REVIEW PANEL

Sponsoring body: NHS Improvement for the United Lincolnshire Hospital NHS Trust (ULHT)

A G E N D A

Date: Wednesday 22 November 2017

Time: Panel members 13.15 for 13.30hrs start to 17.00hrs &
ULHT team from 14.00hrs to 15.15hrs

Venue: Abington Room, TWI Granta Centre, Granta Park, Cambridge CB21 6AL

Teleconference dial in: from landline 0800 9171950 from mobile 0203 4639697
Participant code 75148821#

Clinical Senate has been asked to

examine the current arrangements for Accident and Emergency Services in the three United Lincolnshire Hospitals NHS Trust, Lincoln Hospital, Pilgrim Hospital and Grantham Hospital, and advise whether:

e) the current medical staffing arrangements provide sufficient and appropriate cover for the three ULH NHS Trust Accident and Emergency Departments, including the required level of senior medical cover to supervise more junior staff; and

f) the current and medical staffing arrangements would support the re-opening of Grantham Accident and Emergency Department during the hours of 18.30 – 09.00 seven days a week, and would provide effective, resilient and safe care for patients, with particular reference to the additional pressures that may incur during the 2017/18 winter period.

Clinical Senate has also been asked to advise on:

g) the best use of existing clinical staff in mitigating the staff shortages across all three sites over the winter period December 2017 to March 2018; and

h) the likelihood of any re-opening of Grantham A&E being sustainable in the long term, taking into account the advice of the Independent Review Panel.

Time	Item
13.30 – 14.00	**Review panel members** Welcome, introductions and outline of panel procedure from Clinical Review & Identification of key lines of enquiry Panel Chair Dr Bernard Brett
14.00 – 14.20 **20 mins**	**Review panel members & ULHT team** Presentation and context setting for the panel from the ULHT team
14.20- 15.10 **50 mins**	General clarification questions from the panel to ULHT team
15.10 onwards	Panel discussion in private (including working break as appropriate) Summary and recommendations
No later than 17.00	Close

Next steps information for panel members:

1) Draft report to ULHT team and panel members for points of accuracy check no later than 27 November 2017 with 48 hours turnaround

2) Final draft report to NHS England, NHS Improvement and ULHT Trust no later than 30 November 2017

3) Final draft report to Clinical Senate Council 13 December 2017 (*NB Council cannot make any material changes to the report or its recommendations)*

APPENDIX F: Summary of documents provided by sponsoring body as evidence to the panel

i) Report to ULH Trust Board, 31 October 2017, from Dr Neill Hepburn Medical Director ULHT

ii) Letter of Independent Reconfiguration Panel to Secretary of State, 22 March 2017 (produced in full at Appendix A)

iii) Grantham and District Hospital Quality Report, Care Quality Commission, 11 April 2017 (*NB report provided by Senate Office not ULHT or NHS Improvement)*

iv) Letter of 21 November 2017 from John Turner, Chief Officer & David baker Clinical Chair South West Lincolnshire CCG (including Grantham Hospital Exclusion Protocols)

v) Additional data and information:

a. A&E Four Hour performance
b. A&E admissions to attendances ratio
c. A&E attendances & by postcode
d. Bed occupancy
e. Arrival to Triage (15 min target)
f. Arrival to treat (60 min target)
g. Ambulance conveyances
h. Delayed Transfer of Care
i. Map of three ULHT hospital location
j. Medical, Nursing and AHP staffing and vacancies
k. Total patient attendance and conversions.

END.