Emergency Care Crisis

Briefing Paper
April 2016

Executive Summary

Background context

Hospital emergency departments are staffed by consultants, doctors, and doctors in training. In recent months it has become increasingly difficult to staff our middle grade doctor rota for our emergency departments. This issue has arisen for a number of reasons – there is a national shortage of emergency medicine doctors; we haven't been allocated enough doctors in training who help us staff our rotas; and the application of the national agency cap has affected our ability to secure locums to fill gaps in the rota.

We have taken a number of actions to recruit a permanent workforce including continuous international and national recruitment activities, changing how our service works and adapting some job roles to maintain services, and appointing some GPs to provide additional support to the emergency department.

Current staffing crisis

In response to the current staffing pressures we have not applied the agency cap for emergency department doctors. However we have not been able to secure the additional locum doctors we need. Our consultants have been working extra shifts to cover the middle grade doctor rota. However this isn't sustainable and this approach is beginning to affect our ability to cover the consultant rota.

We currently have just eight of the 14 doctors we need to staff the middle grade rotas.

Where are we now?

Despite the commitment from our consultant team, and ongoing recruitment drive, we identified that we would no longer be able to safely staff our emergency department rotas from April 18th.

Patient safety must always be our first priority. Whilst efforts are continuing to secure all the staff we need, if we are unable to staff our rotas we will simply not be able to provide safe patient care – and that is not acceptable.

What have we done?

The risks have been escalated to the System Resilience Group (SRG), which oversees urgent care in the local area. This group has met regularly to review the current crisis, assess risks, and consider all the potential options for the future provision of services.

The SRG considered all the options; 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. It was therefore concluded with the risk assessment and analysis shared that the supported option was option 2c, with the Urgent Care Centre service operating between the hours of 08:00 – 20:00hrs. This decision was approved and supported by the SRG on 13.04.16 and will be implemented as of 18.04.16.

INTRODUCTION

SECTION ONE; CONTEXT AND BACKGROUND

An overview of Lancashire Teaching Hospitals NHS Foundation Trust

1. Lancashire Teaching Hospitals NHS Foundation Trust provides a range of district general hospital services to the 390,000 local population of Preston, Chorley, and South Ribble, and a range of specialist tertiary services including major trauma, neurosurgery, cancer, vascular, renal, plastics, specialist mobility and rehabilitation to the 1.5m population of Lancashire and South Cumbria. The trust employs 7000 staff including an 841 WTE medical workforce.

2. Services are provided from Royal Preston Hospital, Chorley and South Ribble Hospital, the Specialist Mobility and Rehabilitation Centre, and through peripheral clinics at locations throughout the county.

An overview of the current Emergency Department service

3. The regional major trauma centre is located at Royal Preston Hospital, which is where the majority of Lancashire Teaching Hospitals' specialist services are provided, as well as trauma pathway services including neurosurgery, vascular, plastics, and trauma orthopaedics. The trust's helipad is located at Royal Preston Hospital.

4. Both hospitals provide a 24 hour emergency department service, with consultant cover at Royal Preston Hospital until midnight (on call thereafter). There is no consultant presence at Chorley and South Ribble Hospital after 6pm. Around 79,000 patients attend Royal Preston Emergency Department a year, and around 50,000 patients attend Chorley Emergency Department.

5. NWAS pathfinder process[1] means all major trauma, emergency vascular and paediatric patients are taken directly to Royal Preston Hospital.

6. Any patient who presents at Chorley who requires a specialist review is transferred to Royal Preston Hospital, including children and young people as there is no paediatric service at Chorley and South Ribble Hospital. Only patients with a medical condition are admitted to hospital via Chorley emergency department, all other patients are transferred to Royal Preston for admission. This includes: acute surgical patients, trauma patients requiring inpatient care, all children requiring inpatient care, and those patients requiring specialist inpatient treatment only available regionally at the Royal Preston Hospital (e.g. neurosciences, plastic surgery, vascular surgery, renal medicine).

[1] Paramedic Pathfinder is part of the NWAS Urgent Care Strategy. Paramedics conduct a face to face assessment when they arrive at the scene and, using a flow chart of specific symptoms, determine the most appropriate care pathway for that patient. Depending on the assessment, the next step for the patient could be that they are taken to either a community based specialist service, an Urgent Care Centre or to an Emergency Department.

Staffing arrangements for the emergency departments

7. Hospital emergency departments are staffed by a combination of consultants, middle grade doctors (Trust doctors, SAS doctors and locum doctors), and doctors in training (specialist trainee level 3 and above). The hospitals have one of the few departments in the North West with a full permanent consultant workforce (an establishment of 14.6 WTE consultants, with 14.8 currently in post). This is supplemented by an establishment of 14 middle grade doctors and doctors in training.

8. The consultants and doctors are managed by Lancashire Teaching Hospitals, and the doctors in training (specialist trainee level 3 and above) are managed by Health Education North West (HENW).

SECTION TWO; CURRENT SERVICE PROVISION AND THE EMERGENCY CARE CRISIS

9. The emergency departments need to be staffed to approved levels regardless of the numbers of attendances. In order to maintain a safe rota over both sites, there are minimum staff levels we must have relating to both a consultant and middle grade presence. These staff levels are met within the current establishment in the Emergency Departments on both hospital sites, which is shown below:

Grade	Whole time equivalents
Consultants	14.60
Middle grades	14.00

10. Our current establishment, when at a full complement, enables us to deliver the following service;

Site	Grade	Cover/Hours	Days per week
RPH	Consultant	16 hours per day 08:00-00:00 with on call cover after midnight **	7 days
	Middle Grade	24 hour per day	7 days
CDH	Consultant	09:00 – 18:00	5 days Mon- Fri
	Middle Grade	24 hour per day	7 days

** Although the consultant is scheduled to leave at midnight, our information demonstrates that the consultant does not leave the department until at least 3am on an average shift due to demand levels.

What levels of staff do we have for the emergency department?

11. Lancashire Teaching Hospitals have a full permanent consultant workforce (an establishment of 14.6 WTE consultants, with 14.8 currently in post). This enables us to deliver the consultant rota.

12. However, to run a safe service across the two sites, this consultant rota needs to be supported by a weekly requirement to cover 457 direct clinical hours with middle grade doctors.

13. To deliver the full weekly requirement of 457 hours by middle grades, we need 14 doctors. We currently have just eight of the 14 doctors we need to staff the middle grade rotas.

Current Middle Grade provision

14. The middle grade provision currently (April 2016) for both the Emergency Departments covering the Royal Preston and Chorley Hospital sites is detailed in the table below;

Grade	Site	Establishment	Substantive	Commentary
ST3-6	RPH only	7 posts	3 posts	** The ST 3-6 are training posts and as such can only be based at RPH. There are also very strict conditions around training and teaching time for these posts. In addition to this the 3 of these posts are ST3 trainees – and are unable to provide full night shift cover due to being in a junior training role. We have written to HENW to request permission to move the trainees however this request has been denied.*
Associate Specialist	RPH CDH	2 posts	2 posts	
SAS	RPH CDH	5 posts	2 posts	
Total		14 posts	7 posts	

*The establishment is the number of posts and substantive is the number of employees in those posts

Gaps in provision

15. This table shows us with seven doctors and a gap of seven; however within the substantive workforce listed there are two members of the team who are unavailable to work therefore meaning our gap is actually nine. To mitigate this we currently have three locums working for us – this means that we have eight doctors working on the rota and leaves the current gap as six posts.

How did we get here?

16. This table shows the 14 substantive non consultant posts within the emergency department, and the status of each post since August 2015. It also shows a projection for each the post until July 2016. The table shows that from August 15 to January 16 we were working with five gaps in our substantive workforce. This was supplemented by agency doctors. From February 16 onwards we have seen an increase in gaps to eight and then to nine. This takes us to the situation we find ourselves in today where we have nine doctor gaps in our substantive workforce, as illustrated in the previous section. Also as indicated, we have three agency doctors working for us meaning that we have six gaps overall.

2015-16	AUGUST 2015	SEPTEMBER 2015	OCTOBER 2015	NOVEMBER 2015	DECEMBER 2015	JANUARY 2016	FEBRUARY 2016	MARCH 2016	APRIL 2016	MAY 2016	JUNE 2016	JULY 2016
CT3	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled
CT3	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy
ST4-6	Post filled	Post filled	Post filled	Post filled	Post filled	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy
ST4-6	Vacancy	Vacancy	Vacancy	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled
ST4-6	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled
ST4-6 CT3	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy
ST4-6	Vacancy	Vacancy	Post filled	Post filled	Post filled	Post filled	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy
Associate Specialist	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled
Associate Specialist	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work
Specialty Dr	Post filled	Post filled	Post filled	Vacancy	Vacancy	Vacancy	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled
Specialty Dr	Post filled	Post filled	Post filled	Post filled	Post filled	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work	Absent from Work
Specialty Dr	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy
Specialty Dr	Post filled	Post filled	Post filled	Post filled	Post filled	Post filled	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy
Specialty Dr	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy	Vacancy
GAP	**5**	**5**	**4**	**4**	**4**	**5**	**8**	**9**	**9**	**9**	**9**	**9**

Why has this become an issue?

17. Historically we have used agency (locum) doctors to fill any gaps in our rotas. This is due to a national shortage in the number of doctors choosing a career in Emergency Medicine, an issue that has gained widespread national recognition over the last 5 years.

Health Education North West provision

18. Our doctors in training are supplied by Health Education North West. HENW is responsible for all activities linked with the postgraduate education and training of doctors in hospital medicine. It is acknowledged that there is an undersupply of doctors in Lancashire. In the ST3-6 posts, we should have a compliment of 7 doctors, and we currently only have 3 of those posts filled.

19. HENW has confirmed that it is not acceptable to divert trainees from other specialities to work in the emergency department, and that our net allocation of trainees would not increase even if Chorley was redesigned as an approved training unit.

Agency Cap

20. With the implementation of the agency cap, our ability to retain and attract locum doctors throughout the organisation has been challenged, which has resulted in the middle grade gaps over the last 4 months. For the EDs this has meant a loss of one locum and an inability to attract suitable new locums.

21. Over the last 6 months whilst implementing the agency cap we have managed to safely staff our emergency department service by asking our consultants to work extra shifts, to cover the gaps in the doctor rota, and securing as many agency doctors as we can. Whilst we were aware that this was not a long term solution, we were able to safely staff the departments whilst we undertook other short, medium and long term actions to improve patient flow and ensure that the service was a productive and efficient as possible, including ongoing recruitment activities.

22. However maintaining the capped rates has reduced the number of applicants being sent from agencies to fill gaps as ED doctors have not been prepared to work for the February or the April cap. It has therefore become extremely difficult to fill vacancies or gaps. This is in part due to the fact that the number of suitable middle grade locum doctors qualified to cover the Emergency Department is relatively small. Anecdotally many of this group of doctors have decided to move to other Trusts where the agency cap does not apply (Wales, Scotland and Northern Ireland) or to Trusts in England who have not implemented the agency cap.

23. Despite the commitment from our consultant team and ongoing recruitment drive, we identified that we will no longer be able to safely staff our emergency department rotas from April.

24. As a result of this risk the Trust Board took a decision on 16th March not to implement the final phase of the agency cap in April, however, it is now apparent that despite breaching the agency cap, we are still not able secure the number of agency doctors we need to safely staff the rotas at both Royal Preston Hospital and Chorley and South Ribble Hospitals.

25. Consequently the Emergency Department (ED) consultants have raised a significant concern about patient safety (risk assessment appendix 3).

SECTION THREE; RESPONSE TO THE CRISIS

What mitigation actions have we taken?

26. Over the last 6 months, we have managed to safely staff our emergency department service by asking our consultants to work extra shifts, to cover the gaps in the doctor rota, and securing as many agency doctors as we can. During this period, we have been developing plans to mitigate the issue in the short, medium and long term. This covers recruitment actions, service improvement and working across the health economy to transform urgent care.

27. Whilst we will continue to focus on improving patient flow and the productivity of our services, we will always need a certain level of doctors to maintain safe staffing levels for our emergency departments. This is required with no correlation to the numbers of attendances at the emergency department. Patient safety must always be our first priority. If we are unable to staff our rotas we will simply not be able to provide safe patient care. That is why we've undertaken a significant number of actions in the past eighteen months to recruit to establishment.

Actions to recruit to establishment

28. We have taken a number of actions with regards to recruiting to establishment over the past eighteen months. We are on continual active recruitment for all posts, and permanently have vacancies out for agency doctors.

- Working with HENW to look at reallocation of training posts across the North West
- Implemented local retention premium for ED specialty doctors
- Proactive national recruitment actions including;
  - Exhibited at national recruitment conference
  - Released promotional DVD to attract doctors to the trust
  - Advertised through networks such as Doctors.net
- Proactive international recruitment actions including ;
  - International recruitment through Medacs
  - Skype interviews undertaken to support international recruitment
- Developed a Trust wide vacancy management strategy
- Role substitution through nurse clinicians, physicians associates and emergency nurse practitioners
- Proactive contract and pay actions;
  - Appointed GP's to trust contracts
  - Offered trust contracts and contracts for service
  - Enhanced the internal bank rate of pay
  - Working with a company called Plabright to secure overseas doctors
  - Put in applications for numerous MTI schemes
  - Working with Royal College of Surgeons on an international recruitment project

What actions have we taken in response to the crisis situation?

29. We have undertaken a number of actions as a Trust since 16th March. This includes;

- Agreement from the Board to breach the agency cap
- An agreement with the consultant workforce to undertake additional shifts and to act down into middle grade slots with enhanced pay for a period of two weeks until 18th April 2016.
- Agreement to focus the available middle grades onto the CDH site in the first instance to ensure all the middle grades shifts are covered wherever possible; leaving the RPH site to be covered by consultants and additional support for other specialties.
- Advert placed for consultants to replace middle grades in recognition of difficulty in recruiting to middle grade posts
- Specialties of respiratory, gastro, elderly and orthopaedics asked to support ED with middle grade / consultants on the RPH site during 5-10pm period. This has resulted in shifts on the RPH site being provided by consultant specialist in the evening period to support the reduced ED cover at RPH.
- Maximised utilisation of emergency nurse practitioners and nurse clinicians who have supported providing additional support – however they cannot fulfil / replace the requirement of a middle grade.

30. There are a number of other actions that we have explored for support. This includes;

- Additional GP support
- Request to mobilise the Urgent Care Centre bid – LCFT and the two Out of Hours services: the request to mobilise without prejudicing the current procurement process was agreed by the CCG.
- Re-locate the Chorley GP Out of Hours service into the Urgent Care Centre at CDH– approved by the CCG.
- Request to NWAS to support with Paramedic pathfinder: NWAS supporting data analysis and will implement paramedic pathfinder on any change in service provision.
- Governors and MPs suggested contacting the armed services to see if they are able to offer any support. We already have a working relationship with the local barracks as their medics train in our emergency department and assessment areas. However they have no personnel who would be suitable to work in our emergency departments in the roles we require, so this has not provided any opportunities worth further exploration.

Options Development

31. The System Resilience Group (SRG) met to undertake immediate actions outlined in the section above, and then to develop options as a temporary solution to the crisis.

32. On evaluation of the ED definition it has been established that to maintain the service status it must be available 24/7 and consultant led; which is why a rationalised ED service across both sites has not been considered as part of this options appraisal. In addition, due to the Royal Preston site being a designated as a major trauma centre (MTC), priority has to be

given to ensuring this department is fully staffed; therefore the options have to be focussed on the Chorley and South Ribble District General Hospital.

33. There are three main options that have been identified are temporary proposals, with some sub options. These are as follows;

Option One;	Sustain both sites with ED departments 24/7 by securing additional ED specific resource (status quo)
Option Two;	**Change the service offer at Chorley and South Ribble District General Hospital by opening an urgent care centre[2]:** **2.a. Urgent Care Centre is open 24/7** **2.b. Urgent Care Centre is open 8am – Midnight** **2.c. Urgent Care Centre is open 8am – 8pm** **2.d. Urgent Care Centre is open 9am – 4pm**
Option Three;	**Full Closure of the Emergency Department at Chorley and South Ribble District General Hospital and no urgent care centre provided**

.

34. Risk assessments were undertaken on the options using the Trust risk assessment matrix. The SRG considered all the options; with an aim to deliver a safe service which optimised the service provision at Chorley and which had the least impact on other organisations within the staffing resources available. It was therefore concluded with the risk assessment and analysis shared that the supported option was option 2c, with the Urgent Care Centre service operating between the hours of 08:00 – 20:00hrs.

Recommended Option

35. The SRG considered all the options; 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. It was therefore concluded with the risk assessment and analysis shared that the supported option was option 2c, with the Urgent Care Centre service operating between the hours of 08:00 – 20:00hrs

[2] The Trust has reviewed the national Kitemark requirements for an urgent care centre and it is proposed that this would be a category 2 and 3 only service.

THE URGENT CARE CENTRE - MODEL OF SERVICE

The emergency department at Chorley will be rationalised to an urgent care centre (UCC) operating between the hours of 08:00 and 20:00hrs. Outside these hours patients should phone 111 for advice, or attend their nearest emergency department if they need urgent help for serious and life-threatening injuries and conditions. From Monday, the Euxton GP out of hours service will also be based at the Urgent Care Centre to provide additional support which can be accessed via 111. The urgent care service will be provided by a combination of emergency department consultants, nurse practitioners, GPs, nurses and healthcare assistants. The team will be able to assess patients, and treat minor injuries and illness. Patients who attend the Urgent Care Centre who need specialist treatment will be transferred swiftly to Royal Preston Hospital. On arrival patients will be initially assessed to prioritise the urgency of their care, following this, the patients will be seen and treated by a Doctor or Nurse Practitioner.

North West Ambulance Service has protocols in place to ensure patients are transferred directly to the most appropriate service. From Monday 18 April, 999 ambulances will no longer take patients to Chorley Hospital, but will instead transfer patients directly to Royal Preston Hospital or nearest appropriate emergency department. We have been working with NWAS and the UCC has been kite marked by North West Ambulance service, which means that if patients call an ambulance but their condition is not life threatening, they may be taken to the UCC for treatment rather than to a local Accident and Emergency department, this will further mitigate the potential impact on RPH and other providers.

More than half of the people who currently attend the emergency department at Chorley have conditions that can be treated safely and appropriately by an urgent care service, or by another service such as a GP, pharmacist, or self-care at home.

The UCC Service objectives are;

- To deliver a whole system and integrated response to people with urgent care needs
- To provide quick and safe access to effective evidence base health care
- To provide an integrated triage and treatment of minor illness / injury service
- To reduce unnecessary onwards admissions and referrals
- To provide a service which retains at least 85% of current urgent care activity within Chorley

Service Delivery

The UCC will provide an integrated triage and treatment of minor illness and injury on the Chorley District general hospital. The service will be delivered 12 hours a day, 7 days a week with the support from an Emergency Care Consultant on a sessional basis.

The role of the UCC

The UCC will provide a prompt and timely treatment of minor injury and illness such as;

- Minor nose bleeds
- Minor cuts, bites and stings
- Burns and scalds
- Infections (including abscesses)
- Foreign bodies in wounds, ears and noses
- Muscular sprains and strains to shoulders, arms and legs
- Fractures to shoulders, arms, legs & ribs
- Dislocations of fingers, thumbs and toes
- Minor eye conditions including conjunctivitis and foreign bodies
- Minor chest, neck and back injuries
- Minor head injuries with no loss of consciousness or alcohol-related
- Minor allergic reactions
- Minor ailments such as coughs, colds, flu symptoms, sore throat, earache, urinary tract infections and sinusitis
- Diarrhoea / Constipation
- Emergency contraception

The UCC will not have full facilities and support services of an acute Accident and Emergency department and can therefore not provide a service for acutely unwell patients inclusive of the following:-

- Extensive trauma
- Extensive burns
- Patients requiring resuscitation
- Suspected acute heart attack
- Suspected acute stroke
- High risk gastrointestinal haemorrhage
- Sick children (cardiac arrest/peri-arrest, head injuries)