Public Document Pack

Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Direct Dialling: 01522 552104

E-Mail: katrina.cope@lincolnshire.gov.uk

Democratic Services
Lincolnshire County Council
County Offices
Newland
Lincoln LN1 1YL

In accordance with the powers granted by the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020 this will be a virtual meeting.

A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 17 June 2020 at 10.00 am as a Virtual - Online Meeting via Microsoft Teams

Access to the meeting is as follows:

Members of the Health Scrutiny Committee for Lincolnshire and officers of the County Council supporting the meeting will access the meeting via Microsoft Teams.

Members of the public and the press may access the meeting via the following link: https://lincolnshire.moderngov.co.uk/ieListDocuments.aspx?CId=137&MId=5535&Ver=4 where a live feed will be made available on the day of the meeting.

MEMBERS OF THE COMMITTEE

County Councillors: C S Macey (Chairman), C J T H Brewis (Vice-Chairman), M T Fido, R J Kendrick, C Matthews, R A Renshaw, M A Whittington and R Wootten

District Councillors: S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), S Barker-Milan (North Kesteven District Council), G P Scalese (South Holland District Council), Mrs R Kaberry-Brown (South Kesteven District Council) and Mrs A White (West Lindsey District Council)

Healthwatch Lincolnshire: Dr B Wookey

AGENDA

Item	Title	Pages
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interest**	
3	**Minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 19 February 2020**	3 - 12

Item	Title	Pages
4	**Chairman's Announcements**	13 - 18
5	**Lincolnshire NHS Response to Covid - 19** *(To receive a report from Simon Evans, Health Scrutiny Officer, which advises the Committee of the response taken by the NHS in Lincolnshire to Covid – 19. Senior Management representatives from NHS Organisations in Lincolnshire will be attending the meeting)*	19 - 22
6	**Lincolnshire NHS - Restoration of Services** *(To receive a report from Simon Evans, Health Scrutiny Officer, which advises the Committee on the plans for the 'restoration' phase for NHS Services. Senior Management representatives from the NHS Organisations in Lincolnshire will be attending the meeting)*	23 - 144
7	**Lincolnshire Clinical Commissioning Group** *(To receive a report from Simon Evans, Health Scrutiny Officer, which advises the Committee of the background to establishing the Lincolnshire Clinical Commissioning Group on 1 April 2020. Senior Management representatives from the Lincolnshire Clinical Commissioning Group will be attending the meeting)*	145 - 148
8	**Health Scrutiny Committee for Lincolnshire - Work Programme** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider and comment on its work programme)*	149 - 158

Debbie Barnes OBE
Chief Executive
9 June 2020

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
19 FEBRUARY 2020

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors C J T H Brewis (Vice-Chairman), M T Fido, R J Kendrick, C Matthews, R A Renshaw, R Wootten and L Wootten.

Lincolnshire District Councils

Councillors S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), S Barker-Milan (North Kesteven District Council), G P Scalese (South Holland District Council), Mrs R Kaberry-Brown (South Kesteven District Council) and Mrs A White (West Lindsey District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Liz Ball (Chief Nurse, Lincolnshire East Clinical Commissioning Group), Hazel Buchanan (Director of Strategy, Greater Nottinghamshire Clinical Commissioning Groups), Cheryl Evans (Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Tim Fowler (Director of Commissioning and Contracting, Lincolnshire West Clinical Commissioning Group), Dr Neill Hepburn (Medical Director, United Lincolnshire Hospitals NHS Trust), Suganthi Joachim (Divisional Clinical Director - Family Health, United Lincolnshire Hospitals NHS Trust), Professor Danny McLaughlin (Associate Dean of Medicine, Lincoln Medical School) and James Wright (Project Manager, National Rehabilitation Centre Programme).

53 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor M A Whittington.

It was noted that the Chief Executive, having received notice under Regulation 13 of the Local Government (Committee and Political Groups) Regulations 1990, had appointed Councillor L Wootten to replace Councillor M A Whittington for this meeting only.

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

54 DECLARATIONS OF MEMBERS' INTEREST

There were no declarations made.

55 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 22 JANUARY 2020

RESOLVED

That the minutes of the meeting of the Committee held on 22 January 2020 be agreed and signed by the Chairman as a correct record.

56 CHAIRMAN'S ANNOUNCEMENTS

Further to the Chairman's announcements circulated with the agenda, the Chairman brought to the Committee's attention the Supplementary Chairman's announcements circulated at the meeting.

The supplementary announcements included information on the following:

- Grantham Accident and Emergency – Email Correspondence.
- Connect Health – Public Education Event – 18 February 2020.
- Requests for Further Information from Lincolnshire Partnership NHS Foundation Trust (as per Minutes 47 and 48 – 22 January 2020).
- United Lincolnshire Hospitals NHS Trust (ULHT) – Integrated Improvement Plan (as per Minute 46 – 22 January 2020).
- Living in the Community with Cancer – Healthwatch Lincolnshire.

Councillor R Wootten advised that he would be moving a motion at the meeting of the County Council on 21 February 2020, urging the local NHS to undertake immediate consultation on the future of Grantham A&E and to re-open the department on a 24/7 basis.

57 LINCOLN MEDICAL SCHOOL

The Committee considered a presentation from Professor Danny McLaughlin, the Associate Dean of Medicine at the Lincoln Medical School, University of Lincoln.

The Committee was advised that the Lincoln Medical School was a partnership between the University of Lincoln and the University of Nottingham. The aim of the partnership was to provide a skilled workforce for the NHS in Lincolnshire, including addressing chronic specialist shortages, particularly in primary care and mental health. There was also an aim to support general practice and unlock the potential of the Lincolnshire to create a workforce from the community, for the community.

The presentation made reference to the ten standards across five themes, which the Lincoln Medical School was required to follow, as well as the structure of the course and the outcomes. The particular Lincolnshire 'flavour' of the Medical School would

be the smaller cohort of 80 students in each year group (compared to 350+ at Nottingham); and the focus on developing a collegial culture from the start. The faculty was particularly strong in mental health and general practice.

In the early years of the course there would be an emphasis on communication skills and clinical examination skills. Across years 1 and 2, there would five visits to GP practices and seven visits to hospitals, with students going to Lincoln County and Pilgrim Hospital each time. From 2022, there would be clinical placements, at most of the sites across of all the main NHS providers in Lincolnshire. No clinical placements would be made outside Lincolnshire.

Following the presentation the following comments were made:

- The opening of the Lincoln Medical School in September 2019 represented a welcome development for Lincolnshire and would in the longer term begin to address some of the problems of recruitment in Lincolnshire. Overall the Lincoln Medical School constituted a good news story for the county.
- It was not possible for new medical school building to be carbon neutral, because of the nature of the activities required in the building. However, the aim was for the building to have a very low carbon footprint.
- Although some of the curriculum would be delivered by staff from the Queen's Medical Centre, Nottingham, all the students would remain the Lincoln Medical School's responsibility.
- Reference was made to the Government's New Towns Fund initiative and the links with health and social care qualifications. It was confirmed that entry requirements for the Medical School were based on 'A' levels or the international baccalaureate. Certain other qualifications were not considered to be rigorous.
- Students were being exposed to enthusiastic Lincolnshire medical staff, as a means of making Lincolnshire attractive.

It was agreed that visits to the new medical school building would be arranged at an appropriate point.

RESOLVED

(1) That the Committee's strong support for the Lincoln Medical School as a means of supporting the development of the NHS in Lincolnshire be supported.

(2) That a further update be received at the November 2020 meeting on further developments.

58 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST - CHILDREN AND YOUNG PERSONS' SERVICES UPDATE

The Committee considered a report submitted on behalf of United Lincolnshire Hospitals NHS Trust (ULHT), which updated the Committee on its services for children and young people. The item was presented by ULHT's Medical Director,

Dr Neill Hepburn, and Dr Suganthi Joachim, ULHT's Divisional Clinical Director for Family Health.

The report to the Committee set out the progress with the interim model for children and young people services, which had been put in place as a result of the suspension of inpatient paediatric services at Pilgrim Hospital, Boston, in August 2018 and the introduction of a paediatric assessment unit (PAU). The cause of the suspension of inpatient services had been a shortage of middle grade doctors, as well as Health Education East Midlands relocating trainees from Pilgrim Hospital to Lincoln County Hospital.

The report provided data on the effectiveness of the interim model; progress with the recommendations from the Royal College of Paediatrics and Child Health; workforce issues; and actions taken by ULHT in response to the Care Quality Commission's Section 29A warning notice, which has been issued on 29 July 2019.

The following points were clarified by questions from members of the Committee:

- Pilgrim Hospital continued to provide special care for babies born from 34 weeks onwards, as part of the interim service model (with Lincoln County providing special care for babies from 27 weeks onwards).
- The increase in the number of IR1 (incident reporting) forms reflected a desire to capture everything under the interim service model, including all instances where children stayed at Pilgrim longer than twelve hours in the PAU.
- In relation to the time taken to resolve three serious incidents, there was an acknowledgement that investigating and reporting on serious incidents can take a long time, as they often involved several agencies.
- The twelve hour length of stay guideline for children in the PAU was being reviewed, particularly for instances where a child was likely to be discharged.
- For the students studying the new nursing degree at the University of Lincoln, ULHT's practice would be to 'treat them well and train them well' to encourage the nurses to stay with ULHT on completion of their studies.
- The 'behavioural conditions pathway' referred to children with autism and attention deficit hyperactivity disorder, and was delivered by several agencies.
- The number of births had reduced at Pilgrim Hospital. Proposals to reduce the number of cots at the Hospital would not be implemented, until there had been consideration of all the options, including the potential to provide special care to babies with gestation over 32 weeks.
- The Care Quality Commission inspection had taken place when the interim service model was in operation was running with staff shortages, with out-of-date clinical guidelines, which was currently being addressed.
- The interim service model had formed the basis for work on the development of longer term solutions for children and young people services, with formal public consultation due on the plans for any permanent service reconfiguration as part of the acute services review. There was currently no intention to return to the previous length of stay model for inpatient children at Pilgrim, except for certain children who could exceed the twelve hour length of stay in certain circumstances.

- People in Boston and the surrounding area were supportive of the services provided at Pilgrim Hospital and wanted these to retained for the benefit of the local community. It was, however, important that services for the local community were safe.
- ULHT was asked to consider how the information had been presented to the Committee, particularly as the statistics alone could be construed negatively, without supporting explanations. There was a need for balance in the presentation of information.
- Adverse publicity inevitably affected the morale of existing staff, and could also be a factor in the recruitment of staff to Pilgrim Hospital and ULHT as whole.
- There had been no recent analysis on the impact of the interim service model on paediatric services in neighbouring hospitals, such as Peterborough City Hospital, and Diana, Princess of Wales, Hospital, Grimsby.
- Owing to ULHT continuing to be in financial special measures, access to funds for capital investment remained challenging, so the timescales for securing capital funding and undertaking the required building work could be at least two and half years.
- The Royal College of Paediatrics and Child Health had seen ULHT's action plan in response to their report and had indicated their support for it. However, there would be no value at this stage for a further visit from the Royal College to ULHT.
- Funding for additional nurse training had been received, and the details would be shared with the Committee, when available.
- The most recent patient feedback on the interim service model would be provided to the Committee.

RESOLVED

(1) That United Lincolnshire Hospitals NHS Trust be requested to submit a further report to the Committee on children and young people services in six months.

(2) That United Lincolnshire Hospitals NHS Trust be congratulated on the completion of all the recommendations from the report by the Royal College of Paediatrics and Child Health in October 2018.

(3) That it be noted that United Lincolnshire Hospitals NHS Trust had completed six out of the eight actions, issued by the Care Quality Commission on 29 July 2019 as part of a Section 29A Warning Notice.

59 NON-EMERGENCY PATIENT TRANSPORT SERVICE - UPDATE

The Committee gave consideration to a report from the NHS Lincolnshire West Clinical Commissioning Group, which provided the Committee with an update on the Non-Emergency Patient Transport Service, which was provided by Thames Ambulance Service Limited (TASL).

The Chairman welcomed to the meeting Tim Fowler (Director of Commissioning and Contracting – Lincolnshire West Clinical Commissioning Group (CCG)).

The Committee was advised that the previous update had been provided to the Committee at its June 2019 meeting. Since that time, there had continued to be issues with TASL's delivery and their performance against Key Performance Indicators (KPIs).

It was advised that the CCG had issued a further Contract Performance Notice in late September 2019 and had continued to seek to drive TASL to deliver improvements across their services. Actions were now in place and there had been a marked improvement in outbound journeys from the main hospital sites; improvement in call handling; and improvement in the service to renal patients as confirmed by the renal dialysis unit in Lincoln.

However, it was recognised that these improvements need to be maintained and further improvements made in order for the service to be of an acceptable standard. In order to maintain focus, the CCG had agreed two further KPIs with TASL.

The Committee was advised that the CCG was working to put in place new arrangements for patient transport for renal dialysis patients attending the dialysis units at Boston, Grantham and Skegness following notice given to the CCG on the current contract, which had been operated by University Hospitals of Leicester NHS Trust. Assurances were given that there would be a smooth transition to the new arrangements with very little disruption to patients. TASL had been informed that the CCG would not be commissioning this service from them.

A summary of the activity and KPI position for the contract for the period to April 2019 was detailed at Appendix A to the report. For December 2019, TASL had achieved the contracted level of performance for one out of twelve KPIs (call handling) and had delivered month on month improvement for five KPIs.

TASL had delivered generally poor performance against contract KPIs during the autumn of 2019. Moreover, there had been a number operational issues and significant noise in the system around poor delivery of discharges and outpatient homeward journeys from United Lincolnshire Hospitals NHS Trust and at the Lincoln renal dialysis unit.

Further improvements were required and the CCG remained focused on driving improvement in the TASL service and had recently introduced two further KPIs to the contract for zero tolerance of 're-bedding' patients, due to transport failures and thresholds and maximum time targets for outpatient journeys from hospital.

The Committee was also advised that the CCG continued to commission third party capacity outside of the TASL contract to support discharges at Lincoln and Boston hospitals.

In conclusion, the Committee was advised that the CCG would continue to closely monitor the delivery of the contract. The Committee was advised further that the CCG was not intending to give notice to exit the contract at this time.

A discussion ensued, from which the Committee highlighted the following points:-

- Serious concern was expressed to the lack of improvement across the performance indicators, and how much longer the CCG was prepared to continue with the contract. In response, it was advised that the assessment of risk of termination of the contract remained as previously reported, in essence there was more risk of disruption to patients by terminating the contract compared to working with TASL to improve their performance;
- Serious concerns were expressed regarding the inconsistency of the service and the impact on patients;
- It was advised that for January 2020 performance reporting, further improvements and some marginal improvements had been made by TASL. It was advised that a breakdown of performance for January 2020 could be provided to the Committee at the next scheduled update.
- Reference was made to the penalties that could be applied through the contract through poor performance, and it was agreed that information on the penalty charges, which had already been applied would be provided to the Committee.
- The Committee was assured that when the contract was originally awarded to TASL, this had been following a rigorous, open, fair, and transparent procurement exercise.
- The Committee reiterated its wish for the CCG to give notice to exit the contract with TASL, owing to its continued poor performance. Reference was made to other CCGs across the East Midlands terminating their contracts with TASL without any significant repercussions.
- The Committee was advised that it would be provided with the high level risk assessment relating to TASL on email, to provide the Committee with an understanding of why the decision not to terminate had been made.

RESOLVED

(1) That the proposed new transport arrangements for renal dialysis patients, which do not involve Thames Ambulance Service Limited, be welcomed.

(2) That a further report be received from the Lincolnshire West CCG in six months' time.

(3) That the Committee's view that the Lincolnshire West CCG should strategically exit the contract with Thames Ambulance Service Limited be reiterated.

60 ARRANGEMENTS FOR THE QUALITY ACCOUNTS 2020

Consideration was given to a report by Simon Evans (Health Scrutiny Officer), which invited the Committee to consider its approach to the *quality accounts* for 2020 and to identify its preferred option for responding to the draft *quality accounts*, which would be shared with the Committee, by local providers of NHS-funded services.

Councillors C J T H Brewis, C S Macey and R Wootten volunteered to form part of a working group to consider and comment on the following draft quality accounts for: East Midlands Ambulance Services NHS Trust; and United Lincolnshire Hospitals NHS Trust. It was also agreed that Councillor L Wootten could form part of the working group, as a regular replacement member on the Committee.

RESOLVED

(1) That the Health Scrutiny Officer be requested to make arrangements for the following quality accounts to be considered by a working group of the Committee: East Midlands Ambulance Service NHS Trust; and United Lincolnshire Hospitals NHS Trust.

(2) That a working group be established including the following Councillors: C J T H Brewis; C S Macey; L Wootten and R Wootten.

The Committee adjourned at 12.20 pm and re-convened at 13.30 pm.

Additional apologies for absence for the afternoon part of the meeting were received from Councillors: S Barker-Milan (North Kesteven District Council), B Bilton (City of Lincoln Council) and M T Fido (Lincolnshire County Council) and Dr B Wookey (Healthwatch Lincolnshire).

61 NHS REHABILITATION CENTRE STANFORD HALL

Consideration was given to a report and presentation by Hazel Buchanan (Director of Strategy, Greater Nottinghamshire Clinical Commissioning Groups (CCGs)) and James Wright (Project Manager, National Rehabilitation Centre Programme), which provided information on the proposal for an NHS Rehabilitation Centre at Stanford Hall.

The Committee was advised that the CCGs in Nottingham and Nottinghamshire, along with Nottingham University Hospitals NHS Trust (NUH), were preparing a pre-consultation business case on the proposed development for the NHS Rehabilitation Centre (NRC) at Stanford Hall near Loughborough, on the same site as the Defence Medical Rehabilitation Centre. This formed part of a wider vision for a National Rehabilitation Centre that would consist of an NHS clinical service, an education centre and research and innovation hub on the Stanford Hall Rehabilitation Estate.

A six week consultation period was planned in order to inform the decision on whether to take forward the option of an NRC, including the proposed transfer of existing services to the new facility. The proposal was currently progressing through the NHS England Assurance Process as part of Planning, Assuring and Delivering Service Change, which would inform the next steps.

The proposal outlined a case for a new 64-bed clinical facility which would support Nottingham University Hospitals NHS Trust (NUH), as a major trauma centre and as such, provide services to the East Midlands Trauma Network, including the NHS in Derbyshire, Lincolnshire, Leicestershire and Nottinghamshire. Detailed planning

consent had been received for the proposed NRC and the Government had agreed an allocation of £70m capital funding specifically for an NHS Rehabilitation Centre on the Stanford Hall Estate.

The proposal for an NRC would result in a net increase of 40 rehabilitation beds across the East Midlands Trauma Network and the facilities would allow for a clinical model providing services to patients with fractures following trauma and other conditions, where currently rehabilitation was provided predominantly for neurological patients. It was hoped that the NRC would open in February 2024.

In response to a question, it was noted that specialist rehabilitation services were commissioned and provided across two different levels based on complexity of need. Level 1 and 2a services were the most complex and were provided across a wider area than level 2b services. Within current services across the East Midlands Trauma Network, specialist rehabilitation was only accessible to neurological patients with a level 1 unit in Leicestershire; level 2a units in Leicestershire and Lincolnshire; and Level 2b units in Nottinghamshire and Derbyshire.

During discussion of the report, the following points were noted:

- The Committee welcomed and supported the proposal, as set out in the report, and wished to participate in the forthcoming consultation.
- The Committee was pleased that family rooms would be provided at the Centre and at no charge to the families. It was recognised that this would help reduce feelings of isolation.
- Reference was made to the central aim of the NRC to *return patients to life and work thereby reducing the long-term dependency on health care, financial and other support*. It was confirmed that it would not always be possible for patients to return to work and therefore it was about the centre supporting patients to achieve personal goals and to improve their quality of life.
- The cohort of patients and the proposed criteria of accessing the NRC were discussed. It was confirmed that the CCGs did not want to restrict the admission criteria and they would be dependent on individual need.
- The current waiting times to access rehabilitation services across the East Midlands was as follows: Nottinghamshire: 11 days in Derbyshire: 24 days; and the Ashby Unit in Lincolnshire: 43 days. It was anticipated that the proposed NRC would free capacity and reduce waiting times at these centres.
- The six week consultation would involve engaging with focus groups; surveys; and liaising with engagement leads in relevant CCGs. It was noted that two local groups in Lincolnshire had requested to be involved in the consultation. The Committee was requested to advise officers of any interest groups that may wish to be involved.

RESOLVED

(1) That the report and comments be noted.

(2) That the Committee be engaged on the six week consultation.

62 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

Consideration was given to a report from Simon Evans (Health Scrutiny Officer), which enabled the Committee to consider and comment on the content of its work programme.

It was requested that the item on *Out of Hours Services (including 111 Service)*, which had been programmed for 25 March 2020 should include information on *Ask My GP* electronic service, which had been launched by certain GP practices in Lincolnshire.

Reference was made to the item under the list to be programmed on *Undiagnosed blood pressure and high cholesterol,* where it was suggested that undiagnosed diabetes should also be added to this item.

RESOLVED

That the work programme be approved, subject to the necessary amendments being made.

The meeting closed at 2.35 pm.

Agenda Item 4

Lincolnshire COUNTY COUNCIL *Working for a better future*		**THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE**	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 June 2020**
Subject:	**Chairman's Announcements**

1. First Meeting of the Committee Since 19 February 2020

This is the first meeting of the Health Scrutiny Committee for Lincolnshire for four months, following the cancellation of the March, April and May meetings. It has been appropriate to leave the local NHS to deal with the exceptional circumstances of the covid-19 pandemic.

The announcements numbered 2 – 7 below refer to items that have arisen as a result of covid-19 pandemic. Items 8 - 10 cover issues referred to at the last meeting of the Committee on 19 February 2020.

2. Care Quality Commission – Suspension of Activities

On 16 March 2020, the Care Quality Commission (CQC) wrote to health care providers to advise them that they were suspending inspections until further notice. The CQC stated that in its letter that its primary objective during the period of the covid-19 pandemic would be to support health care providers to keep people safe during a period of unprecedented pressure on the health and care system. The CQC also confirmed that it would not be doing anything to distract health care providers from using their discretion in looking after the public. The CQC stated that it would introduce an interim methodology for the period of the pandemic and certain services would continue.

Prior to this, on 27 February 2020, the CQC had released two reports following unannounced inspections of A&E departments at Lincoln County Hospital and Pilgrim Hospital, Boston, on 6 and 7 January 2020.

3. Dental Services – Routine Face to Face Services

On 25 March 2020, all face to face routine and non-urgent dental care, including orthodontics, was suspended, by the Chief Dental Officer (CDO) of England. Practices could offer telephone or video-link consultations and prescribe pain killers and antibiotics. They were also able to refer those patients in need of urgent treatment to an urgent dental centre.

On 28 May, the Chief Dental Officer advised all dental practices that they should aim to open from 8 June 2020, where they have the necessary infection prevention and control and PPE requirements in place. The CDO advised that the sequencing and scheduling of patients for treatment as services resume should take into account:

- the urgency of needs
- the particular unmet needs of vulnerable groups
- available capacity to undertake activity.

4. NHS Debt Write-off

On 2 April 2020, the Secretary of State for Health and Social announced that over £13 billion of NHS debt would be written off, as part of a financial reset for NHS providers. The Secretary of State stated that the changes would provide much needed financial support during the unprecedented pandemic, as well as laying secure foundations for longer-term commitments, set out last year to support the NHS to become more financially sustainable. This would be part of a package of major reforms to the NHS financial system, designed by the Department of Health and Social Care and NHS England / Improvement.

The detail within the announcement stated that United Lincolnshire Hospitals NHS Trust will have a total of £377.9 million written off (£343.4 million revenue debt and £35.5 million of capital debt).

North West Anglia NHS Foundation Trust will have £268.2 million written off (£212.1 million revenue and £56.1 million capital), while the figures for Northern Lincolnshire and Goole NHS Foundation Trust are £210.6 million (£199.9 million revenue and £10.7 million capital).

5. NHS Test and Trace

On 28 May 2020, the *NHS Test and Trace* Service was launched. The service aims to identify, to contain and control coronavirus, reduce the spread of the virus and save lives. Anyone who tests positive for coronavirus will be contacted by *NHS Test and Trace* and will need to share information about their recent interactions. This could include household members, people with whom they have been in direct contact or within two metres for more than 15 minutes. People identified as having been in close contact with someone who has a positive test must stay at home for 14 days, even if they do not have symptoms, to stop unknowingly spreading the virus.

If those in isolation develop symptoms, they can book a test at nhs.uk/coronavirus or by calling 119, which has been launched to take pressure off the 111 service. If they test positive, they must continue to stay at home for seven days or until their symptoms have passed. If they test negative, they must complete the 14-day isolation period.

Local authorities have been allocated funding to support *NHS Test and Trace* in their local communities, and will be required to develop outbreak control plans, which will focus on identifying and containing potential outbreaks in places such as workplaces, housing complexes, care homes and schools.

6. Lincolnshire Pharmaceutical Needs Assessment

The Health and Wellbeing Board is required to publish an updated Pharmaceutical Needs Assessment (PNA) every three years and the next PNA had been due for publication in March 2021. On 7 April 2020, members of the Committee were advised of a project plan for the development of the PNA in line with this timetable.

On 21 May 2020, the Department of Health and Social Care announced that the requirement to publish a renewed PNA would be suspended until April 2022. The Health Scrutiny Committee will be involved in consultation on its development during 2021.

7. NHS Provider Quality Accounts 2019/20

The NHS Quality Account Regulations 2010 have been amended to allow providers of NHS-funded more time to prepare their draft quality accounts for 2019/20. In effect, the regulations remove the timetable for providers to provide a draft quality account to the local overview and scrutiny committee, healthwatch organisation or clinical commissioning group.

The Health Scrutiny Committee, via its working group, has agreed to focus on the detailed quality accounts of the East Midlands Ambulance Service NHS Trust and United Lincolnshire Hospitals NHS Trust.

8. Online Triage Systems for GP Practices

At the Committee's February meeting, members of the Committee requested more information on services such as *Ask My GP*. Online triaging can help GPs to manage their patient caseload. A*sk My GP* is just one example of an online triaging service and there are at least two other online triaging platforms on the market for general practices.

As a result of the coronavirus pandemic GP practices have been significantly expanding their use of telephone and video consultations, not just the use of triaging services. This development is probably something the Committee will consider in the coming months.

9. Renal Dialysis Services Update

As previously reported to the Committee, NHS England/Improvement commissions renal dialysis services for Lincolnshire from University Hospitals of Leicester (UHL) NHS Trust, which manages services at four sites in Lincolnshire.

The Lincoln dialysis unit is staffed by staff employed by UHL. The 'satellite' units in Boston, Skegness and Grantham are sub-contracted by UHL to other providers. UHL reported in September 2018 on its proposals for re-commissioning the services at the satellite units. I reported to the Committee on 22 January 2020 that Renal Services (UK) Ltd had been awarded a ten year contract to continue the Grantham and Skegness service, and to take over the service in Boston from Fresenius.

UHL had previously announced that the Boston Dialysis Unit contract had been renewed on 1 December 2019 and that Renal Services (UK) Ltd would take over the management of the unit from Fresenius Medical Care.

Planning Permission Granted

Planning permission has now been granted for the new site in Fishtoft Road and work to transform the building will commence week of 24 February 2020. The site was previously an office block and is close to residential premises and a regular bus route. It is 2.4 miles from the current unit.

Fresenius will continue to deliver the service under the current arrangements until the new unit is ready. As a result there will be no change to the current dialysis location and service before June 2020.

10. Non-Emergency Patient Transport for Renal Dialysis Patients

Following the Committee's consideration of non-emergency patient transport arrangements on 19 February 2020, I would like to provide some clarification on the arrangements for transport arrangements patients receiving renal dialysis services.

Lincoln Renal Dialysis Unit

Transport for patients to and from the Lincoln Renal Dialysis Unit has always been included in the Clinical Commissioning Groups' non-emergency patient transport contract, which is now with Thames Ambulance Service Limited (TASL). This unit has staff employed by University Hospitals of Leicester NHS Trust (UHL), and as stated above there has been no change to the operation of the unit, as it was not part of the procurement undertaken by UHL. Similarly, there has been no change to the transport arrangements, which remain with TASL. The commissioners state that they continue to work with TASL to improve the transport service for Lincoln patients.

Boston, Grantham and Skegness Renal Dialysis Units

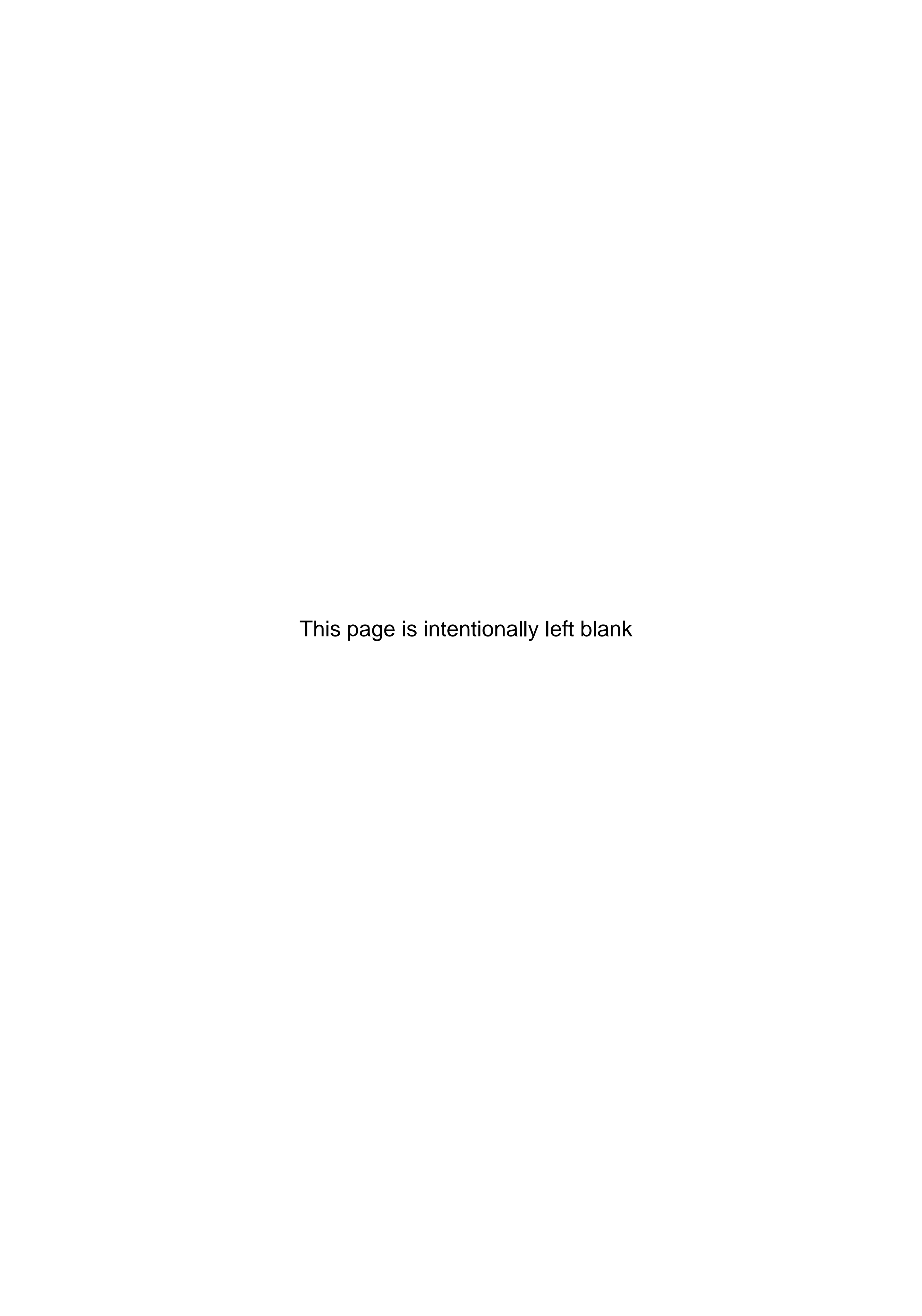
Historically the transport service for dialysis patients at Boston, Grantham and Skegness has been included in a contract between the Lincolnshire CCGs and UHL, which includes a range of elective and non-elective procedures with UHL and in effect the CCGs paid for renal patient transport under this contract for Boston and Grantham and Skegness.

Following the notice given to the CCGs by UHL to end the transport element of the contract, the CCGs have been working to secure transport for dialysis patients for Boston, Grantham and Skegness.

A number of renal patients using the Boston, Grantham and Skegness units have written to the CCGs asking that they continue with the current transport arrangements. This is reflective of the fact that renal patients tend to build close relationships with their regular drivers.

For the Grantham Skegness units, the CCGs have commissioned transport services from Renal Services (UK) Ltd, who are planning to use the same drivers as UHL. As a result, patients should continue to receive the same transport service as they do at present. However, those who need stretcher transport will continue to receive this from TASL.

For Boston patients, Fresenius currently employs drivers directly and provides cars for non-stretcher patients. Stretcher patients are included in the TASL contract. However, when the Boston renal dialysis service transfers from Fresenius to Renal Services (UK) Ltd at the new Fishtoft Road site, the arrangements for transport will need to be confirmed. The CCGs have expressed a preference for the existing drivers to be kept.


This page is intentionally left blank

Agenda Item 5

Lincolnshire COUNTY COUNCIL *Working for a better future*		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 June 2020**
Subject:	**Lincolnshire NHS Response to Covid-19**

Summary

This report provides background on the response of the NHS Lincolnshire to covid-19.

Actions Required

To consider the information presented on the response of the NHS in Lincolnshire to covid-19.

1. Background

Introduction

As reported to the Lincolnshire CCG Board on 29 April 2020, the covid-19 pandemic has presented the biggest challenge to the NHS since its establishment in 1948, and has been described as the most significant challenge to the country since the second world war. The CCG Board also recorded the fact that the way in which NHS services and staff in Lincolnshire had responded to challenges of covid-19 had been outstanding. The CCG Board also recorded its appreciation of and gratitude for the work of partners in the public sector, including social care, community care and the care homes sector, and the voluntary sector.

2. Key Elements of Response

Capacity

In readiness for the outbreak, both United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Health Services (LCHS) expanded their capacity, as part of the surge planning requirements. ULHT had the ability to accommodate 1,150 general and acute patients (normal capacity 920) and 80 patients in ventilated beds (normal capacity 25).

The number of covid-19 inpatient cases at ULHT, LCHS and LPFT peaked at 112 on 9 April. Since that time the figure has fallen significantly. On 29 May ULHT had recorded 20 covid-19 in-patients on its sites.

Cases in Lincolnshire

Lincolnshire continues has had a very low number of covid-19 cases per 100,000 population by comparison to the rest of Midlands Region and England as a whole – third lowest of all Sustainability and Transformation Partnership areas. As of 2 June 2020, Public Health England reported that there had been a cumulative total of 1,118 covid-19 cases in Lincolnshire, which represented 147.9 cases per 100,000 population. This compares to rate of 273.2 for England and 192.3 for the East Midlands. However, Boston has recorded a rate of 327.2.

Key Temporary Changes in NHS Service Provision

There were a number of changes made in service provision across the NHS in Lincolnshire, in order to ensure that there was sufficient capacity to deal with the anticipated increase in covid-19 cases; to manage reduced staffing levels; to maintain essential non-COVID-19 care; and to work within the Government's social distancing requirements.

These changes included:

- the suspension of all elective surgery
- the suspension of all non-essential outpatient appointments
- the closure of the Stamford Minor Injury Unit
- the closure of the Urgent Treatment Centres at both John Coupland Hospital, Gainsborough and Johnson Hospital, Spalding
- the concentration of hyper-acute stroke services at Lincoln County Hospital
- the closure of the Butterfly Hospice in Boston.

LCHS also expanded community hospital bed numbers, the clinical assessment service and their community nursing capacity.

Lincolnshire Partnership NHS Foundation Trust (LPFT) made a number of adjustments in capacity to ensure that they could continue to provide patient services. Many LPFT services became online/digital. LPFT had good capacity in place to prepare for a potential increase in mental health demand.

There were numerous adjustments in primary care capacity, with many GP practices adopting online or telephone consultations.

Personal Protective Equipment (PPE)

The response to Covid19 followed pandemic plans developed nationally and locally at each trust. These plans included the preparation for the large volumes of PPE equipment required. Guidance on usage of PPE was provided from Public Health England.

Throughout the response to covid-19, there has been a great deal of interest and concern on the availability of PPE. A national allocation process was initiated.

At ULHT through a combination of alternative sourcing, the national allocation and a less than average requirement for PPE (stemming from having fewer suspected and confirmed covid-19 patients) there have not been any occasions where PPE has run out. ULHT remains in a place of relative strength where on a number of occasions they have been able to support system and regional partner organisations through mutual aid.

3. Consultation

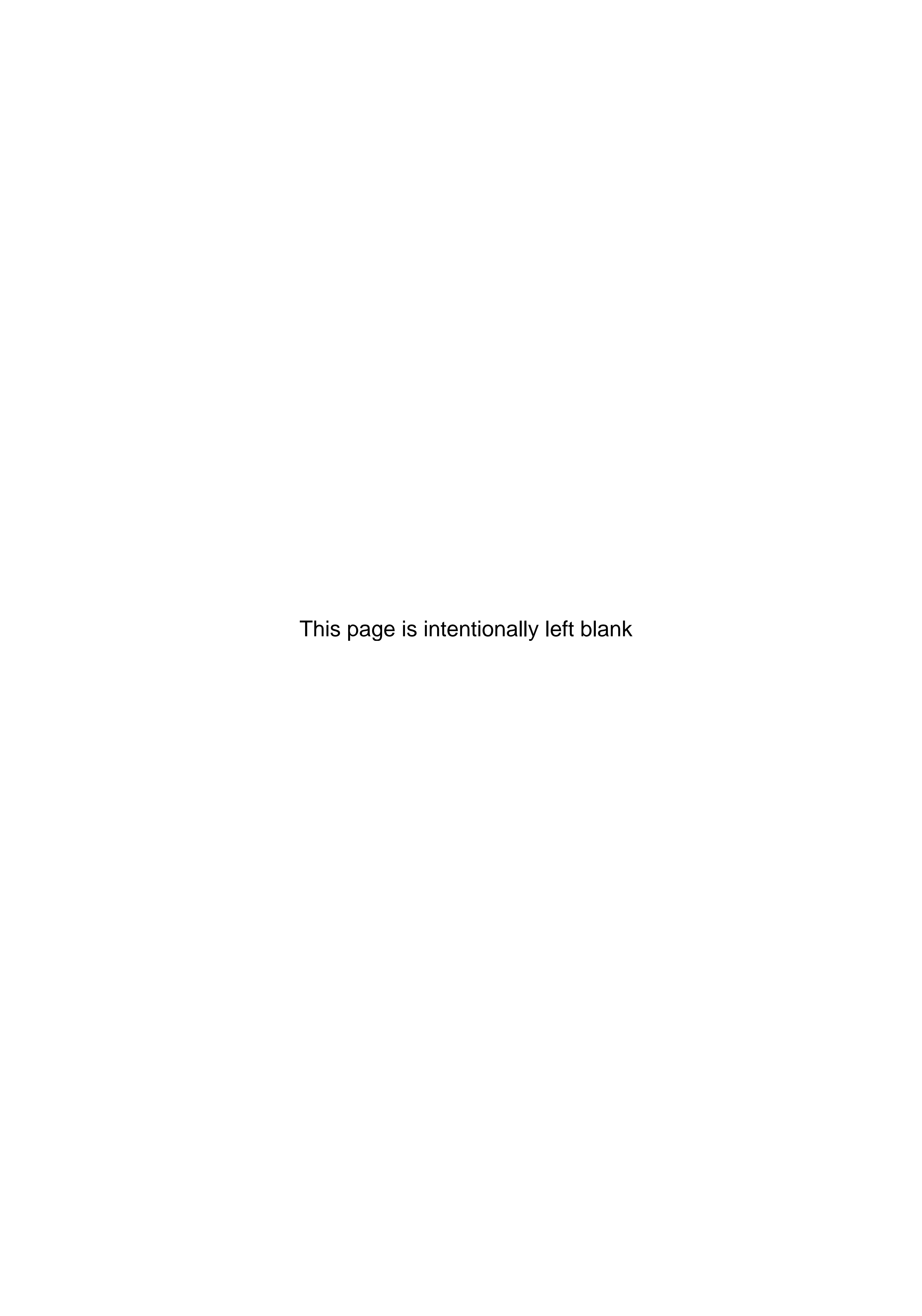
This is not a direct consultation item.

4. Conclusion

The Committee is requested to consider the information presented on the response of the NHS in Lincolnshire to covid-19.

Background Papers - No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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


This page is intentionally left blank

Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 June 2020**
Subject:	**Lincolnshire NHS - Restoration of Services**

Summary

This item focuses on the plans for the 'restoration' phase for NHS services, following the letter to all NHS Chief Executives from NHS England / Improvement on 29 April 2020.

Actions Required

To consider the information presented as the NHS moves into the 'restoration' phase.

1. Background

On 29 April 2020, Sir Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer, wrote to all local NHS Chief Executives, setting out the second phase of the response to covid-19, where the focus is on restoring NHS services.

2. Reports Considered by NHS Boards

Three reports to NHS Boards are attached. The first report to the Lincolnshire Clinical Commissioning Group Board on 27 May takes an overview of services in Lincolnshire. This report, entitled *Update – NHS Lincolnshire Response to and Management of COVID-19 Pandemic*, is attached at Appendix A. The report includes the letter from NHS England / Improvement on 29 April 2020.

The second report to the United Lincolnshire Hospitals NHS Trust (ULHT) Board on 2 June, entitled *ULHT Covid-19 Restore Phase Plan – Executive Summary*, is attached at Appendix B.

The final report is due to be considered by the ULHT Board on 12 June, entitled *Temporary Service Changes as a response to Covid-19*. This is attached at Appendix C.

3. Consultation

This is not a direct consultation item.

4. Conclusion

The Committee is requested to consider the information presented on the restoration of NHS services for Lincolnshire residents.

5. Appendices

These are listed below and attached to the report.

Appendix A	Report to Lincolnshire Clinical Commissioning Group Board (27 May 2020) Update – NHS Lincolnshire Response to and Management of COVID-19 Pandemic, including: Appendix 1 Daily Update – COVID-19 in Lincolnshire (as at 20/05) Appendix 2 Letter of 29 April from Simon Stevens and Amanda Pritchard 'Second Phase of NHS Response to COVID-19' Appendix 3 Slides – Second Phase Lincolnshire Response
Appendix B	Report to United Lincolnshire Hospitals NHS Trust Board (2 June 2020) - ULHT Covid-19 Restore Phase Plan – Executive Summary
Appendix C	Report to United Lincolnshire Hospitals NHS Trust Board (12 June 2020) - Temporary Service Changes as a response to Covid-19, including: Appendix 1 IPC Assurance Framework Appendix 2 Green Site Clinical Model Appendix 3 Quality Impact Assessment Appendix 4 Equality Impact Assessment

Background Papers - No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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

APPENDIX A

BOARD MEETING – PUBLIC

Date of Meeting:	27 May 2020	Agenda item:	4.1

Title of Report:	Update – NHS Lincolnshire Response to and Management of COVID-19 Pandemic
Report Author and Title:	John Turner, Chief Executive NHS Lincolnshire CCG
Appendices:	1. Daily Update – COVID-19 in Lincolnshire (as at 20/05) 2. Letter of 29 April from Simon Stevens and Amanda Pritchard 'Second Phase of NHS Response to COVID-19' 3. Slides – Second Phase Lincolnshire Response

1. Purpose of the Report (including link to objectives)

The purpose of this paper is to update the CCG Board in relation to:

i. The latest position in terms of the COVID-19 pandemic in Lincolnshire; and
ii. The NHS Lincolnshire System response and actions in relation to the 'Second Phase'

2. Recommendations

The Board is asked to note and consider all of the information in this report and the actions being taken.

3. Executive Summary

1. NHS Lincolnshire and CCG Approach

i. The NHS Lincolnshire approach to managing COVID-19 in the county has been one of joint working, partnership and support in the NHS between the CCG, Trusts, EMAS, and General Practice – and commitment to all work closely together to do the best we can for our patients, workforce and partners, whilst at the same time respecting the individual responsibilities which each has.

ii. In similar terms, the NHS in Lincolnshire is working closely through the Local Resilience Forum (LRF) structure with our wider partners in local government, the care sector, police, etc, to support and enable the best possible response to the Lincolnshire population as a whole.

iii. The NHS Lincolnshire System discipline previously described to the Board continues and includes:

a) Daily 0800 Chief Executives calls

b) Full participation in LRF calls and cells

c) Twice weekly Executive calls with Midlands Region NHSEI team, led by Dale Bywater, Regional Director

d) Weekly Chair calls with Dale Bywater, Regional Director

e) Weekly update briefings for Lincolnshire MPs/Leader of County Council

f) Regular ongoing liaison between CCG Chief Executive, Chief Executive of Lincolnshire County Council and Director of Adult Social Services

g) Regular briefings and meetings of the Lincolnshire Coordinating Board.

2. The Board will be aware of the changes recently introduced to the 'lockdown' measures by the Government as per the Prime Minister's national announcement on Sunday 10 May; the focus that there now is on reducing the 'R' number; that England is over the peak; and that numbers of new cases and hospital deaths in England currently is reducing. This position is also reflected locally in Lincolnshire.

3. COVID-19 Case Numbers in Lincolnshire

i. Lincolnshire continues to have comparatively low levels of COVID-19 cases and deaths. At the time of writing the transmission rate of 137/100,000 is third lowest in England; death rate in hospitals are fourth lowest; and excess deaths in Care Homes is the lowest in England.

ii. Appendix 1 shows the latest daily COVID-19 activity numbers update. This is updated daily and sent to Lincolnshire MPs and Leader of the County Council.

iii. Whilst Lincolnshire continues to have much lower transmission rates than most of the rest of the country, the rates at lower tier local authority (district) level are now being published, and show significant difference across the county. Rates per 100,000 (at 18/05) are:

England Average	256
Lincolnshire Average	137
Boston	302
East Lindsay	108
Lincoln	118
North Kesteven	112
South Holland	210
South Kesteven	108
West Lindsey	82

iv. The reasons for the higher rates in Boston are currently unclear. Points for consideration include:

a) Boston is one of the more densely populated areas of Lincolnshire and has a higher proportion of more deprived areas than average for the county (and compared to Lincoln). Urbanisation and deprivation are associated with statistically significantly higher rates of mortality (and potentially by inference infection)

b) The higher proportion of non-British born population, working in certain settings which could lead to an increased risk, plus language barriers, may result in lack of compliance to government advice and recommendations

c) Lack of comprehensive data about testing activity

d) Police advise there has been no significant increase in the use of powers to enforce social distancing in the Boston area.

v. Whilst there remains a huge amount of work going on, there are no significant immediate concerns to highlight to the Board in relation to:

a) PPE supply

b) The testing regime

c) Staffing sickness or availability

vi. The Workforce Cell remains particularly active, leading our approach to staffing support across the wider health (including primary care) sector, and extending a support offer to partners. Areas of ongoing focus include:

a) Support for staff from a Black and Minority Ethnic (BAME) background

b) Continued support to all staff and colleagues and the further development of Staff Wellbeing offers

4. 'Second Phase'

i. The NHS in Lincolnshire has continued to work closely together in progressing actions relating to the 'Second Phase' (up to approximately six weeks, focussed on essential non-COVID-19 services) of the NHS's response to the pandemic, in line with the attached 29 April letter from Simon Stevens and Amanda Pritchard.

ii. The CCG and Trusts have each progressed plans and actions for services which are their own responsibility whilst working very closely together as a System and ensuring a coordinated approach. On Thursday 14 May the NHS Lincolnshire System submitted its return to NHSEI, and key elements of that are highlighted in the attached slides.

iii. We await feedback from NHSEI, but all of the actions either have been, or are being, progressed in line with the plan.

iv. The Lincolnshire System Mental Health Recovery Cell, led by Brendan Hayes and with support and input from a range of partners, met initially on 12 May 2020, and is meeting on a weekly basis going forward. This will likely be a main feature of our response for a long period of time.

5. Third and Fourth Phases

i. As above, the NHS is currently in the Second Phase (approximately six weeks) of its response to the pandemic – restoring essential non-COVID-19 services.

ii. The Third Phase "recovery" will follow for the remainder of the 20/21 year, and the Fourth Phase "reset" from April 2021. Further details and national guidance about these will come from NHSEI in due course.

iii. We will continue to keep close to, and where possible influence, the developing Regional response to the two future phases, and will ensure that the Board is updated as thinking evolves.

6. Conclusion

i. The NHS in Lincolnshire, and across England, has now entered the 'second phase'. We will continue to work closely together to do the best we can for our patients, workforce and partners.

4.	**Management of Conflicts of Interest**
Not applicable to this paper.	

5.	**Finance, QIPP and Resource Implications**
Any implications will be identified in the main part of the paper.	

6.	**Legal/NHS Constitution Considerations**
Any considerations will be identified in the main part of the paper.	

7.	**Analysis of Risk including Assessments**
This section should identify known or potential risks and how these are being mitigated, including conflicts of interest.	

Please state if the risk is on the CCG Risk Register.

Yes		No	

8.	**Outline engagement – clinical, stakeholder and public/patient**
Not applicable to this paper.	

9.	**Outcome of Impact Assessments**
Not applicable to this paper.	

10.	**Assurance Departments/Organisations who will be affected have been consulted**
Insert details of the departments you have worked with or consulted during the process:	

Finance	
Commissioning	
Contracting	
Medicines Optimisation	
Clinical Leads	
Quality	
Safeguarding	
Other	

11.	**Report previously presented at:**
A previous update was presented to the April Board meeting.	

12.	**For further information or for any enquiries relating to this report, please contact**
John Turner, John.turner19@nhs.net	

APPENDIX 1

DAILY COVID-19 SUMMARY for 20/05/20

Date	No. of COVID 19 cases in Lincolnshire	No. of COVID 19 cases in hospital (ULHT, LCHS, LPFT)	No. of COVID 19 Deaths in Lincolnshire Hospitals	Cumulative ULHT COVID 19 discharges
1 Apr	104	46	6	
2 Apr	133	55	7	
3 Apr	153	65	11	
4 Apr	223	77	11	
5 Apr	252	94	24	
6 Apr	275	87	24	
7 Apr	275	89	25	
8 Apr	277	108	28	
9 Apr	319	112	33	
10 Apr	363	96	36	
11 Apr	392	91	42	
12 Apr	412	90	45	
13 Apr	413	97	53	
14 Apr	464	92	58	
15 Apr	480	87	62	
16 Apr	503	93	65	
17 Apr	531	87	69	
18 Apr	551	80	70	129
19 Apr	579	70	72	133
20 Apr	584	68	74	134
21 Apr	585	66	76	136
22 Apr	593	69	83	142
23 Apr	669	59	85	147
24 Apr	712	59	86	151
25 Apr	725	58	91	157
26 Apr	748	59	92	162
27 Apr	759	59	94	162
28 Apr	781	55	94	172
29 Apr	804	51	97	179
30 Apr	804	46	101	184

Date	No. of COVID 19 cases in Lincolnshire	No. of COVID 19 cases in hospital (ULHT, LCHS, LPFT)	No. of COVID 19 Deaths in Lincolnshire Hospitals	Cumulative ULHT COVID 19 discharges
1st May	828	47	102	187
2nd May	834	53	107	194
3rd May	855	58	109	197
4th May	870	53	109	202
5th May	879	57	112	205
6th May	884	54	114	211
7th May	896	49	116	215
8th May	903	49	117	219
9th May	908	42	119	224
10th May	916	44	120	229
11th May	917	43	120	230
12th May	917	49	121	232
13th May	977	53	122	234
14th May	996	44	125	238
15th May	1002	42	126	240
16th May	1015	38	126	245
17th May	1036	35	128	248
18th May	1040	35	129	250
19th May	1042	37	130	252
20th May	1043	31	130	256

APPENDIX 2

Skipton House
80 London Road
London SE1 6LH
england.spoc@nhs.net

From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

29 April 2020

Dear Colleague,

IMPORTANT - FOR ACTION - SECOND PHASE OF NHS RESPONSE TO COVID19

We are writing to thank you and your teams for everything you have achieved and are doing in securing the remarkable NHS response to the greatest global health emergency in our history.

On 30th January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. Then in the light of the latest SAGE advice and Government decisions, on 17th March we wrote to initiate what has been the fastest and most far reaching repurposing of NHS services, staffing and capacity in our 72-year history.

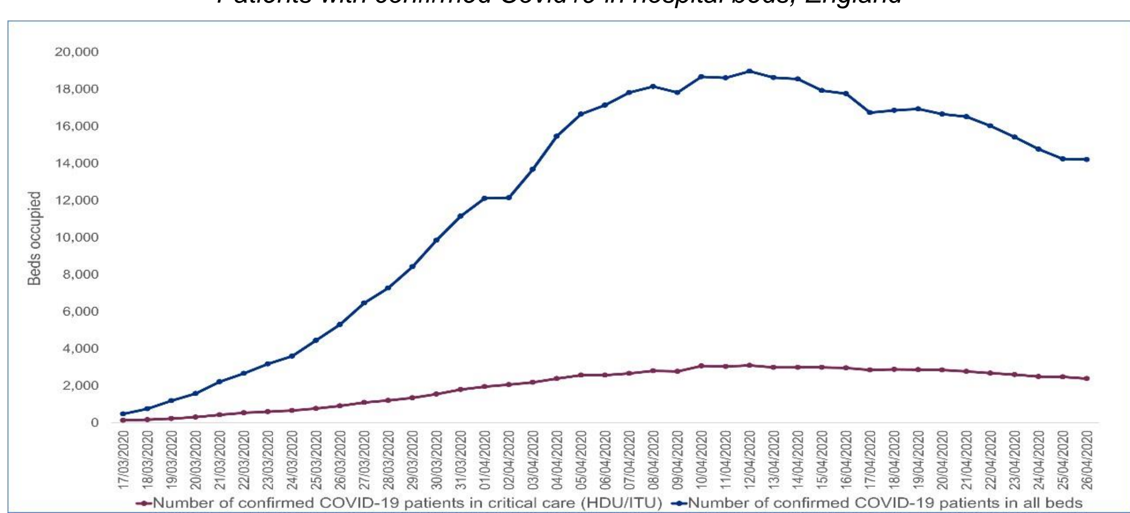
This has enabled us in the space of the past six weeks to go from looking after zero such patients to caring for 19,000 confirmed Covid19-positive inpatients per day, many of whom have needed rapidly expanded critical care support. Alongside this, the majority of patients the Health Service has continued to look after have been receiving care for other important health conditions. Despite real concern going in to the pandemic – following difficult international experience – every coronavirus patient needing hospital care, including ventilation, has been able to receive it.

This has largely been possible as a result of the unparalleled commitment and flexibility of NHS staff, combined with the public's 'social distancing' which remains in

place to cut the spread of the virus. We have also been greatly strengthened by over 10,000 returning health professionals; 27,000 student nurses, doctors and other health professionals starting their NHS careers early; 607,000 NHS volunteers; and the work of our partners in local government, social care, the military, the voluntary sector, hospices, and the private sector.

Sadly coronavirus looks set to be with the us for some time to come, so we will need continuing vigilance. We are, however, now coming through this peak of hospitalisations, as seen by the drop of nearly 5,000 in the daily number of confirmed Covid19-positive patients in hospitals across England over the past fortnight.

Patients with confirmed Covid19 in hospital beds, England



As the Prime Minister set out on Monday, we are therefore now entering the second phase in the NHS's response. We continue to be in a Level 4 National Incident with all the altered operating disciplines that requires. NHS organisations therefore need to fully retain their EPRR incident coordination functions given the uncertainty and ongoing need. The purpose of this letter is to set out the broad operating environment and approach that we will all be working within over the coming weeks.

Based on advice from SAGE, we still expect to be looking after several thousand **Covid19-positive patients**, though hopefully with continuing weekly decreases. This means:

- Ongoing and consistent application of PHE/NHS Infection Prevention and Control guidance in all NHS organisations, with appropriate cohorting of Covid/non-Covid patients (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control).

- In response to the global shortage, DHSC and the Cabinet Office together with BEIS (for UK manufacture) and DIT (for international suppliers) continue to expand the sourcing and procurement of HSE/PHE-recommended PPE for the NHS, social care and other affected sectors of the UK economy, but it is likely that current Covid-specific logistics and distribution arrangements will need to continue for the time being.

- Increased lab capacity now enables testing of all non-elective inpatients at point of admission, the introduction of pre-admission testing of all elective patients, testing prior to discharge to a care home, as well as expanded testing for staff. The corollary is the operational importance of fast turnaround times for test result reporting.

The pressure on many of **our staff** will remain unprecedented, and they will need enhanced and active support from their NHS employers to ensure their wellbeing and safety.

- Increased testing capacity means that we will now be able to extend the offer of regular testing to asymptomatic staff, guided by PHE and clinical advice. This approach is being piloted in a number of acute, community and mental health providers this week, which will inform further roll out from next week.

- As set out in our letter of 17th March, NHS organisations should continue to assess staff who may be at increased risk - including older colleagues, pregnant women, returnees, and those with underlying health conditions - and make adjustments including working remotely or in a lower risk area. Educational material, training and appropriate protection should be inclusive and accessible for our whole workforce, including our non-clinical colleagues such as cleaners and porters.

- Emerging UK and international data suggest that people from Black, Asian and Minority Ethnic (BAME) backgrounds are also being disproportionately affected by Covid19. Public Health England have been asked by DHSC to investigate this. In advance of their report and guidance, on a precautionary basis we recommend employers should risk-assess staff at potentially greater risk and make appropriate arrangements accordingly.

- Now more than ever a safety and learning culture is vital. All our staff should feel able to raise concerns safely. Local Freedom to Speak Up Guardians are able to provide guidance and support with this for any concerned member of staff. As we know, diverse and inclusive teams make better decisions, including in the Covid19 response.

- Employers are also asked to complete the process of employment offers, induction and any necessary top-up training within the next fortnight for all prospective ‘returners’ who have been notified to them.

We are going to see increased demand for Covid19 aftercare and support in **community health services, primary care, and mental health.** Community health services will need to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing health support. High priority actions for mental health providers in this next phase are set out in the Annex. General practice will need to continue to stratify and proactively contact their high-risk patients with ongoing care needs, including those in the ‘shielding’ cohort to ensure they are accessing needed care and are receiving their medications.

Given the scale of the challenges they face, we must also continue to partner with **local authorities** and Local Resilience Forums (LRFs) in providing mutual aid with our colleagues in **social care**, including care homes. This includes:

- Continuing to ensure that all patients safely and appropriately being discharged from hospital to a care home are first tested for Covid19; care homes can also check that these tests have been carried out.

- Under the direction of the LRF, local authority public health departments and CCG infection control nurses can help 'train the trainers' in care homes about PHE's recommended approach to infection prevention and control - particularly focusing on those care homes that lack the infrastructure of the bigger regional and national chains.

- To further support care homes, the NHS will bring forward from October to May 2020 the national roll out of key elements of the primary and community health service-led Enhanced Health in Care Homes service. Further detail will be set out shortly.

- Opportunities to support care homes should also be provided to younger health professional 'returnees' and public volunteers who have offered to help (subject to appropriate personal risk assessment, as described above).

As also seen in a number of other countries, **emergency activity** has sharply reduced in recent weeks. Last week emergency hospital admissions were at 63% of their level in the same week last year. This is likely due to a combination of: a) changed healthcare seeking behaviour by patients, b) reductions in the incidence of some health problems such as major trauma and road traffic accidents, c) clinical judgements about the balance of risk between care in different settings, and d) some NHS care being provided through alternative access routes (eg ambulance 'see and treat', online appointments).

There is therefore considerable uncertainty as to the timing and extent of the likely rebound in emergency demand. To the extent it happens, non-elective patients will potentially reoccupy tens of thousands of hospital beds which have not had to be used for that purpose over the past month or so.

This means we need to retain our demonstrated ability to quickly repurpose and **'surge' capacity** locally and regionally, should it be needed again. It will also be prudent, at least for the time being, to consider retaining extra capacity that has been brought on line - including access to independent hospitals and Nightingale hospitals. The national Nightingale team will work with Regions and host trusts to develop and assure regional proposals for the potential ongoing availability and function of the Nightingale Hospitals. Independent hospitals and diagnostics should be used for the remainder of the current contract which runs to the end of June. Please also start now to build a plan for each STP/ICS for the service type and activity volumes that you think could be needed beyond the end of June, which can inform discussions during May about possible contract extensions with the independent sector.

Over the next six weeks and beyond we have the opportunity to begin to release and redeploy some of the treatment capacity that could have been needed while the number of Covid19 patients was rising so sharply.

This means we are now asking all NHS local systems and organisations working with regional colleagues fully to step up **non-Covid19 urgent services** as soon as possible over the next six weeks, including those set out in the Annex. This needs to be a safe restart with full attention to infection prevention and control as the guiding principle.

In addition, you should now work across local systems and with your regional teams over the next 10 days to make judgements on whether you have further capacity for at least some **routine non-urgent elective care**. Provisional plans will need to factor-in the availability of associated medicines, PPE, blood, consumables, equipment and other needed supplies. We will continue to provide new ventilators to trusts over the coming weeks so as to sustain critical care 'surge' capacity should it again be needed in future, while progressively returning operating theatres and recovery suites to their normal use.

We should also take this opportunity to **'lock in' beneficial changes** that we've collectively brought about in recent weeks. This includes backing local initiative and flexibility; enhanced local system working; strong clinical leadership; flexible and remote working where appropriate; and rapid scaling of new technology-enabled service delivery options such as digital consultations.

In terms of wider action that will also be underway, DHSC will be designing and establishing its new 'Test, Track & Trace' service. The leadership and resourcing of local authority public health departments will be vital. Trusts and primary care networks should continue to support clinicians to enrol patients in the three major phase III clinical trials now underway across the NHS, initially testing ten potential Covid19 treatments. In addition, at least 112 Covid19 vaccines are currently in development globally. We also expect an expanded winter flu vaccination campaign alongside a school immunisation 'catch up programme'.

Looking forward, at the right time and following decision by Government, we will then need to move into the NHS's phase three 'recovery' period for the balance of the 2020/21 financial year, and we will write further at that point.

In the meantime, please accept our personal thanks and support for the extraordinary way in which you and your staff have risen to this unprecedented global health challenge.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX

ACTIONS RECOMMENDED FOR URGENT CLINICAL SERVICES OVER THE NEXT SIX WEEKS

Urgent and routine surgery and care

- Strengthen 111 capacity and sustain appropriate ambulance services 'hear and treat' and 'see and treat' models. Increase the availability of booked appointments and open up new secondary care dispositions (SDEC, hot specialty clinic, frailty services) that allow patients to bypass the emergency department altogether where clinically appropriate.
- Provide local support to the new national NHS communications campaign encouraging people who should be seeking emergency or urgent care to contact their GP, go online to NHS 111 or call 999 if necessary.
- Provide urgent outpatient and diagnostic appointments (including direct access diagnostics available to GPs) at pre-Covid19 levels.
- Ensure that urgent and time-critical surgery and non-surgical procedures can be provided at pre-Covid19 levels of capacity. The Royal College of Surgeons has produced helpful advice on surgical prioritisation available at: (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf)
- In the absence of face-to-face visits, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.
- Solid organ transplant services should continue to operate in conjunction with the clinical guidance developed and published by NHS Blood and Transplant.
- Where additional capacity is available, restart routine electives, prioritising long waiters first. Make full use of all contracted independent sector hospital and diagnostic capacity.
- All NHS acute and community hospitals should ensure all admitted patients are assessed daily for discharge, against each of the Reasons to Reside; and that every patient who does not need to be in a hospital bed is included in a complete and timely Hospital Discharge List, to enable the community Discharge Service to achieve safe and appropriate same day discharge.

Cancer

- Providers have previously been asked to maintain access to essential cancer surgery and other treatment throughout the Covid19 pandemic, in line with guidance from the Academy of Medical Royal Colleges and the NHS (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf and https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf). An exception has been where clinicians consider that for an individual patient the risk of the procedure at the current time outweighs the benefit to the patient.

- Local systems and Cancer Alliances must continue to identify ring-fenced diagnostic and surgical capacity for cancer, and providers must protect and deliver cancer surgery and cancer treatment by ensuring that cancer surgery hubs are fully operational. Full use should be made of the available contracted independent sector hospital and diagnostic capacity locally and regionally. Regional cancer SROs must now provide assurance that these arrangements are in place everywhere.
- Referrals, diagnostics (including direct access diagnostics available to GPs) and treatment must be brought back to pre-pandemic levels at the earliest opportunity to minimise potential harm, and to reduce the scale of the post-pandemic surge in demand. Urgent action should be taken by hospitals to receive new two-week wait referrals and provide two-week wait outpatient and diagnostic appointments at pre-Covid19 levels in Covid19 protected hubs/environments.
- High priority BMT and CAR-T procedures should be able to continue, where critical care capacity is available.

Cardiovascular Disease, Heart Attacks and Stroke

- Hospitals to prioritise capacity for acute cardiac surgery, cardiology services for PCI and PPCI and interventional neuroradiology for mechanical thrombectomy.
- Secondary care to prioritise capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.
- Primary care clinicians to continue to identify and refer patients acutely to cardiac and stroke services which continue to operate throughout the Covid19 response.
- Hospitals to prioritise capacity for stroke services for admission to hyperacute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.

Maternity

- Providers to make direct and regular contact with all women receiving antenatal and postnatal care, explaining how to access maternity services for scheduled and unscheduled care, emphasising the importance of sharing any concerns so that the maternity team can advise and reassure women of the best and safest place to receive care.
- Ensure obstetric units have appropriate staffing levels including anaesthetic cover.

Primary Care

- Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.
- Complete work on implementing digital and video consultations, so that all patients and practices can benefit.
- Given the reduction of face-to-face visits, stratify and proactively contact their high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams. In

particular, proactively contact all those in the 'shielding' cohort of patients who are clinically extremely vulnerable to Covid19, ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary.
- To further support care homes, the NHS will bring forward a package of support to care homes drawing on key components of the Enhanced Care in Care Homes service and delivered as a collaboration between community and general practice teams. This should include a weekly virtual 'care home round' of residents needing clinical support.
- Make two-week wait cancer, urgent and routine referrals to secondary care as normal, using 'advice and guidance' options where appropriate.
- Deliver as much routine and preventative work as can be provided safely including vaccinations immunisations, and screening.

Community Services

- Sustain the Hospital Discharge Service, working across secondary care and community providers in partnership with social care. Includes daily reviews of all patients in a hospital bed on the Hospital Discharge List; prompt and safe discharges when clinically and in line with infection control requirements with the planning of ongoing care needs arranged in people's own homes; and making full use of available hospice care.
- Prepare to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing community health support.
- Essential community health services must continue to be provided, with other services phased back in wherever local capacity is available. Prioritise home visits where there is a child safeguarding concern.

Mental Health and Learning Disability/ Autism services

- Establish all-age open access crisis services and helplines and promote them locally working with partners such as local authorities, voluntary and community sector and 111 services.
- For existing patients known to mental health services, continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding.
- Ensure that children and young people continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school.
- Prepare for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan.
- Annual health checks for people with a learning disability should continue to be completed.
- Ensure enhanced psychological support is available for all NHS staff who need it.
- Ensure that you continue to take account of inequalities in access to mental health services, and in particular the needs of BAME communities.

- Care (Education) and Treatment Reviews should continue, using online/digital approaches.

Screening and Immunisations

- Ensure as a first priority that screening services continue to be available for the recognised highest risk groups, as identified in individual screening programmes.
- Increase the delivery of diagnostic pathways (including endoscopy) to catch up with the backlog of those already in an active screening pathway, followed by the rescheduling of any deferred appointments.
- Antenatal and Newborn Screening Services must be maintained because this is a time critical service.
- Providers and commissioners must maintain good vaccine uptake and coverage of immunisations. It is also likely that the Autumn/Winter flu immunisation programme will be substantially expanded this year, subject to DHSC decision shortly.

Reduce the risk of cross-infection and support the safe switch-on of services by scaling up the use of technology-enabled care

- In response to Covid19, general practice has moved from carrying out c.90% of consultations with patients as face-to-face appointments to managing more than 85% of consultations remotely. 95% of practices now having video consultation capability live and the remaining few percent in the process of implementation or procurement of a solution. GP Practices should continue to triage patient contacts and to use online consultation so that patients can be directed to the most appropriate member of the practice team straight away, demand can be prioritised based on clinical need and greater convenience for patients can be maintained.
- Referral streaming of new outpatient referrals is important to ensure they are being managed in the most appropriate setting, and this should be coupled with Advice and Guidance provision, so that patients can avoid an outpatient referral if their primary care service can access specialist advice (usually via phone, video too).
- All NHS secondary care providers now have access to video consultation technology to deliver some clinical care without the need for in-person contact. As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure, and unless there are clinical or patient choice reasons to change to replace with in-person contact. Trusts should use remote appointments - including video consultations - as a default to triage their elective backlog. They should implement a ‘patient initiated follow up’ approach for suitable appointments - providing patients the means of self-accessing services if required.

Update to Lincolnshire CCG Board Board
System Covid 19 Phase 2 Response

APPENDIX 3

COVID 19 Timeline To Date

- 30 January, NHSEI declared this as a Level 4 National Incident. Incident Command Centres stood upacross Trusts and CCGs
- 17th March 20: Letter from Simon Stevens – free up maximum inpatient and critical care capacity, stress test plans for 'peak'
- 30 March 20: Lincolnshire system established NHS System Response Centre (SRC) and cell structure
- 29th April 20: Letter from Simon Stevens - Second Phase Planning, 'safe re start' of services
- 6th May 20: Letter from Region – Phase 2 Plan submission & Key Lines Of Enquiry(KLOE) due 140520

Covid 19 Phase 2

Phase 2 Key Requirements:

- Safely Restore non COVID19 urgent services that have been stood down to date
- Assess if the system has capacity for non urgent routine elective care and ensure Independent Sector(IS) capacity is fully utilised
- Ensure all plans fully reflect Infection Prevention Control (IPC) guidance and Board Assurance Framework
- Plans need to be agreed with commissioners and be resilient to demand changes
- Clear communication plans with communities and stakeholders

COVID 19 Phase 2

Urgent Care	Lincolnshire Position as at 14/05/20
Increase the availability of booked appointments and open up new secondary care dispositions of Same Day Emergency Care (SDEC), Hot Clinics and Frailty to allow patients to bypass the emergency department altogether where clinically appropriate.	Service already in place, Implemented increased availability for services, but the access remains via A&E - Front Door navigator and Clinical Assessment Service (CAS) and book into the Urgent Treatment Centre (UTC)
Confirm that in the absence of face-to-face visits, primary and secondary care clinicians have a process to stratify and proactively contact their high risk patients.	In place
What have systems partners agreed / put in place to maintain discharge levels; ensuring that all admitted patients continue to be assessed daily for discharge	To ensure continuation of the following: 1) Streamlined referral processes; 2) Single Point of Access (SPA) for all referrals; 3) Trusted assessor documentation; 4) Collaborative system working; 5) Building relationships and standardising processes with out of county partners; 6) Embedding Home First ethos and Discharge To Assess (D2A)Model; 7) Follow-up of patients on pathway 0; 8) Daily review of medically optimised patients; 9) Community links to stranded patient reviews; 10) Aim to discharge patients within 3 hours of becoming medically optimised 11) Redesign medically optimised calls so that there is senior system wide leadership daily; 12) for ULHT to continue as owners and reviewers of SPA inbox; 13) ULHT discharge team extension of hours; 14) to continue with long length of stay patient reviews underpinned by system-wide collaboration.

COVID 19 Phase 2

Routine Surgery & Cardiovascular, Stroke	Lincolnshire Position as at 14/05/20
Provide urgent outpatient appointments at pre-COVID-19 levels.	Delivering 100% Pre Covid, Utilising technology enabled care wherever possible - telephone, VC
Provide urgent diagnostic appointments (including direct access diagnostics available to GPs) at pre-COVID-19 levels.	Delivering 100% Pre Covid, including GP Direct Access
Capacity for cardiology services for angioplasty and stents (PCI & PPCI)	Delivering 100% Pre Covid.
Secondary care capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.	Delivering 100% Pre Covid.
Capacity for stroke services for admission to hyper acute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.	Delivering 100% Pre Covid, Implementation of temporary hub and spoke model, with all hyper-acute admission to Lincoln site, will be maintained for Restore phase to maintain consultant rota As a system we are delivering 100% - interim pathway for some patients to be treated for Hyper acute at NWAFT and rehabilitation after 3 days to Pilgrim Hospital
Primary care clinicians to continue to identify and refer patients acutely to cardiac and stroke services	Remained fully open and continued referrals

COVID 19 Phase 2

Cancer	Lincolnshire Position as at 14/05/20
Local systems and Cancer Alliances must continue to identify ring-fenced surgical capacity for cancer, System cancer SROs must now provide assurance that these arrangementsare in place.	Moving to 7 day operating lists from 18 May, and then from 1 June green pathway potential enabling 4 theatres, 12h lists, 7/7
2WW Referrals, must be brought back to pre- pandemic levels at the earliest opportunity .	Current 50% Pre Covid. Meeting two week wait (2WW) demand, however 2WW referrals demand down by circa. 50% during Covid19. 80% of demand is being seen within 7 days. Communications in place
Cancer diagnostics (including direct access diagnostics available to GPs) must be brought back to pre-pandemic levels at the earliest opportunity .	Diagnostics is split mainly between Radiology (high volume and continued service) and Endoscopy (lower volume, stopped due to COVID), so overall figure would hide large variation. Dependent on referral volumes and national governing bodies advice (eg JAG)
Cancer treatment must be brought back to pre- pandemic levels at the earliest opportunity.	Current 75% Pre Covid. Dependent on referral volumes in to the Trust and any changes in treatment modalities in line with national, COVID19 clinical guidance may have a greater or lesser impact on our treated numbers.
Delivery of urgent and time critical chemotherapy	Current , Urgent 75% , Critical 100% of Pre Covid. Reduced activity due to social distancing, changes to clinical pathways in line with NICE guidance for chemotherapy regimes, based on clinical priority.
Plan to continue to deliver urgent and time critical radiotherapy	Delivering 100% Pre Covid
Please describe the system arrangements in place for oversight of the 62 Day and 104+ backlog – tracking and profiling?	All pts over day 62 are discussed in the weekly Cancer PTL meeting, chaired by the CSS Divisional Managing Director. All pts over 104 days are reviewed every week by the Lead Cancer Clinician with the Cancer Centre Manager

COVID 19 Phase 2

Mental Health, LD, Autism	Lincolnshire Position as at 14/05/20
Confirm your plan to make your 24/7 crisis lines permanent, with appropriate pathways in place for onward referral for children and adults.	All-age open access crisis services in place including 24/7 mental health liaison at Boston and Lincoln. 24/7 helpline launched 22nd March with pathways in place for Children and Young people (CYP). Out of hours CYP referrals are directed into LPFT SPA and handled by Child and Adolescent Mental Health Services (CAMHS). In hours CYP professional, family and service user helpline is in place 9:30 to 16:30. 24/7 Crisis vehicular response commissioned and fully operational.
Please confirm, for existing patients known to mental health services, current levels to continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding.	7 day Community Mental Health Teams (CMHTs) and Home Treatment services in place and new adult CMHT intensive case management model established.
Ensure that children and young people continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school.	Good links in place with local schools and other partners. Traditional referral routes remain open with self referral being promoted through the Healthy Minds emotional wellbeing service
Please detail plans to preparations for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan. This should include preparation for increases in numbers of patients with PTSD, complex trauma and bereavement.	24/7 telephone helpline established. Covid bereavement helpline established via St. Barnabas hospice. Recruitment to posts identified as part of community transformation (Long Term Plan) almost complete. Part of Mental Health System Population workstream

COVID 19 Phase 2

Mental Health, LD, Autism	Lincolnshire Position as at 14/05/20
hat enhanced psychological support is available for all NHS staff who need it, including processes to make sure that BAME staff are considered and protected.	LPFT staff wellbeing service is in place and being supplemented by a dedicated staff helpline during the Covid crisis LPFT staff wellbeing service is in place also: - Introduction of emotional wellbeing line, 'in the moment' support for all Lincolnshire NHS, CCG and GP surgery staff not just LPFT -All BAME staff have received a letter from their NHS Trusts outlining support with respect to risk management and general support. Trusts are also looking at the actual evidence on the impact of their staff.
Please detail the plans in place to segregate COVID-19 + patients, in mental health settings.	Utilisation of available ward space within Inpatient sites. Areas that can be isolated from rest of ward have been identified, these have in some instances ensuite facilities and individual bedrooms which helps facilitate isolation.
Maintaining reductions in Learning Disability Autism (LDA) in-patients numbers (all ages).	Local protocols relating to Care Education and Treatment Reviews (CETR) processes remain viable. Liaison services are still operating. Mental health and LD crisis services are still operating and able to avoid admission as well as support step down.
Please detail the current status of Learning Disabilities Mortality Review (LeDeR) – ensuring delivery of rapid review of deaths and continue or restart the plans for full LeDeR reviews.	All LeDeR review deaths are centraly allocated by the lead based within Lincolnshire CCG. This process has continued during the Covid-19 process.
Care (Education) and Treatment Reviews should continue, using online/digital approaches. Please confirm current percentage pending, and percentage delivered using digital.	CETR 100% delivered or in progress

COVID 19 Phase 2

Primary Care & Community	Lincolnshire Position as at 14/05/20
Please confirm a plan is in place to proactively contact high-risk patients with ongoing care needs, in particular, those in the 'shielding'. Ensuring they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary.	All practices have identified their high risk patients. Medication delivery arrangements are in place and home visits are provided where these are clinically required. Primary Care, Neighbourhood teams (including social prescribing) and the community and voluntary cell have worked together to ensure that the patients needs are identified and the appropriate support provided
Please confirm Community and general practice teams are undertaking a weekly virtual 'care home round' of residents needing clinical support.	Current 25% of Pre Covid , 100% by mid June, A key risk has been identified in some Primary Care Network(PCN) areas regarding primary care capacity to support the high number of care homes in the locality. We are currently establishing a cross agency working group to develop a mitigation plan in order to ensure that the key objectives are achieved for residents in these areas.
Please confirm patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.	Practices have used local media to make , alongside this we have worked with other partners and our communication and engagement team to ensure public information is widely available. 111 / local CAS have accurate information regarding service provision and are able to direct patients to the right service.
Please detail the plan for capacity to support the increase in patients who have recovered from COVID-19 and who having been discharged from hospital needing ongoing community health support.	LCHS undertook community capacity modelling including the acute surge modelling which informed our expected demand. This looked at community hospitals required bed numbers, activity expected through our urgent care clinical assessment services (CAS) and home visiting, community nursing and palliative care. Increased use of digital
Please confirm the essential community health services in line with national guidance continue to be provided fully, (with other services phased back in wherever local capacity is available).	Delivering 100% Pre Covid

COVID 19 Phase 2

Digital	Lincolnshire Position as at 14/05/20
GPs triage patient contacts and utilise online consultation	75 practices out of 86 have implemented, or are implementing text based on- line consultation packages. A further 2 are considering implementation
Referral streaming of new outpatient referrals using Advice and Guidance- (A&G) (access specialist advice via phone/video).	Not Currently Collaborating with system and primary care colleagues to scope implementation of technology enabled new referral streaming using 'Ask My Consultant' Pilot with 2 PCNs
Video or telephone appointments should be offered by default for all outpatient activity without a procedure (were practicable), and unless there are clinical or patient choice reasons to change to replace with in-person contact.	Circa. 50% of Outpatient (OPA) activity now by telephone consultation. Circa. 350 VC consultations undertaken in April 20
Use of remote appointments - including video consultations - as a default to triage the elective backlog.	Partial Booking Waiting List (PBWL) triage being undertaken across specialties with admin and clinical review, telephone contact and appropriate actions, i.e. discharge, Patient Initiated Follow Up (PIFU)
Implement a ‘patient initiated follow up’ approach for suitable appointments - providing patients the means of self-accessing services if required.	Low usage - Scoping to increase the use of PIFU across specialties

COVID 19 Phase 2

Areas of national focus	Lincolnshire Position as at 14/05/20
How many 'Bringing Back Staff' staff have been employed in system services to date?	9 (2 employed, 1 employment being processed and 6 have been contacted to establish their current position). It should be noted that some were offered positions but declined.
How many students have been employed in system services to date? And how many do you plan to use during restoration	126 plus Student Nurses /HCSW(Health Care Support Workers) - these are the Y2 student nurses who were already in the process of joining bank as HCSW - 51 contracted - 11 available. Future state unclear at present
How many COVID-19 volunteers have been deployed in the system services to date?	6 It should be noted that the national call for volunteers has been very successful in Lincolnshire and all LRF community and Volunteer cell requests have been met. Data is not available from the national pool
How many further COVID-19 volunteers are you planning to deploy during restoration?	0 at present. During the recent episode the anticipated surge was not as high as first thought and therefore demand has been met through redeployment of existing substantive workforce as well as use of bank. Future use of voluntary services will depend around service reconfiguration and how we commence essential services over the next few months and whether we experience a further surge. Our system is able to deploy Volunteers as required and this is being monitored.
What arrangements are in place to maintain clear operational oversight of services as they are reinstated and fully restored to identify and escalate any specific service issues?	Trust ICCs are accountable to their own trust board and have a range of cells along with clear Gold, Silver and Tactical command. The current Lincolnshire NHS response centre structure captures daily information through ICCs and Cells into the System Response Centre (SRC). The Incident Management Team (IMT) that oversees the SRC regularly reports into SET/LCB and directly into NHSEI in line with national requirements through ICCs. The Chief execs hold a daily call across the system

COVID 19 Next Steps

The planning aligned with the NHSE/I phases:

- Phase 1: Continue Effective management of COVID-19 (Now)
- Phase 2: Restoration (May – June)
- Phase 3: Recovery & Reset (July – March) – addressing long waits or any backlogs in line with new operating guidance for safe services – this work will start now and run concurrently with Phase 2
- Phase 4: Reset – Shaping the new Norm/ the new NHS (2021/22)

APPENDIX B

Title:	ULHT Covid-19 Restore Phase Plan – Executive Summary
Date:	2 June 2020

Author/Responsible Director: Simon Evans, Chief Operating Officer

Purpose of the report:

To provide summary of United Lincolnshire Hospitals NHS Trust response to the Covid-19 pandemic during the *Restore* phase.

The report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Information	

Summary/key points:

This paper provides a summary of the Trust's response to the Covid-19 pandemic during the Restore Phase including high level descriptors of plans for Urgent and Emergency Care (UEC), cancer, elective care, maternity diagnostics and screening services.

The Restore phase will require step up of non-Covid-19 urgent care services as soon as safe to do so. Emphasis of the plan is on a safe restart with full attention to Infection Prevention & Control (IPC) as the guiding principle.

In addition, some elective care should be restarted based on the same IPC guiding principle but with priority being on cancer care and more urgent non-cancer elective care.

Beneficial changes that have been developed in the Manage phase should be 'locked in' and following assessment of risk, quality and equality impact should be continued on a more permanent basis.

The Trust is on standby and ready to deploy surge plans that were tested during the initial Manage phase of the pandemic response. Although these are not expected to be

deployed they are aligned to scenario plans and teams are briefed and prepared, should the need to deploy a surge response be required. After regional review with regulators, the Trust remains well placed for restoring essential services, with some services already in place and functioning well. Some detail on the full restoration of surgical services is not yet available as options are developed. It is expected that these options will be ready to authorise and mobilise in early June.	
Recommendations: The Board are asked to accept this update, noting the nature of the current national level 4 incident, the nature of frequent new guidance and requirement for all plans to be flexible and responsive.	
Strategic risk register Covid-19 Strategic Risk	**Performance KPIs year to date** All Standards
Resource implications (e.g. Financial, HR) Resource Implications are in line with authorisation SFIs and Covid19 operating parameters.	
Assurance implications This plan is a key component of the Trust's overall Covid-19 pandemic response campaign strategy, previously presented.	
Patient and Public Involvement (PPI) implications In line with National Level 4 response, national guidance and PPI implications issued.	
Equality impact Equality Impact Assessments are conducted on significant changes within the authorisation/governance system in place from the outset of the Covid-19 Level 4 Pandemic	
Information exempt from disclosure No	
Requirement for further review? Yes, further update to be provided July	

1 Background

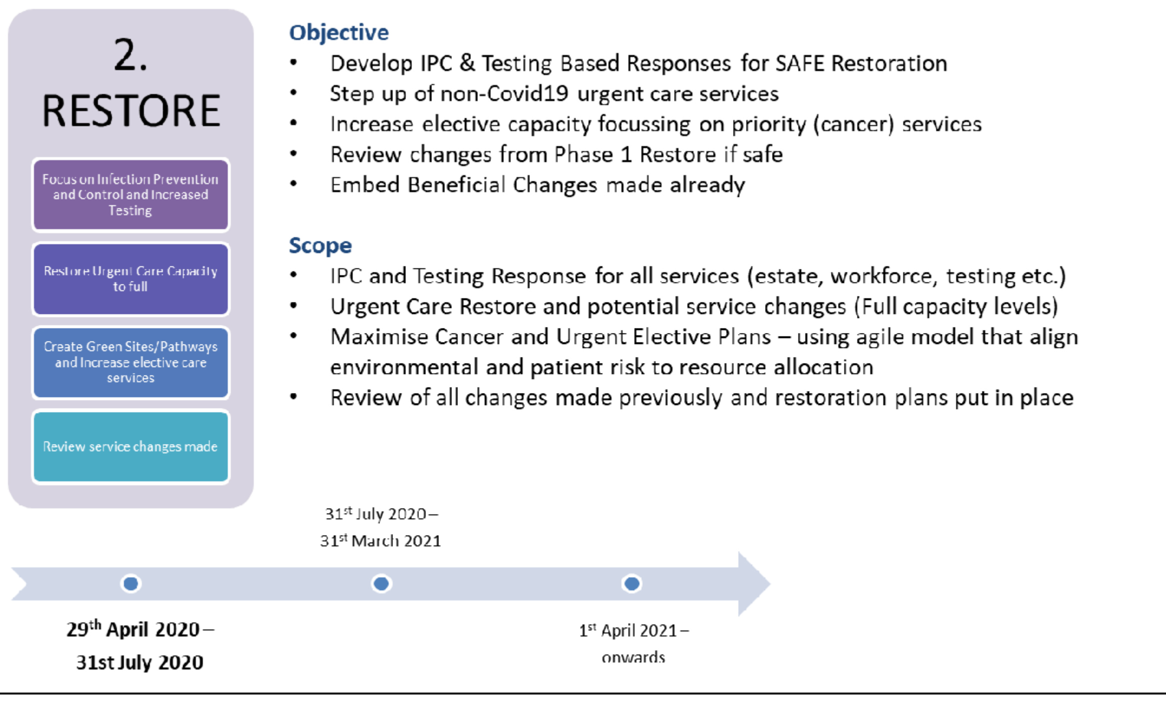
On 30 January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. At the same time Covid19 was confirmed as a High Consequence Infectious Disease (HCID) and the UK risk level was raised from moderate to high. On 3 March the Department of Health and Social Care issued the Coronavirus action plan; a guide to what you can expect across the UK. This reflected the strengthened legal powers announced by Secretary of State for Health and Social Care.

As NHSEI created national and regional Incident Command Centres (ICCs) and Incident Management Teams (IMTs) all trusts were tasked with enacting their own major incident plans and creating similar structures, 7 days per week and at a minimum 12 hours per day.

Nationally objectives of the respond to Level 4 National Incident were set as:

- Save Life
- Prevent Harm
- Protect the NHS

2. Restore Phase



2.1 Objectives:

The *Restore* phase will require step up of non-Covid19 urgent care services as soon as possible. This must be a safe restart with full attention to Infection Prevention & Control (IPC) excellence as the guiding principle. In addition, some elective care should be restarted based on the same IPC guiding principle but with priority being on P2-P3 cancer care and more urgent non-cancer elective care.

Beneficial changes that have been developed in the *Manage* phase should be 'locked in' and where necessary authorisation should be given to continue on a more permanent basis.

2.2 Timescales:

The *Restore* phase will take place from 28th April for a period up to 31st July 2020. As a Trust with comparatively less impact of Covid19 ULHT is well placed to restore many services to appropriate capacity swiftly.

2.3 Scope:

With planning complete on how and when surge responses could be put in place, the current position faced by the Trust and nationally is that the initial wave of Covid19 demand is subsiding. All modelling suggests that whilst subsiding, Covid19 will be a disease that will be in general population for many more months. During this phase focus will be heavily on infection prevention and control measures as well as use of testing services to create optimum levels of protection for patients and staff. Emphasis will be placed on the safe restoration of services and not to create additional risks to patients and staff.

3 Review of service changes

As part of the *Restore* plans the Trust has conducted a review of all service changes that have taken place during the Manage phase and considered those that could be safely reinstated or kept in place temporarily. These changes have been individually assessed for risk, quality and equality impact through the authorisation process previously described in the *Manage* phase. Sections 6 onwards in this report describe at a high level the approach being taken.

The table below identifies the level of restoration of service anticipated by the end of June 2020. ULHT plans alongside system restoration activities have been reviewed with regional regulators NHSE/I and assumptions tested to ensure that services are being safely restored.

Although many services are indicated at 100% levels it is important to note that these services make reference to essential services and do not include all services. Furthermore where services are described at less than 100% this will be in reference to services that contain a mixture of essential and routine services. Vascular services for example have both essential (urgent) services as well as planned routine services. It is these routine services that may not be in place by the 30th June, although they will feature in future *Recovery* plans.

Service	Anticipated Level of Service to Meet Demand by 30th June 2020	Comments
Neonatal Intensive Care	Delivering 100% Pre-COVID-19	
Adult Critical Care (for non COVID-19 indications)	Delivering 100% Pre-COVID-19	
Cystic Fibrosis	Delivering 100% Pre-COVID-19	Utilisation of technology enabled care - telephone, in line with NUH model of care delivery
Cardiac (Cardiology)	Delivering 50% Pre-COVID-19	Urgent cardiology services maintained, routine elective services to be increased through recovery phase
Specialised surgery in children	Delivering 75% Pre-COVID-19	Emergency surgery sustained 100%, limited elective through Restore phase

Service	Anticipated Level of Service to Meet Demand by 30th June 2020	Comments
Paediatric medicine	Delivering 100% Pre-COVID-19	Utilisation of technology enabled care - telephone
Specialised gynaecology services	Delivering 75% Pre-COVID-19	Full cancer unit service 100%, OP utilisation of technology enabled care - telephone
Vascular Services	Delivering 50% Pre-COVID-19	Urgent servcies maintained in line with Vascular Society guidance, increasing activity into the Restore phase in line with surgical prioritisation guidance
Specialised Neuro-rehabilitation	Delivering 100% Pre-COVID-19	Level 2 unit fully operational
2WW Referrals	Delivering 75% Pre-COVID-19	
Cancer diagnostics	Other - See Comments	Diagnostics is split mainly between Radiology (high volume and continued service) and Endoscopy (lower volume, stopped due to COVID), so overall figure would hide variation. Level of activity still subject to national governing bodies advice (eg JAG) and referral volumes.
Cancer treatment	Delivering 100% Pre-COVID-19	
Delivery of urgent chemotherapy.	Delivering 75% Pre-COVID-19	
Delivery of time critical chemotherapy.	Delivering 100% Pre-COVID-19	
Urgent radiotherapy?	Delivering 100% Pre-COVID-19	
Time critical radiotherapy?	Delivering 100% Pre-COVID-19	
Urgent outpatient appointments at pre-COVID-19 levels.	Delivering 100% Pre-COVID-19	
Urgent diagnostic appointments (including direct access diagnostics available to GPs)	Delivering 100% Pre-COVID-19	
Capacity for cardiology services for PCI and PPCI	Delivering 100% Pre-COVID-19	
Secondary care capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.	Delivering 100% Pre-COVID-19	Urgent service maintained fully
Capacity for stroke services for admission to hyperacute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.	Delivering 100% Pre-COVID-19	Implementation of temporary hub and spoke model, with all hyper-acute admission to Lincoln site, will be maintained for Restore phase to maintain safe medical provision

4 Infection Prevention and Control Approaches

The Trust will establish green (the term used for non-Covid) pathways/sites for cancer and elective surgery and non-surgical procedures. These pathways will be distinct from blue (the term used for suspected/potential or confirmed Covid) activity and based on the principles of ensuring the highest standards of IPC: minimising the risk of cross-infection, focused on environmental changes, hygiene, social distancing, screening and segregation of staff and patients.

5 Patient and staff testing

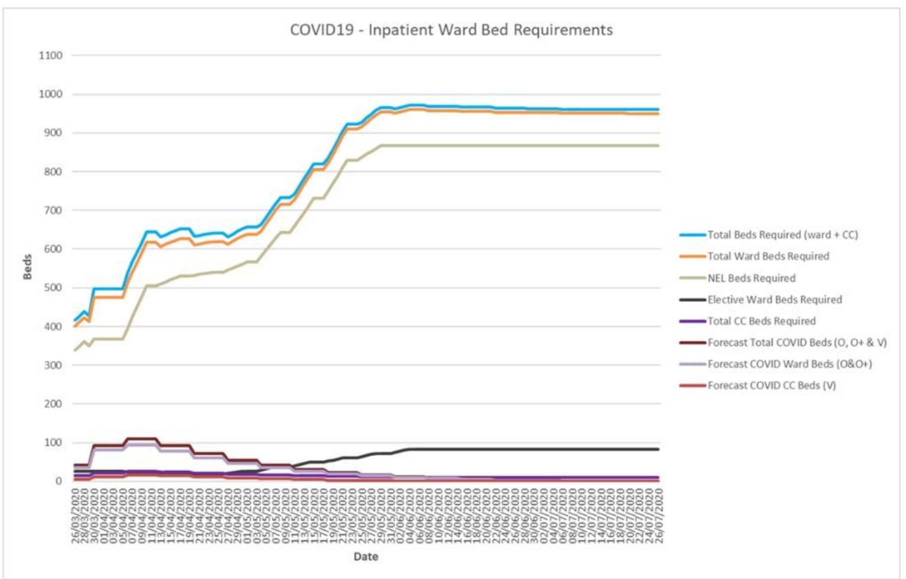
All patients undergoing cancer or elective surgery will be advised to self-isolate for 14 days prior to procedure and will be tested 48-72 hours prior. Patients testing positive will be rescheduled within a clinically appropriate timeframe and advised to follow the self-isolation pathway. Staff screening and testing will be managed by the Occupational Health Staff Testing Cell. Our approach to staff testing will continue in line with PHE guidance, including the adoption of the new antibody tests released in recent weeks. Full detail of how, and the level of testing will take place is still being developed.

6 Urgent and routine surgery and care

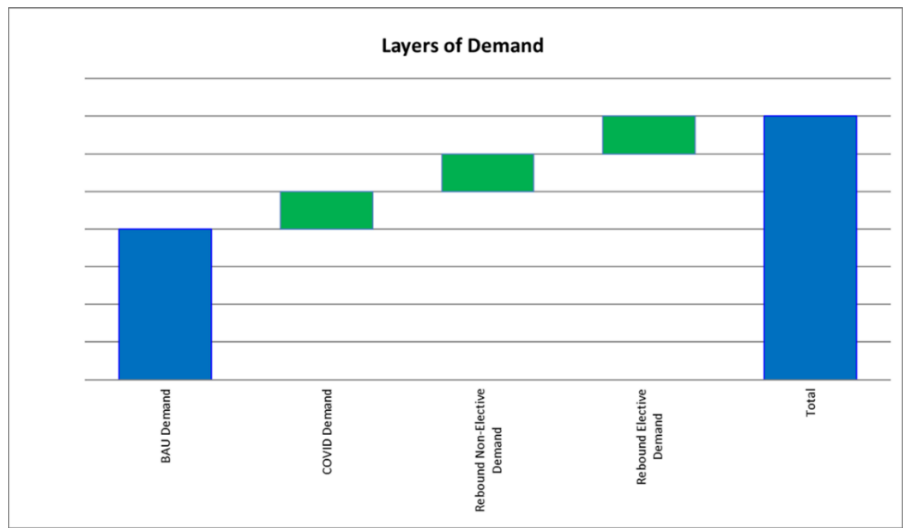
6.1 Urgent and emergency care:

The Trust's urgent and emergency care (UEC) activity has sharply reduced during the *Manage* phase with non-elective admissions at 42% of pre-pandemic average activity. This is likely to a combination of factors including changed healthcare seeking behaviour, reduced incidence of some presentations such as trauma and road traffic accidents and some care being provided through alternative routes.

Current local UEC demand modelling forecasts non-elective admissions to increase by 13.6% per week up to a normal level by the end of May. On to this we must factor a greater bed base requirement due to site configurations to maintain Covid cohort wards and distinct green pathways.



Scenarios have been developed that consider the potential "rebound" of increased demand on urgent care service generated by delayed attendance, deterioration due to delay in seeking medical assistance and postponed activity.



Plans for restoration therefore include scenarios that would utilise surge capacity responses in line with this timeframe should it be required.

6.2 Urgent outpatients and diagnostics:

The Trust continues to provide outpatient consultations for cancer and urgent patients utilising telephone and VC as default to reduce the risk of cross-infection, only offering face to face appointments where clinically required. We will continue to scale up our use of technology-enabled care at pace.

Currently circa. 50% of the Trusts maintained outpatient activity is being conducted over the telephone. This will increase further as more clinicians return to outpatient rotas and resume outpatient activity. The Trust offered VC appointments for the first full month in April and is planning to increase uptake of this at pace through the *Restore* phase.

Therapy outpatient services will ensure urgent patients have access to appointments through new referral triage and prioritisation, maximising the use of telephone and VC consultations, providing face to face clinic appointments only where clinically required following a risk assessment, and ensuring social distancing measures are in place.

The Trust continues to ensure access to urgent diagnostics in line with PHE and national body guidance whilst restoring diagnostics services for long wait patients where safe to do so.

Diagnostics have previously not been ring-fenced for cancer, in line with NHSEI best practice as issued at NHS Midlands & East Cancer Collaborative seminars. However, booking of cancer patients has always been given priority. Currently all diagnostics access is protected for emergency and cancer activity and this will continue. There is in place, the capacity to scan all current and forecast cancer and emergency patients, but not routine and direct access. Throughout the Covid period the Trust has consistently delivered 90-95% access within 7 days.

Endoscopy services nationally are guided by the British Society of Gastroenterologists (BSG) and Joint Advisory Group on GI Endoscopy (JAG) and plans will continue to adhere to their recommendations as and when these change. Endoscopy procedures are considered Aerosol Generating Procedures and current guidance requires significant change in practice that in turn impacts on capacity of the service. Specifically, the additional IPC controls and cleaning time required between patients. Current endoscopy capacity is reduced by 70% of normal activity. Demand management pathways for upper GI and lower GI introduced during the *Manage* phase are proving successful. The Trust continues to monitor and report weekly referrals, performance against DM01 standards and 7 & 10 day cancer standards.

6.3 Urgent surgery and non-surgical procedures:

The Trust will ensure sufficient capacity for urgent and time critical surgery and non-surgical procedures using Royal College of Surgeons (RCS) advice on surgical prioritisation. Green pathways will continue to be used however these pathways are currently extremely limited with mostly Level 2 and 3 (critical care level) surgical activity continuing through green pathways on Lincoln and Pilgrim sites. Restoration plans continue to be developed to increase surgical capacity by circa. 50% from June through the utilisation of additional theatres, extended operating sessions and 7-day working, amongst other strategies. Described in more detail later in this report, the Trust anticipates the use of Independent Sector capacity in Lincoln and Boston with much smaller elements in Nottingham. This will supplement the planned care green pathways in place at Boston and Lincoln.

6.4 Prioritisation and risk stratification:

The approach taken to prioritising elective care is based on clinical risk with the highest priority being cancer treatment, followed by clinically urgent, time critical non-cancer treatment. Only the appropriate levels of capacity for urgent groups across all specialties is in place the process of restarting routine electives will commence. Clinicians across all specialties are risk stratifying high risk patients and ensuring appropriate ongoing care plans are delivered.

6.5 Independent Sector Support:

The Trust will seek to make full use of NHS contracted independent sector hospitals in order to increase capacity available to treat cancer and elective long waits.

The system is contacting local Independent Sector providers on a regular basis to understand any surplus capacity by specialty available in the short term. This will be cross-referenced against known pressure points and long waiting patients. As an example, there are a cohort of long waiting patients for General Surgery and ENT which would be suitable for transfer into the independent hospitals. Priority will be given to urgent patients and long waiting patients first. The system is also requesting access to the weekly IS activity returns to understand activity and capacity opportunities. Activity levels are currently being scoped once capacity is understood.

7. Cancer

The Trust has maintained access to essential cancer surgery and other treatment throughout the pandemic in line with national guidance and in collaboration with the regional Cancer Alliance and provider partners. This will continue to ensure delivery of cancer surgery and treatment, making use of our independent sector contracts and local diagnostic capacity. Urgent action was taken in *Manage* phase to ensure the provision of 2WW appointments at pre-Covid-19 levels, using protected pathways.

Cancer referrals from MDT have significantly reduced during the *Manage* phase and it is anticipated that there will be an increase in 2WW clinic and oncology demand during the *Restore* phase. Monitoring of referrals and specialty activity continues and plans for cancer treatment capacity are adjusted accordingly.

Current available 2WW capacity is 100% of pre-COVID capacity but has not been required due to reduced demand. No 2WW capacity has been withdrawn during COVID, supported by use of technology enabled care (telephone, VC). May 2020 14-day performance is at its highest point since November 2017.

Oncology new and follow up outpatient clinic capacity has been maintained and will continue through the *Restore* phase through the adoption of telephone and VC clinics, with face to face appointments provided for patients requiring physical examination.

All chemotherapy clinics, except combined RT/chemotherapy regimens, are now being provided within a green pathway through Grantham District Hospital site and from the mobile unit delivering clinics from Skegness and Spalding, with a further mobile clinic planned to commence from Louth.

Radiotherapy will continue to be delivered from Lincoln County Hospital at reduced capacity to support social distancing and the safety of patients and staff. Demand management protocols are in place based on senior specialist clinician decision making in order to optimise utilisation of the available capacity and facilitate timely access to treatment.

8 CVD, heart attacks and stroke

Capacity is prioritised for acute cardiac interventions and cardiology services, urgent arrhythmia services, severe heart failure and valve disease. Stroke service capacity remains unchanged offering 24/7 access to thrombolysis and 7-day access to TIA Services.

The majority of elective cardiology operating ceased at the end of March with only PPCI and urgent elective device procedures continuing, alongside urgent echo diagnostics to support the cancer pathway. Waiting lists have not grown significantly due to the lack of other diagnostic testing being undertaken in cardiology during the *Manage* phase. The Trust has in place robust monitoring of current urgent, time critical and routine cardiology demand.

On 31 March, in order to maintain capacity, the Trust’s stroke pathway was revised to a hub and spoke model, supporting a single consultant on call rota. All Hyper-acute strokes are currently conveyed to and received by our Lincoln site. Patients who self-present to our Pilgrim Hospital site showing symptoms of stroke are transferred to Lincoln. Robust monitoring and weekly reporting to Gold Command of stroke ambulance conveyance and admission activity is in place. This pathway will continue during the Restore phase while being under continual review.

9 Maternity

The Trust will ensure direct and regular contact with all women receiving antenatal and postnatal care, clearly explaining how to access scheduled and unscheduled care and reassuring women of the safest place to receive care. Our obstetrics units will be appropriately staffed including anaesthetic cover.

On 24 March, the Trust issued an interim standard operating procedure (SOP) for the management of Covid-19 in maternity services in line with RCOG guidance along with a minimum antenatal and postnatal pathway. This pathway included a reduction in face to face appointments for low risk women, special consideration of high risk and safeguarding concerns, and a temporary suspension of the home birth service.

Review of antenatal and postnatal appointments for low risk women will continue to reduce unnecessary face to face contacts, while our SOP for high risk women and safeguarding concerns will remain in place. This is in line with Royal College of Obstetrics and Gynaecology and Royal College of Midwifery advice. The home birth service was restored from 18 May 2020.

10 Screening and immunisation

The Trust will prioritise making screening services available for the recognised highest risk groups as identified in individual screening programmes. An increase in the delivery of diagnostic pathways initially focused on backlog clearance of those already in an active screening pathway will take place in the *Restore* phase.

10.1 AAA screening:

The AAA screening programme stopped screening on 16 March 2020 in line with PHE and Vascular Society guidance due to the assessed high risk to a vulnerable patient group. This has resulted in the Trust cancelling circa. 1000 screening appointments. All patients cancelled and all affected surveillance patients have been kept informed to enable full disclosure and ease stress surrounding their diagnoses. At the end of 2019, PHE approved the Lincolnshire AAA screening programme to start the 2020/21 cohort early on 7 January. This decision has supported restoration as the Trust was able to complete over 700 scans of this new cohort before the pandemic started in the UK – a significant proportion of the activity cancelled during the *Manage* phase.

10.2.1 Bowel screening:

The bowel cancer screening programme remains suspended nationally and the Trust continues to follow guidance set out by JAG and BSG. The Trust has a robust risk stratification process in place, patients are being closely monitored and, where intervention is required, patients are being referred accordingly.

10.3 Breast screening:

The breast screening service is currently suspended in line with national guidance. The high risk service is provided by Nottingham University Hospitals through a service agreement and this service has resumed.

10.4 Diabetic eye screening:

The DES programme stopped the majority of screening on 20 March due to the assessed high risk to this vulnerable group. Patients identified as at clinical risk have continued to be screened.

10.5 Newborn hearing screening:

Our Newborn Hearing Screening Programme will continue to be maintained. Outreach clinics were suspended from 1 April due to insufficient staffing availability and following PHE guidance. Since, parents have been offered screening for their babies while still an inpatient. We recognise the importance of maintaining the NHSP due to its time criticality and plan to re-instate outreach clinics at the earliest opportunity.

APPENDIX C

Meeting	*Public Trust Board*
Date of Meeting	*11 June 2020*
Item Number	*TBC*
Title	*Temporary Service Changes as a response to Covid-19*
Accountable Director	*Paul Matthew – Director of Finance and Digital*
Presented by	*Simon Evans – Chief Operating Officer*
Author	*Paul Matthew – Director of Finance and Digital* *Simon Evans – Chief Operating Officer*
Report previously considered at	*Private Trust Board* *2 June 2020* *Gold command* *22 May 2020*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	*X*
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*4558 – Local Impact of the Global Coronavirus (Covid-19) Pandemic* *The paper is in direct response to mitigating this risk.*
Financial Impact Assessment	*The changes proposed are a response to a Level 4 National Incident as such a FIA has not been considered.*
Quality Impact Assessment	*Completed – see appendix 3*
Equality Impact Assessment	*Completed – see appendix 4*
Assurance Level Assessment	*Significant*

Decision Required	*Approval from the Trust Board to proceed with the changes proposed, recognising that these are temporary and in response to the Level 4 incident response to the Covid-19 pandemic.*

Foreword

Across the NHS, a huge amount of work has gone into the response to the national level 4 Covid-19 pandemic in recent months, to ensure capacity for managing Covid-19 cases and the provision of safe environments for staff and patients.

Recognising that we are nationally past the first peak of infection, and as case numbers begin to decline, national guidance was recently issued requiring all NHS organisations to develop plans to restore some essential non-Covid-19 services.

These plans need to acknowledge that, although the number of cases nationally may be going down, we are a long way from being free of Covid-19 and it still poses a significant threat to patients and our staff. Therefore, putting in place measures to minimise hospital transmission of Covid-19 to protect patients and staff must be the priority in this next stage of our response. This will help to increase public confidence in accessing our services again.

As a Trust Board, we have a responsibility to the population of Lincolnshire to ensure we can provide the services that they need, in as safe a way as possible, as we progress through this national level 4 incident.

During the initial stages of this incident, many hospital services both locally and nationally were reduced very quickly in order to free up capacity to manage Covid-19 cases and to reduce the risk to patients of going into hospitals where Covid-19 patients were being cared for. This has resulted in a large number of appointments being deferred. As a result many more patients are now waiting for their care.

This includes some cancer surgery, clinically urgent cases and urgent diagnostic testing. If we don't act now, these waiting lists will only grow longer, and those patients whose procedures and investigations have been delayed could suffer harm as a result.

In planning for this next stage of our response, we must also bear in mind that whilst A&E attendances have been low during the initial phase of the pandemic, the demand for urgent care is now rising again and we must be in a position to continue to safely care for these patients too.

All this change needs to be made in line with the new world we are working in, with Covid-19 still circulating and at times still posing a threat to life. This should be expected for some time to come and at least the next 12 months.

Despite this, we need to make provision to expand our range of services, to ensure people do not suffer detriment as a result of delayed appointments or surgery, whilst still offering emergency care for those most in need and also preserving services for those who may have contracted Covid-19. This makes managing our hospitals even more complicated than in the past.

Taking all of this into account, we have assessed what services we can provide, and where, safely. The priority is maximising what we can offer to the people of Lincolnshire in a safe way for everyone.

We are recommending the temporary creation of a largely Covid-19 free Green site at Grantham and District Hospital for this next phase of the pandemic. This would mean an increase in elective patients at Grantham hospital, including transfer of chemotherapy, cancer surgery and other surgery from across Lincolnshire.

To support this, all patients must have a known Covid-19 status on admission to any ward on that site. Therefore, we would need to temporarily change the urgent care offer at the hospital from an A&E, open 8am-6.30pm, to a 24/7 walk-in Urgent Treatment Centre (UTC) and transfer unplanned admissions to our other hospitals. This is necessary to create isolated facilities and help us monitor and control the risk of infection.

We believe these temporary changes are the right approach to manage the pandemic in a way that best protects our patients and staff whilst delivering key services. These temporary changes will be in place starting from 22nd June until at least 31st March 2021.

Executive Summary

The aim of this paper is to:

- Summarise the case for the temporary reconfiguration of services provided by the Trust as part of the next stage of its response to the level 4 incident declared on 30 January 2020
- Describe the options considered and the preferred option
- Outline the legal basis for the change
- Describe the clinical leadership and governance established to oversee and enact the proposed changes
- Provide assurance that the quality and equality impact of the proposed changes has been considered

Enacting the proposed changes will drive the following improvements for the population of Lincolnshire:

Patients that require cancer surgery

The introduction of the Green site model – in addition to the existing Green pathways – will give ULHT the capacity to rapidly treat those patients waiting and protect the delivery of cancer surgery for all of Lincolnshire whilst minimising the risk of contracting Covid-19. Within 2-3 weeks of full implementation there will be no waiting list for cancer surgery and we will be able to continue to meet the demand for cancer surgery on an ongoing basis through the next phase of the pandemic. Only those cancer patients requiring high dependency or intensive care will continue at Lincoln or Pilgrim hospitals with the majority transferring to Grantham hospital.

Patients that require planned elective surgery

Planned elective surgery has been greatly reduced, resulting in significantly increased waiting times. The introduction of a Green site model will enable planned elective surgery to resume and prevent further deterioration of waiting times whilst permitting the treatment of clinically urgent cases. This means a continued low level of elective services at Lincoln and Pilgrim hospitals with operations greatly increasing at Grantham hospital.

Patients that require urgent diagnostic tests

The introduction of a Green site model will enable urgent diagnostics to increase in a low risk environment where all patients, including those who may be vulnerable or susceptible to infection, can receive the necessary tests. This will ensure that patients will receive diagnostics in a timely manner, preventing further deterioration of waiting times and reducing the risk of delay in diagnosis.

The Green site model will support the majority of diagnostics required for cancer patients and urgent elective patients, whilst adhering to the Infection Prevention and Control design principles.

Increasing access to urgent care for patients

Delivering a Green site model in Lincolnshire requires all patients admitted to the site to be screened to minimise the risk that they may be Covid-19 positive. This is not possible for emergency admissions, and so the Green site model cannot support an A&E admission service on site. Furthermore, a Green site model cannot accommodate patients who have not been screened prior to accessing diagnostic services, which prevents a Green site from having an A&E service. However, in order to continue to provide access to urgent care services the proposed model would seee Grantham A&E converting to an Urgent Treatment Centre. Converting the service will incorporate the increase in operating hours to become a 24/7 walk-in function.

A summary of the likely patient impact is below:

Green site model - Patient Impact

Grantham Hospital

Lincolnshire patients who can now be treated at Grantham – Green site (per annum)

Elective surgery – including cancer (high risk)	3,558
Outpatients (high risk)	9,274
Total	**12,832**

Lincolnshire patients whose care is moved away from Grantham (per annum) → Lincoln Hospital

A&E attendances* (low risk)	1,185
Non-elective (low risk)	1,277
Total	**2,462**

Lincolnshire patients whose care is moved away from Lincoln and Pilgrim (per annum) → Grantham Hospital

Elective surgery – including cancer (high risk)	2,335
Day cases – Chemotherapy (high risk)	1,932
Total	**4,267**

Lincolnshire patients whose care is moved away from Grantham (per annum) → Neighbouring Trusts

A&E attendances* (low risk)	3,419

Lincolnshire patients whose care continues at Grantham (per annum)

Day cases – Chemotherapy (high risk)	80
Outpatients (high risk)	2,412
Total	**2,492**

Lincolnshire patients whose care continues at Grantham (per annum)

UTC attendances (high risk)	20,014

Lincoln Hospital · Pilgrim Hospital · Neighbouring Trusts

Key: Blue activity; Green activity

*Patients requiring non-elective admissions are a subset of A&E attendances moved away from Grantham.

* *The numbers described in the above infographic are representative of known modelling assumptions at the point of production of this report. Throughout the Covid-19 pandemic both emergency and planned demand for services have changed much more than normal seasonal variation and, as such, whilst this has been considered it does reduce the accuracy of future forecasts.*

The Board is asked to formally approve the changes, noting that:

- These are temporary in nature and are within the authority of the ULHT Board to make given the emergency pandemic response. The timescale for the Green site is to implement from 15th June 2020, with the conversation of A&E to UTC on the 22nd June 2020 to last for the duration of Covid-19 to at least 31 March 2021. This timescale is subject to quarterly review and commencement of the changes will be phased.

- This is completely separate from the process to make any permanent significant changes to services, which would be led by the NHS Lincolnshire CCG, requires formal public consultation in line with national guidance and is within the authority of the CCG to decide.

- Registration of the change is also required to NHS England and NHS Improvement as part of Covid-19 incident management.

Introduction

On 30 January 2020, a Level 4 National Incident was declared and at the same time Covid-19 was confirmed as a High Consequence Infectious Disease (HCID) and the UK risk level was raised from moderate to high. This triggered a national preparation and response to Covid-19 in the following four phases, beginning with the first Manage phase.

1. Manage – to 29 April
2. Restore – to 31 July 2020
3. Recovery – to 31 March 2021
4. The new NHS – 1 April 2021 onwards

Nationally, objectives of the response to the Level 4 National Incident were set as:

- Save Life
- Prevent Harm
- Protect the NHS

A high-level summary of each phase of the Covid-19 response is provided below:

1. MANAGE	2. RESTORE	3. RECOVERY	4. THE NEW NHS
Use of the Major Incident Plan Use of the Pandemic Flu Plan Initial Response Protect Staff and Services Preparation for Surge Monitor for	Focus on Infection Prevention and Control Increased Testing Restore Urgent Care Capacity to full Create Green pathways/sites Increase elective care	Deliver Constitutional Standards Return all services to operational Build on developments and optimise services	Delivery of Integrated Improvement Plan Best Practice Use of new models of care Improved service provision Improved outcomes

Consequently, United Lincolnshire Hospitals NHS Trust (ULHT) as part of the first Manage phase, quickly repurposed services, staffing and capacity to treat and care for patients with confirmed Covid-19 infection.

A summary of the first Manage phase re-configuration by site is provided below:

Site	Function (High level)
Lincoln County Hospital	Blue site (for the treatment of patients with suspected Covid-19) with a discrete infection prevention and controlled (Green pathway) for any patients in need of urgent surgery, radiotherapy or interventional cardiology
Pilgrim Hospital Boston	Blue site with Green pathway for critical care surgery
Grantham and District Hospital	Blue site with urgent diagnostic services and no surgery
Louth Hospital, BMI Lincoln Hospital and Boston Ramsey Hospital	Currently ULHT and Independent Sector services are temporarily paused to support staffing at other sites.

The first Manage phase is now complete and provides the basis of a surge response that can be reactivated at any time if we experience any future spikes in Covid-19 cases. We are now in the second phase, Restore. The Restore phase will take place from 29 April 2020 for a period up to 31 July 2020. The options described in this paper are being reviewed and subsequently enacted in the Restore phase. However, it is anticipated that they will continue to be a feature of the recovery phase being in place for the duration of Covid-19 up to at least 31 March 2021.

A high-level summary of the Restore phase is set out below:

Objective

- Develop IPC & Testing Based Responses for SAFE Restoration
- Step up of non-Covid19 urgent care services
- Increase elective capacity focussing on priority (cancer) services
- Review changes from Phase 1 Restore if safe
- Embed Beneficial Changes made already

Scope

- IPC and Testing Response for all services (estate, workforce, testing etc.)
- Urgent Care Restore and potential service changes (Full capacity levels)
- Maximise Cancer and Urgent Elective Plans – using agile model that align environmental and patient risk to resource allocation
- Review of all changes made previously and restoration plans put in place

The challenge

There remains material uncertainty on how long the Covid-19 pandemic may last. Some experts in the field cite that the pandemic may last until 2022 and then stabilise as a new seasonal virus, similar to seasonal influenza.

As such, the challenge now facing ULHT as it begins the Restore phase and into the Recovery phase of its response to the outbreak is to maintain the capacity to provide high quality services for patients with Covid-19, whilst increasing other urgent clinical services and important routine diagnostics and planned surgery, for the population of Lincolnshire.

Case for change – What do we need to do?

In order to respond to the initial surge of Covid-19 patients, and reduce the chance of transmission, urgent and non-urgent elective services and routine diagnostics were stopped and treatment for some patients on the cancer pathway delayed.

Urgent surgery and diagnostic activity has continued through carefully planned Green pathways to minimise the risk of infection at Lincoln and Pilgrim hospitals.

As a direct result, the following has been observed:

1. **Cancer 62-day performance**

For a short period cancer surgery was stopped whilst the necessary preparation was undertaken to create discrete Green and Blue pathways. As such, a backlog of cancer patients has been created that now need to be operated on in the Restore phase.

The volume of patients previously treated with cancer surgery was 35 per week prior to the pandemic and since it began this has been less than 22 per week.

As at 5 May 2020, a total of 291 patients were on the waiting list, of which 203 patients (70%) are still to be offered a 'To Come In' (TCI) date. A breakdown is set out below:

Level of urgency	Number of patients on the waiting List	Number of patients on the waiting list with TCI date	Number of patients on the waiting list requiring TCI date
Level 1 (highest)	3	3	0
Level 2	202	82	120
Level 3 (lowest)	86	3	83
Total	291	88	203

The number of patients being referred in on a cancer pathway (also known as a 62 Day), having initially dropped to approx. 30% of pre-Covid-19 levels, is slowly beginning to increase and as at week ending 24 May was at 64% of the pre-Covid-19 baseline rates:

Patient-centred ◆Respect◆ Excellence ◆Safety◆ Compassion

For the patients on cancer pathways there have been a variety of challenges around continuing on their journey. Some include availability of diagnostics, clinical risks around treatments, patient reluctance to attend for outpatient appointments and diagnostic tests or treatments. This may be due to recommended self-isolation, shielding or other risk concerns.

In order for services to respond effectively, address the backlog and treat all cancer patients in a timely way, the Trust needs to reinstate more capacity than was previously available for a period of time. All efforts should be put in place to prioritise this surgery, increase the capacity available and to protect patients from being further delayed by the impact of Covid-19.

Evidence produced through the early phases of the national response to Covid-19 indicates that patients operated on in hospitals who contract Covid-19 have an increased mortality rate. It is vital that we have solutions in place that minimise the chance of contracting Covid-19 in our hospitals.

2. Patients are nervous about seeking help or attending A&E when they need care

Like elsewhere in the UK, the NHS in Lincolnshire has seen a marked decline in the number of people seeking help, whether this be urgent care in A&E or a referral to a specialist. The table below illustrates this point.

Attendances and admissions	% of normal (pre Covid-19) demand as at 1 May 2020
A&E Attendances	64%
Non-Elective - 0 Day Admissions	64%
Non-Elective - 1+ Admissions	56%

Between 2 March and 24 May 2020, the emergency departments have had 10,701 fewer attendances compared to the same 12-week period last year. This shortfall in A&E attendances is broken down as follows:

Site	Lincoln	Pilgrim	Grantham	Total
1 March and 24 May 2020 – 12 weeks	1,673	5,145	3,883	10,701
Per week	139	429	324	892
Per day	20	61	46	127

The shortfall in attendances is even greater when Covid-19 related attendances are removed. This reduction is mirrored by a reduction in GP referrals on the 14-day (suspected cancer) pathway and for urgent assessment. The reasons for the sharp decline in patients seeking help are multifaceted, but concern regarding the risk of contracting Covid-19 in hospital features highly.

Clinical opinion is that this suppressed demand will reverse; with the majority of these patients presenting later (or rebounding). The quantum of this "Rebound" is difficult to predict as there is no precedent. However, a number of scenarios in each of the layers of demand are being modelled.

Layers of demand

Pre Covid-19 demand | Suppressed demand as a result of Covid-19 | Covid-19 Demand | Rebound Demand | Future demand

More broadly, the incidence of disease and morbidity in the population has not reduced. This prompts fears that this deferred demand will result in excess mortality, morbidity and harm from non Covid-19 causes if not addressed.

As such, there is a requirement in the Restore phase to build confidence in the ability to keep patients safe from Covid-19 in a hospital setting, knowing that urgent and emergency demand is likely to increase.

3. **Planned elective and urgent diagnostic activity has reduced resulting in significantly increased waiting times**

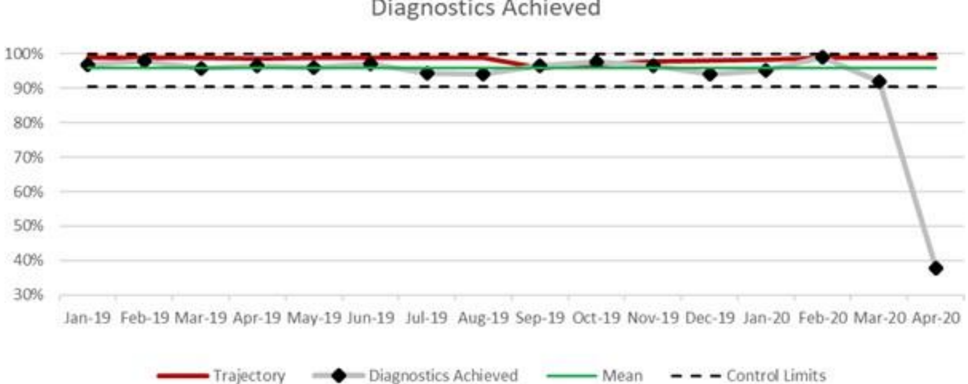
The total number of patients waiting more than 18 weeks on an 18-week (RTT) pathway has significantly increased –from 7,841 patients at week ending 22 March 2020 to 12,838 patients at week ending 17 May 2020 (an increase of 4,997)

Referral activity has significantly reduced – the number of patients on the diagnostics waiting list has reduced from 6,000 patients pre Covid-19 to 4,378 patients at the end of April (a reduction of 1,622)

Since the end of March 2020, reduced levels of routine and urgent diagnostics have been delivered, except for endoscopy which was stopped for a short period of time in line with national guidance. However, alternate diagnostic provision was delivered to those patients who were impacted.

Although the overall waiting list for diagnostic tests has reduced, there has been a significant increase in waiting times. The percentage of patients waiting less than 6 weeks from referral to diagnostic test (DM01 performance) has deteriorated significantly, from 99% in February 2020 (meeting the national standard of 99%) to 37% in April 2020. (a reduction of 67%)

The chart below represents ULHT's diagnostic waiting time performance from January 2019 to April 2020.



The majority of patients waiting over 6 weeks were within echocardiography and endoscopy diagnostic procedures. Endoscopy procedures are aerosol-generating and current guidance is impacting on service capacity due to Infection Prevention and Control (IPC) controls and cleaning time required between patients. Current endoscopy capacity is reduced by 70% of normal activity and is focused on cancer and urgent tests.

What do we need to do? – Conclusion

The Trust must safely and expediently resume surgical services. It must increase diagnostics alongside the response to lowering the risk of hospital-acquired Covid-19.

As such, the focus of the Restore and Recovery phases must be on the need to conduct planned care services in locations where the risk from Covid-19 is minimised to the lowest level possible.

This is particularly the case for patients who are vulnerable and may have compromised immunity, such as cancer patients who are at particular risk.

This assessment of the current challenges faced by ULHT in the context of delivering urgent elective services and urgent diagnostics to the population of Lincolnshire builds a strong case for change.

Any proposed solution to provide planned care in a hospital setting must reduce clinical risk, and that requires that the following three conditions are met –

1. **Infection Prevention Control (IPC) excellence –** Excellence in IPC is required to minimise hospital transmission of Covid-19 to protect patients and staff. In order to achieve this, careful planning, scheduling and organisation of clinical activity is required.

IPC excellence is achieved by evidencing full compliance to the national Infection Prevention and Control board assurance framework. This framework has been developed to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance that organisational compliance has been systematically reviewed.

ULHT has assessed the following within the Infection Prevention and Control board assurance framework (for detail – see Appendix 1):

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7. Provide or secure adequate isolation facilities
8. Secure adequate access to laboratory support as appropriate
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2. **Capacity to deliver at scale –** theatres, staffing and estate. Options for care delivery during this Restore phase must have sufficient capacity to treat cancer patients, those requiring care that is clinically urgent, and within a rapid timeframe. Thus reducing risk associated with delay.

3. **Future service resilience –** Amidst the material uncertainty of how long Covid-19 will last, the service will need to be resilient and capable of addressing ULHT's requirement over an extended timescale. As movements in and out of the county increase, a second wave of Covid-19 is plausible.

Any preferred options should meet these three conditions.

Options appraisal – What's the best way to meet these conditions?

The case for change sets out the requirement to resume urgent elective surgery and urgent diagnostics to protect patients from being further impacted by Covid-19.

An assessment was carried out by joint ULHT clinical and managerial teams to identify options to support resuming elective and planned care.

A high-level description of the options identified is set out in the table below:

Option	Description
Option A – No further change	Configuration of services remains as-is, no further steps taken to minimise the risk to patients with suspected cancer and requiring urgent elective intervention of cross infection from Covid-19.
Option B – Green pathway	Create a Green pathway for Covid-19 negative patients to support elective and planned care in a setting that minimises, wherever practicable to do so, the risk of cross contamination with Covid-19. This will be provided in conjunction with Blue pathways – care for Covid-19 positive patients. Blue activity would adhere to the same principles of IPC. Cohabitation of Green and Blue activity within a single site with some shared areas. Shared workforce for Green and Blue activity within a single site, with limited/no separation.
Option C – Green site	Convert a hospital site into a Green site. The Green site would support elective and planned care in a setting that aims to minimise the risk of cross contamination of Covid-19. Isolation of Blue activity from Green activity – no Blue activity (unplanned or otherwise) would be cohabiting with Green activity. Blue activity and Green activity are physically separated. Staff work in separate Green and Blue areas.

Assessment of the best way to meet these conditions

An assessment of each option was conducted against the 3 conditions. A summary of this assessment is set out in the tables below:

1. **Infection Prevention Control (IPC) excellence** – Excellence in IPC is required to minimise hospital transmission of Covid-19 to protect patients and staff. In order to achieve this careful planning, scheduling and organisation of clinical activity is required.

Option A – Do nothing	Option B – Green pathway	Option C – Green site
Absence of IPC excellence for non-Covid positive patients who require urgent elective care and/or urgent diagnostics leads to an increase in the incidence of Covid-19 in the population.	Blue activity would adhere to the same principles of IPC in preventing cross-contamination, but this activity is unplanned and less controllable. In addition, mixing staff between Blue and Green areas of hospitals leads to an increased risk of patients contracting Covid-19. Green and Blue pathways are for the purpose of undertaking clinical activity appropriately on a risk-based approach – standards of care are uniform across both pathways. Separate time slots and strict cleaning – Risk is minimised but not eliminated.	IPC excellence priorities and integrity can be fully met with Green site models as there is no mix of Blue and Green pathways. Clear inclusion criteria - limited to patients who are screened as Covid-19 negative, with strict social distancing applied. Isolated Blue activity from Green activity – Risk is further minimised (as compared to a Green pathway) but not eliminated.
Assessment: *IPC excellence – Condition not fully met*	***Assessment:*** *IPC excellence – Condition fully met*	***Assessment:*** *IPC excellence – Condition fully met*

2. **Capacity to deliver at scale** – theatres, staffing and estate. Clinical care provided during this Restore phase will be prioritised to treat cancer patients or those requiring care that is clinically urgent.

Option A – Do nothing	Option B – Green pathway	Option C – Green site
Absence of capacity to deliver care in a hospital setting for non-Covid-19 positive patients who require urgent elective care and/or urgent diagnostics leads to an increase in morbidity in the population.	Theatres – Limited capacity as theatre environment restricted by which theatres can be isolated to maintain IPC integrity.	Theatres – All surgery can be planned in a theatre environment which can be isolated to maintain IPC integrity. Full theatre capacity can be realised, as all available capacity is allocated to Green service.
Patients' anxiety is not addressed	Staffing – Robust screening, testing separate Green/Blue teams for sessions of care, unlikely to significantly increase workforce capacity.	Staffing – Robust screening with separate Green team. Support a return to work for staff who were risk assessed as high risk,

Option A – Do nothing	Option B – Green pathway	Option C – Green site
		thus increasing available workforce.
	Estate – Building could be physically separated into distinct Green/Blue areas with a defined point of access with Covid-19 checks and no contact with Blue staff and Blue patients. However, it is likely that complete separation will be challenging as common areas may still be shared with Blue staff and Blue patients. Patients concerns are partially addressed. Co-dependencies available on the same site but with Green/Blue split.	Estate – Building could be physically separated into distinct Green/Blue areas with a defined point of access with Covid-19 checks and no contact with Blue staff and Blue patients. Clear patient flow and site security No shared common areas with Blue staff and Blue patients, thus increasing available physical estate capacity for Green services. Increased Green area available addresses patient concerns to a greater degree than other options. Co-dependencies available on the same site but with Green/Blue split.
Assessment: ***Capacity to deliver at scale – Condition not met***	***Assessment:*** *Capacity to deliver at scale – Condition not fully met*	***Assessment:*** *Capacity to deliver at scale – Condition fully met*

3. **Future service resilience** – Amidst the material uncertainty of how long Covid-19 will last, the service will need to be resilient and capable of addressing ULHT's requirement over an extended timescale. As movement in and out of the county increase, a second wave of Covid-19 is plausible.

Option A – Do nothing	Option B – Green pathway	Option C – Green site
Absence of future resilience to deliver care in a hospital setting for non Covid-19 positive patients who require urgent elective care and/or urgent diagnostics leads to an increase in the incidence of disease and morbidity in the population (aggravated by a potential second wave)	A Green pathway may be suspended in the event of a surge response required for a second wave. As such, future service resilience is compromised amidst the material uncertainty of how long Covid-19 will be around.	A Green site can remain a Green site in a second wave, ensuring future service resilience. The Green site can transform into a dominant elective site throughout the duration of the Covid-19 pandemic.
Assessment: ***Future service resilience – Condition not fully met***	***Assessment:*** *Future service resilience – Condition not fully met*	***Assessment:*** *Future service resilience – Condition fully met*

What's the best way to meet these conditions? – Conclusion

A summary of the above assessment is provided in the table below:

Conditions	Option A – Do nothing	Option B – Green pathway	Option C – Green site
IPC excellence	*Condition not fully met*	*Condition fully met*	*Condition fully met*
Capacity to deliver at scale – theatres, staffing and estate	*Condition not met*	*Condition not fully met*	*Condition fully met*
Future service resilience	*Condition not fully met*	*Condition not fully met*	*Condition fully met*

The Green site option offers the maximum opportunity to protect patients and staff from hospital-acquired Covid-19. This approach to restoring urgent elective services and urgent diagnostics will ensure both speed and quality of access and provide patients and professionals with peace of mind. It also allows for isolated Blue activity from Green activity – conditional on the physical separation of building and no shared common areas where Green staff and Green patients mix with Blue staff and Blue patients.

As such, the proposed option is the introduction of a Green site for cancer surgery and urgent elective services and diagnostics.

Options appraisal – Where do we put it?

An assessment was carried out by joint ULHT clinical and managerial teams to identify options for a Green site in Lincolnshire which could support resuming elective and planned care in a setting.

A summary of the options identified is set out in the table below:

Green site options				
Lincoln	Pilgrim	Grantham	Louth	Independent sector (BMI Lincoln Hospital and Boston Ramsey Hospital)

Where do we put it? – Assessment

An assessment of each option was conducted against the aforementioned three conditions.

1. **Infection Prevention Control (IPC) excellence** – Excellence in IPC is required to minimise hospital transmission of Covid-19 to protect patients and staff. In order to achieve this careful planning, scheduling and organisation of clinical activity is required.

Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
IPC excellence priorities and integrity can be fully met as there would be no mix of Blue and Green pathways.	IPC excellence priorities and integrity can be fully met as there would be no mix of Blue and Green pathways.	IPC excellence priorities and integrity can be fully met as there would be no mix of Blue and Green pathways.	IPC excellence priorities and integrity compromised due to limited opportunity for social distancing.	IPC excellence priorities and integrity can be fully met as there would be no mix of Blue and Green pathways.
Assessment: *IPC excellence – Condition fully met*	***Assessment:*** *IPC excellence – Condition fully met*	***Assessment:*** *IPC excellence – Condition fully met*	***Assessment:*** *IPC excellence – Condition not fully met*	***Assessment:*** *IPC excellence – Condition fully met*

2. **Capacity to deliver at scale** – theatres, staffing and estate. Clinical care provided during this Restore phase will be prioritised to treat cancer patients or those requiring care that is clinically urgent.

Lincoln and Pilgrim

Should Lincoln or Pilgrim be chosen as the Green site, non-elective admissions (admissions to a ward that are unplanned and include emergency admissions) would be displaced at significant volumes per annum – ranging from 19,723 patients in Pilgrim to 29,743 patients at Lincoln. Comparatively, the 6,637 patients displaced from Grantham per annum is 22% of Lincoln's volume or 34% of Pilgrim's volume.

A breakdown of the non-elective admissions by site is provided below:

Site	Lincoln	Pilgrim	Grantham	Louth	ULHT Total
Total non-elective admissions	**29,743**	**19,723**	**6,637**	**2,756**	**58,859**
% of ULHT total non-elective admissions	51%	34%	11%	5%	100%

The patients admitted at Lincoln and Pilgrim hospitals from emergencies and un-planned routes could not be accommodated at any one hospital site. However, a redistribution of emergency and unplanned admissions from Grantham hospital could be accommodated at either Pilgrim or Lincoln sites, without exceeding safe occupancy levels. This is predicated on the reciprocal transfer of equivalent elective or planned patient admissions.

ULHT have already established limited Green pathways on Lincoln and Pilgrim hospital sites for cancer and urgent surgery. However, they cannot be expanded to meet the required patient need whilst meeting the set conditions. ULHT will continue to use these pathways for those patients requiring high dependency or intensive care post-operatively as this cannot be re-provided at an alternative green site. This is a risk-based approach compared with the implications of not operating.

Also, the urgent care response at Lincoln and Pilgrim is going to require increased physical estate, in order to comply with social distancing and IPC principles. An example of this is at Pilgrim where pre-op assessment clinic space is going to be re-tasked to support an increase in the size of the emergency department. Therefore, this will reduce the ability to deliver planned care at these sites.

Independent sector

Independent sector facilities in Lincoln (BMI) and Boston (Ramsey) will temporarily offer limited capacity to a small range of patients that can be treated, but they do not possess the necessary facilities to provide surgical services at scale.

Grantham and Louth

Louth and Grantham hospitals are considered as potential Green site models as these sites offer greater scope of services available, as they are larger than the Independent Sector sites.

Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
Theatres – 12 theatres of which 10 are currently designated for the Blue pathway. However, the theatre capacity for Blue pathway cannot be replicated or absorbed by any other site. As such, this would be detrimental to the wider population of Lincolnshire.	**Theatres** – 11 theatres of which 9 are currently designated for the Blue pathway. However, the theatre capacity for Blue pathway cannot be replicated or absorbed by any other site. As such, this would be detrimental to the wider population of Lincolnshire.	**Theatres** – 4 theatres, all of which are currently unused. All theatres can be used for planned surgery. A Green site can be delivered providing substantial cancer surgical capacity. No other site can provide the level of non Covid-19 capacity.	**Theatres** – 2 theatres of which all are currently unused. All theatres can be used for planned surgery. Impact on cancer and urgent care elective operating will be negligible as the types of cases that can be cared for in Louth is very limited. Likely <5 Cancer surgery operations/week. *(Future application of Louth Capacity will be of great benefit in the Recovery Phase once an approach to social distancing measures have been enacted.)*	**Theatres** – The independent sector has limited capacity to a small range of patients. BMI Lincoln Hospital – with only 1 theatre the hospital would not be able to offer the level of cancer surgery capacity required to address the current need. Boston Ramsey Hospital – smaller than BMI Lincoln Hospital and there is very limited scope to conduct cancer surgery.

Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
Staffing – Limited due to high vacancy rates	**Staffing** – Limited due to high vacancy rates. In addition, the high dependency on agency is a risk to IPC excellence.	**Staffing** – Core staffing model and baseline can support a Green site. This eliminates the reliance on agency and creates a lower risk Green area from an IPC perspective, whereby at-risk staff can return to work.	**Staffing** – Limited – small establishment who work with a specific subgroup of surgical patients only.	**Staffing** – Core staffing model and baseline can support a Green site Both BMI and Ramsey depend on NHS Surgeon and Anaesthetic workforce.
Estates – Separate site with single point of access. Clear patient flow and site security No shared common areas with Blue staff and Blue patients. Co-dependencies available on the same site.	**Estates** – Separate site with single point of access. Clear patient flow and site security No shared common areas with Blue staff and Blue patients. Co-dependencies available on the same site.	**Estates** – Separate site with single point of access. Clear patient flow and site security No shared common areas with Blue staff and Blue patients. Co-dependencies available on the same site.	**Estates** – Green site can be obtained with support from NHS Property Services Separate site with single point of access. Clear patient flow and site security No shared common areas with Blue staff and Blue patients. Co-dependencies available on the same site.	**Estates** – Separate site with single point of access. Clear patient flow and site security No shared common areas with Blue staff and Blue patients. Co-dependencies available on the same site.
Assessment: *Capacity to deliver at scale – Condition not fully met*	***Assessment:*** *Capacity to deliver at scale – Condition not fully met*	***Assessment:*** *Capacity to deliver at scale – Condition fully met*	***Assessment:*** *Capacity to deliver at scale – Condition not fully met*	***Assessment:*** *Capacity to deliver at scale – Condition not fully met*

Note 1: Independent sector - BMI Lincoln Hospital and Boston Ramsey Hospital

3. **Future service resilience** – Amidst the material uncertainty of how long Covid-19 will last, the service will need to be resilient and capable of addressing ULHT's requirement over an extended timescale. As movement in and out of the county increases, a second wave of Covid-19 is possible.

Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
The capacity for Blue patients cannot be replicated or absorbed by any other site, as such this would not ensure future service resilience.	The capacity for Blue patients cannot be replicated or absorbed by any other site, as such this would not ensure future service resilience.	A Green site at Grantham could remain a Green site in a second wave, ensuring future service resilience. The Green site can transform into a dominant elective site throughout the duration of the Covid-19 pandemic.	A Green site at Louth could remain a Green site in a second wave, ensuring future service resilience once social distancing measures have been enacted. The Green site can remain a dominant elective site throughout the later stages of the Covid-19 pandemic once social distancing measures have been enacted.	A Green site in the Independent sector could not remain a Green site as national contracting is due to end, as such this would not ensure future service resilience.
Assessment: *Future service resilience Condition not fully met*	***Assessment:*** *Future service resilience – Condition not fully met*	***Assessment:*** *Future service resilience – Condition fully met*	***Assessment:*** *Future service resilience – Condition fully met*	***Assessment:*** *Future service resilience – Condition not fully met*

Note 1: Independent sector - BMI Lincoln Hospital and Boston Ramsey Hospital

Where do we put it? – Summary

A summary of the assessment is set out in the tables below:

Conditions	Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
IPC excellence – protecting patients and staff	Condition fully met	Condition fully met	**Condition fully met**	Condition not fully met	Condition fully met
Capacity to deliver at scale	Condition not fully met	Condition not fully met	**Condition fully met**	Condition not fully met	Condition not fully met
Future service resilience	Condition not fully met	Condition not fully met	**Condition fully met**	Condition fully met	Condition not fully met

Where do we put it? – Conclusion

Grantham is chosen as the only viable option, as it has the ability to create a large-scale surgical service, whilst having the greatest level of IPC protection to patients and staff and provides future service resilience.

Furthermore, the assessment in this report indicates that Grantham is the only site where urgent care services can be provided whilst maintaining the greatest level of confidence of a non-Covid-19 Green service. i.e. the ability to separate patients with confirmed Covid-19 status from those that are undifferentiated.

Trust service configuration

This temporary service change is part of the Trust's broader response to Covid-19 and part of a holistic approach to Restore and Recovery phases.

A summary of re-configuration required by site is provided below:

Site	High level summary	Changes required from the existing reconfiguration
Lincoln	Blue site with Green pathway for Critical Care Surgery, Radiotherapy and Cardiac Surgery Only	Cease operating on all other cases other than critical care surgery.
Pilgrim	Blue site with Green pathway for Critical Care Surgery Only	Cease operating on all other cases other than critical care surgery.
Grantham	Substantially Green site with all services being devoted to elective/cancer care. Increase capacity. Isolated Blue UTC service.	Increase elective care beds and theatre capacity for cancer. Remove medical admissions and transfer to blue sites. Convert A&E to Urgent Treatment Centre ('UTC') and make physical estate changes to isolate from the rest of site. UTC isolation can be done in a way that removes staff/patient movement between Blue and Green areas *(see Grantham – Blue – Urgent Treatment Centre Overview Section of this report).* Level 1 unit although does not offer critical care can accommodate more surgical capacity that no other Green site has.
Louth	Green site once work has completed with NHS property services	Restart all ULHT services once physical changes have been made to support safe restart.
BMI Lincoln Hospital	Green site limited to elective services. Ophthalmology initially then orthopaedics.	Reopen as currently closed to support staffing at other sites
Boston Ramsey Hospital	Green site limited to elective services. TBC	Reopen as currently closed to support staffing at other sites

NHSE/I change protocols

The proposed change to a Green site at Grantham for elective services and diagnostics would ordinarily constitute 'service change' and require consultation under the public involvement and consultation duties of commissioners as set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs, and require the subsequent service change assurance process as detailed in the 'NHS Planning, assuring and delivering service change for patients' 2018 guidance.

However, these proposed changes are being made as part of the level 4 incident response and are deployed in response to Covid-19. As such, they are not subject to the usual legislative process.

The changes proposed are temporary in nature as part of the level 4 incident response. Any proposal to make them permanant would be subject to formal consultation.

This is completely separate from the process to make any permanent significant changes to services, which would be led by the NHS Lincolnshire CCG, requires formal public consultation in line with national guidance and is within the authority of the CCG to decide.

In addition, these changes will be subject to quarterly reviews against the aforementioned conditions and to ensure any and all alternatives for improvement of services are actioned.

NHSE/I change protocols and registration can be followed with cases being submitted so that the critical pathway for implementation date can be maintained. It is not anticipated that full implementation will be on 15th June 2020, but that the process will commence from this date.

The timescale for the Green site is the duration of Covid-19 – the Green site will be set up to at least 31 March 2021. As such, the Green site will be part of the Restore phase and the Recovery phase.

The changes proposed are a response to a Level 4 national incident, and as such this paper does not include financial considerations. This does not disregard the Trust's approach to financial governance and sound financial stewardship which are considered throughout the decision-making process.

Green site model - detailed design

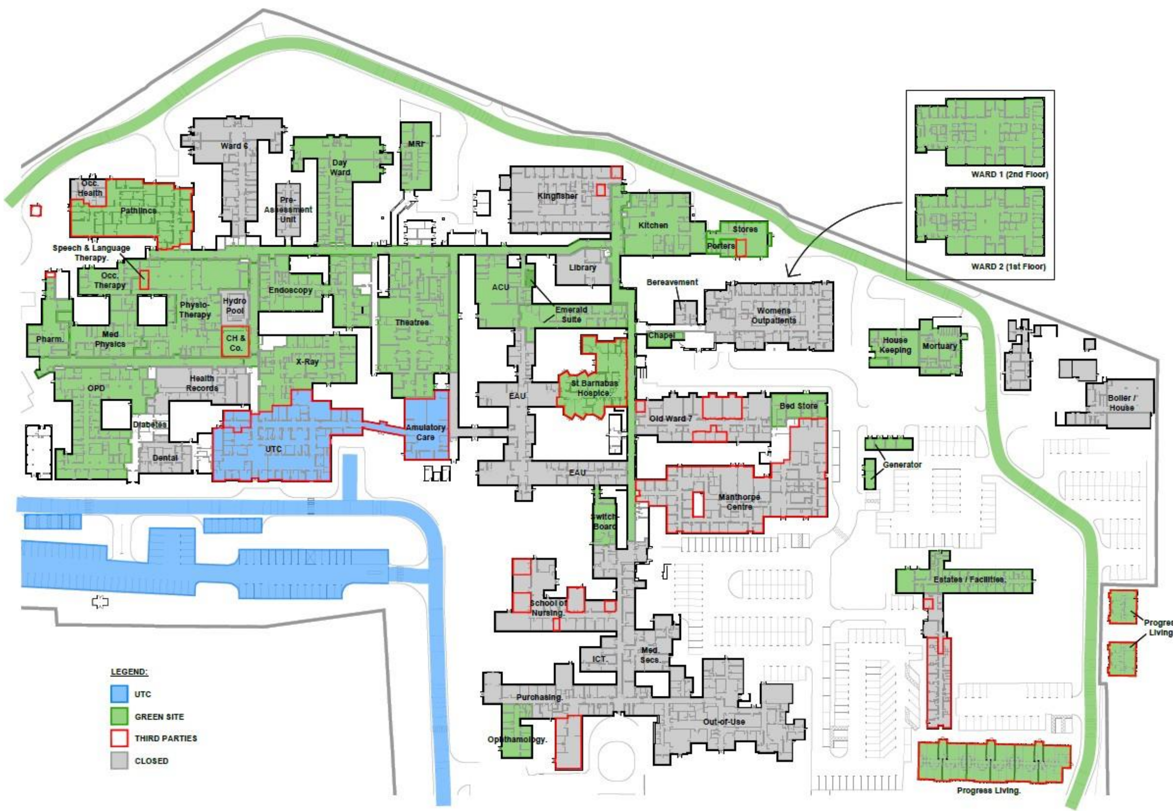
The proposal is for ULHT to establish a Green site at Grantham for elective and diagnostic activity (see Appendix 2 for detailed clinical model).

The three conditions mentioned earlier for a proposed solution require adherence to the following design principles:

- Eliminate the risk of nosocomial infection reducing chance of contracting Covid-19 in our hospitals.
- Access controlled by exemplary IPC and Personal Protective Equipment (PPE) compliance.
- Conform to all guidance and standards provided within the NHS IPC Board Assurance Framework with strict adherence to the NHSE Hygiene Code.

- Adhere to a strict and rigorous regime of monitoring and surveillance for Covid-19 of our patients and staff along with reinforcing social distancing and hand hygiene guidance. This will include the use of any new testing.
- Clinical care provided during the Restore phase will be prioritised to treat cancer patients or those requiring care that is deemed to be clinically urgent, ensuring support is in place to enable patients to comply with requirements - mental capacity, social and other factors.
- Maintain consistency in staff and equipment allocation and restrict movement of staff and equipment between different sites and areas which will support minimising the risk surface contact transmission accompanied by a rigorous cleaning regime.

An overview of the Green site with an isolated Blue UTC and associated car park is shown below:



The Restore phase will focus on cancer surgery and clinically urgent elective surgery and diagnostics.

The services provided at Grantham in this proposal have been assessed against the design principles. The services which will be included are as follows:

Specialty	Service
Surgery (day cases)	Cancer (theatre)
Surgery (day cases)	Clinic - cancer (dermatology)
Surgery (day cases)	Resus
Surgery (day cases)	Sepsis
Surgery (day cases)	Hospital at night
Surgery (theatres and clinics)	General surgery
Surgery (theatres and clinics)	Ear, Nose and Throat (‘ENT’)

Surgery (theatres and clinics)	Oral and maxillofacial ('OMF') (including skins)
Surgery (theatres and clinics)	Orthopaedics
Surgery (theatres and clinics)	Ophthalmology and orthoptics
Surgery (theatres and clinics)	Urology
Surgery (theatres and clinics)	Gynaecology
Surgery (theatres and clinics)	Breast
Surgery (theatres and clinics)	Colorectal surgery
Acute Care Unit (Level 1 care)	Acute Care Unit (Level 1 care)
Medicine	Ambulatory Care
Diagnostics	CT
Diagnostics	MRI
Diagnostics	Ultrasound
Diagnostics	X ray/Screening room hybrid
Diagnostics	Endoscopy
Diagnostics	Clinical engineering
Diagnostics	Ad hoc Complex hearing aid support
Clinical Support Services	Pathlinks
Pharmacy	Full Pharmacy Service
Back office functions	Switchboard
Outpatient Services	OPD Nursing
Outpatient Services	Access, Booking and Choice
Outpatient Services	Health Records
Outpatient Services	Outpatient Department Reception
Cancer Services	Hospice (St Barnabas)
Cancer Services	Chemo Suite/ Oncology and Haematology
Therapies	Physio – inpatient support
Therapies	Occupational Therapy – inpatient support

A number of services will be excluded as they do not currently meet the design principles. These are as follows:

Specialty	Service
Surgery (theatres and clinics)	Paediatrics – (Paediatric surgery will continue to operate on Green Pathways at LCH and PHB sites and would not change from Manage phase processes*)
Out-patient activity	Diabetes
Out-patient activity	Therapies
Out-patient activity	Upper GI
Out-patient activity	Cardiology
Out-patient activity	Endocrinology
Out-patient activity	Nephrology
Surgery (day cases)	Critical care outreach
Orthopaedics	Fracture follow up clinics
Orthopaedics	Elective clinics
Orthopaedics	X-ray guided injection lists
Orthopaedics	Ophthalmology - elective clinics
Orthopaedics	Outpatient injection lists
Urology	Uroflows
Surgery (theatres and clinics)	Orthodontics
Surgery (theatres and clinics)	Vascular
Back office functions	Outpatient Department
Back office functions	Procurement
Back office functions	Social services
Back office functions	Education team
Back office functions	Friends of Grantham
Medicine	Emergency Department
Medicine	Medical Ward Beds

Family health	Fertility
Family health	Antenatal
Family health	Urogynaecology
Family health	Colposcopy
Family health	Hysteroscopy
Family health	Maternity clinics
Family health	Maternity scanning
Family health	General gynaecology
Family health	Breast - Emerald Suite
Family health	Community paediatrics – Kingfisher
Family health	Community paediatrics - Day cases
Diagnostics	Nuclear medicine
Diagnostics	Cardiac & Respiratory Physiology
Outpatient Services	All outpatient services
Cancer Services	Palliative Care
Cancer Services	Abdominal aortic aneurysm ('AAA') screening
Therapies and Rehabilitation	Physiotherapy
Therapies and Rehabilitation	Occupational Therapy
Therapies and Rehabilitation	Dietetics
Therapies and Rehabilitation	Speech and Language Therapies
Therapies and Rehabilitation	Rehabilitation

* Paediatric services at Grantham are limited to Ootpatient services and do not include paediatric surgery. Paediatric surgery requirements to support safe care can only be offered at Lincoln and Pilgrim hospitals(such as facilities equipment and expertise in resuscitation) and, as such, Green paediatric pathways will be used at Lincoln and Pilgrim to continue urgent surgery.

This list will be reviewed regularly with services being permitted to operate on-site when they can demonstrate IPC compliance.

Services no longer continuing in the Green site will be relocated to alternative accommodation offsite, and staff will be redeployed where necessary. Delivery teams will work with all services and teams affected and will use the flexible and remote working solutions developed in the Manage phase of the response to the pandemic. Where these solutions cannot be deployed, accommodation options will be developed that reduce the distance of transfer, using other health and care sector facilities.

A rehabilitation inpatient unit will be established during the recovery phase to support rehabilitation of Green patients. This will provide inpatient services for confirmed Covid-19 negative patients from the Grantham area requiring step down care from Lincoln or Pilgrim hospitals.

The rehabilitation inpatient unit will "Go live" in October/November 2020 in the Recovery phase. This unit will be critical to winter planning in conjunction with the recovery phase.

Grantham – Blue – Urgent Treatment Centre (UTC) overview

The preferred Green site model at Grantham will include an Urgent Treatment Centre in an isolated Blue area.

It will be equipped to diagnose and treat many of the most common ailments people go to A&E for.

Patients may be referred to an urgent treatment centre by NHS 111 or by a GP. You can also just turn up and walk-in.

Conditions that can be treated at an urgent treatment centre include: *(* Please note this is not an exhaustive list)* :

- sprains and strains
- suspected broken limbs
- minor head injuries
- cuts and grazes
- bites and stings
- minor scalds and burns
- ear and throat infections
- skin infections and rashes
- eye problems
- coughs and colds
- feverish illness in adults
- feverish illness in children
- abdominal pain
- vomiting and diarrhoea
- emergency contraception

[1] *National Urgent Treatment Centre standards 2017*

Isolation can be achieved in a way that prevents staff crossing between Blue UTC and Green areas and does not compromise IPC principles.

The preferred model converts the A&E, currently open from 8am to 6.30pm, into a 24/7 walk-in UTC treating patients with a NEWS score of 4 and below and using existing x-ray imaging facilities dedicated to the UTC.

The conversion of the Grantham A&E to a UTC affords the options of having completely Green diagnostics and inpatient services.

Grantham – Blue – Ambulatory Care Unit overview

The preferred Green site model will retain an Ambulatory Care Unit in the isolated Blue area connected to the UTC. The Ambulatory Care Unit will be Consultant and ACP delivered.

The Ambulatory Care Unit offers same day care to patients at the hospital – providing early urgent diagnosis of an urgent clinical condition and treating patients with a NEWS score of 4 and below.

Patients are able to access the Ambulatory Care Unit via walk-ins or via GP referral. The unit will be open from 8am to 6pm – and will be staffed to 8pm to allow a buffer for all treatments to be completed.

[1] https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

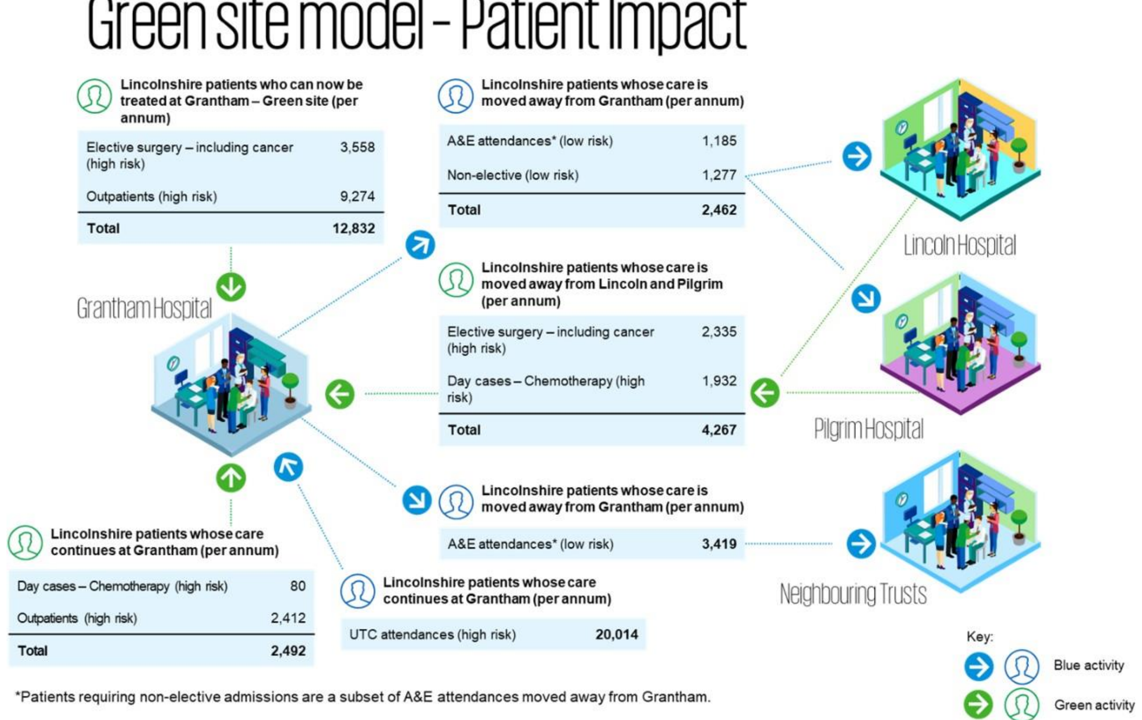
Patients are assessed, diagnosed, treated and are able to go home the same day - this affords patients the benefit of not being admitted into hospital overnight. Currently, on average 10 patients a day access the Ambulatory Care Unit.

Diagnostics services in Ambulatory will be limited to plain film x-ray and pathology. Ultrasound services are also being explored. Pathology services will have closed links to laboratories to protect the Green site status. As such, there will be no access to CT, MRI or other out-of-departmental service. GPs will therefore refer patients that require more than the diagnostics offered to a different acute site which could be; Lincoln, Pilgrim, Nottingham or Peterborough (dependent on the patient's location).

The potential for medical inpatient and diagnostic services to share Blue and Green services has been examined. This option failed to meet the IPC principles of a Green site.

Green site model – Likely patient impact

A summary of the patient impact of the Green site model is provided below:



* *The numbers described in the above infographic are representative of known modelling assumptions at the point of production of this report. Throughout Covid-19 pandemic both emergency and planned demand for services have changed much more than normal seasonal variation and as such whilst this has been considered it does reduce the accuracy of future forecasts.*

Green site – Elective and diagnostic activity – Likely patient impact

Overall, the Green site at Grantham will positively impact the population of Lincolnshire. The case for change evidenced the requirement to temporarily reconfigure services to address the impact on patients as a result of the Covid-19 surge.

The following details how the drivers for change are addressed:

Cancer performance

The volume of patients treated with cancer surgery pre Covid-19 was 35 per week.

For a short period during the latter two weeks of April 2020, cancer surgery was stopped whilst the necessary preparation was undertaken to create discrete Green and Blue pathways. Since the beginning of May, with the introduction of Green and Blue pathways cancer surgery has increased from nil to 22 per week, however, further increases are restricted due to Green pathway capacity at Lincoln and Pilgrim.

The introduction of the Green site at Grantham, this will give ULHT the capacity– in addition to the existing Green pathways – to exceed the previous pre Covid-19 level and deliver cancer surgery for all of Lincolnshire – reducing waiting times and improving patient outcomes.

The Green site at Grantham will support delivery of all cancer surgical activity for patients across Lincolnshire that require Level 1 post-operative critical care. Within 2-3 weeks there will be no waiting list for cancer surgery.

That would be the case for the majority of patients needing surgery for breast, gynaecology, ENT/OMF and urology malignancies.

Patients needing high dependency and critical care post-operatively will continue to be operated on at Lincoln and Pilgrim through their Green pathways, as they are at present.

Chemotherapy will continue at Grantham and, as such, 80 haematology patients and oncology patients will receive treatment. Chemotherapy will also include patients from Lincoln and Pilgrim. As such, 1,932 haematology patients and oncology patients will move from Lincoln and Pilgrim to safely receive treatment at Grantham.

Planned elective

Planned elective surgery has ceased, resulting in significantly increased waiting times. The introduction of a Green site at Grantham will enable planned elective surgery to resume in the Restore phase and maintain the waiting list level ensuring that there is no further deterioration of waiting times.

The number of patients receiving elective surgery for the following specialities at Grantham; colorectal, urology, gynaecology, and cancer minor OPD procedures in dermatology and ENT/ oral Maxillofacial, will increase by over 3,500 patients per annum with Grantham as a Green site.

In addition, the number of patients receiving outpatients care can increase by over 9,000 patients per annum with Grantham as a Green site.

The proposal provides a benefit to all patient groups in an innovative way through providing the ability to continue with elective care in a controlled environment, to stabilise, and avoid the patient waiting list for elective treatments growing whilst we manage the Covid-19 situation.

To mitigate the impact of the extra travel requirement on patients, particularly those on the East Coast, ULHT is working with its partners to provide effective transport solutions. This is not expected to be a constraint on the deliverability of the model given recent experience in the Manage phase of response to Covid-19 pandemic.

Theatre capacity – The theatre capacity available in the Restore phase will only support cancer surgery and limited non-cancer elective surgery. The limited non-cancer surgery capacity will be sufficient to prevent further increase in waiting lists. More theatre capacity will be required to significantly reduce waiting lists.

Urgent diagnostics

The introduction of a Green site model at Grantham will enable urgent diagnostics to increase in a low risk environment where all patients including those who may be vulnerable or susceptible to infection can receive the necessary tests. The capacity will ensure that patients will receive diagnostics in a timely manner, preventing further deterioration of waiting times and reducing the risk of delay in diagnosis.

The Green site model will support the majority of diagnostics required for cancer patients and urgent elective patients, whilst adhering to the Infection Prevention and Control design principles.

Endoscopy – Endoscopy procedures are aerosol generating and current guidance is impacting on service capacity due to IPC controls and cleaning time required between patients. Current endoscopy capacity is reduced by 70% of normal activity and is focused on cancer and urgent work.

The demand management pathways for upper GI and lower GI introduced during the Manage phase are proving successful. Patients are currently scheduled for barium/CT CAP scans in the first instance and results are reviewed by a senior clinician to determine whether patients still require an endoscopy procedure. This will continue in the Restore phase.

Modelling indicates that the Green site will support endoscopy procedures for all cancer patients, whilst adhering to the IPC design principles, based on 12-hour sessions running 7 days a week.

Additional capacity is likely to be required, as due to IPC considerations the number of endoscopies performed cannot rapidly return to the pre Covid-19 level. As such, in the recovery phase, Louth will be operationalised as a Green endoscopy pathway.It is also possible that the Independent sector capacity can be utilised as needed.

Grantham – Blue – Urgent Treatment Centre – Likely patient impact

The conversion from an A&E to a UTC at Grantham will impact the population of Lincolnshire.

Lincolnshire patients whose care is moved away from Grantham (per annum)

The majority of patients (over 20,000 attendances per annum who attended the A&E) will be able to attend the UTC and will benefit from the increase in opening hours from 8pm to 6.30pm to a 24/7 walk-in service.

Nevertheless, 4,603 patients (12 per day) who attend Grantham A&E (19% of total attendances) will be treated at other hospitals as a result of the reduction of NEWS score – of these, 1,184 patients (3 per day), will be treated at Lincoln and Pilgrim and 3,419 patients (9 per day) will be treated at other neighbouring Trusts.

In addition, 1,560 patients (4 per day) of the 4,603 patients who will be treated at other sites will require admission at these other sites. Oof these 401 patients (1 per day) will be admitted and treated at Lincoln and Pilgrim and 1,159 patients (3 per day) will be admitted and treated at other neighbouring Trusts.

Transfers from Grantham as a result of A&E to UTC conversion and withdrawal of medical beds at Grantham

Some patients who attend the UTC will require admission and will be transferred to a different site, as the UTC would not support direct emergency admission to Grantham hospital. Due to the provision of the Ambulatory Care Unit, fewer patients will require transfer to another hospital site than without.

In total, 874 patients (3 per day) will be required to transfer to other sites, the majority of whom will be transferred to other ULHT sites. This represents an additional 20 patient transfers, as 854 patients were already transferred to other ULHT sites in April 2019 to March 2020 under existing protocols.

Re-routed admission from multiple non-A&E routes as a result of a withdrawal of medical beds at Grantham

A total of 1,198 admissions (3 a day) were made to medical beds at Grantham from multiple non-A&E routes between April 2019 and March 2020.

As medical beds will be withdrawn at Grantham, 476 patients will be treated at the Ambulatory Care Unit (largely GP referrals) and 772 patients will be re-routed and admitted at Lincoln. As previously described in this report, these volumes describe previous years' referral models pre Covid-19 and as such may be overstated.

Equality impact assessment and quality impact assessment have been completed and support this configuration (see Appendices 3 and 4).

Addressing the case for change

There will be no medical bed admissions at Grantham to adhere to IPC principles, and as such it would not be possible to have an A&E in the proposed configuration. Nevertheless, converting the A&E to a UTC maintains urgent care for the Grantham population which allows for colocation of a green site and urgent care.

Out of hours (OOH) services at Grantham hospital will continue to operate as part of the Blue – UTC footprint, and therefore patient pathways that involve accessing the existing OOH will be unaffected by changes.

Green site and Blue UTC – Staff impact

The Green site model at Grantham will impact staff at ULHT. The communications and engagement strategy contains detail of the internal communications and staff engagement actions, as staff morale and support is critical to the success of this temporary service change.

To reduce the footfall on the site and maintain IPC principles, a review has been undertaken to identify the staff that can be relocated elsewhere. In total, c.600 ULHT staff and an additional 50-75 staff members from third party tenants have been identified for relocation. Many of these staff are already working from home or have been redeployed as part of the Manage phase of Covid-19 response. The remaining affected staff will be supported in transition to work from home, from a different ULHT site or in the community as required.

In total, the initial configuration of the Green site and Blue UTC will require c.200 staff. This will increase as more services are initiated with the Green site IPC principles

The workforce will be supported by careful adherence to IPC principles and embedded culture of IPC excellence. ULHT will undertake the following reasonable and practicable steps to ensure that staff do not contract or convey Covid-19:

- Defined protocol for migration of staff between sites (especially surgical teams) to ensure no Blue to Green transfer on the same day.
- Screening by wellbeing assessment including temperature check at the start and end of each shift.
- Programme of random staff swabbing to screen for asymptomatic carriers – work is being undertaken to refine this approach.
- Risk assessment for staff not currently in patient-facing roles due to previous risk assessment to facilitate work at Green site.
- Swabbing if symptomatic or for contact tracing - adhere to the new National Test and Trace system.
- Maintain consistency in staff and equipment allocation and restrict the movement of staff and equipment between sites, accompanied by a rigorous cleaning regime that minimises the risk of contact transmission.
- Maintain the advice and guidance in respect of hand washing and social distancing.

The approach will be underpinned by education, training, awareness and compliance and will be consistent for all staff irrespective of the type of activity they are undertaking – Green and Blue.

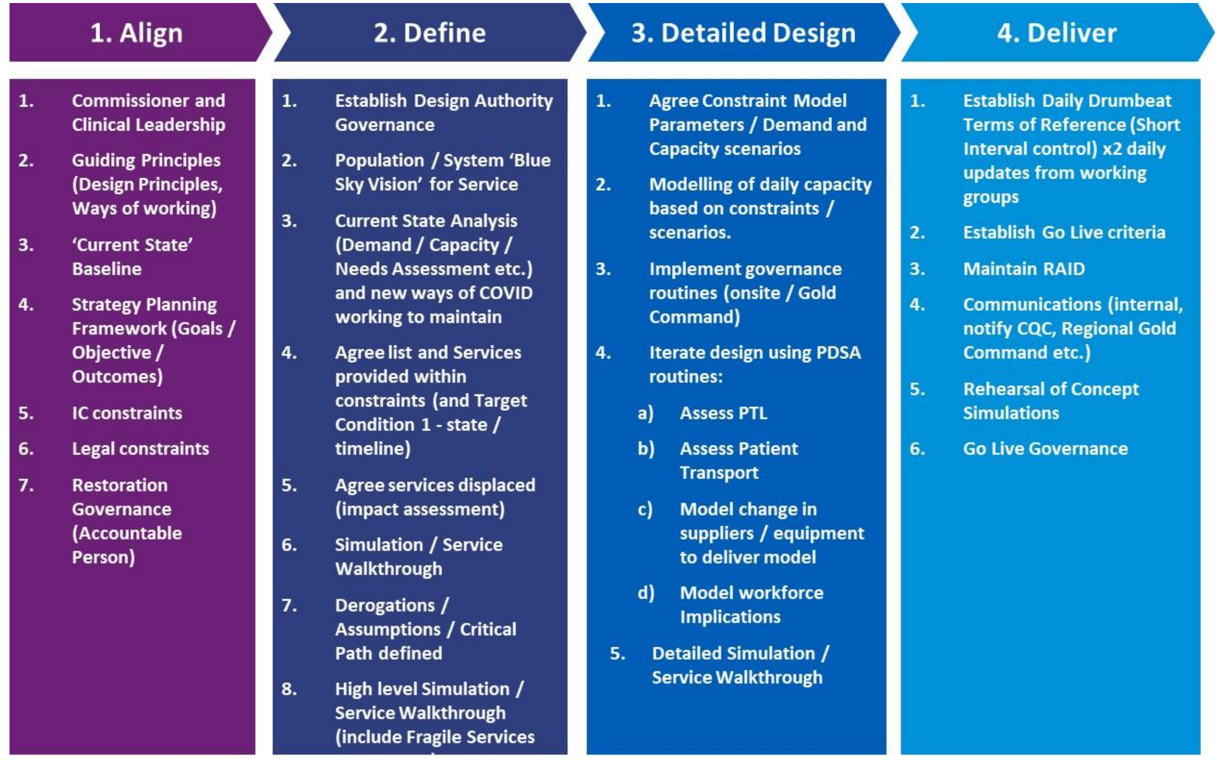
The proposal provides a benefit to staff from the perspective that it provides an opportunity for staff in vulnerable groups to return to work safely in a Green environment following a thorough risk assessment with the Occupational Health Department.

Under this proposal, staff who believe they are vulnerable are able to request a Risk Assessment via their line manager and also access Occupational Health support. Staff who are currently working at home due to the Covid-19 risks may be supported to return to work safely on a Green site, subject to a full risk assessment being completed by the Occupational Health Service.

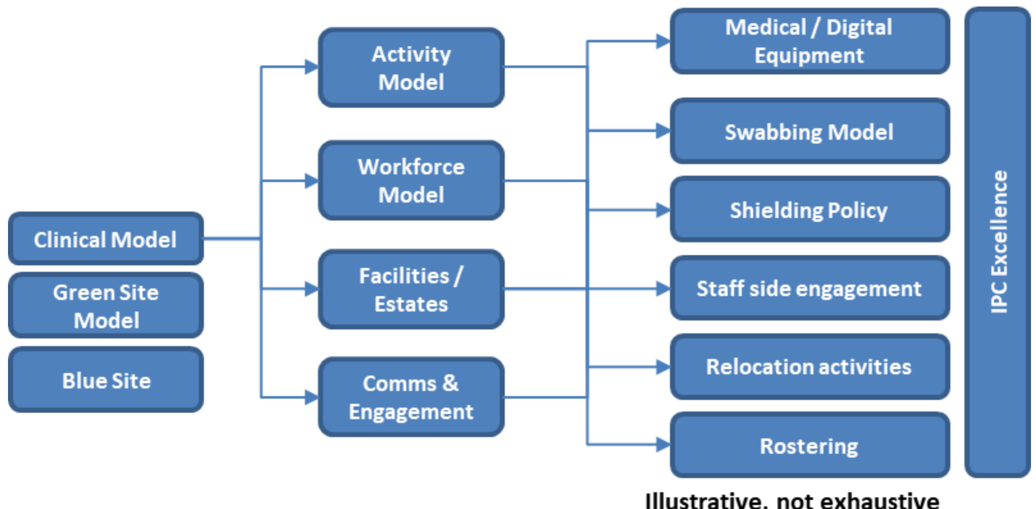
Implementation plan

A Task and Finish group, with programme support from KPMG, was established on 14 May 2020 to progress through to a start date of 15 June 2020.

The programme is to follow the following four key stages:



Programme overview



Illustrative, not exhaustive

Programme Governance

Leadership

Leadership is provided by the following:

- Director of Finance and Digital / Senior Responsible Officer
- Chief Operating Officer / Restore Programme Lead
- Managing Director of Surgery / Programme Lead
- Clinical Director of Surgery
- Clinical Director Clinical Support Services
- Divisional Clinical Lead, Clinical Support Services
- Deputy Divisional Nurse, Lead Nurse Specialty Medicine
- Managing Director of Medicine
- Managing Director of Clinical Support Services
- Managing Director of Family Health

Programme Review

- The Programme Review is a meeting chaired by the Programme Lead.
- The Programme Review ensures that critical decisions are made on key problems that are raised from the Task and Finish group workstreams.
- Following the Programme Review, decisions and actions will be cascaded back to workstreams to action. Any critical decisions, issues, or risks will be raised from Programme level to Gold Command.
- The Programme Review occurs daily and will cover:
    - Workstream updates / review progress against plan (by exception)
    - Establish the week's key milestones
    - Cascade the week's key activities and meetings

- Review critical milestones, risks, assumptions, issues and decisions to escalate
- Escalations and check in (driven by plan milestones) to Gold Command – with a minimum of 1 update per week.

NHS
United Lincolnshire Hospitals
NHS Trust

Programme Structure

Gold Command – Executive Committee

SRO

Elective Programme Leadership Team

Programme Lead

Project Workstreams

Procurement (PPE / Consumables)

Estates

HR / Workforce

Operations

Clinical and Operational Model*

Pharmacy

Compliance and Legal

Education, Training

Clinical Governance & Protocols

Comms

Pathology

Radiology

Medical Bed Reduction

Modelling (Support)

Third Party Partners

UTC

Patient Transport

IPC

Digital and IT

LCHS

*includes the Site Ops Teams

Patient-centred ◆Respect ◆ Excellence ◆Safety ◆ Compassion

NHS
United Lincolnshire Hospitals
NHS Trust

Timeline

W/C 8 June | W/C 15 June | W/C 22 June | W/C 29 June

Governance
- Trust Board paper published – 8 June
- Public Trust Board – 11 June
- Decision to proceed – 11 June
- IPC review and sign off – 16 June
- IPC review and sign off – 23 June

Blue – UTC
- Detailed planning – 8 June
- Rostering UTC commences – 15 June
- Gold - Final Go/ No Go Decision – 21 June
- Go live - 22 June 2020

Green clinical model
- Detailed planning – 8 June
- Medical beds transition commences – 15 June
- Activity planning commences – 15 June
- Patients programme of testing confirmed – 17 June
- All medical patients seen, treated and discharged/ transferred – 19 June
- Rostering Green model commences – 22 June
- Patient testing commences – 25 June
- Gold - Final Go/ No Go Decision – 28 June
- Assessment against "Go Live criteria"

Workforce
- Detailed planning – 8 June
- Workforce engagement commences – 11/12 June
- Staff programme of testing confirmed – 17 June

Comms
- Detailed planning – 8 June
- Internal Comms released – 11 June
- External Comms released – 11 June
- Internal Comms released – 19 June
- Internal Comms released – 22 June
- Internal Comms released – 26 June

Support services and Estates
- Detailed planning – 8 June
- Estates works scoping complete – 9 June
- Theatre deep clean completed – 12 June
- Support services and Estates programme commences – 12 June
- Support services and Estates programme finalised – 22 June
- Ward deep clean completed – 22 June
- All non-essential support services relocated – 26 June
- Support services and Estates operational – 28 June

PPE, consumables and medical equipment
- Detailed planning – 8 June
- PPE, consumables and medical equipment procurement commences – 12 June
- PPE and medical equipment relocated (if required) – 26 June
- PPE et al operational – 28 June

Third party partners
- Space requirements finalised – 10 June
- Third party partners engaged commences – 12 June
- Third party partners services relocated – 26 June
- Third party partners services operational – 28 June

Go live - 29 June 2020

Key:
- System/NHSE/I sign off
- IPC sign off
- Trust Board sign off
- Gold command sign off
- Milestone
- Patients

Patient-centred ◆Respect ◆ Excellence ◆Safety ◆ Compassion

Task and Finish Group update

All workstreams in the Task and Finish group are aligned and have commenced detailed planning. The workstream leads are awaiting the Trust Board decision to proceed in order to commence engagement with staff and third parties and completed this detailed planning ready for the start date of 15 June 2020.

A summary of work to date and next steps is provided in the table below:

Workstream	Work to date – 25 May 2020	Next steps
Green site – clinical model	- Green clinical model confirmed, including expected activity (See Appendix 2) - Staffing model (numbers and skill mix) confirmed - Modelling team has provided a prediction as to when all the outstanding Level 2 and 3 cancer surgery will be cleared	- Activity to be confirmed for outpatients, endoscopy and day case chemo - Modelling team to include urgent elective surgery - Confirm IPC – patient testing regime and demand - Communicate Clean IPC policy for movement of staff and equipment, ensuring Green site, maintaining key principles
Blue – UTC	- Blue UTC model confirmed - Modelling of displacement and transfers as a result of the conversion of the A&E to a UTC and withdrawing medical beds admission has commenced	- Staffing model (numbers and skill mix) to be confirmed to support 24/7 walk-in centre - Finalise medical beds “wind down” plan in transition period - Modelling of displacement and transfers as a result of the conversion of the A&E to a UTC to be completed
Workforce	- Identification of staff volume on Grantham site - Confirmation of staffing model and requirements across all staffing groups - Retraining requirements outlined - Review commenced with OCI Health for a return to work for staff groups that are shielding	- Commence engagement with clinical staff, admin staff, staff side and non-ULHT staff (who are on site at Grantham) after Trust Board decision to proceed - Confirm IPC – staff testing regime and demand
Communication	- A comprehensive Communications and Engagement strategy has been developed for staff, the public, the media and other third parties	- Commence communication and engagement after Trust Board decision to proceed

Patient-centred ◆Respect◆ Excellence ◆Safety◆ Compassion

Estates	- Confirmed feasibility to isolate UTC from the Green site - Estates works required for Green site confirmed - Identified all third parties who occupy space at Grantham and which will require relocation - Staffing model confirmed - Site security requirement confirmed - IPC requirements on estates confirmed (e.g. fogging of theatres and wards)	- Confirm facilities and catering plans - Confirm emergency maintenance plan to ensure it preserves IPC integrity - Create signage around estates after Trust Board decision to proceed and engagement commences
PPE and consumables	- Commenced review of PPE requirements based on clinical model	- Finalise PPE requirements and scale supply to meet
Clinical Support Services	- Radiology and imaging – equipment identified for Green site and UTC - Pharmacy – confirmation of ability to support wards - Pathology – total capacity confirmed	- Radiology and imaging –confirm relocation of any diagnostics which will need to be completed on a different site - Pharmacy – ASEPTIC 7 day pharmacy to be confirmed - Pathology – align demand with capacity
Patient Transport	- Contract meeting with CCGs undertaken for initial scoping and confirmation of requirements	- Commence engagement with third party providers after Trust Board decision to proceed

Conclusion/Recommendations

Having considered all of the available options, the option that satisfies the full criteria set is the temporary change of services at Grantham as a Green site with a Blue isolated UTC. This is combined with the continued limited use of Green pathway services at Lincoln and Pilgrim hospitals for cancer surgery that requires high dependency or critical care facilities.

This paper has outlined the following:

- A summary of the case for the temporary change of services provided by the Trust as part of its response to the level 4 incident declared on 30 January 2020.
- The options considered and the preferred option.
- The legal basis for the change.
- The clinical leadership and governance established to oversee and enact the proposed changes.

This paper has also provided assurance that the quality and equality impact of the proposed changes has been considered.

Decision required

Approval from the Trust Board to proceed with the changes proposed and approval of the necessary work to deliver these changes, recognising that they are temporary and that any proposal to make them permanent will be subject to public consultation.

The timescale for the Green site is the duration of Covid-19 up to at least 31 March 2021. As such, this will be part of the Restore and Recovery phases. This timescale and the wider solution will be subject to quarterly review.

Appendices

Appendix 1: IPC assurance framework

COVID-19 IPC Board Assurance Framework

Appendix 2: Green site – clinical model

Green clinical model v.2.docx

Appendix 3: Quality Impact Assessment

Quality Impact Assessment.xlsx

Appendix 4: Equality Impact Assessment

EIA Rapid Service Change Impact Asses

Publications approval reference: 001559

APPENDIX 1

Infection prevention and control board assurance framework

4 May 2020, Version 1

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating

and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	All patients are screened on admission to the organisation. Those who are suspected COVID-19 are cared for in dedicated wards	Swabbing not a perfect method of screening	The Trust allows for other diagnostic evidence such as CT or X-ray and clinical picture to be considered pending re-testing
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Patients with suspected or confirmed COVID-19 are placed on dedicated wards or placed in isolation room on other wards if deemed clinically necessary	Asymptomatic cases have been detected	If an asymptomatic case is detected, close monitoring of contacts is undertaken
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	The Trust has been consistent in following national guidance on discharges and has supported social care discharges with a supply of PPE for 72 hours	Some initial gaps in notifying discharged patients with swab results	System now in place with Local Authority Public Health to notify post discharge patients of results
• patients and staff are protected with PPE, as per the PHE national guidance	The Trust has followed PHE national guidance throughout the pandemic	There have been occasions where supplies have been running low.	The Trust has sufficient supplies of all types of PPE and is building alternative and compliant PPE for future demand
• national IPC guidance is regularly checked for updates and any changes are	The Trust has subscribed to automated updates and has notified incident commanders at daily briefings with relevant		

effectively communicated to staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	updates cascaded through SBAR communication tool and live webinars Changes to PHE guidance are discussed with strategic commanders and any necessary adjustments or communications are agreed through daily meetings. The Trust BAF and risk register have been updated to reflect the current issues and signed off at subcommittee and board External additional support for non-COVID-19 IPC activity has been sourced by the DIPC.	This work is part of an ongoing refresh piece of all IPC functions & compliance with the hygiene code, currently assurance is limited	IPCT continue to monitor and manage HCAI cases including RCA investigations for alert organisms. Refreshed IPC group in place. Terms of reference approved and will be ratified by Quality & Governance Committee on 19 May 2020. Strengthened reporting arrangements in place
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat	Designated cohorting and isolation areas with specifically allocated teams to reduce the risk of transmission		

patients in COVID-19 isolation or cohort areas	These teams are further supported by IPCNs QM Clin Ed		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	All relevant housekeeping staff are trained to work in these areas. training sessions are recorded		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	In conjunction with IPC areas when identified, are cleaned in line with PHE guidance. Chlor Clean and HPV fogging	Historically there was no deep clean process in use	New process for deep clean currently being implemented with a defined deep clean schedule and accompanying SOP
• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Increased cleaning is in place across all sites/areas during this pandemic in line with the Deep cleaning protocol		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance	All Linen is treated as infectious and is managed using soluble laundry bags double bagged in a clear outer sack to be transported to the laundry. It is then		

and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	laundered as infectious laundry by the 3rd party laundry service		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Ongoing and strengthened accessibility to Antimicrobial Pharmacists for advice on antibiotics and infection management for all staff including junior doctors 7 day working PGME and pharmacy reminders, newsletters, tweets, very good uptake of this availability. C.Diff walk arounds halted, but have been taken over by phone calls to discuss patient where required with the lead consultant.	ASSG meeting cancelled in April as rooms bookings were over-ruled for COVID cells and other organisational purposes without options. ASSG held virtually in May. Productive but not quorate. Nothing to sign off but have progressed some actions and had opportunity for updates.	Direct contact from persons requiring ASSG input for antimicrobial stewardship, encouraged by request for virtual returns as enquired if anyone in group

	RCAs being held at Lincoln for all C.diff cases have antimicrobial input	Not got same assurance for PHB and GDH	New Antimicrobial Pharmacist at PHB will be assigned to pick these sites up for RCA input virtually with support of existing antimicrobial pharmacists if needed
	Antimicrobial stewardship and requests for advice. Virtual platforms used more frequently by pharmacists seeking advice on the wards – mobile, office line, skype, teams, whatsapp groups. Includes frequent requests for advice from Rowlands Outpatient Pharmacists. Comms sent out re availability over mon-sun have had good response and uptake.		
	PII audit(s) still prioritised and completed. Virtual communications with clinical teams and very good response. Confident no gaps in this assurance Repeat PII audit planned and will be prioritised despite pressures, with ward pharmacist involvement	Unable to complete PII investigation with Ribotyping, would be very helpful in drawing further conclusion and assurance for antibiotic prescribing assessment	
	Non-essential (or non-mandatory) Antimicrobial Stewardship audits halted to avoid risk to patient safety due to inaccessibility to patient medical notes and to reduce unnecessary footfall on wards. Junior doctor projects registered with Clin Governance largely concluded, some have actions of final report		

	remaining, which will be completed once pressures are manageable.		
	Ongoing contribution in virtual DTC, working to sign off guidelines related to antimicrobials, providing input in developing safe and effective documents, with feedback mechanisms. Rapid updates sent out around COVID and antimicrobial stewardship – evidences PGME emails, newsletter and pharmacy advice	Usually would be captured in team brief and educational update sessions	Provided updates by email instead. Working on further means of communicating these to increase awareness Sent updates to PGME and all pharmacy staff for sharing with all relevant staff
	Commenced work on an antimicrobial app procured by pharmacy, and being led by Antimicrobial Pharmacy team using STP funds. Collaborative effort captured in the 'long term plan' to improve AMS and support organisations across the patch. Will help with C.diff and ESBL bacteraemia rates related to correct antimicrobial use – governance process to be finalised via DTC before release/launch	COVID priorities have slowed antimicrobial team on antimicrobial guideline work COVID interruption of DTC and PACEF access pathways may impact on governance sign off, but will be pursued as virtual set up is formalised for these committees	Specific resource funded via SPT has been ring-fenced for populating the microguide app, pending governance sign-off, using existing Trustwide guidelines New antimicrobial pharmacist started Mid May will be part of effort to prioritise this work on guideline review
	Review of paediatric antibiotic guidelines out of date by 5 years. Commenced work on this but halted by COVID	Will need to secure microbiologist review and Pathlinks sign off	Antibiotic guideline review will also address some of the feedback from end-users where clarity was requested
	Review of adult antibiotic guidelines due this year and requires some updates to bring in line with NICE		
	Surveillance continues	Extrapolation against occupied bed days and	Using various means and parameters for extrapolation to ensure good level of

		admissions may be skewed on system used for surveillance	confidence in surveillance and trends identified
	RECOVERY trial input including screening patients and advising on antimicrobial choices that have been made, next steps etc. Commas sent out via Trust, pharmacy, and STP		
	Follow up of patients with support of ward pharmacists, including complex patients on microbiology radar	Educational sessions for pharmacy teams halted, and will need to be re-developed depending on means of delivering them amid social distancing	All antimicrobial advice requests include educational aspect on rationale behind this advice and is acknowledged as being very helpful. Evidence of pharmacy colleagues applying this rational in their daily work, as notable difference in those who request advice frequently
	OPAT of patients where feasible	Some issues with premature and error in handover of patients amidst COVID rotas which could have impacted patient outcomes, and have required safety mechanisms to be used.	Tightened OPAT criteria to reduce risk of recurrence, at expense of delays to OPAT but important for patient safety
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure:			
• implementation of national guidance on visiting patients in a care setting	In line with national recommendations, the Trust suspended visiting with controlled exceptions i.e. end of life visiting	Some issues remain on rules for visitors bringing in patient possessions	The Trust has developed a protocol for acceptance of patient possessions
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Dedicated wards have been in use for both suspected and confirmed COVID-19 patients. The Trust has a place based approach to PPE precautions so all clinical areas take the same precautions regardless of the COVID-19 status of any patient		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	There is a link on the Trust website front page taking the user to the national NHS COVID-19 page.		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	The status (known at time of transfer) of each patient is communicated to the receiving organisation. This includes when swab results are pending.	Initial gaps in communication were identified both for discharge home and to social care	Local Authority Public Health now communicate results to discharged patients. Discharge protocol in place
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure:			
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection	Each ED has a designated streaming process for patients with suspected COVID-19.		
• patients with suspected COVID-19 are tested promptly	All patients admitted to ULHT are swabbed on admission.	Some patients have tested positive but have been asymptomatic	Swab turnaround times are less than 24hrs meaning patients can be quickly isolated
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	The Trust follows national guidance in relation to the management of patients who may have either a diagnostic or clinical presentation consistent with COVID-19. In these cases, patients are isolated and re-swabbed	Atypical presentations can cause delays in diagnosis	This has now been largely mitigated by the inclusive testing of all admitted patients
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Patients attending for planned care appointments are requested to shield for 7 days prior to appointment. The patient is then swabbed 48hrs prior to the planned intervention. If the patient is positive or has symptoms consistent with COVID-19, they will be deferred and a new appointment made.	Some anecdotal evidence from a nearby Trust identified that some patients became symptomatic shortly after their procedure meaning they were likely positive during their appointment	All reasonable precautions are in place and are in line with national guidance
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	The Trust uses the published videos and posters provided by PHE to ensure that PPE is correctly used. There is a continuous programme of fit testing in all Divisions to ensure that staff can use all FFP3 mask types issued.	There is no control over the type of PPE received by the Trust from NHS Supply Chain including FFP3 masks. This means some risks exist of having sufficiently fit tested staff on a given mask type	The Trust is procuring reusable respirator masks that can be issued to individuals (400 + 23 Hoods). This will negate the need for high volume repeated fit testing
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	All staff who require fit testing attend training. The Trust uses the PHE videos and posters to assist with training relating to selection, donning and doffing of PPE	High FFP3 fit test failure rate in some areas. Lack of choice with masks further restricting fit tested staff available for a given shift	The Trust has purchased 2 quantitative fit testing kits. These kits can confirm a fit test pass or fail without the reliance on the human factor to smell/taste the fit test solutions
• a record of staff training is maintained	Staff fit testing records are held by Divisions and recorded on Health Roster	Health Roster does not include medical staff.	Evidence of fit trained staff held by clinical areas
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	While arrangements are in place (the published PHE guidance), the Trust has not yet introduced the reusing of PPE		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	The Trust is currently not reusing PPE however if needed, it would follow PHE published guidelines		

• adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	The Trust has consistently abided by the national PHE PPE guidelines and daily reports on PPE usage are supplied to the COVID-19 Tactical Cell The Trust has employed Personal Safety Champions (PSC) to visit all areas to ensure staff are adhering to hand hygiene, PPE, cleanliness and social distancing. Reports are provided daily The Trust has provided soluble red laundry bags to all staff who take uniform home to support safe laundering practices. Staff self-isolate and contact Occupational Health if they experience any symptoms consistent with COVID-19. The Occupational Health team also support national guidance in relation to symptomatic household contacts and support staff isolation.	There is still evidence of inappropriate PPE use however this has significantly reduced The PSC team work across all sites however out of hours is not fully covered.	Personal Safety Champions provide reports on challenges around inappropriate PPE usage and provide immediate training in the work place.
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate	Dedicated suspected or confirmed pathways have been established. This		

facilities or designated areas where appropriate	starts at ED and is facilitated throughout the Patient stay.		
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Designated suspected and confirmed COVID-19 wards have been identified. If a Patient needs care on their base ward, suitable isolation facilities are required.	Many clinical areas are in need of refurbishment	Processes have been agreed (awaiting business case) for the complete refurbishment of 3 wards and environmental upgrades of a further 12 wards across the Trust
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Patients identified with an alert organism or resistant organism are managed as per Trust policy.	Review of alert organism and Gram –ve BSI plans are in progress but not complete	External support for review of IPC function has been sourced by DIPC

8. Secure adequate access to laboratory support as appropriate

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals	Molecular testing is undertaken within the microbiology section of Path Links laboratories which have UKAS accreditation and which are applying for an extension to scope for COVID-19 testing as part of the regional network. HCPC registered BMS staff are undertaking and overseeing the testing. Full validation and verification has been undertaken, and V&V documents, SOPs, training records and manufacturers' information documents are available on request.		

• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	PHE guidance is used as the framework for testing, although some locally arranged additional testing has been taking place. NHSE is co-ordinating across the MidE2 network. Current turnaround time is 13-18 hours from receipt of samples.		
• screening for other potential infections takes place	Demand management has been implemented according to national guidance, and according to the attached letter. Samples of limited clinical value are not being processed, but CPE screening and MRSA screening from high risk contexts is ongoing. We are reviewing the situation in light of "business as usual" guidance, balanced with the additional workforce pressures and demand upon the laboratory.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	The Trust provides daily updates (SBAR) and the Exec team host Facebook Live events to provide advice and information to staff. The Trust has also deployed Personal Safety Champions who visit all areas on all sites to ensure there is good practice on hand hygiene, PPE use, cleanliness and social distancing. The IPC team continue to support wards and	IPC policies need review to support staff. The Trust annual IPC plan and structure is in need of a review.	The DIPC has sourced an external support to review and refresh the Trust IPC policies. Systems and processes

	departments with regular visits to ensure that non-COVID-19 infections are properly managed.		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	The Trust has subscribed to the automated PHE update system and once notifications are received they are reviewed and escalated to the DIPC and COVID-19 Gold command. Any necessary actions or adjustments are communicated as soon as practicably possible		
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	From the outset, the Trust has followed national PHE guidance on waste segregation. This is also in line with the national specification HTM 07-01 (Management of Healthcare Waste)		
• PPE stock is appropriately stored and accessible to staff who require it	PPE is stored centrally and controlled by the Trust procurement teams. There is a PPE 'hotline' so staff can access PPE stocks at short notice. A daily PPE stock report is produced which includes a tracker for each line item stating the number of days stock available.	There have been occasions when stocks of PPE have decreased to dangerous levels	The IPC and Procurement teams have worked to source alternative types of PPE (masks and gowns) that meet the same or better PHE standards. This has meant that stocks are more manageable.
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:	As a Trust we are proactive in recognizing the risk to our staff of Covid19 and provide an action plan that is supportive of their		

• staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff that test positive have adequate information and support to aid their recovery and return to work.	physiological and mental health needs at this time. Individual managers are aware of the risk to our staff and provide time for conversation surrounding the anxieties this may cause for some staff signposting for additional support as required, seeking the advice from Occupational Health, where appropriate the counselling service and wellbeing service offered by the Trust. This includes BAME staff. All staff absence is recoded and on two data bases. All staff who are self-isolating will be contacted by their line manager OH and HR also Maintain contact with individuals considered at greater risk. All staff are offered a swab test. Priority is given to staff and Household members isolating for 7 and 14 days. All staff are called personally by a Nurse from Occupational Health to support them on having a confirmed positive test. They are offered support through wellbeing and counselling	Staff testing through national testing centres id difficult and appts and timeliness of results is poor	Staff are tested through in house NHS testing Labs commissioned for patient services managed by Occ/Health

APPENDIX 2

Clinical Model

IPC Excellence facility supporting a range of surgical activity including

- General Surgery
- Urology
- Breast Surgery
- Gynaecology

With smaller numbers of

- ENT
- OMF

Vascular Surgery and Paediatrics not supported in Restore at GDGH.

Casemix will vary weekly according to clinical prioritisation and be scheduled centrally in Restore.

Cohorting of specialty activity to provide speciality presence over several days to facilitate speciality cover for ward areas and support IPC excellence

A combination of day case and inpatient activity covering 2 28 bed areas, namely Ward 2 and Ward 1.

Green workforce supported by careful adherence to IPC principles and embedded culture of IPC excellence. Screening by wellbeing assessment including temperature check at start and end of each shift. Swabbing if symptomatic or for contact tracing. Programme of random staff swabbing to screen for asymptomatic carriers. Defined protocol for migration of staff between sites (especially surgical teams) to ensure no Blue to Green transfer on same day. Risk assessment for staff not currently in patient-facing roles due to previous risk assessment to facilitate work at IPC excellence site.

Medical cover provided by foundation grade doctors drawn from existing Grantham team. Existing Hospital at Night team to provide out of hours ALS cover with middle tier perioperative medical practitioner cover on call drawn from existing GS/Anaesthetic middle tier doctors. Speciality on call cover and arrangements for postoperative review of inpatients defined by individual specialities. Inpatients will require daily specialty review.

ACU functioning as 6 bed Level 1 postoperative care unit PACU (with outreach facility to support inpatient areas) Medical cover from on site anaesthetic staff (in hours) and middle tier perioperative medical practitioner cover on call drawn from existing General Surgery/Anaesthetic middle tier doctors. Defined SOP for escalation of ward patients into ACU and utilise existing SOP for transfer to L2 / L3 facility if required.

4 theatres operating 5 days a week initially with a view to 7 day working. Lists initially running from 09:00 – 18:00 (soft cap, intention to complete listed activity). Medical staffing of operating lists 8 – 18.00 to accommodate preop visits, consent etc. On call team for out-of-hours returns supported by on call non resident consultant anaesthetist and on call consultant surgeons as per agreed specialty models. Review of planned activity to ensure appropriate facilities (eg laser point), equipment (clinical engineering stream) and staffing skill mix.

Support in theatres from radiography for Urology, and occasional other use. Overnight on call radiographer required for ward / ACU (portable chest xray)
Radiology Support for breast surgery – wire guided and Sentimag machine

Histopathology function to support specimen processing from theatres

Chemical pathology function to support ward requests (including urgent out of hours), outpatient bloods and preassessment including phlebotomy

Haematology function to support ward requests, outpatient bloods and preassessment; blood bank to support elective surgery (including urgent out of hours)

Microbiology function to support ward, theatre and preassessment samples, including arrangements for urgent processing/transport of samples.

Clinical measurement function to support ward, outpatient and preassessment function with ECG.

Pharmacy function to support day case, inpatient and ACU areas and 4 theatres 5 days a week. Additional support for day case chemotherapy unit.

Preassessment function to support elective surgery including telephone assessment where possible. Includes arrangements for self isolation and swabbing (including home swabbing/CCG led swabbing).

Additional services in Green areas

Hospice	Utilises existing staffing arrangements
Day Case Chemotherapy	CSS managed; existing staffing arrangements; SOP needed for deteriorating patients
Endoscopy	CSS led; existing staffing arrangements; SOP needed for screening and for deteriorating patients
Outpatients including Emerald Suite	CSS led remote consultations and defined SOP for screening face to face attendances
Rehab Unit	Ward 6 area (following redevelopment) – therapy led facility for IPC green patients; level of nursing support to be defined. SOP to be defined for medical emergencies/deteriorating patient. Implementation later in Restore

Medical staff movement

Existing foundation tier to be reallocated to surgery (12 doctors) supporting ward work and overnight ward cover. Exception is 3 A&E F1s who will support UTC.
Model to be revisited for August rotation and numbers likely to reduce significantly
Existing Anaesthetic consultant and middle tier (14 doctors) supporting theatre activity. Anaesthetic consultant non resident on call supporting returns to theatre / PACU deterioration/transfer

Existing surgical middle tier (7 doctors) supporting theatre activity.
Anaesthetic and surgical middle tier supporting out of hours ward cover including PACU – this does not include the ST5's who support the Lincoln acute work. Workforce of 11 doctors (3 vacant posts at present)
Surgical consultants support theatre work along with visiting specialty teams. Post operative specialist cover defined by specialty.
Orthopaedic CONS and SAS reallocated to other sites / support OP activity at GKGH. Specialty to define.
Medical and speciality medical CONS, SAS, IMT and CT reallocated to other sites / support OP and endoscopy activity at GKGH. Specialties to define in conjunction with CSS.
A&E CONS and SAS support UTC model – any extra resource reallocated

Background Information and Sign-Off

APPENDIX 3

Please provide some supporting information in the table below:

Name of Scheme:	Green Pathway at Grantham to support 'restore' of Elective Surgery (Phase 1)
Reference:	QIA2020-X (to be numbered by PMO)
Division:	Trust Wide
Proposed Start Date:	June 1st 2020
Brief Description of service change:	Proposal to establish a "full green" site at Grantham for Elective & Diagnostic activity, with a single isolated "blue" service this being an Urgent Treatment Centre.
Is the Service change based on any national guidance received? **(if yes please state the name of the guidance in the opposite column)**	Yes
Is the Service change based on any local guidance received? **(if yes please state the name of the guidance in the opposite column)**	No
Names of those involved in completing the QIA / Risk Assessment:	Simon Hallion- Divisional Managing Director (Family Health) Mark Lacey - Divisional Managing Director (Surgery) Yaves Lalloo - Divisional Managing Director (CSS) Debbie Pook - Divisional Managing Director (Medicine) Julie Pipes - Assistant Director of Strategy & Planning

The National Operating Framework for urgent and planned services in hospitals

Divisional Authorisation			
Name	Signature	Position/Job Title	Date
Dr Grainne O'Dwyer		Clinical Director Surgery	
Dr Ciro Rinaldi		Clinical Director Medicine & CSS	
Dr Suganthi Joachim		Clinical Director Family Health	
Rosalyn Howie		Divisional Nurse Surgery	
David Cleave		Divisional Nurse Medicine	
Carl Ratcliffe		Divisional Clinical Lead CSS	
Executive Leadership Team Authorisation			

Name	Signature	Position/Job Title	Date
Dr Neill Hepburn		Medical Director	
Dr Karen Dunderdale		Director of Nursing	
		Gold Command	

Quality Impact Assessment

	Yes/No (If Yes complete the following)	Risk Description	Initial Assessment				Post Mitigation			
			Impact	Likelihood	Consequence	Rating	Mitigations	Likelihood	Consequence	Rating
Impact on Duty of Quality (CQC/ Constitutional Standards)?	Yes - positive impact	N/A	Cancer wait targets and other constitutional standard targets (18 and 52 week waits) will be supported by this proposal as cancer patients and those defined as 'urgent' by the Royal College of Surgeons will be included in this	0	0	0	N/A			0
Impact on Patient Safety?	Yes	*There may be insufficient equipment, space and staff resulting in transfers from 'green' to 'blue'	The patient group being targeted for admission are already more vulnerable and compromised due to their clinical condition	4	4	16	*Assessment of space has been undertaken and advice sought from Infection Prevention and Control - area identified which is contained with minimal amount of cross over into 'blue' areas (see map) *Assessment of staffing levels and equipment needs confirming *Patients would not be transferred back to 'green'	1	4	4

Impact on Patient Safety?	Yes - potential for adverse impact	Medical patients who would have been admitted to the Grantham inpatient beds will under the green site model be redirected to A&E's at either Lincoln, Pilgrim or out of county to other acute service providers, and if admisson is required, will be admitted to one of these acute hospitals. In summary, the number of service users that will be displaced is as follows: • Of the 24,617 service users attending A&E at Grantham between April 2019 and March 2020, in the green site model, with an Urgent Treatment Centre located in a locked down area of the site, 4,611 (13 per day) service users would displaced to other hospital sites with a full A&E department. • The UTC would not support direct emergency admission to Grantham Hospital, as such patients who require direct admission via an A&E department will be transferred to a different site. Modelling shows that a an additional 847 patient transfers to other hospital sites per annum will be required, as 854 patients were already transferred to other ULHT sites between April 2019 to March 2020. • A total of 1,198 admissions (3 a day) were made to medical beds at Grantham from multiple non-ED routes between April 2019 and March 2020. As medical beds will be withdrawn at Grantham, these 1,198 patients will be re-routed and admitted at Lincoln.	There is a risk that this will place undue pressure on inpatient beds at Lincoln or Pilgrim Hospitals, and on the beds of out of county providers. This could have a knock on effect to the provision of elective surgery at these sites also	3	4	12	Intense work required with Lincolnshire Community Health Services to establish step up facilities in the community to minimise the number of patients requiring admission to acute hospitals.	2	4	8
Impact on Clinical Outcomes?	Yes - positive impact	The number of patients receiving elective surgery for Colorecta, Urology, OMF/ENT, Gynaecology and Dermatology at Grantham Hospital between April 2019 and March 2020 was 43 in total. This will be increased with Grantham as a “Green site”, to approximately 1,250 patients to receive elective (planned) surgical treatment at the Grantham Hospital site.	Cancer patients and those deemed clinically urgent will be able to receive the diagnosis / treatment they require which would impact positively on their outcomes & morbidity and mortality rates	0	0	0	N/A	0	0	0

Impact on Clinical Outcomes?	Yes - potential for adverse impact	Medical patients who would have been admitted to the Grantham inpatient beds will under the green site model be redirected to A&E's at either Lincoln, Pilgrim or out of county to other acute service providers.	There is a risk that outcomes of medical patients could be compromised if the redirection process and protocols are not clear and all stakeholders (EMAS, GP's, Primary Care, other Providers inside & outside of county, Community Care) are informed	2	5	10	Robust communication and engagement plan	2	4	8
Impact on Patient Experience?	Yes	*Patients unwilling to attend Grantham site due to concerns about the risk of contracting COVID *Patients unable to travel to Grantham due to transport availability Clinical services that will stop at Grantham will result in patients having to travel to other locations to access these services e.g. antenatal, nuclear medicine,AAA screening, Vascular, Fracture follow up etc	Patients requiring diagnostics / treatment are not accessing it which will impact on their outcomes, morbidity and mortality	3	4	12	* Established process to ensure timely and sensitive communication with patients by clinical teams about the reasons for the pathway changes and the risks / benefits and importance of attending the appointments offered *Monitoring of DNAs	1	4	4
Impact on Staff Experience?	Yes	*Staff unwilling to return to work within the 'green area' This proposal is likely to require transfer of staff from other sites to Grantham. Staff may not find this attractive.	Insufficient staffing on the green site. (this impact is not envisaged on the blue service)	4	4	16	Develop a workforce plan to reassure the staff of the precautions being taken to keep the green area, green. Emphasise that this is also part of their responsibility to keep it safe	3	4	12
Impact on Staff Experience?	Yes - positive impact	This proposal provides an opportunity for staff in vulnerable groups to return to work safely and in a controlled manner to a Green site		0	0	0		0	0	0

Risk Assessment Form				
What is the specific service change being proposed?	What is the increased risk (to patients, staff, visitors or Trust assets) as a result?	What can be done immediately to control this risk? (Attach documented new procedures, plans, etc.)	If these controls are in place, what is the level of risk? (See Risk Matrix tab)	What further action (if any) would be needed to improve control of this risk?
Proposal to create a "Green Site" at Grantham District Hospital for Elective & Diagnostic activity with a single isolated "blue" service in the form of a UTC.	Breakdown of employee / employer / staff side relations as a result of the changes and the requirement for staff to return to work within the 'green' areas	Discussion with Staffside	**12 - 16**	
	Patients that are awaiting diagnostic procedures or surgical interventions will have had their procedures delayed or deferred which could have led to a change in their clinical presentation and potentially poorer outcomes /increased complications.	Robust assessment of patients by clinical teams prior to procedures / interventions	**12 - 16**	
	Increasing activity will increase amount of PPE usage, linen, number of swabs required (staff and patients), surgical equipment & some surgical equipment may not be routinely used at the Grantham site	Scope requirements for each element	**4 -6**	
	Diagostic / support services (pharmacy, radiology, pathology etc) may not have the capacity to staff and support the expansion of services without compromising provision elsewhere	CSS involvement in the planning and assessment of impact	**8 - 10**	

	Potential for reputational damage, negative public comments and impact on reconfiguration of future services at Grantham	Develop a robust communication process as to the case for change. Engage all stakeholders in the Grantham area.	**20**	
	Potential that out of county Providers e.g. PSHFT, NUH, SFHT and EMAS will not support the proposal due to the impact it may have on their organisations	Engage with stakeholders, re-assure of the effort going into working with Lincolnshire community services to minimise impact	**8 - 10**	

Scoring Guide for Quality Impact and Risk Assessments

Risk type	Risk Ratings & Examples				
	1-3 Very low risk (minimal chance)	**4-6 Low risk** (<1% chance)	**8-10 Moderate risk** (1-10% chance)	**12-16 High risk** (10-50% chance)	**20-25 Very high risk** (>50% chance)
Harm (physical or psychological)	Extremely unlikely to result in severe harm to multiple individuals.	Unlikely to result in severe harm to multiple individuals.	Reasonably likely to result in severe harm to multiple individuals.	Quite likely to result in severe harm to multiple individuals.	Extremely likely to result in severe harm to multiple individuals.
Service disruption	Unlikely to result in noticeable disruption to any services.	Likely to result in noticeable disruption to one or more services.	Reasonably likely to result in temporary, unplanned closure of one or more services.	Quite likely to result in extended, unplanned closure of multiple services.	Extremely likely to result in closure of one or more hospitals.
Compliance & reputation	Unlikely to result in complaints or concerns raised.	Unlikely to result in multiple complaints, serious concerns or adverse media attention.	Reasonably likely to result in multiple complaints, serious concerns or adverse media attention.	Quite likely to result in a large number of complaints, serious concerns raised and sustained adverse media attention.	Extremely likely to result in a loss of public, commissioner and / or regulator confidence.
Finances	Unlikely to result in noticeable adverse financial impact.	Unlikely to result in significant adverse financial impact.	Reasonably likely to result in Significant adverse financial impact.	Quite likely to affect the ability of the Trust to achieve its annual financial control total.	Extremely likely to affect the long-term financial sustainability of the Trust.

Likelihood Score & Descriptor (with examples)				
1 Extremely Unlikely	**2 Quite Unlikely**	**3 Reasonably Likely**	**4 Quite Likely**	**5 Extremely Likely**

Unlikely to happen except in very rare circumstances. Less than 1:1,000 (<0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1:1,000 & 1:100 (0.1-1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1:100 and 1:10 (1-10% probability). Evidence of potential threats with some gaps in control.	Likely to happen in many but not the majority of circumstances. Between 1:10 & 1:2 (10-50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1:2 (>50% probability). Evidence of substantial threats with significant gaps in control.

APPENDIX 4 - Rapid Service or Workforce Change Equality Impact Assessment Tool

This tool has been developed in response to the COVID-19 pandemic and the need for the NHS to respond by rapidly changing delivery of services or to the workforce by Silver / Gold commands whilst also maintaining our public sector equality duty under the Equality Act 2010 to show due regard for equality in decision making. Please complete all sections below. Instructions are in ***italics.*** Email for all correspondence: email to tim.couchman@ulh.nhs.uk

A. Rapid Service or Workforce Change Details	
1. Description of change	As the Trust moves into the 'restore' phase of its response to the COVID-19 pandemic, it is imperative that time critical care pathways are restored safely as a matter of urgency. This equality impact assessment reviews the potential equality related impacts of a green / clean hospital being established on the Grantham Hospital site, with a "blue" service being an Urgent Treatment Centre that would be locked down from the remainder of the site, which would be "green" The green (clean) hospital is defined broadly by Infection Prevention and Control (IPC) as: • Clean patient • Clean team • Clean environment This is established through the rigorous application of targeted IPC interventions, which are further defined in the full business case. Where a green hospital is established, all blue / unclean activity on the site would cease. However, to provide access safely to urgent care for the residents of Grantham and the surrounding villages, , the proposal for Grantham Hospital site is to operate an Urgent Treatment Centre. This is classed as a "blue" service. The Urgent Treatment Centre will see and treat patients in the UTC, any patients requiring admission to an acute hospital will be transferred to either Lincoln or Pilgrim hospital will full IPC measures followed for the transfer. Grantham hospital would not admit any medical emergency or elective medical patients, there would be no medical inpatients on the Grantham site, and there would be no outpatient activity, including Diagnostic activity. Alternative locations in the Grantham area will be sought to provide a level of Diagnostic activity locally. This will ensure the Grantham Hospital "Green" status can be sustained. Outpatient activity at Grantham will transfer to the other Trust hospital sites. The effective implementation of a green site, would enable urgent cancer and elective services to be delivered safely (green) at Grantham Hospital. However, all services outside the green criteria would with the exception of the Urgent Treatment Centre.
2. Type of change	Partial stop and establishing a new pathway
3. Form completed by	Anthony Rosevear, Deputy Chief Operating Officer Tim Couchman, Equality, Diversity and Inclusion Lead Julie Pipes, Assistant Director of Strategy & Planning
4. Date decision discussed & agreed	tbc

DRAFT

This form is based on a template produced by Cambridge University Hospitals NHS Trust and used with their kind permission.

B. Equality Impact Assessment	
Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the Protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation ? Or other groups which can include, but not be limited to, people who are; carers, homeless, living in poverty, asylum seekers/refugees, in stigmatised occupations (e.g. sex workers), use substances, geographically isolated (e.g. rural) and surviving abuse	
1. How does this decision impact on protected or vulnerable groups? eg. their ability to access services and understand any changes?	Patients and Services Users: Age: • Lincolnshire has a higher population of people over 65 years of age compared with the rest of the UK (Census 2011: UK 16%; Lincolnshire 21%). • Older people in England are more likely to develop serious ill health and are more likely to have complex co-morbidities, which place them at greater risk of complications if they contract COVID-19. • Emerging data indicates that older people are disproportionately impacted by COVID-19. • Older people might have additional challenges in relation to transport, if elective surgery is moved away from their local hospital. Public transport from Grantham to Lincoln and Boston is not as comprehensive as it could be, and older people may find using public transport challenging. • People of all age groups will face additional challenges and negative impacts in accessing services no longer provided at Grantham Hospital (Emergency Care, Out-patient services, Ante-natal services, Young peoples' services etc). • People with Covid19 symptoms requiring admission to acute hospital will be diverted to one of the other ULHT hospital sites, Lincoln or Pilgrim both of which have higher intensive care facilities to treat patients with a higher acuity illness if required. This will increase likelihood of a positive outcome for this vulnerable group of people. • The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trust's current restrictions on visitors. • However, having elective surgery provided on a safer (green) hospital site will provide increased likelihood for a positive outcome, and reduced waiting times than if a green site was not established, for this vulnerable patient group using the service. Disability: • People with some long-term conditions (which would be classed as disability under the Equality Act 2010) are more likely to develop serious ill health if they contract COVID-19. • Emerging data indicates that some disabled people are disproportionately impacted by COVID-19. • People with Covid19 symptoms requiring admission to acute hospital will be diverted to one of the other ULHT hospital sites, Lincoln or Pilgrim both of which have higher intensive care facilities to treat patients with a higher acuity illness if required. This will increase likelihood of a positive outcome for this vulnerable group of people • The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trusts current restrictions on visitors. • The communication needs of people need to be assured in relation to access to healthcare in a new pathway. • Disabled people are more likely to access emergency services, out-patient clinics and the Kingfisher Unit. Therefore, a removal of these services from Grantham Hospital would negatively impact this group of people. • However, having elective surgery provided on a safer (green) site will provide increased likelihood for a positive outcome on this vulnerable patient group, with reduced waiting times than if a green site is not established Gender reassignment:

DRAFT

- As the Trust does not provide gender reassignment surgery or services, a neutral impact is envisaged.
- Trans patients will continue to be cared for in their chosen gender identity, in line with national NHS England Same Sex Accommodation policy.
- However, the mental health impact of 'social distancing' on LGBT+ people, who have a greater reliance on external contacts for advocacy and social contact in care settings needs to be understood and considered, alongside the Trusts current restrictions on visitors.

Marriage and Civil Partnership:

- A neutral impact is envisaged for this protected characteristic.

Pregnancy and Maternity:

- A green hospital site for elective surgery at Grantham, would mean that the current Ante-Natal and scanning services would cease on the Grantham site and people would have to travel to other hospital sites to access services and therefore a negative impact is envisaged.

Race:

- Emerging data and research indicates that people from Black, Asian and Minority Ethnic backgrounds are disproportionately affected by COVID-19.
- Whilst Lincolnshire does not have the large BAME communities as other urban areas in the Midlands and England, all BAME groups are still represented in the county.
- People with Covid19 symptoms requiring admission to acute hospital will be diverted to one of the other ULHT hospital sites, Lincoln or Pilgrim both of which have higher intensive care facilities to treat patients with a higher acuity illness if required. This will increase likelihood of a positive outcome for this vulnerable group of people
- People for whom English is not the first language may have less access to information about changes in service delivery.
- The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trusts current restrictions on visitors.
- However, having elective surgery provided on a safer (green) hospital site will provide increased likelihood for a positive outcome on this vulnerable patient group.

Religion or belief:

- A neutral impact is envisaged for this protected characteristic.

Sex:

- Emerging data and research indicates that men are disproportionately affected by COVID-19.
- Therefore, having elective surgery provided on a safer (green) hospital site will provide increased likelihood for a positive outcome on this vulnerable patient group.

Sexual orientation:

- A neutral impact is envisaged for this protected characteristic group.
- However, the mental health impact of 'social distancing' on LGBT+ people, who have a greater reliance on external contacts for advocacy and social contact in care settings needs to be understood and considered, alongside the Trusts current restrictions on visitors.

Other groups:

DRAFT

DRAFT

	Carers: • The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trusts current restrictions on visitors. Geographical isolation: • Some people might have additional challenges in relation to transport, if elective surgery is moved away from their local hospital. The population of Grantham will have additional challenges in relation to accessing the services that would cease being delivered at Grantham Hospital. • The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trust's current restrictions on visitors. Socially / economically deprived: • Some people might have additional challenges in relation to finances, if elective surgery is moved away from their local hospital and if services currently provided at Grantham Hospital are relocated to other Trust sites. • The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trust's current restrictions on visitors, particularly for people experiencing social and / or economic deprivation. Domestic abuse: • It is recognised that people affected by domestic abuse are more likely to access help through locally provided services. • Therefore, if the Trust only provides elective surgery at Grantham Hospital, people at risk of domestic abuse will no longer have access to help through the current local services. Staff: The emerging data and research, highlighted above, in relation to population groups disproportionately impacted by COVID-19 apply also to our staff groups. It is becoming clear that people from BAME backgrounds (race), older people (age), men (sex) and people with co-morbidities (disability) are being disproportionately affected by COVID-19. Therefore, if this is the preferred option, the creation of a green / safe hospital environment for people returning to work and other vulnerable groups is a potential positive impact in reducing risk infection for these groups. If this is the preferred option, a full analysis of the staff impacted by the changes required, would be undertaken by the HR Business Partners and changes implemented according to the Trust's Management of Change Policy. If this is the preferred option, staff who believe they are vulnerable are able to request a Risk Assessment via their line manager and also access Occupational Health support. If this is the preferred option as in interim solution for supporting the Infection Protection Control protocols and enabling patients to receive elective care safely, it will provide an opportunity for staff who are currently working at home due to the covid risks, to return to work safely on a Green site, subject to a full risk assessment being completed by the Occupational Health Service. Further to the above, the following potential impacts need to be considered: Age:

- The Trust has an ageing workforce profile. Therefore, older staff are likely to be impacted by change.

Sex:

- The Trust’s workforce profile demonstrates that 80% of the workforce are women and 20% are men. Therefore, from a statistical perspective, women will be more impacted by change than men.
- Women are more likely than men to be in part-time employment, where potential changes to work patterns / bases could potentially have a negative impact on them.
- Women are more likely than men to have caring responsibilities, where potential changes to work patterns / bases could potentially have a negative impact on them.

Carers:

- All staff with caring responsibilities could potentially be negatively impacted if work patterns / bases are changed.

Economic:

- There is potential that lower paid staff could be disproportionately impacted by changes that have a significant economic impact on them. For example, with additional travel costs and time, right through to the proposed changes in their work being not viable and resulting in the loss of their employment.

The proposal provides a benefit to all patient groups in an innovative way through providing the ability to continue with elective care in a safe and controlled manner, to stabilise, and avoid the patient waiting list for elective treatments growing whilst we manage the Covid19 situation.

The proposal provides a benefit to staff from the perspective that it provides an opportunity for staff in vulnerable groups to return to work safely in a Green environment.

DRAFT

2. Number of patients that will be displaced from the Grantham site

Establishing a Green site at Grantham Hospital will result in a number of patients/service users currently accessing services at Grantham Hospital being displaced to either the Lincoln or Pilgrim sites

A&E-Impact

Activity modelling shows that a minimal number of potential service users will be displaced. Of the 24,617 A&E attendances from April 2019 to March 2020, 4,611 attendances (13 per day), would be displaced, of which 1,187 (3 per day) will be displaced to other UHLT sites and 4,424 (10 per day) will be displaced to neighbouring Trusts.

A summary of this is provided below:

Displacement Destination	Attendances per annum	Attendance s per day	% of total A&E attendances at Grantham in FY20
Other ULHT site	1,187	3	5%
Other neighbouring Trusts	3,424	10	14%
Total	**4,611**	**13**	**19%**

Displacement Destination	Attendances per annum	Attendances per day	% of total A&E attendances at Grantham in FY20
East Anglia NHS Trust – Peterborough	2,950	8	12%
Lincoln County Hospital	1,139	3	5%
University Hospitals Nottingham - Queens Medical Centre	469	1	2%
Pilgrim Hospital Boston	48	<1	<1%
NLAG – Scunthorpe, Kings Lynn FT and NLAG – Grimsby	4	<1	<1%
Total	**4,611**	**13**	**19%**

Acute Medical Admissions

In addition, a number of displaced service users will require admission to an acute hospital due to acute medical problems. Activity modelling has shown that approximately 33 patients per week will need admitting to an acute hospital that would have ordinarily been admitted to Grantham Hospital, this equates to approximately 1,716 per annum. These patients will be admitted to either Lincoln, Pilgrim, Peterborough or Nottingham hospitals depending on which A&E /UTC they present to.

DRAFT

Transfers from Grantham as a result of ED to UTC conversion and withdrawal of medical beds at Grantham

The UTC would not support direct emergency admission to Grantham Hospital (other than via A&E) as such patients who require admission will be transferred to a different site. Modelling shows that a minimal number of patients will require transferring to other sides to be admitted.

This represents an additional 847 patient transfers as 854 patients were already transferred to other ULHT sites in April 2019 to March 2020.

A summary of this is provided below:

Transfers destination (patients will be admitted for inpatient care at these sites)	Attendances per annum	Attendances per day	% of total A&E attendances at Grantham in FY20
Lincoln County Hospital	907	8	4%
Pilgrim Hospital Boston	680	6	3%
Other neighbouring Trusts	113	1	<1%
Total	**1,701**	**15**	**7%**

Re-routed admission from multiple non ED routes as a result of a withdrawal of medical beds at Grantham

A total of 1,198 admissions (3 a day) were made to medical beds at Grantham from multiple non-ED routes between April 2019 and March 2020.

A breakdown of these admission methods is provided below:

Admission Method	Non ED 'Emergency' admissions at Grantham in FY20
Baby Born at home as Intended	3
Emergency - Bed bureau	8
Emergency - Dom Visit	1
Emergency – GP	697
Emergency - OP Clinic	91
Other Emergency Admission	390
Other Immediate	4
Transfer of an Admitted Patient from another Hospital in an Emergency	4
Total	**1,198**

As medical beds will be withdrawn at Grantham, these 1,198 patients will be re-routed and admitted at Lincoln.

Patients will be admitted for inpatient care at these sites	Attendances per annum	Attendances per day
Lincoln County Hospital	1,198	3
Total	**1,198**	**3**

Outpatient activity

Based on January 2019 to December 2019 data – 2,810 first patient appointments for suspected cancer were provided at the Grantham Hospital site for a range of specialities, plus any follow up appointments for these patients. This outpatient activity will not continue at the Grantham site, it will resume at the Lincoln and Pilgrim Hospital sites

To support the reintroduction of cancer surgery at Grantham in the following specialities – colorectal, urology, gynaecology, haematology, and cancer minor OPD procedures in dermatology and ENT/ oral and maxillofacial activity will on resume on the Green pathways

	Lincoln and Pilgrim. This activity is summarised as follows and is based on January 2019 to December 2019 activity data: • 2,810 first patient appointments (and any follow ups for those patients) previously at Grantham will resume at Lincoln/Pilgrim. This is the equivalent to 234 a month, 59 a week and 8 a day. For the same period, there were c.15,000 first patient appointments for non-cancer related conditions, plus any follow up appointments for these patients. This outpatient activity will not continue at the Grantham site, it will resume at the Lincoln and Pilgrim Hospital sites.
3. Number of patients that will be displaced from Lincoln & Pilgrim sites to Grantham Hospital	The section above shows the impact of Establishing a Green site at Grantham Hospital on patients/service users currently accessing services at Grantham Hospital for outpatient appointments, and how these will be displaced to either the Lincoln or Pilgrim sites. This section shows the number of patients currently receiving elective treatment at Lincoln and Pilgrim hospital sites that will be displaced to the Grantham Hospital site for elective surgical treatment. The majority of surgical treatment for cancer will be performed at Grantham for the following specialities – colorectal, urology, gynaecology, and cancer minor OPD procedures in dermatology and ENT/ oral Maxillo Facial. Patients requiring level 3 critical care after surgery (around 6% of cancer patients) will be treated at either Lincoln or Pilgrim hospitals, but all other cancer patients for these specialities will receive surgical treatment at Grantham. In addition, a number of patients who require non-cancer surgery will also be treated at Grantham. The number of patients receiving elective surgery for these specialities at Grantham Hospital between April 2019 and March 2020 was 43 in total. This will be increased with Grantham as a “Green site”, to approximately 1,250 patients to receive elective (planned) surgical treatment at the Grantham Hospital site. Query here about whether chemotherapy will continue at Grantham for Lincoln and Pilgrim patients, and if so, how many more patients will receive chemotherapy at Grantham, the numbers treated April 2019 to March 2020 indicate 80 Haematology patients and 43 Oncology patients received chemotherapy at Grantham.

DRAFT

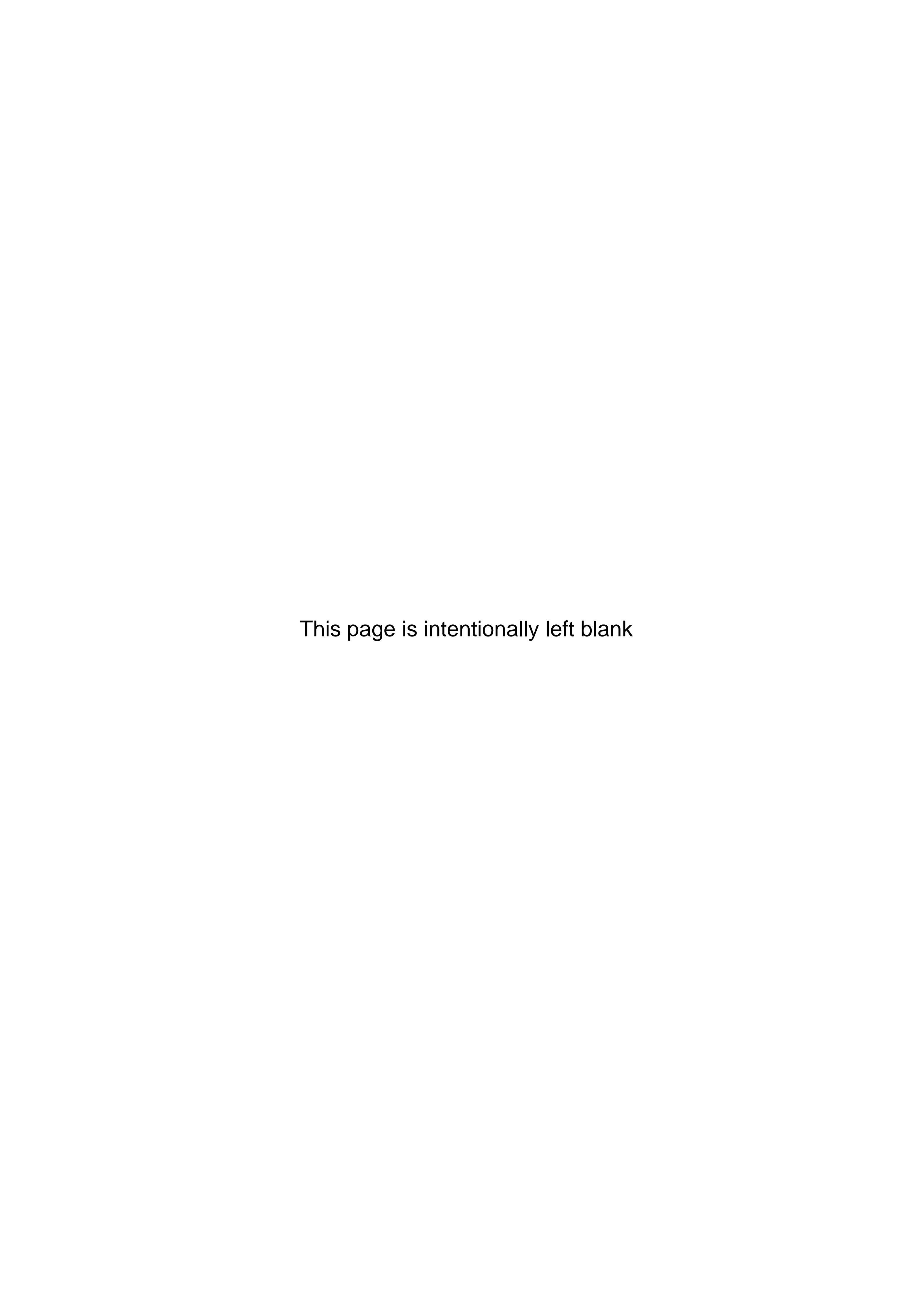
C. Risks and Mitigations	
1. What actions can be taken to reduce/mitigate any negative impacts? (If none please state so)	Patients and Service Users: For all groups: • Review of the welfare payments in relation to increased costs to patients through the changes, particularly for the economically disadvantaged. • Review hospital transport policy for people impacted by the service changes, particularly those unable to arrange their own transport. • Proactive promotion of the Patient Support Service (led by Patient Experience Team) for people impacted by the service change. • Enhanced communication through the NHS Lincolnshire system in relation to the changes, with particular focus on accessible communication for vulnerable groups. • Enhanced focus on accessible communication for patients during their hospital stay (use of remote translation services for spoken languages and British Sign Language). Staff: For all groups: • Effective use of Risk Assessment for staff potentially impacted by change. • Effective and consistent implementation of the Trust's Management of Change Policy. • Effective engagement with Staff-side.
2. What data/ information do you have to monitor the impact of the decision?	Patients and Service Users: • Monitor activity levels of people accessing Emergency Services • Monitor EMAS service responses • Monitor the number of patients and service users who are going out of county to access services • Monitor patients using the Grantham green pathway • Monitor patients using the blue service (UTC) at Grantham • Monitor Datix reports Staff: • ESR data • Employee relations data • Staff Survey data (longer term)
D. Decision/Accountable Persons	
1. Agreement to proceed?	Yes / No *Delete as appropriate and add detail or rationale*
2. Any further actions required?	*Eg. risk to be added to COVID-19 Programme Risk Register ?*
3. Name & job title accountable decision makers	

This form is based on a template produced by Cambridge University Hospitals NHS Trust and used with their kind permission.

DRAFT

4. Date of decision	

DRAFT


This page is intentionally left blank

Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 June 2020**
Subject:	**Lincolnshire Clinical Commissioning Group**

Summary

Lincolnshire Clinical Commissioning Group (CCG) was formally established on 1 April 2020. This report provides background on the new CCG.

Actions Required

To note the formal establishment of the Lincolnshire Clinical Commissioning Group with effect from 1 April 2020.

1. Background

On 15 May 2019, the Committee considered a report on the joint working arrangements which had been developing between the four former Lincolnshire clinical commissioning groups (CCGs). This included the recruitment of a single executive team and closer working on contracts.

Following this, the four CCGs made an application for merger to NHS England / NHS Improvement, which was approved in October 2019, with the new Lincolnshire CCG to be established with effect from 1 April 2020.

Arrangements for the merger had progressed well, so that the merger took place on 1 April 2020, irrespective of the coronavirus pandemic.

2. Details of the New Clinical Commissioning Group

Role of Clinical Commissioning Groups

The merger of the four former CCGs into a new Lincolnshire CCG does not directly affect front line service provision. CCGs are responsible for the commissioning of most health care services, including mental health services, urgent and emergency care, elective hospital services, and community care. CCGs through their primary care commissioning committee also have powers to commission primary care on behalf of NHS England / Improvement.

Board / Governing Body

The CCG Board (formally referred to as the governing body) consists of:

- the Chair
- the Chief Executive
- Director of Finance
- Director of Nursing
- Secondary Care Doctor
- Seven Non-Executive Directors
- Four Locality Clinical Leads
- Two Primary Care Leads

Sean Lyon has been appointed the Chair and John Turner has been appointed as Chief Executive. Full details of the membership of the Board are available on the CCG's website:

https://lincolnshireccg.nhs.uk/about-us/our-governing-body-and-committees/members/

Localities

The four CCG operates four localities, largely based on the previous CCG areas. Each locality is represented by a clinical lead on the Board, and has a chief operating officer, who are also in attendance at each board meeting.

Primary Care Commissioning Committee

The CCG has established, in common with all other CCGs, a primary care commissioning committee, in accordance a delegation from NHS England for primary care commissioning functions. The committee reports to the Board and to NHS England / NHS Improvement.

CCG's Vision and Priorities

Lincolnshire CCG has adopted the following vision and priorities:

Our vision and priorities shape who we are, how we work and help us to make the right decisions of behalf of people in Lincolnshire.

Our goal is to ensure that everyone living in Lincolnshire has the best possible health and wellbeing they can. To achieve this, we work alongside our health and care partners to provide people with access to quality healthcare and reduce the health inequalities that exist today.

Better health and wellbeing for the residents of Lincolnshire.

Our Vision

Our vision is to work with the NHS across Lincolnshire to deliver the ambitions identified in the NHS Long Term Plan. This means working with partners in both the local and district councils, partners across the voluntary sector and the people of Lincolnshire, to improve the quality and experience of services so that the population can live happier, healthier lives. The CCG aims to ensure that everyone living in Lincolnshire has the best possible healthcare and will empower individuals to manage their own personal health and wellbeing. To achieve this, we will collaborate at a local level to provide people with access to quality healthcare and reduce the health inequalities that exist today.

This aligns with the wider system priorities identified in the Lincolnshire Long Term Plan of:

***Start well:** from pregnancy, birth and early weeks of life; through supporting development before starting school; to help in navigating the transition to adulthood*
***Live well:** supporting a healthy lifestyle; ensuring urgent help to deal with accidents or acute illness; working together to manage long term conditions*
***Die well:** preparing, planning, caring and supporting those who are dying and the people who are close to them.*

The new Lincolnshire CCG will play a leadership role in delivering the four system ambitions identified in the Lincolnshire Long Term Plan delivery framework of:

1. ***Prevention** – shifting emphasis from treatment to prevention*
2. ***Person centred care** – giving people choice and control over their care delivery*
3. ***Working together** – joined up and co-ordinated services across the health and care system*
4. ***Care closer to home** – wherever possible services will be provided in the patient’s community*

3. Consultation

This is not a direct consultation item

4. Conclusion

The Committee is requested to note the formal establishment of the Lincolnshire Clinical Commissioning Group with effect from 1 April 2020

Background Papers - No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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

Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 June 2020**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme**

Summary

As this is the first meeting of the Committee since February 2020, the Committee is invited to agree its priorities for its forthcoming meetings. The items on the Committee's work programme have been grouped as 'high', 'medium' and 'low' priority. The Committee may wish to consider removing the low priority items from its work programme.

Actions Required

(1) To agree the priorities for the Committee's future work programme, based on the proposed 'high', 'medium' and 'low' priority lists set out in this report.

(2) To consider whether any or all of the items identified in this report as 'low' priority should be removed from the Committee's work programme.

A. Prioritising the Committee's Work Programme

Covid-19 will clearly impact on the Committee's future work programme, as some items in the programme may no longer be relevant or are a low priority. In addition, as the March, April and May 2020 meetings of the Committee were cancelled; this has led to the delayed consideration of a number of items on programme. As a result, the Committee is requested to prioritise its work programme.

After today's meeting, which is focusing on the response of the NHS to covid-19 and its impact on other NHS services, the following dates are scheduled for meetings of the Committee for the remainder of 2020:

- 22 July
- 16 September
- 14 October
- 11 November
- 16 December

Typically, at each meeting three to four substantive items are considered. In order to manage future business, items have been categorised as 'high', 'medium' and 'low' priority. The Committee may wish to consider removing some or all of the low priority items from the work programme.

High Priority Items	
Item	**Notes**
Restoring NHS Services After Covid-19	Clearly this is a high priority item.
Final Report on *Healthy Conversation* / NHS Long Term Plan Local Delivery Plan	The Committee had been due to consider the final report on Healthy Conversion and the local delivery plan for the NHs Long Term Plan would have been considered in March and April and remain a high priority, as they link to the Lincolnshire Acute Services Review (see below).
Lincolnshire Acute Services Review – Formal Consultation Elements: - ➢ Breast Services ➢ General Surgery Services ➢ Haematology and Oncology Services ➢ Medical Services / Acute Medicine (Grantham and District Hospital) ➢ Stroke Services ➢ Trauma and Orthopaedic Services ➢ Urgent and Emergency Care Services ➢ Women's and Children's Services	Responding to the future consultation on the Lincolnshire Acute Services Review is a major priority for the Committee.
Non-Emergency Patient Transport	The Committee has received regular updates since December 2017, with the most recent on 19 February 2020. This is considered high priority because of the impact on accessing services.

High Priority Items	
National Rehabilitation Centre Programme: Developments in the East Midlands	On 19 February 2020, the Committee was advised that consultation would begin in April or May. As this is a consultation item, it should remain as a high priority for the Committee
Older Adult Mental Health Services	On 22 January 2020, the Committee agreed to consider the feedback on the Older Adult Mental Health Services pilot scheme, which was expected in May. As there will be a consultation, this is a high priority.
Child and Adolescent Mental Health Services - Community Intensive Home Treatment Service	On 22 January 2020, the Committee was advised that a pilot community intensive home treatment service for young people had been launched in November 2019, with in-patient services at Ash Villa ceasing. As there will be a consultation, this is a high priority.

Medium Priority Items	
Item	**Notes**
United Lincolnshire Hospitals NHS Trust (ULHT) – Action in Response to Care Quality Commission (CQC)	Items on the response of ULHT to CQC inspection reports have been a regular feature of the Committee's agenda, and one was last considered on 19 February 2020. As the focus of ULHT has been on covid-19, this is not a high priority.
East Midlands Ambulance Service (EMAS) Update	The Committee has received six-monthly updates, the most recent on 16 October 2019. As the focus of EMAS has been on covid-19, this is not a high priority.
Undiagnosed High Blood Pressure and High Cholesterol	These three items were added to the work programme following the Committee's consideration of the Director of Public Health's annual report. It is considered they should remain on the programme, but not as a high priority.
Musculoskeletal Problems	
Cardiovascular Disease	
Integrated Urgent Care in Lincolnshire (Provided by Lincolnshire Community Health Services NHS Trust)	This item would have been considered on 25 March 2020, but is not a high priority and should remain on the work programme.
Louth County Hospital Inpatient Beds	This item would have been considered on 25 March 2020, but is not a high priority and should remain on the work programme.
Community Pain Management Services Update	The Committee has received two updates on 16 October 2019 and 22 January 2020. This is not a high priority,
Primary Care Networks / New GP Contracts	This item is not a high priority but should remain on the work programme.

Low Priority Items	
Item	**Notes**
Lincoln Medical School Update	The Committee received a presentation on 19 February 2020 and requested an update.
Community Pharmacy Contractual Framework (2019/20 - 2023/24)	This item has previously been added to the work programme. However, the community pharmacy framework was set nationally, and the Committee's influence might be limited.
Continence Services	This item has been previously added to the work programme, but may no longer be relevant.
United Lincolnshire Hospitals NHS Trust: Children and Young People Services Update	The Committee has received regular updates since May 2018, with the most recent on 19 February 2020. Permanent changes to children and young people services will be considered as part of the Lincolnshire Acute Services Review.

2. Previous Committee Activity

Appendix A to the report sets out the previous work undertaken by the Committee in a table format.

3. Conclusion

The Committee is requested to agree its priorities for the Committee's future work programme, based on the proposed 'high', 'medium' and 'low' priority lists set out in this report. The Committee may also wish to consider whether any or all of the items identified in this report as 'low' priority should be removed from the work programme.

1. Appendices

These are listed below and attached at the back of the report	
Appendix A	Health Scrutiny for Lincolnshire: At a Glance Work Programme

Background Papers - No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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

APPENDIX A

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE: AT-A-GLANCE WORK PROGRAMME

KEY
- ✓ Substantive Item
- α Chairman's Announcement
- Planned Item

	2017						2018											2019									2020							
	14 June	19 July	13 Sept	11 Oct	8 Nov	13 Dec	17 Jan	21 Feb	21 Mar	18 Apr	16 May	13 June	11 July	12 Sept	17 Oct	14 Nov	12 Dec	23 Jan	20 Feb	20 Mar	17 Apr	15 May	12 June	10 July	18 Sept	16 Oct	22 Jan	19 Feb	17 June	22 July	16 Sept	14 Oct	11 Nov	16 Dec
Meeting Length - Minutes	170	225	185	170	205	230	276	280	270	230	244	233	188	280	160	275	185	200	150	265	130	130	220	244	245	265								
Cancer Care																																		
General Provision																✓										✓								
CT and MRI Scanners																											α							
Performance																										α								
Head and Neck Cancers														α					α				α											
Care Quality Commission																																		
General																			α															
Children's Social Care																								α										
Clinical Commissioning Groups																																		
Annual Assessment														α																				
Lincolnshire East																✓																		
Lincolnshire West															✓																			
South Lincolnshire																	✓																	
South West Lincolnshire																	✓																	
Community Maternity Hubs								α																										
Community Pain Management												α								α						✓	✓							
Community Pharmacy			α																															
Dental Services							✓		α								α	α		✓						α	✓							
Elections – Impact																			α								α							
Falls Service																											α							

KEY

- ✓ Substantive Item
- α Chairman's Announcement
- Planned Item

	2017						2018											2019									2020							
	14 June	19 July	13 Sept	11 Oct	8 Nov	13 Dec	17 Jan	21 Feb	21 Mar	18 Apr	16 May	13 June	11 July	12 Sept	17 Oct	14 Nov	12 Dec	23 Jan	20 Feb	20 Mar	17 Apr	15 May	12 June	10 July	18 Sept	16 Oct	22 Jan	19 Feb	17 June	22 July	16 Sept	14 Oct	11 Nov	16 Dec
GPs and Primary Care:																																		
Boston – The Sidings																					α													
Cleveland Health Centre Gainsborough																							α											
Crossroads Medical Practice, N Hykeham																											α							
Extended GP Opening Hours								α			α				α																			
GP Provision Overall			α		α																			✓										
Lincoln GP Surgeries		α		α																														
Lincoln Walk-in Centre		✓	α	✓		✓		✓			✓																							
Louth GP Surgeries		α	α																															
Out of Hours Service														α																				
Skellingthorpe Health Centre																						α	α	✓		α								
Sleaford Medical Group									α																									
Spalding GP Provision														α																				
Grantham Minor Injuries Service												α	✓	α																				
Health and Wellbeing Board:																																		
Annual Report												α																						
Joint Health and Wellbeing Strategy		✓						✓																										
Pharmaceutical Needs Assessment					✓		✓																											
Health Scrutiny Committee Role	✓																																	
Healthwatch Lincolnshire											α		α		α									α										
Lincolnshire Community Health Services NHS Trust																																		
Big Conversation																								α										
Care Quality Commission													α		α																			
Healthcare Awards																								α										
Integrated Urgent Care																																		
Louth Inpatient Care																																		
Learning Disability Specialist Care				✓									✓																					

	2017						2018											2019									2020							
KEY ✓ Substantive Item α Chairman's Announcement Planned Item	14 June	19 July	13 Sept	11 Oct	8 Nov	13 Dec	17 Jan	21 Feb	21 Mar	18 Apr	16 May	13 June	11 July	12 Sept	17 Oct	14 Nov	12 Dec	23 Jan	20 Feb	20 Mar	17 Apr	15 May	12 June	10 July	18 Sept	16 Oct	22 Jan	19 Feb	17 June	22 July	16 Sept	14 Oct	11 Nov	16 Dec
Lincolnshire Sustainability & Transformation Partnership / Healthy Conversation 2019																																		
General / Strategic Items				✓			✓				α	✓	α	✓			✓		✓	✓		✓		α	✓									
Breast Services																							✓											
General Surgery																									✓	α								
GP Forward View										✓																								
Grantham Acute Medicine																									✓									
Haematology																										✓								
Integrated Community Care										✓						✓										✓								
Mental Health								✓							✓	α								✓		α								
NHS Long Term Plan																α	✓	✓	✓					α		α								
Oncology																										✓								
Operational Efficiency									✓																									
Stroke Services																							✓											
Trauma and Orthopaedics																									✓	α								
Urgent and Emergency Care									✓							✓						✓					α							
Women and Children Services																							✓											
Lincolnshire Partnership NHS Foundation Trust:																																		
General Update / CQC		✓																α																
CAMHS																											✓							
Older Adults Services																					✓						✓							
Psychiatric Clinical Decisions Unit							α																											
LIVES																											α							
Lincolnshire Reablement & Assessment Service																	α																	
Louth County Hospital														α	✓		α									α								
National Rehabilitation Programme																												✓						
Northern Lincolnshire and Goole NHS Foundation Trust			α												α			α																
North West Anglia NHS Foundation Trust							✓									α				✓							α							

KEY ✓ Substantive Item α Chairman's Announcement Planned Item	2017						2018											2019									2020							
	14 June	19 July	13 Sept	11 Oct	8 Nov	13 Dec	17 Jan	21 Feb	21 Mar	18 Apr	16 May	13 June	11 July	12 Sept	17 Oct	14 Nov	12 Dec	23 Jan	20 Feb	20 Mar	17 Apr	15 May	12 June	10 July	18 Sept	16 Oct	22 Jan	19 Feb	17 June	22 July	16 Sept	14 Oct	11 Nov	16 Dec
Organisational Developments:																																		
Annual Reports 2019-20																										α								
CCG Joint Working / Merger													✓	α				α			α	✓					α							
Integrated Care Provider Contract														α	✓																			
National Centre for Rural Care													α					α																
NHSE and NHSI Joint Working												α						α								α								
Lincoln Medical School			α														α								α	α								
Patient Transport:																																		
Ambulance Commissioning			✓																															
East Midlands Ambulance Service			✓		α					✓	α	α	α	✓		α	α				✓					✓								
Non-Emergency Patient Transport						✓	α	✓	✓	✓		✓	α	✓	α	α	✓	✓	✓	✓			✓				α	✓						
Sleaford Ambulance & Fire Station											α		α																					
Pharmaceutical Needs Assessment																																		
Public Health:																																		
Child Obesity												α	α																					
Director of Public Health Report												✓															✓							
Immunisation					✓																													
Influenza Vaccination Programme																	α																	
Renal Dialysis Services														✓								α					α							
Quality Accounts	✓								✓											✓		α	α					✓						
St Barnabas Hospice																											α							
Skegness Hospital																										α								
United Lincolnshire Hospitals NHS Trust:																																		

A&E Funding		α																																	
Introduction	✓																																		
Care Quality Commission		✓										α	α	✓				✓	α	✓				✓			✓								
Children/Young People Services											✓	✓	✓	✓		✓	α	✓		✓				✓				✓							
Financial Special Measures			α		✓					✓																									
Five Year Strategy																						α													
Grantham A&E			✓				✓	α						α	α	α		✓	✓		α					✓									
Orthopaedics and Trauma												α		α					α																
Smoke Free Policy																											α								
Stroke Services																		α																	
Winter Resilience					α	✓	α	α			✓				✓										✓										

This page is intentionally left blank