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

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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, 16 September 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=5537&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 22 July 2020**	3 - 16

Item	Title	Pages
4	**Chairman's Announcements**	17 - 26
5	**United Lincolnshire Hospitals NHS Trust - Covid-19 Update** *(To receive a report from United Lincolnshire Hospitals NHS Trust (ULHT), which enables the Committee to consider the progress made by the ULHT in its restoration and recovery following the acute phase of the Covid-19 pandemic. Senior representatives from ULHT will be in attendance for this item)*	27 - 70
6	**Healthy Conversation 2019 and Next Steps** *(To receive a report from the Sustainability and Transformation Partnership (STP), which enables the Committee to consider the final report on the Healthy Conversation 2019 engagement exercise and the next steps for the local NHS. Senior representatives from the STP and Lincolnshire Clinical Commissioning Group will be in attendance for this item)*	71 - 178
7	**Lincolnshire Clinical Commissioning Group** *(To receive a report from the Lincolnshire Clinical Commissioning Group, which provides the Committee with background on the establishment of the new Clinical Commissioning Group. A senior representative from the Lincolnshire Clinical Commissioning Group will be in attendance for this item)*	179 - 182
8	**Consultation on NHS Rehabilitation Centre, Stanford Hall Estate Near Loughborough** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider its response to the consultation on the proposed NHS Rehabilitation Centre on the Stanford Estate, near Loughborough)*	183 - 202
9	**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)*	203 - 212

Debbie Barnes OBE
Chief Executive
8 September 2020

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
22 JULY 2020

Lincolnshire County Council

Councillors C J T H Brewis (Vice-Chairman), M T Fido, R J Kendrick, C Matthews, R A Renshaw, M A Whittington, 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) and Mrs A White (West Lindsey District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Deborah Hussey (Quality Improvement and Assurance Lead Specialist Services, Lincolnshire Partnership NHS Foundation Trust), Jane Marshall (Director of Strategy, Lincolnshire Partnership NHS Foundation Trust), Liz Ball (Interim Chief Nursing Officer, Lincolnshire Clinical Commissioning Group), Dr Kakoli Choudhury (Consultant in Public Health Medicine), Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Maz Fosh (Chief Executive, Lincolnshire Community Health Services NHS Trust), Tracy Pilcher (Director of Nursing, Lincolnshire Community Health Services NHS Trust), Yolanda Martin (Associate Director of Communications, Lincolnshire Partnership NHS Foundation Trust), Siu-Ann Pang (Head of Mental Health, Learning Disability & Autism Specialised Commissioning, NHS England & NHS Improvement Midlands) and Steve Roberts (Associate Director of Operations, Older Adult Services, Lincolnshire Partnership NHS Foundation Trust).

County Councillors: Dr M E Thompson (Executive Support Councillor NHS Liaison and Community Engagement) attended the meeting as an observer.

1 ELECTION OF CHAIRMAN

RESOLVED

That Councillor C S Macey be elected as Chairman of the Health Scrutiny Committee for Lincolnshire for 2020/21.

COUNCILLOR C S MACEY IN THE CHAIR

2 ELECTION OF VICE-CHAIRMAN

RESOLVED

That Councillor C J T H Brewis be elected as Vice-Chairman of the Health Scrutiny Committee for Lincolnshire for 2020/21.

3 INTRODUCTIONS BY THE CHAIRMAN

The Chairman welcomed everyone to the meeting, and advised that in addition to the confirmed members of the Committee, the following people were also present at the meeting:

- Councillor Mike Thompson, (Executive Support Councillor for NHS Liaison and Community Engagement);
- Jane Marshall,) Director of Strategy, Lincolnshire Partnership NHS Foundation Trust);
- Deborah Hussey, (Quality Improvement and Assurance Lead for Specialist Services, Lincolnshire Partnership NHS Foundation Trust);
- Steve Roberts, (Associate Director of Operations, Older Adult Services, Lincolnshire Partnership NHS Foundation Trust);
- Yolanda Martin, (Associate Director of communications, Lincolnshire Partnership NHS Foundation Trust);
- Siu-Ann Pang, (Head of Mental Health, Learning Disability & Autism Specialised Commissioning, NHS England & NHS Improvement Midlands;
- Liz Ball, (Interim Chief Nursing Officer, Lincolnshire Clinical Commissioning Group);
- Kakoli Choudhury, (Public Health Consultant); and
- Simon Evans, (Health Scrutiny Officer).

The Committee was advised further that it was expected that Maz Fosh, Chief Executive, Lincolnshire Community Health Services NHS Trust and Tracy Picher, Director of Nursing, Lincolnshire Community Health Services would be joining the meeting later in the proceedings.

The Chairman reminded members of the Committee and other participants of meeting etiquette, and the role of the Committee members as constructive scrutineers.

4 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

An apology for absence had been received from Councillor Mrs R Kaberry-Brown (South Kesteven District Council).

The Committee noted that Councillor L Wootten (South Kesteven District Council) had replaced Councillor Mrs R Kaberry-Brown (South Kesteven District Council) for this meeting only.

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

5 DECLARATION OF MEMBERS' INTEREST

There was no declaration of members' interest made at this stage of the meeting.

6 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 17 JUNE 2020

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 17 June 2020 be agreed and signed by the Chairman as a correct record.

7 CHAIRMAN'S ANNOUNCEMENTS

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

The supplementary announcements provided information on the following four items:

- Fishtoft Road Dialysis Unit, Boston;
- Review of Renal Services;
- Powers for Local Authorities During Covid-19; and
- Parking at Hospitals.

The Chairman also advised the Committee that if they were in agreement, he would send a letter to Dr Jason Wong, congratulating him on his recent appointment as Deputy Chief Dental Officer for England.

The Committee noted that following a request from presenters, it was the Chairman's intention to reverse items 7 and 8, and therefore item 8 would be then next item on the agenda.

RESOLVED

1. That the Supplementary Chairman's announcements and the Chairman's announcements as detailed on pages 15 and 16 of the report pack be noted.

2. That on behalf of the Committee, a letter be sent to Dr Jason Wong, congratulating him on his appointment as Deputy Chief Dental Officer for England.

8 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST: CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

The Committee was advised that Item 8 could be found on pages 25 to 35 of the agenda pack.

It was noted that a decision to close Ash Villa South Rauceby School (attached to the Ash Villa Unit) was due to be made on 31 July 2020 by Councillor Mrs P A Bradwell OBE, (Executive Councillor for Adult Care, Health and Children's Services), as there were no pupils on roll at the school.

The Chairman advised that there were three contributors for this item: Jane Marshall, Director of Strategy Lincolnshire Partnership NHS Foundation Trust, Deborah Hussey, Improvement and Assurance Lead for Specialist Services, Lincolnshire Partnership NHS Foundation Trust and Siu-Ann Pang, Head of Mental Health, Learning Disability & Autism Specialised Commissioning, NHS England & NHS Improvement Midlands.

The Director of Strategy, Lincolnshire Partnership NHS Foundation Trust highlighted to the Committee that a new model of care had been designed as a potential solution to improve Child and Adolescent Mental Health Service (CAMHS) care in Lincolnshire from March 2020. However, when the Ash Villa CAMHS Inpatient Unit near Sleaford was suddenly temporarily closed in October 2019, due to a lack of medical cover, the mobilisation of the planned new model of care was brought forward, with the interim intensive home treatment team commencing the service on 4 November 2019, ahead of the planned date of March 2020.

The Committee noted that the 13 bedded unit at Ash Villa was commissioned by the NHS England Specialist Commissioning Team. The young people who had been in receipt of care at Ash Villa were aged between 13 to 18 years of age and had severe and /or complex mental disorders.

It was noted that since the Committee had given consideration to the pilot at its meeting on 22 January 2020, the outcomes of the new model of care were:

- There had been no serious incidents;
- There had been two out of area patient admissions to General Adolescent Units during the five months of 2019/20, since Ash Villa had been temporarily closed, compared to 22 in the same time period in 2018/19. It was highlighted this had resulted in one of the patients travelling to Northampton and the other patient having to travel to Bristol;
- The Service had done everything it could to minimise the number of children and young people travelling out of area. Confirmation was given that at the time of writing the report, there were no Lincolnshire children and young people out of area;
- There were approximately 2,100 Lincolnshire children using the service at any one time;
- There had been a significant reduction in length of stay;

- The number of occupied bed days were reducing; and
- That positive feedback from patients and carers had increased.

During discussion, the Committee raised the following points:

- Out of hour's provision – The Committee noted that the model of delivery was based on service availability seven days a week from 08:45 to 19:00. Confirmation was given that out of hours provision was available 24/7;
- Respite provision - The Committee was advised that there was no respite provision;
- Plans to move back to the Ash Villa site – The Committee noted that it was not the intention to move back to Ash Villa, as the building was not suitable. It was noted further that the new model was working well, and fitted with the Trust's vision to support young people in their own home;
- Support for Parents – Reassurance was given that support was provided to the child, or young person and the family as part of the offer of support. It was noted that the support might be offered digitally, on-line; by telephone or when necessary face to face;
- The Committee was advised that referrals could be made through various routes, for example GP, school, and self-referral. The Committee noted that there was not a single point of access;
- Out of county placements – There was an understanding that the two placements mentioned earlier in the presentation had travelled some distance to access help. It was highlighted that steps were being taken to work with providers within East Midlands to help reduce travelling. A question was asked what transport arrangements were in place. Reassurance was given that the Trust wanted to support families; and the Trust was working hard to help prevent out of county placements;
- Young Person Unit in the county - Confirmation was given that Lincolnshire did not have a Children and Young Person Unit in the county; and that the testing of the pilot for intensive home treatment; and new ways of working had reduced the need for in-patient provision;
- Future plans for Ash Villa – Confirmation was given that conversations were on going regarding the future use of the building. Confirmation was given that Ash Villa did not meet the required specifications set by NHS England for an in-patient unit. A request was made for a report concerning the future of the Ash Villa site;
- Success of the Pilot – A request was made for a further report regarding the success of the pilot. The Committee noted that NHSE were looking to extend the pilot until March 2021, so that lessons could be learnt from the model in Lincolnshire;
- A question was asked whether all children who required special care were being identified by GP services. The Committee was advised that there were excellent GPs in the county, who were able to identify when children and young people required specialist help and would make a referral. It was however noted that there had been a reduction in the number of referrals made during Covid-19, and that this was a concern;

- What assistance was provided to young people who passed the 18 year old threshold? It was reported that lots of planning was conducted before the transitional period; and that there was a clear transition process which involved the young person and the family, to ensure that a plan was put in place to make sure that the necessary support was provided. The Committee was advised that a copy of the protocol would be shared with the Committee after the meeting;
- How the surge in demand for CAMHS, arising from Covid-19 was going to be managed. The Committee noted that this would form part of the NHS recovery plan. It was noted further that work was on-going with schools and primary care to get the message out, that the service was there for children and young people who needed to access it;
- Lessons to be learnt from the feedback detailed on page 32 of the report pack. Reassurance was given that lessons could always be learnt, and that the Trust needed to get better at reflecting and taking actions forward;
- What form of engagement and consultation would be conducted regarding the changes? The Committee was advised that NHS England/NHS Improvement would be leading on the consultation; and the model recommended would be similar to the one conducted for Learning Disabilities; where all interested parties involved in the service were invited to have input, to ensure that an open honest conversation was had;
- When the Committee would expect a further report regarding the consultation. The Committee was advised that a report following the initial phase of the pilot, after the end of October 2020 would be appropriate.

RESOLVED

1. That Lincolnshire Partnership NHS Foundation Trust be commended for the positive feedback on the interim home treatment team service for Child and Adolescent Mental Health Services.

2. That a further report be received by the Committee after the initial phase of the pilot ending in October 2020.

3. That the Committee wished it to be put on record its concern with regard to the distance children and families will be expected to travel to access a General Adolescent Unit outside Lincolnshire.

9 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST: RESPONSE TO COVID-19

The Chairman invited Jane Marshall, Director of Strategy, Lincolnshire Partnership NHS Foundation Trust (LPFT) and Deborah Hussey, Quality Improvement and Assurance Lead for Specialist Services, Lincolnshire Partnership NHS Foundation Trust to present the report. The report was detailed on pages 17 to 23 of the report pack.

The Committee was advised that some examples of service changes in respond to the pandemic were shown on pages 18 and 19 of the report pack. It was highlighted that services had been adapted to ensure that the organisation remained responsive to its patients, whilst respecting the restrictions in place.

It was reported that levels of patients being referred to the services had reduced during the lockdown period, but the number of people being seen by LPFT services had remained the same. Details of activity and performance statistics were provided on page 20 of the report pack. It was highlighted that the number of people being seen by digital and telephone contacts had increased, as the model of delivery changed during the crisis.

In conclusion, it was highlighted that the Trust had adapted its service delivery to meet patient needs during lockdown; ensured that key delivery targets were met; established staff well-being support, which included the Black, Asian and Minority Ethnic (BAME) workforce; set up recovery and restoration processes to move to the 'new normal' way of working; and the completion of a questionnaire to gauge staff and patient experiences of working during the Covid-19 pandemic.

During discussion, the Committee raised the following points:

- The effect of the pandemic on the service – The Committee was advised that modelling had suggested that the effects of the pandemic on mental health would be seen for up to ten years. The Committee noted that a recovery plan was being developed for Lincolnshire, which included a universal offer of support relating to emotional wellbeing. The Committee was advised that plans were in place and work was in progress; and that by working together with other organisations the Trust would through its restoration process be looking at different ways of spotting early signs of need and then providing services earlier. The Committee was advised that an update on the offer could be considered by the Committee at a future meeting;
- The effect of social distancing on the service – The Committee was advised that ten acute adult mental health beds had been taken out of wards to ensure compliance with social distancing;
- It was highlighted that page 19 of the report pack made reference to a 'mothballed inpatient unit', which was currently being explored as a temporary unit. The Committee was advised that this referred to Ash Villa during Covid-19 being used as a possible temporary accommodation unit; and
- Support for staff – The Committee was reassured that all steps were being taken to provide support to staff, which included testing; additional psychological support services to provide staff with emotional support; more support for staff experiencing domestic abuse; and a special programme of work, led by the Medical Director, to support the BAME workforce.

RESOLVED

1. That the Committee's gratitude be recorded to all staff at Lincolnshire Partnership NHS Foundation Trust on its response to Covid-19.

2. That a report concerning the 'Universal Offer' be considered by the Committee at a future meeting.

10 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST: OLDER ADULT HOME TREATMENT SERVICE

The Chairman highlighted to the Committee that information pertaining to this item could be found on pages 37 to 40 of the report pack.

The Chairman advised that there were three contributors for this item: Jane Marshall, Director of Strategy, Lincolnshire Partnership NHS Foundation Trust, Deborah Hussey, Quality Improvement and Assurance Lead for Specialist Services, Lincolnshire Partnership NHS Foundation Trust and Steve Roberts, Associate Director of Operations, Older Adult Services, Lincolnshire Partnership NHS Foundation Trust.

The Associate Director of Operations, Older Adult Services, Lincolnshire Partnership NHS Foundation Trust presented the report and made reference to the Older People Home Treatment Team Outcomes as detailed on pages 38 to 40 of the report pack. It was highlighted the model had reduced in-patient admissions and the number of patients treated out of area; it had also provided improved treatment efficiency; improved patient wellbeing; reduced clinical incidents; and reduced medication use.

The Committee was advised that the Older People Home Treatment Team pilot over the last 18 months had proven to be successful across all performance, financial and quality indicators. It was highlighted that a process of consultation (or targeted engagement) was now required in order to consider the Home Treatment model as a permanent arrangement taking into account staff, carer, patients and stakeholder views.

During discussion, the Committee made the following comments:

- Need for the service – The Committee noted that it was difficult to foresee need going forward, but it was anticipated that need would increase. It was highlighted that the service was not standalone; and that a continuous care pathway in mental health had been set up, It was noted further that a single point for decision making had been introduced across the pathway, to help decisions to be made in a timely manner;
- Joint working – The Committee was advised that the service worked with a network of services and providers across the county;
- Positive effects of Covid-19 - It was noted that there had been positives from the pandemic, one in particular was that of community engagement; and the need to try to perpetuate some of the enthusiasm going forward, as part of the universal offer;
- Older Adult Home Service Treatment Service and the definition of Age for Older. The Committee was advised that the Home Treatment Team dealt with the most acute patients, who did not need to be in hospital; and that contact through the pandemic had continued to be face to face. It was noted that the

other mental health teams, had experienced a reduction in demand; and the service looked at alternative ways to being able to provide the service required. As mentioned earlier in the item a digital offer was made, as was telephone calling; all patients were monitored and received contact. Clarification was given that for dementia there was no age limit and that the term older age had traditionally referred to someone 65 and above, but services were largely offered irrespective of age;

- Ward Provision – Confirmation was given that only one ward was necessary as the need was no longer there. Since the commencement of the model, of the 394 referrals only 28 of the patients had required progression to in-patient admission. This had represented a potential admission avoidance of circa 93% (366 patients avoided admission);
- Positive feedback – The Committee was advised that overall, patient experience of the model had been consistently high and that this information could be shared with the Committee; and
- When targeted engagement or consultation was likely to take place. Reassurance was given that the Trust would seek the views of staff, carers, patients and stakeholders and that the Trust would be commencing targeted engagement or consultation as soon as it could. The Committee noted that Rochford Ward was temporally closed to fund the Older Adult Home Treatment Service; and that the Trust was happy to commence targeted engagement or consultation, if the Health Scrutiny Committee was in agreement. It was confirmed that the Committee was in agreement with this approach.

The Chairman on behalf of the Committee extended thanks to the contributors for the first three items on the agenda.

RESOLVED

That the progress made with the older adult's home treatment service be noted; and that an item on the targeted engagement/consultation be considered a future meeting of the Committee.

11 INTEGRATED URGENT CARE IN LINCOLNSHIRE

The Chairman advised that the report for this item had been circulated separately by email to all members of the Committee.

The Chairman advised further that there were two contributors for this item: Maz Fosh, (Chief Executive, Lincolnshire Community Health Services NHS Trust) and Tracy Pilcher, (Director of Nursing, Lincolnshire Community Health Services NHS Trust).

The Committee received an introduction from the Chief Executive, Lincolnshire Community Health Services NHS Trust, which provided an update on the Integrated Urgent Care Services in Lincolnshire, which was in line with the integrated urgent care commissioning standards, which sought to bring urgent care access, treatment and clinical advice into a much closer alignment through a consistent and integrated

NHS 111 service model. Details of the Lincolnshire integrated urgent care delivery model was included in paragraph one of the report.

In guiding the Committee through the report, the Director of Nursing, Lincolnshire Community Health Services NHS Trust made reference to:

- NHS England's twenty seven standards for Urgent Treatment Centres (UTCs) the Trust had to meet, to ensure that a consistent service was provided to the public. It was noted that the standards specified that UTCs should be integrated with local urgent care services, usually led by general practitioners and should be ideally located with primary care facilities. Details of the nationally mandated UTC standards were shown in paragraph 2 of the report;
- How Lincolnshire Community Health Services were delivering its elements of urgent care; and how this was being achieved. Paragraph 4 of the report provided the Committee with details relating to the significant amount of transformation that was taking place to move to the integrated model. It was noted that the Clinical Assessment Service (CAS) was well established and was operating 24/7 365 days a year providing phone based clinical advice and guidance with timely call backs to patients to support care, closer to home. The Committee noted further that e-consultations (video conferencing) had been introduced within CAS for those patients wishing to use it. The Committee was advised that the Louth and Skegness UTCs had gone live in October 2019; and Lincoln and Boston UTCs had gone live in December 2019. It was also highlighted that the re-building of Boston UTC had commenced. Further transformational changes were shown within paragraph 4 of the report; and
- The Committee noted the changes made during Covid-19. The changes had included an increase in the daily CAS activity of 21%, increasing daily cases to 399; a reduction in attendances at Gainsborough and Spalding Minor Injuries units; a reduction in attendance at Louth and Skegness UTCs; and the designation of Grantham and District Hospital as a temporary UTC (This decision had been taken by the United Lincolnshire Hospitals NHS Trust Board of Directors on 11 June 2020), as part of plans to provide a Covid-19 free 'green' site at Grantham Hospital.

During discussion, the Committee raised the following points:

- Some concern was expressed for Grantham & District Hospital to return to having an A&E; and not a temporary Urgent Treatment Centre. Confirmation was given that Grantham had a 24/7 walk in UTC. This model had allowed temporary changes to clinical pathways to support United Lincolnshire Hospital NHS Trust (ULHT) in their efforts to create Covid-19 free 'green' site at Grantham;
- Confirmation was given that Lincolnshire Community Health Services Trust (LCHS) did not have a contract with ULHT in relation to the Grantham UTC, but that a Memorandum of Understanding was in place. It was highlighted to the Committee that the arrangements were for a temporary period and both

ULHT and LCHS were working together to ensure services were provided during Covid-19;

- Complaints from Grantham residents contacting NHS 111. It was reported that Grantham residents when contacting NHS 111 were being directed to either Lincoln or Pilgrim Hospital. The Committee was advised that profile details for Grantham had now been updated to reflect the temporary changes. The Committee was invited to pass on any further queries to LCHS;
- Good Communication - The need to make sure that patients were aware of what was on offer and how it could be accessed;
- Staffing – The Committee was advised that a full workforce review had taken place, which ensured that there was the correct number of staff, with the right skills in the right place to meet demand now and for the future;
- GP Out of hours – It was highlighted that GP out of hours was still available where a UTC was integrated. Confirmation was also given that provision was still available at Grantham Hospital;
- Staffing of the Clinical Assessment Service – The Committee was advised that CAS was staffed with suitably qualified staff and included GPs; and that the service was agile; and that in busy times clinicians were able to log on remotely. It was noted that the average waiting time was ten minutes; and as staff numbers had increased, patients were contacted more quickly;
- Reference was made to the role of Primary Care Networks in supporting urgent care, but these were not yet coterminous with Neighbourhood Teams;
- Whether the new NHS 111 could actual cope with the demand. It was highlighted that for patients in Lincolnshire, calls made into NHS 111, which were categorised as being suitable for LCHS services were passed to the CAS. It was highlighted further that CAS was available 24/7, 365 days a year to provide self-care advice where appropriate, provide a telephone consultation with a clinician to assess patient's needs; and when a patient was assessed as needing additional support, the CAS clinician had a range of options available to them to ensure that the best option was provided to the patient, which included: video consultation; same day direct booking into general practice; same day booked appointment into a UTC, or a home visit; or onward referral to the community nursing team;
- Whether Care Homes had access to NHS 111. The Committee was advised that all care homes had a special number to be able to ring to access the CAS service;
- Reassurance was given that anyone presenting themselves at Grantham temporary UTC would be dealt with accordingly; or transferred for treatment, if necessary. There was an appreciation that on occasions it was confusing for members of the public, and it was highlighted that patients were being encouraged to use the 'talk before you walk' concept, by calling NHS111;
- Concern was expressed that the 'overnight walk-in' arrangements had not been reinstated at Louth and Skegness UTC'. Reassurance was given that the situation was being monitored; and that patients had access to home visits and booked consultations. The Committee noted that If there was an increase in numbers, the overnight provision would be re-instated;
- A question was asked as to how many people had been referred from Grantham to A&Es elsewhere and confirmation was sought whether the figure

was still at 3.88% (which represented 44 people). The Committee was advised that the figure was closely monitored; and that currently the figure was between 3 and 5%; and

- The effect of the building works at Pilgrim Hospital, Boston on the UTC. The Committee was advised that the UTC was in a different location; and that the A&E continued to meet the needs of the public.

The Chairman on behalf of the Committee extended thanks to the presenters.

RESOLVED

That the update report on Integrated Urgent Care in Lincolnshire be noted; and that a request be made for a further update to the Committee in three months.

12 CORRESPONDENCE AND OTHER DEVELOPMENTS

The Chairman advised the Committee that the report for this item could be found on pages 41-57 of the report pack. The Committee was advised further that to date a response had not been received to the letter sent on behalf of the Committee to the Secretary of State for Health and Social Care.

The Chairman invited Simon Evans, (Health Scrutiny Officer) to present the report. The Committee was advised of the action taken by Lincolnshire County Council and South Kesteven District Council relating to the plans for NHS Services in Lincolnshire, in particular the impact of services at Grantham and District Hospital.

Attached at Appendix A to the report was a copy of the letter sent on behalf of the Committee to the Secretary of State for Health and Social Care on 23 June 2020; and at Appendices B and C were copies of letters sent following the Lincolnshire County Council resolution made on 26 June 2020 for the Committee's consideration.

The Committee was advised that once any response was received, a copy would be forwarded on to members of the Committee.

RESOLVED

1. That the Committee note that following the Committee's decision on 17 June 2020, a letter had been sent to the Secretary of State for Health and Social Care on 23 June 2020, as shown in Appendix A.

2. That the resolutions passed by Lincolnshire County Council on 26 June 2020 and South Kesteven District Council on 1 July 2020 in relation to NHS Services in Lincolnshire, particularly those services at Grantham and District Hospital be noted.

3. That an update from United Lincolnshire Hospitals NHS Trust on 16 September 2020 on the progress with the restoration plan be noted.

4. That Lincolnshire Clinical Commissioning Group has been requested to report on the Healthy Conversation 2019 engagement exercise and that an update on the Lincolnshire Long Term Plan will be given at the 16 September 2020 meeting, be noted.

13 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

The Chairman invited Simon Evans, (Health Scrutiny Officer) to present the report, which was shown on pages 59 to 67 of the report pack.

During a short discussion, a suggestion made was for introducing a break in proceedings going forward. The Chairman agreed to consider this matter at the agenda setting meeting in early September.

The Chairman advised the Committee that Liz Ball was retiring from the NHS; and that this would be her last meeting she would be attending. The Committee was reminded that Liz had been the Committee's special advisor from the NHS, attending each meeting in her role. On behalf of the Committee the Chairman extended thanks to Liz for her contributions over recent years.

RESOLVED

That the work programme presented be received.

The meeting closed at 1.24 pm

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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:	**16 September 2020**
Subject:	**Chairman's Announcements**

1. Third Phase of NHS Response to Covid-19

On 31 July 2020, Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer, issued the 'third phase' letter on the NHS's response to Covid-19. This followed the first and second phase letters, issued on 30 January and 29 April 2020 respectively. The 31 July letter stated that the national incident level had been reduced from level 4 to level 3 with effect from 1 August.

The third phase letter and supporting guidance are available at the following link:

https://www.england.nhs.uk/coronavirus/publication/third-phase-response/

The letter details the NHS's priorities from 1 August 2020, with a focus on:

A. Accelerating the return to near-normal levels of non Covid-19 health services, making full use of the capacity available in the 'window of opportunity' between now and winter:

A1 **Restoring full operation of all cancer services**. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021.

A2 **Recovering the maximum elective activity possible between now and winter**, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals.

A3 **Restoring service delivery in primary care and community services**.

A4 **Expanding and improving mental health services and services for people with learning disability and/or autism.**

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid-19 spikes locally and possibly nationally:

B1 **Continuing to follow good Covid-19 practice to enable patients to access services safely and protect staff**, whilst also preparing for localised Covid-19 outbreaks or a wider national wave.

B2 **Preparing for winter** by sustaining current NHS staffing and bed capacity; expanding the flu vaccination programme; expanding 111 First; and continuing to work with local authorities.

C. Learning the lessons from the first Covid-19 peak; keeping beneficial changes; and explicitly tackling fundamental challenges such as support for staff, and action on inequalities and prevention:

C1 **Workforce** - keeping staff safe; flexible working; addressing systemic inequality; new ways of working; growing the workforce; and workforce planning.

C2 **Health inequalities and prevention** – protecting the vulnerable; accelerating preventative programmes; strengthening leadership and accountability; and ensuring complete data.

Each sustainability and transformation partnership area will be required to submit a summary plan by 21 September 2020.

2. National Institute of Health Protection

On 18 August 2020, the Government announced the establishment of the National Institute for Health Protection. The new organisation will bring together Public Health England and NHS Test and Trace, as well as the analytical capability of the Joint Biosecurity Centre under a single leadership team as a the first step towards becoming a single organisation.

The new organisation will report directly to the Secretary of State for Health and Social Care, with responsibilities including local health protection teams; support to local authorities; the Covid-19 testing programme and contact tracing; emergency response and preparation; research laboratories; and surveillance of all infectious diseases.

The Government has stated that preventing ill health and reducing health inequalities remain a top priority and it is considering the future options for Public Health England's remaining health improvement functions.

3. Ash Villa, Near Sleaford - New Mental Health Ward for Women

On 22 July 2020, the Committee was advised that, in the overall context of the pilot of the Child and Adolescent Mental Health Services, Ash Villa, near Sleaford, was no longer fit for purpose for mixed in-patient care for young people.

On 10 August 2020, Lincolnshire Partnership NHS Foundation Trust (LPFT) announced that Ash Villa would be providing fifteen additional acute treatment beds for women, who are experiencing a severe, short term episode of mental ill health, and who cannot be safely supported by community services.

Ash Villa will complement existing adult acute mental health wards in Boston and Lincoln, where patients will receive their initial assessment. Following their assessment, female patients, can be transferred to Ash Villa for their treatment and support before discharge, if this approach is supported by their assessment.

LPFT has stated that it wants to eliminate the number of patients travelling for acute care for some time and Covid-19 has magnified this challenge. Over the last two years there have been more females admitted to acute inpatient services than males and these additional beds will allow us flexibility across its entire adult acute inpatient services.

Lincolnshire Clinical Commissioning Group has stated that the Lincolnshire health and care system has been committed to eliminating the inappropriate use of out of area hospital care for mental health patients and there is likely to be increasing demand for mental health services following the pandemic, requiring additional local ward capacity to support those with acute mental health.

LPFT will undertake minor works to the current building and is recruiting a new ward team, with the plans for the ward to be operational by the end of 2020.

4. Allocation of Funding to Accident and Emergency Departments

On 11 August 2020, the Prime Minister announced that 117 acute hospital trusts would be sharing a funding allocation of £300 million to upgrade their accident and emergency facilities in readiness for winter 2020/21. Hospitals are expected to use the funding to increase the number of treatment cubicles and expand waiting areas. This should increase accident and emergency capacity, and thus reduce overcrowding and improve infection control measures. This should in turn help people to feel confident about visiting an accident and emergency department. Projects will be completed by the start of 2021, so hospitals benefit from the upgrades during the peak of winter.

The allocation to United Lincolnshire Hospitals NHS Trust (ULHT) is £2 million; North West Anglia NHS Foundation Trust has an allocation of £3.7 million; and Nottingham University Hospitals NHS Trust will receive £2 million. No allocation has been made to Northern Lincolnshire and Goole NHS Foundation Trust.

ULHT has stated that the £2 million will be used to provide additional clinical space and a new waiting area at Pilgrim Hospital's A&E Department. This will support social distancing and the emergency department will be able accept patients from ambulance crews with improved speed and safety. All of the work from the £2 million allocation will be completed ahead of this winter.

ULHT has confirmed that this funding is in addition to the £21.3 million allocated in 2019 for larger scale improvements at Pilgrim's A&E. On 4 August 2020, the ULHT Trust Board agreed to seek outline planning permission and will discuss the plans with NHS England and NHS Improvement, in order to obtain the required approval for the release of the funding. It is planned that works for the longer term transformation will begin in late spring of 2021 and be completed by early 2024.

5. Midlands Cancer Services Rapid Review

NHS England / Improvement (NHSE/I) has provided a briefing on its rapid review of cancer services. Urgent cancer treatment was one of the services that was maintained during the Covid-19 pandemic. However, pauses in treatment for other patients, interruptions to screening and a general concern about visiting GPs or hospitals are creating a backlog of patients who need to be seen and treated.

NHSE/I states that the full restoration of cancer services has been complicated by their dependence on screening and people's confidence to attend clinics. The longer it takes for screening and confidence levels to return to normal, the greater the backlog becomes. NHSE/I has concluded that doing nothing is not an option, so is reviewing the whole cancer pathway to increase capacity and workforce.

Recommendations will be made at the end of August. This will be followed by joint development of more local implementation plans, and a regional strategy and capacity recommendation document.

6. Breast Screening Restoration of Services

NHS England / Improvement (NHSE/I) has issued an update on restarting NHS breast screening services in the Midlands, which have been affected by the Covid-19 pandemic, with local breast screening services rescheduling invitations and appointments to a later date. NHSE/I, as commissioners of breast screening services, have been working with providers to restore the programme, focusing on the highest priority patient groups.

There has been a reduction in screening capacity owing to the requirements for personal protective equipment, enhanced infection control and social distancing. This, together with invitations, has unfortunately resulted in a backlog of appointments.

Phase 1 Restoration

Phase 1 restoration guidance focuses completing the screening pathway for:

- women who are high risk,
- women who have screened positive
- women whose results were not processed or
- women who were invited but not screened.

Phase 2 Restoration

Under phase 2 women based on the priorities below:

1. women aged 53 and not previously invited;
2. women aged 71+ who were due screening pre-Covid-19 but who have not been screened; and
3. women aged 50 to 70 years.

Any woman aged 71 or over who contacts the service to request an appointment will be advised that self-referrals are not currently available. However, if women notice any symptoms, they should contact their GP.

Open Invitations

A national decision has been taken, as an interim measure, to encourage providers to move to issuing 'open invitations' for routine clients where possible, as opposed to issuing a letter with a date and time for an appointment. Open invitation letters will ask women to contact the service to book a convenient appointment by phone or email. The use of open invitations is intended to reduce *Do Not Attend* rates and maximise the numbers of women screened.

7. Cardiac Services Rapid Review

NHS England / NHS Improvement (NHSE/I) has advised that the Covid-19 pandemic has led to the following: -

- an approximate 35% reduction in the number of heart attack admissions to hospital;
- an increase in cardiovascular mortality in the community, with more than 4,200 excess cardiovascular deaths, predominantly at home or in care homes, not associated with Covid-19;
- an increase in the number of cardiovascular patients presenting to hospital with an out-of-hospital cardiac arrest; and
- a reduction in the number of interventional procedures for cardiovascular disease.

Activity continues to be well below pre-Covid-19 levels, with surgery capacity remaining challenging; infection prevention and control measures impacting diagnostics and catheter laboratories; some staff still re-deployed, shielding or sick; and a decrease in the number of patients presenting and being referred.

For these reasons, following a rapid review NHSE/I has developed a plan and will work jointly with NHS colleagues across the Midlands to:

- provide sustained equitable access to cardiac services;
- adopt new technologies to enhance patient and clinical pathways;
- develop greater integration with primary care;
- develop a commissioning framework and greater collaboration; and
- to support patients whose planned procedures have been delayed.

NHSE/I intends to establish a regional cardiac services strategic delivery board, with six operational delivery networks. Over the next few months, each operational delivery network will develop plans to address the factors limiting recovery from Covid-19, for example, by ring-fencing beds; repatriating redeployed staff; and using the independent sector as well as evening and weekend working. Derbyshire, Nottinghamshire and Lincolnshire are located in one operational delivery network.

NHSE/I will provide further updates as plans develop.

8. East Midlands Renal Services Review

As reported to the Committee on 22 July 2020 *(Paragraph 2, Supplementary Chairman's Announcements)*, NHS England and NHS Improvement (NHSE/I) had re-started a rapid review of renal services in the Midlands as part of the national renal strategy. This review had been paused in early 2020, owing to the Covid-19 pandemic.

NHSE/I has provided an update on the rapid review, which has made eight recommendations for further activity:

(i) Funding a Midlands Renal Network to support, disseminate and implement innovation and across the Midlands and to reduce inequality of access.

(ii) Developing a transplant capacity model through the Renal Network, to include a shared waiting list for equitable access, to reduce waiting times.

(iii) Developing 'pathway integration' with commissioners and providers to improve services and outcomes.

(iv) Providing equitable access to home therapies, as infection risks are much lower for home dialysis than dialysis received in a unit, including a dedicated team to improve education, support training and provide initial set up.

(v) Identification of transplant patients in renal centres through access to staff with specialist transplant knowledge.

(vi) Providing mental health support, as transplant and dialysis patients often have depression and anxiety, which in turn can reduce medical adherence and lead to less positive outcomes.

(vii) Improving access to vascular and diagnostic services In order to improve access to vascular and diagnostic services, a range of measures are being considered to allow more patients to be prepared for either dialysis or transplants. Mutual aid and day case surgery are all being investigated. The review recommends that providers identify and protect capacity for vascular access so that no patient experiences unnecessary delays. It is also recommended that transplant and chronic kidney disease patient diagnostic requirements are included in trusts' plans for restoration of diagnostic services

(viii) Renal Services in Adult Critical Care - Many Covid-19 patients required renal replacement therapy. It is the intention to ensure that workforce in adult critical care can support current and future capacity for renal replacement therapy.

The network is developing a plan to take forward these recommendations which includes options appraisals, review of upcoming guidance and development of baseline capacity models. NHSE/I has indicated it will provide more updates as the review progresses.

9. Care Quality Commission - Provider Collaboration Reviews

The Care Quality Commission (CQC) is undertaking a programme of provider collaboration reviews on integrated care system or sustainability and transformation partnership areas. In the first round, the CQC is focusing on eleven areas, which include the Lincolnshire Sustainability and Transformation Partnership.

The CQC states that provider collaboration reviews will look at how health and social care providers are working together and will aim to help providers learn from each other's experience of responding to Covid-19. The CQC's ambition is to produce one national report on the themes and learning that can be used to inform planning for any subsequent waves of Covid-19 and planning for the coming winter.

The CQC will not be making a judgment on any one system and will not identify individual providers or systems within the report, but with the agreement of the provider may name services where there are examples of practice from which others may wish to learn.

The CQC will undertake the reviews virtually, gathering the views of people, who use services and speak with a range of health and social care providers.

10. Dental Services – Mablethorpe

As previously reported to the Committee, from 8 June 2020 NHS Dental Services have been allowed to re-open, provided the appropriate measures are in place to ensure the safety of staff and patients. This followed their closure for face-to-face consultations in response to the Covid-19 pandemic.

Dental care in Mablethorpe has been an issue, irrespective of Covid-19. NHS England / NHS Improvement (NHSE/I) was unable to secure a new provider of NHS Dental Services in the area, following a procurement exercise in 2019.

From 11 August 2020, urgent NHS dental care sessions have been available at Marisco Medical Practice, Stanley Avenue, Mablethorpe, as an interim measure until 31 March 2021. No walk-in services are allowed to ensure the safety of all patients and staff.

NHSE/I has stated the long term provision of NHS dental services in the Mablethorpe area is a commissioning priority and they will continue to work to address the provision of routine dental care in the area and plan to commission new services during 2020.

11. Annual Reports and Accounts 2019/20 and Annual Meetings

The annual reports and accounts of local NHS organisations have been published, with online annual public meetings scheduled to take place during September. Details are set out below: -

Lincolnshire Clinical Commissioning Group

Lincolnshire Clinical Commissioning Group (CCG) has published the 2019/20 annual reports and accounts for the four former Lincolnshire CCGs, which ceased to exist on 1 April 2020 following the establishment of the Lincolnshire CCG, covering the whole of the county. The four reports are available at: -

https://lincolnshireccg.nhs.uk/annual-report-and-accounts-2019-2020/

United Lincolnshire Hospitals NHS Trust

The annual report and accounts for 2019/20 for United Lincolnshire Hospitals NHS Trust are available at:

https://www.ulh.nhs.uk/about/trust/annual-reports/#annual-reports

Lincolnshire Community Health Services NHS Trust

Lincolnshire Community Health Services NHS Trust's annual report and accounts for 2019/20 will be available at the following link:

https://www.lincolnshirecommunityhealthservices.nhs.uk/about-us/our-publications/annual-reports

The Trust's annual public meeting is due to be held on 8 September 2020 at 12.15pm. Details of this meeting were emailed to the Committee prior to the despatch of this agenda.

Lincolnshire Partnership NHS Foundation Trust

Lincolnshire Partnership NHS Foundation Trust's annual report and accounts for 2019/20 will be available at the following link:

https://www.lpft.nhs.uk/about-us/accessing-our-information/annual-reports-and-accounts

The Trust's annual public meeting is due to be held on 17 September 2020 at 1.30pm – 4.30 pm. Details of this meeting were emailed to the Committee prior to the despatch of this agenda.

East Midlands Ambulance Service NHS Trust

The annual report and accounts for 2019/20 for the East Midlands Ambulance Service (EMAS) are available at the following link:

https://www.emas.nhs.uk/about-us/trust-documents/

EMAS's annual public meeting is due to be held on 9 September 2020 at midday. Details of this meeting were emailed to the Committee prior to the despatch of this agenda.

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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:	**16 September 2020**
Subject:	**United Lincolnshire Hospitals NHS Trust – Covid-19 Update**

Summary

This item enables the Health Scrutiny Committee for Lincolnshire to consider the progress of United Lincolnshire Hospitals NHS Trust (ULHT) in its restoration and recovery following the acute phase of the Covid-19 pandemic. The information submitted to the Committee comprises two reports, which have been submitted to the ULHT Board in July and September 2020.

Management representatives from ULHT are due to attend the meeting to present the information and respond to questions.

Actions Required

(1) To consider the information presented by United Lincolnshire Hospitals NHS Trust on their restoration and recovery, following the acute phase of the Covid-19 pandemic.

(2) To note that a full review of the Grantham Hospital 'green' site is due to be considered by United Lincolnshire Hospitals NHS Trust Board on 6 October 2020.

(3) To consider the timing of the Committee's next update from the United Lincolnshire Hospitals NHS Trust on its recovery from Covid-19.

1. Previous Committee Consideration

On 17 June 2020, the Health Scrutiny Committee considered an item on the arrangements of United Lincolnshire Hospitals NHS Trust to restore NHS services, following the acute phase of the Covid-19 pandemic. The Committee requested a further update within three months.

2. Latest Information

This item comprises two reports, which have been submitted to the Board of Directors of United Lincolnshire Hospitals NHS Trust (ULHT). The most recent report, submitted to the ULHT Board on 1 September 2020, is attached at Appendix A. This followed an earlier report, considered by the ULHT board on 7 July 2020 (Appendix B).

3. Consultation

This is not a direct consultation item.

4. Conclusion

The Committee is invited to consider the information presented by on its restoration and recovery, following the acute phase of the Covid-19 pandemic. A full review of the Grantham Hospital 'green' site is due to be considered by United Lincolnshire Hospitals NHS Trust Board on 6 October 2020.

5. Appendices

These are listed below and attached to this report: -

Appendix A	Report to United Lincolnshire Hospitals NHS Trust Board of Directors (1 September 2020) - ULHT Covid-19 Recovery Phase Update – Progress Summary
Appendix B	Report to United Lincolnshire Hospitals NHS Trust Board of Directors (7 July 2020) - ULHT Covid-19 Restore Phase Update – Progress Summary

6. Background Papers

No background papers, as defined by Part VA of the Local Government Act 1972, were used to a material extent in the preparation of this report.

This report was written by Simon Evans, Health Scrutiny Officer, Lincolnshire County Council, who can be contacted via 07717 868930 or Simon.Evans@lincolnshire.gov.uk

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Public Board*
Date of Meeting	*1st September 2020*
Item Number	*Item 7.1*
ULHT Covid-19 Recovery Phase Update – Progress Summary	
Accountable Director	*Simon Evans, Chief Operating Officer*
Presented by	*Simon Evans, Chief Operating Officer*
Author(s)	*Simon Evans, Chief Operating Officer*
Report previously considered at	*ELT*

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	*X*
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	*Strategic Risk Register Covid-19 Pandemic Entry*
Financial Impact Assessment	*Both Significant Capital & Revenue- Further Described in Financial Reports*
Quality Impact Assessment	*QIAs are completed for service changes in line with Covid-19 Governance As previous reported*
Equality Impact Assessment	*EIAs are completed for major service changes in line with Covid-19 Governance As previous reported*
Assurance Level Assessment	• *Moderate*
Recommendations/ Decision Required	• *The Board are asked to accept this progress update, noting the nature of the current emergency response, the nature of frequent new guidance and requirement for all plans to be flexible and responsive.*
	• *The Board are asked to accept a future report on Grantham Green Site at October Trust Board*
	• *The Board are asked to consider future Covid Reports beyond the October report being reviewed at FPEC, with upward reporting from that Committee only.*

Executive Summary

On the 31 July the Trust received confirmation of the move to Phase 3 of the Covid-19 Pandemic Response. This notification described in more detail the requirements for Recovery phase operating until 31 March 2020.

This report does not describe the response to this plan in full as this extensive exercise similar to an annual planning round is being conducted with submissions due in early September. As such September's report provides an update in between Restoration and Recovery articulating the progress made on Restoring capacity in key service areas.
Phase 3 planning has been split into 3 high level objectives:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first

Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

The Trust's response to date in diagnostic capacity recovery has been positive, with particular progress in Endoscopy and Radiology. Both areas having put in place capacity to support Cancer services and reduce backlogs swiftly. Other areas of diagnostic waiting lists are still large recovery trajectories will be set as part of the Phase 3 plan.

Planned care waiting lists have continued to plateau after a period of decrease in the Restore Phase. In addition to this patients waiting more than 46 weeks for treatment have continued to increase, however increased surgery and progress on treatment capacity in particular at Grantham Hospital is expected to start to impact on these non-urgent waiting lists now cancer waiting lists have reduced.

Cancer recovery has been positive and the Trust has met the objective of reducing patients waiting more than 62 days for treatment by 20% by the 21 August 2020. Patients waiting more than 103 days objective was not met, however significant progress was made reducing the waiting list by more than 60%.

Urgent care demands have continued to increase and waiting time standards have continued to decline. Comparisons with previous years' performance are still positive, however continuing to show improvements.

1. Background

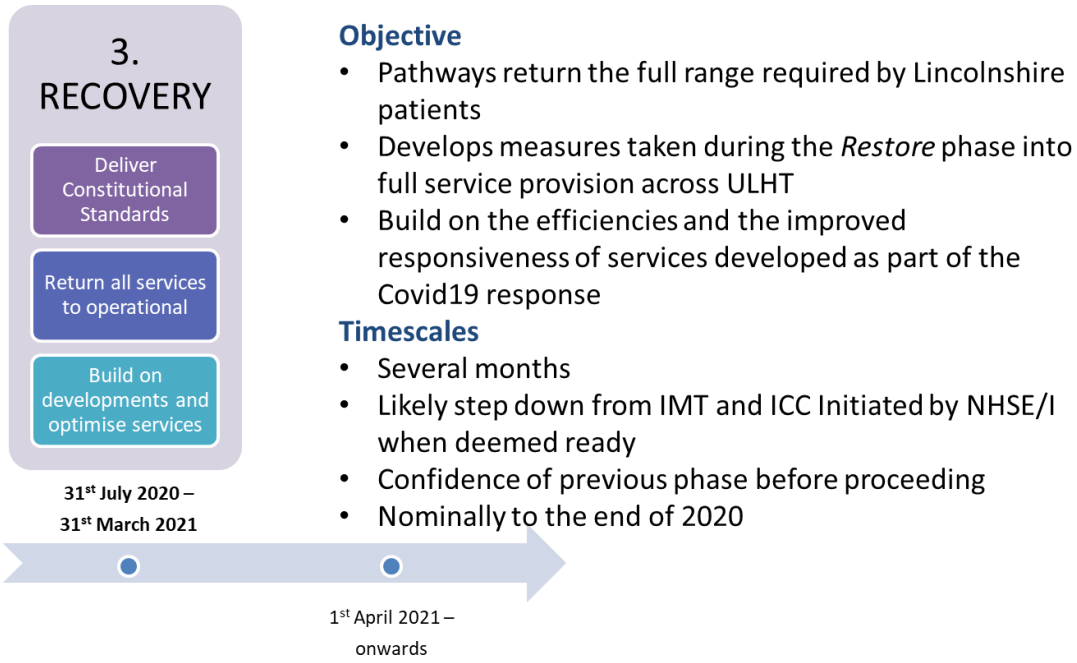
On 30 January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. At the same time Covid-19 was confirmed as a High Consequence Infectious Disease and the UK risk level was raised from moderate to high. On 3 March the Department 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.

On 31 July the Trust received confirmation of the beginning of Phase 3 *Recovery* in a letter to all Trusts from Sir Simon Stevens NHS Chief Executive and Amanda Prichard, NHS Chief Operating Officer. From 1 August the NHS would officially begin its medium-term recovery planning with submission of detailed planning assumptions, activity levels and impact on waiting times due by 8 September 2020.

From 1 August 2020 the NHS National Emergency level was lowered to Level 3 describing the response moving from National to regional direction. During this time Trusts have been reminded that this does not negate the rapid response required should circumstances change and the level of preparedness which must continue to be at its highest, maintaining such key functions as Incident Command Centres and Single Point of Contact systems.

2. Recovery Phase Planning and National

The Trust's campaign plan approved in May 2020 described the main objectives of Phase 3 as per below:



Detailed Phase 3 guidance was issued on the 31 July and describes the following key elements that must be planned for in the remainder of 2020/2021. These three main principles A, B and C are sub-divided into more detailed explanations of what is

required, some of which have targets set for Recovery of capacity levels.

The main objectives are as follows:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

With more detailed explanation of the 'ask' described as:

A1 Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021 to:

- To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.
- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:
    - Ensuring that sufficient diagnostic capacity is in place in Covid-19secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
- Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
- Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
- Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
- Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.
- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre- pandemic levels, with an immediate plan for managing those waiting longer than 104 days.

A2 Recover the maximum elective activity possible between now and winter.

- Trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:

    - In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October (while aiming for 70% in August);
    - This means that systems need to very swiftly return to at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October.
    - 100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).
- Elective waiting lists and performance should be managed at system as well as trust level to ensure equal patient access and effective use of facilities.
- Clinically urgent patients should continue to be treated first, with next priority given to the longest waiting patients, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.
- To further support the recovery and restoration of elective services, a modified national contract will be in place giving access to most independent hospital capacity until March 2021.

Both A3 and A4 Recovery objectives make reference to services in Primary, Community and Mental Health Services.

B1 Continue to follow good Covid-related practice to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave. This includes: Trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:

- Continuing to follow Public Health England's guidance on defining and managing communicable disease outbreaks.
- Continue to follow Public Health England /DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed actions set out on testing on 24 June. All NHS employers should prepare for the likelihood that if background infection risk increases in the autumn, and DHSC Test and Trace secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine Covid testing of all asymptomatic staff across the NHS.
- Ongoing application of Public Health England's infection prevention and control guidance and the actions set out in the letter from 9 June on minimising nosocomial infections across all NHS settings, including appropriate Covid-free areas and strict application of hand hygiene, appropriate physical distancing, and use of masks/face coverings.
- Ensuring NHS staff and patients have access to and use PPE in line with PHE's recommended policies, drawing on DHSC's sourcing and its winter/EU transition PPE and medicines stockpiling.

B2 Prepare for winter including by:

- Sustaining current NHS staffing, beds and capacity, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.
- Deliver a very significantly expanded seasonal flu vaccination programme
- Expanding the 111 First offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly.
- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.
- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.
- Continuing to work with local authorities, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/ Public Health England policies.

C1 Workforce

All systems should develop a local People Plan in response to these actions. It includes specific commitments on:

- Actions all NHS employers should take to **keep staff safe, healthy and well** – both physically and psychologically.
- Specific requirements to **offer staff flexible working**.
- Urgent action to **address systemic inequality** that is experienced by some of our staff, including BAME staff.
- **New ways of working and delivering care**, making full and flexible use of the full range of our people's skills and experience.
- **Growing our workforce**, building on unprecedented interest in NHS careers. It also encourages action to support former staff to return to the NHS, as well as taking steps to retain staff for longer – all as a contribution to growing the nursing workforce by 50,000, the GP workforce by 6,000 and the extended primary care workforce by 26,000.
- **Workforce planning and transformation** that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally.

C2 Health inequalities and prevention

Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:

- Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant

protected characteristics and social and economic conditions; and better engage those communities who need most support.

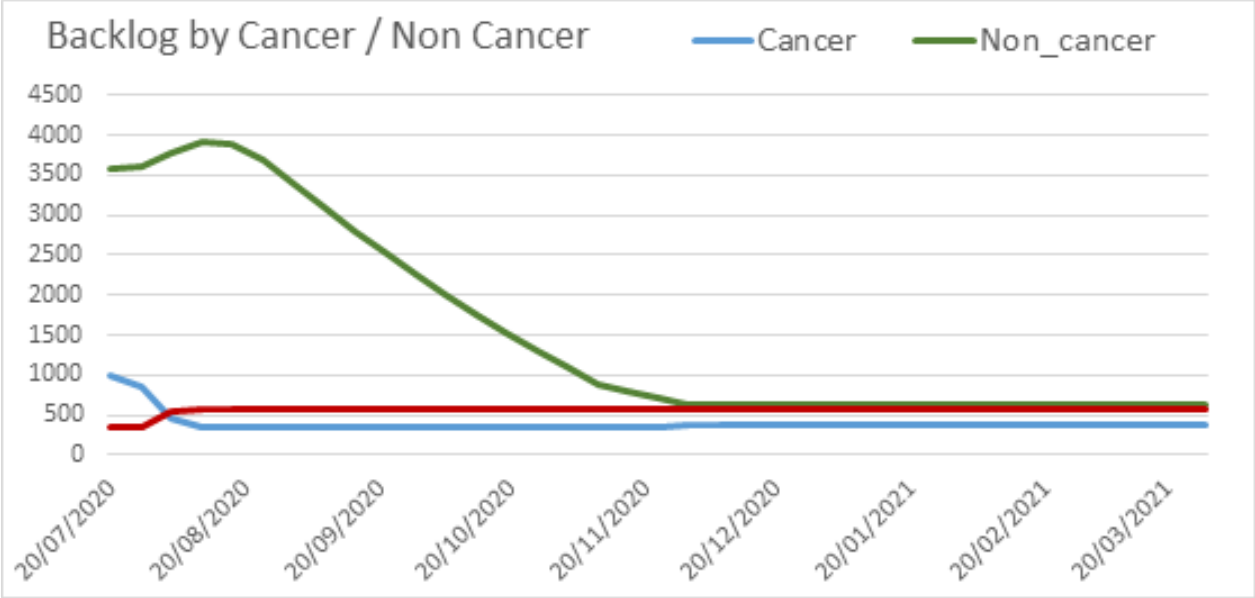
- Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes.
- Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.
- Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities.

3. Progress on Recovery of Planned Care Services including Cancer Care A1 and A2

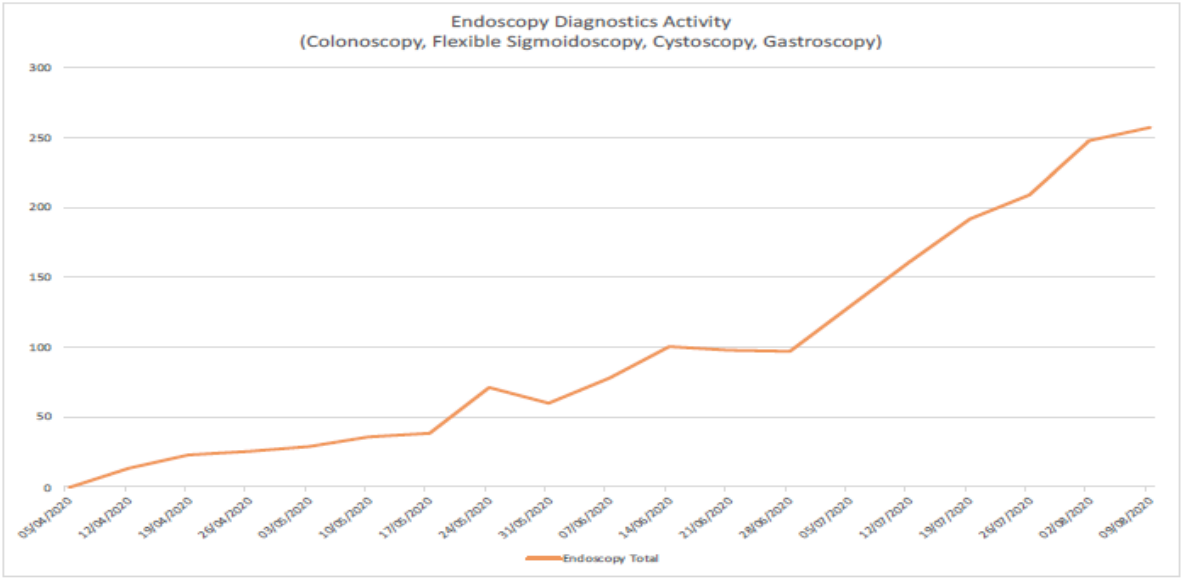
Phase 3 planning is still in progress at the time of production of this report. Submission of the initial draft of the planning assumptions is due on the 1 September with subsequent iterations combined with a confirm and challenge due in the weeks following. This planning process includes many aspects of a traditional planning round with commissioners and regulators, detailing all types of activity in all specialties with a comprehensive financial and workforce plan that sits alongside. Clearly this is a very intensive piece of planning work from divisions and has condensed what is normally in 3 month process into less than 1 with added complexity of planning for scenarios that include resurgence of Covid-19 waves as well as Influenza and other increased urgent care pressures.

3.1. Endoscopy Recovery

Endoscopy recovery plans have continued to show improvements in capacity and reduced waiting times. Initial focus has been to improve access to suspected cancer services, and from the trajectory shown overleaf this reduction has been achieved rapidly. A deliberate prioritisation of clinical time for all staff capable of carrying out endoscopy procedures has led to mitigation in the reduction in productivity through increased IPC measures. In addition to this, restoration of Louth Endoscopy unit as well as all three other hospital sites, together with the use of insourcing has now more than compensated for the original loss because of Covid-19 measures.

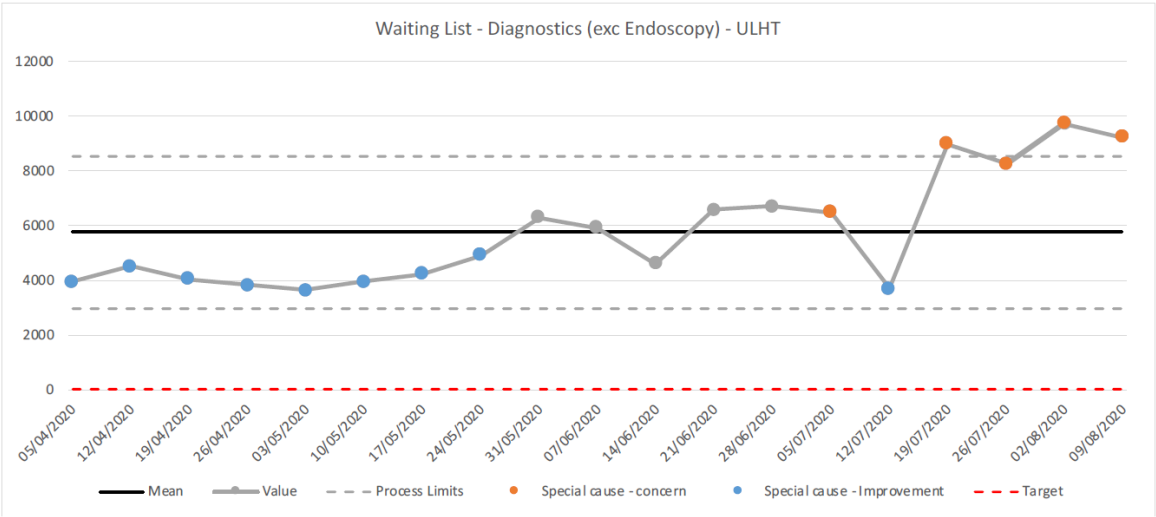


By the 1 September bookings for suspected cancer in Endoscopy will be made within the 14 day window required as part of the cancer 2ww standard.

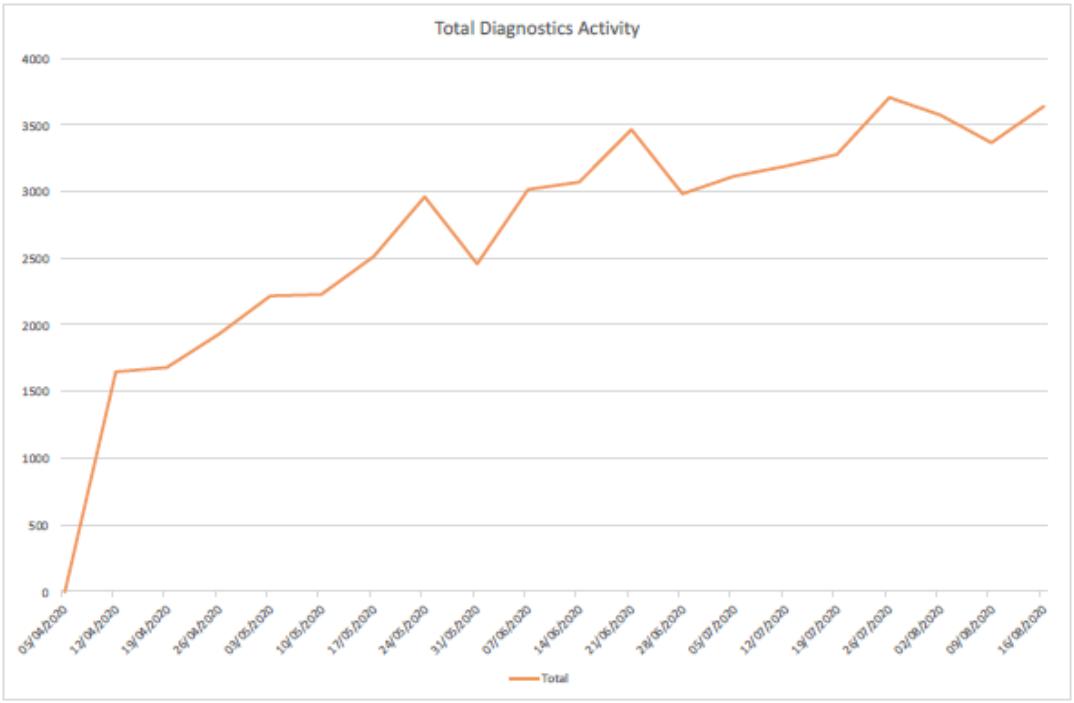


Although the full recovery plan is still being compiled full recovery of all cancer and non cancer endoscopy waiting lists are expected by November/December. Subject to resurgence of Covid-19 and other winter impact.

3.2 Radiology and Other Diagnostic Recovery

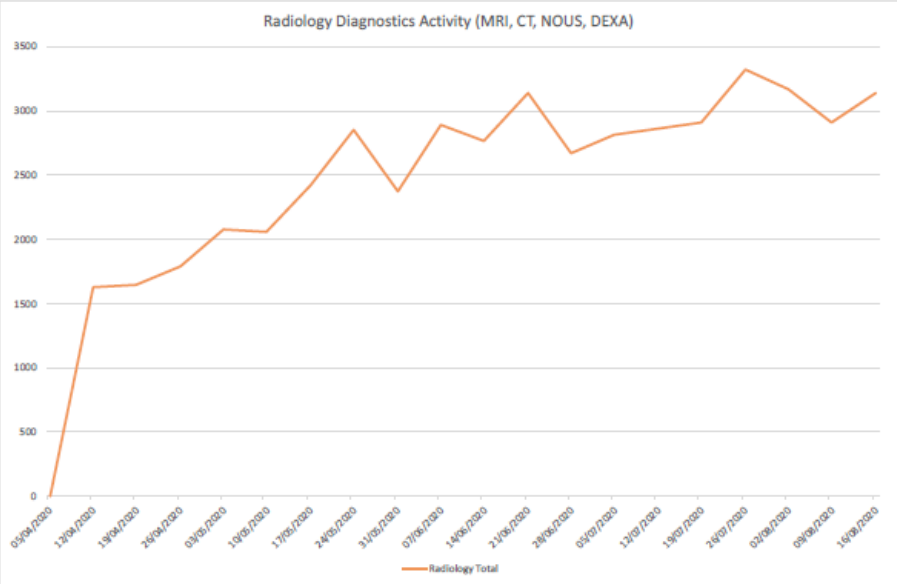


Although diagnostic services have restarted and in most cases steadily increased capacity as part of restore phase, those services that are non-cancer have not had the same priority as services such as Endoscopy. As a result waiting lists have started to slow and now in recent weeks have been maintained without significant increases.



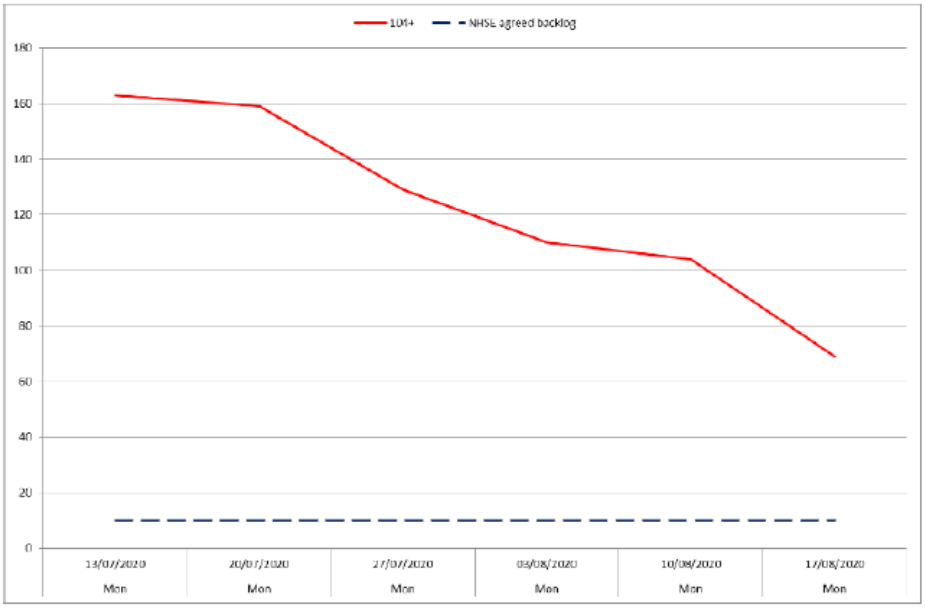
Despite priority having been given to those cancer and clinically urgent services, it is clear to see that the overall increase in capacity that has been achieved since the near complete shutdown of diagnostic service capacity is tangible. This is expected to continue and Phase 3 plans will look to forecast what impact this will have on waiting lists across the remainder of the year.

Of particular note in diagnostic services is the Recovery of diagnostic imaging capacity. Increases in the availability of diagnostic imaging equipment (ultrasound, CT and MRI) as well as developments in the way that the equipment is used in conjunction with Covid-19 precautions has led to the now near full Recovery of pre Covid-19 capacity ahead of the deadline stipulated in the mandate in Phase 3.



Continued work with system partners and the wider regional Diagnostics board is supporting the adoption of best practice in Radiology, and developments continue particularly at the Gonerby Road Health Clinic in Grantham, where possibilities for the Lincolnshire Community Diagnostic Hub are being developed.

3.3 Cancer 62 and 104 Trajectories and Reductions



Cancer services have remained a focus throughout the Restore phase and expectations are clearly stipulated in A1 of the phase 3 directives. Prior to Phase 3 notification all Midlands region acute Trusts were given directives from the regional Medical Directors office stipulating the need for urgent response to patients waiting more than 62 days and 104 days for Cancer treatment.

These objectives were as follows:

All patients waiting 104 days and over including endoscopy, to be seen within 6 weeks by the 21 August 2020.

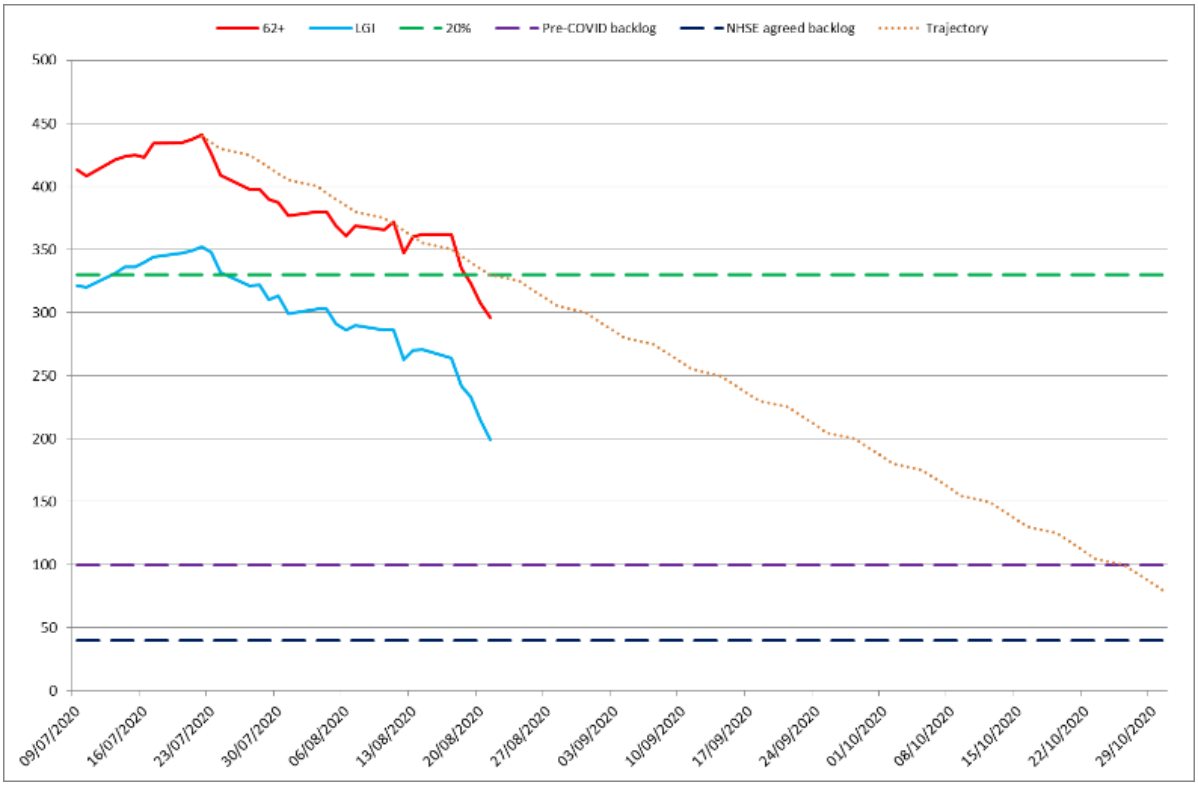
The Trust response to this was to fully maximise the capacity available in diagnostic services described in section 3.1 and 3.2 of this report together with priority access to treatments (particularly at the Grantham Green Site). The result was of the 163 patients who were over 103 days on 9 July, only 27 remain on the pathway on the 21 August.

Of these remaining 27 patients, every patient was seen in an outpatient setting, had a diagnostic investigation or had a telephone consultation with the clinical team. (Telephone consultations were made available to patients who did not want to come to hospital to be seen or treated.)

By 21 August 2020 only 44 total patients were waiting over 104 days. (This number included the 27 from 9 July 2020, plus 17 more patients whose waiting times increased to over 103 days during that time. (These figures exclude where patients chose not to receive treatment or attend the hospital and tertiary patients waiting for services at other hospitals). Recovery of the 104 day cancer standard to pre-Covid levels will be part of phase 3 plan developed for September sign-off.

The second objective for Cancer restoration was :

The number of patients waiting over 62 days should be reduced by 20% within 6 weeks with a trajectory in place for full recovery, high risk non cancer surveillance patients must also be included.



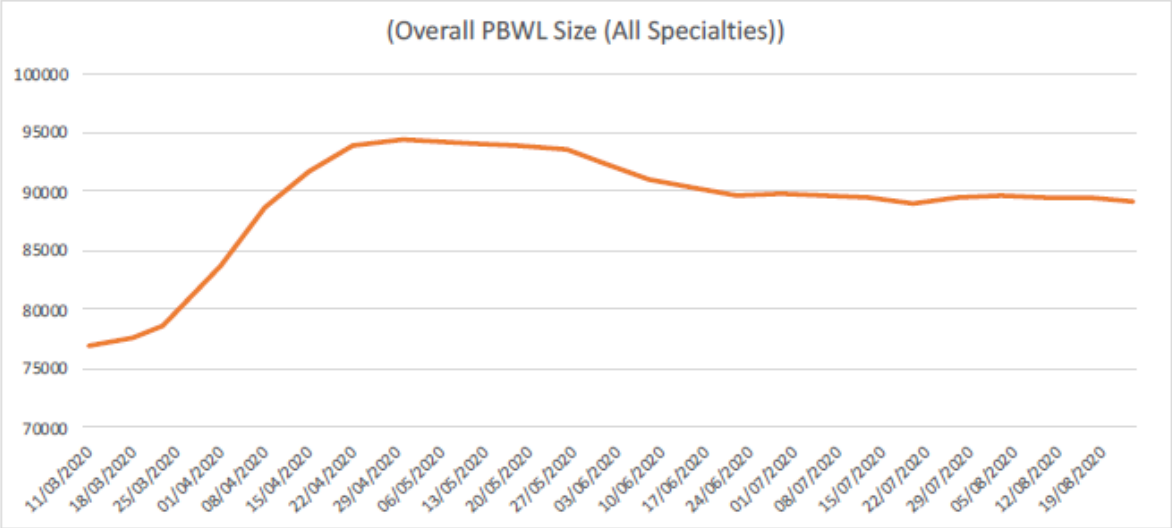
413 patients were waiting over 62 days for cancer treatment on 9 July. A 20% reduction would need to reduce this to below 330 patients by 21 August. As of 21 August 296 patients remained waiting over 62 days representing an achievement of this objective and exceeding the original ask by reducing waiting list further.

Colorectal patients continue to account for c.70% of patients waiting for cancer treatment and remain the greatest concern of patients waiting for cancer treatment. The Colorectal pathway is a complex pathway that has been severely affected by Covid-19, with reduced access to surgery and diagnostics through reduced productivity. Capacity was further impacted on with the loss of surgical capacity as a result of illness and quarantine impacts in the early stages of the Covid-19 response.

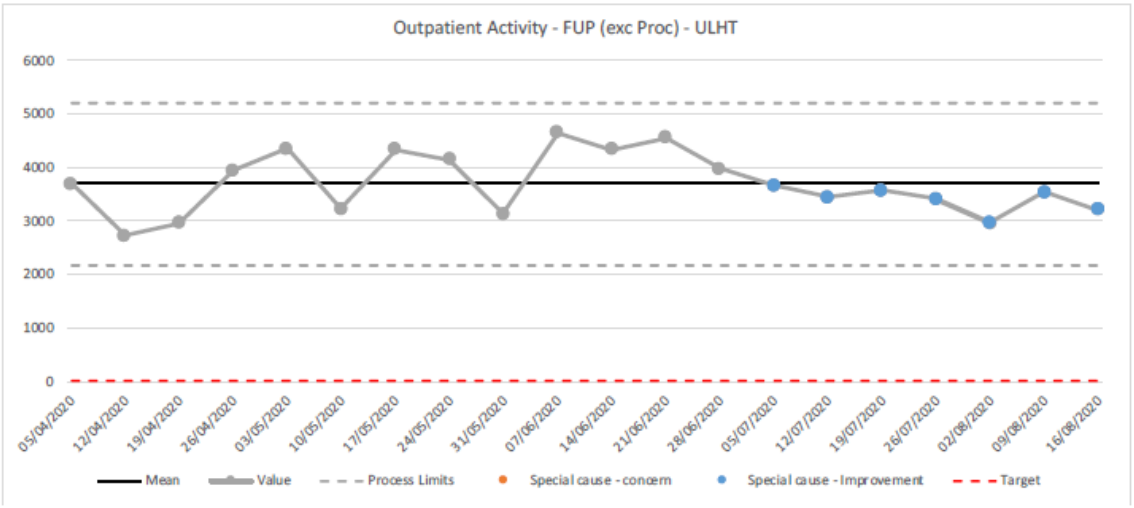
A specific recovery plan for Colorectal will feed into the Trust level plan, using a mixture of internal services as well as Independent Sector capacity, building on the best practice work that has taken place thus far.

Overall trajectory for recovery of the 62day standard to pre-Covid levels by October 2020, with ambition to reduce to a sustainable achievement of constitutional standards in November 2020. Full details of this will be described in future updates that will articulate the Phase 3 plan.

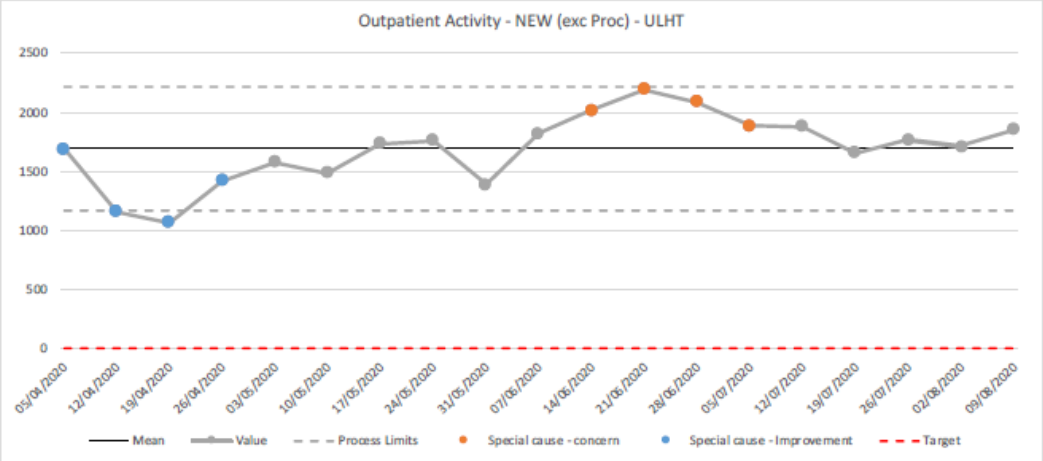
3.4 Planned Care Waiting List



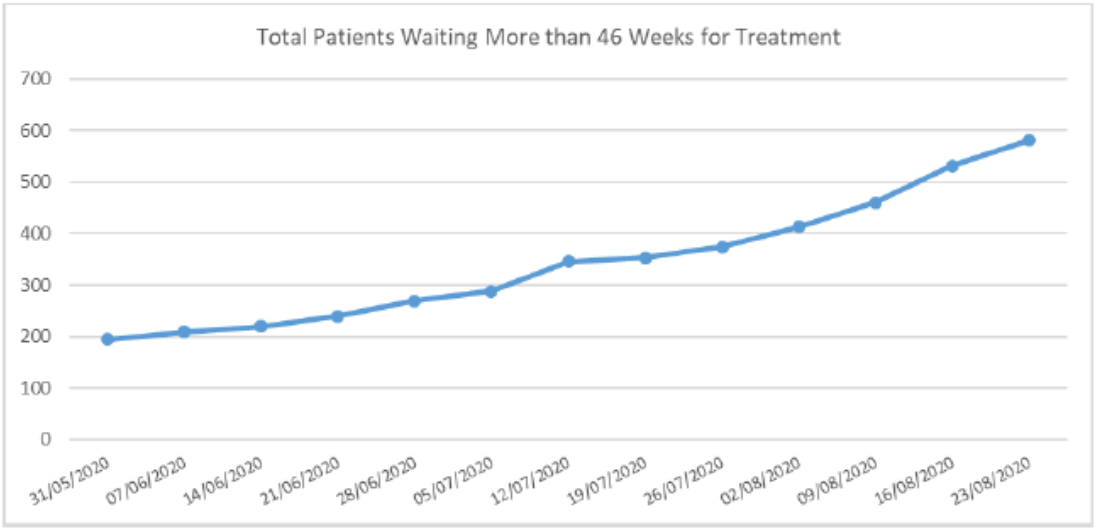
Planned care waiting lists both for people waiting for a follow-up subsequent outpatient appointment (know as the partial booking waiting list) or for treatment and surgery have expectedly increased throughout the early stages of the response to Covid-19. This position echoes the national and regional increase and reflects the prioritisation of services on urgent care and on cancer as Trusts Restore services and start their Recovery.



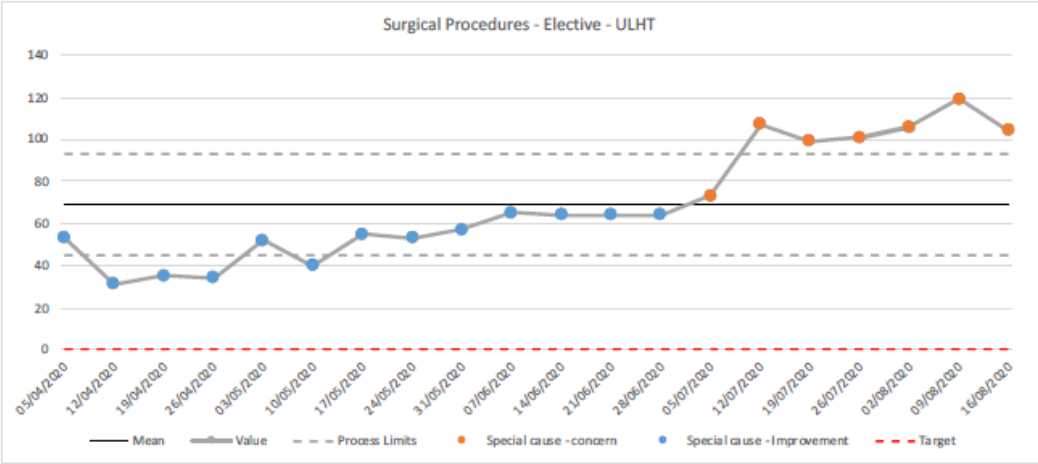
Despite the early growth in PBWL the use of technology and non-face to face appointments meant that the overall waiting list size did start to reduce. However, in recent weeks as other services start and increase in capacity, teams who were working predominantly on outpatients, some of which may have been shielding themselves, are splitting their time more equally across outpatients, surgical and treatment areas. This is in addition to staff needing to take overdue leave, and being released to rest and recuperate, from what has been for many very intense 6 months of Covid-19 response.



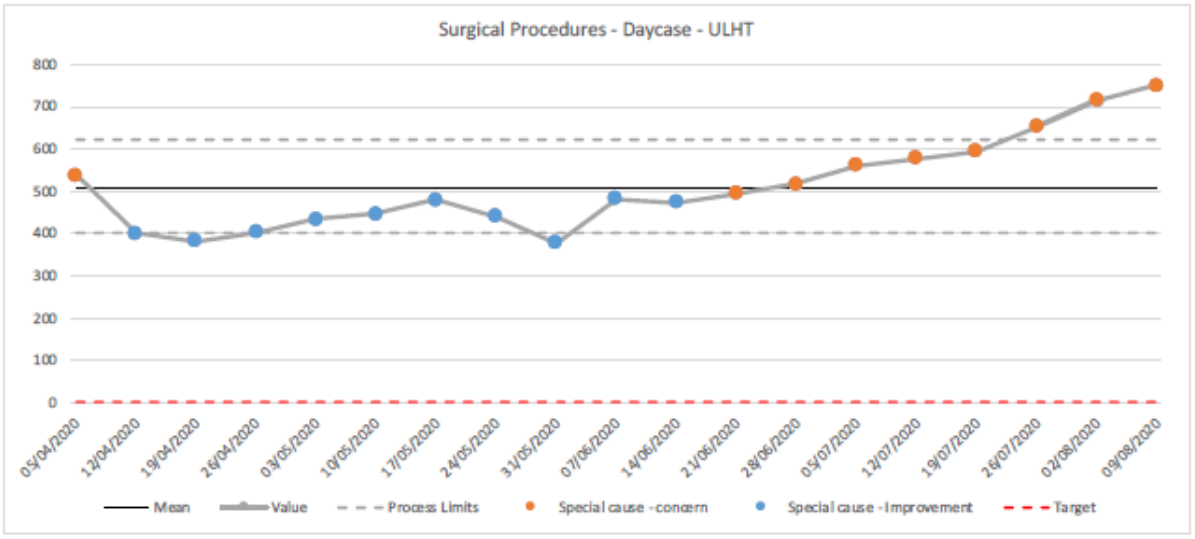
Access to first outpatient appointments has also to date been focussed on suspect cancer 2ww and clinically urgent appointments. In June as services began to restore this saw a substantial increase in new appointments for patients who have been delayed in the first phase. In recent weeks, in a similar way to follow-up clinic capacity, the number of patients seen has reduced as other treatments and services come on line, and staff take overdue annual leave.



Throughout the Covid-19 response the Trust has largely prevented patients from waiting beyond 52 weeks. In July and August this increased, but still to comparably low levels in relation to other Trusts across the region. Patients waiting more than 46 weeks has continued to increase and represents the challenge for Recovery Phase 3 with nearly 600 more patients requiring treatment.

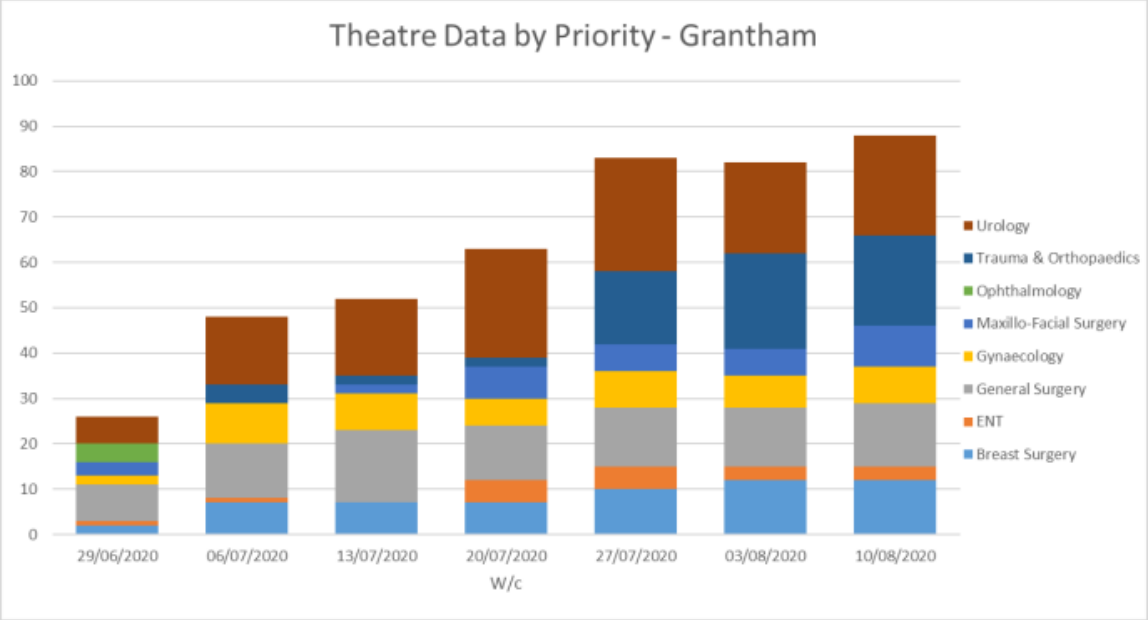


As forecasted the number of Surgical treatments has continued to increase with the introduction of the Grantham Green site model.



Planned Surgery requiring an overnight stay and Day Case procedures have both made excellent progress and will continue to improve as part of recovery.

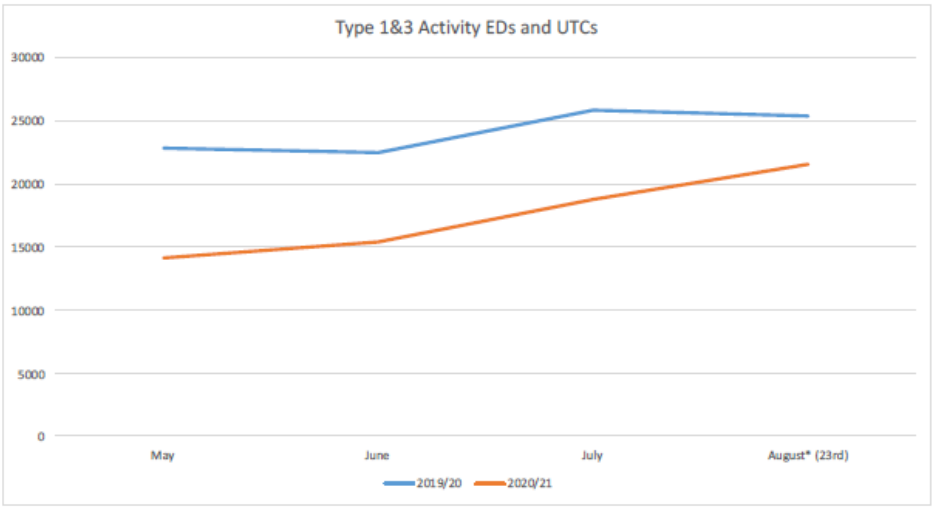
The Grantham Green site continues to deliver an important part of the Restoration of services as both Cancer and Planned care waiting lists are reduced. At this stage there is still much more to be done as can be seen from the waiting list information above, however the protection of patient pathways in this way provides a critical response to Covid-19 and will be an important feature of the Phase 3 plan.



Theatre throughput has increased up to 19 cases per/day, and whilst not achieving the 25 case per day target the number of patients accessing surgery who would otherwise not be able to continues to climb. Recent introduction of urgent Trauma & Orthopaedic operations at weekends has moved operating into a 7 day format maximising the opportunity of the Green site model.

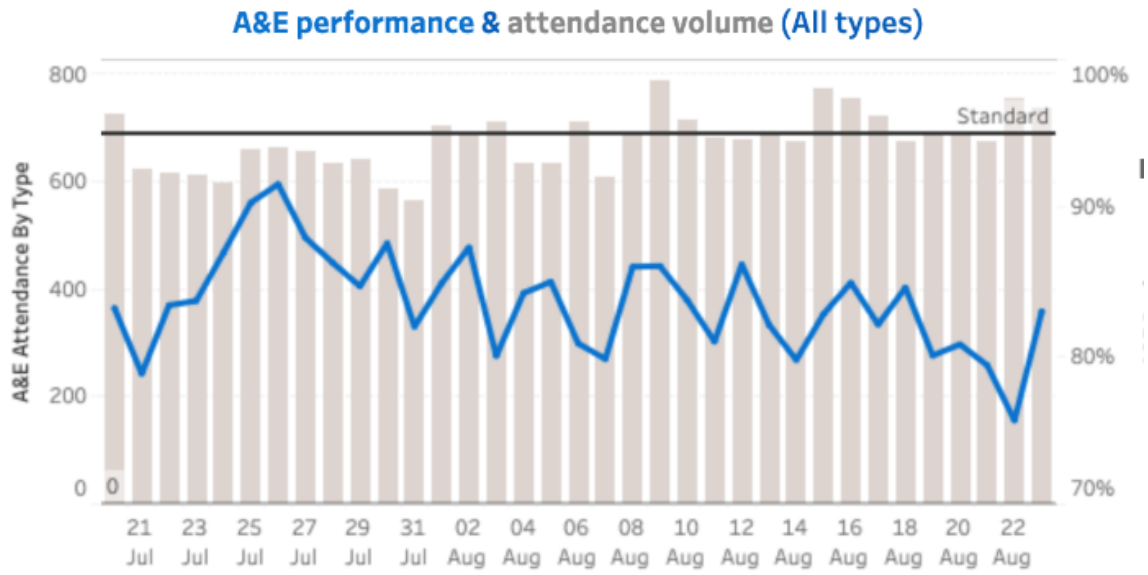
Full quarterly review of the Grantham Green site model is due in October 2020 and will contain a deeper analysis of the impacts of Grantham Green site model, however at the point of publishing this report 0 serious incidents have been recorded at or as a result of the Green Site Model. 0 patients have contract Covid-19 post operatively.

4. Progress on Recovery of Urgent Care Services including Resurgence of Covid and the preparation for Winter B1 and B2

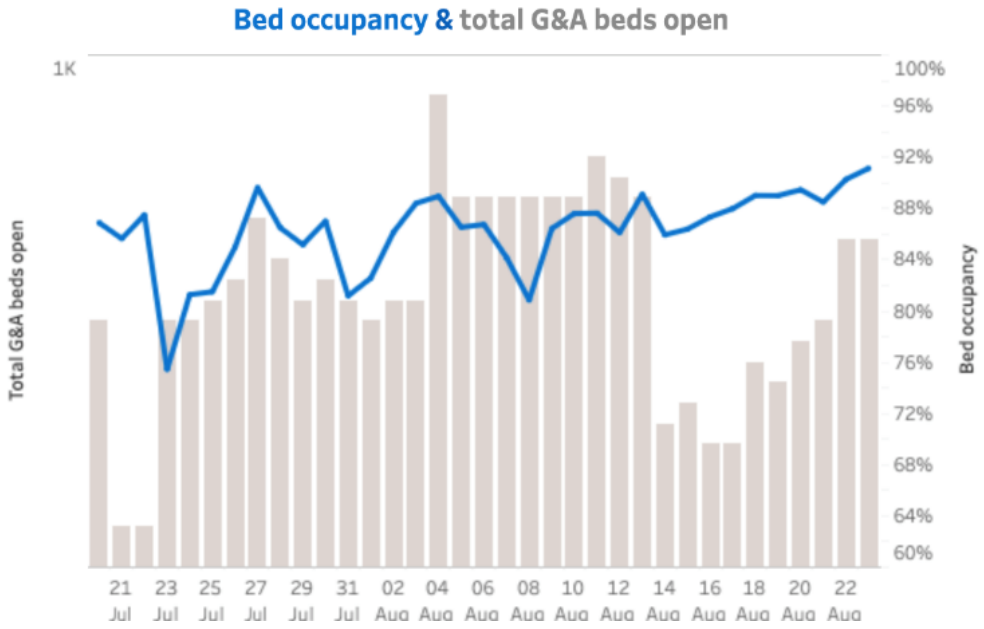


The increase in emergency activity and attendances at the Trusts Emergency Departments and co-located Urgent Treatment Centres demonstrates the relative

increase in confidence in patients accessing hospital services. At the beginning of Covid-19 pandemic demand dropped by more than 66% of previous years' levels. In August to date this has now risen back to pre-covid levels. The increase in demand seen in each year as part of summer season demand (most notably in the east of the region) has not been replicated in July and August weeks, however the steady increase in demand has started to place pressure on urgent care services.

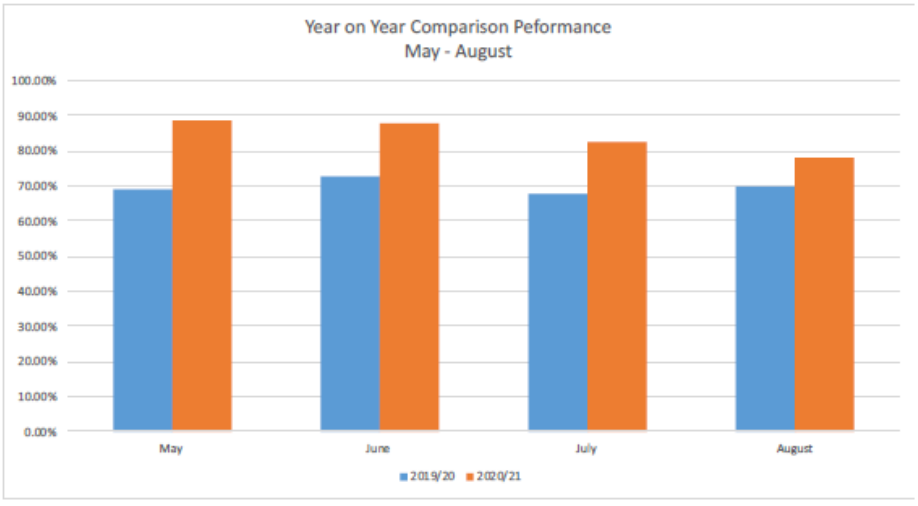


As demand has increased, alongside the increased in bed occupancy access standards have deteriorated. Despite increases in staffing in Emergency Departments agreed prior to Covid-19 response, delays have occurred as a result of overcrowding in departments. Partly as a result of maintaining Covid-19 suspect and non-physical separation and maintaining social distancing where possible, but also as a result of the extra precautions PPE and other safety measures introduced. Combined with reduced flow as be occupancy increases, and reduced discharge rates this has highlighted the need for substantial changes to the Urgent Care physical environment.



*(Please note the scale on the chart for beds is a range from 920-930 beds)

The Trust has been successful in its application for capital to support the increase in Emergency Department capacity at Pilgrim Hospital with a £2M allocation being awarded in August. Other bids have been put forward for Lincoln Emergency Department as well as ward environment improvements to deliver the necessary measures required for IPC in future waves of Covid-19 or other infectious diseases such as Influenza and Norovirus.



Examining the comparison from 2019 to 2020 urgent care performance against the 4 hours standard, it is clear to see that improvements have still been maintained throughout the Covid-19 response although that margin is reducing as bed occupancy and A&E attendances increase. Phase 3 section B planning will be factoring in the necessary measures to reduce occupancy, and to compensate for bed reductions through necessary IPC measures. These schemes although not complete yet, are likely to include the improvement in discharge of patients pending results for Covid-19, as well other length of stay improvements.

OUTSTANDING CARE personally DELIVERED

NHS United Lincolnshire Hospitals NHS Trust

Meeting	*Trust Board*
Date of Meeting	*7th July 2020*
Item Number	*Item 7*
ULHT Covid-19 Restore Phase Update – Progress Summary	
Accountable Director	*Simon Evans, Chief Operating Officer*
Presented by	*Simon Evans, Chief Operating Officer*
Author(s)	*Simon Evans, Chief Operating Officer*
Report previously considered at	*Executive Leadership Team*

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

Risk Assessment	Covid-19 Strategic Risk
Financial Impact Assessment	Resource Implications are in line with authorisation SFIs and Covid19 operating parameters.
Quality Impact Assessment	
Equality Impact Assessment	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
Assurance Level Assessment	*Insert assurance level* • *Moderate*

Recommendations/ Decision Required	The Board are asked to accept this progress 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. In addition, the board is asked to offer thanks and gratitude to system partners who have supported the Trust in enacting this complex and challenging phase of the Covid-19 *Restore* plan.

Executive Summary

On 11 May the Trust confirmed it's *Restore* Phase plan as an important component of its overall Covid 19 campaign strategy. This report presents a high-level review of this *Restore* Phase plan and the progress made to date against required and intended actions.

All service changes made through the Trust's Covid 19 campaign have been assessed for risk, quality and equality impact through the authorisation process previously described in the *Manage* phase. This report describes the approach being taken and progress to date to restore, revert or embed these changes during the *Restore* Phase.

The Trust's *Restore* phase response has been heavily focused on Infection Prevention and Control (IPC) to create optimum levels of protection for patients and staff. An important vehicle to deliver this and an integral component of the Trust's *Restore* phase plan is the creation of a Green site at Grantham, which was approved by Trust Board on 11th June 2020.

The Grantham green site went live on 29 June, an achievement in delivering a large-scale change in a very short time frame. On 1st July cancer surgery commenced and it is anticipated that as efficiency of the surgical model develops over the next month there will be up to 25 cases operated on each day.

At the time of this report, there were no cancer Priority Level 1 cases outstanding and anticipated date to clear all priority Level 2 cases awaiting TCI was 5 weeks (by 9 August). The expected date to clear all priority Level 3 cases and those without a priority level awaiting TCI was 8 weeks (by 26 August). These timescales could be shortened depending on weekend working and productivity increases as teams become acclimatised to the new model of working.

The Trust formally recognises the support it has had from system partners in order to carry out this large scale change. It also recognises the disruption and additional effort required to achieve such a high standard of protection for patients who required urgent and planned care treatments.

The report describes the progress made in enacting *Restore* phase plans and impact on quality and access performance in urgent and emergency care, planned care, cancer, maternity services and screening programmes.

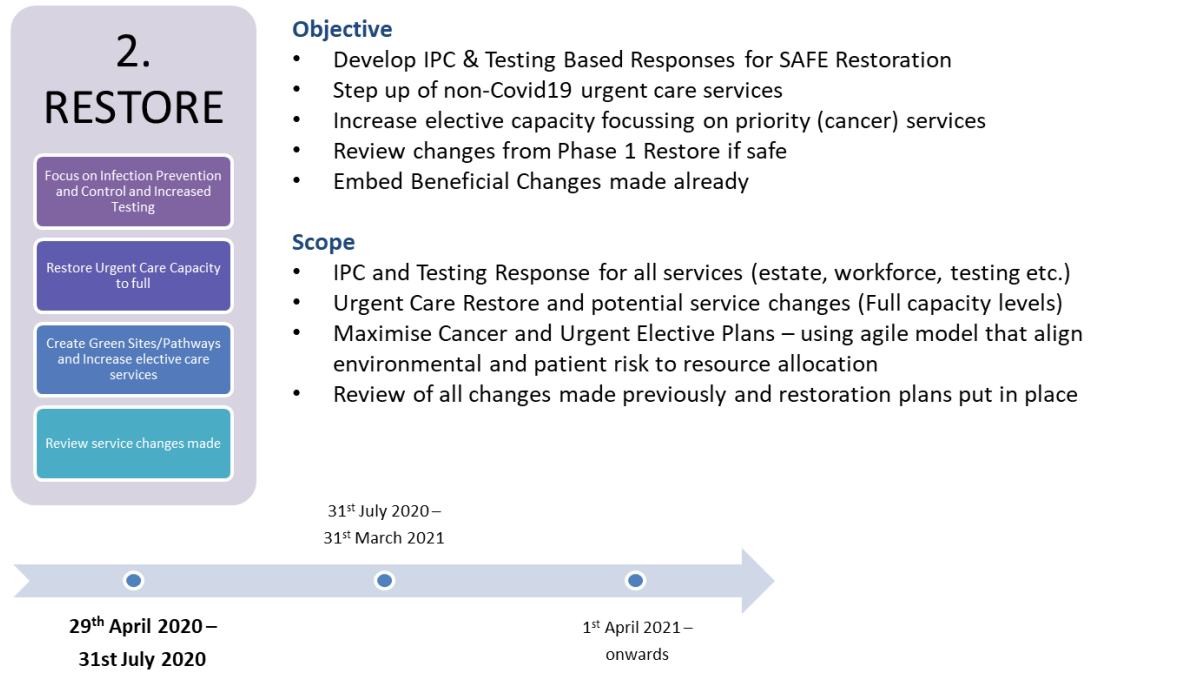
Finally, the Trust's approach to prioritisation, risk stratification and harm review is described and assurance provided regarding monitoring processes in place

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.

On 11 May the Trust confirmed it's Restore Phase plan as an important component of it's overall Covid 19 campaign strategy, which was presented at Trust Board in June. This report presents a summary review of this Restore Phase plan and progress made to date against required and intended actions.

2 Restore Phase



With planning complete on how and when surge responses could be put in place, the current position faced by the Trust and nationally continues to be 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.

3 Review of service changes

All service changes made through the Trust's Covid 19 campaign have been assessed for risk, quality and equality impact through the authorisation process previously described in the *Manage* phase. Sections 6 onwards in this report describes at a high level the approach being taken and progress to date to restore, revert or embed these changes during the Restore Phase.

The following table identifies the service changes made and whether planning sits within the Restore Phase (by 31 July) or Recovery Phase (August 2020 – March 2021). These plans form part of the system restoration activities that are regularly reviewed with regional regulators NHSE/I and assumptions tested to ensure that services are being safely restored.

Table 1: ULHT service changes deployed during Covid 19

Anaesthetics	Pre-Op assessment change	Moved to virtual pre-operative assessments during Covid, and there is a plan to sustain this change, and only bring patients in when absolutely necessary.	Restore
Audiology	Stop service	Audiology service was paused during covid, but is planned to be reinstated.	Recovery
Audiology	Pathway change	Newborn hearing screening programme was continued during covid, but with no call-backs, there is a plan to restore this.	Restore
Cancer	2ww pathway change	Redesign of 2ww pathway for suspected lung and Upper GI cancer patients. More work is to be undertaken through restore and recovery phase to complete pathway redesign. This will depend on reinstatement of endoscopy services, green site development and pathway specific work.	Restore
Cancer	Pathway change	Lung cancer pathway was changed during covid, some of the adjustments such as clinical triage have worked well, and will be maintained. Some of the changes are not sustainable, such as reduced access to diagnostics and will be developed in the remaining Restore and early recovery phase.	Restore
Cancer	Pathway change	Cancer referral pathways and management of cancer cases was altered to support covid-manage (no endoscopy, risk stratification for treatment, triage of referrals) and while the wider plan is to reinstate cancer diagnosis and treatment clinical pathways, the learning from these pathway changes will be taken and developed for the future to benefit patients of Lincolnshire during restore, recovery and Future NHS.	Restore
Cancer	Pathway Change	Chemotherapy delivered on GDH site during covid-*manage*, with the exception of: chemo-radiotherapy (Lincoln) oral-chemotherapy (patient home) It is likely that this arrangement will continue into Covid-restore and be reviewed for covid-recovery.	Restore
Cardiology	Guidance	Cardiology Primary Care Guidelines - introduced during Covid, have had positive feedback for helping primary care management of patients.	Recovery
Covid pathways	Clinical pathways & hospital sites	Creation of Green and Blue pathways and sites (Green covid free, Blue covid)	Restore
Dermatology	Pathway change	Skin Cancer Pathways - some aspects of the dermatology service have been paused or moved during covid, while retaining as much of the cancer service as possible. In reinstating the service, Green Pathways, social distancing and PPE will be contributing factors to where the service is delivered.	Restore
Dermatology	Pathway change	Dermatology during covid has managed urgent and time sensitive cases, in order to reinstate the routine service, Green pathways, social distancing and PPE will be factored into plans.	Restore
Diabetes and Endocrinology	Pause service	Diabetes and Endocrinology - during covid ULHT Medics have been on a 24/7 medicine rota, and only managed emergency diabetes and endocrine cases. It is possible that at this point, we could develop the community diabetes services to take on the acute backlog at the end of Restore and into Recovery Stage.	Restore
Diagnostics	Pause service	Clinical Neurophysiology service was paused during covid but is planned for restoration with social distancing in place.	Restore
Diagnostics	Pause service	Dexa scanning is planned for restoration	Restore

Diagnostics	Pause service	Endoscopy procedures were halted during Covid-manage, and restoration will require BSG and JAG guidance. There will be a significant impact on capacity due to PPE and Social distancing requirements for AGP. (See later section)	Restore
Diagnostics	Reduced service	MRI service is planned to be reinstated during covid-restore, with social distancing in place.	Restore
Diagnostics	Reduced service	Peripheral site X-ray cover was ceased during covid-manage and staff were redeployed onto other sites. The plan is to restore this service only once demand increases for the peripheral sites again.	Recovery
Diagnostics	Pause Service	Respiratory physiology is planned to be reinstated with PPE and social distancing in place	Restore
Diagnostics	Pathway change	Patients suspected of Upper GI cancer have been offered barium swallows instead of endoscopy during covid-manage. See later section for Restore plans in Endoscopy.	Restore
Diagnostics	Diagnostics	The Urodynamics service paused during Covid-manage and is planned to be reinstated	Recovery
Family Health	Paediatrics	Suspension of Paediatric Surgery - the plan is to reinstate paediatric surgery but this will need to be considered with the Green Pathways.	Restore
Head and Neck	Pathway change	Reduced provision of outpatient services for Otolaryngology at Peripheral sites was introduced during covid and it is proposed that this will continue.	Restore
Head and Neck	Pause service	Orthodontics were managed with as little f2f as possible during manage phase, this service could be restarted outside of the acute setting post-covid.	Recovery
Head and Neck	Pathway change	OMF services have been scaled back during covid, but for the future a large amount of the referrals could be seen by dentists, keeping acute for those who need it.	Recovery
Medicine	Pause service	Medical Day Unit - all non-urgent work paused during Covid, if services retain their left-shift post covid, there is a potential to repurpose Medical Day Unit in the future.	Recovery
Neurology	Pathway change	Neurology covid plan - different aspects of clinical pathways were either paused, moved to GP, or delivered remotely during covid. Some aspects of the changes can be kept, while some are to reinstated as require acute neurology assessment.	Recovery
Rheumatology	Pathway change	Rheumatology covid plan - different aspects of clinical pathways were either paused, moved to GP, or delivered remotely during covid. Some aspects of the changes can be kept, while some are to reinstated as require acute rheumatological assessment.	Recovery
Obstetrics	New pathway	Revised maternity pathways (hospital and community) to optimise the safe use of Video Consultation as part of the pathway. This has been assessed as successful, particularly in regard to the community midwifery clinical pathway – in excess of 500 video consultations.	Restore
Orthopaedics	New pathway	Trauma Assessment Unit Established at Pilgrim Hospital (same as in place for Lincoln) to align the process across sites. It is planned for this to continue.	Recovery
Paediatrics	PAU at Lincoln	Use of Safari Unit as a Paediatric Assessment Unit at the Lincoln Hospital site	Restore
Pharmacy	New pathway	Pharmacy provided deliveries of prescriptions during Covid, and these changes are planned to be reviewed and develop in order to support a permanently increased level of remote outpatient activity	Restore
Pharmacy	Pathway change	Rowlands Pharmacy Supply of Methotrexate - this was a pathway developed during Covid to support patients without requiring clinic attendance.	Recovery
Pharmacy	Pathway change	Pathway for Respiratory - Omalizumab & Mepolizumab. Patients receiving these drugs following referrals from NUH have been receiving their care via Homecare under existing contracts during Covid-Manage. Prior to this patient would have attended clinic for injections.	Recovery
Pharmacy	Pause service	Closure of Louth Hospital Pharmacy Department during Covid Manage phase. Reinstating the service will be in line with the recovery phase. Restarting with other services.	Recovery
Respiratory	Guidance	The guidance given to primary care for management of respiratory conditions during Covid-manage, could be developed and kept with clinical input from primary and acute services.	Recovery
Screening	Pause service	AAA screening service was stopped during Covid-Manage, there is a plan to restore the service but social distancing and PPE measures will reduce capacity from 115 appointments per week to 80.	Restore

Screening	Pause service	Bowel Cancer Screening Programme was paused during Covid, and will be reinstated when guidance is given by BSG and JAG. There will be a significant impact on capacity due to social distancing and PPE necessary in AGP.	Restore
Screening	Pause service	Breast screening will be reinstated, and will have capacity impacts due to social distancing.	Restore
Screening	Pause service	Diabetic eye screening programme was paused during covid but is planned for restoration with social distancing and PPE measures in place, which will impact on capacity.	Restore
Therapies	Pause service	The Hydrotherapy service closed during Covid-manage, and is planned to be restored with social distancing and risk assessments in place.	Recovery
Therapies	Pause service	Spasticity clinics were paused during Covid, and are planned to be reinstated with risk assessments, PPE and social distancing	Restore
Stroke medicine	**Patient flow/discharge**	Due to significant COVID related sickness, consultants shielding and the withdrawal of agency locums, it became urgently necessary to move from 2 x single site on Stroke On Call Rotas (1:4) to one trust wide on call rota to maintain safety and sustainability of access to thrombolysis.	Recovery
Elective Care	**Green Site**	A Green site (Covid-19 free) 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.	Restore
A&E	**Urgent Care**	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. 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 UTC will be equipped to diagnose and treat many of the most common ailments people go to A&E for - 81% of patients who attended the A&E will still be able to attend the UTC. Patients may be referred to an urgent treatment centre by NHS 111 or by a GP, and patients can also turn up and walk-in. The Ambulatory Care Unit will be retained to provide day care for patients.	Restore
Medicine	**Inpatient beds**	Withdrawal of medical beds at Grantham - As medical beds will be withdrawn at Grantham a proportion of patients will be treated in the Ambulatory Care Unit (largely GP referrals) at Grantham and a number of patients will be re-routed and admitted at Lincoln.	Recovery

4 Grantham Green site

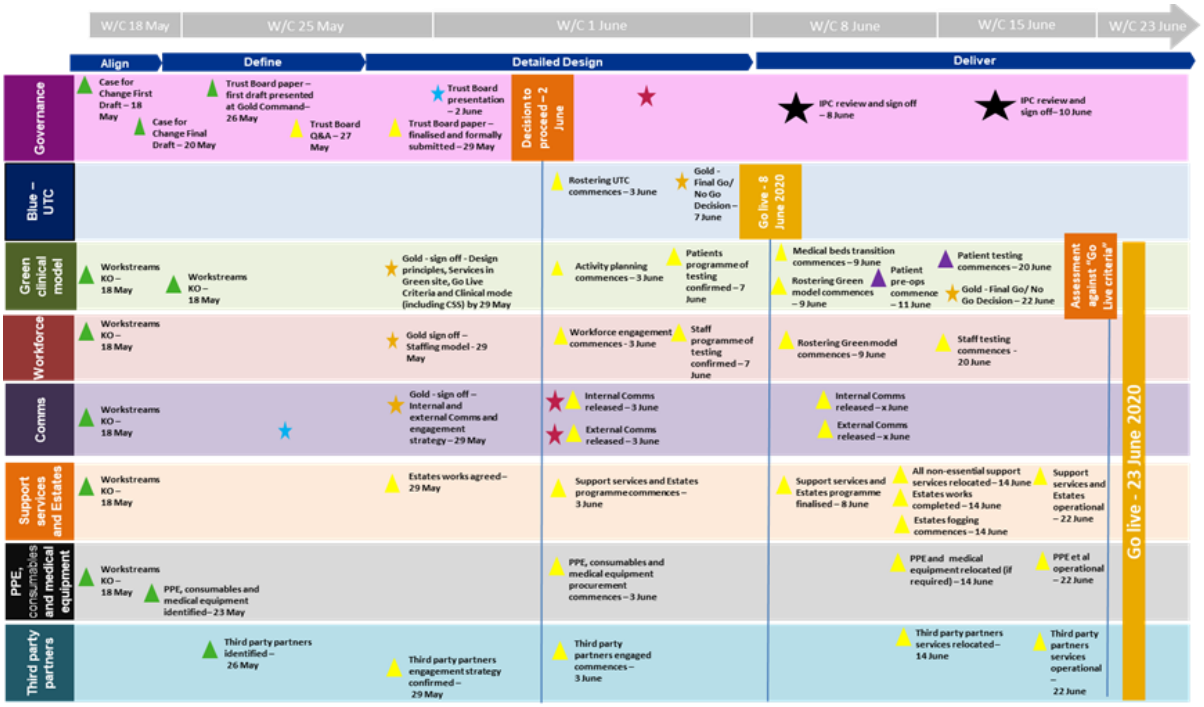
The Trust's Restore phase response has been heavily focused on reducing the risk of hospital acquired Covid-19 and associated Infection Prevention and Control measures. This is with an aim to create optimum levels of protection for patients and staff, drawing on a bundle of measures including social distancing, environmental enhancements, cleaning programmes, hygiene and hand washing, and test and trace. Additional measures are required to ensure that environments can support improvements in IPC including controlling access through hospital areas, reducing footfall wherever possible, and zoning of areas to support Green and Blue designation of areas. An important vehicle to deliver these measures and integral component of the Trust's Restore phase plan is the creation of a Green site.

On June 11th 2020, the Trust Board approved the proposal for temporary reconfiguration of services at Grantham as a Green site with a Blue isolated Urgent Treatment Centre. This decision was made following presentation of a case for the temporary reconfiguration of services as part of the Trust's response to the level 4 incident declared on 30 January 2020. This case for change included the

options considered and the preferred option, the legal basis for the change, clinical leadership and governance established to oversee and enact the proposed changes.

Approval was given to proceed with the changes proposed and approval for the necessary work to deliver this change to commence, whilst recognising that these 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 the Covid-19 Restore and Recovery phases up to at least 31 March 2021.

The critical path below describes the workstreams within the project task and finish group and at a very high level the activities required to achieve go live of the Grantham green site by the target 23 June. Behind this sat detailed plans for clinical leadership and governance models, workforce, IPC protocols and procedures, and a go live checklist. Subsequently the Grantham green site went live on 29 June, 6 days overdue owing to uncontrollable factors, and a very credible achievement in delivering a large-scale change in a very short time frame.



The Trust, in collaboration with LCHS, has converted the (currently open from 8am to 8pm) ED into a 24/7 UTC treating patients with a NEWS score of 4 and below and using existing x-ray imaging facilities linked to the centre, maintaining urgent treatment and care to the population of Grantham. This isolated Blue area within the Green site has been achieved in a way that removes staff crossing between Blue UTC and Green site and does not compromise IPC excellence, while affording the option of having completely Green diagnostics and inpatient services.

In order to maintain the highest level of protection and IPC standards on the Green site it has been necessary to relocate a number of services internally as well as with system partners. In order to reduce the number of services on site overall and remove all services that cannot sustain a Green pathway (Covid-negative patients only) a number of new/alternative locations have been identified

and implemented. This approach has reduced both patients and staff need to transfer to other hospital sites across Lincolnshire.

Table 2: Services requiring relocation or new working practices to limit site presence to essential only

System partners	ULHT clinical services	ULHT non-clinical services
LCC – Social workers	**Community midwifery**	**Medical secretaries and**
LPFT - Neuropsychology	**Orthodontics**	**bookings –** Hybrid solution
LCHS – GU Medicine services	**ENT**	**CNN team**
LCHS – SALT	**Audiology**	**Estates/Facilities**
LCHS – AIR in reach into UTC	**Respiratory**	**Procurement**
LCHS- Out of hours	**AAA screening**	**Divisional support**
Macmillan – remain on site	**Plain film x-ray**	**Corporate Nursing**
Uni of Lincoln –student	**Physiotherapy/OT**	**Library**
nursing support	**Paediatrics**	**Finance**
Respiratory physiology	**Dietetics**	**HR**
OT/Physiotherapy	**Surgical and Medicine**	**PALS** – tbc
System Partners (including	**specialist outpatients**	**Operations Centre**
Marie curie)	**Clinical coding**	
	Research office	

In order to maintain local access to these services within Grantham a number of alternative accommodation solutions have been identified in the town area including South Kesteven District Council offices, Grantham Health Centre and commercial office units, as well as mobile diagnostics facilities.

The Trust formally recognises the support it has had from system partners in order to carry out this large scale change and the disruption and additional effort required in order to achieve such a high standard of protection for patients who required urgent and planned care treatments.

The potential for medical inpatient and diagnostic services to share Blue and Green services is significantly short of the IPC principles set and the design principles of a Green site. Therefore, medical inpatient admissions have been removed from the Grantham model temporarily for the duration of the Covid 19 Restore and Recovery phases. The displacement of urgent care activity and medical admissions to other Trust sites and neighbouring providers has been modelled and will be closely monitored.

A formal Quarterly Review of the Green Site Proposal will be presented in October (i.e. presenting the first 3 months of operation.) However, in the interim each month will present important information on attends, ambulances, cancer treatments and incidents specific to Grantham

On 1 July elective surgery commenced within the Grantham Green site and it is anticipated that as efficiency of the surgical model develops over the next month that throughput will see 25 cases through four extended theatres each day.

Additional diagnostic services are planned for one of the offsite Grantham locations further reducing any unnecessary transfers to other hospital sites, and reducing the demand on services in the UTC. Although the Trust is in a priority list for these diagnostic units with many other trusts across the UK. It is likely that x-ray services will be in place off site from August 2020 until the Grantham Green Site model is reverted and services return to previous configuration.

5 Patient and staff testing and screening

All patients undergoing cancer or elective inpatient procedures on a green pathway are being advised to self-isolate for 14 days prior to procedure and tested 48-72 hours prior to admission. Patients attending for an outpatient appointment or day case procedure are advised to self isolate for 7 days.

Our approach to staff testing is aimed at reducing healthcare associated Covid 19 infections in the Trust. Testing our staff is essential to ensure patient safety, maintain confidence in the Trust and protect the health and wellbeing of our staff. Trust protocol is to test all staff with symptoms or the index case if a household member. We do not test non-symptomatic staff.

In the event of an untoward incident or outbreak the Trust has an outbreak plan and staff and patients from the outbreak department will be tested. If a healthcare worker tests positive this will be risk assessed and colleagues who they've been in contact with may subsequently be identified and tested.

We are currently offering staff the opportunity for antibody test, which tests for the presence of antibodies that will demonstrate whether an individual has had the disease.

All staff attending the Grantham green site to work on the green pathway are now required to have a daily health screen, which includes a health and wellbeing assessment and temperature check.

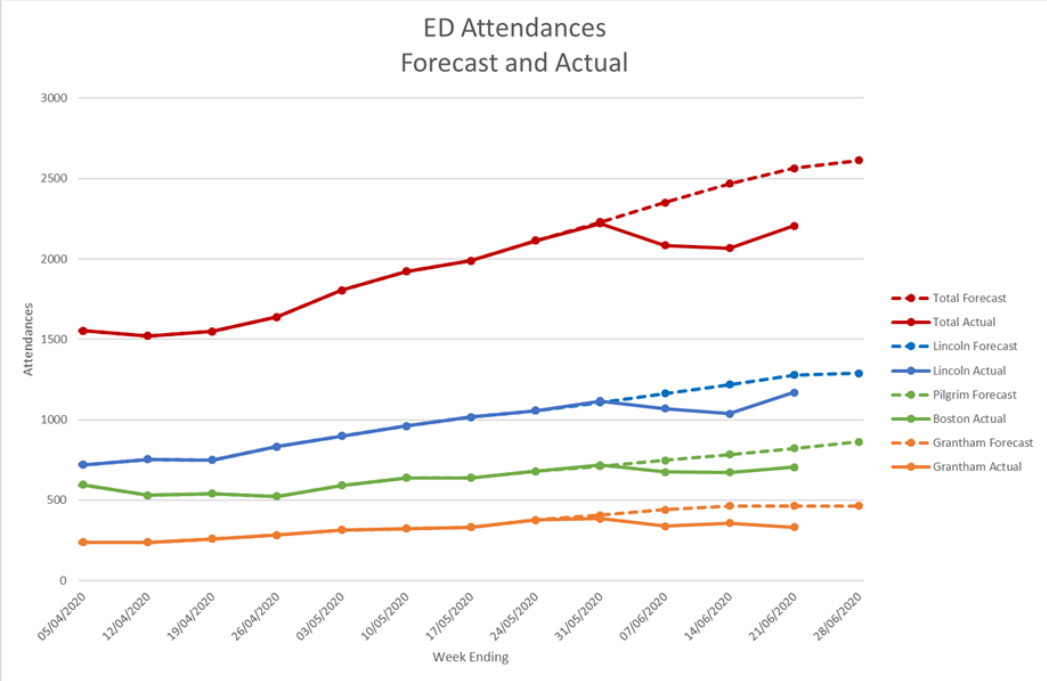
6 Urgent and Emergency Care, Urgent and Routine Surgery

6.1 Urgent and emergency care:

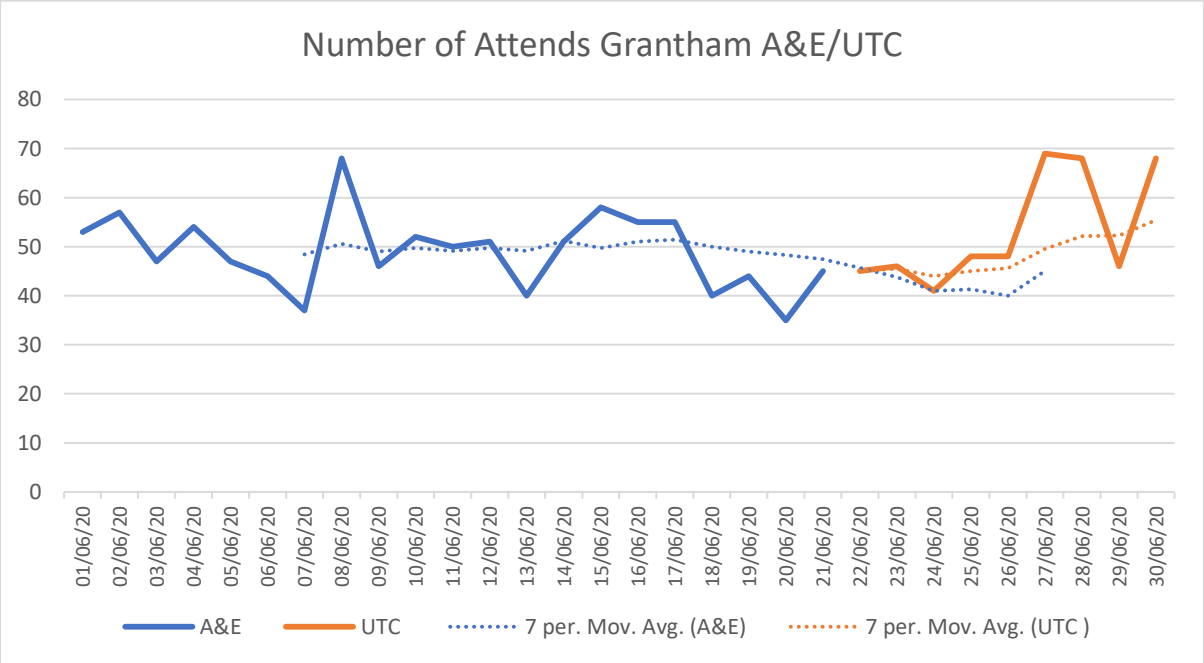
The Trust's urgent and emergency care (UEC) activity reduced during the *Manage* phase with non-elective admissions at 42% of pre-pandemic average activity. Local UEC demand modelling forecasted non-elective admissions to increase by 13.6% per week up to a normal level by the end of May resulting in potential "rebound" of increased demand on urgent care service generated by delayed attendance, deterioration due to delay in seeking medical assistance and postponed activity.

High rates of increase in ED attendances during May drove activity back towards pre-Covid 19 levels; however, in late May and early June the growth rate has plateaued. Currently ED attendance activity compared to pre-Covid 19 levels is

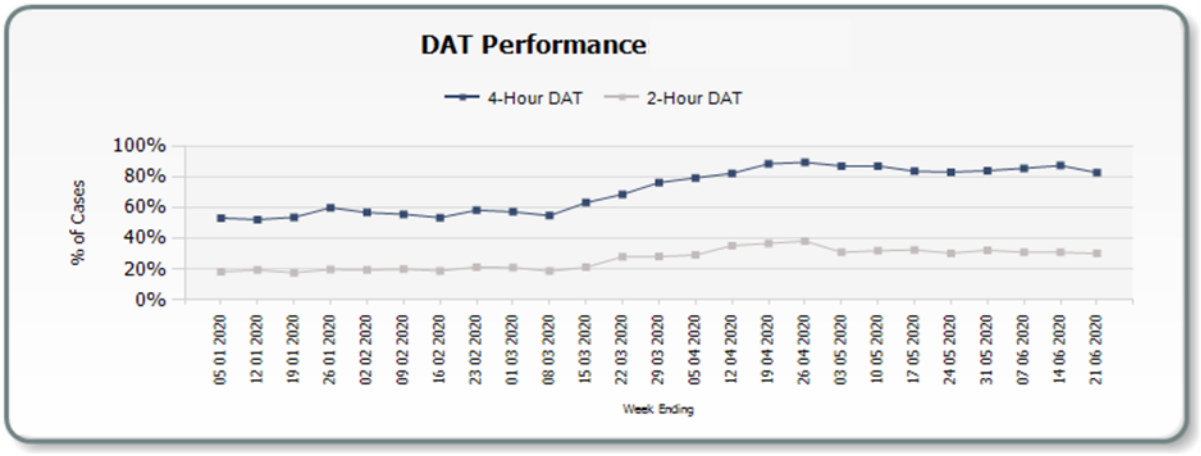
- Lincoln 88%
- Boston 73%
- Grantham 75%



Since transition to an Urgent Treatment Centre (UTC) model Grantham attendances have continued to increase.

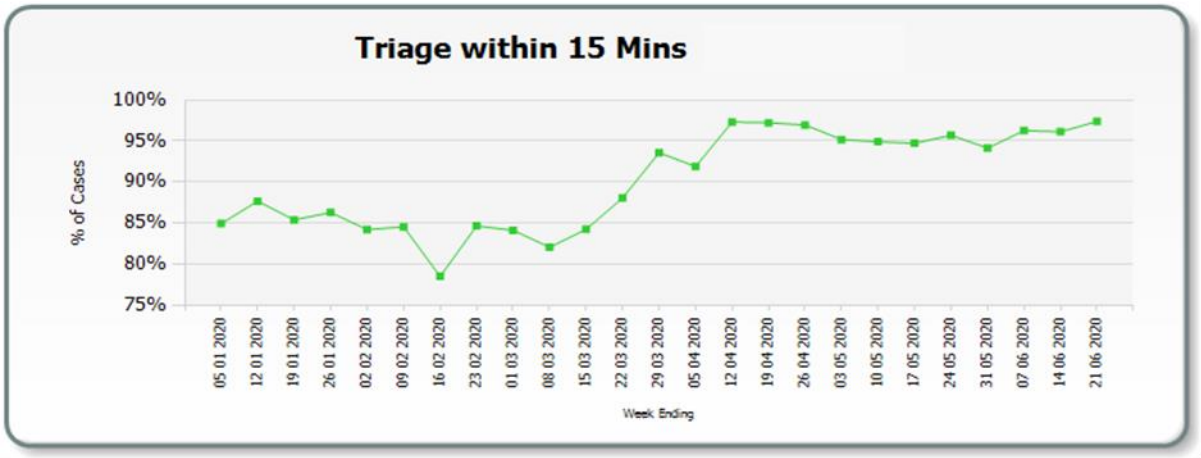


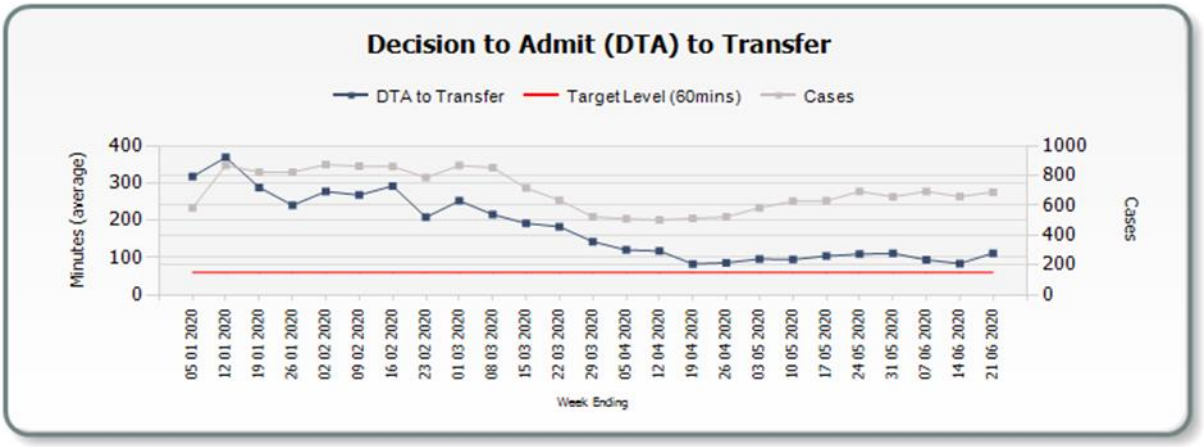
Despite attendances returning to over 80% of pre-Covid 19 levels, the Trust's significantly improved 4-hour performance is being maintained at over 80%. For May, the most recent reporting period, 88.70% was achieved despite a 26% increase in ED attendances compared to the previous month.



Drivers for this have been the reduction in delays due to triage, being seen by a doctor and time to transfer to a base ward. Ambulance handover delays have also significantly reduced across the Trust.

This success has resulted from coordinated work to restore our UEC capability at the required pace and scheduling immediate changes to our front door model, ED pathways, same day emergency care (SDEC) provision and discharge efficiency.

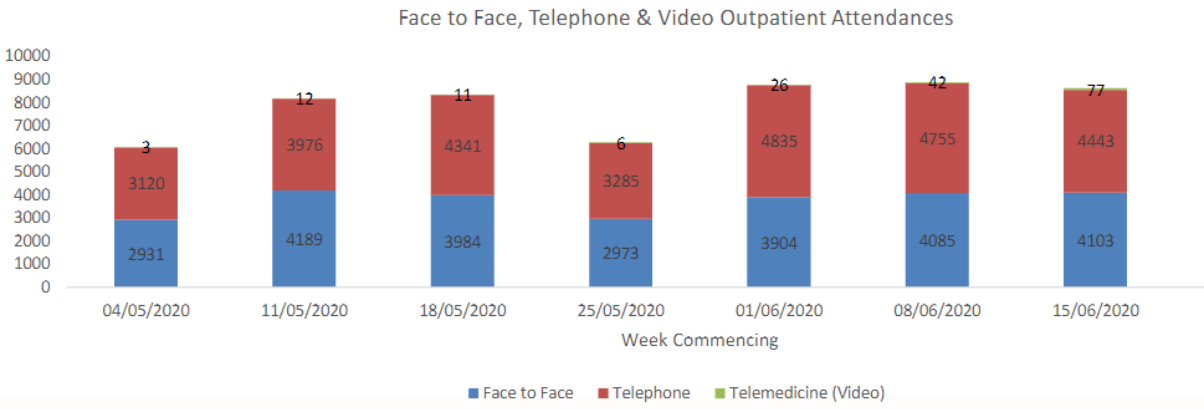




6.2 Outpatients:

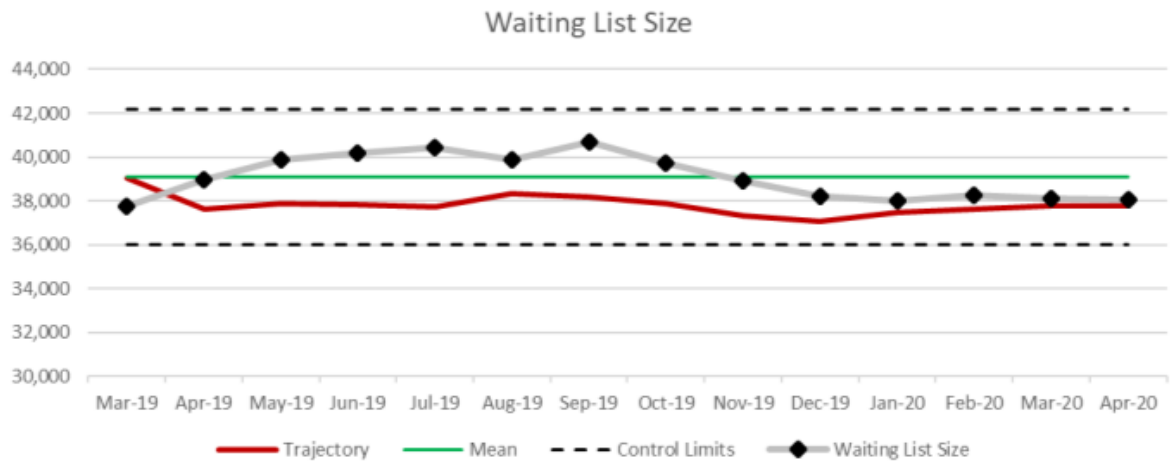
The Trust has continued to provide outpatient consultations for cancer and urgent patients throughout the pandemic, while scaling up routine appointments during June, utilising telephone and VC as default to reduce the risk of cross-infection, only offering face to face appointments where clinically required. The scaling up of our use of technology-enabled care has been very successful, benefiting both patients and clinicians, and our focus is on embedding this new way of working as future business as usual.

During June total outpatient's weekly activity has been approximately 60% of pre-pandemic volume. Currently circa. 55% of the Trusts maintained outpatient activity is being conducted by technology enabled care; over the telephone or by video consultation.

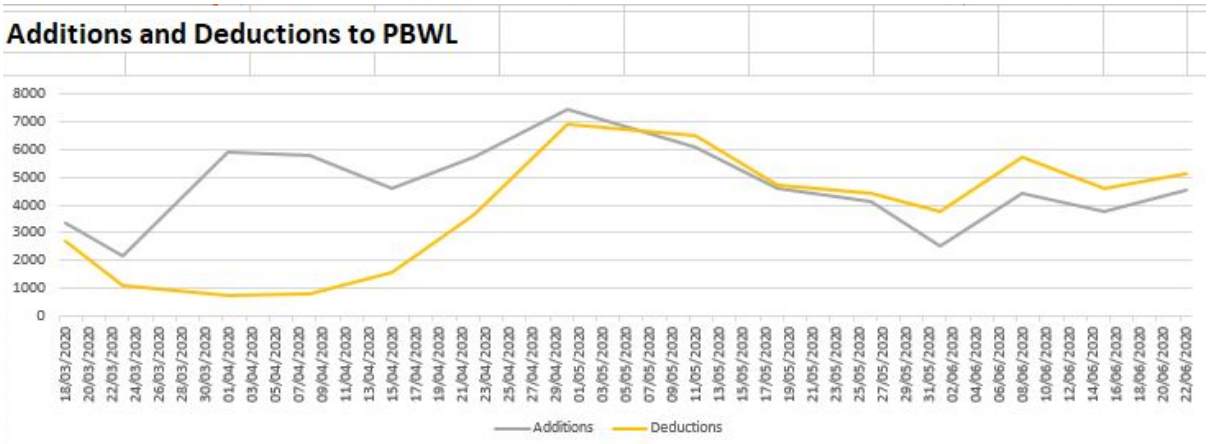


Specialty level waiting list recovery plans are being monitored and current performance is exceeding national and regional peer performance. The Trust reported three RTT incompletes 52-week breaches for April (latest reporting period). However, it should be noted that the volume of 52-week breaches will increase over the next few months, until elective surgery capacity is increased and the admitted backlog has been cleared.

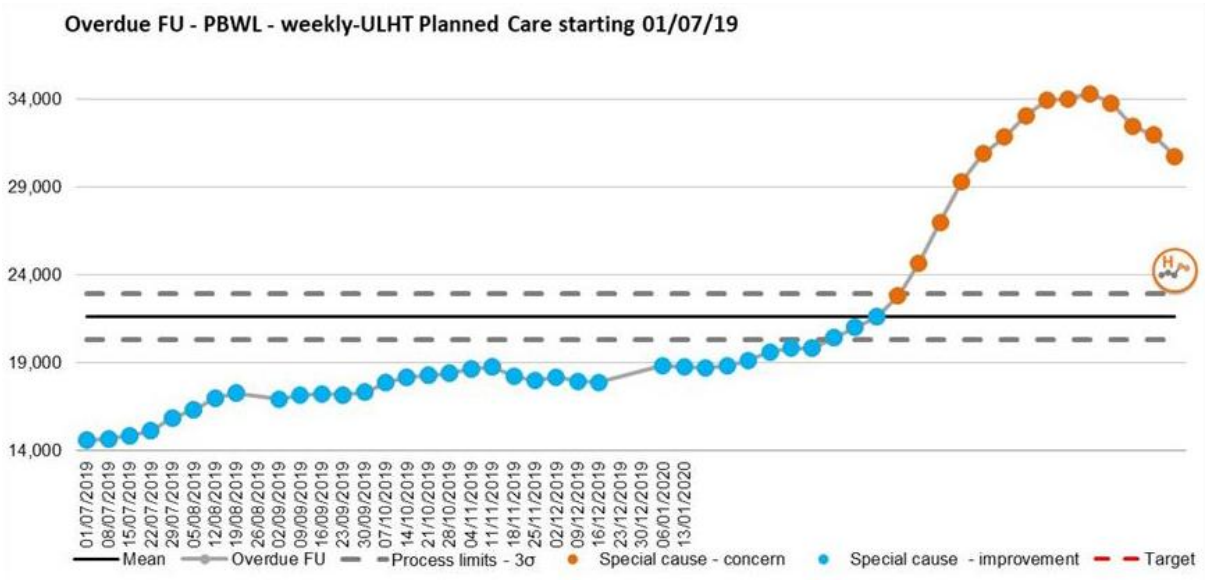
The overall waiting list size has improved from March and remains better than the 2020 target volume.



Following a period of significant growth due to a reduction in routine outpatient activity, the partial booking (follow up) waiting list size has been identified as a key risk. Successful management of this risk so far has been achieved through a programme of recovery actions include clinical triage and validation together with the scaling up of technology enabled care, such as telephone clinics. As a result of these actions waiting list deductions have consistently overtaken additions since mid-May.



Monitoring now illustrates a clear improvement trend and continued reduction of the PBWL by circa. 900 per week.



Risk stratification forms an important part of the Trust's approach to risk management of potential patient harm due to delayed follow up. Prospective clinical reviews are in place across specialties as part of our Covid 19 response in addition to normal operational practices. Our follow up waiting lists are regularly reviewed and prioritised by senior clinicians, with the use of a patient initiated follow up (PIFU) approach wherever suitable to provide patients with the means of self-accessing services if required. We are utilising those health professionals who are shielding during this time to review waiting lists and continue with appointments by telephone or video conferencing from home. If face to face is required we are following all PHE guidelines on IPC.

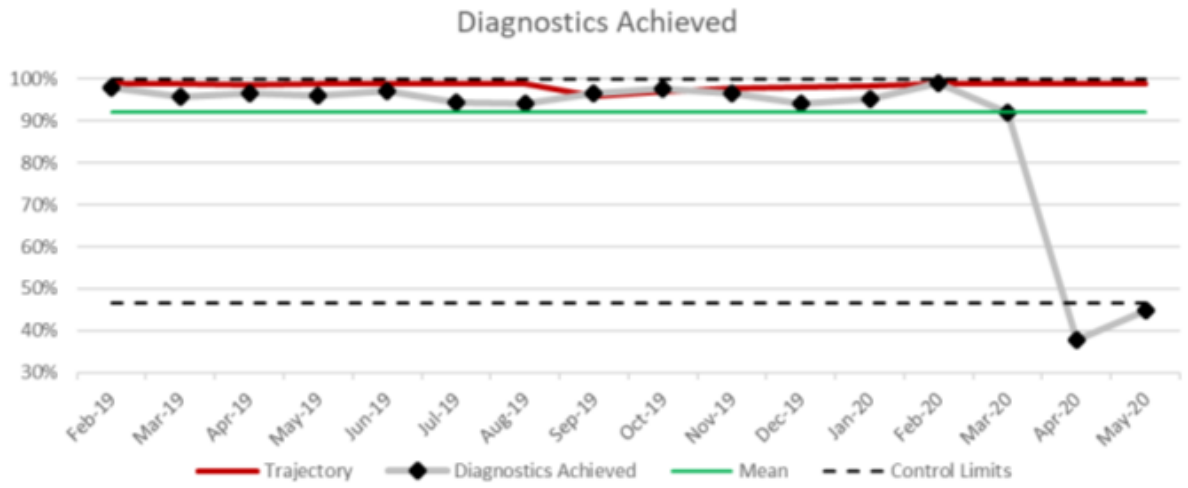
Therapy outpatient services have ensured urgent patients have access to appointments through new referral triage and prioritisation, providing face to face clinic appointments only where clinically required following a risk assessment, and ensuring social distancing measures are in place. Restoration of services to date has involved limited implementation of the reintroduction of outpatients and community provision in order to retain seven day staffing of in-patient settings and support discharge planning.

6.3 Diagnostics

Diagnostics access remains 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 and throughout the pandemic period the Trust has consistently delivered 90-95% access to cancer diagnostics within 7 days.

As a direct result of Covid 19 impact 55% of patients waiting for a DM01 diagnostic test at the end of May were waiting over 6 weeks. This is in line with the average performance of Trust's nationally. Most patients waiting over 6 weeks continue to be within echocardiography and endoscopy diagnostic procedures. We continue to be guided by national and regional body recommendations for the safe restoration of these diagnostics procedures and are proactively planning additional capacity to be implemented at the point when this is possible. In the meantime, demand

management pathways are proving successful and we have implemented robust monitoring procedures for patients awaiting diagnostics.

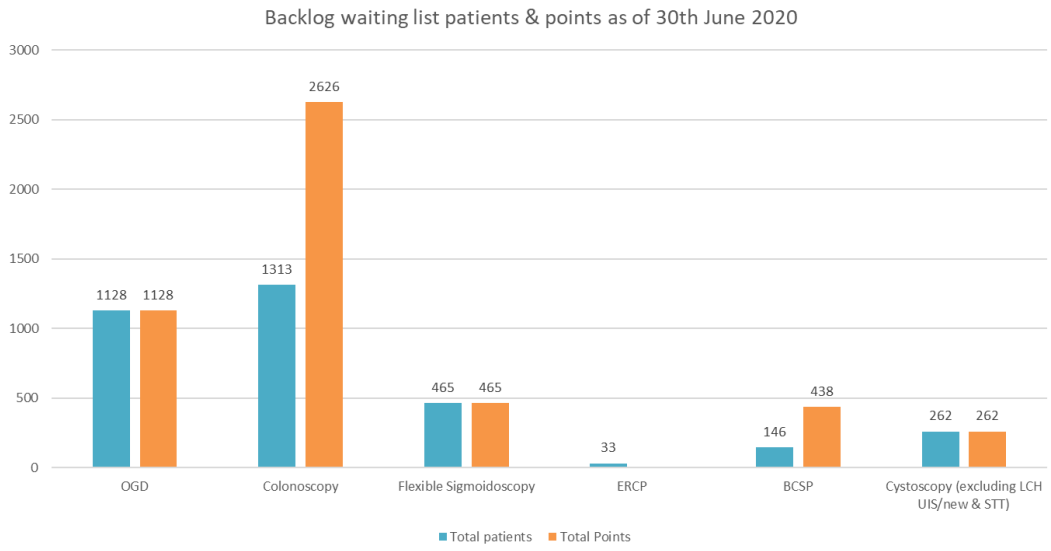


From the end of March only urgent cardiac echo activity continued to support cancer pathways with all routine activity temporarily stopped. This routine activity re-commenced from 8 June as planned at reduced capacity due to social distancing constraints. Estates reconfiguration work has been approved to proceed with investment which will support green pathways for TOE procedures through Lincoln and Pilgrim sites, in addition to Grantham site.

6.4 Endoscopy

6.4.1 Current position

Endoscopy services nationally are guided by the British Society of Gastroenterologists (BSG) and Joint Advisory Group on GI Endoscopy (JAG) and their recommendations remain unchanged. 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.



6.4.2 IPC and ventilation constraints

Under the current PHE guidance, a minimum of 10-12 air exchanges per hour in each procedure room is required. This air exchange requires the room to remain closed for 20 minutes post procedure to allow for airborne droplets to settle. A more efficient ventilation system could potentially reduce this time down to 5 minutes per procedure which would equate to one additional patient per list.

The rooms require cleaning between patients, 10 minutes cleaning time followed by 15 minutes drying time before the next patient and team can enter.

6.4.3 Demand

Demand average based on the last 4 weeks referrals received is 338 points (points are units of endoscopy procedure time measurement) per week. Future demand is difficult to predict due to unknowns in outpatient clinic recovery, screening programme/bowel scope, increased demand of non-GI specialties and any impact on new interventions such as FIT and capsule endoscopy.

If demand returns to pre COVID levels demand would average 700 points per week. Current maximum capacity is 415 points per week. The Endoscopy Recovery Cell is leading development of a strategy to meet this shortfall in capacity of circa. 300 points per week.

6.4.4 Demand management

This recovery strategy will include demand management and alternative capacity plans including:

- Primary Care pathways
- Secondary Care pathways
- Vetting of referrals received
- FIT (faecal immunochemical testing)

- Capsule endoscopy
- Maximisation of capacity through 7 day working and extended session days

6.4.5 Key next actions

To support this recovery strategy the Endoscopy Recovery Cell has identified the following supporting enablers which will be completed within the next few weeks:

- Completion of estates and workforce audits
- Production of a detailed capacity and demand model
- Review of job planning to support additional endoscopy sessions
- Work with estates to review improved ventilation systems in procedure rooms
- Put in place maximum workforce clinical time after reviewing available teams
- Engagement with the independent sector to secure arrangements with all potential IS providers

6.5 Urgent surgery and non-surgical procedures:

The Trust has continued to ensure sufficient capacity for urgent and time critical surgery and non-surgical procedures using Royal College of Surgeons (RCS) advice on surgical prioritisation. Level 2 and 3 (critical care level) surgical activity continues through green pathways on Lincoln and Pilgrim sites, with the earlier described Grantham green site model being the vehicle for all other cancer and elective surgical activity delivery.

Elective surgery commenced at Grantham from 1 July with four theatres running initially Monday to Friday extended days, eventually enabling throughput of a planned 25 surgery cases per day. Once efficiency and capacity are tested and fully understood elective backlog recovery trajectories will be modelled, but initial forecasting is for elective recovery by December 2020.

6.6 Prioritisation, risk stratification and harm review:

The approach taken to prioritising services is based on clinical risk with the highest priorities being cancer treatment, urgent and emergency care, and time critical non-cancer treatment. Only once the appropriate levels of capacity for these priorities is in place the process of restarting routine electives will commence, prioritising long waits.

Although co-dependent, risk stratification (prospective analysis) and harm review (retrospective analysis) should be considered distinctly. Risk stratification forms an important part of the Trust's approach to risk management of potential patient harm as a result of the response to Covid 19. Prospective clinical reviews are in place across urgent and planned care, inpatients and outpatients, cancer and maternity services, as well as other areas, as part of our Covid 19 response in addition to normal operational practices.

The increased UEC demand described earlier in this report raises the potential for delays in ambulance handover times, time patients spend in the ED and delayed discharge, and subsequent risk of harm. To mitigate these risks we have made immediate changes to our front door model, ED pathways, SDEC provision and discharge efficiency. All such incidents are reported using the Datix

incident reporting system, using the Trust's Clinical Harm Review template and Rapid Review Report if applicable. The purpose of a Rapid Review Report is to enable a timely decision to be made as to the level of investigation required following the report of an incident which appears to meet the Serious Incident criteria.

National Guidance issued in March proposed a system of prioritisation for cancer patients requiring surgery. Simultaneously, Royal Colleges issued advice on which treatments should go ahead and which are considered a greater risk due to coronavirus.

Our approach to minimising potential harm has been in line with the three key principles set out in the letter received in June from the National Cancer Director, these being:

1. Capacity: there needs to be sufficient capacity to ensure anyone referred with suspected cancer can be diagnosed and treated promptly
2. Fairness: access to cancer diagnostics and treatment services should be equitable and based on clinical priority
3. Confidence: patients need to have confidence their diagnostics and treatment will take place in an environment and manner that is safe

No moderate or severe harms have been reported in relation to the harm reviews undertaken by the Trust during the response to Covid-19 (93% reported no harm, 7% low harm).

The harm review processes used have been in place within the Trust following co-design and development with the CQC and CCG(s) in 2017.

Learning from harm reviews has fed back into the way that patients on RTT pathways are being tracked, managed and where necessary escalated. As an example, root cause analysis and harm review completed following a gastroenterology 52-week breach in March has led to review and improvements of the standard operating procedure for open referral monitoring and reporting, and hepatology sub-specialty referral mapping, minimising the risk of this happening again in the future.

6.7 Independent Sector Support:

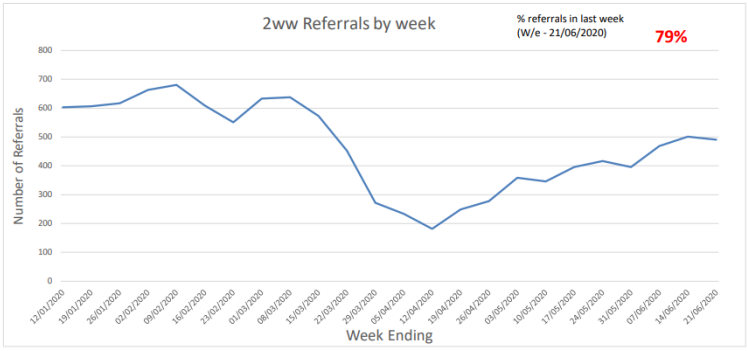
The Trust has been and continues to work with system colleagues to make use of NHS contracted independent sector hospitals in order to increase capacity available to treat cancer, urgent and elective long waits.

At the time of writing BMI Lincoln had undertaken 56 operations on behalf of the Trust; 32 orthopaedics and 24 ophthalmology procedures; this support will continue with plans to maximise available capacity. An agreement has also been reached with Ramsey Boston for 200 endoscopy procedures initially and further opportunity being scoped.

7 Cancer

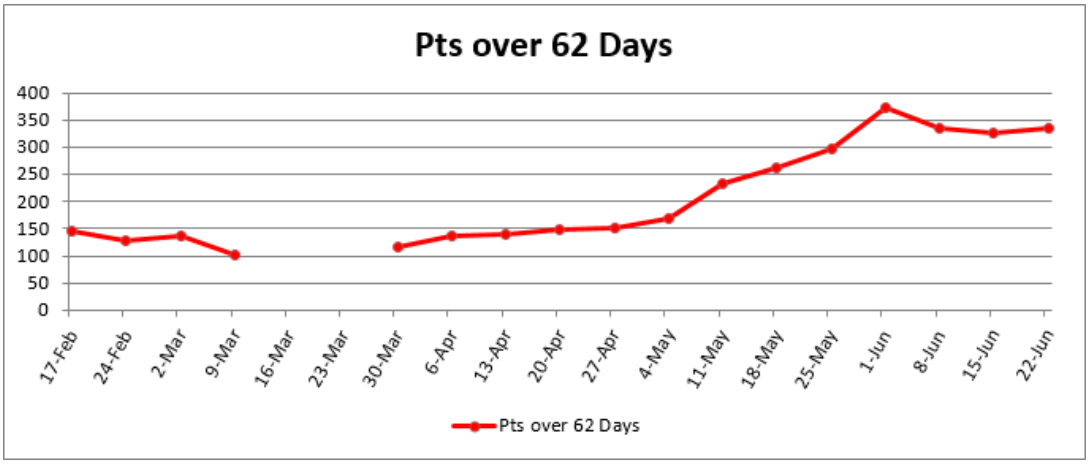
The Trust has maintained urgent access to essential cancer surgery and other treatment, and the provision of 2WW appointments, throughout the pandemic in line with national guidance and in collaboration with the regional Cancer Alliance and provider partners.

2WW referrals significantly reduced during the *Manage* phase and, as anticipated, have increased during the *Restore* phase with some tumour sites now returned to near pre-pandemic activity volume.



	Average referrals on baseline	% referred latest week against base line
Exhibited (non-cancer) Breast Symptoms	38	87%
Suspected brain/central nervous system	5	40%
Suspected breast cancer	70	84%
Suspected gynaecological cancers	49	108%
Suspected haematological malignancies	6	50%
Suspected head and neck cancers	62	97%
Suspected lower gastrointestinal cancers	135	73%
Suspected lung cancer	16	44%
Suspected Sarcomas	4	25%
Suspected skin cancers	102	89%
Suspected upper gastrointestinal cancers	52	79%
Suspected urological cancers (excluding t	82	50%
Total	622	79%

The Trust's 62 day cancer standard performance for June is forecast to be circa. 70% against an agreed recovery trajectory of 70.8%. During the course of the pandemic the over 62 day backlog has increased significantly and as of 19 June was 322 patients. This is similar to other Trust's regionally as is the predominance of colorectal pathways within this backlog cohort (73% of the total) due to the suspension of endoscopy procedures.



Cancer surgery commenced on the Grantham Green site from 1 July. At this time, there were no Level 1 cases outstanding and anticipated date to clear all priority Level 2 cases awaiting TCI was 5 weeks (by 9 August). The expected date to clear all priority Level 3 cases and those without a priority level awaiting TCI was 8 weeks (by 26 August).

Table 3: Outstanding ULHT cancer surgery with no TCI by specialty and priority level as at 1 July 2020

Specialty and Priority Level	No Planned TCI
Breast Surgery	**31**
Level 2	21
Level 3	2
No Priority Level	8
ENT	**5**
Level 2	2
Level 3	0
No Priority Level	3
General Surgery	**30**
Level 1	0
Level 2	7
Level 3	22
Gynaecology	**3**
Level 2	1
Level 3	1
Non-cancer	0
No Priority Level	1
Maxillo-Facial Surgery	**3**
Level 2	0
Level 3	1
No Priority Level	2
Urology	**33**
Level 1	0
Level 2	2
Level 3	31
Grand Total	**104**

8 CVD, heart attacks and stroke

Capacity has been 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. Routine catheter lab activity, including angiograms and complex devices, resumed in June as planned. However, restoration of cardioversions and TOE procedures has been delayed as a result of work on the Grantham green site model. Scaling up of these procedures will be prioritised in July and August.

On 31 March, in order to maintain capacity, the Trust's stroke pathway was temporarily 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 temporarily while being under continual review.

9 Maternity services

The Trust's maternity services are currently delivering all antenatal, intrapartum and postnatal care in line with NICE guidance CG62, CG37 and Fetal Anomaly Screening Standards. The services Covid 19 Standard Operating Procedure remains in place to support management of pregnant women who are symptomatic or positive to Covid 19. Whilst all care is in line with national guidance and supports face to face contacts as required, some care continues to be delivered via telephone and video conference, where this is deemed appropriate. This has been a very successful initiative during the pandemic and is something that will be embedded and continue to be used.

Of note, the Trust has seen an increase in domestic abuse disclosure, as has been seen nationally, and safeguarding referrals to MARAC have increased. This is being managed well by the midwifery teams supported by the safeguarding team and in conjunction with other agencies.

10 Screening programmes

During the Restore Phase we have prioritised making screening services available for the recognised highest risk groups as identified in individual screening programmes. Planning to restore screening programmes has been approved by the Trust's ICC, is on track and outlined below. Recovery Phase activity trajectories are under development and will be presented in the August progress update.

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.

National guidance has advised that activity should be reinstated during the Restore and Recovery Phases prioritising those patients at greatest risk of rupture, with plans agreed at local level.

The Trust currently has 572 patients on follow up with identified known small/medium AAA. Our current AAA screening backlog is circa. 900.

AAA screening will recommence in July with follow up of small/medium AAA patients prioritised.

10.2 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 contacted regularly to check on wellbeing and, where intervention is required, patients are being referred accordingly.

Screening centres have been advised to manage their own capacity and recommence FIT screening colonoscopies when able. Test kits should recommence following backlog clearance and future capacity has been identified. There is no recommendation from national bodies to recommence bowel scope currently.

The Trust is making use of available independent sector capacity from 6 July. Future capacity is being planned ahead of further national guidance on the reintroduction of bowel scope.

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. Cancer 2WW services have been maintained throughout the pandemic.

National guidance describes programme recovery in two phases. Phase one is risk stratified backlog clearance and our plan to commence phase one from August is on track. Phase two will consist of women aged 53+ and not previously invited and 71+ in the screening slippage auto batch, with phase two start date anticipated March 2021.

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, approximately 2% of total normal screening activity.

National guidance describes recovery in two phases. Phase one is risk stratified backlog clearance of digital surveillance, newly diagnosed, pregnant, and previous low level pathology and DNA patients. The Trust will commence this phase in July. Phase two will consist of all other patients with no pathology noted on last screen, with follow up deference protocol guidance enabling a March 2021 start for this phase.

10.5 Newborn hearing screening:

Our Newborn Hearing Screening Programme has been maintained throughout the pandemic. 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 at the bedside while still an inpatient. Outreach clinics will be resumed from July.

11. Corporate Governance – Review of Covid 19 Business Continuity Arrangements

At the April meeting the Trust Board agreed the measures it would put in place to maintain effective corporate governance arrangements, whilst adhering to national guidance and recognising the operational pressures being experienced by the Trust's executive, clinical and operational teams. The Board agreed the temporary suspension of the current governance structure and creation of Covid-19 specific governance arrangements.

Since April 2020 the position has been reviewed by the Chief Executive and Chair on a rolling weekly basis.

The Trust applied the following principles to meetings:

- Follow national advice and guidance relating to avoiding unnecessary social contact and travel
- Protect patients and staff from harm and avoid the spread of coronavirus
- Release staff time to focus on COVID19 and the delivery of front-line care
- Retain appropriate levels of leadership, governance and assurance

All but the most essential meetings were stood down.

At a corporate level the following principles were agreed:

- Decisions made during the period would continue to be in line with standing orders. The Board adopted a streamlined approach to governance and standing financial instructions.
- The Board acknowledged that its risk appetite and tolerance of risks needed to rise. The BAF was updated to reflect risks relating to Covid-19 and continued to be reviewed by the Board and the Quality Governance Committee monthly.

In order to free up Executive and Senior Staff time from the preparation of papers, attending meetings the following changes were agreed:

- Trust Board moved to being held virtually on a monthly basis, lasting no more than two hours. The agenda agreed by the Chair and Chief Executive. Board papers continued to be published on the website and members of the public will be able to submit questions in the normal way. The public will not be able to attend the meeting due to national social distancing requirements. Microsoft Teams has allowed the public to observe Board meetings online with over 140 people watching the June Board meeting in this way.
- Board Development sessions will be stood down
- The Audit Committee to meet (virtually) only as necessary to enable the completion of the final accounts process
- The Quality Committee to meet virtually on a monthly basis to focus on assuring the board on patient safety
- The People & OD Committee and Finance, Performance and Estates Committee were stood down. This position would be kept under review.

All Board and Committee papers would be kept brief, with only critical issues brought to the Board/ Committees attention.

Matters for approval were either:

- Deferred if not urgent
- Circulated vie email, allowing time for response and decision recorded by Trust Secretary/ Deputy Trust Secretary
- Discussed between Chief Executive or nominated Executive with appropriate Board/ Committee Chair for Chairs action

As the Trust moves to restore some services the Board are asked to consider re-instating some additional governance arrangements. It is proposed that monthly meetings for both the Finance, Performance and Estates Committee and the Workforce and OD Committee are re-introduced but with a lean agenda.

The focus for the meetings will be as follows:

- Finance, Performance and Estates Committee
    - Assurance on financial position and governance arrangements
    - Assurance on statutory responsibilities in respect of the estate
    - Assurance against performance standards
- Workforce and OD Committee
    - Assurance on workforce planning
    - Assurance on values and behaviours

The Trust Board and Quality Governance meetings will continue in line with current arrangements. These arrangements will continue to be kept under review, including providing the opportunity for the public to attend Board meetings when social distancing guidelines and access to appropriate venues allow.

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:	**16 September 2020**
Subject:	***Healthy Conversation 2019* and Next Steps**

Summary

This item enables the Health Scrutiny Committee for Lincolnshire to consider the final report on the *Healthy Conversation 2019* engagement exercise and the next steps for the local NHS, for example, the development of plans for public consultation on elements of the Lincolnshire Acute Services Review.

This report includes a summary of the responses of the Committee to the *Healthy Conversation 2019* engagement exercise between May and October 2019. The Committee made comments on:

- all eight strands of the Lincolnshire Acute Services Review;
- two further topics: mental health, learning disabilities and autism and integrated community care; and
- the overall engagement exercise, and the availability of capital funding.

The report on the *Healthy Conversation 2019* engagement exercise is also attached to this report. Senior representatives from Lincolnshire Clinical Commissioning Group will be present to answer questions on both this and the next steps.

Actions Required

(1) To consider the Health Scrutiny Committee's own responses to the *Healthy Conversation 2019* engagement exercise, as background to the Committee's consideration final engagement report.

(2) To consider how the Committee engages in the next steps by the local NHS, as pre-consultation business cases and draft consultation documentation are developed.

1. Healthy Conversation Engagement Exercise

The *Healthy Conversation 2019* engagement exercise took place between March and October 2019. The exercise sought the views of people in Lincolnshire on the eight strands of the Lincolnshire Acute services Review, as well as other topics such as integrated community care and mental health, learning disability and autism.

As stated in the *Healthy Conversation* engagement report summary the key messages are that the people of Lincolnshire:

- have respect and admiration for staff in the NHS
- believe that prevention is better than cure
- would like more education on healthier lifestyles and prevention
- want support to manage their own health conditions pro-actively
- want help to look after themselves better
- recognise that NHS staff and skills are precious and we should use them sensibly
- acknowledge that seeing a doctor is not always the best option
- are enthusiastic about engaging with us through digital means as much as possible
- want joined up care
- are genuinely concerned about how the NHS can help people living in deprived areas

The Final Report for *Healthy Conversation 2019* is attached as Appendix B to this report, together with five further supporting appendices: -

- B1 - Purpose and Activities
- B2 - Engagement Feedback:
- B3 - Workshop Frequently Asked Questions
- B4 - Acute Services Review Survey Report
- B5 - The People's Partnership Acute Services Review - Engagement with Hidden and Hard to Reach Communities (Executive Summary).

2. Health Scrutiny Committee Activity on Healthy Conversation 2019

From May to October 2019, the Committee considered one or more *Healthy Conversation* items at each meeting during this period. In most instances, clinicians were present to support the information presented to the Committee. Following each meeting the Chairman wrote to the Lincolnshire Sustainability and Transformation Partnership, setting out the Committee's views.

The following table lists the dates the items were considered, together with the date the letter was sent on behalf of the Committee.

Committee Date	Item *(*) = Acute Services Review Item*	Date Feedback Letter Sent to Local NHS
15 May 19	Urgent and Emergency Care *(*)*	23 May 19
12 June 19	Stroke Services *(*)* Breast Services *(*)* Women's and Children's Services *(*)*	4 July 19
10 July 19	Mental Health, Learning Disability and Autism Services	19 July 19
18 Sept 19	Healthy Conversation / Estates / Capital Update	26 Sept 19
	General Surgery *(*)* Trauma and Orthopaedics *(*)* Grantham Acute Medicine *(*)*	24 Oct 19
16 Oct 19	Haematology and Oncology *(*)* Integrated Community Care	24 Oct 19

The Committee's responses to the specific *Healthy Conversation* topics are summarised in Appendix A to this report. The response to the general update, dated 26 September 2019, is summarised below.

Committee's General Comments on Engagement - Summary

On 18 September 2019, the Committee considered a general update on the *Healthy Conversation 2019* engagement exercise. Following the meeting, the following points were raised by the Chairman:

- Reach of Engagement Activity – There were concerns over the level of engagement, given the Lincolnshire population of 700,000 people. There was an expectation for a leaflet to be sent to every household for the full consultation proposals, which will lead to better rate of response.

- Workshops in Boston and Grantham – There were concerns recorded over the workshops in Boston and Grantham in June and October 2019.

- Use of Shopping Centres, Supermarkets and Markets – There should have been more advance publicity for this.

- Estates and Capital Expenditure – There was a confirmation made at the Committee meeting on 18 September 2019 that if capital funding was not available for any particular acute services review item, consultation on that item might be deferred. Consultation on other acute services review items with either identified capital funding or no requirement for capital funding would proceed, in line with NHS England rules and guidance.

Concerns were also recorded on the backlog in the repairs and maintenance of buildings, although it was understood that the NHS had prioritised direct services to patients over the fabric of the buildings.

- Transport – The Committee identified the performance of the non-emergency patient contract as key to supporting patient access to services.

3. Consultation

This report includes a summary of the Committee's responses to the *Healthy Conversation* engagement exercise in 2019. It is understood that consultation on the following four elements of the acute services review (not requiring significant capital funding) will take place first:

- Medical Services / Acute Medicine (Grantham and District Hospital)
- Stroke Services
- Trauma and Orthopaedic Services
- Urgent and Emergency Care Services

The following elements of the acute services require significant capital funding and subject to this, consultation will take place when this is available:

- Breast Services
- General Surgery Services
- Haematology and Oncology Services
- Women's and Children's Services

4. Conclusion

The Health Scrutiny Committee id requested to consider its own responses to the *Healthy Conversation 2019* engagement exercise, as background to the Committee's consideration final engagement report. The Committee is also requested to consider how the Committee engages in the next steps for the local NHS, as pre-consultation business cases and draft consultation documentation are developed.

5. Appendices

These are listed below and set out at the end of this report.

Appendix A	Health Scrutiny Committee for Lincolnshire - Responses to Specific Topics in the *Healthy Conversation 2019* Engagement Exercise
Appendix B	Final Report for *Healthy Conversation 2019*
Appendix B1	*Healthy Conversation 2019* - Purpose and Activities

Appendix B2	Engagement Feedback: • Nine open engagement events • Paper and online forms and queries • Workshops 1 & 2 • Market days • Community group meetings • Stamford Freshers' Fayre
Appendix B3	Workshop Frequently Asked Questions
Appendix B4	Acute Services Review Survey Report
Appendix B5	The People's Partnership Acute Services Review - Engagement with Hidden and Hard to Reach Communities (Executive Summary only) Full report available at: https://www.lincolnshire.nhs.uk/healthy-conversation/healthy-conversations-2019-report

6. Background Papers

The following background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

Letters from Councillor Carl Macey, the Chairman of the Health Scrutiny Committee for Lincolnshire, to John Turner, Senior Responsible Officer, Lincolnshire Sustainability and Transformation Partnership.	
Date of Letter	**Items Covered in Letter**
23 May 2019	Urgent and Emergency Care Information Available to the Public
4 July 2019	Women's and Children's Services Breast Services Stroke Services Transport Provision Information Available to the Public
19 July 2019	Mental Health, Learning Disability and Autism Services
26 September 2019	Reach of Engagement Activity Workshops in Boston and Grantham Estates and Capital Expenditure
24 October 2019	Haematology and Oncology
24 October 2019	Grantham Medical Beds Trauma and Orthopaedics General Surgery
24 October 2019	Integrated Community Care

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

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE

RESPONSES TO SPECIFIC TOPICS IN *HEALTHY CONVERSATION 2019* ENGAGEMENT EXERCISE

ACUTE SERVICES REVIEW ITEMS			
The Lincolnshire NHS's Emerging Option (Summary)	**Health Scrutiny Committee**		
	Date Considered	**Date Initial Comments Submitted**	**Summary of Initial Comments**
Breast Services First outpatient appointments and all surgery would be provided at a centre of excellence, either at Lincoln Hospital or Grantham Hospital, with the current preferred emerging option as Lincoln, as it requires the least amount of capital funding. All follow-up outpatient appointments (where most patients receive their care) and routine breast mammography screening services would continue to be available across the county as now.	12 June 19	4 July 19	• Recognition that national clinical guidelines would change the current model of care at ULHT. • Strong support for maintaining local services for mammography, follow-up outpatients and community support services. • Concerns on the finances required (estimated at £4.7m) to expand the breast unit at Lincoln County Hospital as a major risk, owing to a lack of identified funding. • Need for clarification on the 1,151 patients per annum (22.7%) being displaced from current ULHT Breast Services. • Early consultation recommended.

ACUTE SERVICES REVIEW ITEMS

The Lincolnshire NHS's Emerging Option (Summary)	Health Scrutiny Committee		
	Date Considered	**Date Initial Comments Submitted**	**Summary of Initial Comments**
<u>General Surgery Services</u> Most elective care would be at Grantham Hospital as a 'centre of excellence for elective short stay and day case general surgery'. Lincoln and Pilgrim Hospitals will provide some day case/elective care for patients needing complex surgery. Outpatients will remain at all three hospitals.	18 Sept 19	24 Oct 19	• Strong support for reduced cancellation rates, as an outcome of the emerging option. • Support for increasing day-case general surgery. • Support for new surgical facilities at Grantham Hospital, with a fifth theatre to increase activity. • Assurance received that plans for winter resilience would not impact significantly on the number of planned operations, taking place in January and February.

ACUTE SERVICES REVIEW ITEMS

The Lincolnshire NHS's Emerging Option (Summary)	Health Scrutiny Committee		
	Date Considered	**Date Initial Comments Submitted**	**Summary of Initial Comments**
<u>Haematology and Oncology Services</u> • All haematology and oncology inpatient services would be at Lincoln. • All other services stay the same: ➢ haematology and oncology outpatients and day cases to continue at all three hospitals. ➢ chemotherapy and radiotherapy to continue at Lincoln Hospital. ➢ chemotherapy day cases to continue at Pilgrim and Grantham Hospitals.	16 Oct 19	24 Oct 2019	• Concern that the public would see this as a loss of service for Boston and the surrounding area • Reassurance sought that the emerging option would ease pressure on Lincoln and deliver the Lincolnshire Cancer Strategy. • Concerns over transport and travel from Boston to Lincoln, particularly for haematology and oncology patients. • Support for reduced reliance on locums and agency staff. • Concerns over availability of capital funding to increase the number of beds at Lincoln from 32 to 49, to support the transfer of inpatients from Pilgrim. • Emphasis on earlier diagnosis would lead to great demands on diagnostic services.

ACUTE SERVICES REVIEW ITEMS

The Lincolnshire NHS's Emerging Option (Summary)	Health Scrutiny Committee		
	Date Considered	**Date Initial Comments Submitted**	**Summary of Initial Comments**
<u>Medical Services</u> There are two emerging options: (1) Inpatient medical services at Grantham Hospital would be retained as part of a model where hospital doctors and services are part of an integrated service with GP services, community health and other services. This model would also deliver more ambulatory care. A small number of patients currently treated in Grantham would be admitted to hospitals with more specialist services. This is the NHS's preferred emerging option. (2) There would be no medical inpatient services at Grantham Hospital. Diagnostics and outpatients would continue.	18 Sept 19	24 Oct 19	• Initial preference for Option (1), as a means of stabilising Grantham Hospital. • Welcome for the involvement of local clinicians in the development of options. • Different ways of working by all staff involved. • Concern on the availability of funding for Option (1), should it be required. • Medical admissions to Grantham Hospital should continue on a 24/7 basis. • Plans for staff to be integrated, supporting both medical beds and urgent care noted. • Expectation for greater scope for children with more acute needs to be seen at Grantham. • More detail requested on how option (1) would work in practice • Option (2) not supported, as this would remove services from Grantham Hospital.

ACUTE SERVICES REVIEW ITEMS

The Lincolnshire NHS's Emerging Option (Summary)	Health Scrutiny Committee		
	Date Considered	**Date Initial Comments Submitted**	**Summary of Initial Comments**
<u>Stroke Services</u> Two emerging options: (1) This option would provide a centre of excellence, providing acute stroke care from the Lincoln Hospital site. This is the NHS's preferred emerging option because it will provide the best model to meet national care standards for patients, and to recruit and retain staff. (2) This option would retain the current service at Lincoln and Pilgrim Hospitals but with an out of hours combined on-call rota being based at Lincoln. In both options, the NHS's intention is to enhance rehabilitation in the community, to reduce the length of stay in hospital from 14 days to 7 days in line with national best practice.	12 June 19	4 July 19	• Acceptance that the preferred option had been developed in line with national clinical guidelines. • Acknowledgement of significant workforce gaps to meet the clinical guidelines for staffing levels. • Recruitment to a centre of excellence for Stroke Services aimed to recruit and retain staff. • Welcome for the proposal for an enhanced community stroke rehabilitation service as part of the emerging option. • Acceptance of the benefit of a centre of excellence, but concern recorded on the travelling times to the Lincoln County Hospital site for patients across the county. • Concern that patients from Pilgrim Hospital would be displaced to North West Anglia NHS Foundation Trust.

ACUTE SERVICES REVIEW ITEMS

The Lincolnshire NHS's Emerging Option (Summary)	Health Scrutiny Committee		
	Date Considered	**Date Initial Comments Submitted**	**Summary of Initial Comments**
<u>Trauma and Orthopaedic Services</u> • Grantham Hospital as a centre of excellence for planned and day case orthopaedic surgery. • Lincoln and Pilgrim Hospitals to provide some day case surgery and planned care for patients with complex needs. • Outpatient services unchanged.	18 Sept 19	24 Oct 19	• Support for the emerging option for the trauma and orthopaedic service, as the trauma and orthopaedic service pilot has seen a reduction in the waiting list and cancelled operations. • Welcome for the fact that ULHT has been highlighted as an example of good practice. • Concerns from the staff as to the future of the orthopaedic service at Louth County Hospital need to be addressed. • Risks associated with the pilot are being monitored and managed as part of the routine management process at ULHT.

ACUTE SERVICES REVIEW ITEMS

The Lincolnshire NHS's Emerging Option (Summary)	Health Scrutiny Committee		
	Date Considered	**Date Initial Comments Submitted**	**Summary of Initial Comments**
<u>Urgent and Emergency Care Services</u> (a) A&E services at both Lincoln and Pilgrim Hospitals, with urgent treatment centres at each site; (b) Urgent treatment centre at Grantham Hospital to provide 24 hour, seven day a week access to urgent care services, with NHS111 as the entry point to the urgent treatment centre overnight; urgent treatment to receive patients by ambulance, with refinements to the current access criteria; and (c) Develop urgent treatment centre services at Louth, Stamford and Skegness Hospitals; and (d) Exploring options for urgent treatment centres in Spalding and Gainsborough.	15 May 19	23 May 19	• Acceptance that the introduction of urgent treatment centres (by autumn of 2020) is a national initiative, so no major concerns on (a) and (c), other than the need for 24/7 walk in access. • Concerns over continued absence of A&E facilities in the Grantham and surrounding area overnight. • The proposal in (b) should be on a 24/7 walk-in basis. • Need for a list of the services undertaken currently at Grantham A&E and those services proposed for Grantham urgent treatment centre. • Support for (d).

ACUTE SERVICES REVIEW ITEMS

The Lincolnshire NHS's Emerging Option (Summary)	Health Scrutiny Committee		
	Date Considered	**Date Initial Comments Submitted**	**Summary of Initial Comments**
<u>Women's and Children's Services</u> - There are two emerging options. (1) is preferred by the Lincolnshire NHS. (1) <u>Pilgrim Hospital</u> • consultant led obstetrics and co-located midwife-led unit • Special care unit for babies from 32 weeks. • paediatric assessment ward for up to 23 hours low acuity paediatric in-patient beds overnight • paediatric day case surgery. • gynaecology <u>Lincoln Hospital</u> • consultant-led obstetrics and co-located midwife-led unit • neonatal unit for babies born from 27 weeks • short stay paediatric assessment ward • paediatric in-patient beds • paediatric day case and planned surgery. • gynaecology (2) The second emerging option is to have consultant obstetric, neonatal and paediatric services at Lincoln Hospital and a midwife-led unit and short stay paediatric assessment ward at Pilgrim Hospital.	12 June 19	4 July 19	• Work to ensure women across Lincolnshire receive continuity of care to improve outcomes and safety, and offer a more positive and personal experience. • Support for improvements to personalised care and choice through the development of community hubs, which have enabled women and families to access care closer to home. • Support for two additional hubs, and continued collaboration with the local authority to identify appropriate locations for these new sites. • Focus on mental health services, including the development of a multi-professional service for women with high perinatal mental health needs welcomed. • Promotion of more public awareness of the *Healthy Conversation* process for women's and children's services supported. • The Committee also would like to highlight the need for on-going connection and engagement with groups in Boston, to better seek the views of the local community on the emerging options and changes to paediatric services.

OTHER HEALTHY CONVERSATION TOPICS

Summary of Healthy Conversation	Health Scrutiny Committee		
	Date Considered	Date Initial Comments Submitted	Summary of Comments
<u>Mental Health, Learning Disability and Autism Services</u> • Need improve all services in a way which is affordable and linked with wellbeing services, particularly how they are delivered and accessed within our local communities. • Work being undertaken with service users and partners to make it easier for patients in crisis to access support first time. • Parity of esteem with physical health, so that people with mental health problems benefiting from: ➢ equal access to the most effective and safest care and treatment ➢ equal efforts to improve the quality of care ➢ the allocation of time, effort and resources on a basis commensurate with need ➢ equal status within healthcare education and practice ➢ equally high aspirations for service users ➢ equal status in the measurement of health outcomes	12 July 2019	19 July 2019	• Important to ensure information is made widely available on the services provided, so that patients know where to go to get help and how to access it. To this end, the development of an 'app' for use on mobile phones and directories of services were supported. • Need for a continued focus on reducing waiting times, as this was key in preventing further deterioration of an individual's mental wellbeing before they can access support. • Value of support provided through the Managed Care Network and through other independent local schemes. • Support for the expansion of perinatal mental health services.

OTHER HEALTHY CONVERSATION TOPICS			
Summary of Healthy Conversation	**Health Scrutiny Committee**		
	Date Considered	**Date Initial Comments Submitted**	**Summary of Comments**
<u>Integrated Community Care</u> Four key programme areas were identified: • Neighbourhood Working / Neighbourhood Teams • Introduction of Primary Care Networks • Use of Technology • Development of Specialist Community Services.	16 Oct 2019	24 Oct 2019	• As the implementation of neighbourhood teams and primary care networks was a work in progress, no formal comments made at this stage.

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www.lincolnshire.nhs.uk

Final Report for Healthy Conversation 2019

An NHS engagement exercise with the people of Lincolnshire to understand what matters to them in order to inform NHS service development in the future

People are at the heart of everything we do and it's important that they are involved not just in decisions about their care, but also in decisions that shape the current and future health services in Lincolnshire.

Introduction

We are pleased to present our first 'Lincolnshire NHS' engagement report. The engagement campaign 'Healthy Conversation 2019' took place during March to October 2019 and was delivered by the all the Lincolnshire NHS organisations together.

This report provides a summary of the feedback from the Healthy Conversation 2019 (HC2019) campaign to the public, staff, NHS organisations, partners and stakeholders. It details the campaign activity and explains how the feedback and results have informed the development of Lincolnshire's Long Term Plan and NHS work programmes as well as being used to shape emerging options for the Acute Services Review consultation.

The appendices provide further details of the campaign's communication and engagement activities and the feedback received.

Healthy Conversation 2019 Executive Summary

Through the HC2019 engagement campaign and associated communications, there have been a vast number of contacts using a variety of methods such as Facebook, Twitter and other social media platforms. Other methods have included face to face contacts such as events, surveys, forms, market days and supermarkets. Healthy Conversation 2019 has been communicated widely via different channels and with the support of our stakeholders and partner organisations, sharing information on our behalf. Below is a summary of these contacts, and the breadth of opportunity available for people to engage with.

HEALTHY CONVERSATION 2019

Summary of activities

Engagement

Launch day
- Successful event held in a central, accessible location within Lincolnshire
- Press and key stakeholders in attendance
- Clinicians and senior executives available to answer questions and provide interviews
- Also launched through communication channels such as local media, social media and radio
- Key stakeholder briefings took place and information provide via press packs

Open Events
- 9 events across the county
- 'Interactive' face to face approach involving clinicians, senior executives and managers.
- Displays showcasing information and opportunities for involvement in prevention and self-care, integrated community care, mental health, hospital services, enablers (digital, workforce, estates), NHS Long Term Plan, travel and transport
- Promotion of opportunities to get involved e.g. Survey, feedback forms, Keep in Touch forms

Workshops
- 4 workshops held in 2 locations
- 'Deep dive' sessions held in the localities for the public to ask detailed questions
- Clinicians and senior executives present to talk through rationale, opportunities and risks
- Feedback and FAQs from the workshops published

Roadshows
- Spokespeople visited 12 different communities by attending various market days and supermarkets across the county
- Provided opportunities to share information, answer questions and gather feedback
- Helped to reach people that may not attend other events or feel able or confident enough to speak up in unfamiliar settings
- Increased campaign awareness

Existing community meetings
- Captured people's views at community meetings with various groups such as Lincs Sensory Service, Parent and Toddler groups and village friendship groups
- Attended existing external events e.g. New College Stamford Fresher's Fair, Safeguarding Conference 2019, Race Equality Conference and Annual Public Meetings etc.

Stakeholder Management

- Partner working with EMAS, neighbouring Trusts and HealthWatch
- Updates presented to our Stakeholder Board and Voluntary Engagement Team
- Formal attendance at Health Overview and Scrutiny Committee and Health and Wellbeing Board
- Updates sent to local MPs, District Councils, Parish Councils, Health partners, campaign groups, local influencers, staff reps and regulators.

Media

- Press/public hub established March 2019 on the day of the launch
- Encouraged media to attend and report on all events
- 160 enquiries handled from the press and the public
- 19 press releases issued
- Featured on radio, TV and print press
- Healthy Conversation hotline number and email address used for all enquiries
- Regular media monitoring- featured in 40 positive stories, 28 negative and 15 neutral.
- Several case studies created and published on Lincolnshire NHS' website

Marketing

- Pull up banners, leaflets, survey, stakeholder mailing lists, display boards and posters, 'You Said, We Did' leaflets , displays on TV screens in GP practices, information in County News, hand delivered leaflets and posters to local outlets, posted leaflets and posters to all GP practices and NHS organisations
- Freepost address established

Information films
- 20 information films available to all
- Covering various topics such as Breast and Stroke service and Urgent and Emergency Care services etc.
- Promoted and available to watch via YouTube, Facebook, Twitter and the Lincolnshire NHS website
- 1659 video views

Digital

Website
- Website established March 2019
- One central hub available to all for communications and engagement activity and background information
- Creation of FAQs section and 'You Said, We Did'
- Update report published September 2019
- Monthly infographic summarising communications and engagement activity
- 54,695 page views

Social Media
- Creation of Facebook, Twitter and Instagram accounts
- Post reach of over 175,000 Facebook
- A total of 286,531 tweet impressions
- Regular key messages and information shared widely
- Promotion of events and workshops
- Used as a platform for communicating good news stories and connecting with the public

Equality and Diversity

- Worked with People's Partnership to further engage with protected characteristics groups
- Worked with the Equality and Diversity team to distribute translated leaflets via Health Promotion Events which took place on several occasions at Bakkavor, Moy Park
- Survey translated into the 5 most spoken foreign languages in Lincolnshire
- Easy read, braille and audio versions of the survey available on request
- Downloadable and printable version of the survey online

NHS Staff

- Initial detailed team briefings across all 7 organisations in Lincolnshire coincided with the launch day.
- Screen savers displayed on staff computers across 7 organisations
- Built on existing methods of communication in organisations such as websites, staff briefings, bulletins and local intranets
- Regular updates on staff wide bulletins, intranets executive blogs and emails and team briefings
- Captured staff views by attending events such as the STP Digital Connected Care Event where 300+ people attended

Key messages from Healthy Conversation 2019

We have heard that the people of Lincolnshire:

- Have respect and admiration for staff in the NHS
- Believe that prevention is better than cure
- Would like more education on healthier lifestyles and prevention
- Want support to manage their own health conditions proactively
- Want help to look after themselves better
- Recognise that NHS staff and skills are precious and we should use them sensibly
- Acknowledge that seeing a doctor is not always the best option
- Are enthusiastic about engaging with us through digital means as much as possible
- Want joined up care
- Are genuinely concerned about how the NHS can help people living in deprived areas

We heard that people in the Grantham area:

- Want 24/7 ‘walk in’ access to urgent care services at Grantham Hospital
- Support a centre of excellence for elective care at Grantham Hospital

We heard that people in the Boston area:

- Want to keep maternity, neonatal and paediatric services at Pilgrim Hospital (with only one option going into the ASR public consultation)
- Are concerned about travel time for people with symptoms of a suspected stroke if the service is no longer at Pilgrim Hospital

We heard that people across Lincolnshire as a whole:

- Are concerned that Lincoln Hospital is not big enough to have more services moved there
- Are concerned that some patients, families and those from deprived backgrounds will have difficulty travelling to Lincoln Hospital, exacerbated by general issues with road networks and public transport in the county
- Are worried about current difficulties getting a GP appointment, and believe GPs and other services could be better linked
- Are concerned about the recruitment challenges faced by the NHS locally and nationally

Next Steps

All feedback received throughout Healthy Conversation 2019 has been reviewed and analysed by our lead clinicians and is already being, or will be, used as follows:

- Lincolnshire's Long Term Plan (LTP) has been developed and will be published shortly in line with the national timeframe. The LTP details many actions being taken forward which are consistent with the feedback received from the public
- You said that you wanted improved joined up care – we have expanded how we work together through our integrated neighbourhood working teams and Primary Care Networks. These are groups of 'multi-disciplinary' staff, working across their skills in your local area to link up care
- To inform the next stage of the Acute Services Review (ASR) programme, most notably developing the emerging options being considered for full public consultation
- As the NHS enters its national annual planning cycle, all of the HC2019 feedback continues to be delivered to our clinicians and strategists as part of the briefing process which will influence this planning
- You said that you wanted more help on healthy lifestyles. In January 2020, we celebrated a reduction in smoking rates in the county in the past 12 months and we are committed to continuing to work with our Public Health England colleagues in the county to create continued successes across both prevention and self care
- You are concerned about travel in the county, both road networks and public transport. We are actively working with Lincolnshire County Council, who are responsible for these areas, and other relevant partners in order to develop solutions and improvements. A significant example of this co-development is the joint transport strategy we are all signed up to
- You are interested in how digital technology can improve access to the NHS in the county
- We are in the process of establishing a showcase and information event for the public in 2020 to hear your views on what solutions would work best for patients and their carers
- We heard that HC2019 was welcomed and the opportunity for the public to continuously influence decisions in this way is something we all want to commit to continuing. We are actively in the process of establishing Lincolnshire's Citizens Panel, which will help broaden

and deepen our interaction and feedback processes across the county, one of many examples of improved processes we are implementing.

Conclusion

Healthy Conversation 2019 has evidenced the public's willingness to engage in difficult conversations, and offer suggestions regarding how we can improve. They want the NHS to have increasing focus on prevention and self-care, use a common language and link all its different elements better. They welcome that we are listening. Healthy Conversation 2019 has not just been about what people want, but understanding what matters to them, what they think would work best and why.

These conversations have been framed within realistic parameters about what the NHS can and cannot deliver. Lincolnshire NHS pledges to build on Healthy Conversation 2019 and develop this conversation in 2020.

The feedback received has been used to inform the development of Lincolnshire's Long Term Plan, NHS work programmes and further shaped the emerging options for the Acute Services Review consultation. As the NHS enters its national annual planning cycle, all of the HC2019 feedback forms will also be used in the briefing process to influence this planning.

Appendices:

Appendix	Content
1	Healthy Conversation 2019 purpose and activities
2	Feedback from: • Open engagement events • Paper and online forms and queries • Workshops 1 & 2 • Market days • Community group meetings • Stamford Freshers' Fayre • Overview of Acute Services Review survey and The People's Partnership report
3	Workshop Frequently Asked Questions
4	Acute Services Review survey report
5	The People's Partnership Acute Services Review engagement with hidden and hard to reach communities

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Appendix 1: Healthy Conversation 2019 purpose and activities

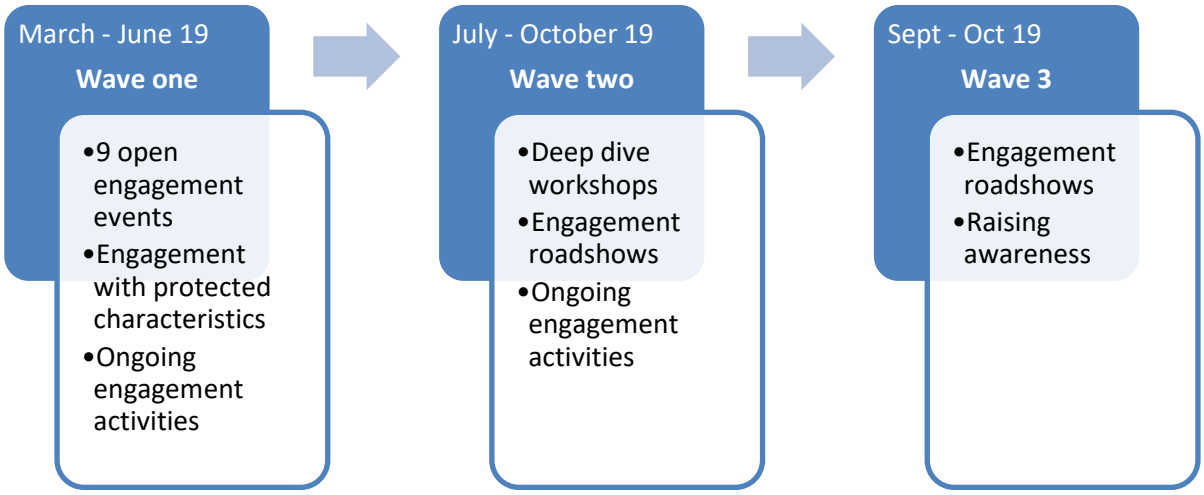
On 5 March 2019, the NHS across Lincolnshire launched its Healthy Conversation 2019. This was an open engagement exercise to shape how the NHS in Lincolnshire takes health care forward in the years ahead. It was a chance for everyone to learn more about the NHS's current thinking on the future of NHS services and a way to get meaningful feedback from our patients, their representatives, the public, NHS partners and staff about what future services may look like. Healthy Conversation 2019 continued throughout the year, with a wide range of engagement events and discussions across the county. Almost seven months of engagement came to a close on 31st October 2019 and has enabled all feedback received to be considered in a timely manner and informed the Lincolnshire's Long Term Plan, alongside the Healthwatch engagement results. Feedback has also been reported into system programmes as well as shaping emerging options for the Acute Services Review consultation.

The key overarching Healthy Conversation 2019 campaign messages have been:

- Lincolnshire's NHS needs to continue to transform to improve quality, attract staff and be fit for the future
- The way we all use the NHS needs to change too
- We need to make this change together – get involved

Engagement activity undertaken:

The various waves of communications and engagement have incorporated a number of activities to give as many people as possible the opportunity to get involved and share their views in a way that suits them:



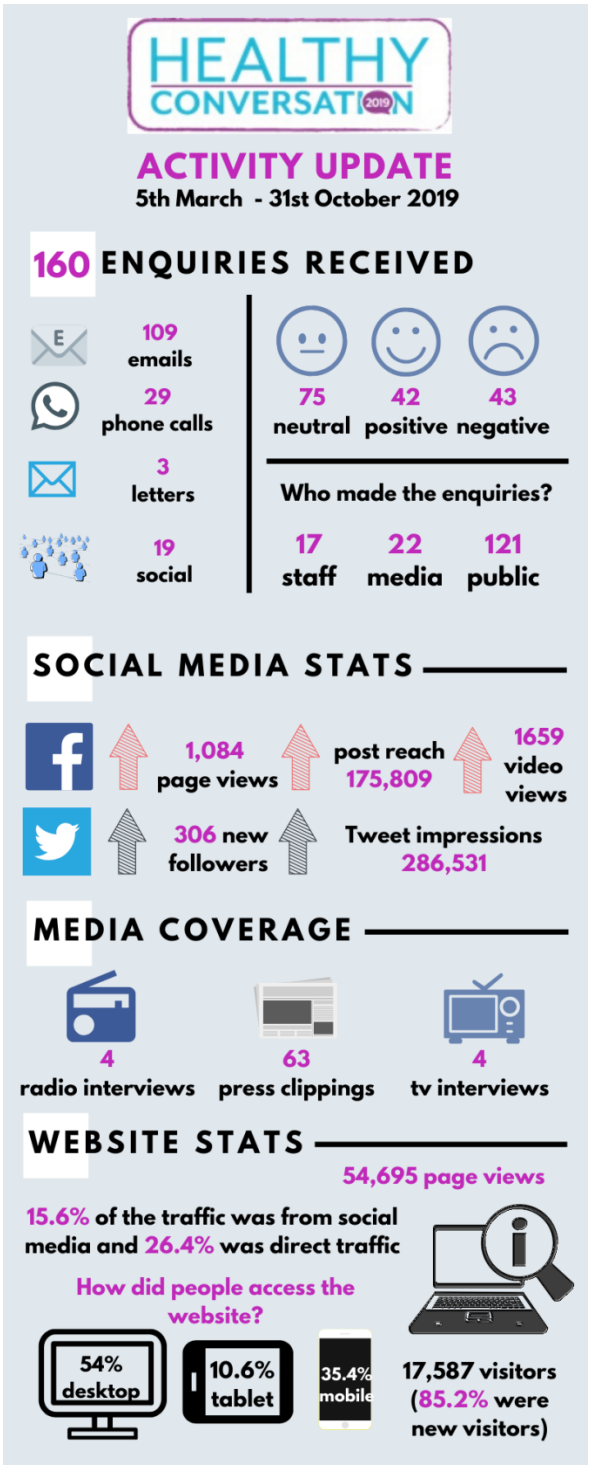
Overview of engagement to date:

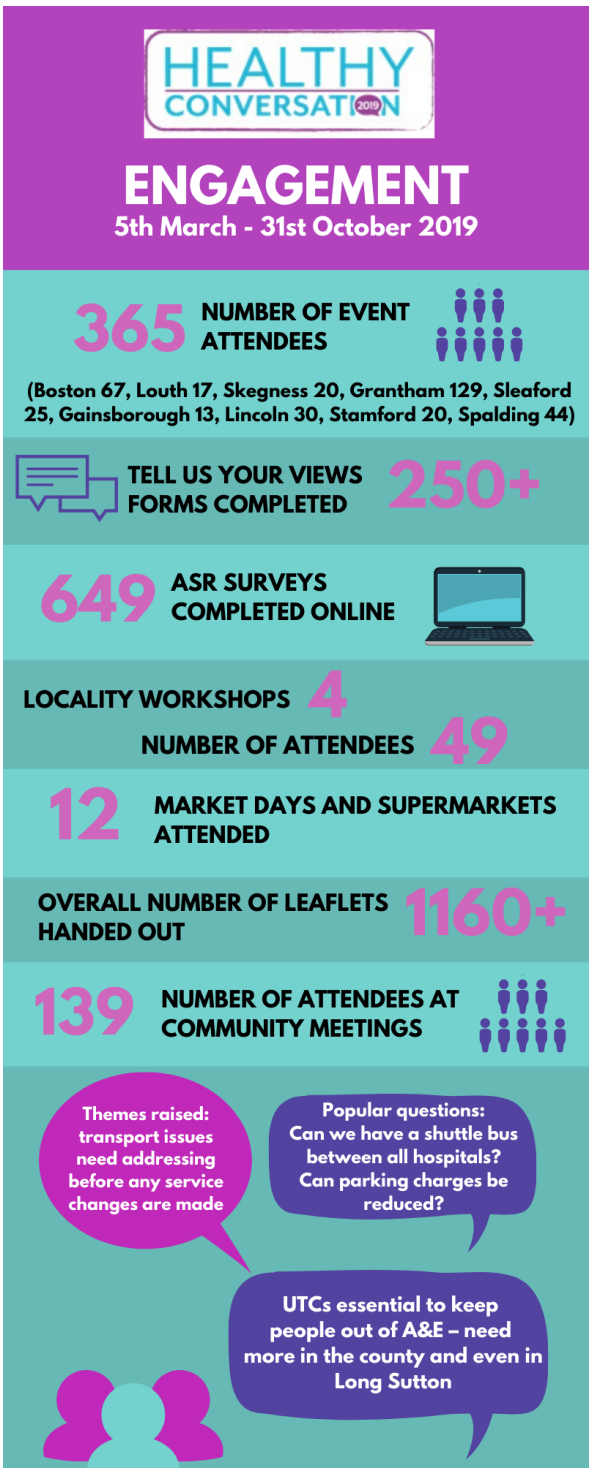
Engagement activity	Reach
Acute Service Review (ASR) survey *(closed 31st August 2019)* (also translated into Romanian, Polish, Russian, Latvian, Lithuanian, and Portuguese)	649 responses
General feedback forms	200+ responses
9 Healthy Conversation open events in Boston, Louth, Skegness, Grantham, Sleaford, Gainsborough, Lincoln, Stamford and Spalding	365 attendees
People's Partnership engagement with protected characteristics	130 responses
Roadshows (market days, supermarkets, shopping centres)	55 feedback forms received and 416 leaflets handed out
Distribution of leaflets and posters (see appendix A)	All NHS organisations and staff, GP practices, libraries, pharmacies, colleges etc
Locality workshops Grantham: 19 June 2019 Boston: 27 June 2019 Grantham: 9 October 2019 Boston: 10 October 2019	49 attendees across the workshops
Community meetings (e.g. Health Improvement Partnership, Toddler Group, Blind Society meetings etc)	139 attendees at meetings with a reach of over 7000 members.
Health Scrutiny Committee meetings • 20 March 2019: Introduction to HC2019 • 15 May 2019: Urgent & Emergency Care proposal • 12 June 2019: Womens & Childrens / Breast Services / Stroke Services case for change and emerging options • 10 July 2019: Mental Health Learning Disabilities & Autism Services • 18 September 2019: HC2019 update / medical services at Grantham Hospital case for change and emerging options • 16 October 2019: Haemotology & Oncology	District Councilors and Public in attendance Subsequent Media reporting Minutes and papers published on LCC website

Stakeholder meetings	Non-Executive Directors/Lay members workshops, District Council meetings, Health Scrutiny Committee updates etc
All staff briefed	All 7 organisations, primary care and the Charity and Voluntary sector.
Media engagement took place on the day of the	
Ongoing direct contact with the HC2019 team via telephone, email and letter	
Social media updates throughout	

This has been supported by widespread media and social media activity as well as direct calls and emails to the team. Although the volume of media coverage has dropped over time, the amount of social media activity continues to grow with to date an audience reach for posts of over 175,000 and over 54,000 website views since the launch of the campaign in March.

The following infographics summarise communications and engagement activity throughout the campaign.


HEALTHY CONVERSATION 2019
ACTIVITY UPDATE
5th March - 31st October 2019
160 ENQUIRIES RECEIVED
109 emails
29 phone calls
3 letters
19 social
75 neutral
42 positive
43 negative
Who made the enquiries?
17 staff
22 media
121 public
SOCIAL MEDIA STATS
1,084 page views
post reach 175,809
1659 video views
306 new followers
Tweet impressions 286,531
MEDIA COVERAGE
4 radio interviews
63 press clippings
4 tv interviews
WEBSITE STATS
54,695 page views
15.6% of the traffic was from social media and 26.4% was direct traffic
How did people access the website?
54% desktop
10.6% tablet
35.4% mobile
17,587 visitors (85.2% were new visitors)


HEALTHY CONVERSATION 2019
ENGAGEMENT
5th March - 31st October 2019
365 NUMBER OF EVENT ATTENDEES
(Boston 67, Louth 17, Skegness 20, Grantham 129, Sleaford 25, Gainsborough 13, Lincoln 30, Stamford 20, Spalding 44)
TELL US YOUR VIEWS FORMS COMPLETED 250+
649 ASR SURVEYS COMPLETED ONLINE
LOCALITY WORKSHOPS 4
NUMBER OF ATTENDEES 49
12 MARKET DAYS AND SUPERMARKETS ATTENDED
OVERALL NUMBER OF LEAFLETS HANDED OUT 1160+
139 NUMBER OF ATTENDEES AT COMMUNITY MEETINGS
Themes raised: transport issues need addressing before any service changes are made
Popular questions: Can we have a shuttle bus between all hospitals? Can parking charges be reduced?
UTCs essential to keep people out of A&E – need more in the county and even in Long Sutton

Appendix 2: Engagement feedback

This appendix summarises HC2019 feedback received from:

- 9 open engagement events
- Paper and online forms and queries
- Workshops 1 & 2
- Market days
- Community group meetings
- Stamford Freshers Fayre

All of the detailed feedback received has been circulated to the Senior Responsible Officers for the system programmes to inform the development of Lincolnshire's Long Term Plan and also to shape their programmes and projects.

Feedback from open engagement events:

Since the campaign launch, we have held 9 Healthy Conversation 2019 events, advertised locally, for the public to attend drop in sessions between 2-7pm in the locations in the table below. These were hosted by a range of senior managers and clinicians, available to talk to the public and walk them around displays showcasing information and opportunities for involvement in prevention and self-care, integrated community care, mental health, hospital services, enablers (digital, workforce, estates), NHS Long Term Plan, travel and transport.

These events have been attended by 365 people and the core themes raised through direct verbal discussions and feedback forms were:

Date	Location	Key Locality Themes	No. of attendees
13/03	Boston	• Accessibility of stroke services in the future • Loss of services to Boston as a whole	67
14/03	Louth	• Threat of hospital closure (this was an initial concern that alleviated once responded to)	17
19/03	Skegness	• Accessibility of stroke services in the future • Loss of services to Boston as a whole	20
20/03	Grantham	• Concern that A&E is being 'downgraded' • Urgent Treatment Centres and what they are	129
20/05	Sleaford	• Lack of GP access • Lack of coordination following discharge from	25

		hospital	
21/05	Gainsborough	• Lack of GP access • Financial difficulties when having to travel to visit family	13
22/05	Lincoln	• Financial difficulties for family members having to travel to hospital • Professionals should be able see each other's notes to make it more streamlined for patient	30
12/06	Stamford	• Ensure links with North West Anglian NHS Trust for services in Stamford • Grantham A&E closure overnight	20
13/06	Spalding	• UTCs essential to keep people out of A&E – need more in the county and even in Long Sutton	44

Throughout all events, we consistently heard that the public are concerned about:

- Transport to services for patients and family
- NHS111 and its effectiveness
- EMAS and response times
- Issues of overburden on Lincoln County Hospital

Feedback from paper and online forms and queries:

We have received over 200 completed HC2019 feedback forms on various elements of the campaign via social media, telephone, email and forms at events and on our website. The detailed feedback has been circulated to programme Senior Responsible Officers and a summary of the key themes and suggestions for each of the services is provided below:

Acute Medical Services

Key themes:

- Capacity issues at Lincoln hospital – delays in being seen
- Length of time to get to hospital

Suggestions include:

- Airlift to specialist hospitals outside of Lincolnshire if case is too complex

Breast services

Key themes:

- Poor infrastructure and road networks causing access difficulties for patients and families who need to get to Lincoln
- Lack of confidence in Lincoln Hospital having sufficient capacity
- Preference of keeping services at Pilgrim

Diabetes, Self-Care and Prevention Services

Key themes:

- Variation in standard of diabetes care between GP Practices
- No infrastructure to support the communities, especially in Mablethorpe

Suggestions included:

- Focus on education and generational change
- Clinic appointments needed outside of working hours to reduce time needed off work
- Regular blood tests for everyone to alert people to problems before they arise

General Surgery Services

Key themes:

- Lack of confidence that current staff will be able to deal with more complex issues
- Team is mainly built up of agency staff meaning current service is not sustainable
- Journey will be too long for people in severe pain to travel
- Lack of signage around Grantham hospital currently

Suggestions include:

- To hold follow up clinics and monitoring in local hospitals

Haematology and Oncology Services

Key themes:

- Capacity/ issues of over burden on Lincoln hospital – overcrowded and poorly staffed, not enough beds
- Costly travel and parking that could cause hardship for both patients and their families when having to visit on such a regular basis
- Frequent cancellations and delays to appointments at present

Suggestions include:

- To have follow up appointments locally

Mental Health Services

Key themes:

- Really good care and support especially with autism
- Impossible to get appointment with CAMHS
- Lack of awareness on how to care for people with dementia and the care plans put in place by social services
- Additional community based services, enabling patients to stay at home with family

Suggestions included:

- More information required for parents about what services are available, especially online
- Improve links (transition) from children to adult services
- Improve flexibility of CBT appointments for those who work
- More information is required about what support is available in times of a mental health crisis – A+E seems too often to be the only option
- Share updates on mental health patients with the police so they have an understanding on how to deal with the individual

Primary Care Services

Key themes:

- Interface between GPs and other services – so patients do not have to tell their story multiple times
- Lack of availability for appointments

Suggestions included:

- Charge patients if they (do not attend) DNAs booked GP appointments
- Communicate all options for appointments as patients don't always need to see a GP
- Suggestion that one 'carer' cares for all of the people in one area; this would give more caring time and cut down on travel

Stroke Services

Key themes:

- 'Golden Hour' not achievable from some parts of the county
- Consideration of population need by locality before determining locations of service
- No mention of step down / rehabilitation
- Ambulance response times are poor – assurance needed
- Capacity issues – overburden on Lincoln hospital
- Loss of service at Pilgrim Hospital

Suggestions included:

- Scope how to link mental health support and stroke community rehabilitation
- Transport issues need addressing before any services are relocated

Technology and Innovation

Key themes:

- Welcome e-consultations to avoid concerns regarding transport/reducing the NHS' carbon footprint
- Refreshing to hear; innovative thinking, digital is the future
- Due to cyber-attacks, how safe is the 'digital system'?
- Many people do not have access to the internet and will need alternative options
- Areas of poor broadband and poor mobile phone signal
- Shouldn't need to keep re-telling your story/medical history

Suggestions included:

- Patients holding their own records and notes like in France
- Other communications needed such as face to face and local newspapers

Travel and Transport

Key themes:

- Issue isn't the hospitals but travelling to them – poor road networks and lack of public transport
- Early appointments not achievable when using public transport
- Costly travelling across the county to hospitals further away
- Hardship to patients and families by having to take additional time off work to travel further
- Can't always rely on family and friends
- Community transport sometimes unreliable
- Unable to get back from hospitals if taken by ambulance

Suggestions included:

- Inter-site transport - provision of shuttle between hospitals or accommodation for family to stay
- Development of a driver volunteer scheme
- Direct trains between Boston, Skegness and Lincoln
- Routes and times clearly displayed at all bus stops
- Introduction of a travel helpline

Urgent and Emergency Care Services
Key themes:

Grantham

- Grantham is on major road and rail links and needs an A&E open 24/7
- New housing developments with increasing local population
- Travelling time is not within the 'golden hour' from parts of the county, especially for those without their own transport
- Poor road networks and lack of public transport, especially in rural villages
- Ambulance availability and response time concerns
- Capacity issues – overburden on Lincoln Hospital
- Inability to get back from hospitals if taken by ambulance
- Lack of transport to attend another A&E during the night
- NHS 111 and its effectiveness

Suggestions included:

- If people call NHS 111, Grantham Hospital needs to be the first option
- Educate the public on how not to abuse the NHS
- Patients need to be clearly informed about the UTC's capabilities and limitations
- Free shuttle bus or volunteer transport to hospitals from main train and bus stations and between hospitals

Stamford (proposal)

- Great service in Stamford Hospital, would like an extended service
- Support for UTC in Stamford to reduce need to travel elsewhere for emergency care
- UTC will reduce the pressure on surrounding hospital

Suggestions included:

- Increase in population anticipated therefore need extended access to urgent care 7 days a week
- Hospital could provide additional outpatient and emergency clinics

Women's and Children's Services
Key themes:

- Lack of transport if service is moved Lincoln
- Length of time taken to get to Lincoln in an emergency is too long
- Loss of services at Boston and the desire to retains women's and children's at Pilgrim

Suggestions included:

- The need for an easier way to access community Paediatrics before children's education is affected
- To send out clearer communication about the situations concerning women's and children's services at Pilgrim hospital

Feedback from Grantham and Boston workshops 1 and 2:

Lincolnshire's NHS held workshops, open to all, in Grantham on 19th June and Boston on 27th June. Two further workshops were held on 9th and 10th October in Grantham and Boston.

In the June workshops clinicians and staff were involved in discussions with attendees about the key themes relating to the ongoing Acute Services Review in the county which had emerged from previous engagement. This focused on the proposed changes to services for women's and children's and stroke services in Boston and Urgent and Emergency Care in Grantham and also travel and transport for each of the services.

This feedback summarises the main points and issues raised during conversations. Our subsequent response to those Frequently Asked Questions (FAQs) and scenarios which emerged during the workshops is attached as appendix 4.

At the follow-up workshops in October, attendees were provided with the feedback from the June workshops and along with staff and clinicians were asked to:

1. Review and sense check the feedback and suggest amendments
2. Make suggestions about how these messages and scenarios could be communicated more widely with the public
3. Raise any outstanding concerns

Main themes raised at Grantham workshops:

- Service and staffing provision within the proposed Urgent Treatment Centre (UTC) and how this may impact other hospitals
- How any proposed changes might affect other wards and services at Grantham Hospital
- Healthy Conversation 2019 engagement process prior to consultation and involvement of those with protected characteristics
- NHS 111 service provision and performance
- NHS support offered to disadvantaged patients, especially for travel and transport
- Access to services and inadequate public transport provision in areas
- East Midlands Ambulance Service (EMAS) service provision, performance and the 'golden hour'

Main themes raised at Boston workshops:

- Travel times and ambulance transfers to Lincoln Hospital
- Treatment times for patients suffering a stroke
- East Midlands Ambulance Service (EMAS) performance and targets
- Advertising of engagement events and provision for those not able to attend
- Additional travel needs of friends and families if paediatric patients moved to other hospitals
- Options being consulted on for women's and children's services
- Recruitment, retention and availability of staff to deliver services in Boston Hospital
- Rural funding for Lincolnshire
- Stroke care in the community

Feedback from market days:

During the months of September and October we visited 12 localities across Lincolnshire where we spent time at local markets and supermarkets, speaking to members of the public. Leaflets were handed out to 416 people and the core themes that were raised (through direct verbal feedback and formal forms) were:

Date	Location	Key Locality Themes	No. of leaflets	No. feedback forms
04/09	ASDA, Lincoln	• Generational change - need to educate the young on self-care and prevention • Bring back nursing apprenticeships	105	6
05/09	Waterside, Lincoln	• Lack of public transport from rural areas • Delayed waiting times at Lincoln Hospital	96	4
23/09	Skegness	• Lack of patient note reading • Cancellation of appointments without the patients being made aware	18	4
01/10	Gainsborough	• Teaching children how to lead a healthy lifestyle • Nursing careers need to be made more attractive	4	3
02/10	Sleaford	• Importance of integrated	12	0

		community care and neighbourhood working		
04/10	Long Sutton	• Staff shortages at Johnson Hospital • Same day available appointments at your GP practice	53	3
10/10	Horncastle	• Encouraging to see NHS staff out in the heart of local communities • Happy with the local GP practice	21	7
11/10	Stamford	• Good to see the NHS out and about, make the NHS seem more accessible and friendly to approach and talk to • Would like to see more mental health support	26	3
17/10	Mablethorpe	• Coming to our local market is better than holding events that many may not be able to get to • Access to GP appointments • Lack of mental health services	32	14
18/10	Alford	• Young people should be educated on healthier lifestyles and prevention to save money • Difficulty in booking GP appointments	18	5
23/10	Louth	• Lack of personalisation when visiting the GP • The NHS should charge for missed appointments	21	5
24/10	Bourne	• People are abusing A&E, we need to re-educate people on what it is for • The NHS should embrace technology	9	1

Across the county, we consistently heard that the public are concerned about:

- Access to GP appointments
- Waiting times in hospitals
- Educating the younger generation on self-care and prevention
- Making sure the NHS is not abused, re-education on what services are for

Feedback from community group meetings:

Throughout HC2019, we have also attended a range of community groups and meetings to raise awareness of HC2019, promote opportunities for involvement and gather feedback about their experiences and any issues or concerns.

The feedback is summarised below:

GPs and primary care:

- Preference for email or text reminders for appointments rather than letters (which can be delayed) and then the appointment is missed, which then looks like the patient Did Not Attend.
- Still experiencing difficulties getting appointments and would like to be told when booking an appointment if it is with a nurse rather than a doctor to manage expectations.
- Some concerns that health visitors are not contacting all new parents and some may be missed.

Workforce:

- It would be good to upskill and increase staff recruitment by being 'attached' to a training hospital
- Staff not well looked after as employees, for example having to supply their own refreshments including tea bags; "how do we expect to fill our vacancies when we are not looking after the ones we've got!"

Technology:

- Welcomed the use of technology such as the care portal, as not having the correct notes in front of the doctor or consultant was very frustrating for some of this group.
- Not sure about using the phone for 'facetime' but liked the idea of having a hub to go to (for example at a GP practice) where people can be supported to log onto e-consultations etc. It was also felt the elderly would embrace this as it means less travel and less costs.

Supporting engagement with hard to reach groups:

- Suggestions provided on how to support deaf / blind people to attend health events such as providing transport and translation into braille etc.

- People with sight or hearing loss struggle with access to services, access to GP appointments, optometrist appointments and dentist appointments and travel to appointments. Often no interpretation service is offered and patients have to sit with a doctor and write notes between them.
- Making a doctor's appointment is usually via phoning the practice- not everyone has access to the online services so it would be useful to introduce text for deaf patients.
- An example was provided of an elderly couple who have sight difficulties and needed to travel by train for a hospital appointment which lasted 10 minutes but they were out of the house for 9 hours.
- One query was raised about how someone will book appointments etc. once they go deaf as they already have an amplifier and still struggle to hear.

Travel and transport

- Travel was a concern for the majority of the group in south Lincolnshire for both GP and hospital visits. Their nearest hospital is Grantham, but a lot of the time they are sent to either Boston or Lincoln for appointments/treatment. This can be extremely difficult for those who do not drive as there is only one bus into Lincoln or they have to pay for a taxi.
- Alternative suggestions include volunteer driver schemes and patients only have to pay for the mileage.
- Frustration with Thames Ambulance Service Limited (TASL) which is now no longer accepting a patient who has been using it previously for six years.
- Some people are often not given a choice of which hospital they would like to go to for treatment and the majority agreed they would travel out of county if it meant receiving treatment quicker.
- In Peterborough they run a service where paramedics, occupational therapists and nurses visit the frail and elderly if ill or had a fall – this team prevents that patient going into hospital and keeps them in their own home.

Feedback from Stamford Freshers Fayre:

On 10th September we attended Stamford Freshers Fayre and received 31 completed surveys, from which we heard the following:

The most important things respondents would like to see improve with the NHS are:

Mental health services – prevention is better than cure, over-stretched and hard to access, not advertised enough locally
GP appointments – improved access, ability to book in advance and more telephone appointments
Being taken seriously – important to be respected like adults are

If they wanted to find out more about NHS services they would use the following methods:

Online	20
Ask your GP	17
Friends and family	14
Hospital website	11
Support group	6
Social Media	6
Email	4
Welfare officer	2
Local press	1

Feedback from the Acute Services Review survey and The People's Partnership Acute Services Review engagement with hidden and hard to reach communities

The Acute Services Review survey was closed on 31st August 2019 following six months of engagement. These results have been analysed and reported into the Lincolnshire NHS system to ensure it informs the next stage of the acute services review programme and informed the emerging options being considered for full public consultation.

The Lincolnshire NHS organisations also commissioned a local specialist, The People's Partnership, to undertake a specific piece of engagement work, in order to ensure our Healthy Conversation 2019 exercise captured the views and concerns of hidden and hard to reach communities across the county. This was an important addition to our established engagement work for a number of reasons:

We were aware that the range of engagement events and activities we publicised to the general public and patients were not always appropriate for people with protected characteristics. This might be because the level of noise could prohibit full involvement, or anxiety about participation in such a group may inhibit and prevent attendance for example.

We know that people with protected characteristics have an important voice, and can often be particularly impacted by any potential service changes. It is important that we seek these voices out in order to ensure they are represented.

The People's Partnership undertook a detailed, and bespoke engagement in order to understand these views. This meant utilising their established networks, and developing new, in order to reach the people often missed. Our survey was adapted to become meaningful and understandable to the audiences we approached, and time was spent to ensure that the purpose was understood.

The following document details the outputs from this exercise, information which is being incorporated into our next stages of development and service review alongside all other outputs of our engagement events and surveys. The full analysis and reports are available at appendices 4 and 5.

Appendix 3: workshops summary feedback report and FAQs

Healthy Conversation 2019 workshops summary feedback report

Grantham 19th June 2019 / 9th October 2019
Boston 27th June 2019 / 10th October 2019

1. Purpose

Lincolnshire's NHS held workshops, open to all, in Grantham on 19th June and Boston on 27th June. Two further workshops were held on 9th and 10th October in Grantham and Boston.

In the June workshops clinicians and staff were involved in discussions with attendees about the key themes relating to the ongoing Acute Services Review in the county which had emerged from previous engagement. This focused on the proposed changes to services for women's and children's, stroke services and Grantham A&E and also travel and transport for each of the services.

This document provides a summary of the main points and issues raised during conversations and our subsequent response to those Frequently Asked Questions (FAQs) and scenarios which emerged during the workshops.

At the follow-up workshops in October, attendees were provided with the feedback from the June workshops and along with staff and clinicians were asked to:

1. Check the feedback makes sense and make any amendments required following their review
2. Gather their suggestions for how we can communicate these messages and scenarios more widely with the public
3. Ask if they have any more outstanding concerns

This document now includes any supplementary questions which resulted from the workshops held on 9th and 10th October and any amendments to the previous FAQs or additional responses are highlighted in bold/blue.

2. Summary of feedback from June and October workshops Discussions were held around the following main themes and specific questions and answers are presented in the subsequent section of the report.

<u>Main themes raised at Grantham workshops:</u>

- Service and staffing provision within the proposed Urgent Treatment Centre (UTC) and how this may impact other hospitals
- How any proposed changes might affect other wards and services at Grantham Hospital
- Healthy Conversation 2019 engagement process prior to consultation and involvement of those with protected characteristics

- NHS 111 service provision and performance
- NHS support offered to disadvantaged patients, especially for travel and transport
- Access to services and inadequate public transport provision in areas
- East Midlands Ambulance Service (EMAS) service provision, performance and the 'golden hour'

Main themes raised at Boston workshops:

- Travel times and ambulance transfers to Lincoln Hospital
- Treatment times for patients suffering a stroke
- East Midlands Ambulance Service (EMAS) performance and targets
- Advertising of engagement events and provision for those not able to attend
- Additional travel needs of friends and families if paediatric patients moved to other hospitals
- Options being consulted on for women's and children's services
- Recruitment, retention and availability of staff to deliver services in Boston Hospital
- Rural funding for Lincolnshire

2. FAQs

2.1 Grantham service change FAQs

What is the current service at Grantham A&E?
Grantham Hospital has not had a full A&E department for a number of years. It provides a restricted range of services.

Grantham A&E is open from 8am – 6.30pm, seven days a week.

After 6.30pm, there are services in place such as the NHS111 Services, the Lincolnshire Clinical Assessment Service (CAS), East Midlands Ambulance Service (EMAS) and the out of hours service to maximise the number of patients who can still be treated at Grantham Hospital. This means that some patients may still be brought by ambulance to Grantham overnight.

Our emerging option envisages the vast majority of patients who are treated at Grantham Hospital today, will be able to receive the same care in the Grantham Urgent Treatment Centre (UTC). In fact, there is very little difference in the service which has been available in the Grantham A&E department in recent years to that of a UTC.

A fully functioning A&E department requires a comprehensive range of back up services and facilities, such as specialist critical care and specialist medicine, emergency surgery, paediatric assessment and maternity services. Grantham Hospital does not currently have these services.

If someone is critically ill or injured, it is crucial that they get to the right hospital with the right facilities, first time, in order to ensure the best chance of a positive outcome.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

Are we aware of the impact on other hospitals following the closure of A&E?
Do we have statistics showing how many people are being sent elsewhere?
Do we have statistics to show the number of patients pre and post closure?
Since the overnight closure of Grantham A&E, we have seen a small increase in the number of patients from Grantham being seen at our A&Es in Lincoln and Pilgrim – an average of just over two people each day. The growth in patients to Peterborough, which has been widely reported in the media, equates to three patients a week. This reflects the overall increase in A& E attendances both locally and nationally over the last few years. We consider these figures with the commissioners and remain aware of the activity at the other hospitals for both planned and emergency care.

Why are staff being moved from Grantham to cover Lincoln?
There is no evidence that ULHT is instructing staff to do this or that it is happening locally either. On occasion, however, all staff working in any of our three acute hospitals (Lincoln, Boston and Grantham) may be asked to volunteer to cover additional shifts in other hospitals.

If Grantham A&E becomes an Urgent Treatment Centre, what services will be provided?

UTCs, which are slowly being introduced into Lincolnshire, having just launched in Louth and Skegness, provide urgent care for people whose conditions are not life threatening. Services provided by UTCs means Emergency Departments (A&E) services are protected for those who need specialist emergency care. UTCs are GP-led, staffed by multi-disciplinary teams of doctors, nurses, therapists and other professionals, who are trained in life support for adults and children. At Grantham specifically, there will be a higher level of staffing than the national specification – including staff with skills equivalent to middle grade A&E doctors; GPs and nurse practitioners - to ensure the vast majority of patients who are treated at Grantham Hospital today, will be able to receive care in the UTC.

Examples of conditions which may be treated at a UTC include:

- 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

There will be minimal changes to services currently provided at Grantham A&E. Patients who are likely to require critical care services will be cared for at Lincoln, Boston, Nottingham or Peterborough hospitals, where they will receive the specialist care they require to enable the best outcome possible. These patients are likely to have been assessed by a GP or paramedic and taken directly to the most appropriate place for treatment. Those patients with critical care / specialist needs who do arrive at Grantham in the first instance will be stabilised and then transferred. This works out at approximately 200 patients a year who currently attend Grantham Hospital but are very ill and require specialist treatment at a more specialist hospital.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

Will patients with long term conditions still be seen and treated at Grantham?

Yes. The appropriate place for treatment depends on the level of severity of the patient's symptoms.

What will happen to the cardio ward at Grantham?

Grantham does not now have a cardiology ward.

Would Grantham Urgent Treatment Centre be open 24/7?
The national specification is that UTCs are required to be open for at least 12 hours a day, seven days a week, including bank holidays. People can walk into UTCs during the opening hours, while others may be referred by NHS111 or by a GP.
Our emerging preferred option is to have 24/7 access to urgent care through the introduction of a UTC at Grantham Hospital.

The emerging option suggests that in the 'out of hours' period, access would be through NHS 111 for the reasons of patient safety. We will be listening to a wide range of feedback in order to inform our thinking, including people's views on how the service could best be accessed.

The NHS 111 service is able to book the patient into the right urgent care service first time so they have an appointment which is convenient for the patient and reduces their waiting time. The NHS 111 and Clinical Assessment Service (CAS) has a Directory of Services informing, for example, where and when an x-ray service is available. They are able to advise the patient where to go to receive such a service meaning the patient goes to the right place first time. It will improve the speed of treatment and stop patients having to move between services. Crucially it will advise when an A&E attendance is necessary, preventing the patient wasting potentially vital time going to the UTC first.

Patients with booked appointments will take precedence over walk in patients – unless there is a clinical priority and will therefore not have to wait as long.

A final decision on UTCs will not be made until after the formal consultation.

What if national funding is reduced? Would this mean Grantham UTC would be reduced to the national minimum specification of 12 hours per day?
While we cannot predict what might happen in the future, our current commitment is to offer Grantham residents a quality service which is sustainable and deliverable, e.g. we can attract the right staff, and one which instils confidence throughout the community. There will be a formal consultation on the proposed option of an UTC and the outcome will inform future decisions on the UTC such as opening times etc.

Who will staff work for in a UTC? Will they be able to stabilise patients?
All staff working in the UTC will be able to provide emergency care. It is anticipated that the majority of staff in the UTC will be employed by Lincolnshire Community Health Services NHS Trust (LCHS). It is also proposed that staff on the Grantham Hospital site will work in an integrated way so clinicians on the site (employed by other organisations) will be available to provide advice. Today, consultants on other hospital sites already provide advice when needed for example, consultants are available via telemedicine or to review scans sent to them.

If this proposed UTC is implemented following the formal consultation, transfer of staff from the current A&E to the UTC (with additional staff to deliver the model if needed) will be looked into in more detail. We will consult with staff and follow HR guidance. This does not mean a downgrade in services or skills and we will support our staff to have the right skills if there are changes to any roles. Our staff are our greatest asset.

What will happen to ambulance admissions into Grantham Hospital overnight if there is a UTC?
If an ambulance is dispatched, the paramedic will decide if the patient's needs can be met in the UTC or whether the patient has more specialist needs that require a specialist hospital. The paramedic is able to take advice by phone, talking with clinicians either in the CAS or a consultant in an A&E, to assist making this decision. This happens now.

The paramedic will take the patient to the right service that will be able to meet the patient's needs and ensure the best possible outcome.

One of the options for care will be taking low acuity patients to Grantham Hospital at night and directly admitting the patient (with prior agreement with night teams). Treating patients locally and within the Grantham community is important, as is keeping people out of hospital whenever that is possible.

What do we mean when we refer to the "right place, right time"?
We know that the best outcome for critically ill patients comes from being in the right place, where the right service can be provided as quickly as possible.

While this may mean they are not treated at the hospital closest to them, it means they will be taken directly to a hospital which can give them the immediate treatment they require, therefore giving them the best possible chance of a positive outcome.
Arriving at a hospital which is not equipped to treat them (and their specific condition) can waste critical time. The extra travel time getting to the right place far outweighs the risk of delayed treatment.

Patients who do arrive at a hospital that cannot treat their specific condition will still be cared for and the model being discussed does include a contingency for this scenario. Appropriate processes will be in place and staff will be able to stabilise those patients until they are transported safely to the most appropriate place.

ADDITIONAL QUESTION FROM 9th OCTOBER WORKSHOP

Who decides where a patient goes if an ambulance is called?
Ambulances go to Grantham hospital where this is appropriate. If an ambulance is dispatched, the ambulance crew will decide if the patient's clinical needs can be met or whether the patient has more specialist needs that require a specialist hospital. The paramedic is able to take advice by phone, talking with clinicians either in the CAS or a consultant in A&E, to assist making this decision. Our senior clinicians recommend that our patients go to the right hospital first time, rather than going to the closest NHS location, as this will not necessarily be able to provide the right care. Patients, carers or families should always phone 999 for an emergency ambulance if they believe that there is a life threatening health situation. Our senior clinicians are reviewing the current exclusion protocol (restriction criteria) to ensure that critically injured and ill patients will be cared for at the right service; treated safely and quickly by staff who have the right training and experience to give the best outcome.

If a patient is given a diagnosis at Grantham's A&E or proposed Urgent Treatment Centre but then transferred to another hospital, would they need to be triaged twice?
Triage is a process carried out on all patients attending A&E. Triage ensures people with the most serious conditions are seen first. Triage should not be required twice; however it is right that when the patient with a serious condition arrives on a new hospital site that they are assessed again so the specialist clinicians can make a clinical decision on further treatment.

Who will run medical beds in Grantham Hospital? What exactly are they?
Our preferred option is to maintain medical services at Grantham Hospital by joining up the hospital services with local primary and community services and be managed as part of the local enhanced neighbourhood team. This new model would be led by Lincolnshire Community Health Services NHS Trust (LCHS) which means that medical staff would in future be able to provide care in people's homes and local community settings, as part of a local integrated service, as well as to patients in the hospital. However, they will be working closely with the hospital trust and other health care providers so staff can support patients who, for example, deteriorate and need additional care. This model aims to keep patients out of hospital where appropriate but also to get them back home as soon as possible if they are admitted. This model of care in Grantham will be the first in the county.

The medical beds will be for patients with, for example, pneumonia, diabetes, chest infections, asthma, other respiratory diseases, i.e illnesses not requiring surgery – those who have a range of chronic ailments who can manage perfectly well most of the time but sometimes have a crises and need to go to the right place to be stabilised.

How have the views of the people who signed the petition to keep the A&E been taken in to account? How are the rallies we had in the town with 4000 or 5000 people to save A&E going to be taken in to account? How have all the views so far been taken into account?
We have listened carefully to the voices of the public and councilors and will continue to do so. We have also received a copy of the petition. Sometimes it is not possible to make the changes that are suggested to us because of factors such as patient safety or staffing. Through Healthy Conversation 2019, we have been open with the public about what is and is not possible for us to deliver, and the clinical and service reasons for that. It is right that any NHS service must be safe and sustainable. We have to be realistic as we do not have the staff to run three full A&E departments and it is highly unlikely that will change with a national shortage of A&E Consultants. We have 19 A&E consultant posts in Lincolnshire but only four of these have substantive consultants in posts.

Our emerging preferred option of a 24/7 UTC would enable more patients to receive services in Grantham than is currently the case.

Whilst the Healthy Conversation 2019 has taken place, how have you reached hard to reach and protected characteristic groups?
The workshops are publicised extensively through the following media channels: local newspapers/magazines, local radio, social media, websites, e-shots to stakeholder groups and through relevant third parties. As this event was open to all and was not invite only, we could not guarantee that people with protected characteristics would attend but ensured a wide reach with our communications so the opportunity was there.

In addition, these workshops are only one part of the much bigger programme of engagement we are undertaking and understand that events like this are not the best way

for some people to engage with us. Therefore, we offer a variety of ways for people to tell us their views if they don't want to or are unable to come along to a workshop, for example our paper and online surveys which are also available in different languages, paper and online feedback forms, meeting us when we're out and about in town centres and supermarkets, and people can phone, email or write to us. Consultation opportunities will continue as we move into the formal public consultation.

The purpose of these specific workshops was a 'deep dive' into the particular themes which emerged from the wave 1 engagement events and therefore smaller, more detailed group discussions was an appropriate way to achieve this. We are also mindful that our clinical staff's time is extremely valuable and we are grateful that they were able to sit around tables and have a conversation with our patients and the public, something which would not have been possible with larger scale events.

Further details of our proactive engagement with groups with protected characteristics will be made publically available on completion and we will share this with you. As reported in the Health Scrutiny Committee, we are working with The People's Partnership, an independent partner to ensure proactive engagement with people with protected characteristics.

The People's Partnership is made up of a Leadership Team who represent major areas of disability and some areas of the protected characteristics. In addition to the Leadership Team, they have individual members, members of groups and communities, and members who support the hidden and hard to reach communities.

The current members of the Leadership Team are:

- Age UK Lincoln & South Lincolnshire
- CarersFIRST
- Children's Links
- Every-One (contributes and facilitates the organisation of the People's Partnership)
- Linkage Community Trust
- Links Lighthouse
- South Lincolnshire Blind Society

As part of the engagement, The People's Partnership has engaged with a number of hidden and hard to reach communities which included 56 respondents who identified as having sight loss.

Will a formal consultation exercise be undertaken on the Grantham UTC?
Yes. The Healthy Conversation 2019 engagement exercise is providing invaluable feedback and will help to shape any emerging options on our proposed service changes. We will go out to formal consultation to gather further views and no final decision will be made until after this has concluded.

ADDITIONAL QUESTION FROM 9th OCTOBER WORKSHOP

When will the public consultation around Grantham take place? Why is taking so long?
Before we can start public consultation, capital funding must be secured so that we can be confident we can implement any proposals. As soon as there is any progress, the consultation will be widely publicised and we will inform the public of our next steps.

NHS 111

Is Grantham Hospital given as an option when you call NHS111 for minor conditions?
If you call NHS111 for a minor condition, Grantham Hospital is currently offered to patients as an option if it is the most appropriate place for their treatment.
The Directory of Services profile for the Grantham Minor Injury Unit is a nurse-led profile in operation 7 days a week 18:30 – 23:30. Patients ringing NHS111 within these timeframes with clinically appropriate symptoms for this unit will be directed there.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

Is Grantham Hospital available as NHS111 option?

Yes. The Out of Hours service at Grantham Hospital operates between 18.30 to 08:00 Monday to Thursday and from 18:30 on Friday through to 08:00 on Monday. Access is via NHS111 and the Clinical Assessment Service. The service offers telephone advice, face to face consultations (15 minute appointments) or home visits if required. Appointments can be made during the night if necessary although most activity is before 23:00.

Are we going to see any improvements with NHS111?
NHS111 is receiving an increasing number of calls, particularly just for advice or guidance, with CAS fielding 10.5k calls per month across Lincolnshire.

How is NHS111 currently monitored?
We receive monthly reports on the activity, performance and quality in the 111 service and attend formal monthly meetings with our NHS111 provider that are led by the lead commissioner. In addition, ad hoc issues are raised to the lead commissioner and provider as they arise.

How do foreign nationals access NHS111?
In the same way.

How does our CAS performance compare to other regions?
We cannot make direct comparisons between our CAS and other CASs in the country because they operate differently. It is also pertinent to note that all cases reaching CAS have been assessed as being safe to wait for at least 30 minutes, although 22% were still called back within ten minutes.

Around 70% of calls from NHS111 got to CAS and, of those, approximately 70% of those calls have their needs met and treatment provided by CAS.

What is NHS111 and who will answer my call?
The NHS111 service is available 24 hours a day, every day of the year and is intended for urgent but not life-threatening health issues. Depending on the situation the caller will be advised what local service can help; be connected to a nurse, emergency dentist, pharmacist or GP; get a face-to-face appointment booked if required; be told how to get any medicine that may be needed; and get self-care advice. NHS111 can also send an ambulance if needed.

A Health Advisor takes the calls and asks the caller a series of questions to determine what the best service is for their needs. Health Advisors undergo 12 weeks of intensive training to enable them to answer NHS111 calls. Health Advisors are not clinicians and do not make clinical decisions. They follow a nationally agreed and signed off algorithms (NHS Pathways) that determine the clinical need of the patient. In addition to this, the Health Advisors are supported by a range of clinical staff to provide any advice required.

If a patient needs to speak to a local clinician the health advisor will arrange this, or arrange for a clinician to call the patient back in a time frame suitable to the clinical urgency. The Lincolnshire Clinical Assessment Service (CAS) picks up these clinical calls. The Clinical Assessment Service is staffed by Lincolnshire clinicians; GPs, nurses, paramedics, pharmacists. This clinician is able to discuss the patient's health needs, recommend and arrange treatment and/or refer the patient onwards to the most appropriate service within the county. Around 70 per cent of calls from NHS111 go to CAS and, of those, approximately 70 per cent of callers have their needs met and treatment provided by CAS.

ADDITIONAL QUESTION FROM 9th OCTOBER WORKSHOP

Do NHS111 call handlers know the local area?
The NHS111 call handler is able to see information relating to the caller's location and while they may not be *familiar* with the local area, services pertinent to the caller's condition/query will be visible to the call handler on the Directory of Services (DoS), such as service opening times, appropriateness for the caller's needs and distance from the caller's location. Call handlers are supported by local clinicians via CAS.

What are the waiting times since Clinical Assessment Service (CAS) has been introduced?
The introduction of CAS means that if NHS111 decides the patient needs to talk to a clinician, a Lincolnshire clinician will take that call. The clinician is able to discuss the patient's health needs, recommend and arrange treatment and/or refer the patient onwards to the most appropriate service within the county. CAS exists to get to the right solution quickly – this means no unnecessary travel and waiting time for the patient and no unnecessary use of acute services.

The introduction of CAS has, so far, saved 35,000 visits for patients, therefore saving time and reducing the need to travel. We are still awaiting final statistics but its initial six months has resulted in a saving of over £600,000 for Lincolnshire NHS.

What is being done to encourage the public to call NHS111 to book appointments at an Urgent Treatment Centre day or night, rather than just turning up?
The national winter NHS England / Improvement communications campaign is designed to do exactly that and it is where the majority of the investment for winter is being made this year.

UTCs in Louth and Skegness are being introduced into Lincolnshire in October so not currently 'live' to NHS111 and promoting these services has already started. The main message is to access an UTC, patients should ideally contact NHS111 although there may be the ability to walk in. Patients who are booked in using the NHS111 service will be seen before patients who have walked in, as will patients who may present with more serious conditions. Only clinically appropriate patients will be booked into UTCs. If a patient's situation is very serious, then that patient will be referred or transported to the most appropriate place for treatment.

Calling 111 will ensure patients are directed to the right place for treatment in the first instance, rather than walking in to an UTC and then being transferred elsewhere for the right treatment.

If you are concerned about your health but it is not an emergency, call NHS111 or walk in to the Urgent Treatment Centre. If you are concerned because you are clearly very ill, call 999 and an ambulance will be sent and your condition will be assessed, so that you are taken to the most appropriate place for treatment.

WHAT WOULD HAPPEN IN THE FOLLOWING SCENARIOS IF GRANTHAM BECAME AN URGENT TREATMENT CENTRE?

Suspected heart attack or stroke
If the patient rang NHS 111 and described the symptoms of a potential heart attack or stroke, then an ambulance would be dispatched. The paramedic would assess the symptoms and start treatment in the ambulance, depending on the condition. If the paramedic's assessment indicated a heart attack or a stroke, he / she would liaise with The Lincolnshire Heart Centre/ stroke unit and transport the patient direct to the Heart Centre / stroke unit at Lincoln Hospital to ensure the patient receives the specialist treatment needed. If the paramedic's assessment was that the patient did not require these specialist services e.g. chest pain NOT suggestive of a heart attack- they could be taken to Grantham hospital – see scenario below.

If the 111 call handler was unsure about the patient's symptoms, they can call CAS to talk to a clinician, who will advise about whether the patient needs an ambulance, or should attend the UTC.

If a patient arrived at an Urgent Treatment Centre with a suspected heart attack they would not be turned away. They would immediately be assessed and triaged as a priority while initial stages of treatment – such as blood tests and ECG – took place. If it's evident they were having a heart attack, then the most appropriate care would be to transport them in a blue light ambulance to Lincoln Hospital's Heart Centre where the patient would have the best and most appropriate care, and therefore the best possible outcome. There would be liaison between the UTC, ambulance service and The Heart Centre pre and during transfer of the patient.

Patients arriving with other suspected serious conditions, such as suspected stroke, will be treated in the same way. Staff will be on hand to start treatment until the patient is transported, via blue light ambulance, to the most appropriate place for care e.g the stroke unit at Lincoln County hospital.

Someone collapses and needs resuscitating
If the patient collapses in an UTC, resuscitation and treatment would take place.

If someone in a surrounding village / in the community collapses, the ambulance paramedics would resuscitate and treat them, then take them to the hospital which can provide the best specialist care.

Compound Fractures with compartment syndrome (needing immediate treatment or risk limb amputations)
A compound fracture – where a broken bone has pierced the skin – is a medical emergency and a 999 call would result in patients being transported to Boston or Lincoln hospitals. If someone presented to an UTC with a compound fracture they would be assessed, stabilised then transported to the right place for treatment.

Non-specified chest pain
The appropriate place for treatment depends on the level of severity of the chest pain. A patient who is in low level / moderate pain who presents at the UTC would be assessed / treated accordingly. So, for example, the chest pain is muscular or indigestion, it would be treated in the UTC.

If a patient is in severe pain and has called 999, paramedics would assess if it was felt to be a heart problem and would stabilise and transport the patient if needed to the The Lincolnshire Heart Centre. Similarly, if someone presented to an UTC with severe chest pain they would be assessed, stabilised and where this was felt to require specialist treatment they would then be transported to the right place for treatment.

Breathlessness
The appropriate place for treatment depends on the level of severity of the breathlessness. If the patient is in acute respiratory distress with oxygen saturation <91% on room air 'unless' the patient has significant frailty or known significant chronic lung disease they would be taken to another hospital with more specialist services. We would not expect a patient or their family to make these assessments.

If a patient attends an UTC, staff will be able to treat their symptoms (for example with an inhaler or nebulizer, oxygen).

If a patient's breathing is highly compromised at home, they should dial 999; the paramedics will stabilise and transport to the most suitable place for treatment. Similarly, if someone presented to an UTC with severe breathing problems they would be stabilised then where necessary transported to the right place for treatment.

Acute exacerbation of inflammatory bowel diseases
The appropriate place for treatment depends on the level of severity of the patient's symptoms and whether the patient knows that they have inflammatory bowel disease and is confident to manage their illness.

A patient who has low level / moderate symptoms could ring their GP and / or 111 and talk with a clinician for advice. If advised, they could be booked into an appointment at the UTC for further assessment / treatment. Those who present at the UTC would be assessed / treated accordingly.

If a patient is experiencing severe symptoms and has called 999, paramedics would assess the symptoms and treat the patient accordingly which could be to take further clinical advice over the telephone. If further treatment is indicated, the patient will be transported to the right place for treatment.

Anaphylaxis

An anaphylactic reaction is a severe and potentially life-threatening reaction to a trigger such as an allergy or bee sting.

If the patient has a reduced conscious level, an ambulance should be called and the paramedic can make a decision about treatment / next steps. If someone already knows that they have an allergy and carries an epipen (medication used in emergencies to treat very serious allergic reactions to insect stings/bites, foods, drugs, or other substances) whose reaction is not improving despite self-medicating, should seek urgent clinical advice via GP, 111, at an UTC or A&E depending on the severity of their condition. In this circumstance, if the patient experiences any reduced conscious level, an ambulance should be called and the paramedic can make a decision about treatment / next steps.

Sepsis

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. A diagnosis can be made in the UTC and a first treatment may be administered. The most appropriate next steps for treatment will be decided by the UTC clinical staff depending on the severity of the illness.

If the patient has a reduced conscious level (not alert) at home, an ambulance should be called and the paramedic can make a decision about treatment / next steps. The paramedic will assess the patient and if the paramedic decides that the symptoms could be severe sepsis they will usually not be taken to an UTC.

Diabetic emergencies

If someone's condition is life threatening then it is crucial that the person gets to the right place at the right time. As with any life threatening situation, a call should be made to 999. If someone presents at an UTC with a diabetic emergency then the clinical team will assess that person and start treatment.

Complications of cancer

The appropriate place for treatment depends on the level of severity of the patient's symptoms and the type of cancer diagnosis that the patient has received.

Some potential complications of cancer and cancer treatment, e.g. chemotherapy, can be anticipated and the patient will already know the plan of care should such symptoms occur, such as directly ringing the cancer ward at Lincoln Hospital and getting clinical advice. Other complications / symptoms will not be anticipated and should be treated as an unexpected illness and depends on the severity of the symptom.

Kidney failure

Acute kidney injury (AKI) is when your kidneys suddenly stop working properly. It can range from minor loss of kidney function to complete kidney failure. AKI normally happens as a complication of another serious illness. This type of kidney damage is usually seen in older people who are unwell with other conditions and the kidneys are also affected.

The appropriate place for treatment depends on the level of severity of the patient's symptoms.

A patient who has low level / moderate symptoms could ring their GP and / or 111 and talk with a clinician for advice. If advised, they could be booked into an appointment at the UTC for further assessment / treatment. Those who present at the UTC would be assessed / treated accordingly.

If a patient is experiencing severe symptoms and has called 999, paramedics would assess the symptoms and treat the patient accordingly which could be to take further clinical advice over the telephone. If further treatment is indicated, the patient will be transported to the right place for treatment.

Seizures

If someone's condition is life threatening then it is crucial that the person gets to the right place at the right time. As with any life threatening situation, a call should be made to 999. If someone presents at an UTC with a seizure then the clinical team will assess that person, start treatment and decide whether the person needs to be transported to a more specialist site.

Mental health emergencies

If a patient arrives at an UTC with a mental health emergency, the appropriate place for treatment depends on the level of severity of the patient's symptoms. The UTC staff will liaise with the mental health crisis team and agree a plan of care.

Overdose

The appropriate place for treatment depends on the level of severity of the patient's symptoms.

A patient who has low level / moderate symptoms could go to the UTC for further assessment / treatment. The UTC staff will liaise with A&E consultants on another site for advice if required. They will refer the patient to Mental Health services.

If a patient is experiencing severe symptoms and has called 999, paramedics would assess the symptoms and treat the patient accordingly which could be to take further clinical advice over the telephone. If further treatment is indicated, the patient will be transported to the right place for treatment.

If the patient has a reduced conscious level (not alert) at home, an ambulance should be called and the paramedic can make a decision about treatment / next steps.

Suicide attempt

An example was given of a young male who cut a vein in his arm and lost a lot of blood. An ambulance was called, his arm was dressed and then transported to Grantham A&E where he received four units of blood. He was then transferred to Boston Hospital for an operation to repair the vein. We were asked in this scenario, what would happen with an UTC?

If Grantham A&E becomes an UTC, the young male would still be attended by paramedics following the 999 call. They would start treatment, e.g. by giving him intravenous fluids and dressing his wound and care for him while they transport him directly to Boston or Lincoln Hospital where he would receive blood and surgical care.

3.2 Grantham travel and transport FAQs

Some people may not be able to afford to travel to other A&Es outside of Grantham – what support can you offer them?
Our preference is to reduce the need for patients to be transported to another hospital by providing care locally when appropriate. We will only ask patients to travel further if they have complex, specialised needs and/or their outcome(s) will be improved by additional travel. We have heard from Lincolnshire's public that they agree with this approach and receiving the right care, first time is their priority, even if that means further travel.

It could be that some need for transport becomes reduced, for example by increasing numbers of virtual consultations such as telephone calls, Skype or online services. We understand that some members of the public want virtual consultations and others prefer face to face, this will be accommodated. For other people, the need for transport can be reduced if we help them to manage their long term conditions better through local community-based care.

If someone's condition is life threatening then it is crucial that the person gets to the right place as fast as possible. As with any life threatening situation, a call should be made to 999. We have worked with EMAS throughout the process to date and continue to do so.

If someone's condition means that they need assistance to travel for health reasons, this is provided through non-emergency patient transport services and will be provided to and between services.

If someone's condition means that they need to travel for health care but they do not have any health reasons for transport, they will not receive non-emergency patient transport. It is then that affordability, convenience and other forms of (non health) transport need to be considered.

Lincolnshire County Council (LCC) has responsibility for statuary Home to School, Adult and Children's Social Care transport and for Public Transport services. The NHS has responsibility for transport if there is a health reason; this does not include affordability and convenience.

Both the NHS and LCC understand how crucial transport is so that patients can access NHS services, therefore we are working closely together on a joint transport strategy to improve public transport and look at other viable options to supplement non-emergency patient travel.

At the Grantham Healthy Conversation workshop on 19 June, the public suggested some ideas to resolve the affordability and convenience issues. This proved a very useful starting point and the following list is a summary of the ideas on which we are now actively working with the LCC;

- Co-ordination of transport budgets, infrastructure and existing transport provision to maximise the value of what's already there
- Digital mechanisms to reward providers of lift-shares (UBER style) - digital payment infrastructure that tracks per mile travelled in a registered car share. Automated payments on a cost-share basis. Rates set by the scheme to avoid profiteering. Scheme provides safeguarding and vetting of participants.
- Vehicle loan schemes e.g. wheels to work. Broaden the scope, capitalise on the added value of these schemes.

- Tackling “The last mile”: Create transport hubs/interchanges; make waiting more social, comfortable or usable time. Integrate transport information and potentially other rural information hubs.
- Goods delivery: identify opportunities for village retailers to provide distinctive offers: align rural services with delivery hubs, e.g. delivery of medicines.
- There are already a variety of local and voluntary transport services which could be utilised, such as Call Connect and Grantham Community Transport, for example. Maximise the opportunities these services offer.
- A bus service that travels between hospital sites for staff, patients and carers.

These are ideas and final ideas will be finalised in the joint transport strategy.

ADDITIONAL QUESTIONS FROM 9th OCTOBER WORKSHOP

What is being done / what support is being provided for patients with transport difficulties?

The NHS is responsible for delivering medical and health care services and only has responsibility for transport if there is a health reason; this does not include affordability and convenience. Lincolnshire County Council is responsible for public transport, statutory Home to School, Adult and Children’s Social Care transport. However, while we must spend our funds on health provision, we fully appreciate how crucial transport is so that patients can access NHS services, therefore we are working closely with Lincolnshire County Council on a joint transport strategy to improve public transport and look at other viable options to supplement patient travel. If someone’s condition is life threatening then it is crucial that the person gets to the right place as fast as possible. As with any life threatening situation a call should be made to 999. We have worked with EMAS throughout the process to date and continue to do so.

If someone needs assistance to travel for health reasons, this is provided through non-emergency patient transport services and will be provided to and between services. If someone needs to travel for health care but they do not have any health reasons for transport, they will not receive non-emergency patient transport. It is then that affordability, convenience and other forms of (non-health) transport need to be considered.

Call Connect is a public bus service that operates in response to pre-booked requests. Registration is free but you must be a member to book a journey. You can then use the service for any reason and as frequently as required. The fully accessible minibuses operate from 7am – 7pm, Monday to Friday, and from 7.30am – 6.30pm on Saturdays, with some local variations. In most cases. Call Connect will pick up and set down at designated locations in each village or town. Passengers with a disability or those living in more isolated locations can be picked up and returned to their home address, if it is safe and practical to do so.

You can use Call Connect to travel anywhere within each service’s operating area. You can also use it to connect with the main Interconnect bus service or other bus and train services. Concessionary bus passes are valid on all services.

We are working to a principle of the most regular care requirements remaining close to home, such as routine screens in cancer care for example. It is when care needs become more complex and specialised that further travel is required; we have heard from Lincolnshire’s public that the right care, first time is the priority, even if that means further to travel.

We are also working to a principle of trying to reduce the need for transport, for example by increasing the numbers of virtual consultations such as telephone calls, Skype or online services. We understand that some members of the public want virtual consultations and others prefer face to face, this will be accommodated. For other people, the need for transport can be reduced if we help them to manage their long term conditions better through local community-based care.

Can we share the data collated by HealthWatch Lincolnshire around non-emergency transport? These are worrying figures as the number of people denied access has increased.

Healthwatch received 15 items of patient feedback in relation to all non-emergency transport over the last six months. These are included in Healthwatch monthly reports which are in the public domain and can be accessed via the Healthwatch website: **https://www.healthwatchlincolnshire.co.uk/**

The population is increasing and the public consider that public transport is inadequate. What is being done to improve the access to Lincoln if everything is going there?
We have taken into account the expected growth in population in Grantham town and feel that our emerging option of an UTC would meet this demand.

We are part of the 'One Public Estate' initiative with many partners involved in the development planning around Grantham, and are therefore fully aware of the future potential growth in housing, which has been incorporated into our planning work.

The NHS and Lincolnshire County Council are working together on the single travel and transport strategy, so that we start to address the issues that the public are describing. See above FAQ.

What happens if a patient is taken to an alternative hospital by ambulance and ambulances are queueing outside?
There is a lot of work being undertaken to improve this. Critically ill patients are handed over immediately to the hospital and do not have to sit and wait, as the ambulance is able to contact the hospital so hospital staff are waiting for the patient on arrival.

Patients whose needs are less urgent who are not able to be handed over to the hospital straightaway are constantly monitored and looked after by the ambulance crew while they wait. The most clinically unwell patients are seen first.

Patients taken to hospital by ambulance will not necessarily get priority treatment over someone who has transported themselves to hospital. If a patient is clinically well enough they will be transferred from the ambulance to the waiting room with everyone else.

What is the 'golden hour' and is it achievable?
The golden hour is the period of time following a traumatic injury during which there is the highest likelihood that prompt medical and surgical treatment will prevent death. While initially defined as an hour the exact time period depends on the nature of the injury, and can be more than or less than this duration. It is well established that the person's chances of

survival are greatest if they receive care within a short period of time after a severe injury; however, there is no evidence to suggest that survival rates drop off after 60 minutes. Some have come to use the term to refer to the core principle of rapid intervention in trauma cases, rather than the narrow meaning of a critical one-hour time period.

The golden hour for stroke services
The golden hour refers to the door to needle time, i.e. from the patient arriving in hospital to administering the thrombolysis treatment. It is a target and has no clinical significance to outcome. The sooner the treatment is given, the better the chance of a better outcome for those who are going to benefit from the treatment; not everybody can have this treatment as it depends on the type of stroke. 15% of all stroke patients can receive this treatment. Out of this 15% of stroke patients that receive thrombolysis, one third will benefit from the treatment (5%). Our clinicians believe their recommendations for stroke services will improve care and outcomes for the overwhelming majority of patients (95%).

There is a 4.5 hour time limit in the national clinical stroke guidance which refers to the time within which we can administer the thrombolysis treatment within the current licence. It is more relevant to clinical practice, but it starts from the time of onset of stroke symptoms, or from when the last time the patient was seen well.

People are concerned about Lincoln Hospital A&E not being able to cope with demand and, as a result, do not want to want to go there instead of Grantham Hospital.
There is no evidence to suggest that Lincoln hospital is unable to cope with the increased number of patients from the Grantham area. Lincoln hospital A&E sees an average of two additional patients per day from Grantham since the overnight closure of Grantham's A&E, against an average of 200 attendances per day - an increase of only one per cent.

Why are we not using the Kingfisher Ward?
We are using the Kingfisher Ward – it is our children's clinic at Grantham hospital, which is used for general paediatric and community paediatric clinics throughout the week. Currently, between 750 and 900 children are seen there per month.

Will Grantham be a Centre of Excellence?
As outlined in the Healthy Conversation 2019, our NHS preferred emerging option is to consolidate most elective care and make Grantham Hospital a 'centre of excellence' for elective short stay and day case orthopaedic and general surgery. The benefits of this emerging option could include:

The benefits of this emerging option could include:

- Far fewer cancelled operations for all in the county
- Better clinical results for patients, lower rates of re-admission, reduced length of hospital stay and reduced risk of infections and injuries
- Improved job satisfaction, morale and productivity for our staff

3.3 Boston stroke services FAQs

Attendees of the workshops in June (and this was raised again at the October workshop)felt that travel times to Lincoln Hospital, especially for those living on the coast, are a concern.

Our clinicians tell us that the best outcome for critically ill patients comes from being in the right place first time, where the right service can be provided as quickly as possible.

While this may mean patients are not treated at the hospital closest to them, it means they will be taken directly to a hospital which can give them the immediate treatment they require; therefore giving them the best possible chance of a positive outcome. Arriving at a hospital which is not equipped to treat them can waste critical time. The extra travel time getting to the right place far outweighs the risk of delayed treatment.

Historically, patients would be taken to the nearest hospital but we now know that getting to specialist care results in better outcomes. An example of this is major trauma - we don't have specialist major trauma centres in Lincolnshire and patients have had better outcomes by traveling to Nottingham, where their care is delivered by a specialist trauma team who look after larger numbers of patients and have the expertise and skills to deliver this care. This is the same for hyper acute stroke care.

The preferred option for stroke services - a fully staffed single multi-disciplinary team on the Lincoln site - will improve the outcomes of all patients who are cared for in the stroke unit. Even if patients have to travel further, outcomes and recovery will be greatly improved.

It's about getting to the right place as quickly as possible - even if that means going past a more local hospital to get to specialist care.

When will the joint conveyances start to happen?

In terms of JACP (Joint Ambulance Conveyance Project), EMAS has a partnership with Lincolnshire Fire Service and LIVES, and Lincolnshire Fire provide a co-responder response to emergency calls in a fire ambulance, staffed by LIVES trained fire responders. If the EMAS response to that incident is a car and not an ambulance, it gives the option of transport without waiting for an EMAS ambulance with the paramedic travelling in the fire ambulance. They do not transport patients without EMAS presence.

ADDITIONAL QUESTIONS FROM 10th OCTOBER WORKSHOP

Why not centralise stroke services in Boston? If the heart centre is also moved to Boston, the heart, stroke and vascular services would all be together

The over-riding, influential factor is staffing – it is easier to recruit to Lincoln, than it is to Boston, therefore the current and the future stability of the service will be protected if we specialize in Lincoln. We also know it is very difficult to recruit doctors to Boston for stroke services.

Co-location of services is very important, but we already have an established and highly successful heart centre in Lincoln. The cost of transferring estates is high and potentially unachievable and very risky, as is the cost and likelihood of successfully transferring all staff of this service.

More patients would be displaced if the centre was moved from Lincoln. There has been lots of analysis undertaken – there would be greater displacement across the county if located in Boston than in Lincoln. Lincoln is a better solution for more of Lincolnshire's population.

Can clarification be given as to when treatment starts, as the time taken for patients to begin receiving treatment after a stroke is critical?
There is a 4.5 hour time limit in the national stroke clinical guidance which refers to the time within which we can administer the thrombolysis treatment within the current drug licence. It is more relevant to clinical practice, but it starts from the time of onset of stroke symptoms, or from when the last time the patient was seen well.

Sometimes the 'golden hour' is talked about in relationship to stroke services. This refers to the door to needle time, i.e. from the patient arriving in hospital to administering the thrombolysis treatment. It is a target and has no clinical significance to outcome. The sooner the treatment is given, the better the chance of a better outcome for those who are going to benefit from the treatment; not everybody can have this treatment as it depends on the type of stroke. 15% of all stroke patients can receive this treatment. Out of this 15% of stroke patients that receive thrombolysis, one third will benefit from the treatment (5%). Our clinicians believe their recommendations (preferred option) for stroke services will improve care and outcomes for the overwhelming majority of patients (95%).

Obesity, hypertension or cardiovascular disease, for example, all need to be addressed as part of the STPs approach to stroke and stroke care, what is being done about prevention services?

Lincolnshire County Council has protected and invested in primary preventative services when other areas have been reducing them. The Lincolnshire system is taking a life-course approach, supporting children to have the best start in life and providing parenting support to families in the early years, and focusing on diet, physical activity and mental health support for school age children.
In addition, we have recently commissioned a new integrated lifestyle service, 'One You Lincolnshire', which comprises smoking, alcohol and a tier 2 weight management service. This is targeted at the population with chronic disease, such as hypertension and/or type 2 diabetes.

Attendees of the workshops had concerns about staffing.
There are currently only two substantive consultants in post across Lincoln and Pilgrim Hospitals compared to national guidelines which recommend eight full time posts.

Staffing issues are not about money; in fact more is being spent at the moment through the need to have locums and agency staff. It is recognised that nationally more consultants are needed, as there are more vacancies than staff. Our preferred option is to treat more patients in a single site which means concentrating our skilled workforce in one place to provide improved care, treating a greater number of patients and more opportunity to develop specialist skills.

Another challenge is that some consultants have retired and a number of staff are getting near retirement age too.

We now have the new medical school at Lincoln University and are hoping that trainee doctors stay in Lincolnshire when they qualify. This is not a quick solution and will have an impact in the coming years. We're working with Visit Lincolnshire and looking at what other organisations, such as Siemens, have done to attract staff; all of the NHS partner organisations are working together to resolve our recruitment issues.

Will EMAS be able to cope with the transfer of stroke patients to Lincoln Hospital?
We recognise that Lincolnshire is a large geographic county and travel times vary across the county, particularly coming to and from the coast. We also know that the best outcome for critically ill patients comes from being in the right place where the right services can be provided and, at times, this means driving past a more local hospital to get to specialist care.

EMAS take on average 60 calls a day in Lincolnshire for category one patients with life threatening conditions and the ambulance aims to get to the patient within seven minutes. EMAS constantly reviews where their ambulances are needed and moves them around the county if needed. EMAS has a range of quick response cars and four wheel drive cars for inclement weather.

We have been working jointly with EMAS on the stroke service options and EMAS can transport the patients.

ADDITIONAL QUESTIONS FROM 10 OCTOBER WORKSHOP

When will EMAS achieve its targets?
EMAS has plans to meet key performance targets in April 2020. Current performance is not meeting the trajectory and it is unlikely that EMAS will be able to meet the April 2020 position. There are a number of reasons for the lower than planned performance including increased demand for ambulance services, hand over delays at hospitals and resources within EMAS. We are continuing to work with EMAS to achieve targets as soon as possible.

EMAS should be held to task for not meeting targets for cat 1 and 2
The trajectory is to hit targets by April 2020 due to an increase in staff completing the correct training. By April next year, EMAS will have enough people with the right skills to help achieve its targets. EMAS has additional cars and responders who can help stroke patients. Additionally, representatives regularly attend the Health Scrutiny Committee.

EMAS funding is inadequate and Simon Stevens should be challenged. There has been millions spent on the TV campaign FAST yet patients are not reached in time as there are not enough ambulances. The £1.25 million received 4 years ago for ambulances is not adequate. Fundamental aspects for stroke need to be in place before looking at changes and conveyances is one of them.
Patients calling EMAS with stroke symptoms are prioritised.

In Lincolnshire we do not have any 4x4 ambulance, this is not acceptable on Lincolnshire roads especially in the winter; there could be a three hour ride due to the weather conditions.
EMAS has a range of quick response cars and four wheel drive cars for inclement weather. We recognise that Lincolnshire is a large geographic county and travel times vary across the county, particularly coming to and from the coast. We also know that the best outcome for critically ill patients comes from being in the right place where the right services can be provided and, at times, this means driving past a more local hospital to get to specialist care. EMAS take on average 60 calls a day in Lincolnshire for category one patients with life threatening conditions and the ambulance aims to get to the patient within seven minutes. EMAS constantly reviews where their ambulances are needed and moves them around the county if needed. We have been working jointly with EMAS on the stroke service options and EMAS can transport the patients.

What about the air ambulance for moving patients?
Although there are some conditions for which this isn't appropriate, the air ambulance can and is regularly used to transfer patients. There is one aircraft available in Lincolnshire but we also get support from neighbouring counties and coast guard search and rescue if necessary under exceptional circumstances. The air ambulance is a 24 hour service but there are limitations to this service due to night time flying regulations.

How are events advertised for people with visual impairment and how are all organisations implementing the Accessible Information Standard?
Since the workshop in June, meetings have been held with several community groups to ensure messages reach all communities in Lincolnshire. These included South Lincolnshire Blind Society and Lincolnshire Sensory Services, to improve our communications with deaf, blind and deaf / blind members of the public. We are now able to utilise existing newsletters and bulletins sent out by both organisations plus Lincolnshire Blind Society has offered to hold focused workshops with blind and visually impaired people to hear their views and opinions. We have also met with Carers First to improve our communications and opportunities for engagement with carers in Lincolnshire. Over the next few months, it is our intention to meet with further organisations to strengthen communications with members of their communities such as groups who support people with disabilities, Black Minority Ethnic groups, travellers, eastern European groups, faith groups and LGBT+ communities etc.

The Clinical Commissioning Groups (CCGs) across Lincolnshire are working with their GP practices to reiterate their responsibilities around the Accessible Information Standard. Information can be found on the CCGs websites. Additionally, all systems at Lincolnshire Partnership Foundation Trust (LPFT) are now AIS compliant. United Lincolnshire Hospitals Trust (ULHT) has, since the AIS was published, been working on a structured approach to implement the standard and continues to undertake further promotion with service users. ULHT will also be undertaking a gap analysis of its own systems to ensure best delivery of the AIS.

Lincolnshire Community Health Service NHS Trust (LCHS) has raised awareness of how to record patients' access needs, and sign-ups in clinics encourage patients to declare any access needs.

3.4 Boston women's and children's services FAQs

There are concerns that paediatric patients are being moved to Lincoln, Peterborough, Kings Lynn and Grimsby Hospitals rather than Boston, resulting in additional travel for families.
The NHS is responsible for delivering medical and health care services and local councils are responsible for public transport. However, we fully appreciate how crucial transport is so that patients can access NHS services and family can visit their loved one. Therefore we are working closely with Lincolnshire County Council on a joint transport strategy to improve public transport and look at other viable options to supplement patient travel. We have worked to a principle of the most regular care requirements remaining close to home, such as routine outpatient appointments for example. It is when care needs become more complex and specialised that we introduce further travel; we have heard from Lincolnshire's public that the right care, first time is the priority, even if that means further travel.

For carers– if there's a transfer from Boston to Lincoln - travel may be an issue. There is support for carers - personal budget that pays for that transport.

At the Grantham Healthy Conversation 2019 workshop on 19 June, the public suggested some ideas to resolve the affordability and convenience issues for travel across Lincolnshire. This proved a very useful starting point and the following list is a summary of the ideas on which we are now actively working with LCC;

- Co-ordination of transport budgets, infrastructure and existing transport provision to maximise the value of what's already there
- Digital mechanisms to reward providers of lift-shares (UBER style) - digital payment infrastructure that tracks per mile travelled in a registered car share. Automated payments on a cost-share basis. Rates set by the scheme to avoid profiteering. Scheme provides safeguarding and vetting of participants.
- Tackling "The last mile": Create transport hubs/interchanges; make waiting more social, comfortable or usable time. Integrate transport information and potentially other rural information hubs.
- There are already a variety of local and voluntary transport services which could be utilised, such as Call Connect and Grantham Community Transport, for example. Maximise the opportunities these services offer.
- A bus service that travels between hospital sites for staff, patients and carers.

These are ideas at this stage and their feasibility is being explored; final options will be incorporated into the joint travel strategy.

ADDITIONAL QUESTIONS FROM 10 OCTOBER WORKSHOP

Why do we have two options if one option is not viable and the NHS preference is for one only?
National guidance suggests that it is preferable to consult on more than one option for a service change, but this is not always necessary or possible. On those occasions, if only one option for change is viable this one option can be consulted on. The Healthy Conversation 2019 is about engaging and hearing people's views about both options for women's and children's services. All of the work that has been done since August 2018 is striving to avoid a single site option and the NHS' preferred option is to continue with these services at Pilgrim Hospital.

There is a lack of trust in survey questions – we will only get the answers to the questions we ask – if you ask if people are prepared to travel a bit further for the specialist services, then most people will say yes but if you asked would they prefer having the specialist services in their local hospital then most people would prefer this.
We will not give an option if this isn't viable, for example, if there are not enough specialist staff to provide a local service. We want to be open and honest with the public even when messages are difficult. We always allow a section for people to share their own concerns or comment in order to ensure people do not feel there are any restrictions upon what they want to say.

Back in 2015 – Alan Kitt and Dr Tony Hill stated in the LHAC document that "nothing is going to change until there has been a full consultation" however things are changing under the banner of safety concerns. Changes are being made by stealth.
This statement remains true. We will engage and consult with the public on any significant changes to services. However, it is also our duty to ensure our services are safe and on

occasion urgent changes are needed to maintain the safety of patients / services. Any changes made on this basis are temporary and a full consultation will follow.

How have you taken into account population increases when determining the preferred emerging option?
Yes, we use predicted population growth identified by the County Council.

The STP is supposed to not disadvantage people. In the East coast residents are extremely disadvantaged. There is a lot of deprivation. Everyone seems to be pushed towards Lincoln. Lincolnshire is so big it should have two hospitals which are equally as big. Should be equal on all levels – it must be something to do with finances?
The east coast population does have a high rate of deprivation. The options presented for service reconfigurations were assessed using four criteria, one of which was financial sustainability. However, all four criteria were equally weighted. Our ability to recruit staff to the east coast is the most significant challenge.

Are there enough staff to deliver these services?
Recruitment challenges are a national issue as well as a local one for Lincolnshire and a lot of work is being undertaken to recruit staff at all levels. We are working with many partners in the county in order to ensure Lincolnshire is presented as a thriving and appealing place to live and work.

Our Talent Academy brings together health and care organisations from across the county to help recruitment and skills development for our current and future workforce. The academy's initiatives include visiting schools, organising careers fairs, and developing our apprenticeship programme to inform and encourage careers in health care.

Alongside our colleagues across the health and care sector in the county, we have also established Lincolnshire's Attraction Strategy programme. This group focuses upon promoting the appeal of Lincolnshire as a place to live and work, as well as raising awareness of the career opportunities in the county.

Lincolnshire has developed a model for GP international recruitment that has now been adopted across England, thanks to the success we saw in the county. Central to Lincolnshire's 'grow our own' recruitment initiative, the University of Lincoln's Medical School's first students have started training in September 2019 alongside two other much needed staff groups, paediatric nurses and midwives who have also started in September 2019.

Our recruitment strategy includes increasing the number of Advanced Neonatal Nurse Practitioners in the service and their use across the Trust (there is a role for ANNPs in the SCBU at Boston). We are unlikely to attract trained ANNPs as they are in short supply across the country. The nursing team are therefore looking at getting local nurses onto training courses – final plans are currently in development.

ADDITIONAL QUESTION FROM 10 OCTOBER WORKSHOP

Is recruitment and retention improving? Are staffing vacancies still an issue?
Workforce shortages and a decrease in the number of training places have led to an increase in vacancy figures across the system especially within our acute services. We have a high number of vacancies and shortage of supply locally (and nationally) for registered nursing and midwifery staff, learning disability and other professions such as radiologists, Children's Nurses, Consultants and Middle Grade (SAS/Speciality Doctors). The geographical component is also often overlooked. Sparser and smaller populations, higher employment rates, an older population and relatively fewer younger people pose challenges for recruitment, retention and workforce development in rural areas and down the East Coast of our County especially.

Lincolnshire finds itself competing with employers on our boarders as well as those nationally from a reduced supply and labour pool and therefore success of attraction and retention very much depends upon the "total reward" package offered and the experience felt by candidates which is being addressed through our People Plan objectives particular "to become the employer of choice". Our primary focus is to reduce agency costs through substantive recruitment, attracting the best talent to Lincolnshire with a positive candidate experience and career opportunities. Our acute provider has recently contracted with a Strategic Partner in regard to International Recruitment, whilst the System as a whole implements new ways of working including different employment models, portfolio working, detailed job plans and changes to rotas, introduction of new roles and return to practice to aid the attraction and retention of our workforce. Using the positive relationship with our local University and Medical School as well as those colleges and higher education institutions further afield, we are increasing clinical placements, developing further opportunities with various apprenticeship roles and ensuring that investment supports our current workforce's future skills and competency need.

The NHS should be engaging with schoolchildren at an early age to educate them about careers in the health service. Schools are an untapped opportunity. Aspirations for young people in Lincolnshire are very low and we need to let them know everyone is needed – we need home grown talent. ParentMail is an easy system which reaches a lot of people quickly.
We are working with schools and colleges throughout the county, as well as undertaking work with the Talent Academy, and note the helpful comments around reaching children at an earlier age to 'plant the seed' of a career in the health service.

General questions

Why isn't more being done to increase funding that Lincolnshire receives?
Our executives and non-executives are in regular contact with politicians and central government about funding opportunities and promoting Lincolnshire. We have had some recent successes:

- The Prime Minister recently announced £21m fir ULHT (around one fifth of the money we have requested from NHSE)
- Mental health early implementation funding was also announced in September 2019.
- Funding has been sought, and received to support a range of initiatives from NHSE.
- A number of training initiatives have been funded by Health Education England

- Some of the Trusts have received extra funding from the Provider Sustainability Fund for their performance from NHSE
- The NHS applies for capital monies at every opportunity and has received funding to support with the development of business cases from NHSE digital

The Long Term Plan also refers to extra funding for initiatives such as digitally enabling primary care and outpatient care. We also appreciate efforts by members of the public who encourage their local MPs to lobby for more funding for Lincolnshire.

Why is the Government removing funding from rural pharmacies?
A new funding settlement has been agreed for all pharmacies contractors for the next 5 years. This should enable pharmacies to be able to plan and make any necessary changes. As part of this there is a recognition of rural pharmacies who receive Pharmacy Access Scheme payment. This gives rural pharmacies an additional level of funding.

Further information can be found here:

https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacy-contractual-framework/

https://psnc.org.uk/our-news/contractor-announcement-funding-negotiations-result-in-five-year-cpcf-deal/

Is getting patients back out into the community the best approach? Is the money there to care for patients at home? Is it the best use of resources – especially with shortages of staff? Aren't patients better off in hospitals rather than sending them home?
At first glance it might seem obvious that hospital would be the best place to look after someone, but in fact there is evidence to show that this may not be the case.

Studies suggest that admitting frail older people to hospital can lead to a decline in their physical ability. For all ages, there is also a risk of getting a hospital-acquired infection, which can cause serious complications or even death. And if someone is already receiving regular care at home, sending someone into hospital can interrupt the relationship with their carer and their family. The carer bond can be hard to re-establish.

There are also financial as well as personal costs associated with hospital care. Keeping people in hospital is costly, and people over 85 account for a quarter of all bed days in the NHS. Avoiding this would be better for older people, reduce admission to residential care and keep people living at home longer, and also save money.

How successful is being stabilized by a paramedic?
Paramedics have a highly responsible role, often being the most senior ambulance service health care professional in a range of emergency and non-emergency situations. They are trained to deliver their care in the pre hospital setting and so by doing this are considered experts in their field.

They are highly skilled professionals who assess a patient's condition and make potentially lifesaving decisions. In an emergency they are trained to managed complex situations and use high tech equipment such as defibrillators and intravenous drugs. In essence they provide a mobile emergency clinic and are capable of delivering advanced life support techniques to resuscitate/stabilise

patients using sophisticated procedures, techniques, equipment and drugs. They do all of this autonomously, but do have facilities to speak with other clinicians to support their clinical decision making, for example, speaking with a doctor from a trauma centre.

Paramedics follow guidelines to support them in their role and have the facilities to consult this guidance via an electronic system which they carry with them.

Have we considered the coast in the summer and tourism? How do we factor in the extra number of visitors?
We are very adept at managing and forecasting trajectories for activity increases, for example seasonal swells such as summer or winter tourism. We are kept informed of most events taking place within the county, such as large shows, and have business continuity plans in place to ensure everything is managed well.

Alison Marriott would like to see published the options appraisal information complete with scoring from January 2017.
Options appraisal scoring from February 2018 will be published with the Pre-Consultation Business Case prior to public consultation.

END

THE FOLLOWING QUESTIONS AND ANSWERS HAVE BEEN INCLUDED UPON REQUEST BY ALISON MARRIOTT.

Why is option 2, centralising consultant-led maternity etc. to Lincoln, still in the engagement options? We have been told that it is to ensure that "there is a conversation" and so that "there isn't a done deal". Who decided that this was the case? Who decided that this unacceptable option would be included (high-risk, high-impact on patients and families) and why not a lower-risk option?

Through 2018, Clinicians considered a long list of options and reduced these to a short list of options. It is this short list that we are currently engaging on through Healthy Conversation. National guidance suggests that it is preferable to consult on more than one option for a service change, but this is not always necessary or possible. On those occasions, if only one option for change is viable this one option can be consulted on. The Healthy Conversation is about engaging and hearing people's views about both options. All of the work that has been done since August 2018 is striving to avoid a single site option and the NHS's preferred option is to continue with these services at Pilgrim Hospital.

If it is to be a genuine conversation/consultation at the next stage, why are you not putting forward an option to have the inpatient paediatric beds and level 2 neonatal unit (LNU) at Pilgrim instead of Lincoln? As the RCPCH review report said that in some ways Pilgrim should be the site for the LNU as the population needs it. Also as

ULHT have admitted that the larger population of children with the highest needs are in this side of the county? Surely this would be a more genuine conversation if you had more than 2 options (including an option which keeps inpatient children's services at Pilgrim). Especially given that one of the current options is completely unacceptable from a risk point of view (centralisation - option 2) when considered objectively based on all the available research evidence and experience of staff. Sources of evidence can be provided on request.

Through 2018, Clinicians considered a long list of options and reduced these to a short list of options. It is this short list that we are currently engaging on through Healthy Conversation. Their experience continues to be that recruiting staff to Pilgrim Hospital remains difficult. However recent recruitment campaigns have proved more successful when recruiting to paediatric posts on a rotational basis working at both Lincoln and Pilgrim Hospitals.

What sources are you basing your travel times on between Boston and Lincoln, Skegness and Lincoln? Please quote the travel times you are using along with the sources.

The travel time is dependent on the patient's condition and road conditions. We have used the following travel time thresholds for modelling purposes. These are locally agreed thresholds, there are no national travel times guidance.

The three thresholds are 45 minutes (A&E, maternity and non-elective paediatrics), 60 minutes (all other non-electives and outpatients) and 75 minutes (elective paediatrics, day case surgery and elective surgery).

What impact will the national neonatal transformation programme have on Lincolnshire, and in particular Pilgrim neonatal unit? Has any member of staff in Lincolnshire (any of the NHS organisations) actually seen the draft report yet? If so how will it impact on your plans and the proposed options?

The national neonatal report has been drafted and a number of people have had sight of the draft report. Our ULHT Divisional Head of Midwifery and Nursing) is a member of the national working party, and we have ensured that the plans for Lincolnshire are aligned to this as much as possible. The neonatal work programme is an essential part of the Lincolnshire Local Maternity and Neonatal System. The latest information suggests that the national review will not be published, but there will be a focus on delivery. We are actively engaged with the East Midlands Neonatal Network to ensure that we are able to meet the national standards to sustain a full SCBU at PHB.

At the moment we have dedicated ambulances for transferring children from Pilgrim to Lincoln... if the changes are to be made permanent as in option 1, what will you be putting in place regarding transfers? Will there be a dedicated ambulance? Will EMAS be providing extra services ? Especially as moving stroke patients too are in the options...

The additional ambulance service on the Pilgrim site (started in August 2018 to support the interim model) will continue to transfer any patient that does not meet the category 1 classification (an immediate response to life threatening condition). Category 1 patients will be transferred by EMAS via 999 emergency vehicle. For neonatal babies and children being transferred to tertiary units there are specialised retrieval teams, with their own ambulance, who will attend the hospital to move patients.

6. On the SSNAP audits, Pilgrim stroke unit is mainly scored higher than Lincoln, and the figures of patients are often very similar.... so why not centralise the service Pilgrim? What is the specific and detailed rationale for choosing the Lincoln site, including specific details of any co-located dependent services, whether those services previously existed at Pilgrim, if so why were they moved, reduced or closed, what consultation process was followed, and was the potential future impact on other services made clear to the public at the time?

The stroke unit at Pilgrim does get good outcomes, but the medical staffing is fragile with temporary staffing plus one retired consultant who is returning on an annual contract. The intention is to change the stroke model so care after 7 days takes place in the community and this rehabilitation will better meet patients' needs and will reduce the overall number of beds required. The combination of a single unit will make it more attractive to staff, facilitate access to advanced treatments as they evolve, allow patients to recover in the community and make it more cost effective. The treatment that is expected to evolve over the coming years is the Mechanical Thrombectomy Service. This is currently not provided in Lincolnshire. It is anticipated that this service will be co-located with the Cardiac service in future years. The centralisation of the Cardiac Service at Lincoln Hospital has improved mortality over the last 5 years.

Where has this event been publicised? In which other languages and formats? What facilities are you providing at the venue to allow disabled people to participate equally and information in a range of formats so that everyone can understand? Please list specifically what you are doing/providing so that residents with protected characteristics can participate fully and on an informed basis.

The workshops are publicised extensively through the following media channels: local newspapers/magazines, local radio, social media, websites, e-shots to stakeholder groups and through relevant third parties. As this event was open to all and was not invite only, we could not guarantee that people with protected characteristics would attend but ensured a wide reach with our communications so the opportunity was there.

In addition, these workshops are only one part of the much bigger programme of engagement we are undertaking and understand that events like this are not the best way for some people to engage with us. Therefore, we offer a variety of ways for people to tell us their views if they don't want to or are unable to come along to a workshop, for example our paper and online surveys which are also available in different languages, paper and online feedback forms, meeting us when we're out and about in town centres and supermarkets, and people can phone, email or write to us. This is just the first part of our engagement and we will continue with many more extensive engagement and consultation opportunities as we move into the formal public consultation.

The purpose of these workshops was a 'deep dive' into the particular themes which emerged from the wave 1 engagement events and therefore smaller, more detailed group discussions was an appropriate way to achieve this. We are also mindful that our clinical staffs' time is extremely valuable and we are grateful that they were able to sit around tables and have a conversation with our patients and the public which would not have been possible with larger scale events .

Further details of our proactive engagement with groups with protected characteristics will be made publically availability on completion and we will share this with you. As reported in the Health Scrutiny Committee, we are working with People's Partnership, an independent partner to ensure proactive engagement with people with protected characteristics.

The People's Partnership is made up of a Leadership Team who represent major areas of disability and some areas of the protected characteristics. In addition to the Leadership Team, they have individual members, members of groups and communities, and members who support the hidden and hard to reach communities.

The current members of the Leadership Team are:

- *Age UK Lincoln & South Lincolnshire*
- *CarersFIRST*
- *Children's Links*
- *Every-One (contributes and facilitates the organisation of the People's Partnership)*
- *Linkage Community Trust*
- *Links Lighthouse*
- *South Lincolnshire Blind Society*

As part of the engagement, The People's Partnership have engaged with a number of hidden and hard to reach communities which included 56 respondents who identified as having sight loss.

Funding - what are you doing to ensure that Lincolnshire gets its fair share of funding and are you getting the support you need politically? For example, this report from the Nuffield foundation and NCRHC (based in Lincoln) suggests that we are underfunded. So this is not just driven by safety, is it? https://www.nuffieldtrust.org.uk/research/rural-health-care

We are aware of this report having contributed to its development and we understand that the NCRHC are taking this forward nationally. With the current national methodology on funding allocation, we are receiving our 'fair share' so any national review is welcomed.

A set of four criteria were developed for the purpose of assessing any future options and proposals, namely: 'quality of care', 'access to care, 'affordability' and 'deliverability'. Safety

is part of quality and funding is part of affordability. These four criteria are considered as equal and not weighted.

What are the exclusion protocol for ambulances and GP's, i.e not taking or sending babies, children and pregnant women to the Pilgrim at the moment? What were they before the August 2018 changes? What will they be under the proposals? (by each option). For example, will all pregnant women under 37 weeks experiencing any problem be told to go to Lincoln (or taken by ambulance) under option 2?

Today, babies born pre 29-weeks and children under five who require surgery are all treated out of county. Some of these patients will require planned care, other patients will receive initial treatment in county and be transported to tertiary services as their care needs require specialist support. This will continue in the future.

There are no exclusion protocols for ambulances and GPs taking babies, children or pregnant women to Pilgrim Hospital now nor before August 2018. There will no exclusion criteria for option 1 in the proposals.

For option 2, there would be no neonatal service or consultant obstetric service at Pilgrim Hospital. This means that if the lady is planned to have a consultant led birth, they will attend Lincoln Hospital or a hospital outside of the county for treatment / the birth. Pregnant women can still attend Pilgrim Hospital, would be treated and transferred with their baby if necessary.

We were informed by ULHT on 18th June that the reason for including Women & Children's option 2 in the Healthy Conversation engagement documents was due to advice from NHS England that these two options were necessary for valid public consultation.

We believe the event you refer to was the Paediatric Engagement Event held at Pilgrim Hospital, United Lincolnshire Hospitals Trust (ULHT) on 18th.

NHS England (NHSE) does not give instructions on the number of options to consult on. NHSE's approach is to issue guidance and promote the use of 'best practice'.

It is preferable to consult on more than one option for a service change, but this is not always necessary or possible. On those occasions if only one option for change was viable this one option can be consulted on.

Please note there are other Acute Services Review services too where we have included a second option, which is theoretically deliverable, even though we have been clear that it is not our NHS preferred option.

Please would you provide a copy of the advice from NHS England, or from any other source if it wasn't NHS England.

We are currently engaging on our options and are using the NHSE guidance available at

https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

Appendix 4: Acute Services Review survey report

Contents:

Background and introduction

During 2018 we engaged with our communities on hospital services to start developing options for how services need to change. We undertook a survey and number of public events to explore this.

All of the feedback we received was shared with clinicians and senior leaders to consider these views and experiences when thinking about the options for how we might deliver these services in the future. Any options that suggest significant change to hospital services will go through NHS England assurance processes and public consultation before service changes are made.

This previous engagement helped us to identify some emerging options upon which we invited further views using a variety of engagement activities as part of the Healthy Conversation 2019 campaign, such as open events and a survey. This report summarises the results of this survey as well as respondents' thoughts on travel and transport and technology to support these possible changes in services.

All of the detailed feedback received has been circulated to the Senior Responsible Officers for the system programmes to inform the development of Lincolnshire's Long Term Plan and also to shape their programmes and projects and emerging options prior to any public consultation.

Survey feedback:

During the course of the engagement we received 649 completed surveys with a varying number of respondents answering each question.

Respondent profile:

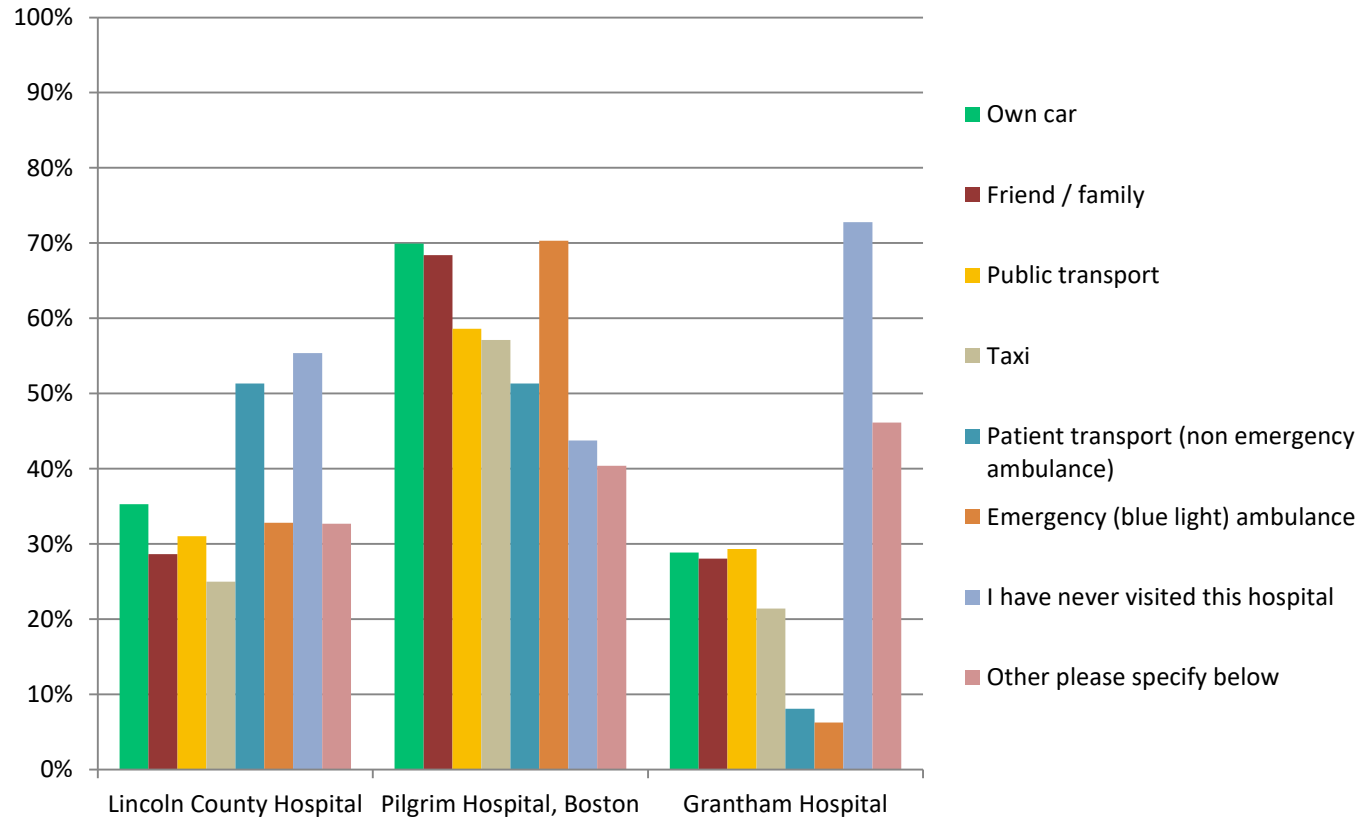
- 83% (537) members of the public
- 11% (73) member of NHS staff
- 5% (34) Organisation or other
- 5 did not answer this question

Travel to and use of Lincoln, Pilgrim Boston and Grantham Hospitals

Initial questions in the survey asked respondents how they travelled to hospitals, how often they attended and if they experienced any difficulties attending any of the sites.

These results demonstrate that a higher proportion of respondents to the survey visit Pilgrim Hospital, Boston than Lincoln and Grantham Hospitals and so subsequent answers received will also show a larger number of views relating to Pilgrim Hospital.

Q3: If you have used any/all of the 3 main hospitals in Lincolnshire within the last 12 months what was the main way you travelled to each of these hospitals?



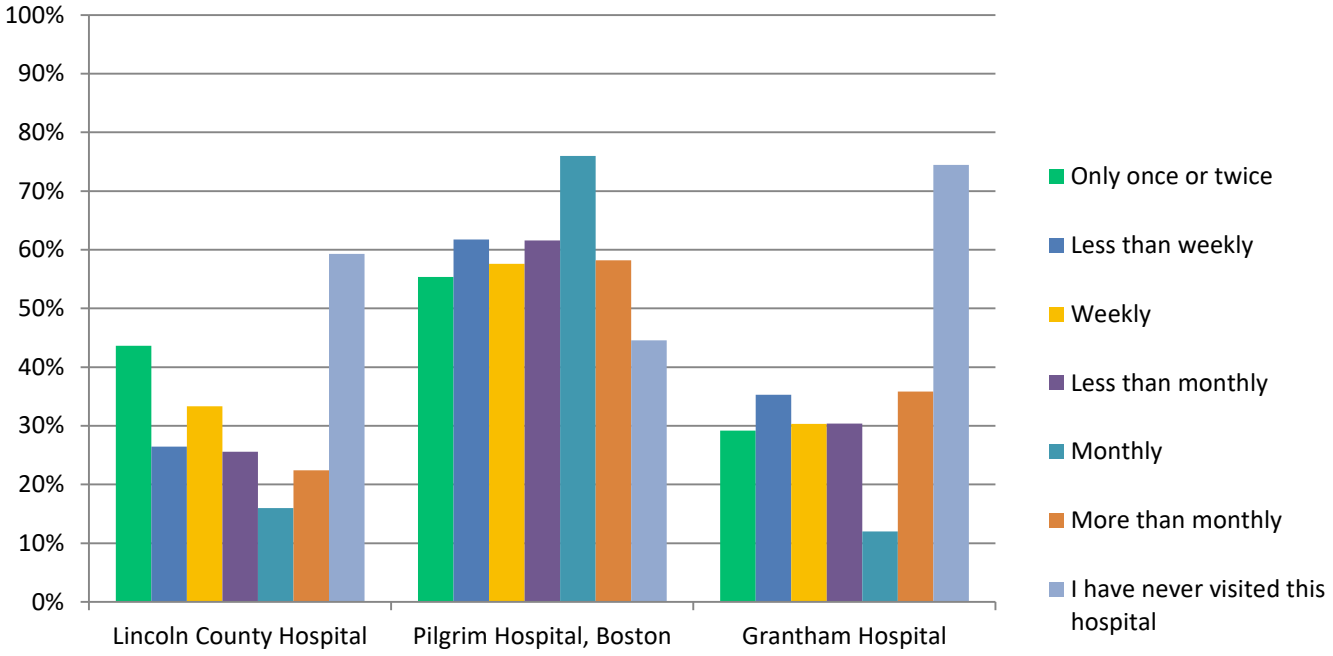
A large proportion of respondents visited each hospital using their own cars.

Lincoln Hospital: the highest number of those who have visited the hospital attended by patient transport. Those who suggested other methods of travel indicated that they either walked or attended a different hospital.

Pilgrim Hospital Boston: most respondents attended by emergency (blue light) ambulance. Those who suggested other methods of travel indicated that they walked, used voluntary transport or attended a different hospital.

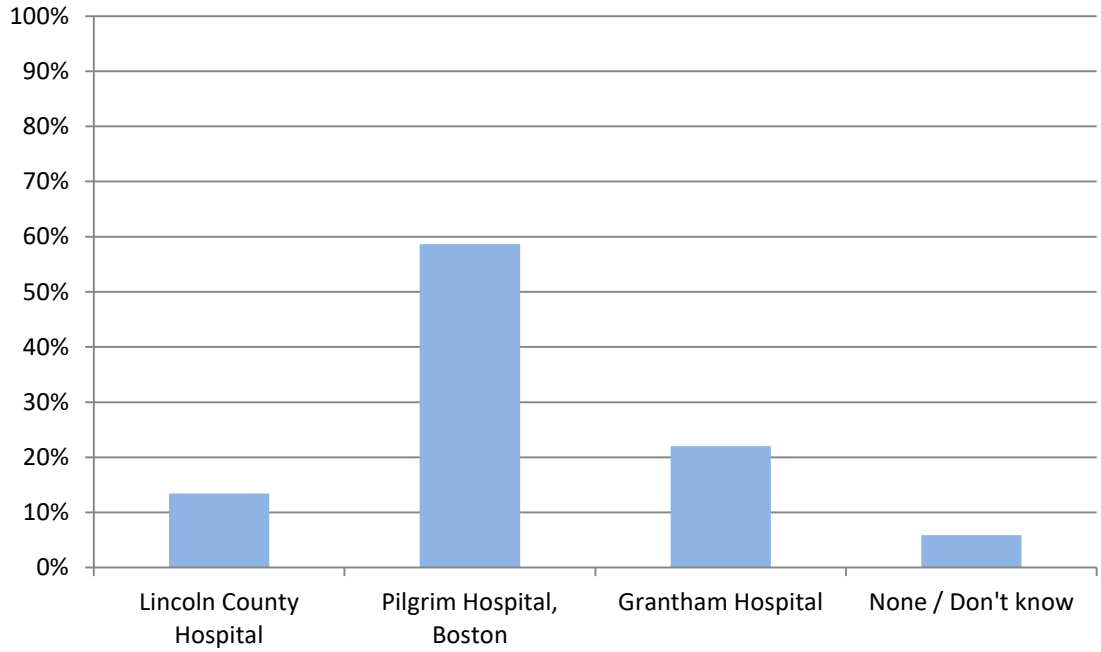
Grantham Hospital: the majority of respondents who didn't use one of these travel methods indicated that they walked to the hospital.

Q4: Over the last 12 months, approximately how often have you visited each of the 3 hospitals?



Most respondents indicated that they hadn't visited Lincoln and Grantham Hospitals.

Q5: Which is the main hospital site you have travelled to?



Q6: Why is this the main hospital you travel to?

	Lincoln Hospital	Pilgrim Hospital	Grantham Hospital	None / Don't Know
Responses	84 (13%)	367 (59%)	138 (22%)	37 (6%)
I am given appointments for this hospital	**50%**	25%	22%	8%
It is closest to where I live	27%	**64%**	**66%**	8%
It is easy to get to using public transport	1%	1%	1%	3%
My family / carer can take me	2%	2%	1%	0%
There is enough parking at the hospital	0%	0%	1%	0%
It is in an area where I work or shop	2%	2%	3%	0%
Other reason (please specify)	17%	5%	7%	**41%**
Answer left blank				41%

23 respondents did not answer this question. The main reasons for visiting each hospital are highlighted in green.

Other reasons:

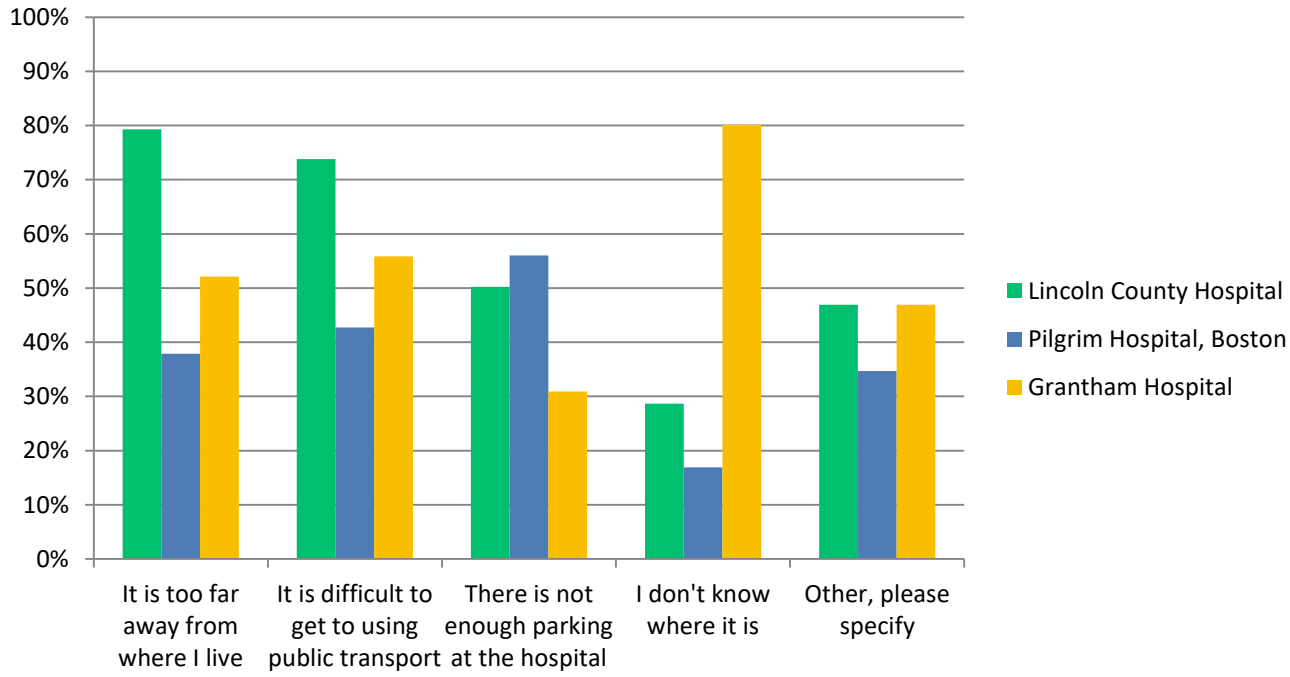
Lincoln Hospital: Closest A&E open 24/7; only location for treatment required; advised to attend this hospital

Pilgrim Hospital, Boston: Only location for clinic/treatment; closest for family to visit; better roads and familiar with hospital

Grantham Hospital: Requested to go here; easy to get to; quicker treatment in A&E

None/Don't know: Use other hospitals especially Stamford or Peterborough

Q7: For each hospital please tell us if there is ONE main thing that makes it difficult to access services at each hospital



The main reason it is difficult to access services:

Lincoln Hospital: It is too far away from where patients live.
Other reasons: too expensive to get there; long delays to get appointments; traffic congestion; would access another hospital.

Pilgrim Hospital, Boston: There is not enough parking at the hospital.
Other reasons: cost of parking; reputation; too far to travel in an emergency

Grantham Hospital: Patients don't know where it is.
Other reasons: other hospitals are easier to access; reduced services; cost of parking

Digital:

Q8: Virtual consultations could be phone or video call with a clinician rather than needing to travel for a face to face appointment. Please tell us to what extent you would like to be offered a virtual consultation instead of having to travel to an appointment?

I would definitely like to be offered a virtual consultation	14%	46% positive
I might like to be offered a virtual consultation	32%	
I don't think I would like to be offered a virtual consultation	23%	50% negative
I definitely would not like to be offered a virtual consultation	27%	
Don't know	4%	

Q9: Please tell us the reasons for your answer to question 8

Positive	• Great for patients too poorly to drive • Often difficult to arrange transport so this would be great • Saves time and more environmentally friendly • Much easier than having to travel and pay for fuel and parking • More time efficient when hospital conversations sometimes only last minutes but travelling could take hours • Reduces need for patient/family to take time off work • Much better for patients with children or dependents • Better use of clinician time and resulting in more appointments available
Negative	• Lack of confidence in dealing with people via technology, far more comfortable with face-to-face meetings • Not everybody has access to the internet or technology • Physical examinations are far better • Those with disabilities may have difficulties with technology • Some important information could be missed by not seeing the patient • It would feel strange and impersonal • Concerns about discussing personal information on the internet/via computer

Q10: Some digital solutions can be used at home to monitor your own health (for example, self-monitoring or remote monitoring technology such as blood sugar monitor, blood pressure monitor, activity tracker).

To what extent would you use these if that meant you could avoid an unnecessary appointment or stay in your home for longer rather than having to go into hospital?

I would definitely use technology to monitor my health at home	49%	86% positive
I might use technology to monitor my health at home	37%	
I don't think I would use technology to monitor my health at home	6%	10% negative
I definitely would not use technology to monitor my health at home	4%	
Don't know	4%	

Q11: Please tell us the reasons for your answer to question 10

Positive	• Frees up time for other patients • Saves the NHS time and money • Reduction in time away from work, less pressure on NHS resource, reduction in carbon footprint re travel • Many patients already monitor their health at home such as blood pressure – just need plenty of support and information about when to seek help and when to continue alone at home • The technology exists and produces the same results with less inconvenience to myself and frees up resources for other people who may have no other option but to physically attend • With advancing age travel is becoming a problem • We all need to take more responsibility for our own health. It is our responsibility to monitor day to day health
Negative	• Would not feel reassured as much as seeing a doctor • Not suitable for certain conditions • I do not understand the technology and don't trust it. I dislike doing things on line

Q12: If you were offered support and training to use digital technology to what extent would this encourage you to use it?

I would definitely consider using it after support and training	50%	85% positive
I might consider using it after support and training	35%	
I don't think I would use it even after support and training	7%	11% negative
I definitely wouldn't use it even after support and training	4%	
Don't know	4%	

Q13: Family members or carers could have access to parts of your medical records with your permission. This would mean that they could check your upcoming appointments, see your prescribed medications or contact a medical provider on your behalf.

Please tell us if you would like to give permission for family members or carers to access your medical records

I would definitely like to give family or carers permission to access my medical records	36%	71% positive
I might like to give family or carers permission to access my medical records	35%	
I don't think I would like to give family or carers permission to access my medical records	12%	26% negative
I definitely would not like to give family or carers permission to access my medical records	14%	
Don't know	4%	

Q14: Please tell us the reasons for your answer to question 13

Positive	• The more people involved in my care the better for me • Useful for older people or those with additional needs who need support with these things • Patients happy for family to know their medical details • If it speeded up diagnosis and meant better treatment
Negative	• Privacy concerns • Totally inappropriate unless incapable of making own decisions • Maybe as I get older but not at the moment

Q15: If you have any concerns about using digital technology such as having video/skype consultations, using self-monitoring technology or apps please tell us below

- This is fine as long as patients are given a choice
- Privacy and cyber security are a concern
- Patients might not understand how to do it
- Patients might not have concerns but would like to be given suitable training how to use these technology
- Do not have internet access or technology to use it
- Sometimes only face to face appointments are suitable

Q16: If there is anything that would help you to use these technologies to take advantage of the benefits they bring, please tell us below

- Suitable training and support would be needed
- Each step at a time- patients can't even access medical records online yet. GP front line staff need to be fully trained in assisting/encouraging would-be NHS digital users
- Full subtitles and not having to use a phone
- Guarantee security of information
- Possibly, a dedicated room in public buildings such as surgeries, libraries, council offices etc, where the public can drop in to use technology for telehealth consultations. This could be beneficial in areas where connectivity is poor
- Provide the technology for patients to use
- Better broadband, easy access to support 24hrs a day if there are problems using the technology
- Once they are proved to be secure patients might consider it

The following questions were based on the eight services included in the Acute Services Review. Due to the nature of the questions asking respondents to identify concerns and problems they have about the emerging options, the responses are mainly negative. This will enable us to consider what we can do to mitigate any of the problems people might face if services are changed.

Breast services

Q17: Please tell us if you would have any problems accessing these breast services at Lincoln County Hospital and if you have any suggestions of how we could overcome this

52% of 644 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility - hospital is far away from home; too far to travel
- Transport – unable to drive or rely on family/friends
- Cost – hardship to patients or family

9% of respondents provided neutral answers to this question, 7% were positive and respondents felt they wouldn't have any problem with this option and 33% were unanswered.

Suggestions included:

- Mobile units at GP Practices
- Provide free, reliable transport for sick patients, for example scale up the charity car projects
- Send out details of travel and transport with appointments
- Keep outpatients appointments local

(Respondents unaware that this is already part of the emerging option)

Q18: Please tell us if you would have any problems accessing these breast services at Grantham Hospital and if you have any suggestions of how we could overcome this

41% of 647 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility - hospital is far away from home; too far to travel
- Transport – unable to drive and lack of public transport
- Cost – hardship to patients or family

6% of respondents provided neutral answers to this question, 15% were positive and respondents felt they wouldn't have any problem with this option and would be prepared to travel if it meant a quicker appointment and 38% were unanswered.

Suggestions included:

- Offer hospital transport
- Better parking and free for disabled patients
- Skype would help for routine follow up appointments

Q19: Please tell us if you have any other comments or suggestions about our emerging options for breast services

Other comments included:

- Concern about services being centred around Lincoln
- Services should be more widely available in all hospitals across Lincolnshire
- Could utilize other hospitals such as Grantham, Pilgrim Boston, Peterborough and Stamford
- Would need travel support to and from Lincoln Hospital
- Centralising is sensible
- Received great care at Lincoln previously

Stroke services

Q20: Please tell us if you would have any problems accessing these stroke services at <u>Lincoln County Hospital</u> and if you have any suggestions of how we could overcome this

62% of 644 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – concern about the 'Golden Hour', long distance away for people at the coast, road infrastructure inadequate
- Transport – no public transport from some areas, would have to rely on family/friends
- Cost – hardship to patients or family

3% of respondents provided neutral answers to this question, 7% were positive and respondents felt they wouldn't have any problem getting to Lincoln and would appreciate swift treatment at a centre of excellence and 28% were unanswered.

Suggestions included:

- Retaining stroke services as Pilgrim Boston
- Consider the impact on friends and family
- Provide a fully funded transport system

Q21: Please tell us if you would have any problems accessing these stroke services at <u>Pilgrim Hospital,</u> Boston and if you have any suggestions of how we could overcome this

28% of 643 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far to travel , excessive traffic congestion and long delays
- Transport – no transport links from some areas, unable to drive and would have to rely on family/friends

3% of respondents provided neutral answers to this question, 28% were positive and respondents felt they wouldn't have any problem getting to Boston as this was closer to home and 40% were unanswered.

Suggestions included:

- Improved parking required and at reduced costs
- Use Skype if possible

- Provide stroke services in Grantham and other local hospitals

Q22: Please tell us if you have any other comments or suggestions about our emerging options for stroke services

Other comments included:

- Treatment in a timely manner is important but where this is located varies depending on where patients live in the county
- Provision of stroke services in other local hospitals
- Local rehabilitation

Women's and children's services

Q23: Please tell us if you would have any problems accessing Lincoln County Hospital for consultant led services for both consultant led and maternity services and if you have any suggestions of how we could overcome this

54% of 643 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far away from where some patients live, difficult to get to especially with young children or in emergencies
- Transport – difficult in times of heavy traffic, inadequate public transport and can't get there for early appointments,
- Cost – hardship to patients or family, can take a whole day for appointments with the additional travel and need to take unpaid leave, difficult to travel with other work and family commitments

7% of respondents provided neutral answers to this question, 4% were positive from respondents who lived closer to Lincoln and felt it would be easier to travel to and 35% were unanswered.

Suggestions included:

- Provide additional parking – extra land needed
- Keep maternity services at Pilgrim Boston and use both Lincoln and Pilgrim Hospitals
- Improved transport links for patients

Q24: Please tell us if you would have any problems accessing Pilgrim Hospital, Boston for maternity-led services or both consultant-led and maternity services and if you have any suggestions of how we could overcome this

19% of 643 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far away from where some patients live, still a long way to get to using public transport from the coast
- Transport – traffic congestion at certain times of the day; terrible public transport options, other hospitals are closer and easier to get to

9% of respondents provided neutral answers to this question, 20% were positive from respondents who lived closer to Boston and felt it would be easier to travel to and 52% were unanswered.

Suggestions included:

- More staff needed to deliver the fabulous care they are capable of
- Keep services as they are
- Deliver services in other local community hospitals

Q25: Please tell us if you have any other comments or suggestions about our emerging options for women's and children's services

Other comments included:

- Concern about services becoming Lincoln centric
- Localise services to make them accessible for all
- Increase staffing levels
- Consider the impact of the wider family and dependents if women and children have to travel to a hospital further away from their homes.

Medical services at Grantham Hospital

Q26: Please tell us if you would have any problems accessing acute medical beds at Grantham Hospital and if you have any suggestions of how we could overcome this

30% of 644 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far away from where some patients live,
- Transport – poor public transport links and difficult to access if unable to drive
- Cost – hardship to patients or family who cannot afford the travel costs

6% of respondents provided neutral answers to this question, 18% were positive from respondents who felt they would have no problems accessing Grantham Hospital and were keen for services to remain there and 46% were unanswered.

Suggestions included:

- Need to keep all medical treatment local and easy to access
- Train staff in-house and build on the apprenticeship scheme to share knowledge of experienced staff
- More beds and staff needed at Grantham Hospital.

Q27: Please tell us if you have any other comments or suggestions about our emerging options for acute medical beds at Grantham Hospital

Other comments included:

- The acute care beds might take some pressure from Pilgrim and Lincoln hospitals
- Use of other local community hospitals
- Keeping as many services as possible at Grantham is very important. If we only have 3 main hospitals in this county we need to keep as many local services available as possible.

- The community healthcare support model is being used at Hospice in the Hospital at Grantham and has thrown up a variety of challenges which should be considered before any changes are made to the hospital itself.

Trauma and Orthopaedics

Q28: Please tell us if you would have any problems accessing trauma and orthopaedic services at Grantham Hospital and if you have any suggestions of how we could overcome this

36% of 648 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – Grantham Hospital is too far away from people living in South Lincolnshire and they would go to Peterborough, too far to travel in pain after an operation
- Transport – poor public transport links and the railway is too far away from the hospital, no public transport available to get to the hospital early in preparation for operations, some journeys would take over 3 hours

5% of respondents provided neutral answers to this question, 17% were positive from respondents who felt it was convenient for those living locally and some had good experiences of orthopaedic care at Grantham and 42% were unanswered.

Suggestions included:

- Offer these services at multiple hospital sites
- Provision of transport for hospital services

Q29: Please tell us if you have any other comments or suggestions about our emerging option for trauma and orthopaedic services at Grantham Hospital

Other comments included:

- I would be happy to travel to Grantham knowing there was a reduced chance of the appointment being cancelled and a day off being wasted
- Centralisation cannot work without a complete change in transport and road infrastructure
- Too far to travel from certain areas of the county

General Surgery

Q30: Please tell us if you would have any problems accessing general surgery services at Grantham Hospital and if you have any suggestions of how we could overcome this

35% of 642 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far to travel especially when on top of already feeling ill or after surgery
- Transport – accessing for early start surgery would be impossible using public transport, difficult to use public transport straight after day surgery and if you don't have a car it would be impossible to get home

3% of respondents provided neutral answers to this question, 18% were positive from respondents who would have no problems accessing Grantham Hospital if they were local and others were happy to travel for planned care and 44% were unanswered.

Suggestions included:

- Put more resources at a local level – need 3 centres of excellence
- Transport needed to the hospital from the train station
- Appointment times should reflect train / bus arrival times

Q31: Please tell us if you have any other comments or suggestions about our emerging option for general surgery services at Grantham Hospital

Other comments included:

- Other community hospitals should also deliver these services
- A vast rural area like Lincolnshire need services in local hospitals rather than centres of excellence
- Retain breast surgery with general surgery
- Support for general surgery to be delivered at Grantham Hospital

Urgent and Emergency Care services

Q32: Please tell us if you would have any problems accessing urgent and emergency care services at Grantham Hospital and if you have any suggestions of how we could overcome this

35% of 644 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far away for some especially in an emergency and treatment may be outside of the 'Golden Hour', many would go to their nearest hospital
- Transport – without a car access is very difficult from other areas in the county and the poor and inadequate roads are dangerous to drive on in an emergency.

8% of respondents provided neutral answers to this question, 13% were positive from respondents who would have no problems accessing Grantham Hospital if they were local and recognise the need to relieve emergency services at the other hospitals and 45% were unanswered.

Suggestions included:

- Upgrade other local community hospitals to provide urgent and emergency care
- Urgent and emergency care services required 24 hours a day 7 days a week
- Offer walk in services 24/7 with full resuscitation and imaging

Q33: Please tell us if you have any other comments or suggestions about our emerging option for urgent and emergency care services at Grantham Hospital

Other comments included:

- Development of other community hospitals to provide urgent and emergency care and urgent treatment centres, especially for Stamford and Spalding
- 24/7 access to urgent and emergency care in Grantham
- Improve the NHS 111 service

- More education required on self-care

Haematology and Oncology services

Q34: Please tell us if you would have any problems accessing inpatient haematology and oncology services at Lincoln Hospital and if you have any suggestions of how we could overcome this

47% of 643 respondents to this question provided negative examples of how they could have problems accessing services and of those, the reasons given included:

- Distance and accessibility – too far away for many people, 3-4 hour round trips are unacceptable when having treatment for cancer and poorly, parking is inadequate
- Transport – little public transport and not suitable for such poorly patients and friends and family unable to visit
- Cost – too expensive to travel so far even if you have a car, if you don't and can't use public transport due to being so poorly then taxis are even more expensive, friends and family will be unable to visit due to cost

3% of respondents provided neutral answers to this question, 9% were positive who felt able to access Lincoln Hospital as long as outpatients are offered at Grantham and mobile units still available and 41% were unanswered.

Suggestions included:

- Set up telephone conversations for follow ups and reviews
- Supply transport for patients
- Increase the use of voluntary car schemes

Q35: Please tell us if you have any other comments or suggestions about our emerging option for haematology and oncology services at Lincoln Hospital

Other comments included:

- Consider accessibility options for service users in the south, north and east of the county, especially those who are unable to drive
- Use more local hospitals
- There should be equally good services at all sites
- Centralisation cannot work without a complete change in transport and road infrastructure

Equalities monitoring

Under the provisions of the Equality Act 2010, all NHS organisations are required to demonstrate that their processes are fair, and that they are not discriminating or disadvantaging anyone because of their age, disability, gender reassignment status, marriage or civil partnership status, pregnancy or maternity, race, religion or belief, sex or sexual orientation.

Age group	Responses	
Under 18	0%	1
18- 25	3%	18
25-30	6%	38
31 - 35	10%	60
36 - 40	9%	56
41-45	7%	42
46-50	10%	64
51-55	8%	52
56-60	9%	55
61-65	11%	69
66-70	14%	87
71 +	12%	78
Rather not say	1%	8
	Answered	**628**
	Skipped	**21**

Do you consider yourself to have a disability?		
	Responses	
Yes	24%	151
No	71%	445
Rather not say	5%	29
	Answered	**625**
	Skipped	**24**

If yes do you have a:		
	Responses	
Physical Impairment	42%	66
Sensory Impairment	7%	11
Learning Disability	1%	1
Mental Health Condition (Long Term)	10%	16
Other Health Condition (Long Term)	41%	65
	Answered	**159**
	Skipped	**490**

Gender	Responses	
Male	20%	127
Female	76%	476
Rather not say	3%	20
	Answered	**623**
	Skipped	**26**

Do you now, or have you ever considered yourself to be transgender?		
	Responses	
Yes	0%	1
No	96%	557
Rather not say	4%	21
	Answered	**579**
	Skipped	**70**

Religion or beliefs	Responses	
Atheism	11%	67
Agnosticism	3%	18
Buddhism	1%	3
Christianity	54%	323
Hinduism	0%	1
Humanism	1%	4
Islam	0%	1
Jainism	0%	0
Judaism	0%	2
Sikhism	0%	1
Any Other Religion/Belief	2%	13
No Religion or Belief	18%	110
Rather not say	9%	53
	Answered	**596**
	Skipped	**53**

Ethnicity	Responses	
Bangladeshi	0%	0
Indian	0%	3
Pakistani	0%	0
Any Other Asian Background	0%	0
African	0%	1
Caribbean	0%	0
Any Other Black Background	0%	0
White and Asian	1%	4
White and Black African	0%	0
White and Black Caribbean	0%	0
Any Other Mixed Background	1%	5
White British	89%	546
White Irish	0%	3
Any Other White Background	2%	11
Chinese	0%	0
Gypsies & Travellers	0%	1
Any Other Ethnic Group	0%	1
Rather not say	6%	39
	Answered	**614**
	Skipped	**35**

Sexual orientation	Responses	
Bisexual	2%	14
Gay Man	0%	0
Gay Woman	0%	1
Heterosexual	87%	501
Lesbian	0%	2
Other	1%	4
Rather not say	9%	53
	Answered	**575**
	Skipped	**74**

Pregnancy and maternity - are you an expectant mother?		
	Responses	
Yes	3%	18
No	94%	549
Rather not say	3%	15
	Answered	**582**
	Skipped	**67**

Pregnancy and maternity - have you utilised local maternity services in the last 18 months		
	Responses	
Yes	11%	64
No	86%	488
Rather not say	3%	17
	Answered	**569**
	Skipped	**80**

Carer- are you currently providing support and care to a partner, child, relative, friend or neighbour who cannot manage without your help or/ and support?		
	Responses	
Yes	34%	199
No	61%	357
Rather not say	5%	29
	Answered	**585**
	Skipped	**64**

You said, we did

All of the detailed feedback received has been circulated to the Senior Responsible Officers for the system programmes to inform the development of Lincolnshire's Long Term Plan and also to shape their programmes and projects.

This feedback has also informed the continued development of the emerging options for changes to hospital services which will go through NHS England assurance processes and public consultation before service changes are made.

Appendix 1: survey

Lincolnshire Acute Services Review Engagement 2019

During 2018 we engaged with our communities on hospital services to start developing options for how services need to change. We undertook a survey and number of public events to explore this.

All of the useful feedback we received has been shared with clinicians and senior leaders to consider these views and experiences when thinking about the options for how we might deliver these services in the future. Any options that suggest significant change to hospital services will go through NHS England assurance processes and public consultation before service changes are made.

This previous engagement has helped us to identify some **emerging options** which we would now like your views on before they are finalised for the formal public consultation. We would welcome feedback on these and in particular your thoughts on travel and transport and technology to support these possible changes in services.

Please visit our website for more information about these services, explanations of why we need to change and the benefits of these emerging options: https://www.lincolnshire.nhs.uk and get involved in a #HealthyConversation.

We would like your views on all of the questions, but if you don't want to answer some or feel they are not relevant, please just skip them and move onto the next question.

Please return this survey to:
Central STP Office
Room 2
Wyvern House
Kesteven Street
Lincoln
LN5 7LH

1. Please tell us the first 5 digits of your postcode

2. Are you:

☐ Member of the public
☐ Member of NHS staff
☐ GP
☐ Organisation or other, please tell us below:

3. If you have used any/all of the 3 main hospitals in Lincolnshire within the last 12 months what was the <u>main</u> way you travelled to each of these hospitals? (one tick per column)

	Lincoln County Hospital	Pilgrim Hospital, Boston	Grantham Hospital
Own car	☐	☐	☐
Friend / family	☐	☐	☐
Public transport	☐	☐	☐
Taxi	☐	☐	☐
Patient transport (non-emergency ambulance)	☐	☐	☐
Emergency (blue light) ambulance	☐	☐	☐
I have never visited this hospital	☐	☐	☐
Other, please specify below	☐	☐	☐

4. Over the last 12 months, approximately how often have you visited each of the 3 hospitals? (one tick per column)

	Lincoln County Hospital	Pilgrim Hospital, Boston	Grantham Hospital
Only once or twice	☐	☐	☐
Less than weekly	☐	☐	☐
Weekly	☐	☐	☐
Less than monthly	☐	☐	☐
Monthly	☐	☐	☐
More than monthly	☐	☐	☐
I have never visited this hospital	☐	☐	☐

We recognise that in an emergency you will go to your nearest, most appropriate hospital. Please consider the following questions for outpatient or planned appointments.

5. Which is the main hospital site you have travelled to? (please tick one box):

☐ Lincoln County Hospital ☐ None / don't know

☐ Pilgrim Hospital, Boston ☐ Grantham Hospital

6. Why is this the main hospital you travel to?

☐ I am given appointments for this hospital
☐ It is closest to where I live
☐ It is easy to get to using public transport
☐ My family / carer can take me
☐ There is enough parking at the hospital
☐ It is in an area where I work or shop
☐ Other reason (please specify)

7. For each hospital please tell us if there is ONE main thing that makes it difficult to access services at each hospital (one tick per column)

	Lincoln County Hospital	Pilgrim Hospital, Boston	Grantham Hospital
It is too far away from where I live	☐	☐	☐
It is difficult to get to using public transport	☐	☐	☐
There is not enough parking at the hospital	☐	☐	☐
I don't know where it is	☐	☐	☐
Other, please specify below	☐	☐	☐

Improvements in information technology is important for all of the service transformation in Lincolnshire for both staff and patients. In a rural county like Lincolnshire, some patients have to travel long distances for appointments - we need to look at how technology can help, such as self-monitoring technology and video/skype consultations so patients do not have to travel unnecessarily.

8. Virtual consultations could be phone or video call with a clinician rather than needing to travel for a face to face appointment.

Please tell us to what extent you would like to be offered a virtual consultation instead of having to travel to an appointment?

☐ I would definitely like to be offered a virtual consultation
☐ I might like to be offered a virtual consultation
☐ I don't think I would like to be offered a virtual consultation
☐ I definitely would not like to be offered a virtual consultation
☐ Don’t know

9. Please tell us the reasons for your answer to question 8

10. Some digital solutions can be used at home to monitor your own health (for example, self-monitoring or remote monitoring technology such as blood sugar monitor, blood pressure monitor, activity tracker).

To what extent would you use these if that meant you could avoid an unnecessary appointment or stay in your home for longer rather than having to go into hospital?

☐ I would definitely use technology to monitor my health at home
☐ I might use technology to monitor my health at home
☐ I don't think I would use technology to monitor my health at home
☐ I definitely would not use technology to monitor my health at home
☐ Don't know

11. Please tell us the reasons for your answer to question 10

12. If you were offered support and training to use digital technology to what extent would this encourage you to use it?

☐ I would definitely consider using it after support and training
☐ I might consider using it after support and training
☐ I don't think I would use it even after support and training
☐ I definitely wouldn't use it even after support and training
☐ Don't know

13. Family members or carers could have access to parts of your medical records with your permission. This would mean that they could check your upcoming appointments, see your prescribed medications or contact a medical provider on your behalf.

Please tell us if you would like to give permission for family members or carers to access your medical records

☐ I would definitely like to give family or carers permission to access my medical records
☐ I might like to give family or carers permission to access my medical records
☐ I don't think I would like to give family or carers permission to access my medical records
☐ I definitely would not like to give family or carers permission to access my medical records
☐ Don't know

14. Please tell us the reasons for your answer to question 13

15. If you have any concerns about using digital technology such as having video/skype consultations, using self-monitoring technology or apps please tell us below

16. If there is anything that would help you to use these technologies to take advantage of the benefits they bring, please tell us below

Breast services

Breast services refer to a range of screening, diagnosis and treatment of breast problems, including cancer. These services are currently delivered across Lincoln County, Pilgrim and Grantham hospitals with a small number of patients seen in Louth Hospital. There is also a mobile breast screening mammography service that travels across the county.

We think that a centre of excellence approach would work well in Lincolnshire as has already proven so in rural Cornwall – visit our website to see a case study. We think this will help us address the quality of care issues and shortage of specialist staff.

In practice, this emerging option would mean that all follow-up outpatient appointments and routine breast mammography screening services would continue to be available across the county as they are now. These appointments are where most patients receive their care. First outpatient appointments and all surgery would be provided at the centre of excellence. This would enable specialist staff to fully cover rotas, see more patients and retain and develop their skills. Together, this means patients will be seen more quickly and receive a better standard of care.

Our emerging options indicate that this centre of excellence could be at Lincoln Hospital or Grantham Hospital. **The NHS's current preferred emerging option is Lincoln Hospital for this centre of excellence** as it requires the least amount of capital funding. If located at Grantham, any complex breast surgery would be done at Lincoln.

17. Please tell us if you would have any problems accessing these breast services at Lincoln County Hospital and if you have any suggestions of how we could overcome this

18. Please tell us if you would have any problems accessing these breast services at Grantham Hospital and if you have any suggestions of how we could overcome this

19. Please tell us if you have any other comments or suggestions about our emerging options for breast services

Stroke services

Stroke services refer to a range of services for the diagnosis of stroke, acute treatment, rehabilitation and follow-up after discharge from hospital. Currently these services are delivered at Lincoln and Pilgrim Hospitals. Diagnostic services start in our emergency departments and then patients have treatment on the acute stroke units in these two hospitals. There is also a stroke rehabilitation service in the community that cares for people after they have been discharged from hospital.

Our first emerging option, similar to that for breast services, is to take a centre of excellence approach, providing acute stroke care from the Lincoln Hospital site. This is the NHS's current preferred emerging option because it will provide the best model to meet national care standards for patients, and to recruit and retain staff.

The second emerging option is to retain the current service at Lincoln and Pilgrim Hospitals but with an out of hours combined on-call rota being based at Lincoln.

In both emerging options, our intention would be to enhance rehabilitation in the community across Lincolnshire to reduce the length of stay in hospital from 14 days to 7 days in line with national best practice.

20. Please tell us if you would have any problems accessing these stroke services at Lincoln County Hospital and if you have any suggestions of how we could overcome this

21. Please tell us if you would have any problems accessing these stroke services at Pilgrim Hospital, Boston and if you have any suggestions of how we could overcome this

22. Please tell us if you have any other comments or suggestions about our emerging options for stroke services

Women's and children's services

Women's and children's services refer to a wide range of services across acute and community settings including obstetrics (maternity care), neonatal (care of premature or sick babies), paediatric (care of children) and gynaecology (care for women and girls, especially related to the reproductive system).

Currently all these hospital services are delivered in both Lincoln and Pilgrim Hospitals. We have a neonatology intensive care unit at Lincoln Hospital and a special care baby unit at Pilgrim Hospital. Babies born pre 29-weeks and children under five who require surgery are all treated out of county. Women in Lincolnshire have a choice of giving birth at home or in a consultant-led obstetrics unit at these two hospitals. Midwife services are available in the community and at home.

There are two emerging options.

The first emerging option is to have the following services at the two hospital sites;

At Pilgrim Hospital

- to continue with a consultant led obstetric service with the addition of a co-located midwife-led unit
- to continue with a specialist care baby unit caring for babies born from 32 weeks (the interim position is that it currently cares for babies born from 34 weeks. Prior to August 2018 it cared for babies from 30 weeks)
- to have a short stay paediatric assessment ward for children needing up to 23 hours of care
- to have low acuity paediatric in-patient beds overnight
- to have paediatric day case surgery.

At Lincoln Hospital

- to continue with a consultant led obstetric service with the addition of a co-located midwife-led unit
- to have a neonatal unit caring for babies born from 27 weeks
- to have a short stay paediatric assessment ward
- to have paediatric in-patient beds
- to have paediatric day case and planned surgery.

We would wish to keep the gynaecology services the same as now on both Lincoln and Pilgrim Hospital sites with our clinicians working as one team across these two sites. **This is currently the NHS's preferred emerging option.**

The second emerging option is to have consultant obstetric, neonatal and paediatric services at Lincoln Hospital and a midwife-led unit and short stay paediatric assessment ward at Pilgrim Hospital. Both hospitals will have midwifery-led units.

23. Please tell us if you would have any problems accessing Lincoln County Hospital for consultant led services or both consultant led and maternity services and if you have any suggestions of how we could overcome this

24. Please tell us if you would have any problems accessing Pilgrim Hospital, Boston for maternity-led services or both consultant-led and maternity services and if you have any suggestions of how we could overcome this

25. Please tell us if you have any other comments or suggestions about our emerging options for women's and children's services

Medical services at Grantham Hospital

The medical services at Grantham Hospital support urgent and acute patients in the A&E Department, on the in-patient wards and in the out-patients department. There is currently a range of medical conditions which Grantham Hospital does not provide
services for, meaning that the most acutely ill patients with life threatening illness and injuries go to a more specialist site, first time to receive treatment. Specialist doctors from Lincoln Hospital also remotely support Grantham Hospital staff and patients (using online technology) when required.

There are two emerging options.

The first emerging option is to maintain inpatient medical services at Grantham Hospital and adopt a new model whereby they are joined up with local primary and community services and managed as part of the local enhanced neighbourhood team. This new model would be led by Community Health Services (not ULHT) with hospital doctors and the hospital services
being part of an integrated service with GP services, community health and other local services. **This is the NHS's preferred emerging option.**

The second emerging option is to have no medical inpatient services at Grantham Hospital. Diagnostics and outpatients would continue.

26. Please tell us if you would have any problems accessing acute medical beds at Grantham Hospital and if you have any suggestions of how we could overcome this

27. Please tell us if you have any other comments or suggestions about our emerging options for acute medical beds at Grantham Hospital

Trauma and Orthopaedics

These services diagnose and treat a wide range of conditions of the musculoskeletal system. This includes bones and joints and their associated structures that enable movement - ligaments, tendons, muscles and nerves. Currently, both urgent and planned care is delivered in Lincoln, Pilgrim and Grantham Hospitals, with additional activity in our local community hospitals. These services are out-patients, minor procedures and operations.

National clinical best practice evidence is that separating urgent work from planned work prevents operations being cancelled. Planned care sites have better outcomes for patients, lower rates of readmission, reduced lengths of stay and reduced risk of infections and injuries.

We have been testing this way of working since August 2018 at Grantham Hospital and this pilot is due to conclude in April 2019. This pilot has virtually eliminated cancelled operations. The evaluation will help decide whether the best practice model of care works in Lincolnshire, including the extent to which non-complex trauma could continue at the Grantham Hospital site. Outpatient services will remain at all sites.

Our emerging option is to make Grantham Hospital a 'centre of excellence' for planned and day case orthopaedic surgery.

Lincoln and Pilgrim Hospitals would provide some day case surgery and planned care for those patients with complex needs. Outpatient services would remain at Lincoln, Pilgrim and Grantham Hospital as now.

28. Please tell us if you would have any problems accessing trauma and orthopaedic services at Grantham Hospital and if you have any suggestions of how we could overcome this

29. Please tell us if you have any other comments or suggestions about our emerging option for trauma and orthopaedic services at Grantham Hospital

General Surgery

These services focus mainly on the abdominal organs; stomach, gall bladder, small bowel, colon, rectum and anus. Benign skin conditions and hernias are also included within general surgery. This surgery is currently carried out at Lincoln, Pilgrim and Grantham Hospitals, with more complex cases seen at Lincoln and Pilgrim Hospitals only.

Our emerging option is to consolidate most elective care and make Grantham Hospital a 'centre of excellence' for elective short stay and day case General Surgery. Lincoln and Pilgrim Hospitals will provide some day case/elective care for patients needing complex surgery, those with complex needs. Outpatients will remain at all three hospitals.

30. Please tell us if you would have any problems accessing general surgery services at Grantham Hospital and if you have any suggestions of how we could overcome this

31. Please tell us if you have any other comments or suggestions about our emerging option for general surgery services at Grantham Hospital

Urgent and Emergency Care services

Emergency care is when you have a serious or life threatening accident or illness and you would usually have to be treated in a major hospital. Urgent care relates to less serious health problems requiring attention which can be treated by services such as NHS111, pharmacies, GP practices, GP Extended Access Hubs, and Urgent Treatment Centres. The vast majority of urgent care needs are met by our GPs and community health services.

Emergency care is provided in A&E departments and we currently have three A&E departments at Lincoln, Pilgrim and Grantham Hospitals. For the last five years, Grantham's A&E has had restrictions upon the conditions that can be treated at this site, for example, the ambulance service does not take patients with suspected stroke or certain types of heart attacks to Grantham. Since August 2016, Grantham's A&E has had restricted opening hours.

Our emerging option is to maintain A&E services at both Lincoln and Pilgrim Hospitals and to add an Urgent Treatment Centre at both sites. We would introduce a new Urgent Treatment Centre at Grantham Hospital to provide 24 hour, 7 day a week access to urgent care services locally. This means that the vast majority of local patients who need care quickly

will be supported in Grantham as they are now. To ensure the local population receive the right urgent and emergency care, overnight, access to this Urgent Treatment Centre will be supported by NHS111, to ensure patients are sent to the right place, first time.
NHS111 will serve as the entry point to the Urgent Treatment Centre during the overnight period.

Grantham's UTC would still be able to receive patients by ambulance. Refinements to the current access criteria will ensure that critically injured and ill patients will be cared for at their nearest A&E; treated safely and quickly by staff who have the right training and experience to give the best outcome.

This emerging option would also see the 24/7 Grantham Hospital Urgent Treatment Centre provided by Community Health Services rather than ULHT, with hospital clinicians providing specialist advice where this is required for patients. We would also like to develop Urgent Treatment Centre services at Louth, Skegness and Stamford Hospitals and explore options for Spalding and Gainsborough.

32. Please tell us if you would have any problems accessing urgent and emergency care services at Grantham Hospital and if you have any suggestions of how we could overcome this

33. Please tell us if you have any other comments or suggestions about our emerging option for urgent and emergency care services at Grantham Hospital

Haematology and Oncology services

Haematology services diagnose and treat blood disorders for conditions such as haemophilia and leukaemia and provide treatments including blood transfusion services. Oncology deals with the treatment of cancer. These services are delivered in outpatient clinics and in-patient beds. We currently provide these services across Lincoln, Pilgrim and Grantham Hospitals (haematology out-patients only at Grantham), with the majority of care delivered at Lincoln Hospital.

Our emerging option is to have all haematology and oncology inpatient services at Lincoln Hospital.

All other services stay the same. This means that haematology and oncology outpatients and day cases will continue to be provided from all three hospital sites, creating no additional travel for these most frequent appointments. Chemotherapy and radiotherapy will be provided at Lincoln Hospital as now. Chemotherapy day cases will continue to be provided locally at Pilgrim and Grantham Hospitals.

34. Please tell us if you would have any problems accessing inpatient haematology and oncology services at Lincoln Hospital and if you have any suggestions of how we could overcome this

35. Please tell us if you have any other comments or suggestions about our emerging option for haematology and oncology services at Lincoln Hospital

Equalities Monitoring

Under the provisions of the Equality Act 2010, all NHS organisations are required to demonstrate that their processes are fair, and that they are not discriminating or disadvantaging anyone because of their age, disability, gender reassignment status, marriage or civil partnership status, pregnancy or maternity, race, religion or belief, sex or sexual orientation. Please help us to monitor how well we engage with the population we serve, by completing the monitoring section below.

Your answers will be kept strictly confidential in line with the Data Protection Act 1998 and you will not be personally identifiable through your answers.

Age

○ Under 18 ○ 18 - 25 ○ 26 – 30 ○ 31 – 35 ○ 36 - 40 ○ 41 – 45 ○ 46 – 50
○ 51 – 55 ○ 56 – 60 ○ 61 – 65 ○ 66 - 70 ○ 71 and above
○ Prefer not to say

Do you consider yourself to have a disability or long term health condition?

○ Yes ○ No

If yes, please tell us below:

○ Physical impairment ○ Sensory impairment
○ Mental health condition ○ Learning disability / difficulty
○ Long standing illness ○ Prefer not to say
○ Other (please specify)

How do you describe your ethnic origin?

○ White British ○ White Irish ○ White European
○ White other ○ Black British ○ Black Caribbean
○ Black African ○ Black other ○ Asian British
○ Asian Indian ○ Asian Pakistani ○ Asian Bangladeshi
○ Asian Chinese ○ Asian other ○ Mixed background
○ Prefer not to say
○ Other (please specify)

Gender

○ Male ○ Female ○ Prefer not to say

Do you now, or have you ever considered yourself to be transgender?

○ Yes ○ No ○ Prefer not to say

What is your religion or belief?

○ Atheism ○ Agnosticism ○ Buddhism ○ Christianity ○ Hinduism ○ Humanism ○ Islam ○ Jainism
○ Judaism ○ Sikhism ○ No Religion or Belief
○ Rather not say ○ Other (please specify

Please indicate the option which best describes your sexual orientation

○ Lesbian ○ Gay ○ Bisexual ○ Heterosexual ○ Prefer not to say

Pregnancy and maternity - are you an expectant mother?

○ Yes ○ No ○ Prefer not to say

Pregnancy and maternity - have you utilised local maternity services in the last 18 months?

○ Yes ○ No ○ Prefer not to say

Carer- are you currently providing support and care to a partner, child, relative, friend or neighbour who cannot manage without your help or/ and support?

○ Yes ○ No ○ Prefer not to say

Thank you for completing this survey, your views are important to us.

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Acute Services Review

Engagement with Hidden and Hard to Reach Communities

Report on Findings

(Final - Version 006)

Client: Lincolnshire Sustainability and Transformation Partnership

Delivered by: The People's Partnership

May 2019

1.0 Executive Summary

Lincolnshire Sustainability and Transformation Partnership (STP) commissioned the People's Partnership to engage with hidden and hard to each communities as part of the Acute Services Review engagement between 5 and 25 March 2019.

The People's Partnership were asked to focus on the following support:

- To obtain general feedback that comes out of the discussion;
- To understand the impact of the proposed changes and how these specifically affect the groups we are engaging; and
- Identify suggested mitigations for the adverse impacts on the groups.

In the 15 working days of the engagement 130 questionnaires were completed. These submissions identified 258 difference protected characteristics, groups and communities focus around sensory impairment, physical disability, learning disability, mental health, carers, young people and families, older people, race, pregnancy and maternity and social economic deprivation.

The impact on the protected characteristics, groups and communities focused around the longer distance needed to travel to the proposed centres of excellence and the associated increases in cost. A number of families and individuals highlighted restricted income and savings would be a barrier to travelling further. In addition, 21 of the submissions highlighted they could not drive and either relied on family members for transport or would need to use public transport or taxis with the associated practicalities and cost implications. In some cases, it was stated that no public transport was available. Being physically disabled or with mobility issues made access more difficult, especially if public transport was used. The proposals also had a knock on impact on family members as they either needed to drive individuals to hospital or family members had to travel further to see their loved ones in hospital. The impact on health, mainly due to the longer journey time coupled with their health conditions. Anxiety of the longer travel times impacted by a mental health condition, unfamiliar hospital settings or their long term health condition impacted some individuals.

Mitigations were proposed to reduce the impact on these groups. It is proposed that the public transport infrastructure and network are looked at together with hospital transport and any voluntary services to understand the gaps and identify any additional support and practical steps to support vulnerable groups and communities impacted by proposed changes. In particular, work is required to understand what support could be provided to the socially and economically deprived to enable greater access to services which move further away from where they live. Work is needed to look at the provision for people who do not speak English or have limited English vocabulary to enable people to access services more effectively. Look at ways health services, Lincolnshire County Council Highways and Social Services, voluntary sector services can work together to support vulnerable individuals and families access health services. Finally, develop a co-production group of patients and their families from the protected characteristics and invest time in discussing the options and working with them to look at alternative solutions that support their communities.

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:	**16 September 2020**
Subject:	**Lincolnshire Clinical Commissioning Group**

Summary

On 17 June 2020 consideration of a report on the Lincolnshire Clinical Commissioning Group (CCG), which had been formally established on 1 April 2020, was deferred. This report was not considered on 22 July, as this date coincided with a board meeting for the new CCG.

The intention of this item is to provide background on the establishment of 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:	**16 September 2020**
Subject:	**Consultation on NHS Rehabilitation Centre, Stanford Hall Estate Near Loughborough**

Summary

On 19 February 2020, the Committee agreed to engage in the consultation on the proposed NHS Rehabilitation Centre on the Stanford Hall estate, near Loughborough. The consultation was launched on 27 July 2020 and concludes on 18 September 2020. This item invites the Committee to consider its response.

Actions Required

That arrangements for a response to the consultation by Nottingham and Nottinghamshire Clinical Commissioning Group on the NHS Rehabilitation Centre on the Stanford Hall Estate, near Loughborough, be approved

1. Background

Previous Committee Consideration

On 19 February 2020, the Committee considered a report on proposals for the NHS Rehabilitation Centre on the Stanford Hall Estate, near Loughborough. The Committee agreed to engage in the consultation, which at that time was expected in April 2020. (The Committee's relevant minute from 19 February is attached as Appendix A.)

Launch of Consultation

On 27 July 2020, NHS Nottingham and Nottinghamshire Clinical Commissioning Group, which is the leading on the consultation, launched an eight week public consultation on the proposed £70 million rehabilitation centre. The consultation period continues until 18 September 2020. Details of the consultation materials and events (see below) were sent to members of the Committee.

Consultation Materials

Below is a link to the CCG web page which contains all of the information and materials for this consultation, including the full consultation document:

https://nottsccg.nhs.uk/rehab-centre-consultation/

Consultation Events

Three online events have taken place on 4, 10 and 19 August, with two focus groups on 24 August and 1 September.

Responding to the Consultation

If members of the Committee are able to attend the consultation events, they can pass on their views to Simon Evans. Following this, a draft consultation response may be prepared for consideration at the Committee's meeting on 16 September 2020.

2. Conclusion

The Committee is invited to make arrangements responding to the consultation by Nottingham and Nottinghamshire Clinical Commissioning Group on the proposed NHS Rehabilitation Centre on the Stanford Hall Estate, near Loughborough

3. Appendices

The following documents are appended to this report.

Appendix A	Minute 61 (NHS Rehabilitation Centre Stanford Hall) of Health Scrutiny Committee for Lincolnshire – 19 February 2020
Appendix B	Extracts from Pre-Consultation Business Case - NHS Rehabilitation Centre Stanford Hall Part of the Vision for a National Rehabilitation Centre July 2020
Appendix C	Draft Response of the Health Scrutiny Committee for Lincolnshire to the Consultation on the NHS Rehabilitation Centre at the Stanford Hall Estate.

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 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

EXTRACT FROM MINUTES OF HEALTH SCRUTINY COMMITTEE

19 FEBRUARY 2020

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.

APPENDIX B

Extracts from Pre-Consultation Business Case

NHS Rehabilitation Centre Stanford Hall
Part of the Vision for a National Rehabilitation Centre
July 2020

Executive Summary

The clinical commissioning groups (CCGs) in Nottingham and Nottinghamshire, along with Nottingham University Hospitals NHS Trust (NUH) have prepared the Pre-Consultation Business Case (PCBC) on the proposed development for the NHS Rehabilitation Centre Stanford Hall. This is part of a wider vision for the defence and NHS to be on the same site and to have a National Rehabilitation Centre (NRC) that will include an NHS clinical service, an education centre and research and innovation hub on the Stanford Hall Rehabilitation Estate, near Loughborough.

The Defence Medical Rehabilitation Centre (DMRC) at Stanford Hall opened in 2018. The Stanford Hall Rehabilitation Estate (SHRE), as the estate is now known, was conceived from the outset as an opportunity where serving defence personnel and NHS patients could all benefit from a bespoke state-of-the-art environment for rehabilitation where facilities and expertise could be shared.

The PCBC therefore presents the case for a new 64-bed clinical facility which will support 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 has been received for the proposed NRC and the Government has provided an allocation of £70m capital funding specifically for an NHS Rehabilitation Centre on the Stanford Hall Estate.

It is proposed that the NHS Rehabilitation Centre would provide the opportunity for an increased number and a wider cohort of patients to access rehabilitation. The proposal for the NHS Rehabilitation Centre will result in a net increase of 40 rehabilitation beds across the East Midlands Trauma Network and the facilities will allow for a clinical model providing services to patients with fractures following trauma and other conditions, where currently rehabilitation is provided predominantly for neurological patients.

Provision is to be managed within existing budgets and it is expected that this can be achieved by transferring services and beds from NUH and through the cashable benefits of rehabilitation.

Following an options appraisal, the shortlisted options considered include the following:

- Do nothing and maintain business as usual
- Implementation of a new centre with a clinical facility only and the introduction of a new clinical model serving a wider cohort of patients. This option includes transferring existing services from NUH

- Do maximum option of the implementation of a NRC with a clinical facility, education and training centre and research and innovation hub. Due to the allocation of capital funding and the identification of a NHS Rehabilitation Centre as the preferred way forward, the PCBC considers this option along with the transfer of relevant services from NUH. The value for money economic assessment of this as a shortlisted option offers positive benefit to cost ratios compared to business as usual.

Context and Case for Change

There is a substantial body of trial-based evidence and other research to support both the effectiveness and cost effectiveness of specialist rehabilitation for neurological conditions and injuries. Despite their longer length of stay, the cost of providing early specialist rehabilitation for patients with complex needs is rapidly offset by longer term savings in the cost of community care, making this a highly cost-efficient intervention. Applying a recent study to the opportunity for additional neurological capacity, cost efficiency is demonstrated through net lifetime savings for informal and formal care costs of the unmet need for neuro patients equating to £39,269,237. The evidence is not as available for the cost-efficiency for patients receiving specialist in-patient rehabilitation for a fracture however it is recognised that a multi-disciplinary approach to rehabilitation after major trauma can optimise care, minimise mortality and provide a framework for an accelerated post-injury programme.

There is currently no national strategy for rehabilitation and this has resulted in disjointed services across each region which creates delays in the pathway rather than a smooth transition in a timely manner between acute care and rehabilitation. This is particularly relevant where there is a Major Trauma Centre as with NUH, impacting on accessibility in the East Midlands. A series of reports have identified that the UK and in particular the East Midlands are underprovided for in rehabilitation. In the East Midlands rehabilitation bed provision is at 31% of the level recommended by the British Society of Rehabilitation Medicine (BSRM) indicating a shortfall of 174 beds across the region. Owing to the under provision, patients endure long waits for access to rehabilitation and often need to be repatriated to their local district hospitals or trauma units from a Major Trauma Centre, to wait for a specialist rehabilitation bed to become available.

Specialist rehabilitation services are commissioned and provided across two different levels based on complexity of need. Level 1 and 2a services are the most complex and are provided across a wider area than level 2b services. Within current services across the East Midlands Trauma Network, specialist rehabilitation is 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. Patients are referred to services based on complexity of need however, access may be impacted by location and waiting times.

It is expected that the proposal will deliver a step change in the provision of rehabilitation services for the East Midlands Trauma Network by addressing the following:

- Creating a high-quality centre of rehabilitation excellence
- Contributing to a deficit in rehabilitation capacity
- Improving access to services
- Improving outcomes and the patient experience through a new clinical model

- Ability to respond to changes in future service needs and models
- Reducing pressures on the acute bed base
- Reducing system financial pressures and providing a saving to the health and social care system and wider economy by:
  - Reducing waits in acute beds
  - Reducing the overall length of inpatient stay
  - Delivering better outcomes, reducing the need for ongoing health and social care costs
  - Returning more people back to work, contributing significantly to the economy through taxes and increased spend of individuals
  - Reducing the burden on family members to be main carers.
- Returning people to work and active lives
- Improving recruitment, retention, education, training and skills for clinical staff with a specialty in rehabilitation.

Clinical and Staffing Model

The central aim of the NHS Rehabilitation Centre will be to return patients to life and work thereby reducing the long-term dependency on health care, financial and other support. Nationally, there is the opportunity for the NHS Rehabilitation Centre to provide the clinical model to be used across other major trauma networks.
The enhanced offer delivered through the clinical and staffing model can be summarised as follows:

- Timely access managed by a responsive referral system
- Active management of the patient journey through the whole pathway with the introduction of clinical case managers
- Three weekly assessments of mental health status for all patients
- Input from a wider range of professionals with a focus on vocation where appropriate
- Access to the wider facilities and an environment fully conducive to rehabilitation created by the estate
- New building designed to facilitate independence and therefore encouraging patients to do as much as they can for themselves.

Locally and regionally the rehabilitation centre will be the hub of a hub and spoke rehabilitation network, where services work together to provide a seamless transition for the patient. The NHS Rehabilitation Centre's programme will enable patients to benefit from a more intensive treatment regime delivered six days per week by a multi-disciplinary team of specialists. During the times that they are not involved in their programme, the facilities and grounds within the Estate will also contribute to patients' efforts to rehabilitate.

Clinicians in the NHS Rehabilitation Centre will be fully focused on rehabilitation and they will benefit from the knowledge sharing with other, equally focused, clinicians from both the NHS Rehabilitation Centre and the DMRC. The staff skill mix will provide a greater focus on rehabilitation assistants and exercise instructors, or similar roles to support patients with fitness sessions based on their own motivation and capabilities. This will also enable the approach to rehabilitation to be reinforced throughout the day and accelerate recovery. Also, new roles will be introduced as well as new ways of working, including the

opportunity for staff to have rotations that include community services, acute trusts and the rehabilitation centre.

Early planning for discharge and return to life and work will be offered through the support of clinical case managers, enabling the transition from inpatient rehabilitation to home and community-based services, if required, to be timely and smooth.

Finance Case

The finance case describes the impact of the option for a 64-bed NHS Rehabilitation Centre at a cost of approximately £13m per annum. It has been prepared on the basis of the proposed activity model and a cost neutral position. The finance case has been developed to understand the likely impact from the provision of a net increase of 40 specialist rehabilitation beds across the East Midlands and associated transfers of agreed activity and beds from the system.

The finance case takes into account the currently known capital and revenue consequences from the increase in specialist rehabilitation provision and accompanying decrease in acute beds. Specifically the finance case proposes the transfer of 21 beds from the current 2b rehabilitation facility at NUH, Linden Lodge, the release of the equivalent of 33 beds at NUH and meeting the current demand for NHS funded specialist neuro rehab currently provided outside of NHS facilities.

The capital case provides for an NHS Rehabilitation Centre within a £70m capital budget. The design of the new building allows for extensive rehabilitation facilities providing a combination of single and multi-bed rooms, a rehabilitation flat, rooms for families to stay, two gyms plus therapy rooms.

Pre-Consultation Business Case Objectives and Next Steps

This PCBC has been prepared to make a compelling case for an NHS centre which will transform rehabilitation provision across the East Midlands Trauma Network, acting as an example of national best practice for the whole country.

The new centre involves transferring services and providing rehabilitation in a new way for patients in the region of the East Midlands Trauma Network, making the most of the unique opportunity presented to the region by the development of the DMRC site at Stanford Hall. This is part of a wider vision for an NRC that includes a research and innovation hub and education and training centre.

NUH runs the programme team that will take the proposal through to full implementation. The PCBC is based on planning undertaken by the CCGs, in conjunction with the programme team established by NUH, and has used the relevant national guidance for rehabilitation services and outcomes from across Europe as its benchmark. In drafting the PCBC, provider and commissioner system partners in the East Midlands, along with clinicians and patients, have had the opportunity to input to development of the options. The programme governance arrangements include a monthly programme board which key commissioning, Department of Health and Social Care and clinical stakeholders attend.

The PCBC seeks to demonstrate that we have embarked on developing a transparent planning process with NHS England (NHSE), other CCGs, providers, patients and carers, the public, staff and stakeholders. It demonstrates, as a minimum, compliance against the four key tests set by the Secretary of State for Health and Social Care:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Clinical commissioner support.

a. Current provision of specialist rehabilitation services

Specialist rehabilitation services are commissioned and provided across England at three different levels dependent on complexity of need. The most complex is level 1, complex specialised rehabilitation services, the next level down is level 2 specialist rehabilitation services and then level 3, non-specialist rehabilitation services. The levels are further defined into categories a, b, c and d based on rehabilitation needs of patients. Further information is provided in the Context section. For the purposes of this Introduction, this PCBC considers changes to Level 2b rehabilitation services only.

Specialist rehabilitation in England is currently predominantly focused on those patients with neurological needs or injuries, unlike European countries whose in-patient rehabilitation focuses on a wide range of patients requiring rehabilitation. Also, the rehabilitation units in England have not been co-ordinated to follow a regional pathway; unlike many of the acute regional services they serve, for example, major trauma and neurosciences.

It is important to note that the PCBC is considering rehabilitation services within the East Midlands Trauma Network which includes Derbyshire, Leicestershire, Lincolnshire and Nottinghamshire. As NUH is a Major Trauma Centre, it is important that any consideration of rehabilitation needs adequately provides for this cohort of patients. Also, within the context of the wider services across the different levels, it is expected that with increased beds and access, all rehabilitation services will be positively impacted by the provision of a more effective clinical pathway.

Rehabilitation services are commissioned by either NHSE or CCGs. NHSE commission specialised services on a regional basis and CCGs commission local services. NHSE also commission major trauma services. Table 2.1 provides an overview of the rehabilitation services capacity currently provided within the East Midlands Trauma Network.

Provision	Nottinghamshire	Leicestershire and Rutland	Derbyshire	Lincolnshire
Level 1 Brain Injury Unit (regional service commissioned by NHS England)				
Location	Provided in Leicester	Leicester General Hospital	Provided in Leicester	Provided in Leicester
Bed Provision		9 beds		
Level 2a Neuro Rehabilitation (regional service commissioned by NHS England)				
Location	Provided in Leicester or Lincoln	Specialised Rehabilitation Unit, Leicester General Hospital	Provided in Leicester or Lincoln	Ashby Ward, Lincoln County Hospital
Bed Provision		16 beds		12 beds
Level 2b Neuro Rehabilitation (local services commissioned by CCGs)				
Location	Linden Lodge, City Hospital Nottingham	No commissioned service	Kings Lodge London Road Community Hospital	No commissioned service
Bed Provision	24 beds		18 beds	

The overall provision of rehabilitation beds is currently 79 for the East Midlands Trauma Network including levels 1, 2a and 2b. The British Society of Rehabilitation Medicine (BSRM) recommends rehabilitation provision of between 45 and 65 beds per million people, or 60 per million excluding stroke services. With a population of 4.6 million people and taking a mid-point of 55 beds per million, this would indicate an overall requirement for 253 beds, indicating a shortfall of 174 rehabilitation beds across the region. Put another way, only 31% of the recommended level of provision is currently being provided in the region with the busiest Major Trauma Network in England.

Categories for Rehabilitation Needs

The table below explains the four types of rehabilitation needs for patients as categorised by the British Society of Rehabilitative Medicine.

Definitions of Patient Rehabilitation Needs
Category A
• Patient goals for rehabilitation may include: O Improved physical, cognitive, social and psychological function/independence in activities in and around the home O Participation in societal roles (such as work, parenting and relationships) O Disability management, for example, to maintain existing function, manage unwanted behaviours, facilitate adjustment to change O Improved quality of life and living including symptom management, complex care planning, support for family and carers, including neuro-palliative rehabilitation • Patients have complex or profound disabilities, for example, severe physical, cognitive communicative disabilities or challenging behaviours • Patients have highly complex rehabilitation needs and require specialised facilities and a higher level of input from more skilled staff than provided in the local specialist rehabilitation unit. In particular rehabilitation will usually include one or more of the following: ○ Intensive, co-ordinated interdisciplinary intervention from four or more therapy* disciplines, in addition to specialist rehabilitation medicine/nursing care in a rehabilitative environment ○ Medium to long term rehabilitation programme required to achieve rehabilitation goals – typically two to four months, but up to six months or more, providing this can be justified by measurable outcomes ○ Very high intensity staffing ratios, for example, 24-hour one-to-one nurse “specialling”, or individual patient therapy sessions involving two to three trained therapists at any one time ○ Highest level facilities/equipment, for example, bespoke assistive technology/seating systems, orthotics, environmental control systems/computers or communication aids, ventilators ○ Complex vocational rehabilitation including inter-disciplinary assessment/multi-agency intervention to support return to work, vocational retraining, or withdrawal from work/financial planning as appropriate • Patients may also require: ○ Highly specialist clinical input, for example, for tracheostomy weaning, cognitive and/or behavioural management, low awareness states, or dealing with families in extreme distress ○ Ongoing investigation/treatment of complex/unstable medical problems in the context of an acute hospital setting ○ Neuro-psychiatric care including risk management, treatment under sections of the Mental Health Act ○ Support for medico-legal matters including mental capacity and consent issues ○ Patients are treated in a specialised rehabilitation unit such as a level 1 unit • Patients may on occasion be treated in a level 2 unit depending on the availability of expert staff and specialist facilities as well as appropriate staffing ratios.

Category B

Patient goals for rehabilitation may be as for category A patients

- Patients have moderate to severe physical, cognitive and/or communicative disabilities which may include mild to moderate behavioural problems
- Patients require rehabilitation from expert staff in a dedicated rehabilitation unit with appropriate specialist facilities
- In particular, rehabilitation will usually include one or more of the following:
  - Intensive co-ordinated interdisciplinary intervention from two to four therapy disciplines in addition to specialist rehabilitation medicine/nursing care in a rehabilitative environment
  - Medium length rehabilitation programme required to achieve rehabilitation goals – typically one to three months, but up to a maximum of six months, providing this can be justified by measurable outcomes
  - Special facilities/equipment, for example, specialist mobility/training aids, orthotics, assistive technology or interventions such as spasticity management with botulinum toxin or intrathecal baclofen
  - Interventions to support goals such as return to work, or resumption of other extended activities of daily living, for example, home-making and managing personal finance
- Patients may also have medical problems requiring ongoing investigation/treatment
- Patients are treated in a local specialist rehabilitation unit - a level 2 unit.

Category C

- Patient goals are typically focused in restoration of function/independence and co-ordinated discharge planning with a view to continuing rehabilitation in the community
- Patients require rehabilitation in the context of their specialist treatment as part of a specific diagnostic group
- Patients may be medically unstable or require specialist medical investigation/procedures for the specific condition
- Patients usually require less intensive rehabilitation intervention from one to three therapy disciplines in relatively short rehabilitation programmes (up to six weeks)
- Patients are treated by a local specialist team (a level 3a service) which may be led by consultants in specialties other than rehabilitative medicine (for example, neurology) and staffed by therapy and nursing teams with specialist expertise in the target condition.

Category D

- Patient goals are typically focused in restoration of function/independence and co-ordinated discharge planning with a view to continuing rehabilitation in the community if necessary
- Patients have a wide range of conditions but are usually medically stable
- Patients require less intensive rehabilitation intervention from one to three therapy disciplines in relatively short rehabilitation programmes (typically six to 12 weeks)
- Patients receive an inpatient, local non-specialist rehabilitation service (level 3b) which is led by non-medical staff.

Rehabilitation Service Levels

Level 1 – Specialised Rehabilitation Services

- Tertiary specialised rehabilitation services - provided at regional/national level
- Provided by specialised rehab teams led by consultants trained and accredited in the specialty of

- rehabilitation medicine and/or neuropsychiatry
- Serve a regional or supra-regional population (catchment of 1-3 million) and taking patients with category A needs – for example, severe physical, cognitive communicative disabilities or challenging behaviours, with highly complex rehabilitation needs* that are beyond the scope of their local specialist rehabilitation services, and have higher level facilities and skilled staff to support these
- Predominantly highly complex caseload:
    - At least 85% patients have category A needs on admission
    - At least 70% patients with Rehabilitation Complexity Scale – Trauma (RCS-E) score ≥11 cross-sectionally
- Collect and report full National Specialist Rehabilitation Dataset.

Level 2 – Local Specialist Rehabilitation Services – Provided at District Level

- Local (district) specialist rehabilitation services.
- Provided by inter-disciplinary teams led/supported by a consultant in rehabilitation medicine, and meeting the BSRM standards for specialist rehabilitation services.

Level 2a – Supra District Services

- Led by consultant in rehabilitation medicine. Serving an extended local population (catchment 600,000-1 million) in areas which have poor access to level 1 services
- Take patients with a range of complexity, including category B and some category A with highly complex rehabilitation needs*
- Mixed caseload
    - 50-80% category A needs on admission
    - 50-70% Rehabilitation Complexity Scale – Trauma (RCS-E) score ≥11 cross-sectionally
- Collect and report full National Specialist Rehabilitation Dataset.

Level 2b – Local District Services

- Led/supported by a consultant in rehabilitation medicine. Serving a local population (catchment: 250,000-500,000), predominantly patients with category B needs
- Less complex caseload:
    - For example, 30-50% category A needs on admission
    - 30-50% RCS-E Rehabilitation Complexity Scale – Trauma (RCS-E) score ≥11 cross-sectionally
- Collect and report at least the minimum national dataset.

Level 3 - Local non-specialist services - includes generic rehabilitation for a wide range of conditions, provided in the context acute, intermediate care and community facilities, or other specialist services
Level 3a • Other specialist services led or supported by consultants in specialties other than rehabilitation medicine, such as services catering for patients in specific diagnostic groups (for example, stroke) with category C needs • Therapy/nursing teams have specialist expertise in the target condition.
Level 3b • Generic rehabilitation for a wide range of conditions, often led by non-medical staff, provided in the context acute, intermediate care and community facilities, for patients with category D needs.

APPENDIX C

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

RESPONSE OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE TO NATIONAL REHABILITATION CENTRE CONSULTATION (July – September 2020)

1. To help us understand your response better, please can you tell us if you are answering this questionnaire on behalf of…

☐ A current or former patient of rehabilitation services

☐ A member of the public

☐ A carer/friend/family member of an individual who is accessing/has accessed rehabilitation service

☐ An organisation (please specify in the box below)

Health Scrutiny Committee for Lincolnshire

2. To what extent do you support or oppose the proposal to create a NHS Rehabilitation Centre at the Stanford Hall Estate near Loughborough?

☐ Strongly support

☐ Slightly support

☐ Neither support or oppose

☐ Slightly oppose

☐ Strongly oppose

3. The NHS Rehabilitation Centre would provide 63 rehabilitation beds – an increase of 39 beds across the East Midlands. As a result, we propose to transfer the service currently provided at Linden Lodge at Nottingham City Hospital to the Regional Rehabilitation Centre.

   To what extent do you support or oppose the transfer of the service at Linden Lodge at Nottingham City Hospital to the NHS Rehabilitation Centre?

   ☐ Strongly support

   ☐ Slightly support

   ☐ Neither support or oppose

   ☐ Slightly oppose

   ☐ Strongly oppose

4. If you have any comments about the transfer of Linden Lodge, please provide them in the comment box below.

5. The NHS Rehabilitation Centre would be located at the Stanford Hall Rehabilitation Estate near Loughborough. The 360-acre countryside estate hosts the Defence and National Rehabilitation Centre, which provides rehabilitation facilities for military personnel.

   The Defence Medical National Rehabilitation Centre would continue to operate independently and prioritise military rehabilitation, while a regional rehabilitation centre would provide treatment for NHS patients only. NHS patients would be able to benefit from the state-of-the-art facilities that the DNRC has (for example the hydrotherapy pool, the gait analysis system and the Computer Aided Rehabilitation Environment).

   The location would provide peaceful, tranquil surroundings for NHS patients to focus on their rehabilitation.

Do you think treating NHS patients on the same site as military personnel will be suitable?

- ☐ Yes, definitely
- ☐ Yes, to some extent
- ☐ Not sure
- ☐ No

If no, please explain why in the comment box below.

6. If you wanted to visit patients at the NHS Rehabilitation Centre, how easy would this be for you?

A regional rehabilitation service as part of the NHS Rehabilitation Centre development would be situated on the Stanford Hall Rehabilitation Estate at Stanford Hall near Loughborough.

- ☐ Very easy
- ☐ Easy
- ☐ Neither easy nor difficult
- ☐ Difficult
- ☐ Very difficult

If you feel this would be difficult, please provide a brief explanation in the comment box below.

7. To reduce the travel impact for relatives, friends and carers, it is proposed that the NHS Rehabilitation Centre would provide free family accommodation with three family rooms available, free parking as well as super-fast broadband to enable patients to keep in touch with their families via communication channels such as FaceTime and Skype. Discussions are also taking place around enhancing local public transport.

Do you feel that the factors listed above (i.e. family rooms, free parking & super-fast broadband) would help reduce the impact of increased travel time that some might face?

- ☐ Yes, definitely
- ☐ Yes, to some extent
- ☐ Not sure
- ☐ No

If no, do you have any further suggestions in how we could support family, friends and carers who may be visiting someone at the Regional Rehabilitation Centre?

8. What do you think the benefits are of being located on the Stanford Hall Rehabilitation Estate?

9. What do you think the issues are of being located on the Stanford Hall Rehabilitation Estate?

10. The NHS Rehabilitation Centre will take a fresh and innovative approach to rehabilitation, putting the patient at the centre of care.

    It would be staffed by a multi-disciplinary team consisting of rehabilitation consultants, orthopaedic consultants, other speciality consultants (e.g. for cancer treatment), therapy assistants, physiotherapists, mental health nurses, occupational therapists, speech and language therapists, social workers and other professionals as needed.

    There would be a focus on occupational and vocational rehabilitation to help people get back to work.

    Each patient would be assigned a dedicated person (a clinical case manager) to co-ordinate their care throughout – from referral through to discharge.

There would be an increase in the number of hours of therapy per patient per week (both one-to-one and group sessions), with patients being able to spend their additional time on the rehabilitation estate supported by occupational and vocational therapists.

Patients would have access to facilities such as a gym, hydrotherapy pool and a system to help patients practice their mobility and balance on a range of different surfaces.

What are your thoughts about the care that patients would receive at the NHS Rehabilitation Centre?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

11. What are your thoughts about the range of health and social care professionals that patients would have access to at the NHS Rehabilitation Centre?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

12. We recognise that it is important that a patient's mental wellbeing is equally considered alongside their physical rehabilitation. It is therefore essential that proposals for the NHS Rehabilitation Centre take mental health, particularly helping patients to avoid feelings of isolation and boredom, into consideration. This will be done in relation to:

- The way in which clinical and other staff will help patients create an environment of support, helping to minimise any feelings of social isolation.
- Making assessment of patient's mental health part of ongoing assessments at least three times a week.

- Support provided by a mental health nurse.

- The design of the social facilities and use of the grounds. Evidence suggests that ‘green spaces’ are linked to improvements in patient wellbeing, mental health, levels of stress and positive behaviours.

Based on the information above, what are your thoughts on the approach to managing the mental wellbeing of patients during their time at the NHS Rehabilitation Centre?

☐ I feel confident that patients' mental health has been taken into account.

☐ I feel that patients' mental health has been taken into account, but more needs to be done.

☐ I feel that more needs to be done to manage patients' mental health.

If you feel more needs to be done to manage patients' mental health, please provide your suggestions in the box below.

13. Do you have any other comments that you would like to make with regard to the development of the NHS Rehabilitation Centre?

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:	**16 September 2020**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme**

Summary

This report sets out the Committee's work programme, with items listed for forthcoming meetings.

The report also includes a schedule of the items previously considered by the Committee since 2017.

Actions Required

To consider and comment on the Committee's work programme.

1. Background

At each meeting, the Committee is given an opportunity to review its forthcoming work programme. Typically, at each meeting three to four substantive items are considered, although fewer items may be considered if they are substantial in content.

2. Today's Work Programme

The items listed for today's meeting are set out below: -

16 September 2020 – 10 am	
Item	*Contributor*
United Lincolnshire Hospitals NHS Trust – Restoration Plan Update	Mark Brassington, Deputy Chief Executive, United Lincolnshire Hospitals NHS Trust Simon Evans, Chief Operating Officer United Lincolnshire Hospitals NHS Trust
Final Report on *Healthy Conversation*	John Turner, Chief Executive, Lincolnshire Clinical Commissioning Group Pete Burnett, Interim Sustainability and Transformation Partnership Programme Director
Lincolnshire Clinical Commissioning Group introduction	John Turner, Chief Executive, Lincolnshire Clinical Commissioning Group
National Rehabilitation Centre Consultation	Simon Evans, Health Scrutiny Officer

3. Future Work Programme

Planned items for the Health Scrutiny Committee for Lincolnshire are set out below:

14 October 2020 – 10 am	
Item	*Contributor*
Community Pain Management Service	Sarah-Jane Mills, Chief Operating Officer, Lincolnshire Clinical Commissioning Group
Non-Emergency Patient Transport Service	Sarah-Jane Mills, Chief Operating Officer, Lincolnshire Clinical Commissioning Group

11 November *2020 – 10 am*	
Item	*Contributor*
Integrated Urgent Care in Lincolnshire	Maz Fosh, Chief Executive, Lincolnshire Community Health Services NHS Trust Tracy Pilcher, Director of Nursing and Deputy Chief Executive, Lincolnshire Community Health Services NHS Trust
East Midlands Ambulance Service	Sue Cousland, Lincolnshire Divisional Manager, East Midlands Ambulance Service
Lincolnshire Acute Services Review – Consultation Plan *(Provisional Item)*	*To be confirmed.*

16 December *2020 – 10 am*	
Item	*Contributor*
Child and Adolescent Mental Health Services – Community Intensive Home Treatment Service	Jane Marshall, Director of Strategy, Lincolnshire Partnership NHS Foundation Trust

Prioritisation of Items

On 17 June 2020, the Committee prioritised items as follows: -

High Priority Items
Restoring NHS Services After and Planning for Covid-19
Healthy Conversation / NHS Long Term Plan Local Delivery Plan
Lincolnshire Acute Services Review – Initial Consultation Elements: - ➢ Medical Services / Acute Medicine (Grantham and District Hospital) ➢ Stroke Services ➢ Trauma and Orthopaedic Services ➢ Urgent and Emergency Care Services
Lincolnshire Acute Services Review – Consultation Elements Requiring Capital Funding: - ➢ Breast Services ➢ General Surgery Services ➢ Haematology and Oncology Services ➢ Women's and Children's Services
Non-Emergency Patient Transport
National Rehabilitation Centre Programme: Proposals in the East Midlands

Older Adult Mental Health Services
Child and Adolescent Mental Health Services - Community Intensive Home Treatment Service

Medium Priority Items
Item
United Lincolnshire Hospitals NHS Trust (ULHT) – Action in Response to Care Quality Commission (CQC)
East Midlands Ambulance Service (EMAS) Update
Undiagnosed High Blood Pressure and High Cholesterol
Musculoskeletal Problems
Cardiovascular Disease
Integrated Urgent Care in Lincolnshire (Provided by Lincolnshire Community Health Services NHS Trust)
Louth County Hospital Inpatient Beds
Community Pain Management Services Update
Primary Care Networks / New GP Contracts

4. Previous Committee Activity

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

5. Conclusion

The Committee's work programme for the coming meetings is set out above. The Committee is invited to highlight any additional scrutiny activity which could be included for consideration in the work programme.

5. 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 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

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

	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
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	203	205	160	200				
Cancer Care																																		
General Provision																✓										✓								
CT and MRI Scanners																											α							
Performance																										α								
Head and Neck Cancers														α					α				α											
Care Quality Commission																																		
General																			α										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	✓		α	α				
Elections – Impact																			α								α							
Falls Service																											α							

	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
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																														
Online Triage Systems																												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																							✓										
Covid-19 Response																													✓				
Covid-19 Restoration of 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																										✓			✓				
Covid-19 Response																													✓				
Older Adults Services																					✓					✓			✓				
Psychiatric Clinical Decisions Unit							α																										
LIVES																										α							
Lincolnshire Pharmaceutical Needs Assessment																												α					
Lincolnshire Reablement & Assessment Service																	α																
Louth County Hospital														α	✓		α									α							

	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
NHS Debt Write-Off																												α					
NHS Test and Trace																												α					
National Rehabilitation Programme																											✓						
Northern Lincolnshire and Goole NHS Foundation Trust			α												α			α															
North West Anglia NHS Foundation Trust							✓									α				✓							α							
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	✓	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		α					
Quality Accounts	✓								✓											✓		α	α					✓	α					
St Barnabas Hospice																											α							
Skegness Hospital																										α								

	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
United Lincolnshire Hospitals NHS Trust:																																	
A&E Funding		α																															
Introduction	✓																																
Care Quality Commission		✓										α	α	✓				✓	α	✓				✓			✓							
Children/Young People Services											✓	✓	✓	✓		✓	α	✓		✓				✓				✓						
Covid-19 Restoration of Services																													✓					
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			✓				✓										✓									

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