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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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 15 December 2021 at 10.00 am in the Council Chamber, County Offices, Newland, Lincoln LN1 1YL

MEMBERS OF THE COMMITTEE

County Councillors: C S Macey (Chairman), L Wootten (Vice-Chairman), M G Allan, R J Cleaver, S R Parkin, T Smith, Dr M E Thompson and R Wootten

District Councillors: S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), Mrs L Hagues (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
5	**Lincolnshire Acute Services Review - Orthopaedic Surgery** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider the details provided on the Lincolnshire Acute Services Review of Orthopaedic Surgery; and to highlight any areas which the Committee's working group might wish to explore in further detail. Mr Vel Sakthivel, Consultant in Trauma and Orthopaedic Surgeon and Pete Burnett, System Strategy and Planning Director, Lincolnshire NHS will be in attendance for this item)*	41 - 72
6	**Lincolnshire Acute Services Review Acute Medical Beds at Grantham and District Hospital** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider the details provided on the Lincolnshire Acute Services Review of Acute Medical Beds at Grantham and District Hospital; and to highlight any areas which the Committee's working group might wish to explore in further detail. Dr Dave Baker, South West Lincolnshire Locality Clinical Lead, Lincolnshire Clinical Commissioning Group, Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services NHS Trust and Pete Burnett, System Strategy and Planning Director, Lincolnshire NHS will be in attendance for this item)*	73 - 104
7	**Humber Acute Services Programme - Update** *(To receive a report from Simon Evans, Health Scrutiny Officer, which provides the Committee with an update on the progress of the Humber Acute Services Review Programme. Ivan McConnell, Programme Director, Claire Hansen, Programme Director – Interim Clinical Plan, Linsay Cunningham, Associate Director Communications and Engagement and Steven Courtney, Partnership and Stakeholder Engagement Manager will be in attendance for this item)*	105 - 134
8	**Health Scrutiny Committee for Lincolnshire _ Work Programme** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider and comment on its forthcoming work programme)*	135 - 138

Debbie Barnes OBE
Chief Executive
7 December 2021

Please note: This meeting will be broadcast live on the internet and access can be sought by accessing Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 15th December, 2021, 10.00 am (moderngov.co.uk)

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
10 NOVEMBER 2021

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors L Wootten (Vice-Chairman), M G Allan, R J Cleaver, S R Parkin, Dr M E Thompson, R Wootten and M A Whittington.

Lincolnshire District Councils

Councillors S Woodliffe (Boston Borough Council), B Bilton (City of Lincoln Council), Mrs S Harrison (East Lindsey District Council), Mrs L Hagues (North Kesteven District Council), G P Scalese (South Holland District Council) and Mrs A White (West Lindsey District Council).

Healthwatch Lincolnshire

Dr Maria Prior.

Also in attendance

Katrina Cope (Senior Democratic Services Officer) and Simon Evans (Health Scrutiny Officer).

The following representatives joined the meeting remotely, via Teams:

Dr Dave Baker (GP Chair, South West Lincolnshire Clinical Commissioning Group), Charley Blyth (Director of Communications and Engagement, Lincolnshire Sustainability & Transformation Partnership), Alison Christie (Programme Manager, Strategy and Development), Dr Abdul Elmarimi (Consultant in Stroke Medicine, United Lincolnshire Hospitals NHS Trust), Dr Yvonne Owen (Medical Director, Lincolnshire Community Health Services NHS Trust), Carole Pitcher (Primary Care Senior Contract Manager, NHS England – Midlands & East (Central Midlands)), Rose Lynch (Commissioning Manager- Primary Care Dental Services) and Allan Reid (Consultant in Healthcare Public Health (Oral Health))

County Councillor C Matthews (Executive Support Councillor MHS Liaison, Community Engagement, Registration and Coroners) attended the meeting as an observer.

42 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors R P H Reid, R Kayberry-Brown (South Kesteven District Council) and Dr B Wookey (Healthwatch Lincolnshire).

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

It was also noted that Dr Maria Prior (Healthwatch Lincolnshire) had replaced Dr B Wookey (Healthwatch Lincolnshire) for this meeting only.

The Committee was advised that an apology had also been received from Councillor Mrs S Woolley (Executive Councillor for NHS Liaison, Community Engagement, Registration and Coroners).

43 DECLARATIONS OF MEMBERS' INTEREST

No declarations of members' interest were made at this stage of the proceedings.

44 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 13 OCTOBER 2021

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 13 October 2021 be agreed and signed by the Chairman as a correct record.

45 CHAIRMAN'S ANNOUNCEMENTS

Further to the Chairman's announcements circulated with the agenda, the Chairman brough to the Committee's attention the supplementary announcements circulated on 9 November 2021. The supplementary announcements referred to:

- The most recent Covid-19 data, compiled by Lincolnshire County Council Public Health Division;
- Care Quality Commission (CQC) Inspection of United Lincolnshire Hospitals NHS Trust made between the 5 and 8 October 2021. It was noted that the CQC was following these inspections with a 'Well Led Review' of United Lincolnshire Hospitals NHS Trust between 9 and 11 November, the results of which were not expected to be published until early 2022; and
- The Lincolnshire Community Health Services NHS Trust (LCHS) launch of the Lincolnshire Urgent Community Response Service (4 October 2021), which aimed to care for people at home through an urgent crisis response service within two hours.

During a short discussion, the Committee raised the following comments:

- Concern was expressed relating to the Covid-19 data, and to the increase in the number of cases in Lincolnshire, with particular reference being made to the rise in the number of positive cases in the South Kesteven District Council area;

- Some concern was also expressed regarding the number of NHS vacancies at Pilgrim Hospital, Boston; and to the reducing number of GPs across Lincolnshire;
- Whether the new Urgent Community Response Service was a Countywide service. The Scrutiny Officer agreed to seek a response to this question; and
- One member enquired whether details had been made available relating to the financial impact of the Acute Services review. The Scrutiny Officer agreed to follow up after the meeting.

RESOLVED

That the supplementary Chairman's announcements circulated on 9 November 2021 and the Chairman's announcements as detailed on pages 17 to 28 of the report pack be received.

46 LINCOLNSHIRE ACUTE SERVICES REVIEW - STROKE SERVICES

Councillor S R Parkin joined the meeting at 10.08am.

The Chairman invited Dr Abdul Elmarimi, Consultant in Stroke Medicine, United Lincolnshire Hospitals NHS Trust and Charley Blyth, Director of Communications and Engagement, Lincolnshire Clinical Commissioning Group, to remotely, present the item to the Committee.

In his introduction, Dr Abdul Elmarimi provided an introduction for Committee regarding the impact of a stroke on a patient; the services required to treat the three main levels of stroke within certain timescales, and the rehabilitation period required for a patient to recover from a stroke.

It was reported that Hyper-Acute and Acute stroke services were provided by highly trained and skilled doctors, nurses and therapists who specialised in looking after people who had had a stroke.

It was highlighted that there were two key hospital services for the treatment of strokes which were, firstly thrombolysis, a 'clot busting drug' which was used to treat strokes caused by blood clots. The use of this treatment was time critical and had to be administered within 4.5 hours of the stroke's onset; and the second treatment was mechanical thrombectomy or 'clot retrieval'. It was noted that this was a relatively new procedure and was only available in a small number of hospitals; the nearest for Lincolnshire was the Queen's Medical Centre, Nottingham.

Appendix A to the report provide the Committee with further details relating to how services were currently organised at ULHTs hospitals (pre-Covid).

The summary of services pre-Covid was:

Lincoln County: Hyper-acute stroke services including Thrombolysis; Acute stroke Services and Transient Ischaemic Attack (TIA) mini stroke clinics; and

Pilgrim Hospital: Hyper-acute stroke services including Thrombolysis; Acute stroke Services and Transient Ischaemic Attack (TIA) mini stroke clinics.

The Committee was advised of the challenges and opportunities for stroke services and what was hoped to be achieved by making the changes. It was highlighted that national best practice was that hyper-acute stroke units should admit a minimum of 600 patients a year, below this level doctors and nurses in hospital stroke services risked becoming deskilled. The Committee was advised that Lincoln County Hospital admitted 670 stroke patients a year and Pilgrim Hospital, Boston around 500 stroke patients a year. It was noted that even when considering growth in the size of the ageing population over the next five years, Pilgrim Hospital Boston, was unlikely to admit 600 stroke patients each year.

It was reported that more doctors, nurses, and therapists were needed to deliver the existing hospital stroke services and that there was a shortage of such staff locally and nationally. Locally, this was causing problems as there had already been a temporary closure of some of the stroke services as there was not enough doctors and nurses available. As a result of this, both Lincoln County and Pilgrim Hospital Boston had struggled to consistently perform well in the national audit of service quality and performance, despite the skills and dedication of staff.

It was highlighted that feedback from engagement, particularly through the Healthy Conversation 2019 had supported the consolidation of hospital stroke services, and that this needed to be balanced against increased travel time for patients; ambulance response times; loss of services from Pilgrim Hospital, Boston, the overburdening of Lincoln County Hospital; and that a patient should be able to undergo rehabilitation closer to home. It was highlighted further that all public and stakeholder feedback had been taken into consideration throughout the process.

The Committee was advised that the preferred proposal for change was to establish a 'centre for excellence' for hyper-acute and acute stroke services at Lincoln County Hospital, which would be supported by increasing the capacity and capability of the community stroke rehabilitation service. It was highlighted that the TIA clinics would be unaffected at Pilgrim Hospital, Boston. It was highlighted further that the change would affect on average 1 to 2 patients a day receiving hyper-acute and acute stroke services at an alternative site. However, the change would ensure that stoke services were sustainable for the long term, the stroke service would receive over 600 patients a year, which would ensure that doctors and nurses maintained their specialist skills; it would improve the ability of hospital stroke services to attract and retain substantive and talented staff, reducing the reliance on temporary and expensive staffing solutions; stroke patients would spend the minimum time necessary in a hospital bed; patients were more likely to receive timely assessment, treatment and diagnosis when they arrived at the hospital; and overall health outcomes and patient experience would be improved.

It was reported that the option of basing the services at Pilgrim Hospital, Boston, instead on Lincoln County Hospital had been explored, but as a result, displacement would be higher, as

more people would seek treatment outside of Lincolnshire. It was noted that it was also difficult to attract staff to work at Pilgrim Hospital Boston.

During consideration of this item, the Committee raised some of the following comments: -

- Recruitment issues: the Committee was advised that there had been a major shift over the last few years, with some professionals not considering medicine as a career, or a dedication, but as a skill they could sell to the highest bidder. Some professionals were leaving their jobs to become professional locums as they had more flexibility. Reassurance was given that the Trust sought the best locums they could, and that patient safety was a priority;
- The critical period for stroke patients. Some concern was expressed to the waiting times seen at hospitals; and whether stroke patients received treatment prior to arriving at the hospital. The Committee noted that specialist nurses were available 24/7 and that paramedics would make contact from the site, and that sometimes patients were treated in the ambulance on route to the hospital. The Committee was advised that someone admitted as a stroke patient at Lincoln would bypass A & E, as it was important for the patient to receive a scan as soon as possible, so that if thrombolysis was the appropriate treatment, it could be administered within four and a half hours from the onset of the symptoms. It was noted that 60% of scans were done within 1 hour; and that those timeframes were continuously improving as practices were being modified;
- Whether consideration had been taken to the plans for stroke services for hospitals outside of Lincolnshire in the south of the County. The Chairman advised the Committee that he had been told that a health system was prevented by law from destabilising the services provided in a neighbouring health system;
- Further explanation was sought regarding the number of patients in line with best practice required for doctors and nurses to become deskilled (minimum 600 stroke patients), reference was made to the 500 stroke patients seen at Pilgrim Hospital, Boston. The Committee was advised that the figure of 600 stroke patients made a stroke unit more sustainable. It was highlighted that the audit had been very detailed and looked at 93 parameters per patient. It was also highlighted that strokes cases seen at Pilgrim Hospital, Boston were less severe than those seen at Lincoln County Hospital, who needed to be seen by a specialist team. As a result of the increasing preventive work being carried out in primary care the number of stroke patients was not increasing year on year. The benefits of a single unit would be better for patients, and for staffing, as the current arrangements were not sustainable;
- TIA service at Pilgrim Hospital, Boston. The Committee was advised that there was national guidance on quick assessment, with patients having to be seen within 24 hours. Confirmation was given that the TIA clinics would continue to be run at Pilgrim Hospital, Boston, three days a week. The only change would be that patients with a high-risk score would be offered an appointment at either Boston or Lincoln. The higher risk ones if there was not a clinic in Boston would be offered an appointment in Lincoln. It was highlighted that most people would be seen within a one to two days, depending on the severity of the stroke. The Committee was

advised that for outpatient activity, patients would be offered appointments at peripheral hospitals closer to home, reference was made to Spalding and Skegness for follow up appointments;

- Some concern was expressed on the data presented, particularly the high number of ageing patients on the east coast; and the travelling time for a patient from the east side of the County to be able to get to Lincoln or Peterborough. One member felt that without direct admission to Pilgrim Hospital, Boston, the proposal would create greater problems on the east coast. The Committee was referred to page 41 of the report pack which provided details relating to hospital catchment areas; and information relating to the displacement of patients from Boston and surrounding areas if the preferred option was adopted. It was highlighted that the analysis and modelling had been completed by Operational Research in Health Ltd (ORH) in 2018. It was noted that the ORH had used a combination of East Midlands Ambulance Service NHS Trust data and data on FAST-positive stroke patients from Lincolnshire. It was noted further that travel time analysis had been undertaken to quantify the base position for Pilgrim Hospital, Boston patients and how travel times would be expected to change, as changes to the services occurred. There was recognition of the issues raised and that the proposed model would ensure that patients received the best care; reference was also made to the potential for a mobile stroke unit (same size as an ambulance), which would be equipped with a scanner and connections to the central unit, which was part of the overall plan, once staffing levels were consistent;
- Concern was also expressed to the difficulties patients were still encountering getting appointments with GPs in the Boston area; the long waiting times for ambulances on the east coast; and the poor state of the roads in Lincolnshire;
- What could be done further to promote the County better to encourage medical staff to come to Lincolnshire. It was agreed that the attractiveness of working in Lincolnshire needed to be promoted better and that having better quality services would be part of that package; and
- The proposal presented appeared to work on the basis that staff working at Pilgrim Hospital, Boston would move to Lincoln to help mitigate the current shortages currently experienced within the stroke service. A question was asked whether a plan was in place should the preferred option not happen. The Committee was advised that staff had been moving to help provide cover, for services, however, staff had a choice. It was noted that the service had staff currently travelling from Nottingham and Chesterfield.

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

RESOLVED

1. That the details presented on the Lincolnshire Services Review of Stroke Services be noted.

2. That the Committee's initial findings on the proposal be recorded for consideration by the Committee's working group.

47 LINCOLNSHIRE ACUTE SERVICES REVIEW - URGENT AND EMERGENCY CARE

The Committee considered a report, which provided details on the Lincolnshire Acute Services Review of Urgent Emergency Care.

The Chairman invited Dr Dave Baker, South West Lincolnshire Locality Clinical Lead, Lincolnshire Clinical Commissioning Group, Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services NHS Trust and Charley Blyth, Director of Communications and Engagement, Lincolnshire Clinical Commissioning Group, to remotely present the item to the Committee.

Appendix A to the report provided an extract of the Lincolnshire NHS Public Consultation Document relating to four of Lincolnshire's NHS Services – Urgent and Emergency Care at Grantham and District Hospital; and Appendix B provided a copy of the Pre-Consultation Business Case for the Lincolnshire Acute Services Review for the Committee's consideration.

The Committee were reminded of the background relating to Grantham and District Hospital since 2007/08. It was highlighted that the A & E had only dealt with a limited range of emergency conditions, due its small size and its limited availability of specialist staff and limited range of 24/7 support services to support very ill patients after they left the A & E department.

It was reported that most patients treated at Grantham and District Hospital A & E department could be safely treated at an Urgent Treatment Centre (UTC).

The Committee was advised that if a patients presented themselves at Grantham and District Hospital A & E department with conditions that the hospital was not able to deal with, the skills and experience were there to manage the patient whilst a transfer was quickly arranged to a more specialist unit for the appropriate treatment.

Summary details relating to the current provision at United Lincolnshire NHS Hospital Trust's A & E departments were shown on page 64 of the report. It was noted that in addition to the three A & E departments, six UTCs were provided by Lincolnshire Community Health Services NHS Trust (LCHS).

The Committee was advised that the proposal was to establish a 24/7 Walk in Urgent Treatment Centre at Grantham and District Hospital, in place of the current A & E. It was highlighted that the multi-disciplinary workforce would have the ability to manage all presentations, and that it was anticipated that the change would affect around 3% of patients currently attending Grantham and District Hospital. This was equivalent to two patients a day on average being transferred for immediate specialist care.

Page 67 of the report pack provided a summary of the level of stakeholder and public support for the change proposal.

During consideration of this item. The Committee raised the following comments:

- Some concern was expressed regarding challenges being experienced by LCHS in providing staffing cover at other UTCs. Reassurance was given that services had not been impacted and that LCHS had to be constructive with its staffing to maintain services. It was noted that this was a temporary issue, and was one that was being felt across all health services, mainly due to Covid-19;
- One member expressed concern that the report did not express the views of the people of Grantham. Reassurance was given that the views of the people of Grantham were being listened to, an example given was the change to the proposal, which had been set out in the Healthy Conversation engagement exercise, to make the service a 24/7 walk in service, rather than an 8am to 80m service. It was highlighted that every comment would be captured and analysed during the consultation process. The Committee was advised that Grantham had a very limited provision of specialist services to provide support for A & E. For example Grantham had none of the following services: paediatrics; gynaecology; obstetrics; acute surgery; acute orthopaedics; ear, nose and throat; stroke medicine; and acute interventionalist cardiology. Thus, it was not possible to provide A & E Services at Grantham and District Hospital;
- The success of UTCs in other areas of the County and the role they played in taking the pressures of A & E's; and the realisation that there were not the resources available within the County to enable the continuation of A & E Services at Grantham and District Hospital;
- Some concern was expressed regarding transport costs when a patient was transferred from Grantham to another hospital for specialist treatment; but not admitted and then had to return to Grantham. One member felt that the Council had a role to play in this regard, as an enabler of public transport;
- Concern was expressed to the waiting times encountered before patients were seen in A & E, some even having to wait in ambulances outside of the hospital. The Committee was advised that the four-hour target was still in place, and that all A & E's and UTCs were measured against the four-hour target. The Committee noted that the delays were not just in Lincolnshire, but across the country. It was reported that Lincoln and Boston had both seen increased activity and that UTC's on those sites were managing the extra activity including ambulance patients. It was reported further UTCs were treating 95% of their patients within the four-hour target, despite the increased activity. The Committee was advised that the delay in ambulance handovers was due to lack of flow through the hospitals and bed availability. The Committee was advised further that as the Grantham A & E dealt with less complex cases, they were meeting the four-hour target and reassurance was given that this would continue to be met if Grantham Hospital became a UTC;
- Conflicting messages to the public, paragraph 10.2.9 on page 74 of the report pack advised that the UTC would be open 24 hours a day, seven days a week, and then the next sentence advised that the preferred route of access for the service should be via NHS 111. Reassurance was given that the proposal was for 24/7 access. The reason the message says to ring 111 was to make sure that any treatment required

would not be unnecessarily delayed. If a patient was able to wait, then they should ring 111, which provided them with the ability to book an appointment for later in the day;

- Clarification was sought on the terminology of: a level 3 A & E and a UTC Plus. The Committee was advised that the term level 3 A & E had in effect ceased, and that the term UTC had replaced it;
- Further concern was expressed that the general public were unaware of how to access treatment; as services were being changed, and that better communication was needed to help alleviate patients concerns;
- Pages 74 and 81 of the report pack provided workforce details for the proposed UTC, a further question asked was what was in place for medical cover arrangements overnight. Reassurance was given that a doctor would be on site overnight supported by two ACP Nurses. It was also noted that doctors, when possible, would also assist the clinical assessment service;
- Reference was made to paragraph 10.6.19, which referred to moderate capital investment being required for expansion into adjoining departments, a request was made as to how much capital funding would be required; and
- How the extension of Pilgrim Hospital A & E affected the overall staffing needs for urgent and emergency care in Lincolnshire. The Committee noted that the main reason for the expansion was to provide extra accommodation for people visiting the A & E and to revamp the layout to provide a more usable space. The Committee was advised that the expansion would not result in the need for more staff.

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

RESOLVED

1. That the details presented on the Lincolnshire Acute Services review of Urgent and Emergency care be noted.

2. That the Committee's initial findings on the proposal be considered by the Committee's working group.

48 UPDATE ON NHS DENTAL SERVICES IN LINCOLNSHIRE

The Chairman invited Carole Pitcher, Senior Commissioning Manager, NHS England and NHS Improvement (Midlands), Allan Reid, Consultant in Healthcare Public Health (Oral Health) and Rose Lynch, Commissioning Manager, Primary Care Dental Services, to remotely present the item to the Committee.

The report presented provided an update to the Committee on the provision of NHS dental services commissioned in Lincolnshire and provided an overview of the continuing effect of the Covid pandemic and the steps being taken to restore and recover services.

Whilst guiding the Committee through the report, reference was made to the NHS contracts in primary and community dental care that had been in place since 2006; the dental services offered in Lincolnshire, including out of hours service and secondary care.

The Committee was advised of the impact of the national pandemic upon dentistry and a timeline was available for the Committee to consider, which was detailed on pages 94 to 96 of the report.

The Committee was advised that during April – September 2021 (Q1 & Q2), providers had been required to deliver a minimum of 60% of their pre-Covid contractual activity, to continue to receive 100% payment. Figure 1 on page 99 provided details of the achievements of the Lincolnshire providers during this period.

The Committee was advised that to ensure that NHS Dental services were at the forefront of the new Integrated Care System, NHS England/Improvement had appointed Kenny Hume as the new Local Dental Network Chair for Lincolnshire.

The issue of oral health in Lincolnshire was highlighted. The Committee noted that the results of a recent survey had shown that in Lincolnshire average levels of dental decay were higher than the average for England. The report highlighted that children living in Boston had the highest levels of child dental decay in the region. South Holland, East Lindsey and Lincoln also had child dental decay that placed them in the top ten lower tier local authorities in the region. It was highlighted there was an east/west divide in childhood decay in Lincolnshire, and that this disparity was because the west of the County's water supply was fluoridated under an existing fluoridation agreement and that the east of the County did not receive fluoridated water. It was also highlighted that there were fewer dental services available in the east of the County. Priorities for tackling child dental decay were shown at paragraph 8.8 of the report.

Note: Councillor S R Parkin left the meeting at 12:50pm.

During consideration of the item, the Committee raised the following points: -

- Whether an NHS dentist was able to offer private treatment. The Committee noted that most NHS dentists had a mix of NHS and private patients and that the percentage varied. The Committee was advised that information was not available relating to private dental practices. The Committee was advised further that general dentistry was provided through an annual contract;
- The impact of non-fluoridation in the east of the County and its impact on dental decay in children;
- Concerns were expressed to the lack of provision of dental services across Lincolnshire; as dental services no longer visited schools and the lack of provision of dental service in the east of the County;
- The proposed new arrangements for commissioning under the Integrated Care System from April 2022;

- Some concern was expressed that not enough information had been included as to what was being done to secure dental services for those areas who were unable to access services; and how many people entitled to free dental services were currently not receiving it in Lincolnshire. A request was made for future reports to contain solutions for the problems patients were having in Lincolnshire and how Lincolnshire compared to the rest of the country;
- A request was made for contracts for the Spilsby, Mablethorpe and Skegness areas to be prioritised. The Committee noted that during the pandemic procurement had been paused, but this was now resuming and that there were plans to re-start the process out in the market;
- Whether the availability of NHS dentists in Lincolnshire would improve in the future. The Committee was advised that the situation would improve, with the recovery of services post the pandemic and the procurement process re-starting again in the new year to get better access to dental services across Lincolnshire; and
- Whether overseas recruitment had yielded any positive outcomes and what the current picture was relating to retention of staff. The Committee was advised that overseas scheme had been put on hold, but work was being taken forward with Health Education England regarding work issues and other initiatives to attract people into the profession. It was also noted that programmes were being looked at and roles were being reviewed i.e., the roles of a therapist and hygienist being combined.

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

RESOLVED

1. That the information presented by NHS England and NHS Improvement on dental Services in Lincolnshire ne noted.

2. That a further update be received six months' time, which should take on board the comments raised by the Committee.

49 HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE - WORK PROGRAMME

The Chairman invited Simon Evans, Health Scrutiny Officer, to present the report, which invited the Committee to consider and comment on its work programme as detailed on pages 110 to 112 of the report pack.

The Committee was advised that the United Lincolnshire Hospitals NHS Trust – Nuclear Medicine item would not be included on the December agenda.

Other items highlighted to be scheduled for the new year were:

- Dental Services;
- Lakeside Healthcare Stamford;

- Non-Emergency Patent Transport;
- Lincolnshire Clinical Commissioning Group – lessons learnt regarding GP practices. The Health Scrutiny Officer agreed to speak to CCG colleagues regarding this matter.

The Committee was also advised that dates for the Working Group meetings would be circulated in due course.

RESOLVED

That the work programme presented be received and that the items highlighted above be considered.

The meeting closed at 1.30 pm

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:	**15 December 2021**
Subject:	**Chairman's Announcements**

1. Membership of the Committee

Councillor Tom Smith has permanently replaced Councillor Robert Reid as one of the county councillor representatives on this Committee.

2. Information Requested at Previous Meetings

There are four outstanding requests for additional information from the previous two meetings:

(a) Grantham Urgent Treatment Centre – Usage Numbers as part of the 'green' site operation – This information is contained in paragraph 5 below.
(b) List of All NHS Services provided at Louth County Hospital – A full list of the services provided by three NHS trusts at the hospital will be circulated when it is available.
(c) Orthopaedic Patients from the East Lindsey Area – The question of the availability of follow-up appointments at Louth County Hospital for patients who have been treated at the proposed centre of excellence at Grantham, can be covered as part of item 5 on this agenda.
(d) Primary Care Networks in Lincolnshire - As an initial response to this the Lincolnshire Primary Care Network Alliance annual report for 2019/20 was circulated. The 2020/21 annual report is now available at the following link: Annual_Report_2020-21.pdf (lpcna.nhs.uk)
(e) Urgent Community Response Service – It has been confirmed that this service, provided by Lincolnshire Community Health Services NHS Trust since 4 October 2021, is a county-wide service.
(f) Lincolnshire Acute Services Review – Financial Details – Financial details of the Lincolnshire Acute Services review may be found in chapter 13 of the Pre-Consultation Business Case, available at: Pre-Consultation Business Case :: Lincolnshire STP

(g) Capital Expenditure for Proposed Grantham Urgent Treatment Centre – The Lincolnshire Acute Services Review Pre-Consultation Business Case (PCBC) refers to a moderate amount of capital investment to address backlog maintenance and the functional suitability of the environment, including expansion of the proposed UTC into underused adjoining departments. The figure is not quantified, but the PCBC states that the Lincolnshire system has sufficient reserves to meet all the anticipated capital needs. Furthermore, PCBC states that capital works are not required prior to the implementation of the proposal.

3. Covid-19

An update on Covid-19, based on information available on 29 November 2021 is attached at Appendix A. A further update, which will include information up to and 13 December 2021, will be circulated just prior to the Committee's meeting.

4. Intermediate Minor Oral Surgery

On 23 November 2021 NHS England (Midlands) launched a consultation on the contracts for intermediate minor oral surgery, which are due for renewal in 2023. Details of the consultation, which is due to close on 21 December 2021, are attached at Appendix B to these announcements.

Intermediate minor oral surgery is a specialist dental service for patients over the age of 16 years which provides complex extractions and treatment in a community setting. The service is provided by clinicians with enhanced specialist qualifications and experience, following a referral from a general dental practitioner. Existing locations in Lincolnshire for intermediate minor oral surgery are available in Lincoln, Boston, Grantham Gainsborough and Skegness. Across the East Midlands in 2019/20 the service accepted 37,000 referrals and treated 33,000 patients.

I intend to propose to the Committee that, in consultation with the Vice Chairman, I am authorised to respond on behalf of the Committee to the consultation, advising NHS England that intermediate minor oral surgery should at least continue in the existing five locations in Lincolnshire (Lincoln, Boston, Grantham, Gainsborough and Skegness) and consideration should be given by NHS England to extending the provision to other towns in the county.

5. Grantham and District Hospital: Temporary Urgent Treatment Centre Usage Data

On 13 October 2021, the Committee requested information on the patient attendances at temporary urgent treatment, which had operated at Grantham Hospital as part of its 'green' site activity between June 2020 and June 2021. The following figures have been provided for the eight months from October 2020 to May 2021.

Month	Attendances	Percentage Treated within Four Hours	Number Referred to A&E	Percentage Referred to A&E
October 2020	2,250	97.8	97	4.3
November 2020	2,084	98.0	88	4.2
December 2020	2,013	98.4	81	4.0
January 2021	1,945	98.4	69	3.5
February 2021	1,815	98.8	72	4.0
March 2021	2,386	97.9	112	4.7
April 2021	2,675	98.6	90	3.4
May 2021	1,641	98.2	66	4.0

The Lincolnshire Acute Services Review Pre-Consultation Business Case includes the following paragraphs on the temporary arrangements.

10.2.16 *Although caution should be exercised when comparing the proposed 24/7 UTC at Grantham Hospital identified through the ASR programme with the temporary UTC provided as part of the Covid-free 'Green' site at Grantham Hospital in response to the pandemic, the temporary changes do provide useful insights.*

10.2.17 Key considerations to consider in the context of these insights is the proposed UTC model set out within this PCBC would be able to see patients with a higher level of acuity and additional pathways of attendances such as 111 appointments (much more in line with what was provided 'pre-covid', compared to the temporary UTC that was implemented. The temporary UTC was also operating in a 'constrained' COVID-19 environment which will have shaped patient behaviour.

6. Revenue and Capital Funding Announcement – Winter 2021-22

On 3 December 2021, the Government confirmed funding of £700 million to help tackle waiting lists and improve care. This sum includes £330 million for upgrading NHS facilities; £250 million for new technology; and £120 million for supporting revenue costs.

United Lincolnshire Hospitals NHS Trust (ULHT) received a share of this funding totalling £11.6 million, which includes £8.2 million of capital for upgrading facilities; £3.1 million for new technology; and £0.3 million of revenue funding. The Lincolnshire Integrated Care System Partnership was allocated £1 million, bringing the total allocation for Lincolnshire to £12.6 million.

ULHT has confirmed that it will be spending:

- £5 million for two new laminar flow theatres at Grantham and District Hospital;
- £3.3m for the refurbishment and expansion of its critical surgical wards at Pilgrim Hospital, Boston, and Grantham and District Hospital;
- £1.1 million for the replacement of its digital cardiology system, including the replacement of some of the existing paper systems;
- £2.5 million for an artificial intelligence solution to support triage and management of its patient waiting list; and
- £0.6 million for digital support for the musculo-skeletal service.

North West Anglia NHS Foundation Trust's share of this funding totals £4.5 million, which includes £0.9 million of capital for upgrading facilities; £3.5 million for new technology; and £0.1 million of revenue funding. As a result of this funding, the Trust's initiatives will include:

- providing more space for outpatient orthopaedic appointments at Peterborough City Hospital;
- enhancing diagnostic facilities at several sites, including Stamford and Rutland Hospital, by converting x-ray facilities to digital radiography; and
- extending the hours of the emergency gynaecological assessment unit at Peterborough City Hospital.

Northern Lincolnshire and Goole NHS Foundation Trust's allocation was £0.6 million, which includes £0.5 million of capital for upgrading facilities; and £0.1 million for new technology.

7. United Lincolnshire Hospitals NHs Trust – Care Quality Commission Inspection

Between 5 and 8 October 2021, the Care Quality Commission (CQC) undertook an unannounced and focused inspection on four core services provided by United Lincolnshire Hospitals NHS Trust (ULHT). These services were:

- urgent and emergency care;
- medicine;
- children and young people; and
- maternity services.

In addition to this, between 9 and 11 November the CQC undertook an announced 'well-led' inspection of ULHT. The publication of a full report on the CQC's findings is expected in January 2022. In advance of this, the ULHT Board on 7 December 2021 considered the informal feedback from the CQC, which was given immediately following the inspections, and then summarised in two letters, dated 11 October and 12 November 2021, which are attached as Appendices C and D respectively.

8. Health and Care Bill 2021-22

The Health and Care Bill is currently at its second reading stage in the House of Lords, after its completion of its House of Commons stages. A summary of the main provisions is set out in Appendix E to these announcements.

9. Proposed Merger of Newark Road Surgery and Portland Medical Practice, Lincoln

On 3 December 2021m, a six-week engagement exercise was launched on the plans to merge Newark Road Surgery and Portland Medical Practice. The engagement period closes at noon on 15 January 2022.

Newark Road has over 7,000 registered patients at the surgery, while Portland has nearly 22,000 patients registered across its three sites: Portland Street, Newland Health Centre, and the University of Lincoln Health Service. The two practices are encouraging patients to share their views, which can be done via an online questionnaire:
https://nhslincolnshire.qualtrics.com/jfe/form/SV_bkpkNB5Pay5bnFk

Alternatively patients may request a paper copy of the questionnaire. In addition, a series of events for patients to attend have been planned, where patients can hear more about the proposals, and ask questions or share their views. Patients wishing to attend will need to book in advance (except for event one). The times, dates and locations are as follows:

- Event 1: 13 December 2021, 9am -2pm CCG Stand at Lincoln University in the Minerva Building Atrium, Brayford Pool Campus, Brayford Pool, Brayford Wharf N, Lincoln LN6 7TS. No booking required.
- Event 2: 15 December 2021, 6-8pm at Ruston Sports & Social Club, Newark Rd, Lincoln LN6 8RN. To book online: https://www.eventbrite.co.uk/e/proposed-merger-event-6-8pm-at-ruston-sports-social-club-tickets-221514414577 or call 07890 047 409.
- Event 3: 16 December 2021, 6-8pm at Bridge Central, Portland Street, Lincoln, LN5 7NN. To book online: https://www.eventbrite.co.uk/e/proposed-merger-event6-8pmbridge-central-portland-streetlincolnln5-7nn-tickets-221019403987 or call 07890 047 409.
- Event 4: 13 January 2022, 6-8pm at at Ruston Sports & Social Club, Newark Rd, Lincoln LN6 8RN. To book online: https://www.eventbrite.co.uk/e/221894922687 or call 07890 047 409.

10. Appointment of Chief Executive for NHS Lincolnshire Integrated Care Board

On 15 November 2021, it was announced that John Turner had been appointed as Chief Executive designate for the NHS Lincolnshire Integrated Care Board, which is due to be established on 1 April 2022. John, who is currently the Chief Executive of NHS Lincolnshire Clinical Commissioning Group, was appointed following a recruitment process, led by NHS England and NHS Improvement. John will be accountable for the development of the long-term plan for the new Integrated Care Board and, through this, for delivering improvements in the quality of patient care, patient safety, health inequality, workforce productivity and financial health for the population of Lincolnshire.

The next steps will be to recruit a Designate Chair, as well as Non-Executive Members and Executive Directors to the ICB.

APPENDIX A

COVID-19 UPDATE

This update has been compiled using data provided by Lincolnshire County Council's Public Health Service.

1. LATEST DATA

A. Tests (updated: 29 November 2021)

	Total Tests Carried Out	Total Positive Tests	% Positive Tests	Positive Cases	Rate of Positive Cases per 100,000 Population
Lincolnshire	**85,721**	**3,930**	**4.6%**	**3,049**	**397.9**
Boston	6,540	338	5.2%	273	385.4
East Lindsey	14,698	499	3.4%	376	264.7
Lincoln	9,506	547	5.8%	412	411.8
North Kesteven	15,091	670	4.4%	521	441.0
South Holland	10,648	455	4.3%	345	359.9
South Kesteven	18,350	971	5.3%	767	535.5
West Lindsey	10,888	450	4.1%	355	369.1

The data in the table above are a rolling seven-day summary of Pillar 1 and Pillar 2 Tests. Data have been extracted from Public Health England (PHE) daily line lists, which provide data on laboratory confirmed cases and tests captured through their Second Generation Surveillance System. The rates shown are crude rates per 100,000 resident population.

B. Cases (updated: 29 November 2021)

	Cases in the Last Seven Days	Cases to Date
Lincolnshire	**3,049**	**104,729**
Boston	273	10,209
East Lindsey	376	17,812
Lincoln	412	15,940
North Kesteven	521	15,432
South Holland	345	12,406
South Kesteven	767	19,820
West Lindsey	355	13,110

Data on cases are sourced from Second Generation Surveillance System. This is PHE's surveillance system for laboratory confirmed cases. Lab confirmed positive cases of Covid-19 confirmed in the last 24 hours are reported daily by NHS and PHE diagnostic laboratories. This is the most accurate and up to date version of data and as such it will not align with the data that is published nationally due to delays in reporting.

C. Deaths (updated: 28 November 2021)

Area	Total deaths	Total Deaths in the last Seven days
Lincolnshire	**1,824**	**12**
Boston	192	0
East Lindsey	438	5
Lincoln	212	1
North Kesteven	245	1
South Holland	225	3
South Kesteven	298	2
West Lindsey	214	0

Total number of deaths since the start of the pandemic of people who have had a positive test result for Covid-19 and died within 28 days of the first positive test. The actual cause of death may not be Covid-19 in all cases. People who died from Covid-19 but had not tested positive are not included and people who died from Covid-19 more than 28 days after their first positive test are not included. Data on Covid-19 associated deaths in England are produced by Public Health England from multiple sources linked to confirmed case data. Deaths newly reported each day cover the 24 hours up to 5pm on the previous day. As of 31 August 2020, the methodology for counting Covid-19 deaths was amended and, as such, the total number of Covid-19 related deaths was reduced.

D. Vaccinations in Lincolnshire – Period Covered 8 December 2020 – 21 November 2021 (Published: 25 November 2021)

Total number of vaccines given in Lincolnshire up to 21 November was 1,346,318

Age Group	First Dose	Second Dose	Booster or Third Dose	% who have had at least one dose	% who have had both doses	% who have had a booster or third dose
12 - 15	17,170	2,470		51.9%		
16 -17	11,372			73.6%		
18 - 24	48,073	43,166	20,847	80.5%	72.2%	
25 - 29	34,139	31,194		81.9%	74.8%	
30 - 34	37,053	34,353		85.5%	79.2%	
35 – 39	36,990	35,109		86.8%	82.4%	

Age Group	First Dose	Second Dose	Booster or Third Dose	% who have had at least one dose	% who have had both doses	% who have had a booster or third dose
40 – 44	37,258	35,847		92.1%	88.6%	
45 – 49	41,581	40,439		87.8%	85.4%	
50 – 54	51,909	50,822	10,572	96.4%	94.4%	19.6%
55 – 59	55,167	54,215	13,352	96.9%	95.2%	23.5%
60 – 64	50,242	49,280	16,599	99.0%	97.1%	32.7%
65 – 69	45,247	44,822	26,377	94.9%	94.1%	55.3%
70 – 74	48,180	47,899	37,515	94.8%	94.2%	73.8%
75 – 79	37,694	37,499	31,646	100%*	100%*	86.5%
Over 80	45,801	45,533	38,317	97.0%	96.5%	81.2%

The number of people who have been vaccinated for Covid-19 split by age group published by NHSEI. All figures are presented by date of vaccination as recorded on the National Immunisation Management Service (NIMS) database. *100% signifies that the number who have received their first dose exceeds the latest official estimates of the population from the ONS for this group.

2. RECENT DEVELOPMENTS

- In the seven days prior to 29 November, 92.4% of cases in Lincolnshire that were genome sequenced were the Delta variant. The remaining 7.6% were the Delta Plus (AY 4.2) variant.

- The Omicron variant is under investigation by the UK Health Security Agency and has been classified as a variant “of concern” by the World Health Organization. This variant includes several mutations which could potentially change the way the virus reacts to vaccines, treatments and transmissibility.

- All individuals who have been in contact with a suspected Omicron case must self-isolate immediately, regardless of vaccination status. NHS Test and Trace will contact these individuals to advise on next steps.

- On or before 29 November 2021, ten countries had been added to the UK travel red list: South Africa, Namibia, Zimbabwe, Botswana, Lesotho, Eswatini, Angola, Malawi, Mozambique and Zambia. Nigeria was added to the list with effect from 6 December 2021. Travellers from these countries will be unable to enter the UK unless they are UK or Irish nationals or UK residents. Upon returning to the UK, travellers from these countries must self-isolate in a government-approved hotel for ten days.

- Data published by the UKHSA on 25 November show no consistent differences between birth outcomes in vaccinated pregnant women and all pregnant women. Approximately 20% of pregnant women hospitalised with Covid-19 require preterm delivery to aid recovery and around 20% of their babies require care in neonatal units. As only 22% of women who gave birth in August were vaccinated, health officials are urging pregnant women to get the Covid-19 vaccine.

- The UK Health Security Agency has updated the infection prevention and control guidance for health and care settings. The aim of this update is to help prevent transmission of seasonal respiratory viral infections, such as Covid-19, Influenza and Respiratory Syncytial Virus in health and care settings. Updated guidance can be found at Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 - GOV.UK (www.gov.uk).

- As 30 November 2021, face coverings became compulsory in shops, supermarkets, indoor shopping centres, post offices, banks, building societies, estate and letting agents, pharmacies, takeaways without space for the consumptions of food and drink, and on public transport.

- On 4 December 2021 the Government announced that from 7 December anyone aged 12 and above wishing to travel to the UK would need to show a negative pre-departure test (LFD or PCR) as close as possible to departure and not more than 48 hours before to slow the importation of the new variant.

APPENDIX B

Intermediate Minor Oral Surgery East Midlands Stakeholder Briefing

1 Introduction

The purpose of this briefing paper is to provide an update to Health and Wellbeing Boards, Overview and Scrutiny Committees and key stakeholders on the engagement outcomes of the Intermediate Minor Oral Surgery services across the East Midlands and plans for recommissioning of services.

2 Background Information

NHS England and NHS Improvement is responsible for commissioning NHS Dental Services
e.g. primary, community and secondary care to meet the local population needs.

Intermediate Minor Oral Surgery (IMOS) is a referral service for over 16 years and is provided within a community setting. The service provides specialist treatment e.g. complex dental extractions by a clinician with enhanced skills and experience that is either on the oral surgery specialist list or accredited in line with national guidance. Treatment may be provided under local anaesthetic and the clinician may use quality behavioural management techniques or provide treatment under conscious sedation where appropriate for minor oral surgery procedures. Once the one-off treatment has been completed, the patient is then returned to the referring General Dental Practitioner.

The IMOS contracts are commissioned using a Personal Dental Services (PDS) Agreement, the earliest of which commenced in 2008/09 and are due to expire. The existing contractual agreements have no Units of Dental Activity (UDA) contracted activity nor financial value, financial payments are made in arrears based on claims submitted for cost per case for either assessment, assessment and treatment or assessment, treatment and sedation.

There are 36 IMOS providers across the East Midlands area, which cover Northamptonshire, Leicester, Leicestershire & Rutland, Lincolnshire, Derbyshire and Nottinghamshire. Please see Appendix 1 for existing locations. Due to historic contracting arrangements, the service arrangements are on different contracting terms and payments rates. Within the existing contracting arrangements treatment may be provided under conscious sedation in Derbyshire and Nottinghamshire, however, there is limited access in Lincolnshire/Northamptonshire and no access in Leicester, Leicestershire and Rutland. In 2019/20, the service accepted approximately 37,000 referrals and treated 33,000 patients.

A Midlands IMOS service specification has been developed in line with the Oral Surgery Commissioning Guide to standardised the service model, payments and reduce inequalities in access/treatment under conscious sedation, where appropriate.

3 Engagement Outcomes

As part of the pre procurement planning, it has been agreed to undertake a two-stage engagement and consultation process to seek views and feedback from patients, public and the dental profession.

A four week patient, public and dental profession engagement process was undertaken in May/June 21. Approximately 5,000 patients who had received treatment under the IMOS pathway were contacted to complete the online engagement survey. Communications was sent to Healthwatch, Local Authorities and other voluntary organisations requesting their support to promote the public engagement and all East Midlands dental providers, Oral Surgery Managed Clinical Network, IMOS providers received communications regarding the engagement survey. We received the following responses:

Engagement Group	Number of Responses Received
Patients and/or carers/guardians of patients who have had treatment	167
Public	12
Dental Profession	45
Total	**224**

Outcomes and themes are as follows:

Patients:

- Responses received across all ICS areas with Leicestershire having the largest response rate (58.68%)
- Just over half of patients were not offered choice of IMOS provider
- 78.44% were involved with their treatment decision
- Approximately 50% of patients travelled between 0-5 miles vs 8.98% who travelled more than 21 miles, which increases to 12.5% for Lincolnshire
- Majority of patients felt the distance travelled was acceptable
- 85.63% travelled by car vs 4.19% using public transport; in Leicestershire 57.14% walked to the practice
- 73.65% were satisfied with the waiting time
- 55% waited 3 months; 42.30% waited over 6 months in Lincolnshire vs 15.5% for East Midlands and 29.26% felt they had waited longer for treatment due to impact of COVID
- Majority of patients felt their personal and physical needs were met; however, concerns were raised regarding anxiety due to waiting times; lack of care for those with physical needs due to disability and management of records
- 79.64% did not have any complications, however, there were some poor experiences regarding aftercare and complications following treatment
- 90.41% received one form of aftercare advice vs 7.19% who did not receive any aftercare advice
- 55.69% were extremely satisfied with the service vs 8.38% who were not at all satisfied
- Patients felt: Quality of care; appointment availability; waiting time for treatment and location of services were important when accessing the services

Public:

- Responses received from all ICS areas except Leicester, Leicestershire and Rutland
- Majority of the public were happy to have IMOS treatment within primary care, however, some would prefer treatment in secondary care due to lack of confidence in staff having skills and knowledge to provide treatment
- Over half would feel extremely or very anxious if they had to go for complex extraction
- 100% are happy for a Specialist to be support by a Specialist trainee
- Over half felt it is important services are accessible by public transport (particularly in Nottinghamshire, Derbyshire and Lincolnshire)
- 50% are willing to travel between 16-20 miles to access treatment; 16.67% wiling to travel between 0-5 and 6-10 miles
- The majority would prefer to be seen between 12noon to 5pm, followed by 9 am to 12 noon or after 5pm
- Would like services to be accessible between 9am to 5pm Monday to Saturday and some would like to be seen on a Sunday
- Public felt Quality of care; waiting time for treatment and location of services and car parking availability were important.

Dental Professional:

- Response from all ICSs and health care professionals.
- Majority of dentists have access to digital radiography with 2 respondents advising they use plain film or radiograph facility not computerised.
- Majority of respondents do not provide conscious sedation currently vs 28.89% that do in Nottinghamshire and Derbyshire
- Majority felt clinical triage in the current referral management system pathway is beneficial
- Waiting times; fees/funding and clinic access were identified as the top three improvements
- Confirmed they would be happy to approach a colleague for advice and guidance
- Over half stated they could always or most of time take on an emergency referral within 24 hours for treatment for failed extraction or patient in acute pain
- Identified potential gap in provision of 3a cases being provided and not covered in the draft Midlands Service Specification and potential to impact on secondary care.

The engagement feedback has been considered along with other public health data factors to develop proposed locations for the new services for formal consultation and service specification feedback received from the dental profession has been reviewed.

4 Next Steps

A consultation document for each ICS area will be developed with support from the Communications and Public Health teams. A stakeholder and ICS webinars will be arranged to promote the formal consultation process. The consultation is planned for be undertaken in November/December 21. Feedback will be considered to support finalising the commissioning intentions for tender.

We will continue to update Health and Wellbeing Boards, Overview and Scrutiny Committees and key stakeholders on the outcome of the IMOS consultation processes and plans for recommissioning.

Appendix 1 – Existing IMOS Service Locations

Area	Locations
Derbyshire	Derby City Chesterfield Kirk Hallam Alferton Matlock Belper
Nottinghamshire	Nottingham West Bridgford Wollaton Hyson Green Mansfield Keyworth Carlton
Leicester, Leicestershire and Rutland	Leicester Coalville Hinckley Loughborough Market Harborough
Lincolnshire	Lincoln Boston Grantham Gainsborough Skegness

APPENDIX C

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon
Tyne NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email

Mr. Andrew Morgan Chief Executive Officer
United Lincolnshire Hospitals NHS Trust
Greetwell Road
Lincoln
Lincolnshire LN2 5QY

Date: 11 October 2021

CQC Reference Number: INS2-11012116741 Dear

Mr Morgan

Re: CQC Core Service inspection of United Lincolnshire Hospitals NHS Trust

Following your feedback meeting with Michelle Dunna and Anna Kerrigan on 6 and 8 October 2021, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meetings.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 6 and 8 October 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied into this letter.

An overview of our feedback

The feedback to you was:

Pilgrim Hospital

<u>Children and young persons</u>

- Children and young people were cared for in a safe way.
- Medical staff felt well supported and described a good experience.
- All staff described good educational opportunities

- Staff told us they were proud of the improvements made within the service.

However:

- There was no dedicated pharmacy service which meant staff were often taken away from clinical duties to sort discharge medicines.
- Staff were anxious about being moved to work in adult areas.
- Staff described a poor experience when working in the emergency department but did acknowledge work had been done to address this.
- Staff described delays in in moving children from the emergency department to the ward.

Maternity

- Good MDT working.
- Strong leadership of the service.
- A positive culture.
- No concerns with staffing.
- Good governance processes in relation to management and learning from incidents and risk management.

Medical

- All patients were cared for in a safe way.
- The inspection team recognised significant improvements in the service specifically, diabetes management, MCA and DoLS, falls and non-invasive ventilation.
- Generally, staff morale was good especially on Ward 6B and Bostonion and staff were happy to work at the Trust.
- Patient feedback was mostly positive.

However:

- There appeared to be no oversight, in terms of leadership, of the discharge lounge which impacted on a good patient experience.
- Staff morale on Ward 6A was poor however, this was not seen to impact on patient care.

Urgent and emergency care

- All patients were cared for in a safe way.
- The inspection team recognised significant improvements in the care of the deteriorating patient including the recognition and treatment of sepsis.
- Improvements had been made in areas of the department dedicated to the care of children and young people including resus.
- The inspection team saw a good pathway for children and young people.
- All staff were described as caring and doing their best for patients despite an extremely busy environment and patient feedback was positive.
- Where concerns were identified for example, an unlocked medicine cupboard staff responded quickly and appropriately.

However:

- Oversight of flow out of the emergency department did not appear to be given sufficient priority. Some staff felt ‘left to get on with it’ when the department was full.
- Specialties did not appear proactive in ‘pulling’ patients from the department.

- The inspection team expressed concern that where a patient had to remain on an ambulance due to capacity in the department, ED staff would not physically have sight of the patient for a minimum of 60 minutes when the first comfort round was due. They did, however, acknowledge that observations would be carried out and escalated appropriately.

Pharmacy

- The pharmacy team recognised significant improvement in medicines management since our last inspection.
- The MOCH pilot in elderly care was seen as a particular area of good practice.

However:

- The prescription chart within the emergency department lacked scope to add medicines administered outside of the department. I.e. during conveyance or whilst waiting on the ambulance. This meant there was a risk patients could receive more medicines than required.
- Prescribing within the emergency department tended to be for 'immediate' medicines with no mechanism in place to prompt staff to prescribe a patient's regular medicine.

Lincoln County Hospital

Children and young persons

- We saw good MDT working.
- Staff were caring and we observed some good examples of care delivery in the neonatal Unit.
- Staff described good executive oversight of Children and young persons and said it felt better than previously.

However:

- At times, there was no evidence to suggest interpreting service were used when required and we saw two occasions where a relative was used.
- There was no dedicated breast feeding/milk kitchen available.

Maternity

- Comprehensive risk assessments were carried throughout a lady's pregnancy.
- We saw good MDT working.
- We saw areas of good practice. For example, mechanical induction of labour.
- We saw evidence of learning from incidents.
- At the time of our inspection, mums and babies were safe.

However:

- We were concerned midwifery staff were not appropriately trained to recover women post C-Section. However, we have since received information giving assurance that staff are appropriately trained.
- We were not assured staff reported all incidents appropriately.
- The physical environment was in poor condition although we appreciate estates have been on site addressing our issues.
- On two separate occasions we found medicines which were not secure.
- Not all staff appeared engaged, morale was mixed, and we found an inconsistent safety culture with not all staff happy to challenge.

- The temperature of the treatment room was not monitored despite feeling warm. We were concerned that medicines may not be stored at the correct temperature. In addition, there was not restricted access to this room.

Medical

- Staff were patient focused.
- We saw good MDT working with staff describing how supportive they were of each other.
- Patients were safe and appeared well cared for.
- Patient information boards in the ward areas enabled staff to clearly identify where the sickest patient was.
- We saw good record keeping.
- We were told about projects in place to reduce falls and saw positive outcomes on the wards.

However:

- On MEAU there was only one shower for 26 patients (previously 50 patients). This shower was not working. Whilst MEAU was a 'short stay' area, one patient had been on the ward for 14 days. In addition, the area was mixed sex.
- We saw three patients across two wards who were self-medicating with no documented risk assessment in place.
- We saw loose tablets in the clinical area on two wards. On one occasion there were approximately 25 sleeves of unsecure tablets.

Urgent and emergency care

- Local leadership was strong.
- Staff demonstrated a willingness to embrace change and improve.
- Patients were well cared for and patient feedback was overwhelmingly positive.
- We saw good learning from incidents. For example, diabetes.

However:

- We felt there was a lack of ownership of the paediatric area and did not feel there was one individual taking the lead.
- We saw some inconsistencies with record keeping especially in relation to risk assessments for falls and mental health.
- The medicines room door was open for the entirety of the inspection.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater at NHSEI.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Sarah Dunnett

Head of Hospitals Inspection

c.c. Elaine Baylis, Chair

Dale Bywater, Midlands Regional Director NHSEI

Jonathon Davies, CQC regional communications manager

APPENDIX D

Care Quality Commission
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By email

Mr. Andrew Morgan Chief Executive Officer United
Lincolnshire Hospitals NHS Trust
Greetwell Road
Lincoln
Lincolnshire LN2 5QY

Date: 12 November 2021

CQC Reference Number: INS2-11012116741

Dear Mr Morgan

Re: CQC Well Led inspection of United Lincolnshire Hospitals NHS Trust

Following your feedback meeting with Sarah Dunnett, Michelle Dunna, Caroline Bell and Garry Marsh on 11 November 2021, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 11 November 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

W1. There is the leadership capacity and capability to deliver high quality, sustainable care.

- There is a strong, cohesive leadership team.
- There is a strong board development programme.

W2. There is a clear vision and credible strategy to deliver high-quality sustainable care to people and robust plans to deliver.

- There was bold decision making of the board that underpinned a well-planned and understood strategy.

W3. There is a culture of high-quality, sustainable care.

- Without exception the patient is now at the heart of this organisation.
- The organisation's approach to changing the culture is supported by credible plans and a palpable energy within the board.
- The work that has already started needs to continue at pace to ensure the requirements of duty of candour are met.

W4. There are clear responsibilities, roles and systems of accountability to support good governance and management at board level.

- However, there are inconsistencies in its application at some levels of leadership across the organisation of which, the trust has plans in place to address.

W5. There are clear and effective processes for managing risks, issues and performance.

- The trust should continue to ensure they are using timely data to gain assurance and continue their described work on the integrated performance report.
- The trust should continue to review and manage the work required to improve medicines management across the organisation.

W6. Appropriate and accurate information is being effectively processed challenged and acted on.

W7. People who use services, the public, staff and external partners are engaged and involved to support high-quality sustainable services.

- There are positive and collaborative relationships with stakeholders and providers across the Lincolnshire system.
- There is executive presence across all sites, engaging with staff at all levels.

W8. There are robust systems and processes for learning, continuous improvement and innovation.

- Quality improvement is embedded across the organisation and we have heard of some good examples where the quality and safety of patient care has improved.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater at NHSEI.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

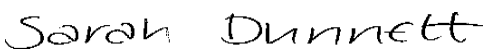
If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Sarah Dunnett

Head of Hospitals Inspection

c.c. Elaine Baylis, Chair
Dale Bywater, Midlands Regional Director NHSEI Jonathon
Davies, CQC regional communications manager

APPENDIX E

HEALTH AND CARE BILL 2021-22

Introduction

The Health and Care Bill was introduced in Parliament in July 2021. The Government has stated that the purpose of the Bill is to give effect to the policies that were set out as part of the NHS's recommendations for legislative reform following the Long Term Plan and in the White Paper *Integration and Innovation: Working together to Improve Health and Social Care for All,* published in February 2021.

The Government's stated aim is that the Bill will :

- promote local collaboration;
- reform the NHS Provider selection regime;
- improve accountability and enhance public confidence in the health and care system; and
- deliver a range of targeted measures to support people at all stages of life.

The Health and Care Bill has completed its House of Commons stages and is currently due for its second reading in the House of Lords on 7 December 2021. On arriving in the House of Lords, the Bill comprised 154 clauses and 17 schedules. The main provisions in the Bill are as follows:

Establishment of NHS England

The term 'NHS England' has been widely used for several years to describe the NHS Commissioning Board, which was established by the Health and Social Care Act 2012. Two other legislative entities 'Monitor' and the 'Trust Development Authority' had in effect previously merged to form NHS Improvement from 1 April 2016. In turn, NHS England and NHS Improvement have been working as a single organisation since 1 April 2019, referred to as NHS England and NHS Improvement. The Bill seeks to abolish Monitor and the Trust Development Authority, and transfer their functions to NHS England, as a new statutory entity.

Establishment of NHS Integrated Care Boards and Abolition of Clinical Commissioning Groups

The Health and Social Care 2012 led to the establishment of 211 clinical commissioning groups across England, with responsibilities for the planning and commissioning of health care services in local areas. Clinical commissioning groups assumed many, but not all the functions, of primary care trusts which were abolished by the 2012 Act. Following a series of mergers, there are currently 106 clinical commissioning groups in England.

Since 2016, health and care organisations have increasingly been working together to co-ordinate services and to plan in a way that improves population health and reduces inequalities between different groups. Non-statutory integrated care systems (ICSs) have been formed to bring together commissioners and providers.

The Bill proposes the establishment of NHS integrated care boards (ICBs), which will assume the commissioning functions of the CCGs, as well as some of NHS England's commissioning functions. However, the Government states that an ICB will not simply be a larger clinical commissioning group and it will be expected to work differently in practice. Its governance model will reflect the need for integration and collaboration across the system and it will also be directly accountable for NHS expenditure and performance within the system.

In anticipation of the new legislation, NHS England and NHS Improvement has been publishing detailed guidance on ICS and ICB development. The Lincolnshire ICS is co-terminous with the boundary of the county council and will be formally named: *Better Lives Lincolnshire*; and the name of the ICB will be: *NHS Lincolnshire Integrated Care Board*.

Establishment of Integrated Care Partnerships

Each NHS integrated care board and its partner local authorities will be required to establish an integrated care partnership (ICP), which will bring together health, social care and public health. Each ICP will be tasked with developing a strategy to address the health, social care and public health needs of its system. The NHS ICB and local authorities will have to have regard to that plan when making decisions. In Lincolnshire, the Health and Wellbeing Board has been undertaking the role of ICS Partnership board in shadow form.

Reconfiguration of NHS Services

The Bill provides several powers to the Secretary of State in relation to health service reconfigurations, which are summarised as follows:

- If an NHS commissioning body proposes a reconfiguration of its NHS services it must notify the Secretary of State.
- If an NHS commissioning body, NHS trust or NHS foundation trust is aware of circumstances that it thinks are likely to result in a need for the reconfiguration of NHS services, it must notify the Secretary of State.
- The Secretary of State may give an NHS commissioning body a direction calling in any proposal by the body for the reconfiguration of NHS services.
- Where a direction is given as above, the Secretary of State may take any decision in relation to the proposal that could have been taken by the NHS commissioning body.

The Secretary of State must publish guidance on the above provisions and a reconfiguration of NHS services is defined as a change in the arrangements made by an NHS commissioning body for the provision of NHS services where that change has an impact on: (a) the manner in which a service is delivered to individuals (at the point when the service is received by users), or (b) the range of health services available to individuals.

Guidance on the Bill issued to the House of Lords on 24 November 2021 states that these new powers are intended to be used in cases which are complex, a significant cause for public concern, or where Ministers can see a critical benefit to taking a particular course of action. Cases such as these can lead to difficult debate and lengthy processes. To support this intervention power, the current referral power of health overview and scrutiny committees will be amended, but there is no intention to remove the requirement to involve these committees in reconfigurations.

Powers to Direct NHS England

The Bill provides further powers to the Secretary of State to direct NHS England, for example to ensure that NHS England continues to work effectively with other parts of the system for which the Secretary of State has responsibility including social care and public health, to support integration and tackle broader priorities such as health inequalities. There are also powers to direct NHS England to take on certain public health functions.

Other Provisions

The Bill also includes provisions relating to:

- hospital discharge arrangements;
- the regulation of professional bodies;
- medical examiners within the NHS to investigate deaths;
- reimbursements to pharmacies;
- hospital food standards;
- reducing exposure to advertising of less health food and drink;
- water fluoridation; and
- powers to amend retained EU law.

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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:	**15 December 2021**
Subject:	**Lincolnshire Acute Services Review – Orthopaedic Surgery**

Summary:

On 13 October 2021 the Committee agreed its approach to its consideration of the NHS's consultation on the Lincolnshire Acute Services Review. This included consideration of each of the four elements of the review in detail. The first two elements: stroke services and urgent and emergency care were considered on 10 November 2021. The remaining two elements are due to be considered at this meeting, with orthopaedic surgery as one of these.

The Committee also established a working group, which would support the work of the Committee, and give detailed consideration of the consultation materials. As part of its consideration the Committee is requested to consider whether it wishes to highlight any areas, which the working group might explore.

Actions Requested:

(1) To consider the detailed on the Lincolnshire Acute Services Review of Orthopaedic Surgery.

(2) To highlight any areas which the Committee's working group might wish to explore in further detail.

1. Background

On 30 September 2021, the consultation on the Lincolnshire Acute Services Review was launched. On 13 October 2021 the Committee considered an introductory item and agreed its approach to the consultation.

2. Orthopaedic Surgery

Mr Vel Sakthivel, Consultant in Trauma and Orthopaedic Surgeon, United Lincolnshire Hospitals NHS Trust and Pete Burnett, System Strategy and Planning Director, Lincolnshire NHS are due to attend the meeting to present information on this topic. To facilitate the Committee's consideration, pages 22-26 of the consultation document, which relate specifically to Orthopaedic Surgery, are attached as Appendix A to this report. Chapter 9 of the Pre-Consultation Business Case (PCBC) provides further detail and is attached at Appendix B. It should be noted that chapter 9 of the PCBC in turn refers to the following documents, all of which are available at: Pre-Consultation Business Case Appendices:

- Appendix H – Access Impact Analysis by Neighbourhood Team
- Appendix I – Quality Impact Assessments
- Appendix J - Equality Impact Assessment

At the Committee's meeting on 13 October 2021, when an introductory item on the Acute Services Review consultation was considered, more information was requested on whether patients from the East Lindsey area, who had been treated at the proposed centre of excellence at Grantham, would be able to attend follow-up appointments at Louth County Hospital.

3. Consultation and Conclusion

The Committee is invited to consider the presentation on the detailed elements of the Lincolnshire Acute Services Review.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Extract (Pages 22 – 26) from Lincolnshire NHS Public Consultation Document – Relating to Four of Lincolnshire's NHS Services – Orthopaedic Surgery
Appendix B	Chapter 9 of the Pre-Consultation Business Case for the Lincolnshire Acute Services Review

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

Orthopaedic surgery

What are we asking you to consider?

We want you to tell us what you think about our preferred change proposal to develop:

- A 'centre of excellence' in Lincolnshire for planned orthopaedic surgery at Grantham and District Hospitals, along with
- A dedicated day case centre at County Hospital Louthfor planned orthopaedic surgery

What are the services and how are they organised (pre COVID-19 temporary changes)?

Orthopaedic surgery relates to planned surgery (e.g. hip and knee replacements) and unplanned surgery (e.g if a patient has been involved in an accident).

Planned surgery can be provided:

- As a 'day case', where the patient is admitted to anddischarged from hospital following their surgery on the same day; or
- As an 'inpatient', where the patient stays in hospitalovernight after their surgery

In August 2018 the orthopaedic surgery service provided by United Hospitals Lincolnshire NHS Trust (ULHT) became part of a national orthopaedic pilot to look at how service quality and patient outcomes couldbe improved.

Prior to the pilot beginning, planned and unplanned orthopaedic surgery was carried out at three hospital sites; Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital. In addition, planned orthopaedic surgery was provided from CountyHospital Louth.

Under the pilot all unplanned orthopaedic surgery is now carried out at Lincoln County Hospital and PilgrimHospital, Boston, and as much planned orthopaedic surgery as possible is carried out at Grantham and District Hospital.

	Before the pilot in August 2018	After the pilot changes in August 2018
Lincoln County Hospital	· Planned surgery · Day case · Inpatient · Unplanned surgery	· Planned surgery · Day case *high risk patients* · Inpatient *high risk patients* · Unplanned surgery
Pilgrim Hospital, Boston	· Planned surgery · Day case · Inpatient · Unplanned surgery	· Planned surgery · Day case *high risk patients** · Inpatient *high risk patients* · Unplanned surgery **some non-high risk patients also seen to manage day to day operational demands*
Grantham and District Hospital	· Planned surgery · Day case · Inpatient · Unplanned surgery	· Planned surgery · Day case *non-high risk patients* · Inpatient *non-high risk patients*
County Hospital Louth	· Planned surgery · Day case · Inpatient	· Planned surgery · Focused on day cases *non-high risk patients*

Please see earlier section for description of temporary changes in response to COVID-19

Lincoln County Hospital and Pilgrim Hospital, Boston continue to provide some planned orthopaedic surgery for high risk patients with multiple health problems, which is comparatively small in volume.

In addition, throughout the pilot Louth hospital has focused on day case planned orthopaedic surgery.

A summary of orthopaedic surgery provision prior to the pilot changes and after the pilot changes in August 2018 (pre COVID-19) is set out above.

A report of the pilot and outcomes can be found on our website.

What are the challenges and opportunities for orthopaedic surgery?

This section sets out the challenges and opportunities for orthopaedic surgery and what we hope to achieve by making changes.

Challenges (pre pilot)

- A lack of 'protected' planned orthopaedic surgery beds across United Lincolnshire Hospitals NHS Trust(ULHT) meant that the high volumes of medical emergencies experienced all year round resulted in fewer beds being available for planned orthopaedicsurgery
- On average, around 10 patients each month had their planned orthopaedic surgery cancelled on theday of surgery due to a lack of beds. This is a very poor experience for patients and their families
- Failure to consistently meet nationally set referral to treatment time targets – limited separation of planned and unplanned orthopaedic surgery made attainment and sustainment of the target a challenge
- The orthopaedic service had high doctor and nursevacancies
- Over 3,000 patients from Lincolnshire each year received a planned orthopaedic procedure in the private sector (funded by the NHS), much of which took place outside of Lincolnshire. This is because sufficient capacity is not available in the NHS locally.The money that is spent with these private providerscould go towards the delivery of local NHS services

Opportunities

By making changes, we can look to ensure:

- Improvements in the quality of patient care and outcomes evident during the pilot become permanent
- Reductions in the number of patients who have theirplanned orthopaedic surgery cancelled on the day due to lack of beds
- Reductions in the time patients wait for their plannedorthopaedic surgery is reduced, so they are treated quicker
- Best practice for the length of stay for patients in hospital after surgery
- Overall patient experience and satisfaction is improved, including reducing the amount of time spent in hospital after surgery
- More Lincolnshire patients choose to have their orthopaedic surgery in Lincolnshire
- The number of patients going to the private sector for planned orthopaedic surgery, paid for by the localNHS, is reduced
- The need for temporary staff to cover vacancies is reduced
- The orthopaedic service is able to attract and retain talented and substantive staff to build an effective, high quality, successful team

- Orthopaedic services are provided to Lincolnshire's patients in line with national best practice and care standards

The feedback from engagement about orthopaedic surgery and how we have used it

There has been ongoing engagement with the public throughout the Lincolnshire Acute Services Review programme, particularly through the 'Healthy Conversation 2019' engagement exercise.

Some consistent themes in relation to orthopaedicsurgery have been shared by the public and stakeholders throughout our engagement to date:

- Acknowledgement of the problems with the current situation e.g. the number of cancelled operations andthe number of patients travelling out of county for treatment
- The principle of separating planned and unplanned care is considered sensible if it will enable a reductionin the number of cancelled operations and allow staffto become more specialist
- A desire for information about where any planned and unplanned sites would be located, and to better understand how different sites would be utilised in future if services changed
- Concerns about the distances needed to be travelled, with the transport infrastructure and rurality identified as major challenges. The ability forfamily members to visit the patient was also seen asimportant
- The process of being discharged from secondary care, specifically the link between 'bed blocking' and the cancellation of planned operations, and the need to improve 'step down' care and integrate more closely with social care
- Working with existing resources by making use of oursmaller hospitals as diagnostic treatment centres

We have consistently taken into account all of the public and stakeholder feedback throughout our work.

In addition to the feedback received through our engagement exercises, the orthopaedic surgery pilot has sought feedback from its patients.

The overarching theme from the patient experience and feedback is how impressed and happy people arewith the level of care and treatment received from all staff involved. Just prior to the onset of COVID-19, 95% positive feedback was achieved in the NHS Friends and Family Test (a post treatment survey).

What is our proposal for change?

Our proposal for change (which reflects the pilot arrangements) is to establish a 'centre of excellence'in Lincolnshire for planned orthopaedic surgery at Grantham and District Hospital, and a dedicated day case centre at County Hospital Louth. Outpatient clinics would be unaffected.

This would mean Grantham and District Hospital would not provide unplanned orthopaedic surgery.

Lincoln County Hospital and Pilgrim Hospital, Boston would continue to provide unplanned orthopaedic surgery, and some planned orthopaedic surgery for high risk patients with multiple health problems, which is comparatively small in volume.

It is anticipated the change would affect on average:

- Between 3 and 4 patients a day for planned orthopaedic surgery, these patients would receive treatment at either Grantham and District Hospital orLouth hospital; and
- Around 1 patient a day for unplanned orthopaedic surgery, these patients would have previously received care at Grantham and District and would now be treated at a different site

If more planned orthopaedic surgery capacity became available at Grantham and District Hospital and County Hospital, Louth, more patients could be seen at these sites and benefit. This includes seeing more of the patients who receive their planned care in the private sector (much of which takes place outside of Lincolnshire) paid for by the NHS.

A key part of our evaluation of options to tackle the service challenges, was to hold a clinically led health system stakeholder workshop and four workshops withrandomly selected members of the public.

For orthopaedic surgery, where only one solution remained following the shortlisting of options, attendees at these workshops were asked whether theyagreed or disagreed that the changes proposed would help to improve the current situation and meet the challenges identified.

The table below summarises the level of stakeholderand public support for the change proposal.

Support for change proposal to consolidate planned orthopaedic services at Grantham and District Hospital		
Support for change proposal	**Stakeholder**	**Public Workshops**
Agree (strongly/ tend to)	98%	84%
Disagree (strongly/ tend to)	0%	14%
Neither agree nor disagree	2%	2%

Impact Analysis

As we have developed our proposals we have considered the quality and equality impact of the preferred option for orthopaedic surgery.

We have also benefited from the evidence collated through the pilot (pilot evaluation is based on data for the period August 2018 to February 2020).

Through our equality impact assessment we identified three groups of people, two of which are defined by protected characteristics that may be more likely to be impacted, positively or adversely, by this proposal.

These three groups are age, disability and those who are economically disadvantaged.

Our observations from the pilot evaluation and these assessments are set out below. We will continue to review and develop these, including the impact on different groups of people within our population, with independent support, through our public consultation in light of the feedback we receive.

Potential positive impacts

Evaluation of the pilot pre COVID-19 identified:

1. A reduction in waiting times for planned orthopaedic surgery, which means patients were getting treated quicker
2. Cancellations on the day of planned orthopaedic surgery due to a lack of beds reduced:
    - From 10 a month to 3 a month across United Hospital Lincolnshire NHS Trust (ULHT)
    - To 0 at Grantham and District Hospital
3. Length of stay reduced:
    - From 2.9 days to 2.3 days across ULHT
    - From 2.7 days to 1.7 days at Grantham and District Hospital

4. ULHT performed better than many other hospitals in terms of the length of time patients stayed in hospital after their planned surgery

5. An improvement in overall patient experience and satisfaction. In February 2020 a score of 95% was achieved in the 'Friends and Family Test'

6. The number of patients going to the private sector for planned orthopaedic procedures, funded by thelocal NHS, reduced

7. The pilot workforce model successfully removed the need for temporary staff to cover vacancies, and the service is more attractive to junior doctors whichsupports long term service sustainability

Potential adverse impacts

1. Receiving planned orthopaedic surgery at Granthamand District Hospital or County Hospital Louth, wouldmean treatment is received at an alternative hospital site for some patients (3 to 4 a day on average).

   As the pilot has demonstrated, these patients would receive high quality care and outcomes; however it is acknowledged that needing to travel further for this care may be seen as an adverse impact by some people.

   - Of those receiving planned orthopaedic surgery atan alternative hospital site it is estimated around 1 a day, on average, will travel more than 75 minutes by car for their surgery, the threshold agreed by the local health system for this type of activity

   - The friends and family of those patients receiving treatment at an alternative hospital, may have to travel further to see them

2. For those patients who were previously admitted to Grantham and District Hospital for unplanned orthopaedic surgery (around 1 a day on average), care would be received at an alternative hospital site

   These patients would receive the specialist input they need at the right time, in the right setting; howeverit is acknowledged that needing to travel further for this care may be seen as an adverse impact by some people.

   - Of those receiving unplanned orthopaedic surgeryat an alternative hospital site it is estimated none will travel more than 60 minutes by car for their surgery, the threshold agreed by the local health system for this type of activity

   - The friends and family of those patients receiving treatment at an alternative hospital, may have to travel further to see them

1 Acute Services Review: Preferred option – Orthopaedics (elective and non-elective)

Note the case for change and proposed model of care described in this chapter are set against the current model of care (i.e. that provided pre-pilot and before the COVID-19 pandemic and subsequent temporary service changes).

9.1 Case for change

9.1.1 Nationally there has been a deterioration in the number of patients (all specialties) seen within the 18-week standard (national target is 92%). Lincolnshire CCG is currently performing better than the national average however it is well below the national target. Between April 2017 and February 2020 Lincolnshire's performance reduced from 89.5% to 82.7%.

9.1.2 At United Lincolnshire Hospitals NHS Trust (ULHT) there is an extensive recovery programme in place to move towards the national 92% target including delivery of additional outpatient clinics over and above core capacity. In addition, the clinical divisions have completed a range of further actions to improve processes within individual speciality areas and increase capacityin order to support the required improvements in the key planned care metrics.

9.1.3 These actions have supported improvements, however given the current configuration of services and limited separation of elective and non-elective services attainment and sustainment of this target will continue to be a challenge.

9.1.4 Historically ULHT has struggled with delivering the optimal mix of capability, capacity and resources across its hospital sites. Services have tended to be delivered across all sites, however the rurality of Lincolnshire means that the distance between the sites and poor transport infrastructure limits opportunities for scale and networked working. Over recent years ULHT has experienced pressure on elective beds from medical emergencies all year round.

9.1.5 Prior to the pilot in orthopaedics, where a 'hotter' and 'colder' site model was trialled, analysis showed that c.30% of planned orthopaedic patients (c.900 patients) had their activity cancelled every year. Around half of these (c.450 patients) had their surgery cancelled on the day. On average, around 10 patients each month had their surgery cancelled on the day due to a lack of beds. Cancellation of surgery at any time leads to poor patient experience and satisfaction, however being cancelled on the day of surgery is extremely distressing for patients and their families.

9.1.6 A mismatch between elective capacity and demand across ULHT means patients are already treated at hospital sites that may not be their closest geographically or are going to the independent sector (over 3,000 per year) to access elective orthopaedic services (still funded by the NHS).

9.1.7 Patients going to the independent sector, in or out of county, for elective orthopaedic surgery also have financial implications for the health system as a whole as funding allocated to the Lincolnshire Clinical Commissioning Group is not being spent on local NHS services.

9.1.8 The new NHS Long Term Plan published on 7 January 2019 fully supports the split of elective and non-elective work onto different sites to drive improvements, and recognises that managing complex, urgent care on a separate hot site allows improved trauma assessment and better access to specialist care, so patients have better access to the right expertise at the right time.

9.1.9 In addition to the current performance and capacity challenges, high nursing and medical vacancies exist across ULHT in the Orthopaedics (elective and non-elective) service (c.15% of nursing posts and c.10% of medical posts vacant).

9.1.10 In light of these challenges, the preferred option for the future provision of orthopaedics across Lincolnshire is to consolidate elective orthopaedics at Grantham Hospital.

9.1.11 It should be noted that the case for change presented here reflects the situation before theOrthopaedic pilot commenced.

9.2 Consolidation of elective orthopaedics at Grantham Hospital

Overview

9.2.1 At the time of the ASR Programme commencing, ULHT offered a 7-day non-elective orthopaedic service at Lincoln, Pilgrim and Grantham Hospitals. Major complex Trauma was only provided at Lincoln and Pilgrim Hospitals with patients presenting at Grantham Hospital with Major Trauma or requiring a high level of Intensive Treatment Unit (ITU) support post-surgery being transferred to Lincoln Hospital.

9.2.2 All three of these ULHT hospital sites also offered elective orthopaedic capacity, with further elective capacity offered at Louth Hospital (owned by Lincolnshire Community Health Service NHS Trust - LCHS). Outpatient clinics were held at Lincoln, Pilgrim, Grantham and Louth Hospitals, with further outpatient lists held at John Coupland Hospital (another LCHS site).

9.2.3 The preferred option identified through the ASR programme options appraisal process was for:

- Grantham to be a centre of excellence for elective and day case surgery;
- Lincoln and Pilgrim to provide some day case surgery and elective care for complex patients with significant co-morbidities and all complex non-elective and trauma services;
- Day case activity to be distributed across the Louth and Grantham sites;
- All fractured Neck of Femurs to be managed at Lincoln and Pilgrim hospitals;
- Evaluation of the pilot to be used to shape the extent of non-complex non-elective orthopaedic activity that continues on the Grantham hospital site; and
- Outpatient clinics remain unchanged across all sites (ULHT and others).

9.2.4 The model was designed through a number of clinically led workshops directed by the clinical leads for orthopaedics at ULHT with contributions, support and advice from Professor Briggs, and input from local acute, primary and community based health professionals. When this model was presented to the East Midlands Clinical Senate as part of the options appraisal process the panel recommended that the Lincolnshire STP proceeded with it.

9.2.5 In parallel with the ASR programme progressing, ULHT volunteered to be involved with the national Getting It Right First Time (GIRFT) programme and to be one of a small number of trusts across England to pilot a 'hotter' (emergency/unplanned non-elective care) and 'colder' (elective/planned care) site plan for orthopaedic services.

9.2.6 The orthopaedic pilot commenced on Monday 20 August 2018 with the following arrangements:

- All appropriate elective orthopaedic cases to be undertaken at Grantham Hospital with dedicated ring fenced beds on site;
- Lincoln and Pilgrim* to provide some day case surgery and elective care for complex patients with significant co-morbidities and all complex non-elective and trauma services (* Pilgrim continue to provide surgery for some non-high risk day case patients to manage day to day operational demands);
- Louth Hospital to be a dedicated day case centre for orthopaedics;
- All fractured Neck of Femurs to be managed at Lincoln and Pilgrim hospitals;
- Trauma to remain at Grantham Hospital for the duration of the trial to inform decisions on future approach; and
- Outpatient clinics remained unchanged across all sites (ULHT and others).

9.2.7 These arrangements aligned to the preferred option identified through the ASR programme options appraisal process.

9.2.8 However, it should be noted that the preferred ASR option was based on additional theatre and bed capacity being provided on the Grantham site to enable the full activity shift (which also reflected changes in other services, particularly General Surgery), whereas the pilot utilised existing capacity.

9.2.9 The local health system has therefore found itself in the position of being able to pilot key elements of the preferred option for the future provision of orthopaedic services across Lincolnshire identified through the ASR programme and refine as appropriate.

9.2.10 At the end of February 2020 the evaluation of the orthopaedics pilot showed very positive results. The experience of the pilot has reaffirmed the preferred option for the future provisionof orthopaedic services identified through the ASR options appraisal (to consolidated elective orthopaedic services at Grantham Hospital) and allowed it to be refined.

9.2.11 As well as refining the ASR proposal in terms of non-elective activity provided at the Grantham Hospital (no unplanned surgery provided), the pilot has also refined the proposals in terms of Louth becoming a dedicated day case centre for orthopaedics, i.e. does not provide orthopaedic elective inpatient activity.

9.2.12 It is now proposed this service change is taken forward in two phases:

- Phase 1 – making the pilot, which utilised the existing theatre and bed capacity on the Grantham Hospital site, a permanent change. The focus of this PCBC.
- Phase 2 – creating additional capacity on the Grantham Hospital site to allow for the full shift of orthopaedic day case and elective activity currently seen at ULHT's sites planned under the proposal and support further repatriation of patients going to the independent sector for orthopaedic surgery

Quality

9.2.13 Since the start of the orthopaedic trial in August 2018 the ward at Grantham Hospital which looks after the elective orthopaedic patients has always received extremely positive feedback.In January and February 2020 a score of 95% was achieved in the Friends and Family Test, against a target of 90%.

9.2.14 The overwhelming theme from the patient experience feedback was how impressed and happy patients were with the level of care and treatment received from all staff involved.

An excellent experience, cannot fault my treatment and procedures. The team are amazing, so friendly, informative, caring. Nothing is too much trouble for them. My stay has been really 'enjoyable'.

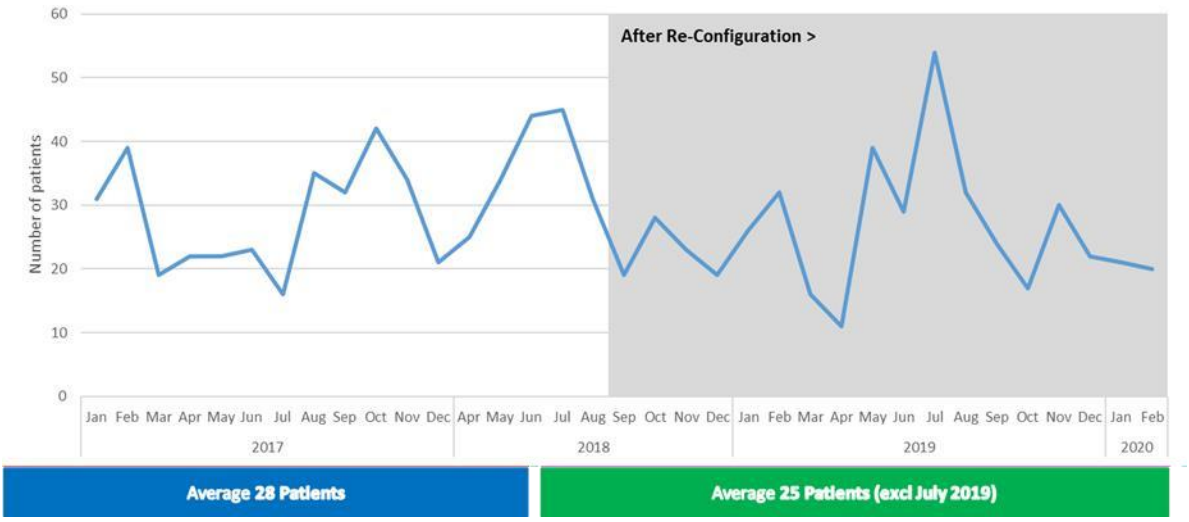
My experience since referral has been excellent. Fast tracked from consultation on 28/11/18 to surgery on 18/01/2019. Amazing, surprised and happy. Again my whole experience from check in at 07.30 (a little early for surgery at 2pm) to surgery, then overnight on Ward 2 was fantastic and little unexpected. All staff were very caring, professional. 100%, 10/10++

Wow certainly 'Enhanced Recovery'. Impressed lovely staff very friendly. Ward soclean and nothing any trouble. Comfortable stay. Well done everyone

9.2.15 Since the pilot started the department has not regularly sought the views of the staff in the formof a questionnaire. Verbal feedback from the staff is extremely positive, however it's recognisedstaff satisfaction feedback needs to be regularly collected and quantified.

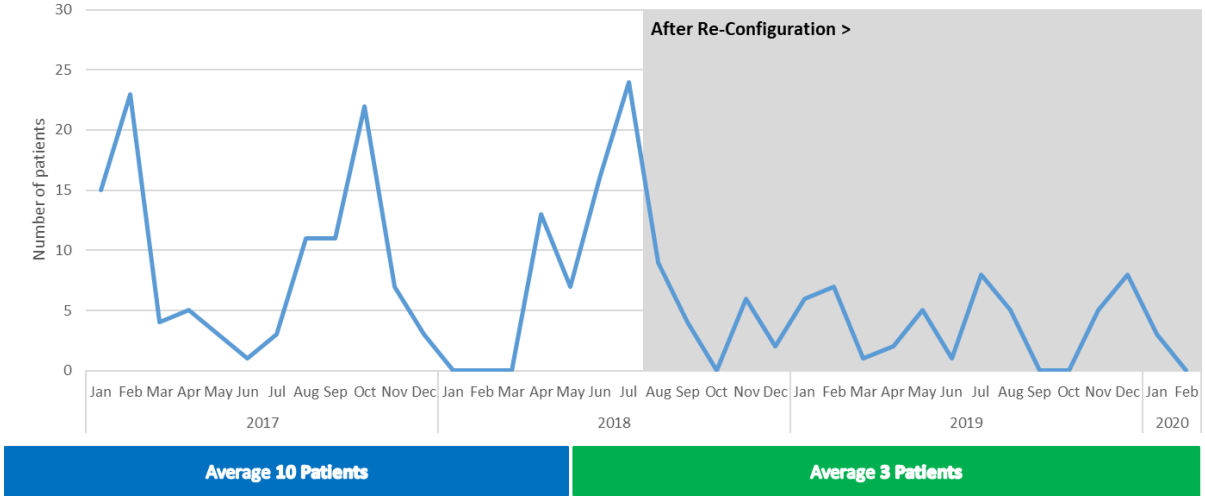
9.2.16 Before the pilot commenced, between January 2017 and July 2018 the average number of elective orthopaedic patients who had their surgery cancelled on the day each month was 28. With numbers above 40 in some months. Since the orthopaedic project commenced the Trust wide cancellation rate on the day for non-clinical reasons has reduced to an average of 25 patients (July 2019 data was excluded from the average figure due to the abnormally extreme adverse weather conditions).

Figure 126 – ULHT wide hospital initiated cancellations on day of surgery for elective orthopaedics



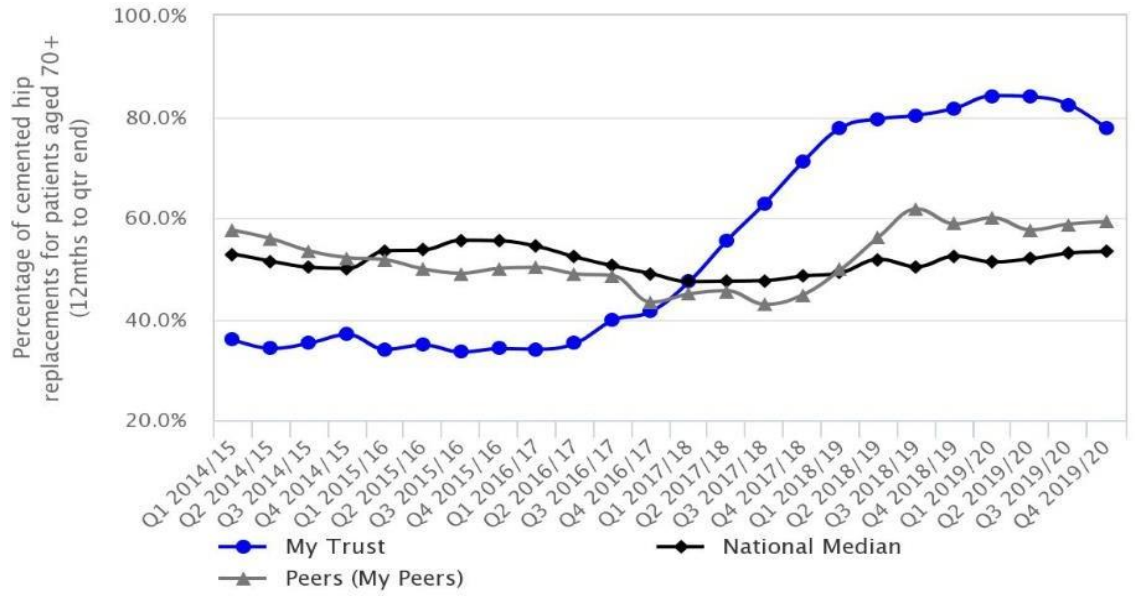
9.2.17 The Trust wide average cancellation rate on the day due to a lack of beds was 10 patients each month before the pilot commenced. This has now reduced to 3 patients per month cancelled onthe day due to a lack of beds across the Trust. Cancellations on the day at Grantham Hospital due to a lack of beds is nil.

Figure 127 – ULHT wide hospital initiated cancellations on day of surgery due to a lack of beds for elective orthopaedics



9.2.18 GIRFT have recommended to ULHT that the department tracks the percentage of cemented hips for patients aged 70+ as part of the success factors of the pilot. Not only has the outcome target of 80% of patients over the age of 70 to have a cemented hip replacement been achieved, the stretch target of 87% has also been achieved.

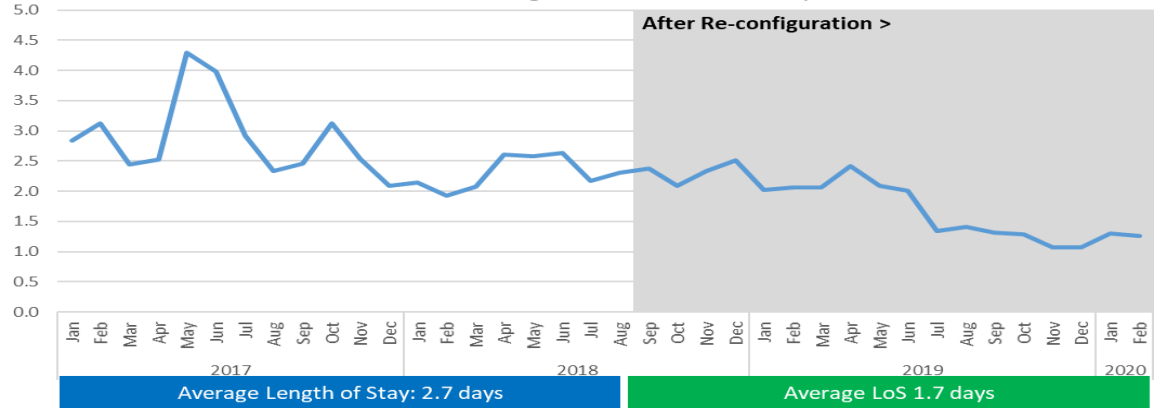
Figure 128 – Percentage of cemented hip replacements for patients aged 70+ performance comparison (12mths to quarter end)



9.2.19 The evaluation of the orthopaedic pilot also identified a reduction in the average length of stay for elective orthopaedics at Grantham Hospital from 2.7 days to 1.7 days, demonstrating strong operational performance. A marginal increase in length of stay was seen in January 2020, this was due to hip and knee revision surgery commencing at Grantham Hospital.

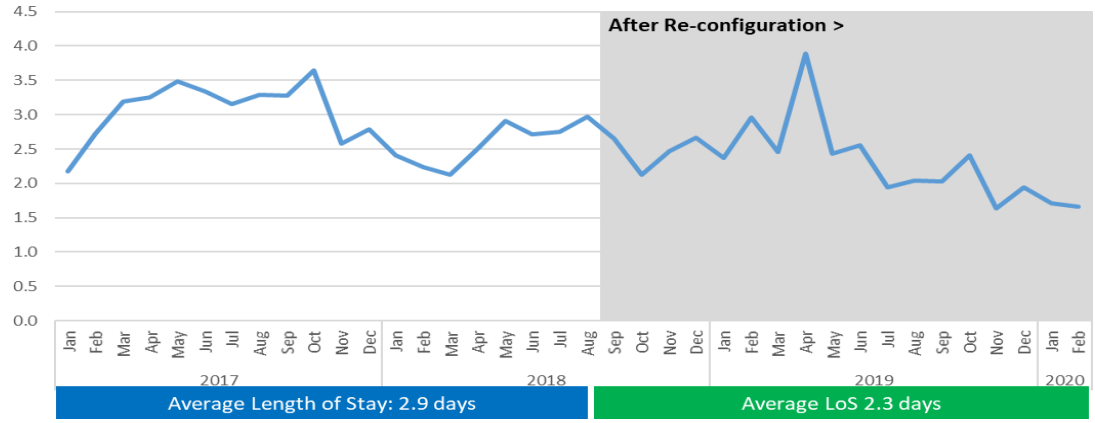
9.2.20 An enabler to the reduced length of stay is the commencement of total hip and total knee replacements being undertaken at Grantham Hospital as day-case procedures. Patients having these procedures as day-cases are followed up by telephone to ensure their outcome is as planned.

Figure 129 – Grantham Hospital elective orthopaedic inpatient average length of stay



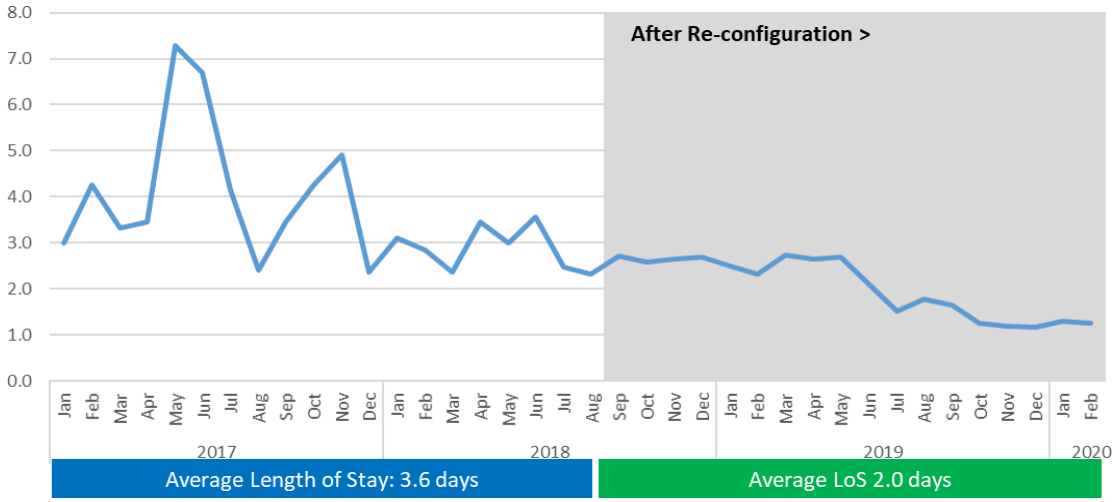
9.2.21 A reduction in the Trust-wide orthopaedic elective length of stay has been achieved from 2.9 days to 2.3 days.

Figure 130 – ULHT wide elective orthopaedic inpatient average length of stay



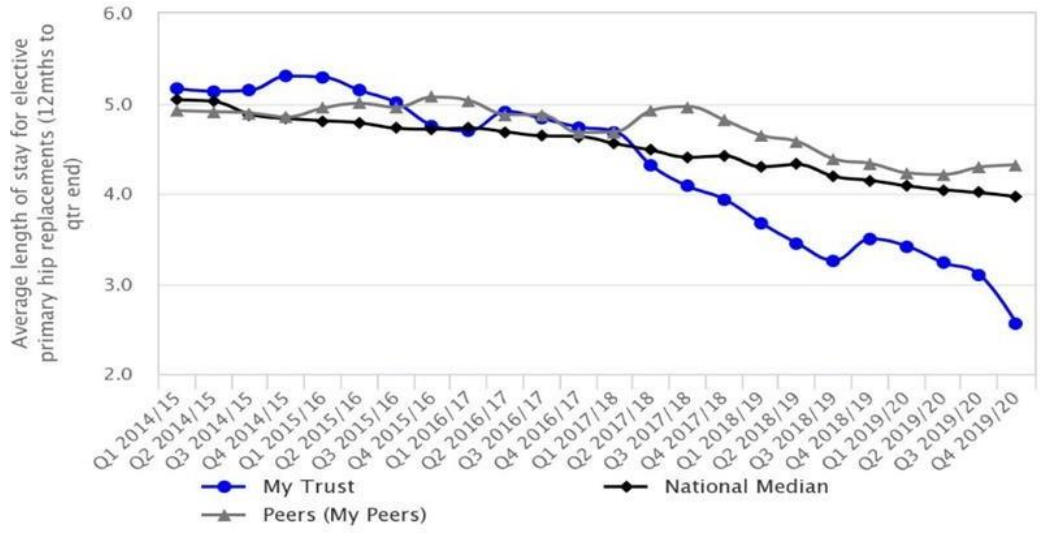
9.2.22 The length of stay for primary hip replacements at Grantham Hospital has reduced to an average of 2.0 days compared to 3.6 days before the pilot commenced. In February 2020 the average length of stay was reported as 1.3 days. ULHT is performing significantly better than both its peer trusts and the national median for primary total hip replacement length of stay.

Figure 131 – Grantham Hospital primary hip replacement average length of stay



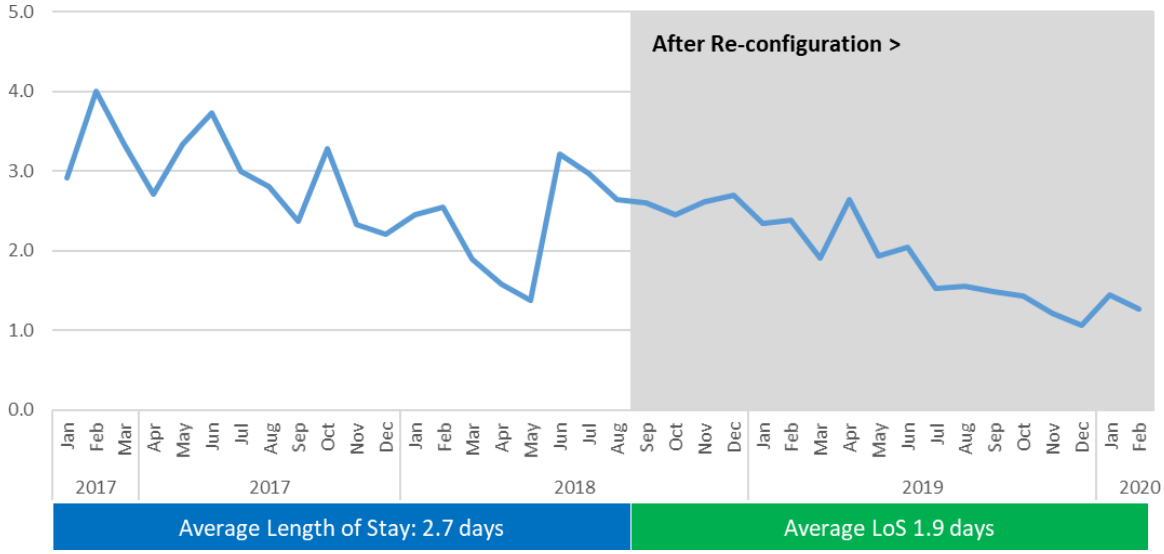
9.2.23 As the graph below demonstrates, ULHT is performing significantly better than both its Peer Trusts and the national median for primary total hip replacements length of stay.

Figure 132 – Primary hip replacement average length of stay performance comparison (12 mths to quarter end)



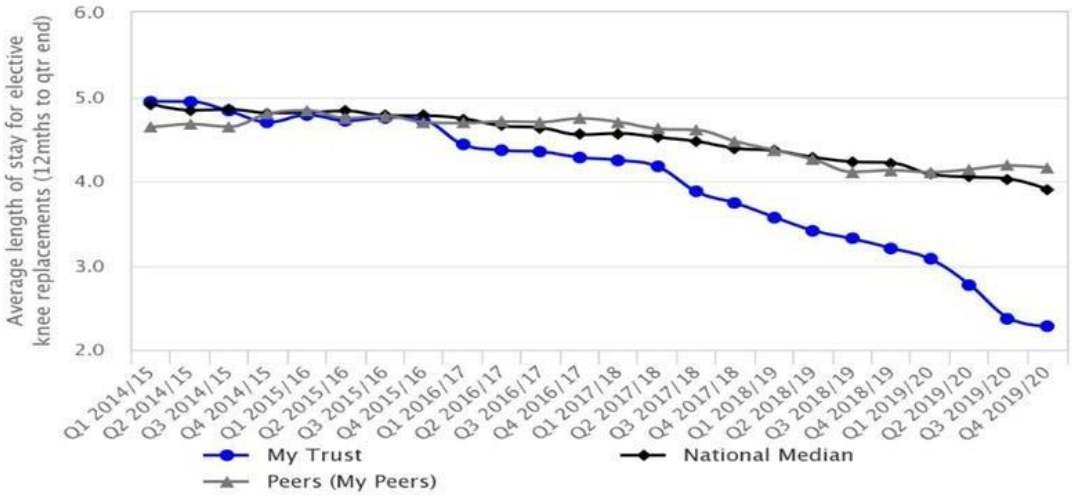
9.2.24 The length of stay for primary knee placements at Grantham Hospital has also reduced to an average of 1.9 days compared to 2.7 days before the pilot commenced. Length of stay at Grantham Hospital has outperformed all other pilot Trusts within the GIRFT programme.

Figure 133 – Grantham Hospital primary knee replacement average length of stay



9.2.25 As the graph below evidences, the length of stay for total knee replacements is far better than the national median and ULHT peer trusts, mirroring the achievement in the reduction of length of stay for total hip replacements.

Figure 134 – Knee replacement average length of stay performance comparison (12 mths to quarter end)



9.2.26 ULHT being able to deliver the quality and performance levels (and beyond) achieved through the orthopaedics pilot at Grantham would provide critical support to the recovery and restoration programme 'post-Covid' to reduce elective 'back logs'.

Access

9.2.27 It has been estimated that once the ASR preferred option has been fully implemented it will displace c.2,275 (c.1,375 EL, c.490 DC, c.410 NEL) patients per year (by 2023/24) currentlyseen by ULHT. It is the intention to keep all of the displaced elective and day case activity within Lincolnshire and be seen at a ULHT site and it is estimated around a third of the non-elective activity will stay within the county.

9.2.28 The vast majority of non-elective activity (c.215 patients) that goes out of the county would go to North West Anglia NHS Foundation Trust with the majority of the remainder (c.40 patients) going to Nottingham University Hospitals NHS Trust.

9.2.29 In addition, there is the potential to repatriate over 3,000 patients back into a ULHT site who are currently seen in the independent sector once the preferred option is fully implemented.

9.2.30 It is estimated pre-pilot c.70 patients travel more than 75 minutes for day case and elective orthopaedic surgery and procedures within Lincolnshire, however this does not include the patients that currently go out of county to the independent sector.

9.2.31 Once the preferred option is fully implemented it is estimated this figure would increase by c.580 by 2023/24 (see Appendix H for breakdown by neighbourhood team), however waiting times and cancellations would be reduced. It should also be noted that the increase in the number of patients travelling more than 75 minutes does not reflect reduced travel times for those being repatriated to receive care back in the county.

9.2.32 The table below provides a summary of the estimated impact on the number of patients displaced and associated travel times once the preferred option is fully implemented (2023/24). This reflects activity seen across the ULHT sites before the pilot started, and does not include any repatriated activity back from the private sector. Within this forecast an assumption of a reduction in day case activity of 10% was assumed over the period due to 'left-shift' i.e. the activity moving to a 'lower level' of care.

Figure 135 – Estimate of displaced activity to and from Grantham Hospital and travel times once preferred option is fully implemented (excluding repatriation)

	Grantham Hospital 23/24	Lincoln Hospital 23/24	Pilgrim Hospital 23/24	Louth Hospital 23/24	Out of County Hospitals 23/24
Elective activity					
Volume of activity	+1,374	-600	-508	-266	0
Travelling +75 mins	+521	+112	+179	+230	0
Daycase activity					
Volume of activity	+231	-488	0	+257	0
Travelling +75 mins	+43	+58	0	+15	0
Non-Elective activity					
Volume of activity	-409	+137	+12	0	+260*
Travelling +60 mins.	0	0	0	0	0

** (215 to North West Anglia NHS FT, 40 to Nottingham University Hospitals NHS Trust)*

9.2.33 The orthopaedic pilot at Grantham Hospital started on Monday 20 August 2018. An estimate ofthe volume of displaced activity and associated travel time that has occurred through the pilot has been made by comparing activity seen at each site in 2017/18 the last full year before the pilot started and 2019/20 the first full year it has run.

9.2.34 It is estimated that since the Orthopaedic Pilot started c.1,710 (c.825 EL, c.475 DC, c.410 NEL) patients per year have been displaced. This figure does include a small proportion of patients being repatriated from providers out of the county.

9.2.35 This analysis has estimated that under the current pilot arrangements an additional c.365 patients per annum travel more than 75 minutes by car for elective orthopaedic surgery and procedures within Lincolnshire.

9.2.36 An additional factor that has occurred during the period of the pilot is a change to the Referral Facilitation Service (RFS) that covers what were 3 of the 4 Lincolnshire CCGs, with full effect occurring in 19/20.

9.2.37 Between 2017/18 and 2019/20 there has been a reduction in inpatient and daycase activity at out of county (OoC) and independent sector (IS) providers, some of which seems to have been redirected to ULHT under the RFS and some of which has been converted into ‘left shift’.

9.2.38 It is estimated that between 2017/18 and 2019/20 there has been a ‘left shift’ of c.9.3% of day case activity.

Figure 136 – Estimate of displaced activity and travel times (excluding repatriation) observed through pilot

	Grantham Hospital 17/18–19/20	Lincoln Hospital 17/18–19/20	Pilgrim Hospital 17/18–19/20	Louth Hospital 17/18–19/20	OoC & IS Hospital 17/18–19/20	*Estimated impact of 'left-shift'* 17/18–19/20
Elective activity						
Volume of activity	+824	-229	-170	-270	-444	*+289*
Travelling +75 mins	+337	+43	+60	+234	-	-
Daycase activity						
Volume of activity	-336	-345	+35	+442	-475	*+679*
Travelling +75 mins	+21	+6	0	+27	-	-
Non-Elective activity						
Volume of activity	-409	+137	+12	0	+260*	-
Travelling +60 mins.	0	0	0	0	0	-

** (215 to North West Anglia NHS FT, 40 to Nottingham University Hospitals NHS Trust)*

9.2.39 The main constraint to delivering the full extent of the planned activity shift to Grantham Hospital under the preferred option is bed and theatre capacity. The pilot has utilised the existing capacity on the Grantham Hospital site and to consolidate any more activity wouldrequire an increase in capacity. This is described further below.

9.2.40 One of the risks identified at the start of the trial was whether patients would be prepared to travel 30 miles or more to have their elective treatment at Grantham Hospital. However, on review of all the patient feedback received on the orthopaedic pilot no reference or issues were highlighted with travelling or transport delays.

9.2.41 This is certainly a positive outcome, given concerns around access and travel in relation to orthopaedics services were a common theme throughout public engagement exercises. However, through the most recent pre-consultation engagement exercise (Healthy Conversation 2019) feedback received from the community group meetings identified the majority of attendees said they would travel (incl. out of county) if it meant receiving treatment quicker.

9.2.42 Conversations are ongoing with Lincolnshire County Council regarding public transport and how it supports access to health services in the wider sense. The impact of the proposed service changes on access has been considered in the Equality Impact Assessment and this will be tested and explored further through consultation with the public before any plans are finalised.

9.2.43 These plans, for example, could include providing additional non-emergency patient transport, cohorting appointments by postcode and providing a shuttle service and further integrating existing voluntary and non-emergency patient transport services. Any plans developed would need to be done so in the context of existing local and national patient transport policies and criteria, however a financial provision has been made in the financial case for the proposed service changes.

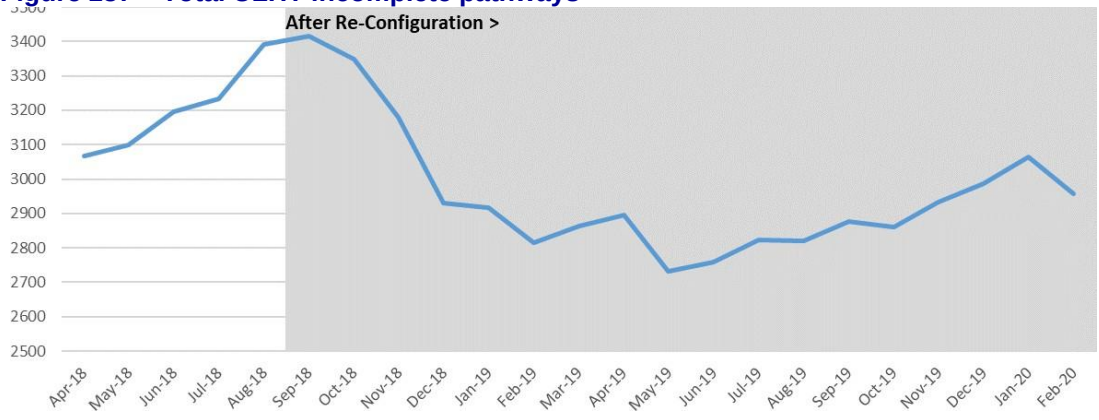
9.2.44 In addition, through workshops with stakeholders proposals have been developed to improve support to patients with regards to travel in the broadest sense across Lincolnshire (i.e. not just relating to proposed service changes under the Acute Services Review). These include:

- Ensuring a seamless process for advice, eligibility assessment and booking
- Improved coordinated way of ensuring the appropriate transport is arranged for dischargesfrom hospital:
  - The default should be Non-Emergency Patient Transport Services (NEPTS) unless there is a 'medical need'
  - Better planning and coordination with the family/patient early in a patients stay as an integral part of discharge planning
  - Coordination of NEPTS with potential other options through a single system approach to discharge planning
- Booking of clinics:
  - More proactive choices regarding clinic bookings should include a discussion on 'how are you intending to travel'
  - Real time information to support administrators in understanding public transport should be easily accessible on their IT systems so that is the patient is travelling bybus and the first bus doesn't arrive until 10:00 the patient is offered an appointmentafter this time
- Integration of CallConnect and NEPTS journey planning to reduce duplication
- Integration of systems to allow funded, non-funded and concessionary fares/bus passes touse multiple types of transport

9.2.45 Since April 2019 the highest performing RTT month for orthopaedics was November 2019 (91.17%), this month also saw one of the highest overall waiting list sizes (2,932 patients).

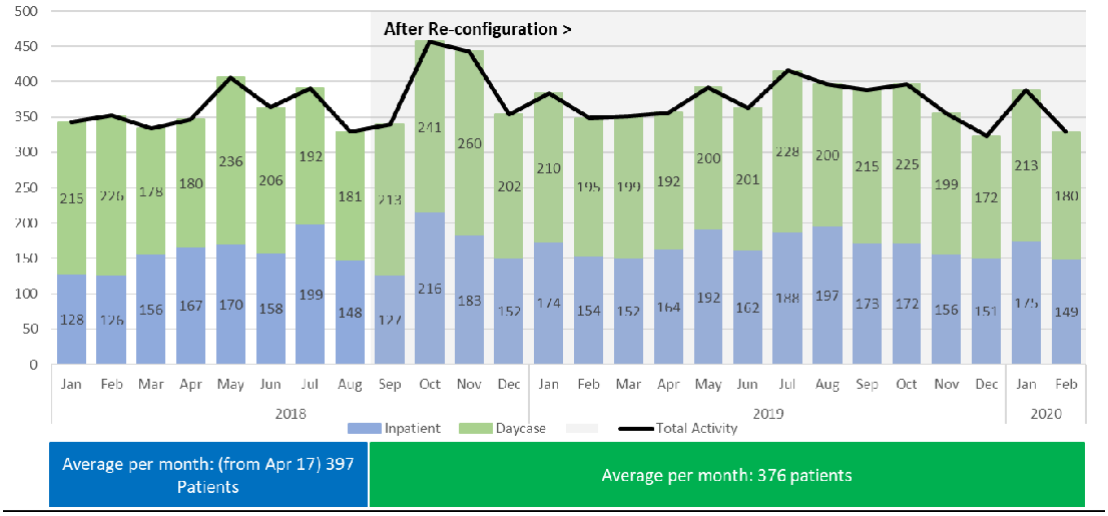
9.2.46 As the waiting time is shorter on the non-admitted pathway i.e. wait to first appointment and subsequent follow up, the Trust is now attracting more referrals. All outpatient elective clinics were full and theatre efficiency has improved. In order to maintain RTT and to reduce the waiting list size, due to the efficiencies already made the department needs to consider operating on Saturdays and Sundays.

Figure 137 – Total ULHT incomplete pathways



9.2.47 The Trust wide elective orthopaedic activity increased from an average of 397 patients each month to 411 patients after the trial commenced, although this gradually returned down to 376. One of the main challenges the department has faced is at the start of the pilot it was agreed to have 14 less trust wide theatre lists per week for orthopaedics. However, this has been successfully mitigated with the capacity allocated.

Figure 138 – Total ULHT orthopaedic activity (daycase and inpatient)



9.2.48 Through the pilot it has been shown that the consolidation of elective orthopaedic services at Grantham Hospital (together with a greater focus on day cases at Louth) can deliver a reduction in the amount of time people wait to have their surgery as well as the potential to increase the number of patients treated by ULHT. It has also shown people are prepared to travel to have their elective surgery if it means they will have their operation quicker.

9.2.49 ULHT being able to deliver these levels (and beyond) achieved through the Orthopaedics pilot at Grantham would provide critical support to the recovery and restoration programme 'post-Covid' to reduce elective 'back logs'.

Affordability and Deliverability

9.2.50 Before the pilot started orthopaedic services used on average 8 elective beds and 8 non-elective beds (16 beds in total) at the Grantham Hospital site based on a 92% occupancy rateand operating 5 days a week. During the pilot orthopaedic services have used on average 16 elective beds on an occupancy of 92% and operating 5 days a week.

9.2.51 To deliver the full extent of the preferred option excluding repatriation, a further four elective beds would be required taking the total up to 20 beds, based on a 1.5-day length of stay at 92% occupancy and 5-day operating. To enable the full repatriation of all patients currently treated out of county and/or in the independent sector it is estimated an additional 15 beds would be required (based on the same length of stay and occupancy assumptions). However,these additional capacity requirements are outside the scope of this business case.

9.2.52 There are currently two laminar flow orthopaedic theatres at Grantham Hospital. Spare capacity did exist in these theatres pre-pilot, which is now being used. Through the pilot theatre utilisation increased to around 85%, based on two session days, five days a week. However, the full extent of the proposed model cannot be fully implemented without additional theatre capacity being built on the Grantham Hospital site, based on the current two sessions a day five days a week operating model.

9.2.53 To fully implement the proposal, excluding repatriation, a further one theatre (0.75 based on the calculations) would be required assuming two theatre sessions a day five days a week and the average theatre time used per procedure at Grantham Hospital. To accommodate the repatriation of activity that currently goes out of the county and/or to the independent sector 2.5 additional theatres would be required.

9.2.54 The development of a business case for additional elective orthopaedic capacity at Grantham Hospital (Phase 2) would require the current working patterns of two theatre sessions a day, five days a week to be considered further.

9.2.55 Through the orthopaedics pilot the workforce model has changed and been sustained in a number of areas:

- The consultant on-call model at Grantham has been removed and the on-call function is now provided by a core of middle grade orthopaedic doctors. The on-call middle grade report into the receiving 'hot' site (Lincoln or Pilgrim) for support if required. The receiving sites alternate on 3-weekly intervals.
- The middle grade and consultants who work at Grantham for orthopaedics are now part of the ULHT wide (Lincoln, Pilgrim and Grantham Hospitals) orthopaedic rota.
- The number of orthopaedic F2s has reduced at Grantham from 7 to 3 with effect from April 2020.
- Orthopaedic consultants now operate across multiple sites as part of the ULHT wide Orthopaedic team.
- The pilot workforce model has successfully removed all agency doctor usage ULHT wide. Before the pilot, agency doctors were used to cover one consultant post, F2 posts and middle grade posts.
- The current workforce in the pilot model still carries one consultant vacancy, two middle grade vacancies and two F2 vacant posts, however all of these vacancies are covers through the new workforce model, without the need to bring in agency doctors.

9.3 East Midlands Clinical Senate recommendations and workforce improvements

9.3.1 The East Midlands Clinical Senate has been involved all the way through the options development and appraisal process for Orthopaedics. This included an independent clinical review where they were asked to consider whether there is a clear clinical evidence base underpinning the proposal.

9.3.2 The review focussed on the clinical interdependencies and the totality of the changes proposed. Specifically, the clinical review team was asked whether it supported the ASR proposals based on clinical sustainability, workforce deliverability and improvements in clinical outcomes.

9.3.3 Through this review the East Midlands Clinical Senate supported the proposal for Orthopaedic services and made a number of recommendations and workforce improvements. The table below sets out the recommendations and progress against them.

Figure 139 – East Midlands Clinical Senate recommendations and progress

EM Clinical Senate Recommendation	Progress
Involve HEE early in the process with regards to the training experience of junior surgeons	The pilot has shown no detriment with regards to middle grade training because when a surgeon from Lincoln or Pilgrim goes to Grantham they take their middle grade with them to give that exposure. The view is this is better for training as ULHT is cancelling fewer patients and trainees are seeing more patients. Junior doctor training hasn't changed.
Confirm arrangements for on-call at Grantham Hospital	Under the pilot the on-call pattern at Grantham is hospital at night, which looks after all patients. There is a middle-grade resident on call system to look after very unwell patients. Lincoln County Hospital and Pilgrim Hospital do 24hr Orthopaedic on-call, the resident on-call at Grantham can contact the Orthopaedics team on-call at these sites and a transfer can be arranged if required. Since August 2018 only 1 patient has nearly needed transferring but this didn't happen.
Ensure clarity around clinical responsibility	Under the Pilot the patient still belongs to the operating consultant, there is a ward round every day in the morning by a senior Orthopaedic doctor who liaises with the original operating consultant as required. The patient's follow-up is with the consultant who performed the operation/procedure. After 6pm all patients are under the care of the on-call consultant. On a Monday, Wednesday, Friday and Sunday the Lincoln County Hospital consultant is in charge, the other days it is the Pilgrim Hospital consultant.
The potential for unintended effects which impact on other departments and colleagues, for example relating to medical Orthogeriatric reviews, also needs to be factored in	Input for elective Orthopaedic from care for elderly is unusual. Likely to need medical input, if this is the case the medical consultant on-call at Grantham Hospital is called.
More detail is required around the transport plan for patients that require it	The pilot has shown no additional demands on transport solutions and no negative feedback from patients in relation to transport. Transport solutions already exist, that will continue to evolve: • Patient Transport Service (PTS) based on eligibility criteria (Lincolnshire aiming for an ITT on PTS contract Feb/Mar 2021) • Volunteer services • Contingency of £1m included in finances to support PTS There is also a commitment from Lincolnshire County Council to co-develop transport solutions e.g.: • Integration of CallConnect and PTS • Integration to allow funded, non-funded and concessionary fares/bus passes to use multiple types of transport
The service should work with EMAS to ensure the impact on emergencies is factored in	When the pilot started a dialogue was had with EMAS about fractured neck of femur and to transport them to Lincoln County Hospital and Pilgrim Hospital. No concerns around these arrangements have been raised through the pilot. EMAS are fully aware of the exclusion criteria at Grantham.
Recognising the quality of aftercare is closely connected to acute care more detail should be provided	Immediate post-operative care – is available to all receiving care (see on-call arrangements above) Planned post-operative care – Outpatient appointments will continue to be provided from Grantham, Lincoln and Pilgrim Hospitals, care will remain as close to home as possible. Patient follow-ups are by the surgeon who carried out the procedure/operation.

9.4 Milestone plan

9.4.1 In light of the revised approach to the ASR programme (in light of capital not being secured to support the implementation of the full scope of the ASR proposals) the preferred option for Orthopaedics has been split into two phases:

- Phase 1 – making the pilot, which utilised the existing theatre and bed capacity on the Grantham Hospital site (and includes optimising productivity and efficiency of existing capacity), a permanent change. The focus of this PCBC.
- Phase 2 – creating additional capacity on the Grantham Hospital site to allow for the full shift of activity currently seen at ULHT's sites planned under the proposal and support the further repatriation of patients going out of county and/or to the independent sector for orthopaedic surgery.

9.4.2 The ambition is for Phase 2 to be implemented around 12 months from now, once the required processes have been followed.

9.5 Quality and Equality Impact Assessments

9.5.1 A Quality Impact Assessment (QIA) has been completed for the proposed service change for Orthopaedic (elective and non-elective) services to identify clinical risks to the reconfiguration. This has been completed using a standard template by the Clinical Director and Lead Nurse forTrauma & Orthopaedics at ULHT.

9.5.2 The QIA for the service proposal:

- Identifies the key relevant quality measures for the areas of safety, clinical effectiveness, and patient experience;
- Identifies any risks to achieving an acceptable quality in these areas; and
- Presents mitigating actions.

9.5.3 A summary of the QIA for the proposed changes to orthopaedic (elective and non-elective) services is set out below and the full version is included in Appendix I.

Figure 140 – Summary of QIA for proposed orthopaedic (elective and non-elective) service changes

Area	Summary Impact (+ve & -ve)	Summary Actions
1.Quality		
Duty of Quality	▪ Will ensure lists are cancelled less frequently, and improve opportunities for staff to be developed in post ▪ A reduction in access may be perceived by those patient groups less able to travel	▪ Patients will be assessed for transport support using existing criteria
Patient Safety	▪ Will allow both planned and unplanned T&O patients to receive treatment quicker – improved access to care and health outcomes ▪ Segregation of orthopaedic patients will drastically reduce the risk of post-op infections ▪ To deliver full extent of change headcount/ skill mix at Grantham Hospital will need to change	▪ Recruit to staff vacancies
2. Experience		
Patient Experience	▪ Patients will be asked to travel further - this will be offset by reduction cancellations and treatment in a centre of excellence ▪ Number of sites in Lincolnshire care is provided from will reduce, however potential for fewer patients go out of county for care once fully implemented ▪ Reduction in 18-week backlog and shorter admission to operating times ▪ Ward staff at all sites will increase specialism and be able to focus on the management of orthopaedic patients more directly	▪ Comprehensive communication strategy and robust consultation ▪ Communicate benefits of a single site centre of excellence ▪ Script developed for booking staff and medics explaining reasons for travel
Staff Experience	▪ Should make roles more attractive by reducing cancellations ▪ Should make remaining in post more attractive ▪ Will reduce cancellations and overruns	
3. Effectiveness		
Clinical Effectiveness & Outcomes	▪ Changes in line with national GIRFT principals ▪ Reduced chance of post-op infection, extended us of enhanced recovery ▪ Reduce 'downtime' for clinicians ▪ Reduce cancellations and risk of pot-op infection ▪ Improvement in cancellation rate and RTT	

9.5.4 Quality for the domains of patient experience, patient safety and clinical effectiveness will be monitored and assured for United Lincolnshire Hospitals Trust (ULHT) through a combination of surveillance mechanisms throughout the Acute Services change and improvement program.

9.5.5 A system wide Lincolnshire Quality Surveillance Group is now meeting bi-monthly chaired by the CCG Director of Nursing with Clinical & Quality lead attendance from all Lincolnshire main providers (including ULHT and LCHS), NHSE/I including Specialised Commissioning, HealthWatch; HEE and Social Care. Any significant Quality concerns will be alerted and mitigated through the work of that forum.

9.5.6 Quality metric hard and soft intelligence for ULHT and LCHS is also considered through the CCG Quality and Patient Experience Committee (QPEC) that also meets bi-monthly as a sub-committee to the CCG Board. This committee will continue to consider Quality improvement requirements for ULHT, plus identifying any areas of Quality concern, where improvement action is required.

9.5.7 There are four dedicated CCG Quality Officers that work closely with ULHT, each with a focus on a respective hospital site. These CCG Officers are responsible for daily surveillance to identify any areas of Quality concern for ULHT, working with the Trust to secure improvementswhere required. This is through meetings with leads from relevant areas of the Trust, through attendance at the Trust's own Quality Governance Committee, via a regular CCG led Patient Safety Group and when indicated through Quality visits to the Trust as required.

9.5.8 There is also regular liaison between CCG Leads and their counterparts in the Trust to flag any areas of concerns plus now a regular system Clinical Forum that meets with ULHT attendance. There are similar quality monitoring processes for all Lincolnshire main providers, each having at least one dedicated Quality officer.

9.5.9 The lead CCG Quality Officer reports any concerns into QPEC and from a CCG perspective re: ULHT into the system Quality Surveillance Group. There is therefore an alerting system for any deteriorating quality areas for ULHT, which can be quickly identified for improvement, immediately if indicated.

9.5.10 Services undergoing any significant change will be monitored via the Trust's own Quality monitoring processes and also through the system and commissioner processes outlined above, to ensure as the change occurs and new service models become embedded that there are no deleterious effects on patient care at ULHT, LCHS or any other providers.

9.5.11 In addition the impact of any proposed changes on staff will be kept under ongoing review through the evaluation of measures such as the NHS Staff Survey, local surveys, absence rates, staff health and wellbeing, and retention rates.

9.5.12 As well as a QIA, a Stage 1 and Stage 2 Equality Impact Assessment (EIA) has also been completed for the proposed orthopaedic (elective and non-elective) service changes.

9.5.13 Within the Stage 1 analysis the populations/groups defined by protected characteristics that were identified that may face adversity as a result of the proposed activity/project were Age, Disability and Economically Disadvantaged.

9.5.14 To help address adverse impact on these groups The People's Partnership, on behalf of the Lincolnshire Sustainability and Transformation Partnership (as was) carried out an engagement exercise to reach hidden communities between 5 and 25 March 2019.

9.5.15 Over 15 days 130 questionnaires were completed. These submissions received views relating to sensory impairment, physical disability, learning disability, mental health, carers, young people and families, older people, race, pregnancy and maternity and social economic deprivation.

9.5.16 In addition, through March to October 2019 all Lincolnshire health organisations conducted the *'Healthy Conversation 2019'* engagement exercise. Within this period there were a number of engagement opportunities including an ASR-focused survey, drop in events with lead clinicians and executives to discuss proposed service changes, dedicated locality workshops offering more detailed discussion opportunities and a direct response/query mechanism.

9.5.17 During this engagement period, accessibility issues were again taken into account and the survey and promotional materials were made available in different formats on request and translated into different languages. Our partner and stakeholder organisations also worked with us to promote the various ways the public could get involved and supported their groups and audiences to engage. This process yielded broader feedback, however, it is noted that the themes and concerns were similar

9.5.18 Using the results of the engagement exercises and additional research the following themeswere identified in the Stage 2 EIA:

- Age:
  - Older population: Longer travel requirements which is impractical, especially whensome will not be able to drive for much longer; negative impact on health; concerns of greater reliance on family and friends for increased travel needs; reliance on public transport that is perceived to be limited in accessibility; impractical to travel longer distance from some areas.

- Younger population: Negative impact on health; reliance on hospital transport; longer travel requirements which is impractical; reliance on public transport, whichis perceived to be limited in accessibility.

- Disability:
  - Longer travel requirements which is impractical;
  - Additional cost related to travelling services further away;
  - Inability to drive especially if sight impaired or wheelchair user;
  - Greater reliance on family and carers for increased travel needs; and
  - Negative impact on health and anxiety levels
- Economic Disadvantaged:
  - The specific engagement from The People's Partnership did not receive feedback from groups with this protected characteristic.
  - But the wider Healthy Conversation 2019 engagement identified that the possible negative impacts of this proposed change on deprived population include longer travel requirements and additional cost of this and specific concern about the costs of return travel from hospital, especially at times of limited/no public transport.

9.5.19 A summary of the EIA for the proposed changes to orthopaedic (elective and non-elective)services is set out below and the full version is included in Appendix J.

9.5.20 The Equality Impact Assessment will continue to be developed and refined throughout theconsultation period, drawing in feedback received through the process.

9.5.21 Plans to mitigate impact on travel and access will be finalised once the public has been fully consulted on any proposed service changes. These plans will be finalised in the context of existing local and national patients transport policies and criteria.

Figure 141 – Summary of EIA for orthopaedic service changes

Impact / issue identified	Key actions or justification to address impact/issues	Anticipated outcome – will this remove negative impact

1. Longer travel requirements	• Patients will potentially incur longer travel times for day-surgery and inpatient surgery.
	• Estimated that since the Orthopaedic Pilot started c.1,710 (c.825 EL, c.475 DC, c.410 NEL) patients per year have been displaced. This figure does include a small proportion of patients being repatriated from providers out of the county.
	• Estimated that before the Orthopaedic Pilot c.70 patients travelled more than 75 minutes for day case and elective orthopaedic surgery and procedures within Lincolnshire, the threshold agreed through for this type of activity. However, this figure does not include the patients that currently go out of county to the independent sector.
	• Analysis of Orthopaedic Pilot activity has estimated that under the current pilot arrangements an additional c.365 patient per annum travel more than 75 minutes by car for orthopaedic surgery and procedures within Lincolnshire.
	• However:
	  • Cancellations will be reduced and patients will be seen quicker leading to improved access and health outcomes.
	  • Patient feedback on pilot has been supportive of increased travel times.
	  • Patients will not incur longer travel for outpatient appointments as they will not change.
		• No. For some patients there may be longer travel times, but this is balanced against reduced waiting times and improved service quality and outcomes.

2. Negative impact on health	• Patients will have fewer cancellations, be seen quicker, receive a better quality service and achieve better outcomes. • The pilot has shown these improvements are possible	• Yes. Proposed service should have a positive impact on health • This has been demonstrated through the evaluation of the orthopaedic pilot.
3. Greater reliance on family and friends for increased travel needs 4. Greater reliance on public transport, which is perceived to be limited in accessibility 5. Concerns about costs of travel to and from hospital, especially at times of limited/ no public transport	• Some patients may potentially have a greater reliance on public transport for travel support. However: • ULHT currently provides a patient transport service based on eligibility criteria; and • Volunteer services currently provide patient transport services where confidence or mobility issues can make it difficult to attend hospital *The NHS is not responsible for the public transport infrastructure in the county (Lincolnshire County Council controls this), however the NHS is undertaking partnership working with LCC and others in order to review and improve travel and transport in the county.*	• Yes. For some there may be a greater reliance on family and friends for transport. However, NHS and voluntary sector patient transport services already exist to help in certain situations. • The proposed service changes do not make any changes to these patient transport services. • The Grantham pilot has evaluated very well and these issues were not observed in the feedback. • Plans to mitigate impact on travel and access will be finalised once the public has been fully consulted on any proposed service changes. These plans will need to be finalised in the context of existing local and national patients transport policies and criteria.

9.6 Vignettes to demonstrate the positive impacts of the clinical model

Patient 1

9.6.1 A 55 year old female lives in Skegness. She attends an outpatient appointment with an Orthopaedic surgeon at Pilgrim Hospital in Boston after being referred by her GP. The surgeon advises she needs a total knee replacement, and that this can be done at Grantham Hospital and she won't have to wait long for the surgery.

9.6.2 The surgeon advises the procedure will be a day-case. He tells her he will do the operation, she will receive an initial follow-up via telephone to ensure everything is as planned and he willthen see her for a follow-up outpatient appointment back at Pilgrim Hospital.

9.6.3 The patient's operation goes ahead at Grantham Hospital on the day it was scheduled for. The patient does not have relatives to take her to the hospital and so is taken to Grantham and returned home after surgery on patient transport. She receives a phone call the day after her surgery to check everything is ok and has an outpatient appointment at Pilgrim Hospital 8 weeks after the operation to check on progress.

9.6.4 Outcomes:

- The patient doesn't have to wait long to receive the operation and receives it on the day it was planned for. The patient is seen as a day-case so doesn't spend any more time in hospital than is needed and receives after care close to home.
- The Orthopaedic doctors and nurses are very pleased to be doing the patient's knee replacement at Grantham Hospital where they can give her excellent quality care and the best outcomes. The Orthopaedic team receive very positive feedback from the patient.

Patient 2

9.6.5 An 80 year old male lives in Sleaford. He attends an outpatient appointment with an Orthopaedic surgeon after being referred by his GP, and is told he needs a total hip replacement. The surgeon advises he will need to have the procedure at either Lincoln County Hospital or Pilgrim Hospital in Boston because of his respiratory condition. This is because of the risk he may need to have intensive care for a short time after surgery.

9.6.6 The patient's operation goes ahead at Lincoln County Hospital on the day it was scheduled for. Following a post-operative triage the patient is admitted to the intensive care unit for 1 day, and then returned to the Orthopaedic ward for a further 2 days. Following discharge the patient receives a phone call the day after the surgery to check everything is ok and has an outpatient appointment at Lincoln County Hospital 6 weeks after the operation to check on progress.

9.6.7 Outcomes:

- The patient is seen in the most appropriate care setting for their clinical needs, ensuring they receive the best outcomes and excellent quality care.
- The Orthopaedic doctors and nurses utilise all the specialist skills and capabilities available at the hospital, not just from their own department but also from others, to ensure the patient receives the best possible care.

9.7 Assessment against tests for service change

9.7.1 In line with the guidance set out in *'Planning, assuring and delivering service change for patients'* published by the NHS in 2018, all proposals for significant service change must beassessed against the Government's four tests for service change and NHS England and Improvement's test for reductions in hospital beds.

9.7.2 An assessment against these tests for the proposed change to consolidate orthopaedic services at Grantham Hospital has been conducted and is set out below. This assessment reflects and aligns to the description and narrative for the preferred option for orthopaedic services set out in this chapter.

Test 1: Strong public and patient engagement

9.7.3 There has been strong ongoing engagement with the public throughout the life of the ASR programme and its predecessor programmes. The breadth and depth of this work is set out infull in the stakeholder engagement chapter later in this document with more detail provided inthe detailed engagement reports in Appendices K and L. The focus here is therefore on the engagement relating to orthopaedic services.

9.7.4 During July 2018 a series of nine engagement events to discuss hospital service in Lincolnshire were held, each in a different area in the county. In total 170 members of the public were engaged across these nine events. The meetings were designed to focus on the case for change for particular health services and the possible solutions to the challenges faced. The main themes raised in relation to orthopaedic (elective and non-elective) services were:

- Acknowledgement of the problems with the current situation e.g. the number of cancelled operations and the number of patients travelling out of county for treatment. Therefore, the principle of separating planned and urgent care was considered sensible if it could support a reduction in the number of cancelled operations and allow staff to become more specialised.
- Desire for information about where any planned and urgent sites would be located, and to better understand how different sites would be utilised in future if services changed. There was also some confusion about whether the separation of the two elements meant planned and urgent care would have to be located on separate sites, or if they would be 'ring-fenced' on the same site.
- Concerns about the distances needed to be travelled, with the transport infrastructure and rurality again identified as major challenges. The ability for family members to visit the patient was also seen as important.
- The process of leaving secondary care, specifically the link between 'bed blocking' and the cancellation of planned operations, and the need to improve 'step down' care and integrate more closely with social care.
- Working with existing resources by making use of smaller hospitals as diagnostic treatment centres.

9.7.5 As well as the stakeholder events a questionnaire was made available in online and paper formats to enable the public and other stakeholders to share their views. A total of 256 questionnaires were received between 11 July and 5 August 2018. Feedback from the public inrelation to orthopaedic (elective and non-elective) services included:

- 20% of respondents were prepared to travel 0-15 minutes for a planned procedure; 34% were prepared to travel 15-45 minutes; 26% were prepared to travel 45-60 mins; and 19% were prepared to travel over an hour.
- 33% of respondents were prepared to travel 0-15 minutes for an urgent procedure; 38% were prepared to travel 15-45 minutes; 16% were prepared to travel 45-60 mins; and 13% were prepared to travel over an hour.
- 67% or respondents said they would travel to a hospital appointment by car; 14% by public transport; 2% patient transport; 1% taxi; and 15% friend or family.
- When asked about a set of statements and which was most important in relation to orthopaedic (elective and non-elective) services:
  - 24% said 'I will be offered care closer to home when appropriate'
  - 19% said 'I can access care when I need it and not just Monday – Friday 9am-5pm'
- However, it should be noted that on reflection of how questions were posed in the questionnaire the elective provision of orthopaedic services should have been made more explicit. Looking at the responses it is possible the description of 'Trauma and Orthopaedics' led people to focus on the non-elective element. When looking at responses for General Surgery, the most important statement was identified as 'My planned operation is less likely to be cancelled'. 29% of respondents identified this.

9.7.6 In October 2018 four public options evaluation workshops were undertaken across Lincolnshire in Sleaford, Mablethorpe, Bourne and Gainsborough to enable member of the public to share their views on the options against the evaluation criteria and supported the ongoing process of developing the final options being proposed for consultation. At these events the proposal to consolidate elective orthopaedic services at Grantham Hospital and make it a centre of excellence for orthopaedic elective and day case surgery was considered:

- Overall the proposal was supported by a substantial majority of participants (84%); 14% of participants disagreed and 3% neither agreed or disagreed.
- Those who were in agreement with the proposals thought it would improve patient outcomes and experience insofar as the number of cancelled elective operations may reduce. It was also felt that this would enhance Grantham Hospital's reputation.
- Some though were concerned about travel and access particularly as the service will be on the border of the county.

9.7.7 In 2019 *Healthy Conservation 2019* was launched, which was an open engagement exercise to shape how the NHS in Lincolnshire takes health care forward in the years ahead. This included pre-consultation engagement on the emerging options in the ASR:

- Feedback relating to the orthopaedic (elective and non-elective) service proposals identified the following key themes:
    - Distance and travel times to Grantham Hospital; poor road networks and lack of public transport;
    - Cost of travelling to hospitals further away; cannot always rely on families and friends; and
    - Suggestions to support the proposal included inter-site transport, development of a driver volunteer scheme, direct trains between Boston, Skegness and Lincoln, routes and times clearly displayed on all bus stops, and introduction of a travel helpline.
- Feedback was also obtained from hidden and hard to reach communities relating to the impact on the protected characteristics, groups and communities focussed around the longer distance need to travel to proposed centres of excellence, such as for orthopaedic services, and the associated increase in cost. This highlighted restricted incomes and savings would be a barrier to travelling further and a need to rely on family members for transport or public transport and taxis with the associated cost and practicality implications. Being physically disabled or with mobility issues makes access more difficult.

9.7.8 Throughout the duration of the ASR programme there has been ongoing engagement with the Lincolnshire County Council Health Scrutiny Committee. Between May and October 2019, the Committee commented on each of the services within the scope of the ASR programme where an emerging preferred option for the future delivery of services had been identified. The Committee considered the change proposals for orthopaedic (elective and non-elective) services on 18 September 2019 and submitted initial comments on the 24 October 2019.

9.7.9 These were:

- Support for the emerging option for orthopaedic (elective and non-elective) services, as the orthopaedic pilot has seen a reduction in the waiting list and cancelled operations;
- Welcome 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 needs to be addressed; and
- Risks associated with the pilot are being monitored and managed as part of the routine management process at ULHT.

Test 2: Consistency with current and prospective need for patient choice

9.7.10 The Department of Health guidance on this test sets out that a central principle underpinning service reconfigurations is that patients should have access to the right treatment, at the right place at the right time. Services should be locally accessible wherever possible and centralised where necessary.

9.7.11 The guidance goes on to state that in this context, local commissioners need to consider how proposed service reconfigurations affect choice of provider, setting and intervention; and that commissioners will want to make a strong case for the quality of proposed services and improvements in the patient experience.

9.7.12 The concept of services being locally accessible wherever possible and centralised where necessary is at the heart of the Lincolnshire Acute Services Review, and at the heart of theproposed orthopaedic (elective and non-elective) model.

9.7.13 Consolidating elective and day case orthopaedic services at Grantham Hospital will reduce the number of locations in Lincolnshire from which certain procedures are provided (the number of providers is not reducing under the change proposals). However, there is a compelling case to reconfigure and consolidate these services to improve the quality and safety of services, reduce waiting times and cancellations, make best use of available resources and improve overall patient satisfaction.

9.7.14 Key drivers of change are the current performance in the time patients wait for a procedure, the high cancellation rate and the high number of patients who currently go out of county for their procedure or operation. Over time more patients should be able to choose to have their surgery in Lincolnshire as opposed to having to go out of the county.

9.7.15 The consolidation of elective and day case surgery onto the Grantham Hospital site will be supported by pre and post-operative outpatient appointments continuing to be provided locally. Which over time will be increasingly supported by digital options giving even more flexibility to patients and staff in terms of where these can happen. This was identified in the engagement with the public as a good way to support the proposed service change.

Test 3: Clear clinical evidence base

9.7.16 The development of the case for change for orthopaedic (elective and non-elective) services has been led by the orthopaedic consultants supported by Professor Briggs, National Clinical Director for Getting It Right First Time. Key elements of it were:

- Pressure on elective beds from medical emergencies all year round;
- 30% of planned orthopaedic patients had their surgery cancelled each year, half of these had it cancelled on the day;
- High nursing and medical vacancies exist in orthopaedic (elective and non-elective)services;
- Combination of cancelled elective orthopaedic activity and local residents going out of county has a detrimental impact on the financial position of the Lincolnshire health system; and
- The NHS Long Term Plan published in January 2019 supports the split of urgent and planned care onto different sites to drive improvements in quality and patient satisfaction.

9.7.17 The options for service change to address the significant challenges faced by orthopaedics services (elective and non-elective) in Lincolnshire have also been developed by the ULHT orthopaedic consultants supported by Professor Briggs.

9.7.18 The case for change and proposals for the future configuration of stroke services were tested through two Clinical Summits with over 55 leads from across the system, facilitated by the East Midlands Clinical Senate.

9.7.19 The preferred option for the future configuration of acute stroke services was identified through a clinically led options appraisal event attended by over 60 stakeholders – the conversation on orthopaedic (elective and non-elective) services at this event were led by a ULHT orthopaedic consultant.

9.7.20 The presentation of the preferred option for the future configuration of trauma and orthopaedics to the East Midlands Clinical Senate was led by local lead clinicians.

9.7.21 The ULHT orthopaedic (elective and non-elective) service has been trialling the proposed changes since late 2018. An evaluation of these services has shown reductions in cancellations and waiting times, reduced waiting times and high patient satisfaction.

Test 4: Support for proposals from clinical commissioners

9.7.22 The Lincolnshire CCG(s) have been main sponsors of the ASR programme since its inception. The members of all of the Governing Bodies recognise the case for change and accept that doing nothing is not an option.

9.7.23 Clinical leads from CCGs have played a key role in developing and refining clinical models, working closely with colleagues in the acute setting. This joint approach between clinicians inprimary care and acute care will continue into the public consultation meetings.

9.7.24 The four CCG Governing Bodies and 'Shadow' Joint Committee, as they were at the time,considered the outputs of the evaluation process and the independent reviews as the ASRprogramme developed.

9.7.25 The four CCG Governing Bodies, as they were at the time, agreed the original PCBC that set out the preferred option for the future configuration of acute services in Lincolnshire at their Governing Body meetings in October 2018. The proposed changes to go to consultation set outin this PCBC are the same as they were in the original PCBC.

9.7.26 Most recently the newly formed single Lincolnshire CCG Governing Body reviewed this PCBC on 22 July 2020 and gave its support to the proposed changes to be submitted to NHSEI to start its assurance process. An extract of the minutes of that meeting can be found in Appendix M.

Test 5: Capacity implications

9.7.27 Prior to the orthopaedic pilot commencing spare bed and theatre capacity existed at Grantham Hospital. This spare capacity has been utilised by the pilot and it has therefore not needed additional bed or theatre capacity.

9.7.28 For additional activity over and above that has been delivered through the pilot additional bed and theatre capacity is likely to be required.

9.7.29 In light of this and the limited availability of capital the implementation of this option will happen in phases:

- Phase 1 – making the pilot, which utilised the existing theatre and bed capacity on the Grantham Hospital site (and includes optimising productivity and efficiency of existing capacity), a permanent change. The focus of this PCBC.
- Phase 2 – creating additional capacity on the Grantham Hospital site to allow for the full shift of activity currently seen at ULHT's sites planned under the proposal and support the further repatriation of patients going out of county and/or to the independent sector for orthopaedic surgery.

9.7.30 The focus of this business case is on Phase 1. An initial assessment of the additional bed andtheatre capacity required for Phase 2 has been made, however, any additional capacity required will be the subject of a separate business case.

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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:	**15 December 2021**
Subject:	**Lincolnshire Acute Services Review – Acute Medical Beds at Grantham and District Hospital**

Summary:

On 13 October 2021 the Committee agreed its approach to its consideration of the NHS's consultation on the Lincolnshire Acute Services Review. This included consideration of each of the four elements of the review in detail. The first two elements: stroke services and urgent and emergency care were considered on 10 November 2021. The remaining two elements are due to be considered at this meeting, with acute medical beds at Grantham and District Hospital as one of these.

The Committee also established a working group, which would support the work of the Committee, and give detailed consideration of the consultation materials. As part of its consideration the Committee is requested to consider whether it wishes to highlight any areas, which the working group might explore further.

Actions Requested:

(1) To consider the detailed on the Lincolnshire Acute Services Review of Acute Medical Beds at Grantham and District Hospital.

(2) To highlight any areas which the Committee's working group might wish to explore in further detail.

1. Background

On 30 September 2021, the consultation on the Lincolnshire Acute Services Review was launched. On 13 October 2021 the Committee considered an introductory item and agreed its approach to the consultation.

2. Acute Medical Beds at Grantham and District Hospital

The following representatives from the NHS are due to attend the meeting to present information on this topic:

- Dr Dave Baker, South West Lincolnshire Locality Clinical Lead, Lincolnshire Clinical Commissioning Group
- Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services NHS Trust.
- Pete Burnett, System Strategy and Planning Director, Lincolnshire NHS.

To facilitate the Committee's consideration, pages 32-36 of the consultation document, which relate specifically to acute medical beds at Grantham and District Hospital, are attached as Appendix A to this report. Chapter 11 of the Pre-Consultation Business Case (PCBC) provides further detail and is attached at Appendix B. It should be noted that chapter 11 of the PCBC in turn refers to the following documents, all of which are available at: Pre-Consultation Business Case Appendices:

- Appendix H – Access Impact Analysis by Neighbourhood Team
- Appendix I – Quality Impact Assessments
- Appendix J - Equality Impact Assessment

3. Consultation and Conclusion

The Committee is invited to consider the presentation on the detailed elements of the Lincolnshire Acute Services Review.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Extract (Pages 32 – 36) from Lincolnshire NHS Public Consultation Document – Relating to Four of Lincolnshire's NHS Services – Acute Medical Beds at Grantham and District Hospital
Appendix B	Chapter 11 of the Pre-Consultation Business Case for the Lincolnshire Acute Services Review

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

Acute medical beds at Grantham and District Hospital

What are we asking you to consider?

We want you to tell us what you think about our preferred change proposal to develop:

- Integrated community/acute medical beds atGrantham and District Hospital

What are the services and how are theycurrently organised?

Acute medical beds work alongside, but are separate from, Accident and Emergency (A&E) departments.

The primary role of these services is to provide assessment, investigation and treatment for patients with particular medical (i.e. not surgical) conditions suchas severe headache, chest pain, pneumonia, asthma or chronic obstructive pulmonary disease (COPD), who are referred by their GP or come via the A&E department.

In these services the care is provided by a multi-disciplinary team of doctors, nurses, therapists and support staff.

The acute medical beds team is responsible for coordinating initial medical care for all the patients theysee, whether they need a hospital stay or are able to return home after assessment and treatment in one of the walk in (ambulatory) units.

If patients do need a hospital stay they will either be admitted to an acute medical assessment bed or transferred to another specialist ward or department. This can sometimes involve patients being transferred between hospital sites to ensure they get to the team that provide the right care and treatment.

United Lincolnshire Hospitals NHS Trust (ULHT) currentlyprovides acute medical beds at Lincoln County Hospital,Pilgrim Hospital, Boston and Grantham and District Hospital.

In line with the limited range of presenting emergency conditions (as highlighted in the urgent and emergency care section) that Grantham and District Hospital A&E department can deal with, the level of care and complexity of patients seen by the acute medical beds service at this hospital is lower than that at Lincoln County Hospital and Pilgrim Hospital, Boston.

The reduced service available at the Grantham and District Hospital is well understood by the local healthcare system, including the ambulance service. If they assess a patient local to Grantham as having a care need greater than can be dealt with at Grantham and District Hospital, they will take them to the next closest hospital with the right facilities and skills to care for them.

A summary of the current acute medical beds provision at ULHT's hospital sites is set out below.

Lincoln County Hospital	**A&E** · Operates 24/7 · Services: full A&E **Acute medical beds** · Same day emergency care · Medical emergency assessment unit · Medical emergency short stay · Acute medical short stay ward
Pilgrim Hospital Boston	**A&E** · Operates 24/7 · Services: full A&E **Acute medical beds** · Integrated assessment centre · Acute medical short stay ward
Grantham and District Hospital	**A&E** · Operates 08:00 – 18:30 · Services: not full A&E **Acute medical beds** · Emergency assessment unit · Acute medical short stay ward

Please see earlier section for description of temporary changes in response to COVID-19

What are the challenges and opportunities for acute medical beds at Grantham and District Hospital?

This section sets out the challenges and opportunities for acute medical beds and what we hope to achieve bymaking changes.

Challenges

- There is a rising demand for acute medical beds services and more patients have complex needs
- Our local acute medical beds services struggle to recruit enough doctors and nurses, which means:
    - We cannot consistently provide the level of service quality we aspire to
    - We need to fill vacancies with temporary staff, which itself is not always possible
    - There are increased service and patient safety concerns
    - In addition, Grantham and District Hospital faces further staffing challenges in this area as:
        - Its Accident and Emergency (A&E) department sees a limited range of presenting emergency conditions because of its small size and limited availability of specialist staff; which in turn means
        - Its acute medical beds service treats fewer patients with a lower level of care needs compared to Lincoln County Hospital and Pilgrim Hospital, Boston

Opportunities

By making changes, we can look to ensure:

- High quality acute medical services are delivered locally in a sustainable way for the long term
    - The volume and complexity of presenting emergency conditions at hospitals in Lincolnshire ismatched to the level of acute medical beds service provided at each site
    - Improving the ability of services to attract and retain talented and substantive staff through building a strong, high quality and successful service
- Patients who require specialist care are identifiedearly and attend the right service, first time and receive the best possible care
- Patient health and the overall patient experience are improved
- Better integration and collaboration with patients' GP surgeries and community teams

The feedback from engagement about acute medical beds at Grantham and District Hospital and how we have used it

There has been ongoing engagement with the public throughout the Lincolnshire Acute Services Review programme, particularly through the 'Healthy Conversation 2019' engagement exercise.

Some consistent themes in relation to acute medical beds, a number of which specifically relate to Granthamand District Hospital, have been shared by the public and stakeholders throughout our engagement to date:

- A need to keep medical treatment as local and easy to access as possible
- Concerns around distance and accessibility, poor public transport and access for patients or family who cannot afford the travel costs
- The ability of the ambulance service to transfer patients safely when required
- Specific to Grantham and District Hospital:
  - Acute medical beds at Grantham and District Hospital might take pressure off Lincoln CountyHospital and Pilgrim Hospital, Boston
  - Concerns around how any proposed changes might affect other wards and services at Granthamand District Hospital

We have consistently taken into account all public and stakeholder feedback throughout our work.

What is our proposal for change?

Our preferred proposal for change is to establish integrated community/acute medical beds at Granthamand District Hospital, in place of the current acute medical beds.

The integrated community/acute medical beds would be delivered through a partnership model between a community health care provider and United LincolnshireHospitals NHS Trust. The care of patients would still be led by consultants (senior doctors) and their team of doctors, practitioners, therapists and nursing staff.

It is anticipated this change would affect around 10% of those patients currently receiving care in the acute medical beds at Grantham and District Hospital. This is equivalent to 1 patient a day, on average. These patients would receive care at an alternative hospital with the right skills and facilities to ensure the best possible outcome. We envisage the number of medicalbeds required at Grantham in this new model will not be reduced.

A key part of our process to evaluate options to tackle the challenges we face was to hold a clinically led health system stakeholder workshop and four workshops with randomly selected members of the public.

For acute medical beds two solutions remainedfollowing the shortlisting of options:

- No provision of acute medical beds at Grantham and District Hospital
- Provision of integrated community/acute medicalbeds at Grantham and District Hospital

Attendees at the workshop were asked to think aboutthe advantages and disadvantages of the two options against agreed criteria.

The following table summarises the level of stakeholder and public support for each change proposal.

Support for change proposals for acute medicalbed services at Grantham and District Hospital		
Support for changeproposal	Stakeholder Workshop	Public Workshops
Integrated community/ acute beds at Grantham hospital	85%	81%
No acute medical beds at Grantham hospital	9%	11%
No preference	6%	8%

Impact Analysis

As we have developed our proposals we have considered the quality and equality impact of the preferred change proposal for acute medical beds.

Through our equality impact assessment we identifiedtwo groups of people, one of which is defined by a protected characteristic, which may be more likely to be impacted positively or adversely by this proposal. These groups are age and those who are economicallydisadvantaged.

Our observations from these assessments are set out below. We will continue to review and develop these, including the impact on different groups of people within our population, with independent support, through our public consultation in light of the feedbackwe receive.

Potential positive impacts

1. Acute medical beds provision would continue to be delivered at Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term – including a more sustainable medical and nursing workforce.
2. The majority of patients (estimated to be around 90%) cared for in the acute medical beds at Grantham and District Hospital would continue to becared for in the integrated community/acute medical beds
3. The preferred proposal for change would delivera more comprehensive local service provision at Grantham hospital, specifically in relation to the frail' population, thereby reducing pressure on acutehospital sites at Lincoln and Boston
4. The preferred proposal for change would enable Grantham and District Hospital to build a centre of excellence for integrated multi-disciplinary care(particularly for frail patients), which supports bothimproved community-based management of longterm conditions and reduced lengths of stay in hospital beds
5. An estimated 10% of patients (equivalent to 1 a day on average) currently cared for in the acute medical beds at Grantham and District Hospital would not beable to have their care needs met in the integrated community/ acute medical beds. Instead, they wouldreceive their care at an alternative site with the right facilities and expertise to ensure the best outcomes

Potential adverse impacts

1. For the small number of patients (estimated to be around 1 a day) with higher acuity needs who wouldn't be able to have their care needs met by the integrated community/ acute medical beds, treatment will be received at an alternative site with the facilities and skills to look after the most seriouslyill patients

These patients would get the specialist input they require at the right time and receive the best possiblecare. However, it is acknowledged that needing to travel further for this care may be seen as an adverse impact by some people.

- Of those patients seen at an alternative site, it is estimated that there would be no increase in the number of patients travelling more than 60 minutesby car, the threshold set by the local health system for this type of activity. However, given the serious nature of the conditions these patients are expectedto have, most are likely to travel by ambulance

- Of those attending an alternative site, it is estimated around 40% would attend Lincoln County Hospital. The remainder would attend hospitals closer to them,but outside of the county, with the majority going to Peterborough City Hospital.

- The friends and family of those patients receiving treatment at an alternative hospital, which better meets the patients care needs, may have to travel further to see them.

11 Acute Services Review: Preferred option – Acute Medicine (including respiratory and cardiology)

Note the case for change and proposed model of care described in this chapter are set against the current model of care (i.e. that provided before the COVID-19 pandemic and subsequent temporary service changes).

11.1 Case for change

11.1.1 There is an unequivocal case for change relating to acute medicine across the United Lincolnshire University Hospitals NHS Trust (ULHT). The ULHT acute medicine service including respiratory and cardiac services experiences significant workforce challenges in their ability to deliver a safe, quality service. It is widely recognised to be clinically and operationally unstable in its current form.

11.1.2 Across the ULHT acute medicine service there are significant recruitment and agency spend challenges, 50% of consultant posts are filled by locums at Lincoln and Grantham Hospitals (2019/20).

11.1.3 There is a 40% vacancy rate (out of 10 posts) for respiratory consultants across ULHT's three hospital sites, leading to reliance on agency staffing. There are no substantive respiratory consultants at Grantham Hospital, the service is currently led by an agency locum, and there are significant gaps in the respiratory consultant workforce at Pilgrim Hospital (2019/20).

11.1.4 There are longstanding issues with cardiology consultant recruitment at Pilgrim Hospital and a sub-optimal cardiology service at the hospital as it is unable to develop CT and pacing due to workforce challenges.

11.1.5 A key specific issue relating to Grantham Hospital is the sustainability of the acute medicine service as it has a selected medical 'take' (exclusion criteria) with low volumes compared to the other two ULHT sites.

11.1.6 Through the Acute Services Review (ASR) programme two alternative service delivery options for acute medicine across ULHT have been considered:

- No provision of acute medical beds at Grantham Hospital; and
- The provision of integrated community/acute beds at Grantham Hospital

11.1.7 To help inform the development of these options, as well as their appraisal, in August 2018 a Grantham Clinical Summit was convened to specifically consider the future of acute medical provision at Grantham Hospital.

11.1.8 A key part of this clinical summit was a clinical audit of acute medicine at Grantham Hospital. The purpose of the audit was to identify the clinical status (acuity) of current patients using the Grantham Hospital acute medical service provided by ULHT.

11.1.9 A small group of clinicians and managers conducted an audit on the Grantham Hospital site that comprised of two approaches:

- A review of one year of NEWS data for the period ending May 2018; and
- A review of a cohort of patients in the hospital (on that day) who had at some point or stillhad a NEWS ≥7 at any time during their stay.

11.1.10 NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice when patients present to or are being monitored in hospital.

11.1.11 The audit review of the one year of NEWS data showed:

- Total number of A&E attendances to Grantham of 23,463
- Total number of medical admissions to Grantham Hospital of 3,892
- Number of medical inpatients with a first NEWS ≥7 = 230
- Number of medical inpatients with a first NEWS ≥5 = 313

11.1.12 Following this initial audit the following observations were made:

- 36.1% of medical patients with NEWS of ≥7 on admission had subsequent score of ≤3.
- 82.4% of medical patients with NEWS of ≥5/6 on admission had subsequent score of ≤3.
- There are some patients currently admitted to Grantham Hospital that should be considered for exclusion now as it was considered a current concern e.g. severe asthma and overdose patients with a reduced conscious level.
- NEWS is the preferred method to assess acuity, however to improve selection of patients suitable for different care settings using NEWS combined with Frailty Scores would potentially be more robust e.g. a patient with a NEWS of 7 but a frailty score of ≥7 would not be for escalation to level 2/3 critical care and therefore would be appropriate to be seen and remain in a consultant supported community model. This was tested when the audit team reviewed the cohort of patients in the hospital (on that day).

11.1.13 The cohort of patients identified for review was agreed as any patient in the hospital on 3 August 2018 who had at some point or still had a NEWS of ≥ 7 at any time during their stay.

11.1.14 The audit team looked at the patients notes, discussed with nursing staff to identify the reason for admission, considered what had happened during admission, used clinical judgment on what clinical service was required to care for the patient and completed a frailty score (used Canadian Frailty Score). The results were:

- 17 patients were audited with an average age of 77 years
- 12 were not suitable for escalation, 2 were and 1 was unclear (2 were elective).
- The 2 elective patients were medically unwell as a result of surgery and were on the Acute Care Unit.
- 5 patients required specialist acute care based on the current exclusion criteria and the recommended additions to exclusions identified in the first part of the audit meant they should therefore not be on the Grantham Hospital site.
- 7 patients required general acute care which could be managed by consultant supported medical beds run by a community provider; 4 of these could potentially be discharged earlier with a community plan if new pathways were introduced.
- 2 patients required lower acuity care i.e. community hospital/neighbourhood team model or new pathway as part of neighbourhood team model.
- 1 patient was suitable for hospice bed.

11.1.15 On 17 August 2018 a second audit was completed on the Grantham Hospital site. This second cohort of patients identified for review was agreed as any patient in the hospital on 17 August who had a NEWS score of ≥5 at any time during their stay.

11.1.16 The audit team looked at the patient's notes, discussed with nursing staff to identify the reason for admission, considered what had happened during admission, used clinical judgement on what clinical service was required to care for the patient and completed a Frailty Score. The results were:

- 9 patients were audited with an average age of 82 years
- 6 were not suitable for escalation and 3 were for escalation
- 2 patients were transferred to Grantham from Lincoln Hospital stroke service for rehabilitation
- 4 patients required general acute care which could be managed by consultant supported medical beds run by a community provider; 2 of these could potentially be discharged earlier with a community plan if new pathways were introduced.
- 3 patients required lower acuity care, i.e. community hospital/neighbourhood team model or new pathway as part of a neighbourhood team model

- A summary of the NEWS and Frailty Score for all 9 patients at the time of their review were as follows:
    - All 9 patients had a NEWS score of ≤4
    - 2 patients had a Frailty Score of ≥7
    - 3 patients had a Frailty Score of 5/6
    - 2 patients had a Frailty Score of ≤3
    - 2 unrecorded

11.1.17 The recommendations from the audit were:

- The combination of the NEWS and Frailty Score provide a clear evidence base for identifying acuity; and
- To review the Grantham Hospital Exclusion Criteria and include respiratory distress, patients with reduced consciousness and non ST segment Elevation Myocardial Infarct (STEMI)

11.1.18 The discussions by system clinical and managerial leaders in relation to the audit findings were predominantly around making sure that patients get to the definitive treatment, first time whether that be Grantham Hospital or an alternative site. The acuity of the patient, using combined NEWS and the Frailty Scores, was agreed to be the way to accurately identify need.

11.1.19 There was also an agreed aspiration to reduce the number of intra hospital transfers to another site so demonstrating that the patient was getting to the definitive treatment site, first time. There was also acknowledgement that the number of transfers will never be a zero figure as some patients will deteriorate after admission; a declining figure should be the aim.

11.1.20 The conclusion drawn on NEWS and Frailty Scores, using the audit results and evidence, have been articulated into a clinical acuity model for the Grantham Hospital site.

Figure 148 – Grantham Hospital Clinical Acuity Model

Outline Assessment Criteria for Suitability for Grantham Hospital

For individuals assessed by a healthcare professional, including ambulance arrivals

- NEWS <7 would continue to be assessed and admitted to the site.
- NEWS ≥7 with a frailty score ≥5 (including admissions from nursing / care homes and housebound patients) to continue to be admitted to and assessed on the Grantham site as these patients would not normally be for escalation for intensive treatment.
- NEWS ≥7 but a frailty score of <5 (patients requiring escalation) – should go to the right site first time, or be transferred to an alternative site (i.e. Lincoln, Peterborough, Nottingham).

Where clinically and operationally appropriate patients will be given a choice about where they receive their care

For walk-ins

Staff in identified clinical teams at Grantham Hospital will retain the required skills to stabilise individuals who have deteriorated or who arrive as a walk-in and require emergency intervention prior to transfer. The admission criteria for Grantham is as detailed above, irrespective of arrival method; where clinically indicated, ambulance transfer to the most appropriate unit will be arranged.

11.1.21 Findings from the audit, that combined NEWS and Frailty Scores, were used to model and understand demand on services so new ways of working could be described. Taking the conclusions from the audit, demand was modelled through in terms of patient numbers, acuity and projected bed usage.

11.1.22 This was undertaken by analysing the non-elective medical admissions to Grantham Hospital from 2017/18 data across the following categories and the proportion of beds associated within each category at 92% occupancy:

- NEWS of ≥7 with any length of stay (LoS)
- NEWS 5-6 with any LoS
- NEWS ≤4 at 1 day LoS, 2-3 day LoS, 4-7 day LoS, >7 day LoS

11.1.23 Based on the clinical audit results and in consultation with the Grantham Clinical Summit members the following principles were proposed and agreed for acute medicine services at Grantham Hospital:

- Transfer to specialist site – A proportion of patients with higher acuity and lower frailty would transfer to a specialist site and this would be modelled using two scenarios at 50% and 25% transfers.
- Patients to remain at GDH – this would include the following:
  - A proportion of patients with higher acuity and high frailty modelled. These patients are not affected by the above scenarios
  - Lower acuity patients for the first 7 days of predominantly clinical need
- Alternative model of care would be developed for patient of lower acuity and longer LoS depending on social and clinical need i.e. > 8 days
- Alternative models of care would also be developed for lower acuity patients with 1-3 day LoS to avoid admission to hospital and enable assessment and discharge

11.1.24 Applying the above principles to the analysis, the demand for the various care settings was estimated. Two scenarios were modelled based on a proportion of patients that require escalation to a specialist site.

11.1.25 The second clinical audit on 17 August 2018 of 9 patients with >5 NEWS scoring suggested 3 patients of that cohort required escalation (33%) which is a good sense check however as the sample size is not significant two scenarios were developed:

- Scenario 1- 25% of patients with NEWS >5 are transferred to a specialist site and 75% remain at Grantham Hospital – assumed to be closest to reality and therefore the base case
- Scenario 2 – 50% of patients with NEWS >5 are transferred to a specialist site and 50% remain at Grantham Hospital

Figure 149 – Grantham Hospital demand modelling based on acuity model

Care Setting	Scenario 1	Scenario 2
Specialist site *Transfer to an alternative hospital site*	11%	21%
Beds run by community provider with predominantly clinical input *High Acuity beds*	60%	50%
Alternative model of care for low acuity longer LoS incl. rehab phase Lower Acuity beds	19%	19%
Admission avoidance / assessment	10%	10%
Total	**100%**	**100%**

1.2 Integrated community/acute beds provided at Grantham Hospital as part of an extension of the neighbourhood team

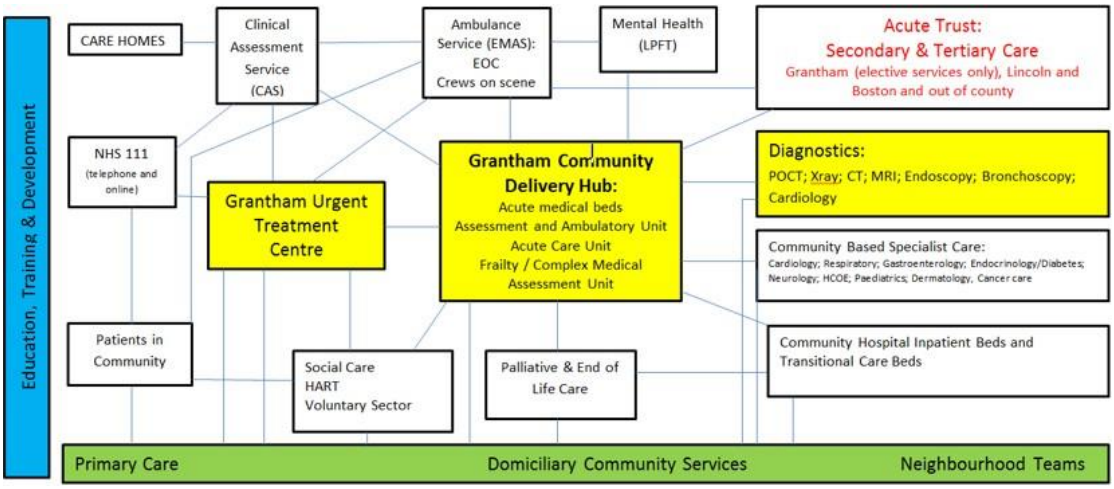
Overview

11.2.1 Through the ASR options appraisal process the preferred option identified for ULHT's acute medicine services was identified as the provision of integrated community/acute beds at Grantham Hospital as part of the neighbourhood team.

11.2.2 This innovative integrated community/acute model has been developed through extensive discussions by local clinicians, commissioners and provider organisations and reflects feedback received from the East Midlands Clinical Senate and takes into consideration feedback received during the various ASR public engagement activities.

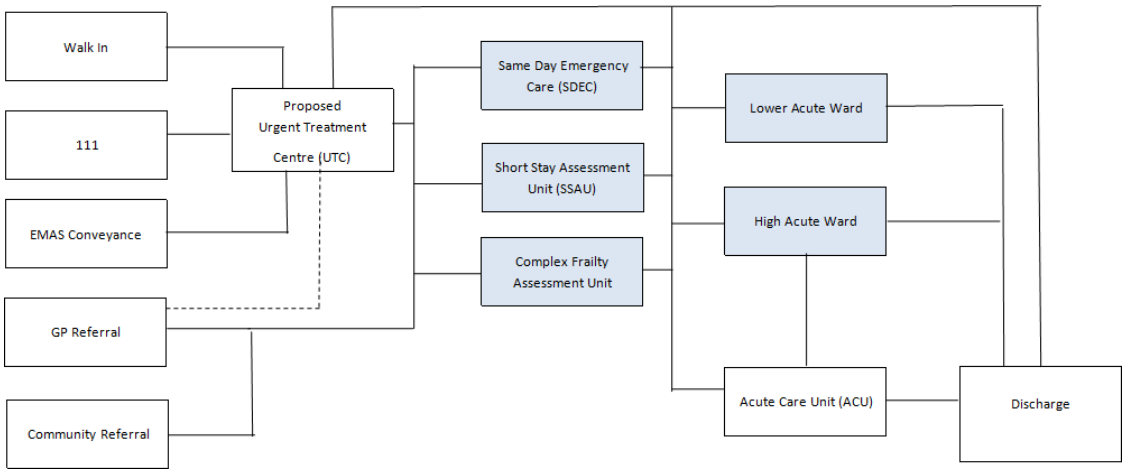
11.2.3 This model will see Grantham Hospital as a hub for supporting community teams and community services across the county, (including existing inpatient community hospital beds).

Figure 150 – Grantham Hospital's proposed acute medicine service within the wider system



11.2.4 The components of the proposed Grantham Hospital acute medicine service that underpin the community delivery hub are set out and described in the diagram below.

Figure 151 – Proposed Grantham Hospital acute medicine service



11.2.5 A description of each of the components of the proposed Grantham Hospital acute medicine service is set out in the table below.

Figure 152 – Proposed Grantham Hospital acute medicine service

Service	Provider	Description
Same Day Emergency Care (SDEC)	Community	Development in line with national directive to expand same day emergency care. Service would offer equivalent specification to that provided at Lincolnand Boston Hospitals. Service will be consultant-led with operating hours 08.00-20.00 7 days a week. This will replace the current Assessment and Ambulatory Care (AAC) service.
Complex Frailty Assessmen tService	Community	This will be an integrated model offering urgent and elective assessment, careand treatment from a multi-disciplinary team, including community-based careteams. Consultant oversight will be provided and provision will primarily be from the SDEC although it can be facilitated across the proposed Urgent Treatment Centre and into inpatient areas. Enhanced Assertive in-reach provision will be provided. Services operating hours will be 10am – 8pm, with an agreed 'cut-off' point earlier in the day for new admissions. The service will enable an integrated frailty service at the front door.
Short Stay Assessmen tUnit (SSAU)	Community	Care delivery model will be as per provision through the current Emergency Assessment Unit (EAU). Provision will transition to a community-provided service. This inpatient unit will offer initial assessment and care planning and short-stay (up to 72 hours) higher acuity care. The service will be consultant-led with frequent ward rounds.
Medical Wards - **High Acuity** - **Lower Acuity**	Community	A mixture of beds will be provided offering high and lower acuity. *High Acuity Beds* These will be consultant-led offering specialist care under a variety of specialties. Care will be provided following transition from EAU, step-down from ACU or step-up from lower acuity beds. Patients will be allocated under the care of the most appropriate consultant to support their needs, for example respiratory. Other specialities will support either on-site or remotely as required. This model offers greater flexibility in care provision and drives a more holistic approach to care. *Lower Acuity Beds* These will be nursing and therapy-led providing step-up from community services and step-down from higher acuity beds (at Grantham Hospital and other sites). They will also provide inpatient rehabilitation. *Overnight Medical Consultant Cover* The long-term vision is to support overnight medical consultant cover remotely facilitated by telemedicine, moved to with transitional arrangements
Acute CareUnit	Acute	This service is currently provided at Grantham Hospital and will continue. It is run by an acute provider, consultant-led and offers care for the highest acuitypatients at Grantham Hospital, primarily for post-surgical patients. The unit additionally supports medical inpatients requiring escalation via joint care.

11.2.6 The clinical acuity model for Grantham Hospital, developed through the Grantham Clinical Summit work and described in the case for change section, focuses on the inclusion of those patients with lower acuity need or on a high level of frailty. This specialist function will, over time, enable Grantham Hospital to offer specialised care for the most vulnerable and frail patients, extending the geographic catchment of this patient cohort.

Quality

11.2.7 The most significant quality benefit of the preferred option for acute medicine, as articulated by the East Midlands Clinical Senate during the review process, is it provides an *'excellent balance between access and sustainable long term outcomes'*.

11.2.8 The proposed model is ambitious in design, and will see more activity moving from a traditional acute setting into a community-led, integrated service in line with the Lincolnshire Integrated Care System (ICS) plans and supporting a greater number of individuals in receiving their care closer to home.

11.2.9 The proposal enables Grantham Hospital to offer services which may not be offered elsewhere and build a centre of excellence for integrated multi-disciplinary care, particularly for frail patients. This will offer some the opportunity to receive care at Grantham Hospital where this is not possible presently, expanding the geographic catchment for some services.

11.2.10 This new model offers a more comprehensive service provision for Grantham Hospital than currently provided, further reducing pressure on the acute sites at Lincoln and Boston (and those out of county) and enhancing the provision of community-based services, not just locally but across Lincolnshire.

11.2.11 This model will see Grantham Hospital as a hub for supporting community teams and community services across the county (including existing inpatient community hospital beds), reducing acute medicine admissions not just at Grantham Hospital but potentially across the county. This approach is very much in line with the feedback received from the public during the public engagement events.

11.2.12 The proposal sees a continuation of consultant specialists in acute medicine, general medicine, respiratory medicine and health care for the elderly based on-site at Grantham and providing support to the new model.

11.2.13 For other specialties, joint working between ULHT (or other acute providers, particularly for tertiary services) and community providers will facilitate specialist input; telemedicine facilities would support these interactions in the longer term.

11.2.14 The Same Day Emergency Care (SDEC) unit will offer an expansion of the current Ambulatory Assessment Unit (AAU), which is to be re-named in line with the national shift to 'Same Day Emergency Care'. The unit would receive referrals directly from the UTC, EMAS and primary / community care teams. The SDEC unit will be led by an Acute Physician team.

11.2.15 The new Complex Frailty Service will offer specialist care and support for elderly and frail patients, including those with complex needs. The team will offer a day assessment and care service, supporting frail/complex patients who require diagnostics, multi-disciplinary assessment, medical review, therapy and social service assessments. Patients referred electively to the team would have transport arranged to enable them to arrive in a timely manner at the start of the working day and have all the necessary assessments and interventions carried out before returning home at the end of the day. The service will also support an 'integrated frailty service at the front door approach'.

11.2.16 The Short Stay Assessment Unit (SSAU) would continue to provide the same function as the current Emergency Assessment Unit (EAU) offering short-stay spells for initial assessment and treatment for patients admitted through the UTC, and SDEC (where care cannot transition directly to the acute medical wards). The unit will be staffed by acute medicine physicians, supported by a team of medical trainees, ACPs and other healthcare professionals.

11.2.17 The SSAU would provide care for patients who meet the criteria for admission to Grantham and require a higher level of monitoring and/or care than can be provided on the medical ward.

11.2.18 Beds on the acute medical wards will be a mixture of high acuity and lower acuity, provided on a generic basis supported by medicine for the elderly, respiratory and other specialists. Patients will be allocated to the consultant with the most appropriate skills to meet the patient's medical needs.

11.2.19 There is no current intention to reduce the beds available on the site for medical inpatients. Retaining current provision is essential to supporting stabilisation of the wider system. However, ensuring only those that require an admission and reducing length of stay and delayed transfers of care will be a priority, thereby supporting a greater patient cohort.

11.2.20 Beds will additionally support current community hospital pathways, which are lacking within the south-western Lincolnshire geography.

11.2.21 The Acute Care Unit (ACU) would continue to be run by an acute provider, offering care for the highest acuity patients at Grantham Hospital. This consultant-led unit would be primarily for post-surgical patients, the unit would additionally support medical patients requiring escalation.

11.2.22 The implementation of the proposed model and development of a fully-integrated service at Grantham Hospital additionally offers opportunities to improve care across Lincolnshire, through the introduction of a number of consultant posts to the community provider structure and improved links with acute consultant teams.

11.2.23 Grantham Hospital will assume a new function as a community services hub for the county. In addition to overseeing pathways for outpatient and inpatient care at Grantham Hospital, the community-employed consultant team will support community-based specialist nursing teams, community hospital ward teams (at Skegness, Louth, Gainsborough and Spalding) and integrated neighbourhood teams across Lincolnshire. This new and innovative function will bring specialist knowledge and capability for care delivery directly into communities, with the following expected benefits:

- Improved community-based management of Long Term Conditions
- Reduced acute hospital admissions and length of stay
- Improved utilisation of community hospital bed resource
- Reduced length of stay in community hospital beds
- Improved accessibility to specialist advice for primary care and community-based teams
- Greater consistency in quality and delivery of care across all communities
- Opportunities for upskilling of specialist nursing teams

11.2.24 There is scope in particular to develop community respiratory services and community diabetes services, as well as enhancing the support offered to the frail elderly population.

11.2.25 This community function is expected to be delivered remotely, though potential for rotational posts for a variety of staff groups would facilitate positive working relationships between colleagues. It is expected that telemedicine (and technology generally) will support delivery, offering potential for video consultations and ensuring shared access to records.

11.2.26 As community-based and integrated care models are developed across the NHS, this innovative function will put Lincolnshire in a position to attract a high quality workforce into the future and to build further on current medical, nursing and AHP training provision within the county.

11.2.27 This new innovative model will also 'uncouple' ULHT from direct provision of non-elective care on the Grantham site so 'protecting' elective services from non-elective admissions at times of surge. ULHT becomes a key supporting partner for non-elective admissions.

Access

11.2.28 Grantham Hospital currently has 3,919 (2019/20) acute medicine admissions (3,858 non-elective and 61 elective) a year, plus a further 2,954 acute medicine day cases. These patients largely come from Grantham and the surrounding area. This is forecast to grow to 4,025 acute medicine admissions by 2023/24 (3,963 non-elective and 62 elective) plus a further 3,034 acute medicine day cases.

11.2.29 Once the preferred option to establish an integrated community/acute inpatient model for acute medicine at Grantham Hospital is fully implemented, c.385 patients per year (c.10% of current non-elective inpatient admissions) currently seen at Grantham Hospital would be displaced (based on 2019/20 activity). This displacement is due to their care needs being better met in a more specialised service at an alternative hospital – these are the patients identified in the audit of acuity of patients in Grantham Hospital medical beds as having higher acuity and lower frailty.

11.2.30 Under the proposal it is estimated that no more patients than currently do now will be travelling over 60 minutes for non-elective care, the travel time threshold set by the local health system for activity of this type. This is based on the assumption they travel to their nearest appropriate hospital by car and against a baseline of c.2,000 patients across Lincolnshire who currently travel more than 60 minutes to attend acute medicine services based on the assumption they travel by car.

11.2.31 However, in reality given the existing exclusion criteria and current usage of the Grantham Hospital site many of the patients who would no longer attend Grantham Hospital would actually travel by ambulance and therefore their travel time would likely to be less than 60 minutes.

11.2.32 Approximately 40% (c.150) of the patients would attend Lincoln Hospital and the others would attend hospitals out of county, with the majority going to North West Anglia NHS Foundation Trust (55%, c.210) followed by Nottingham University Hospitals NHS Trust (5%, c.25).

11.2.33 The table below provides a summary of the estimated impact on the number of patients displaced and associated travel times by car when the preferred option is fully implemented (based on 19/20 activity and forecast 23/24 activity).

11.2.34 This includes a sensitivity analysis relating to the number of patients that would transfer to a specialist site based on the scenarios defined in the Grantham Clinical Summit audit (set out in the case for change section above).

Figure 153 – Estimate of displaced Grantham Hospital acute medicine activity and impact on travel times

	Grantham Hospital		LincolnHospital		Out of county hospital	
	19/20	23/24	19/20	23/24	19/20	23/24
Base Case: Scenario 1 - 25% of patients with NEWS ≥5 are transferred to a specialist site (equivalent to 10% of overall activity)						
Acute Medicine Activity	-385	-396	149	153	236*	243*
Travelling +60 mins.	0	0	0	0	0	0
Sensitivity: Scenario 2 - 50% of patients with NEWS ≥5 are transferred to a specialist site (equivalent to 20% of overall activity)						
Acute Medicine Activity	-770	-792	298	306	472	486
Travelling +60 mins.	0	0	0	0	0	0

** (19/20 c.210 to NWAFT & c.25 to NUH; 23/24 c.220 to North West Anglia NHS FT, c.25 to Nottingham University Hospitals NHS Trust)*

11.2.35 During the various public engagement exercises that have taken place a number of people have raised some concern about travel time for urgent and emergency care if services are no longer provided at Grantham Hospital.

11.2.36 However, it is not widely understood by the public that an exclusion criterion has successfully existed for some time (since 2007/08) for the Grantham Hospital site to ensure the care it provides aligns to its size and level of specialism it is able to deliver. As highlighted in the feedback provided by the Independent Review Panel (IRP) to the Secretary of State for Health in relation to the opening hours of Grantham A&E (as described in the Preferred Option - Urgent and emergency care chapter).

11.2.37 In addition, under the current model, when necessary patients are transferred from Grantham Hospital to Lincoln Hospital to ensure they receive the clinical input they need, although numbers are comparatively small.

11.2.38 Under the proposed model of an integrated community/acute medicine model the exclusion criterion for Grantham Hospital would be refined, meaning a relatively small number of patients currently admitted to acute medicine services, would not be in the future. This would mean more patients going to the right place for care first time and minimising subsequent transfers.

11.2.39 However, it should also be noted the proposed model offers a more comprehensive service provision for Grantham and the surrounding areas and this will offer some the opportunity to receive care at Grantham Hospital where this is not currently possible. This is particularly true for the frail elderly population and aligns to the feedback and suggestions from the public engagement events.

11.2.40 Conversations are ongoing with Lincolnshire County Council regarding public transport and how it supports access to health services in the wider sense. The impact of the proposed service changes on access has been considered in the Equality Impact Assessment and this will be tested and explored further through consultation with the public before any plans are finalised.

11.2.41 These plans, for example, could include providing additional non-emergency patient transport such as cohorting appointments by postcode and providing a shuttle service. Any plans developed would need to be done so in the context of existing local and national patient transport policies and criteria.

11.2.42 In addition, through workshops with stakeholders proposals have been developed to improve support to patients with regards to travel in the broadest sense across Lincolnshire (i.e. not just relating to proposed service changes under the acute services review). These include:

- Ensuring a seamless process for advice, eligibility assessment and booking
- Improved coordinated way of ensuring the appropriate transport is arranged for discharges from hospital:
    - The default should be Non-Emergency Patient Transport Services (NEPTS) unless there is a 'medical need'
    - Better planning and coordination with the family/patient early in a patients stay as an integral part of discharge planning
    - Coordination of NEPTS with potential other options through a single system approach to discharge planning
- Booking of clinics:
    - More proactive choices regarding clinic bookings should include a discussion on 'how are you intending to travel'
    - Real time information to support administrators in understanding public transport should be easily accessible on their IT systems so that if the patient is travelling by bus and the first bus doesn't arrive until 10:00 the patient is offered an appointment after this time
- Integration of CallConnect and NEPTS journey planning to reduce duplication
- Integration of systems to allow funded, non-funded and concessionary fares/bus passes to use multiple types of transport

Affordability and Deliverability

11.2.43 Acute medicine is currently provided from three wards on the Grantham hospital site that have a combined capacity of 79 beds:

- Emergency Assessment Unit - 28 beds (19/20 non-elective av. length of stay = 2.8)
- Ward 1 - 28 beds (19/20 non-elective av. length of stay = 7.1)
- Ward 6 - 23 beds (19/20 non-elective av. length of stay = 5.6)

11.2.44 Based on the current activity levels and the current average lengths of stay across the wards the required bed capacity for acute medicine at Grantham hospital is estimated to be 73 beds, based on a 92% occupancy.

11.2.45 Of these it is estimated 63 are used for non-elective admissions and 10 for elective admissions and day cases. Based on the findings from the audit conducted as part of the Grantham Clinical Summit it is estimated the non-elective beds broadly split 2:1 high acuity to low acuity, so 42 high acuity and 21 lower acuity.

11.2.46 It is estimated that if the clinical model stayed as it currently is, based on ONS population based projections the required acute medicine bed capacity at Grantham Hospital would increase by 2 beds to 2023/24 based on a 92% occupancy rate.

11.2.47 However, under the proposed integrated/acute bed model it is estimated that c.10% of the current admissions will be cared for in a more specialist unit – Scenario 1 from the bed audit conducted. This would require a future bed requirement of 69 beds by 2023/24, which is comfortably within the current acute medicine bed capacity at Grantham Hospital.

11.2.48 This modelled base case scenario for the required acute medicine bed capacity at the Grantham Hospital site is believed to be a prudent one. Two sensitivity tests have been applied both of which result in a reduced medical bed requirement at Grantham Hospital:

- Within the current care model it is generally accepted that there is an opportunity for admission avoidance and length of stay improvements across the non-elective acute medicine admissions. This is supported by the findings of the clinical audit that identified 10% of patients audited could have had their admission avoided. This opportunity should be easier to realise given the integrated acute/community model and is a key focus of the Integrated Community Care (ICC) clinical model 'left shift'; and

- If Scenario 2 from the bed audit is modelled, i.e. 50% of patients with a NEWS ≥5 transferred to specialist site (equals c.20% reduction), then fewer beds are required on the Grantham Hospital Site.

11.2.49 This bed capacity analysis is set out in the table below.

Figure 154 – Estimated future acute medicine bed requirement analysis

Grantham acute medicine bed requirement under preferred option	Non-Elective		Elective		Day Case		Total	
	19/20	23/24	19/20	23/24	19/20	23/24	19/20	23/24
ONS based population projection								
Admissions	3,858	3,963	61	62	2,954	3,034	**6,873**	**7,059**
Acute medicine beds	63	65	1	1	9	9	**73**	**75**
High Acuity Beds	42	43						
Lower Acuity Beds	21	22						
Basecase: ONS growth & 25% with NEWS ≥5 transferred to specialist site (equals 10% reduction)								
Admissions	3,858	3,566	61	62	2,954	3,034	**6,873**	**6,662**
Acute medicine beds	63	59	1	1	9	9	**73**	**69**
High Acuity Beds	42	40						
Lower Acuity Beds	21	19						
Sensitivity 1: Basecase PLUS 10% admission avoidance / early discharge								
Admissions	3,858	3,170	61	62	2,954	3,034	**6,873**	**6,266**
Acute medicine beds	63	52	1	1	9	9	**73**	**62**
High Acuity Beds	42	35						
Low Acuity Beds	21	17						
Sensitivity 2: ONS growth & 50% with NEWS ≥5 transferred to specialist site (equals 20% reduction)								
Admissions	3,858	3,170	61	62	2,954	3,034	**6,873**	**6,266**
Acute medicine beds	63	52	1	1	9	9	**73**	**62**
High Acuity Beds	42	35						
Lower Acuity Beds	21	17						

11.2.50 Recruitment and retention of medical staff has been a long-standing concern for ULHT, although Grantham Hospital has not had as many issues as Lincoln and Pilgrim Hospitals. At Grantham Hospital the majority of consultant posts are held by permanent Trust employees offering a consistency of service and training provision. Though there has been an increase in agency cover for some specialties more recently.

11.2.51 A key specific issue relating to Grantham Hospital is the sustainability of the acute medicine service as it has a selected medical 'take' (exclusion criteria) with low volumes compared to the other two ULHT sites.

11.2.52 The move to a more generic provision of beds and therefore no longer having defined cardiology and gastroenterology inpatient beds on the Grantham Hospital site will mean amendments to the medical staffing structure will need to be made to support the proposed acute medicine model.

11.2.53 However, in practice a large proportion of the work carried out by this cohort of doctors is within the outpatient environment and so the impact is manageable. Given the focus on outpatient provision by these specialties at Grantham Hospital the cardiology and gastroenterology medical teams will remain under ULHT going forward.

11.2.54 Consultant-led provision will be maintained for the relevant specialties of acute medicine, respiratory medicine, and health care for the elderly, and those currently ULHT employed consultants providing these specialties on the Grantham site will be offered the opportunity to transition their employment to the new community provider. Arrangements for specialist provision outside of these specialties to provide advice and support would be discussed and agreed with the acute provider.

11.2.55 The middle grades, currently attached to these consultants would continue to support them and provide care as they currently do and would also be offered the opportunity to transition their employment to the new community provider. Core trainees and foundation doctors would remain part of ULHT to support required training needs, however stay aligned to the service as they currently are.

11.2.56 To support the middle grade rota the cardiology and gastroenterology middle grades currently supporting acute medicine would need to be replaced, likely with respiratory and health care for elderly medicine middle grade doctors. Cardiology and gastroenterology foundation doctors/trainees currently supporting acute medicine would be replaced, including by GP VTS, IMT and ACPs.

11.2.57 ULHT and the community provider would work together closely to establish the employment arrangements for the consultants and middle grades ensuring due consideration is given to the cover provided to the relevant rotas of each organisation and training requirements are appropriately met.

11.2.58 Consultant roles will vary to those in place at present as they will offer their specialist leadership for management of individuals within other community hospitals and residences across Lincolnshire, for example managing an exacerbation of a long term condition for an individual in a community setting, or offering education and guidance to nursing teams in community hospitals to improve quality of care delivery or alleviate the need for escalation into an acute bed.

11.2.59 The proposed integrated care model will introduce exposure to community-based services for the medical teams, particularly trainee roles, developing new specialists for the future with a more detailed understanding of the capabilities of community teams and the growing capacity for higher acuity care in the community. These posts would be ideal for GP trainees

11.2.60 The Complex Frailty Service will offer a further new function for the development of consultant (and junior) staff delivering the new model. Greater collaboration with the local Neighbourhood Teams and primary care colleagues will additionally be built into the delivery, with a shift in culture compared to current ‘acute’ care provision to a holistic approach, facilitated and delivered by a multi-disciplinary team.

11.2.61 The table below sets out the current acute medicine workforce (funded establishment) model at Grantham Hospital together with the workforce model developed for planning purposes under the proposed preferred option. The workforce model for the preferred option will be subject to ongoing review and refinement once the service is fully operational.

Figure 155 – Acute medicine workforce model (funded establishment)

Staff Group	Current configuration (wte)	Preferred Option (wte)*
Medical		
General / Acute Medicine		
• Consultants	3.0	3.0
• Middle/Trust Grade	2.0	2.0
• Foundation/Trainee	6.0	6.0
Respiratory		
• Consultants	2.0	2.0
• Middle/Trust Grade	1.0	1.0
• Foundation/Trainee	3.0	3.0
Health Care for Elderly		
• Consultants	2.0	2.0
• Middle/Trust Grade	2.0	2.0
• Foundation/Trainee	2.0	2.0
		PLUS
Gastroenterology	Majority of care provided in OP setting	• 1.0 additional consultant (to give a total of 8**)
• Consultants	3.0	• 3.0 additional middle grades, likely in respiratory medicine and medicine of elderly (to give a total of 8)
• Middle/Trust Grade	2.0	
• Foundation/Trainee	2.0	• Gastro and Cardiology Foundation/Trainee to be replaced including by GP VTS, IMP and ACPs
Cardiology		
• Consultants	2.0	
• Middle/Trust Grade	1.0	
• Foundation/Trainee	4.0	
Admin	14.0	14.0
Nursing (SDEC / Frailty Service / Ward)		
• Registered	49.0	49.0
• Nursing Associate	7.5	7.5
• Non Registered	37.5	37.5
• Ward Clark	5.5	5.5

**Planning assumptions: All subject to review and change once service is fully operational – optimal nursing skill-mix will be refined over time once service is fully operational to ensure alignment with patient need*
*** In line with the innovative acute/community model consideration will be given to one of the consultants being a non-medical consultant.*

11.2.62 Medical consultant on-call on site availability would initially be 24/7, however the ultimate vision is to retain medical consultant on site availability until midnight (possibly reducing to 10pm) and to transition to medical consultant cover being provided remotely from Lincoln or Pilgrim Hospital after this time, facilitated by telemedicine.

11.2.63 Overnight consultant on-call cover would only move to these arrangements once it has been demonstrated that this was a suitable model in terms of meeting patients' needs and there is no impact on training (working with Health Education England). This would be reviewed on a six monthly basis.

11.2.64 With a shift to a more holistic approach to care provision and the move to more generic inpatient provision, it is anticipated the consultants in the team will also have a specialist interest (one of which should cover diabetes).

11.2.65 For example, the consultant with a diabetes interest would play a valuable part in the new integrated diabetes pathway which has recently been agreed for roll-out across Lincolnshire by spring 2021.

11.2.66 The Health Care for the Elderly team will support inpatient, ambulatory and outpatient services. The team will be essential in leading an integrated community service, to include the delivery of the new Complex Frailty Service, the acute medical beds, neighbourhood teams and providing remote advice and support to community teams and hospitals across the county. This team will be pivotal in ensuring that individuals are able to be supported back to their own 'home' as quickly as possible, receiving ongoing support without the need for extended inpatient stays.

11.2.67 The retention of respiratory physicians is essential to support both inpatient and outpatient services. A large proportion of the acute patients have respiratory problems necessitating the continued provision of respiratory teams on the Grantham Hospital site.

11.2.68 Respiratory consultants would also support community respiratory teams across the county providing advice to the specialist respiratory teams and to prevent admissions to hospitals across the county.

11.2.69 Trainee roles offer significant value to the medical establishment, both financially and in terms of care delivery. With the exception of the withdrawal of cardiology and gastroenterology trainee posts, there are no plans at present to further reduce training posts at Grantham as part of the transition to the new model; indeed, it is hoped that improved opportunities for training support at Grantham could be offered.

11.2.70 As medical trainees proceed through their training pathways, posts must offer exposure to education and development opportunities. Trainees will be seeking opportunities to 'tick off' specific criteria defined within their training programme and future posts at Grantham will be need to offer clarity to applicants as to the value which can be added to their development pathway.

11.2.71 The CCG Clinical Lead, LCHS Medical Director, the medical team at Grantham and UHLT's medical training leads, are in discussion with Health Education England (HEE) with regards to the anticipated delivery of care in the future and the opportunities which will be available to trainees under the proposed model.

11.2.72 Discussions with HEE to date have been positive; there is an acknowledgement that the structures for specialist roles will develop over time as models of integrated care develop across the country, with a greater emphasis on holistic management and consideration of the functions of care which can be safely managed within an individual's own residence.

11.2.73 The placement of trainees for specialty roles within a community-based Trust will offer a variety of new experiences which may not currently be available. In addition to the hospital-based functions, we would expect the new provider to work alongside system colleagues to offer trainees opportunities to experience integrated urgent care and community-based care delivery (for example, the Clinical Assessment Service, or Neighbourhood MDTs). In the medium to long term, telemedicine delivery will additionally be a key function of training opportunity with the consultants' responsibilities for supporting community hospitals and community-based specialty teams (e.g. Respiratory).

11.2.74 In addition to the opportunities for speciality trainees, General Practice training opportunities are being discussed. There are not currently any GP trainees based out of Grantham's medicine services, though there are a small number of posts offered across ULHT sites. Medical teams from both Primary Care services locally and Lincolnshire Community Health Services (LCHS) consider that there could be scope for the provision of integrated trainee posts within the proposed Grantham model. The CCG are in contact with the local GP Training facility and are working alongside the ULHT training teams and appropriate GP training locations to explore these opportunities further, and Health Education England have approved four GP trainees from August 2020.

11.2.75 The current Advanced Nurse Practitioner team at Grantham Hospital provide a rotational service within A&E, ambulatory care and the emergency assessment unit. The team of four individuals work alongside the medical teams, offering support in the assessment, diagnosis and treatment of patients within their scope of work.

11.2.76 The expectation for the new model is that existing provision will be extended, offering a number of benefits:

- Roles integrated into community provision, supporting working across both a community base and hospital units / wards.
- Reducing medical workload and reliance. Supporting any gaps in junior medical staffing / medical trainees within the new model.
- Increased consistency in service provision.
- Specialist knowledge across a range of disciplines, offering high level intervention in non-medical areas, for example frailty specialist therapy assessment and care planning.

11.2.77 The volume and specialism of roles required will be reviewed as part of the overall workforce structure for the new model, taking into consideration the outcome of ongoing discussion with regards to medical trainees.

11.2.78 The development of rotational posts within the workforce model will be a key variation to the current model of care and will reinforce the integration between community-based and hospital-based service provision. Such opportunities for staff will facilitate the breaking down of the existing barriers in understanding of individual and service capability between acute and community care, which are so often cited as reasons for extended hospital stays due to 'risk' of discharge.

11.2.79 All staff groups will be encouraged to utilise opportunities to experience a variety of services and working environments to build a more detailed knowledge of the structure and capability of services within the locality (Grantham and Sleaford PCN / neighbourhood areas).

11.2.80 For medical trainees, whether specialist or general practice routes, the rotations will offer experience of the developing intermediate and urgent care provision, for example Clinical Assessment Service. There could additionally be opportunities for shared rotational posts with acute hospital sites (potentially both in and out of county). Should GP training posts be secured, these placements could offer rotation into General Practice, including new services as they develop within the local PCNs.

11.2.81 The combination of community and hospital experience which could be offered has great potential for newly training GPs, but also for doctors planning a career in hospital medicine, wanting a rural bias.

1.3 East Midlands Clinical Senate recommendations and workforce improvements

11.3.1 The East Midlands Clinical Senate has been involved all the way through the options development and appraisal process for Acute Medicine. This included an independent clinical review where they were asked to consider whether there is a clear clinical evidence base underpinning the proposal.

11.3.2 The review focussed on the clinical interdependencies and the totality of the changes proposed. Specifically, the clinical review team was asked whether it supported the ASR proposals based on clinical sustainability, workforce deliverability and improvements in clinical outcomes.

11.3.3 Through this review the East Midlands Clinical Senate supported the proposal for Acute Medicine and made no further recommendations.

1.4 Quality and Equality Impact Assessments

11.4.1 A Quality Impact Assessment (QIA) has been completed for the proposed service change for acute medicine services to identify clinical risks to the reconfiguration. This has been completed using a standard template by the NHS Lincolnshire CCG Clinical Locality Lead and Medical Director for Lincolnshire Community Health Services NHS Trust.

11.4.2 The QIA for the service proposal:

- Identifies the key relevant quality measures for the areas of safety, clinical effectiveness, and patient experience;
- Identifies any risks to achieving an acceptable quality in these areas; and
- Presents mitigating actions.

11.4.3 A summary of the QIA for the proposed changes to acute medicine is set out below and the full version is included in Appendix I.

Figure 156 – Summary of QIA for proposed acute medicine service changes

Area	Summary Impact(+ve & -ve)	Summary Actions
1.Quality		
Duty of Quality	▪ Will not effect the rights and pledges of the NHS Constitution. ▪ Will not effect the organisation's commitment to being an employer of choice. ▪ EIA completed.	
Patient Safety	▪ All patients cared for in most appropriate setting for needs. ▪ Integrated community/acute provision that safely meets patient's clinical needs and maintain access. ▪ Ambulatory and bed based care that meets patient's acuity. ▪ Shared integrated response on the site to deteriorating patients. ▪ Frailty expertise is fully developed in the local teams. ▪ Development of an integrated community/acute provision that safely meets patient's clinical needs and maintains access locally should address workforce challenges.	▪ Implementation needs to be completed through a sequence of changes to clinical practice and the workforce. ▪ Exclusion Criteria for site reviewed and implemented to ensure those people with high acuity and life threatening illness and injury go more specialist site first time to receive treatment ▪ Ongoing refinement of workforce model
2. Experience		
Patient Experience	▪ Highly likely new model will be able to meet the needs of a significant majority of patients, locally. For the small cohort of patients who will receive care further away this will be provided by a facility most appropriate to their needs. ▪ 'Uncouples' ULHT from direct provision of non-elective care on Grantham site so 'protects' elective services from non-elective admissions at time of surge. ▪ Integrated community/acute provision will allow for a service that safely meets patients' clinical needs and maintains access locally.	▪ Monitor performance ▪ Joint planning with Neighbourhood Integrated Care Team
Staff Experience	▪ Will support pressure currently experienced by ULHT with regards to significant workforce challenges in acute medicine ▪ Greater role for advanced clinical practitioners and physician posts	▪ Work with Health Education England on recruitment/new roles ▪ Ongoing monitoring of staff surveys ▪ Consultation with staff
3. Effectiveness		
Clinical Effectiveness & Outcomes	▪ Integrated community/acute model based on research, evidence and significant clinical engagement ▪ Greater integration between hospital and Neighbourhood Integrated Care Teams ▪ 'Uncoupling' ULHT from direct provision of non-elective care will enable elective admissions to be protected ▪ Current model has 'selected' medical take with low volumes, which creates sustainability challenges ▪ New care pathways developed for care of patients that better integrate care between acute and community setting ▪ Support improvements against constitutional standards	▪ Monitor clinical outcomes ▪ Joint planning with Neighbourhood Integrated Care Team

11.4.4 Quality for the domains of patient experience, patient safety and clinical effectiveness will be monitored and assured for United Lincolnshire Hospitals Trust (ULHT) through a combination of surveillance mechanisms throughout the Acute Services change and improvement program.

11.4.5 A system wide Lincolnshire Quality Surveillance Group is now meeting bi-monthly chaired by the CCG Director of Nursing with Clinical & Quality lead attendance from all Lincolnshire main providers (including ULHT and LCHS), NHSE/I including Specialised Commissioning, HealthWatch; HEE and Social Care. Any significant Quality concerns will be alerted and mitigated through the work of that forum.

11.4.6 Quality metric hard and soft intelligence for ULHT and LCHS is also considered through the CCG Quality and Patient Experience Committee (QPEC) that also meets bi-monthly as a sub-committee to the CCG Board. This committee will continue to consider Quality improvement requirements for ULHT, plus identifying any areas of Quality concern, where improvement action is required.

11.4.7 There are four dedicated CCG Quality Officers that work closely with ULHT, each with a focus on a respective hospital site. These CCG Officers are responsible for daily surveillance to identify any areas of Quality concern for ULHT, working with the Trust to secure improvements where required. This is through meetings with leads from relevant areas of the Trust, through attendance at the Trust's own Quality Governance Committee, via a regular CCG led Patient Safety Group and when indicated through Quality visits to the Trust as required.

11.4.8 There is also regular liaison between CCG Leads and their counterparts in the Trust to flag any areas of concerns plus now a regular system Clinical Forum that meets with ULHT attendance. There are similar quality monitoring processes for all Lincolnshire main providers, each having at least one dedicated Quality officer.

11.4.9 The lead CCG Quality Officer reports any concerns into QPEC and from a CCG perspective re: ULHT into the system Quality Surveillance Group. There is therefore an alerting system for any deteriorating quality areas for ULHT, which can be quickly identified for improvement, immediately if indicated.

11.4.10 Services undergoing any significant change will be monitored via the Trust's own Quality monitoring processes and also through the system and commissioner processes outlined above, to ensure as the change occurs and new service models become embedded that there are no deleterious effects on patient care at ULHT, LCHS or any other providers.

11.4.11 In addition the impact of any proposed changes on staff will be kept under ongoing review through the evaluation of measures such as the NHS Staff Survey, local surveys, absence rates, staff health and wellbeing, and retention rates.

11.4.12 As well as a QIA, a Stage 1 and Stage 2 Equality Impact Assessments (EIA) has also been completed for the proposed acute medicine service changes.

11.4.13 Within the Stage 1 analysis the populations/groups defined by protected characteristics that were identified that may face adversity as a result of the proposed activity/project were; Age and Economically Disadvantaged

11.4.14 To help address adverse impact on these groups The People's Partnership, on behalf of the then Lincolnshire Sustainability and Transformation Partnership (now Integrated Care System), carried out an engagement exercise to reach hidden communities between 5 and 25 March 2019.

11.4.15 Over 15 days 130 questionnaires were completed. These submissions received views relating to sensory impairment, physical disability, learning disability, mental health, carers, young people and families, older people, race, pregnancy and maternity and social economic deprivation.

11.4.16 In addition, through March to October 2019 all Lincolnshire health organisations conducted the *'Healthy Conversation 2019'* engagement exercise. Within this period there were a number of engagement opportunities including an ASR-focused survey, drop in events with lead clinicians and executives to discuss proposed service changes, dedicated locality workshops offering more detailed discussion opportunities and a direct response/query mechanism.

11.4.17 During this engagement period, accessibility issues were again taken into account and the survey and promotional materials were made available in different formats on request and translated into different languages. Our partner and stakeholder organisations also worked with us to promote the various ways the public could get involved and supported their groups and audiences to engage. This process yielded broader feedback, however, it is noted that the themes and concerns were similar.

11.4.18 Using the results of the engagement exercises and additional research the following themes were identified in the Stage 2 EIA:

- Age:
    - Older population: Longer travel requirements which is impractical; negative impact on health; concerns of greater reliance on family and friends for increased travel needs; reliance on public transport that is perceived to be limited in accessibility.
    - Younger population: Negative impact on health; reliance on public transport, which is perceived to be limited in accessibility; additional cost
- Economic Disadvantaged:
    - The specific engagement from The People's Partnership did not receive feedback from groups with this protected characteristic
    - But the wider Healthy Conversation 2019 engagement identified that the possible negative impacts of this proposed change on deprived population include longer travel requirements and additional cost of this and specific concern about the costs of return travel from hospital, especially at times of limited/no public transport.

11.4.19 A summary of the EIA for the proposed changes to acute medicine services is set out below and the full version is included in Appendix J.

11.4.20 The Equality Impact Assessment will continue to be developed and refined throughout the consultation period, drawing in feedback received through the process.

11.4.21 Plans to mitigate impact on travel and access will be finalised once the public has been fully consulted on any proposed service changes. These plans will be finalised in the context of existing local and national patients transport policies and criteria.

Figure 157 – Summary of EIA for proposed acute medicine service changes

Impact / issue identified	Key actions or justification to address impact/issues	Anticipated outcome – will this remove negative impact

1. Longer travel requirements	• This will potentially be the case for some patients, however:
	  • They will be small in number and only those with higher acuity health needs
	  • Current exclusion criteria means this is already happening, refinement of this criteria will mean an additional small number of patients will travel longer
	• Estimated c.385 patients per year who are currently admitted to Grantham Acute Medicine beds will be displaced to an alternative site.
	• This is equivalent to c10% of the current activity, and the displacement is due to their care needs being better met in a more specialised service at an alternative hospital.
	• Under the proposed changes it is estimated that there will be no increase in the number of patients travelling more than 60 minutes by car, the threshold agreed for this type of activity
		• No. For some patients there may be longer travel times, but this is balanced against ensuring those patients receive treatment in the right place first time.

2. Negative impact on health	• This model is focused on delivering the optimum balance of access, sustainability and outcomes. • For those patients with high acuity that need to attend a more specialist hospital it is crucial they get to the right hospital with the right facilities first time in order to ensure the best chance of a positive outcome	• Yes. Proposed service should have a positive impact on health as patients are cared for in the most appropriate setting for their needs.

3. Greater reliance on family and friends for increased travel needs
4. Greater reliance on public transport, which is perceived to be limited in accessibility
5. Concerns about costsof travel to and from hospital, especially attimes of limited/ no public transport
	• Acute medical beds will remain on the same site/location as they currently do. Only patients with thehighest acuity needs will go to alternative sites, however their level of acuity means this will likely be by ambulance.
	• Friends and family of those admitted to hospitals further away will need to travel further – this is the current situation for cases covered by the exclusion criteria.
	• Some patients may potentially have a greater reliance on friends/family or public transport for travel support to return home. However:
	  • ULHT currently provides a patient transport service based on eligibility criteria; and
	  • Volunteer services currently provide patient transport services where confidence or mobility issues can make it difficult to attend hospital
	  • The impact of the proposed service change proposals on access, particularly on groups with protected characteristics, will continue to be explored and understood through consultation with the public and plans only finalised once that process is complete.
	
	The NHS is not responsible for the public transport infrastructure in the county (Lincolnshire County Councilcontrols this), however the NHS is undertaking partnership working with LCC and others in order to review and improve travel and transport in the county
		• Yes. For some there may be a greater reliance on family and friends or public transport. However, NHS and voluntary sector patient transport services already exist to help in certain situations.
		• The proposed service changes do not make any changes to these patient transport services or associated criteria.
		• Plans to mitigate impact on travel and access will be finalised once the public has been fully consulted on any proposed service changes. These plans will need to be finalised in the context of existing local and national patients transport policies and criteria.

1.5 Vignettes to demonstrate the positive impacts of the clinical model

Patient 1

11.5.1 An 86 year old female is brought to the Grantham UTC by ambulance with increased confusion, and a history of fall one week earlier. She is a resident of a local Care Home, taking multiple medication and has had three admissions to acute care with urosepsis in the past 12 months.

11.5.2 Clinicians working within the UTC have direct access to this patient's GP record and are able to establish pre-morbid health status and level of frailty. If necessary, there will be direct communication with the patient's integrated community team (ICT), care coordinator and family to establish whether acute escalation is appropriate.

11.5.3 Investigations including blood tests, plain film x-ray and, if felt appropriate clinically, a CT Head will be carried out within the SDEC on site at Grantham. There will be further liaison with the ICT to agree the best outcome for the patient.

11.5.4 Outcomes, following liaison with the ICT may be:

- Discharge back to Care home with additional ICT/therapy support
- Admission to an acute community bed on site for management of this acute event
- Short term admission or referral to the frailty unit to review holistic needs and prepare for safe discharge and/or palliative care.

Patient 2

11.5.5 A 67 year old male with worsening breathlessness and cough, known underlying COPD and cor pulmonale and lives alone attends the Grantham UTC.

11.5.6 The UTC clinicians have direct access to the GP record to establish previous history, medication details including allergies and what support is in place. They check if the patient is known to ICT and/or Specialist Community Teams (Respiratory, Heart Failure) so information can be gained about social circumstances and support needs.

11.5.7 The UTC clinicians undertake an assessment of health status to include blood testing, ECG and plain film X-ray. Advice is sought from the Respiratory Medicine Consultant if necessary and an appropriate management plan agreed based on the patient's medical and social needs.

11.5.8 Outcomes, following attendance may be:

- Discharge home with appropriate pharmacological treatment with additional social support (HART, ASC) from Specialist Nursing Teams and ICT and direct liaison with GP Practice to arrange a timely review at home
- Short term admission to an acute-community bed on the Grantham Hospital site until the patient can be safely discharged home
- Escalation to Acute Trust if deteriorating clinical condition and patient appropriate for critical care input.

NOTE: These vignettes are also included in the Urgent and Emergency Care (UEC) chapter (Chapter 10) given the proposals for UEC and Acute Medicine at Grantham Hospital reflect a full integrated pathway.

1.6 Assessment against tests for service change

11.6.1 In line with the guidance set out in *'Planning, assuring and delivering service change for patients'* published by the NHS in 2018, all proposals for significant service change must be assessed against the Government's four tests for service change and NHS England and Improvement's test for reductions in hospital beds.

11.6.2 An assessment against these tests for the proposed changes to Acute Medicine provision has been conducted and is set out below. This assessment reflects and aligns to the description and narrative for the preferred option for acute medicine services set out in this chapter.

Test 1: Strong public and patient engagement

11.6.3 There has been strong ongoing engagement with the public throughout the life of the ASR programme and its predecessor programmes. The breadth and depth of this work is set out in full in the stakeholder engagement chapter later in this document with more detail provided in the detailed engagement reports in Appendices K and L. The focus here is therefore on the engagement relating to acute medicine.

11.6.4 During July 2018 a series of nine engagement events to discuss hospital services in Lincolnshire were held, each in a different area in the county. In total 170 members of the public were engaged across these nine events. The meetings were designed to focus on the case for change for particular health services and the possible solutions to the challenges faced. In relation to urgent and emergency care and acute medicine the focus of the conversations were very much on urgent and emergency care service provision rather than acute medicine beds.

11.6.5 In October 2018 four public options evaluation workshops were undertaken across Lincolnshire in Sleaford, Mablethorpe, Bourne and Gainsborough to enable member of the public to share their views on the options against the evaluation criteria and supported the ongoing process of developing the final options being proposed for consultation.

11.6.6 At these events the potential options for the future provision of acute medicine services were considered, these being no provision of acute medicine beds at Grantham Hospital and the provision of integrated community/acute beds at Grantham Hospital.

- Overall, the vast majority (81%) of stakeholders thought the provision of integrated community/acute beds at Grantham Hospital satisfied the evaluation criteria significantly or somewhat better than the proposal to have no acute medical beds at Grantham Hospital.
- Only 11% of attendees thought that the proposal to have no acute medicine beds at Grantham Hospital better satisfied the criteria, and 8% reported they felt both proposals satisfied the criteria equally well.
- The provision of integrated community/acute beds at Grantham Hospital was felt best to satisfy all criteria, particularly; quality - 91%, access - 80% and affordability - 89%.
- There was little interest from participants discussing there being no provision of acute medicine beds on the Grantham Hospital site. They were much more focused on the feasibility of the integrated/community acute beds.
- The integrated community/acute beds proposal was considered beneficial in supporting better care pathways so long as an integrated, joined up network of services is created to enable satisfactory patient flow.

11.6.7 In 2019 *Healthy Conservation 2019* was launched, which was an open engagement exercise to shape how the NHS in Lincolnshire takes health care forward in the years ahead. This included pre-consultation engagement on the emerging options in the ASR:

- In relation to acute medicine services care services, and specifically relating to Grantham Hospital, key themes related to:
    - Concerns around distance and accessibility, poor public transport and access and hardship to patients or family who cannot afford the travel costs
    - Needing to keep medical treatment local and easy to access, train staff in-house and more beds/staff needed at Grantham Hospital
    - Acute beds might take pressure of Pilgrim and Lincoln Hospitals and keeping as many services in Grantham as possible is important
- Feedback from a workshop held in Grantham relating to acute medicine services highlighted themes relating to:
    - How any proposed changes might affect other wards and services at Grantham Hospital
    - NHS support offered to disadvantaged patients, especially for travel and transport
    - Access to services and inadequate public transport (EMAS) service provision, performance and the ‘golden hour’.

- Feedback was also obtained from hidden and hard to reach communities relating to the impact on the protected characteristics, groups and communities focussed around the longer distance need to travel to proposed centres of excellence, such as for stroke services, and the associated increase in cost. This highlighted restricted incomes and savings would be a barrier to travelling further and a need to rely on family members for transport or public transport and taxis with the associated cost and practicality implications. Being physically disabled or with mobility issues makes access more difficult.

11.6.8 Throughout the duration of the ASR programme there has been ongoing engagement with the Lincolnshire County Council Health Scrutiny Committee. Between May and October 2019, the Committee commented on each of the services within the scope of the ASR programme where an emerging preferred option for the future delivery of services had been identified. The Committee considered the change proposals for acute medicine on 18 September 2019 and submitted initial comments on the 24 October 2019.

11.6.9 These were:

- Initial preference for integrated community/acute bed model as a means of stabilising Grantham Hospital
- Welcome the involvement of local clinicians in development of options
- Different way of working by all staff involved
- Concern on availability of funding for integrated community/acute model, should it be required
- Medical admission 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 seen at Grantham
- More detail on how the integrated community/acute model would work in practice

Test 2: Consistency with current and prospective need for patient choice

11.6.10 The Department of Health guidance on this test sets out that a central principle underpinning service reconfigurations is that patients should have access to the right treatment, at the right place at the right time. Services should be locally accessible wherever possible and centralised where necessary.

11.6.11 The guidance goes on to state that in this context, local commissioners need to consider how proposed service reconfigurations affect choice of provider, setting and intervention; and that commissioners will want to make a strong case for the quality of proposed services and improvements in the patient experience.

11.6.12 The concept of services being locally accessible wherever possible and centralised where necessary is at the heart of the Lincolnshire Acute Services Review, and at the heart of the proposed acute medicine service model for Grantham Hospital.

11.6.13 Implementing the preferred option for acute medicine will not reduce the number of hospital sites from which acute medicine is provided from (the number of providers is not reducing under the change proposals). However, for a small number of patients (c.385 patients per year) with higher acuity needs they will receive care specialist treatment elsewhere.

11.6.14 It should also be noted that the under this proposed model Grantham Hospital will be able to support a larger proportion of frail and elderly patients from the geographic area to receive inpatient care at Grantham.

Test 3: Clear clinical evidence base

11.6.15 The case for change and proposals for the future configuration of acute medicine were tested through two ASR programme Clinical Summits with over 55 leads from across the system, facilitated by the East Midlands Clinical Senate.

11.6.16 Subsequent to the ASR programme Clinical Summits and their initial outputs and conclusions a Grantham Clinical Summit was convened to specifically look at the provision of acute medicine services at Grantham Hospital. The clinical summit took place on 10 August 2018 followed by subsequent meetings and telephone conferences.

11.6.17 The summit comprised professionals from both acute and primary care including the Clinical Chair for South West Lincolnshire CCG, local GP lead, Medical Director for Lincolnshire Community Health Services NHS Trust, Medical Director of ULHT, Associate Medical Director ULHT, Consultant Nurse Cardiology/Associate Chief Nurse ULHT and Transformation Lead EMAS. In addition, external independent clinical expertise was provided by Dr Jay Banjeree Consultant in Geriatric Emergency Medicine at University Hospitals of Leicester NHS Trust and Chair of the Royal College of Emergency Medicine SIG in Geriatric Emergency Medicine.

11.6.18 The preferred option for the future configuration of urgent and emergency care services was identified through a clinically led options appraisal event attended by over 60 stakeholders – the conversation on acute medicine at this event was led by the Clinical Chair of South West Lincolnshire CCG who was instrumental in the Grantham Clinical Summit.

11.6.19 At this options appraisal event overall 85% of participants thought the proposal to provide integrated acute/community beds at Grantham Hospital satisfied the evaluation significantly better or somewhat better than no medical beds at Grantham Hospital. There was a strong preference across all criteria.

11.6.20 The presentation of the preferred option for acute medicine services to the East Midlands Clinical Senate was led by the clinicians who had led the Grantham Clinical Summit. Two presentations were given to the East Midlands Clinical Senate on the proposals, following the second presentation the clinical senate panel confirmed they were left with the impression that all system partners are engaged and cohesive with a clear vision for the future of medicine for Grantham Hospital.

11.6.21 The East Midlands Clinical Senate panel described the proposal as innovative and achieved an excellent balance between access and sustainable long term outcomes.

Test 4: Support for proposals from clinical commissioners

11.6.22 The Lincolnshire CCG(s) have been main sponsors of the ASR programme since its inception. The members of all of the Governing Bodies recognise the case for change and accept that doing nothing is not an option.

11.6.23 Clinical leads from CCGs have played a key role in developing and refining clinical models, working closely with colleagues in the acute setting. This joint approach between clinicians in primary care and acute care will continue into the public consultation meetings.

11.6.24 The four CCG Governing Bodies and 'Shadow' Joint Committee, as they were at the time, considered the outputs of the evaluation process and the independent reviews as the ASR programme developed.

11.6.25 The four CCG Governing Bodies, as they were at the time, agreed the original PCBC that set out the preferred option for the future configuration of acute services in Lincolnshire at their Governing Body meetings in October 2018. The proposed changes to go to consultation set out in this PCBC are the same as they were in the original PCBC.

11.6.26 Most recently the newly formed single Lincolnshire CCG Governing Body reviewed this PCBC on 22 July 2020 and gave its support to the proposed changes to be submitted to NHSEI to start its assurance process. An extract of the minutes of that meeting can be found in Appendix M.

Test 5: Capacity implications

11.6.27 Acute medicine is currently provided from three wards on the Grantham Hospital site that have a combined capacity of 79 beds

11.6.28 Based on the current activity levels (19/20) and the current average lengths of stay across the wards the required bed capacity for acute medicine (elective and non-elective) at Grantham hospital is estimated to be 73 beds, based on a 92% occupancy.

11.6.29 Of these it is estimated 63 are used for non-elective admissions and 10 for elective admissions and day cases.

11.6.30 It is estimated that if the clinical model stayed as it currently is, based on ONS population based projections the required acute medicine bed capacity at Grantham Hospital would increase by 2 beds by 2023/24 based on a 92% occupancy rate.

11.6.31 However, under the proposed integrated/acute bed model it is estimated that 10% of the current admissions will be cared for in a more specialist unit. This would require a future bed requirement of 69 beds by 2023/24, which is comfortably within the current acute medicine bed capacity at Grantham Hospital.

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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:	**15 December 2021**
Subject:	**Humber Acute Services Programme – Update**

Summary:

This report provides the Committee with an update on the progress of the Humber Acute Services Programme, specifically in relation to:

- engagement undertaken and outcomes to date;
- Programme 2 (Core Hospital Services) and Programme 3 (Building Better Places); and
- an overview of future plans, timelines and next steps.

Actions Requested:

The Committee is requested:

(1) To consider and note the details presented in this report and appendices, including the reasons for change, the work undertaken to date and the next steps as part of the Humber Acute Service Programme.

(2) To note the intention to complete a Pre-Consultation Business Case in early 2022 Humber Acute Service Programme, with the aim of formally consulting on potential clinical models with the public and other stakeholders in Spring 2022.

(3) To note current legislative framework governing statutory consultation with local authorities in relation to NHS reconfiguration proposals, recognising existing health scrutiny arrangements and provisions may change as the current Health and Care Bill (2021) is enacted and becomes law.

(4) To identify any specific aspects where further and/or more detailed information may be required.
(5) To provide feedback on how they would like to be engaged over the next phase of the programme.
(6) To determine any other specific future scrutiny activity at this time.

1. Background

Hospital Trusts Involved in Humber Acute Services Programme

The Humber Acute Services Programme covers the services provided by two acute hospital trusts: Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH).

The reason for this Committee's consideration is that two of the three main hospitals operated by NLaG are Diana, Princess of Wales (DPoW) Hospital in Grimsby, and Scunthorpe General Hospital. These two hospitals, but in particular DPoW in Grimsby, are used by a significant number of residents in the administrative county of Lincolnshire. By way of an overview, for 2020-21 Lincolnshire CCG commissioned £50.3 million of acute hospital activity from Northern Lincolnshire and Goole NHS Foundation Trust, as part the CCG's baseline contract.

Update on the Programme

An update on the Humber Acute Services Programme is set out in Appendix A to this report. The update will be presented by the following Representatives from the programme Team:

- Ivan McConnell, Programme Director
- Claire Hansen, Programme Director - Interim Clinical Plan
- Linsay Cunningham, Associate Director Communications and Engagement
- Steven Courtney, Partnership and Stakeholder Engagement Manager

Previous Committee Consideration

The Committee has not yet considered the Humber Acute Services Programme as a substantive agenda item. However, the Chairman has included updates in his announcements on the following dates: 10 November 2021 and 15 September 2021.

Overview and Scrutiny Committee Arrangements

From an overview and scrutiny perspective, the Lincolnshire Acute Service Review and the Humber Acute Service Programme differ in in that the former, which is focused on one hospital trust, is being considered by one committee only - this Committee. The Humber Acute Services programme is being considered by four other health overview and scrutiny committees:

- East Riding of Yorkshire Health, Care and Wellbeing Overview and Scrutiny Sub-Committee
- Hull Health and Social Well-Being Overview and Scrutiny Commission
- North East Lincolnshire Health and Adult Social Care Scrutiny Panel
- North Lincolnshire Health Scrutiny Panel

3. Consultation and Conclusion

The Committee is invited to consider the presentation on the detailed elements of the Humber Acute Services Programme; to identify any specific aspects where further or more detailed information may be required; to provide feedback on how they would like to be engaged over the next phase of the programme; and to determine any other specific future scrutiny activity at this time.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Humber Acute Services Programme Update (November 2021)

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

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HUMBER ACUTE SERVICES PROGRAMME UPDATE

(NOVEMBER 2021)

Purpose

1. The purpose of this report is to provide members of the Committee with a further update on the progress of the Humber Acute Services Programme, specifically in relation to:

    - Engagement undertaken and outcomes to date
    - Programme 2 (Core Hospital Services) and Programme 3 (Building Better Places)
    - An overview of future plans, timelines and next steps

2. It also sets out some of the current legislative requirements in relation to health scrutiny and provides an opportunity for members to ask questions, seek more information and provide feedback on their future engagement with the programme.

Background

3. The Humber Acute Services (HAS) Programme is designing hospital services for the future across the Humber region to deliver better and more accessible health and care for the population. The programme involves the two acute trusts in the Humber – Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) – and the four Clinical Commissioning Groups (CCGs).

4. The Programme sets out a vision that: everyone across the Humber will have access to the best possible healthcare and opportunities to help them live healthy, happy lives. All partners across the health and care system in the Humber have an important role to play in the short, medium and longer-term to deliver this vision, which is much wider than the acute hospital sector alone.

5. The Humber Acute Services Programme is comprised of three distinct but inter-related programmes:

    - Interim Clinical Plan (Programme One) – stabilising services within priority areas over the next couple of years to ensure they remain safe and effective, seeking to improve access and outcomes for patients.

    - Core Hospital Services (Programme Two) – long-term strategy and design of future core hospital services, as part of broader plans to work more collaboratively with partners in primary, community and social care.

    - Building Better Places (Programme Three) – working with a wide range of partners in support of major capital investment to develop our hospital estate and deliver significant benefits to the local economy and population.

6. This paper is one of a series of updates on the progress of the Humber Acute Services Programme provided to the Health Overview and Scrutiny Committees in each of the local authority areas across the Humber. Links to previous updates are provided in the background papers for further reading.

7. An update on Programme One (the Interim Clinical Plan) was circulated to Health Overview and Scrutiny Committee members in September / October 2021, which is available here.

Why hospital services need to change

8. Our health and care system across the Humber needs to change. It is not always meeting the needs of everyone in the region and, as currently designed, is not set to do this in the future:

    - We're not providing the standards we should be in all our services
    - We don't have enough staff to continue to do everything everywhere
    - Some of our buildings and equipment are falling apart and are not fit for the future

9. These and other challenges we face were detailed in the programme's Case for Change (November 2019) and are set out in more detail below.

We're not providing the standards we should be in all our services

10. Our waiting lists are growing. When the case for change was published in 2019, both Trusts were in the bottom quartile for performance against the referral to treatment time (RTT) standard. The impact of the pandemic has led to significant growth in waiting times and the overall waiting list size. People are not being seen as quickly as they could be if services were organised differently. For example, our operating theatres and other facilities sometimes get taken up with emergency cases, which means some people who need a planned operation have to wait even longer.

11. Many NHS services have specific clinical standards that should be met. These can include caring for a specific number of patients or doing a set number of procedures or operations to ensure staff maintain the necessary level of skill and competency. Some of our services are struggling to meet these standards. For example, some of our neonatal services do not see the number of babies that the national guidelines recommend for staff to keep their skills up to date and maintain the necessary expertise to adequately care for such vulnerable babies. National guidelines recommend that every year a Level 2 neonatal care unit should admit at least 25 babies with birth weights of less than 1500g. Over the last 3 years, data shows that on average the Level 2 units at Grimsby and Scunthorpe, treated 26 and 19 babies[1], respectively. Similarly, activity levels for the neonatal intensive care unit (NICU) at Hull Royal Infirmary (HRI) are lower than the recommended level, with a 3-year average of 72 births of very low birthweight babies, where the recommended level for a NICU is 100 per year.

12. In addition, many of our services need trained staff to cover rotas 24/7, 365 days a year and we don't have enough staff to do this for all our services, all the time. This means that some staff are often on the rota more than we would like them to be. We know from staff engagement that maintaining a healthy work/life balance is very important to our staff. This also increases our reliance on agency and locum staff to cover shortages, which leaves

[1] Based on data from the Yorkshire and Humber Neonatal Operational Delivery Network (ODN) as follows: 2018/19 – HRI (75), Grimsby (23) and Scunthorpe (14); 2019/20 – HRI (75), Grimsby (28) and Scunthorpe (23); and 2020/21 – HRI (67), Grimsby (26) and Scunthorpe (19)

services more vulnerable and at risk of failing should existing members of staff become ill and unable to work, or if they move to another job.

We don't have enough staff to continue to do everything everywhere.

13. Some services may be just about managing to deliver services now. However, with over 30% of our staff eligible to retire within the next five to 10 years, it is imperative that we plan for workforce changes now[2]. Failing to plan for these predicable changes to our workforce will lead to the need to implement urgent service changes due to patient safety issues in future years.

14. In some services, there are shortages of staff with specific skills that are needed to deliver services and provide the best care to our patients. Some of these shortages can be on a national or international scale, which makes it extraordinarily difficult to recruit staff with the right skills – which adds further difficulties on how 24/7 rotas are covered. Therefore, we need to change how we offer care and treatment across the Humber to maximise the number of patients existing staff can see and treat. For example, there is a national and international shortage of oncologists. UK-wide there was an estimated shortfall of oncologists in 2019 of 19% or 207 consultant oncologists[3]. The impact of these shortages in our region has placed significant and ongoing pressure on oncology services, resulting in some temporary changes to where some patients access some aspects of oncology services.

15. In addition, many staff want to work in hospitals that run research and teaching programmes. Not all our hospitals across the Humber currently offer such opportunities. Therefore, if we change what we do and how we do it, including investing in more research facilities and working with our universities, we will provide the best opportunity to be able to attract and retain more staff. Working collaboratively with our universities could also open up and/or create new jobs and opportunities, which in turn could help us to recruit more staff in the longer term.

Some of our buildings and equipment are falling apart and are not fit for the future

16. Our hospital buildings across the Humber need £105 million additional investment just to keep them running. We have some fantastic new buildings on some of our sites, but these are the exception rather than the rule. As an example, 82% of Scunthorpe General Hospital's critical infrastructure is at risk of failing within five years and we have already had to close parts of that hospital to patients because the buildings were not safe. If we don't do something now, the situation will only deteriorate and lead to the closure of other parts of the hospital. This programme of change offers an opportunity to build new and better facilities that will benefit the whole region.

17. We also know that we don't have enough operating theatres to do the number of operations we need to – which has a significant impact on waiting lists and waiting times. This problem has been exacerbated by the COVID-19 pandemic, including existing theatres

[2] 32.8% of NLaG workforce are 50yrs+ and 29.6% of HUTH workforce are 50yrs+. Some professions are eligible for retirement at 55 years.

[3] 'Clinical oncology UK workforce census report' (2019), The Royal College of Radiologists, https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-oncology-uk-workforce-census-2019-report.pdf

becoming less efficient as a result of additional time needed between operations to undertake deep cleans, and we need to perform more operations to cover the backlog of operations that have built up (see below table for a snapshot).

	Total waiting list size		Patients waiting >1 year	
	(pre-Covid)	(post-Covid)	(pre-Covid)	(post-Covid)
Hull University Teaching Hospitals NHS Trust	54,000	58,000	0	9000
Northern Lincolnshire and Goole NHS Foundation Trust	28,000	31,000	9	700

18. We use lots of different digital systems across the different hospital sites that are not based on the latest technological developments and do not work together. As such, we need investment in our equipment and digital systems so we can offer care in different, more effective and efficient ways that will also have a positive impact on addressing the waiting times and the length of stay in hospital.

19. The Case for Change (November 2019) describes in detail the reasons why we need to do things differently. Since this was published, the reasons for change have not diminished. Indeed, a number of our challenges have grown as a direct consequence of the COVID-19 pandemic.

20. Without significant investment in our healthcare estate, we cannot deliver the necessary clinical changes to ensure services are fit-for purpose, sustainable and meet the needs of our communities in the future. However, it is very clear that without delivering substantial clinical changes, we cannot attract the level of capital investment needed to significantly improve our healthcare estate and infrastructure.

21. Despite the hugely successful vaccination programme, the health and care system across the Humber is continuing to work hard to support patients who are waiting for treatment, and the increases in waiting lists, waiting times and intensifying pressure across the entire health and care system remain. As such, we cannot continue to provide services in the same ways we have done in the past and we need to increase the amount of collaboration between all health and care organisations across the Humber, sharing (wherever possible) the limited resources available to deliver the timely, safe care our patients require.

22. As a system, we are working on changes to all our health and care services. Partners from primary, community and hospital services are working together to design new ways of supporting patients in their own homes or as close to them as possible. Part of our overall strategy is to ensure that hospitals are only used for the things that can only be provided in a hospital setting and where we can help people to access advice, tests or treatment at home, at a GP surgery, on the high street or another easy to access location in the community we will. The complexity of the heath and care system means that we cannot change everything at once, but we will continue to work with partners to ensure all our plans are aligned and deliver the change we need for our population.

Our engagement with patients, the public and staff

23. Ongoing dialogue with patients, staff, the public and other stakeholders has been a key feature of the Humber Acute Services programme since its inception – starting with a conversation about the issues and challenges facing the acute hospital sector across the Humber undertaken between March and September 2018 (see issues paper feedback report). A full summary of our engagement work to date is presented at Appendix 1.

24. Throughout 2021, in spite of the challenges posed by the pandemic and ongoing restrictions we have undertaken extensive engagement with patients, the public, staff and other stakeholders. This engagement has been across a number of areas to support the development of proposals for service change across core hospital services.

25. In particular, we have:

- Asked staff, patients, the public and their representatives *What Matters to You?* to help ensure that future services reflect the views of a broad range of stakeholders and are designed to meet the needs of those who will use them.
- Surveyed women, birthing people and their families about their *Birthing Choices* to find out where they would choose to give birth and why.
- Spoken to people who have used our Emergency Departments about their experiences and whether they would consider using alternatives to A&E.
- Made a particular effort to engage with and listen to the views of those facing additional barriers to accessing care or opportunities to improve their overall health and wellbeing.

What Matters To You?

26. Nearly 4000 people took part in this engagement exercise (between February and May 2021) either by filling in a questionnaire or taking part in a focus group. Some of the main feedback we received included:

- The majority of respondents (82%) had accessed one or more type of hospital service within the last two years and 83% of those were **satisfied** or **very satisfied** with their care.
- The most common areas of positive feedback were in relation to:
    - workforce – praising kind, compassionate and caring staff;
    - waiting times – praising efficient and well-run services; and,
    - clinical standards – commenting on how safe and well looked after respondents felt, often in relation to concerns they had around Covid.
- The most common areas where respondents felt improvements could be made were in relation to:
    - clinical outcomes – in particular, improving communication with patients and between different parts of the health and care system; and,
    - travel and access – in particular, improving access to car parking facilities.

- A summary of what mattered most to people when thinking about future hospital services is presented below:

27. While showing the overall position of what stakeholders told us through that engagement work, we have also established there are different priorities when we consider different demographic information and different stakeholder group, as presented below:

28. While this snapshot shows a high degree of consistency between different age groups / demographics and different stakeholders in terms of matters that are most important, it also highlights some differences in the identified priority areas. The full feedback report (published in May 2021) is available here, with a summary version of also available here.

29. We have continued to engage with different cohorts of patients, the public and other stakeholders to gather more views and perspectives on what matters most to our communities. We are continuing to ask *What Matters to You* within all our engagement activities and will continue to listen to feedback.

30. The findings from the *What Matters to You* engagement will help us to decide which clinical models best meet the needs, priorities and preferences of our different stakeholders by shaping the evaluation framework we use.

What Matters To You – our staff and teams

31. We delivered an awareness raising campaign and targeted engagement for our staff across the Humber, including a specific *What Matters To You* on-line staff survey that ran throughout July 2021. In this, we asked our staff what was most important to them when thinking about their day-to-day roles, their teams and their future career aspirations within the NHS or health and care.

32. This generated nearly 600 responses, which identified the following themes:

- Making a difference to patients' lives and maintaining a healthy work/life balance are really important to staff.
- Solving the workforce issues is the most important issue that the Humber Acute Services Programme must get right.
- Improved communication – in particular ensuring staff are involved in any changes before they take place – is also important to staff.

33. Following the survey, we also held two, targeted staff focus groups in September 2021. The outcomes of the focus groups are included in the overall staff survey feedback report, which is available here.

34. We are continuing to engage with staff across both Trusts, as well as clinicians and teams in partner organisations through a range of mechanisms. These include, clinical workshops, Question and Answer sessions, briefing sessions on different aspects of the programme, an online portal to allow the opportunity for staff to ask questions and fortnightly newsletters for staff at both hospital trusts and partner health and care organisations across the Humber.

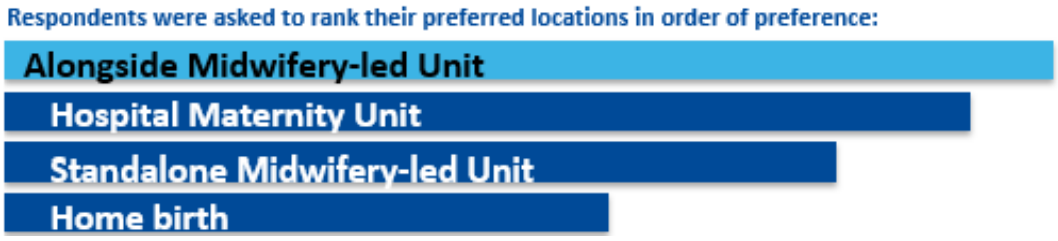
35. Over 700 staff have also been involved in clinical design workshops since November 2020, and we will continually involve and engage staff as the programme progresses. We will also use the feedback from staff to help refine and evaluate potential clinical models.

Your Birthing Choices

36. The *Your Birthing Choices* engagement was undertaken to understand what is important to women and birthing people, partners and support people when choosing where to give birth. This included identifying the main concerns around the different birthing options (i.e. births at home, in a hospital or other midwife-led settings) and what measures could be put in place to alleviate those concerns.

37. Feedback was gathered through a combination of targeted focus groups and an online questionnaire. Focus groups were set up to hear from people with lived experience of neonatal services, young families, women from Black, Asian and Minority Ethnic (BAME) backgrounds, dads, birthing partners and co-parents. The online survey generated over 1100 responses, with over 750 responses from people with a Humber postcode. Some of the main feedback received from respondents living within the Humber included:

    - **74.3% would not choose** to give birth at **home** due to **concerns around safety** should any complications arise during labour.
    - **56.7% would not choose** to give birth in a **standalone midwifery-led** unit due to **concerns around safety** should complications arise during labour resulting in the need to be transferred to a hospital, many feel the delay in receiving specialist care is a **risk** not worth taking.
    - **43.3%** of respondents **would choose** to give birth at a **standalone midwifery-led** unit as they feel it is **a more homely environment** and have **confidence in the care provided by midwives**.
    - **86.0% would choose** to give birth at an **alongside midwifery-led unit** as it feels a **much safer option** as additional support is close by if needed.



38. A detailed feedback report from the *Your Birthing Choices* engagement is currently being finalised and will be published in the near future. The feedback received will help to shape the clinical models we put forward for maternity and neonatal services and will help us to consider the different ways we might be able to provide choice for women and birthing people across our region.

    A&E survey

39. During July to August 2020, an engagement exercise was undertaken across the Humber, Coast and Vale Health and Care Partnership area to understand the reasons why people attend A&E/Emergency Departments (ED) in our region.

40. In total, 2008 people responded to the survey and shared their experiences of Urgent and Emergency Care and views on alternatives to A&E.

41. A summary of the key findings from those who had used one of the three Emergency Departments (EDs) within the Humber (Hull Royal Infirmary, Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby) is set in feedback report – available here. Some headlines include:

    - Most people attending the ED had been advised to attend by another healthcare professional – most commonly NHS 111.

- Where the individual (the patient) believes it is appropriate to their condition, most people would use an alternative service if they could be seen/ treated more quickly by a healthcare professional.
- Of the alternative services available, there was less awareness of Urgent Treatment Centres (UTCs), particularly amongst those attending ED in Grimsby or Scunthorpe. (This is possibly because the UTCs are co-located on the ED site and therefore respondents may not be aware they have been seen and treated through the UTC provision.)

42. These findings (and follow up engagement) are helping to shape our options for Urgent and Emergency Care and ensure we are putting in place alternatives to A&E that will work for our population and meet their needs and expectations. The report is available here and a Humber-specific summary will be included in the Pre-Consultation Business Case evidence pack.

Ongoing Engagement and Next Steps

43. As we refine potential clinical models, we are continuing to listen to what our stakeholders tell us about their experiences of healthcare services across the Humber and what matters most to them. Details of our current live surveys are available on the Humber, Coast and Vale Health and Care Partnership's Engagement Hub. Examples of our ongoing engagement include the following:

- In August 2021 we reopened our ***What Matters to You?*** survey to capture more views on the needs, priorities, and preferences of our different stakeholders, which will help us shape the evaluation framework we use to assess which clinical models meet these needs, priorities and preferences. The survey is available here.
- In October we launched some further engagement, targeted at ***children and young people***, their parents, carers and families to help shape clinical models for paediatric services and to ensure we fully understand any impacts of potential changes on our younger patients. Details of how to take part are available here.
- We are also continuing to work with voluntary and community sector and local authority partners to gather experiences and insights from ***individuals and communities with protected characteristics*** and others who might be less able or willing to engage with statutory services. This engagement will support our options evaluation as well as informing the Equalities Impact Assessment.

44. In addition, we are starting to develop our plans for consulting with the public on potential clinical models in Spring 2022 and would welcome the opportunity to engage with members and seek views from relevant Health Overview and Scrutiny Committees in early 2022, whilst consultation plans are still at a formative stage.

Responding to our challenges now – the Interim Clinical Plan (Programme One)

45. The challenges within our health and care services, set out above, are significant. Whilst we work to develop plans for the longer term, we are also putting in place a number of changes now that are helping to address the challenges in the short term.

46. We need to do both to ensure we can continue to provide good quality care for our population now and into the future.

47. Our short-term programme of change is referred to as the Interim Clinical Plan (or Programme One). The Interim Clinical Plan is focused on specific services that are considered the most fragile or vulnerable across one or both of Northern Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust. This programme is about pooling resources, skills and expertise to provide more resilient services that patients across the Humber can access equitably. It is also about providing better career opportunities for current and future staff.

48. An update on the progress of this work was shared with members in September / October 2021, (and is available here). This update provides an overview of progress specialty-by-specialty together with the next steps and anticipated timelines. This included those specialties where urgent temporary changes had been implemented to continue to deliver services safely. It also provides details of the establishment of the Humber Neurology Service that launched in October 2021 –the first specialty to run as a joint Humber-wide service across both hospital trusts – which is also outlined below:

Humber Neurology Service

49. Neurology is a branch of medicine dealing with diagnosis and treatment of a range of disorders and diseases relating to the nervous system (including the brain and spinal cord).

50. In developing a single Neurology Service across the Humber, service teams across Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) have been working together to implement the following shared clinical vision and principles:

- **Patients** will be **treated by the most appropriate clinician** in the **most appropriate setting**.
- **Clinicians** will be able to **work from any location**, with **access to all relevant clinical records** and will be **able to request diagnostics and other tests at any site**.
- The service will be **provided and managed as a single service** with a single team; and all **staff will work as a single team** with **consistent policies, procedures, pathways and support** (irrespective of the employing Trust).
- **All referrals** will be managed through a **single point of access**, with **a single waiting list** and **consistent pathways in place** at both sites.

51. By working together across the Humber, we will be able to provide a more resilient, patient-focused and equitable Neurology service for all patients across the Humber. Patients will be triaged more quickly and directed to the right specialist clinician straight away; rather than the existing two-step process (for patients on the south bank) that involves an initial general neurology assessment and referral (if required) to the relevant specialist Neurologist. While specialist clinics and services will continue to be located at HUTH (as the Specialist Tertiary Neurosciences Centre), the new triaged approach will shorten waiting times for individual patients (particularly on the south bank) and create additional capacity across the service, by streamlining how patients are assessed and directed to the right service. This approach

will help reduce waiting lists overall and ensure patients get to the right specialist more quickly.

52. Patients will also be supported by the Specialist Nurse at their nearest site, rather than having their care automatically transferred to HUTH if they see a HUTH consultant. This will be a significant improvement to patient care, as travel can be extremely difficult and challenging with some neurological conditions.

53. The development of a single service model is supported and has been informed by patient feedback previously gathered[4], where patients shared their views on the services provided.

54. How the Neurology service has and will continue to respond to patient feedback is set out in the Neurology *How Your Voice is Making a Difference* feedback report, available here.

55. A number of the developments outlined above have not been done before and require detailed technological changes and testing to ensure the new system works as intended, in order to put this type of work into practice across Neurology and other service areas.

56. The developments represent a minor change to the patient pathway in terms of where and how some patients will receive care – for example, being able to go straight to test rather than having to wait for a first outpatient appointment before being referred for a test or to the relevant sub-specialist. Such changes respond to the patient feedback previously gathered and it is anticipated these will significantly improve waiting times, the overall care patients receive and their general experience of the service.

57. Commissioners and GPs have worked with the service teams and are fully engaged in the development of the approach. Primary care colleagues are supportive of establishing and developing a single Humber-wide service. Impact assessments have been conducted and commissioners have been engaged in reviewing contracting and oversight arrangements for the new services. Required documentation to support the change will be published appropriately through relevant commissioners (CCGs).

58. Mobilising in October 2021, the Humber Neurology Service is anticipated to continue to go through a period of transition and development, likely to run until March 2022. During this time the single service will continue to be consolidated and embedded, alongside an ongoing assessment of the longer-term resource requirements (compared to planned assumptions) to ensure the long-term sustainability and delivery of a combined, single service.

Other Interim Clinical Plan Services

59. The September / October 2021 update on the Interim Clinical Plan provides a comprehensive update, including the following key highlights and improvements:

- Outline vision drafted for **Ophthalmology** the service with an agreement in principle for **Post-Operative Cataract Assessments to be moved into Primary Care**.

[4] Humber Acute Services - Focus Group Feedback Report (April 2019) – available here

- Service vision drafted for **Cardiology** and building on successes such as pilot of the **Clinical Health Network model** which has **reduced waiting times**, **reducing need for hospital attendance** and **cleared the patient backlog**. More details of the **Clinical Health Network model** are presented at Appendix 2.
- **Joint Clinical Leads** working across both Trusts appointed for **Neurology, Cardiology, Dermatology, Haematology** and **Oncology**.

60. In order to support the pooling of resources, skills and expertise, the Interim Clinical Plan is establishing single clinical leadership across each specialty. Putting in place dedicated leadership will help, by:

    - Creating a more resilient workforce through joint recruitment that is able to respond to changes in demand for services.
    - Establishing Humber-wide clinical leadership that helps build a sustainable workforce with pooled resource that supports staff to meet the demands of each service and provides better access to training and development.
    - Developing a 'one team, one service' approach and providing access to a wider range of colleagues for support, mentoring, sharing knowledge and expertise.
    - Providing more opportunities for innovation and looking at doing things differently.
    - Enhancing career development by providing more training opportunities within a single workforce.

61. The ultimate aim of these changes to leadership and management is to ensure that by working together the two trusts can provide services that patients across the Humber region can access equitably. All specialties within the scope of the Interim Clinical Plan are developing service strategies for the short to medium term, which will set out how they can make best use of resources to deliver safe and effective care to patients across the region.

62. The Humber Neurology Service model will be used as a pilot to test and adapt the approach, and will then be used to inform, replicate and develop arrangements across other specialties.

63. In the immediate term we are also working with partners across the Humber, Coast and Vale Health and Care Partnership (Integrated Care System/ICS) on a number of other programmes to make improvements in the here and now. Some examples of other programmes and improvement activities are set out in Appendix 3.

64. Whilst many of these interventions are making things better for patients today and helping to address some of the impacts of the Covid-19 pandemic, short-term changes on their own will not be sufficient to address all the challenges facing our hospital services. In particular, long-term plans for clinical services that are fit-for-purpose and meet the needs of our communities in the future are required if we are to be successful in securing the capital investment needed to improve our healthcare estate, equipment and technology.

Programme two (Core Hospital Services)

65. The Humber Acute Services programme provides a huge opportunity to improve services by doing things differently. To improve the ways we provide care, which our patients tell us are often fragmented, have high levels of duplication and, sometimes, poor communication

between organisations. We have an ambition to deliver more care closer to or at home, but this will only work if we change our existing models of care.

66. The work across Programme Two is clinically led and involves detailed options development and appraisal to help identify clinically viable models for core hospital services:

    - Urgent and Emergency Care
    - Maternity, Neonatal Care and Paediatrics
    - Planned Care and Diagnostics

67. The complexity of the heath and care system means that we cannot change everything at once, but we will continue to work with partners to ensure all our plans are aligned and work together to deliver the changes we need for our population.

Progress on the development of clinical models

68. We started identifying potential models of care by generating a really long list of possible outline ideas that were discussed at a series of public involvement workshops in October 2019. Feedback from these workshops (report available here) was incorporated to refine the outline ideas into potential models of care.

69. After an initial hiatus following the onset of the pandemic, work has continued over the last 12 months to develop and refine potential clinical models. We have been working to define the impact of each of the potential clinical models from a patient, staffing and a range of other perspectives utilising a wide range of data and intelligence.

70. Identification of clinical interdependencies have enabled us to remove some clinical models from consideration. Clinical interdependencies have been identified through discussion and engagement with a range of clinicians through our Clinical Design Group. An example of how clinical interdependencies might be applied is – providing doctor-led maternity services (Obstetric Lead Unit (OLU)) without also providing care for sick or premature babies (neonatal care) staffed by paediatricians on the same site was not considered a viable clinical model.

71. Whilst causing some delays or disruption to the Programme, the pandemic has highlighted and reinforced some of what we already knew about our healthcare system – specifically that planned care and unscheduled care (Urgent and Emergency Care) are too interdependent and pressures in urgent and emergency care (often brought about by sudden and sustained increases in demand for services) have a significant impact on the overall care we provide to patients and the performance of our hospitals against waiting times and other key standards. As such, planned care in the future needs to be provided in a way that protects those services from winter pressures and any future pandemics. The planned care clinical models we are currently modelling focus on looking for ways to deliver dedicated facilities for planned care that protects them from urgent care pressures in the future.

72. As we continue to define the impact of each of the potential clinical models from a patient, staffing and a range of other perspectives, potential trade-offs may emerge and need to be considered. For example, centralisation of a service onto a single site may lead to improvements in staffing, such as reductions in number of on-call rotas required or meeting

standards on patient numbers and staff competencies, however, this may have a detrimental impact in other areas, such as patient or staff travel – particularly for members of our communities who are least well-off and/or already find it difficult to access care.

73. We are currently evaluating potential clinical models in order to include in our Pre-Consultation Business Case (PBCB). The PCBC will be subject to independent assurance processes in the first quarter of 2022, including NHS England and Improvement and the Clinical Senate. Subject to the independent assurance, we are then aiming to take forward deliverable clinical models for public consultation, starting in Spring 2022.

Programme three (Building Better Places)

74. The Building Better Places programme is about securing the investment we need to redevelop and rebuild our healthcare buildings. Our current healthcare estate is one of our biggest challenges – with many of our buildings being old, unfit for purpose, not very ecologically friendly and in need of immediate investment.

75. We are seeking approval to develop a large-scale capital investment plan for our hospital estate across the Humber that will support better clinical care but also make a significant contribution to the wider economic regeneration of the region.

76. This work is closely aligned to Programme two (Core Hospital Services) and there continues to be widespread enthusiasm and support for our collective plans to develop an approach to investment that will maximise the impact and benefit to local residents in the form of new and rewarding careers, improved local infrastructure, investment in innovation and improved environment.

77. Through the Building Better Places programme we are seeking to design and build healthcare facilities for the future that are more flexible, more integrated and better equipped for the provision of 21st century healthcare. While our communities have grown and changed around us, the way in which we offer acute healthcare services has stayed largely the same and is no longer delivering what they need.

78. In response to the government's invitation for expressions of interest from NHS trusts wanting to be considered for inclusion in the next wave of the New Hospitals Programme, in September 2021 the Humber, Coast and Vale Health and Care Partnership submitted an expression of interest – in the region of £720m – for the development of healthcare infrastructure across the Humber.

Interdependencies

79. We have emphasised above that we cannot continue to provide existing hospital services in the same ways we have done in the past and we need to increase the amount of collaboration between all health and care organisations across the Humber. Wherever possible, this will include sharing the limited resources available to deliver the timely, safe care our patients need.

80. The Humber Acute Services Programme is not seeking to address all the challenges currently facing services across the Humber, Coast and Vale Health and Care Partnership. As previously highlighted, some examples of other programmes across the Partnership are presented in Appendix 3.

81. Equally, due to the complex arrangements for all health and care services, it is not practicable or feasible to try to change all our services, all at the same time. However, that complexity cannot be a reason for not aiming to improve services where we can.

82. Programme two and Programme three are mutually interdependent and one cannot be delivered without the other. Significant changes across our health and care system are needed to successfully deliver both programmes.

    - **Without significant investment in our healthcare estate, we cannot deliver the necessary clinical changes to ensure services are fit-for purpose, sustainable and meet the needs of our communities in the future; and,**
    - **Without delivering substantial clinical changes, we cannot attract the level of capital investment needed to not only significantly improve our healthcare estate and infrastructure, but also to be truly transformative to the wider economic regeneration of the region.**

83. Nonetheless, developing potential clinical models (Programme 2) in tandem with developing a Strategic Outline Case (SOC) for capital funding (Programme 3) is complex, challenging and ground-breaking. Although supported by regional and national teams, this approach moves away from the traditional approach of two separate processes for major service change and capital investment.

84. No decisions have been made in relation to Programme 2 and there are a number of potential clinical models still being worked through, which will be evaluated by the end of 2021 for inclusion within the Pre-Consultation Business Case. While the expression of interest submitted to government set out highly ambitious plans for our healthcare infrastructure, it is important that 'form must follow function'. As such, decisions around the final configuration of buildings cannot and **will not be made** until the public consultation on clinical models has been completed in 2022 and decisions have been made about the clinical model in the light of information gathered through the public consultation. This will ensure our communities and other key stakeholders help to shape the final proposals.

Local authority – health scrutiny arrangements

85. Health scrutiny is usually discharged through local authority appointed Health Overview and Scrutiny Committees (HOSCs), which form part of the overall accountability and governance arrangements of local health and care systems. The primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services.

86. Under current legislation, NHS bodies must consult with the appropriate local authorities where there are any proposed substantial developments or variations in the provisions of health services (substantial service reconfiguration) in the area(s) of a local authority under consideration. Details are set out in the Local Authority (Public health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (the Regulations).

87. In consulting with the appropriate local authorities, NHS bodies must provide, publish and keep up to date the proposed date by which a decision as to whether or not to proceed with

the proposed service reconfiguration is intended to be taken; and the date by which HOSCs must provide any formal response on such proposals.

Joint health overview and scrutiny committees

88. The Regulations also make provision for the establishment of mandatory joint health overview and scrutiny committees (JHOSC) where NHS bodies plan to consult more than one local authority in relation to any specific proposed substantial service reconfiguration.

89. Where the need for a mandatory JHOSC has been identified, the identified local authorities must appoint a JHOSC for the purposes of that consultation and it is only the established JHOSC that may:

    a) Make formal comments on the proposal(s) under consideration – i.e. submit a formal consultation response.

    b) Require the provision of information about the proposal(s) under consideration; or

    c) Require a member or employee of the relevant NHS body to attend before it to answer questions in connection with the consultation and the proposal(s) under consideration.

Health and Care Bill 2021

90. Members are likely to be aware that the Health and Care Bill 2021-22 (the Bill) proposes some wide-ranging NHS reforms aiming to make it less bureaucratic, more accountable, more integrated, and incorporating lessons learned from the COVID-19 pandemic.

91. The proposals include establishing existing Integrated Care Systems (ICSs) on a statutory footing, formally merging NHS England and NHS Improvement, and making changes to procurement and competition rules relating to health services.

92. The Bill also proposes new powers for the Secretary of State for Health and Social Care to intervene in (or call-in) any proposed health service reconfiguration (at any stage). While it is understood the role of local Health Overview and Scrutiny Committees (HOSCs) and the requirement to involve them in reconfigurations will remain, the status of the current Local Authority referral power and how that will relate to the Secretary of State intervention proposals is less clear.

93. Future scrutiny arrangements and requirements are particularly pertinent to the Humber Acute Services Programme at this time, as substantial service reconfiguration proposals are planned to be consulted on in Spring 2022. Such consultation is likely to be undertaken under a new legislative framework, as the projected timeline is expected to allow Integrated Care Systems to become statutory bodies from April 2022. Nonetheless, the exact impact of any new legislation on future health scrutiny arrangements is not yet known, and it will be important to maintain oversight of the emerging landscape over the coming weeks to ensure appropriate planning and implementation of any necessary arrangements, specifically in relation to the Humber Acute Services Programme.

Next steps

94. Work is progressing to further refine and evaluate potential clinical models for hospital services in the future. It is anticipated that this evaluation work will be completed by the end of 2021 to feed into the Pre-Consultation Business Case (PCBC). This will be developed

alongside the outline Strategic Outline Case (SOC) for capital investment purposes in early 2022.

95. During the first quarter of 2022, there will be an assurance process in relation to the PCBC involving NHS England and Improvement and the Clinical Senate; and in April 2022 Integrated Care Systems are set to become statutory bodies (subject to the conclusion of the parliamentary process).

96. We are aiming to start formal consultation on deliverable clinical models with the public and other stakeholders, after the decision on the PCBC and authority to proceed. This is anticipated to be May 2022, subject to the timing of decisions in relation to the capital programme. It is important to highlight that, subject to Parliamentary processes in relation to the Health and Social Care Bill 2021, the decision to proceed to public consultation will most likely sit with the new Integrated Care Board that will come into being from 1 April 2022. It is anticipated that Clinical Commissioning Groups (CCGs) will cease to exist from this date.

97. Notwithstanding any unexpected delays in the process, we are continuing to develop our public consultation plans and would welcome the opportunity to discuss the draft plan with relevant health overview and scrutiny committees in early 2022.

Conclusion

98. In summary, **our local health system across the Humber needs to change**. It is not always meeting the needs of everyone in the region and, without changes to the way services are organised, this will likely worsen in the future.

99. This paper provides members of the Committee with an update on the progress of the Humber Acute Services Programme, specifically in relation to:

- Engagement undertaken and outcomes to date
- Programme 2 (Core Hospital Services) and Programme 3 (Building Better Places)
- An overview of future plans, timelines and next steps

100. This paper also sets out some of the current legislative requirements in relation to health scrutiny and provides an opportunity for members to ask questions, seek more information and provide feedback on their future engagement with the programme.

101. **Programme two and Programme three are mutually interdependent** and one cannot be delivered without the other. Significant changes across our health and care system are needed to successfully deliver both programmes. That is:

- Without significant investment in our healthcare estate, we cannot deliver the necessary clinical changes to ensure services are fit-for purpose, sustainable and meet the needs of our communities in the future; and,
- Without delivering substantial clinical changes, we cannot attract the level of capital investment needed to not only significantly improve our healthcare estate and infrastructure, but also to be truly transformative to the wider economic regeneration of the region.

102. Our expression of interest submitted to government set out highly ambitious plans for our healthcare infrastructure. However, 'form must follow function' and therefore **decisions around the final configuration of buildings <u>will not be made</u> until the public consultation on clinical models has been completed in 2022**. This will ensure our communities and other key stakeholders have the opportunity to help shape the final proposals.

103. Over the next six to eight weeks, **we aim to finish evaluating a range of clinical models and looking more closely at their potential impact**.

104. We are **working collaboratively to put forward potential options on what hospital care might look like in the future** (in five to ten years) and **aiming to consult the public (and other key stakeholders) on these options in Spring 2022.**

Recommendations

105. Members are specifically asked to:

- Consider and note the details presented in this report and appendices, including the reasons for change, the work undertaken to date and the next steps.
- Note the intention to complete a Pre-Consultation Business Case in early 2022, with the aim of formally consulting on potential clinical models with the public and other stakeholders in Spring 2022.
- Note the current legislative framework governing statutory consultation with local authorities in relation to NHS reconfiguration proposals, recognising existing health scrutiny arrangements and provisions may change as the current Health and Care Bill (2021) is enacted and becomes law.
- Identify any specific aspects where further and/or more detailed information may be required.
- Provide feedback on how they would like to be engaged over the next phase of the programme; and,
- Determine any other specific future scrutiny activity at this time.

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Background Papers and further reading

Hospital Services for the Future: Humber Acute Services Review - Issues Paper (October 2018), available here
Humber Acute Services Review: Case for Change (November 2019), available here.
Humber Acute Services Review – Interim Clinical Plan (October 2020), available here.
The Yorkshire and Humber Clinical Senate report (November 2020), available here.
The Interim Clinical Plan Update (September 2021), available here).

Engagement reports

Hospital Services for the Future: Public Engagement Feedback Report (Issues Paper) (October 2018), available here
Hospital Services for the Future: Humber Acute Services Review – Focus Group Feedback Report (April 2019), available here.
Hospital Services for the Future: Humber Acute Services Review – Patient Workshop Feedback Report (October 2019), available here.
Hospital Services for the Future: Humber Acute Services Review – Targeted engagement (February 2020), available here.
Accident & Emergency Public / Patient feedback report (October 2020) available here
What Matters To You (May 2021) full feedback report and the summary report
What Matters To You – response to patient and public engagement in Neurology (September 2021) available here
What Matters To You – Our Staff and Teams (October 2021) available here.

Appendix 1

Humber Acute Services Programme

Engagement Timeline Overview

Timeframe	Engagement	Purpose/Scope	Responses	Link to Report
March to October 2018	Issues Paper	To start a conversation with patients, public and other stakeholders about the issues and challenges facing the acute hospital sector across the Humber we published the Humber Acute Services Review - Issues Paper and invited responses through a short survey.	393 responses	Public Engagement - Issues Feedback Report
November 2018	Established a Citizen's Panel	To ensure the voices of local populations are heard, to help inform the development and approaches for our broader engagement work and patient-facing information.	Citizen's Panel	N/A
Oct 2018 to April 2019	Focus Groups – five specialties	Deliberative workshops to support the development of change plans and to gather wider feedback to support the review, focusing on five specialties (8 events in total across the Humber region): • Cardiology • Complex rehabilitation • Critical care • Neurology • Stroke	119 participants	Humber Acute Services Review – Focus Group Feedback Report
Jan to Oct 2019 (note: report published Feb 2020)	Targeted Engagement	Targeted Engagement commissioned by the Review from a local Voluntary and Community Sector organisation – Humber and Wolds Rural Action. The scope was to engage with a wide range of individuals from diverse communities and/or with protected characteristics under the Equalities Act and gather views on the potential impact of any changes to services.	192 people (with protected characteristics)	Targeted Engagement Report

Humber Acute Services Programme

Engagement Timeline Overview

Timeframe	Engagement	Purpose/Scope	Responses	Link to Report
Oct to Nov 2019	Focus Groups – core hospital services	Workshops and focus groups undertaken to gather patient and public feedback on long-list of models for core hospital services: • Urgent and emergency care • Maternity and paediatrics • Planned Care (8 events in total across the Humber region)	77 participants	Patient Workshop Feedback Report
November 2019	Citizen's Panel	Feedback on Case for Change	Citizen's Panel	Citizen's Panel Feedback on Case for Change
November 2019	Citizen's Panel	Feedback on Long List Clinical Models	Citizen's Panel	Citizen's Panel Feedback on Long List Clinical Models
March 2020	Citizen's Panel	Feedback on Access and Experience	Citizen's Panel	Citizen's Panel Feedback on Access and Experience
July to Aug 2020	A&E Survey (HCV-wide)	Online survey undertaken to understand behaviours, attitudes and barriers to using alternatives to A&E across the region.	2008 responses (931 – Humber hospitals)	A&E survey (2020) - HCV-wide
Feb to May 2021	What Matters to You	Engagement exercise undertaken to gather the views and perspectives of a range of stakeholders to enable decision-making within the programme to reflect the priorities and preferences of local people. The engagement took the form of an online survey and a series of focus groups. (6 workshops were held in total – all undertaken virtually due to Covid restrictions)	3946 people (3883 survey responses + 63 focus group participants)	What Matters To You – Feedback Report

Appendix 1

Humber Acute Services Programme

Engagement Timeline Overview

Timeframe	Engagement	Purpose/Scope	Responses	Link to Report
July 2021	What Matters to You – Our Staff and Teams	Targeted engagement exercise to gather the views and perspectives of staff to further inform decision-making within the programme. The engagement took the form of an online survey and two focus groups (undertaken virtually due to Covid restrictions)	563 staff responses	What Matters to You – Our Staff and Teams Feedback Report
June to July 2021	Your Birthing Choices	Targeted engagement exercise to understand what is important to women, birthing people, partners and co-parents when choosing where to give birth to help inform the development of maternity and neonatal services. The engagement took the form of an online survey, alongside a series of focus groups (held virtually due to Covid restrictions). The engagement was undertaken across Humber, Coast and Vale and responses analysed to provide specific feedback from people across the Humber.	1133 survey responses (753 responses from people within the Humber).	Feedback report in development.
October to November 2021	Children and Young People's Engagement	Targeted engagement exercise to hear from children and young people to better understand what works well, what doesn't and what could change to improve the patient experience.	Children and young people.	Survey due to close on 22 November.
October to November 2021	What Matters to You – Parents and Carers	Targeted engagement exercise to hear from parents/ carers of children and young people who have experience of accessing paediatric services in one of our hospitals, to better understand what works well, what doesn't and what could change to improve the patient experience.	Parents/ carers of children and young people	Survey due to close on 22 November.

Appendix 1

Humber Acute Services Programme

Engagement Timeline Overview

Timeframe	Engagement	Purpose/Scope	Responses	Link to Report
August to November 2021	What Matters to You – Revisited	Engagement exercise undertaken to gather more views and perspectives to enable decision-making within the programme to reflect the priorities and preferences of local people. This engagement is based around an online survey with options available for offline participation.	Patients and the public	Survey due to close on 15 November.
October to December 2021	A&E engagement	Collaboration with Healthwatch to undertake 'Enter and View' visits and gather insight from people attending A&E about their experiences. Gather further insight into behaviours and why people choose A&E and the barriers to using alternative provision.	People using A&E services	Interim results due early December
October to December 2021	Healthwatch engagement (planned care)	Collaboration with Healthwatch to undertake survey of current patients (particularly those on waiting lists) regarding their opinions and experiences of planned hospital care (as part of a wider engagement exercise on the impact of Covid-19 across the region).	Patients and the public	Interim results due mid-December (work continuing through to January 2021)

Humber Acute Services Programme

The Connected Health Network Model

Introduction

Northern Lincolnshire and Goole NHS Foundation Trust and Meridian Health Group have piloted an innovative model for delivering outpatient services, working across traditional boundaries and putting the patient at the centre of the care delivery model.

The Connected Health Network (CHN) model represents a transformative break from the traditional model of patients being referred by primary care into secondary care, by health and care professionals working across organisational boundaries, with GPs working in partnership with specialists to provide ongoing care and support to patients when they need it. The CHN can be considered as an extension of the GP practice rather than the traditional model which sees GPs referring patients to secondary care, subsequent waiting lists for patients and then patients eventually discharged by the specialist to the care of their GP until specialist advice is once more required and the cycle repeats for the patient.

In order to reduce cardiology outpatient waiting times and provide cardiology patients with integrated care, this pilot scheme involved senior clinicians from NLaG worked with colleagues at Meridian Primary Care Network (PCN) to deliver a radically different model of cardiology outpatient care. This involved partners working across traditional boundaries and referral processes by sharing care and putting the patient at the centre of the delivery model.

What's different about the Connected Health Network (CHN) model

The traditional model of patient care often includes patients being referred from primary care (GPs) into secondary care (hospitals) for specialist care and then discharged back from the specialist to the care of their GP once the assessment and treatment has been completed. This cycle is repeated each time the GP needs specialist advice in the care and treatment of the patient.

The CHN model brings GPs and specialists together in partnership to provide ongoing care and support to patients when they need it, enabling fast and easy communication and decision-making between GPs and specialists, with the patient avoiding visiting clinical settings wherever possible.

How the Connected Health Network (CHN) model works

GPs refer into the service using their own primary care patient record system without needing to refer into secondary care. The CHN administration process is jointly managed by administrative staff from the PCN and secondary care, with shared access to the primary care patient record. The administrative team carry out a digital literacy assessment of every patient and obtain their consent for how they would like to be contacted e.g. text, email, telephone, letter.

Specialist will typically review the referral within a week and in most cases the patient does not need to be seen in person and any additional information can be obtained by speaking to the patient directly from any location.

In cases instances where invasive diagnostics are needed and where the patient needs to attend hospital, the specialist will make the necessary arrangements, supported by administrative colleagues who ensure all clinic administration is completed and facilitate arrangements with patients. Both the primary care and secondary care records are also updated to ensure all systems remain up-to-date.

Humber Acute Services Programme

The Connected Health Network Model

Benefits of the Connected Health Network (CHN) model

The Connected Health Network (CHN) model offers the opportunity to deliver a number of benefits to patients in terms of reduced waiting times, seamless care and only attending hospitals when needed.

The CHN pilot delivered some impressive results from working in a different way:

- waiting times for patients drastically reduced (typical wait time for CHN referral = 1 week compared with 16 weeks wait time for new outpatient appointment).
- The backlog of follow up appointments for Meridian PCN cardiology patients was cleared within 4 months.
- Only 30% of patients required hospital-based intervention.
- Minimised 'in person' clinical attendances and supported patients to make use of digital communication

The CHN model is currently being rolled out in cardiology across additional Primary Care Networks.

Summary

The Connected Health Network (CHN) model is a great example of some of the outcomes we are trying to achieve through the Interim Clinical Plan; and how working differently can help us deliver improved patient experiences, reduce waiting times, and make better use of our collective resources to deliver good patient outcomes.

There are plans to trial the CHN model across additional specialties during 2021/22.

Humber Acute Services Programme

Examples of other programmes and improvement activity

Work across all areas of the HAS Programme is not being undertaken in isolation; and there are a number or other programmes of work and improvement activities underway across the Humber, Coast and Vale Health and Care Partnership and also at individual acute trusts. Examples of these include:

- **Acute Care Collaborative** – a partnership that brings together NHS trusts that deliver acute hospital services across Humber, Coast and Vale. It is about local hospitals working in partnership with one another to give patients access to the very best facilities and staff.
- **Getting It Right First Time (GIRFT)** – a national programme designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies, such as the reduction of unnecessary procedures, and cost savings.
- **Elective Care Programme and COVID recovery** – focusing on taking a consistent approach to clinical prioritisation to ensure the care and safety of people is maintained whilst they are on a waiting list; as we continue to work hard to restore service levels following the coronavirus pandemic.
- **Cancer Alliance** – The Cancer Alliance brings together all the organisations that commission and provide cancer services in the Humber, Coast and Vale area, enabling effective and co-ordinated partnership working to improve patient experience, awareness and diagnosis, treatment and patient pathways.
- **Outpatients' transformation programme** – working towards a new model of care that will shorten waiting times by moving away from the traditional outpatient models of care with referrals from primary care to specialists in secondary care. The aim being to give patients access expert opinion and advice on patient care without extra referrals to hospital in many cases.
- **Community diagnostics** –aiming to reduce waiting times by providing easier and timelier patient access to planned diagnostics and investigative work and services. Where possible, developing facilities away from the Acute Hospital sites – including dedicated facilities like Community Diagnostic Hubs and mobile diagnostic services, such as mobile MRI and CT scanner equipment.

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:	**15 December 2021**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme**

Summary

This report sets out the Committee's work programme, and includes items listed for forthcoming meetings, together with other items, which are due to be programmed. The Committee is required to consider whether any further items should be considered for addition to or removal from the work programme.

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: -

15 December 2021		
	Item	*Contributor*
1	Lincolnshire Acute Services Review: Orthopaedic Surgery	Representatives from United Lincolnshire Hospitals NHS Trust: • Mr Vel Sakthivel, Consultant in Trauma and Orthopaedic Surgeon • Pete Burnett, System Strategy and Planning Director, Lincolnshire NHS
2	Lincolnshire Acute Services Review: Acute Medical Beds at Grantham and District Hospital	• Dr Dave Baker, South West Lincolnshire Locality Clinical Lead, Lincolnshire Clinical Commissioning Group • Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services NHS Trust • Pete Burnett, System Strategy and Planning Director, Lincolnshire NHS
3	Humber Acute Services Review – Core Hospital Services Programme	Representatives from the Humber Acute Services Review Team: • Ivan McConnell, Programme Director • Claire Hansen, Programme Director - Interim Clinical Plan • Linsay Cunningham, Associate Director Communications and Engagement • Steven Courtney, Partnership and Stakeholder Engagement Manager

3. Future Work Programme

19 January 2022		
	Item	*Contributor*
1	Lakeside Medical Practice Stamford – Update on Response to the Inspection Report of the Care Quality Commission and Lessons Learned.	• Wendy Martin, Associate Director of Nursing and Quality, Lincolnshire Clinical Commissioning Group • Nick Blake, Nick Blake, Head of Transformation and Delivery (South Locality), Lincolnshire Clinical Commissioning Group

19 January 2022		
	Item	*Contributor*
2	Lakeside Medical Practice Stamford – Update on Response to the Inspection Report of the Care Quality Commission and Lessons Learned.	• Wendy Martin, Associate Director of Nursing and Quality, Lincolnshire Clinical Commissioning Group • Nick Blake, Nick Blake, Head of Transformation and Delivery (South Locality), Lincolnshire Clinical Commissioning Group
3	United Lincolnshire Hospitals NHS Trust – Nuclear Medicine	Representatives from United Lincolnshire Hospitals NHS Trust: • Simon Evans, Chief Operating Officer • Laura White, Head of Nuclear Medicine
4	East Midlands Ambulance Service Update	Representatives from East Midlands Ambulance Service
5	Care Portal Data Sharing Update	Samantha Francis, Information and Systems Manager, Adult Care and Community Wellbeing, Lincolnshire County Council Theo Jarratt, Head of Quality and Information, Adult Care and Community Wellbeing Lincolnshire County Council
6	Consultation on Lincolnshire Acute Services Review (Finalisation of Response)	Simon Evans, Health Scrutiny Officer
7	Humber Acute Services Review – Engagement Activity (Finalisation of Response to Engagement Exercise)	Simon Evans, Health Scrutiny Officer

16 February 2022		
	Item	*Contributor*
1	United Lincolnshire Hospitals NHS Trust – Urology Services	Representatives from United Lincolnshire Hospitals NHS Trust
2	Director of Public Health Annual Report	Derek Ward, Director of Public Health
3	Continuing Healthcare	Wendy Martin, Associate Director of Nursing and Quality, Lincolnshire Clinical Commissioning Group

16 March 2022		
	Item	*Contributor*
1	Community Pain Management Service (CPMS) Update	Representatives from Lincolnshire Clinical Commissioning Group
2	Lincolnshire Pharmaceutical Needs Assessment	Shabana Edinboro, Senior Public Health Officer

13 April 2022		
	Item	*Contributor*
1	GP Services Access Update	Dr Kieran Sharrock, Medical Director Lincolnshire Local Medical Committee

18 May 2022		
	Item	*Contributor*
1	Pharmaceutical Needs Assessment – Approval of Committee's Response	Simon Evans, Health Scrutiny Officer

Items to be Programmed

The following items are due to be programmed at forthcoming meetings:

- **Care Quality Commission Report: Protect, Respect, Connect – Decisions about Living and Dying Well During the Covid-19 Pandemic** – On 18 March 2021, the Care Quality Commission published its report, with eleven recommendations, three of which were directed at NHS providers.
- **Cancer Care –** The Committee has previously requested an update on the treatment of cancer in Lincolnshire, in particular on the impact of the Covid-19 pandemic.
- **Staffing Challenges in Hospitals and NHS Lincolnshire People Plan –** On 21 July 2021 the Committee requested inclusion of an item on staffing, particularly at Grantham and District Hospital.
- **Future Commissioning Arrangements for Dental Services, Ophthalmology and Pharmaceutical Services** – The commissioning of these services is due to transfer to Lincolnshire Clinical Commissioning Group in shadow form from April 2022.

4. **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