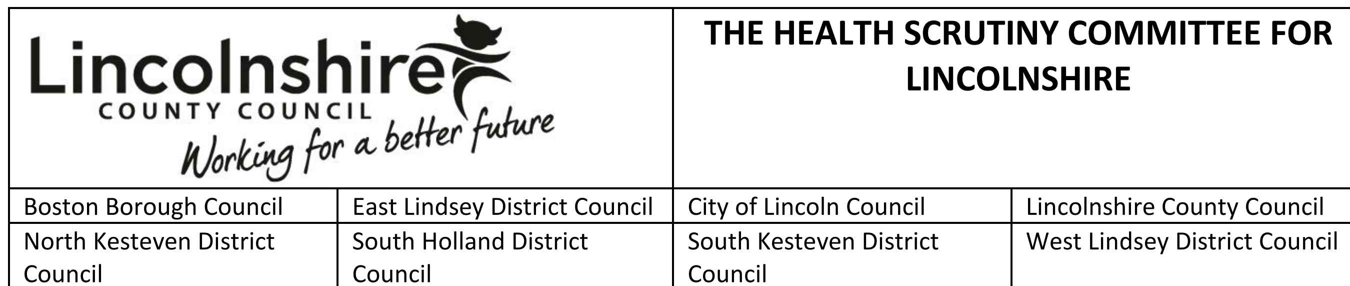
Public Document Pack



THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE

Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Direct Dialling: 07385 463994

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

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

A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 10 November 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, R P H Reid, 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
1	**Apologies for Absence/Replacement Members**	
2	**Declarations of Members' Interest**	
3	**Minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 13 October 2021**	3 - 16
4	**Chairman's Announcements**	17 - 28

Item	Title	Pages
5	**Lincolnshire Acute Services Review - Stroke Services** *(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 Stroke Services; and to highlight any areas which the Committee's working group might wish to explore in further detail. Senior representatives from United Lincolnshire Hospitals NHS Trust will be in attendance for this item)*	29 - 60
6	**Lincolnshire Acute Services Review - Urgent and Emergency Care** *(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 Urgent and Emergency Care; 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 Commissioning Group and Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services NHS Trust will be in attendance for this item)*	61 - 92
7	**Update on NHS Dental Services in Lincolnshire** *(To receive a report from NHS England and NHS Improvement (Midlands), which provides the Committee with an update on the provision of NHS dental services commissioned in Lincolnshire. Carole Pitcher, Senior Commissioning Manager and Tom Bailey, Senior Commissioning Manager will be in attendance for this item)*	93 - 108
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 and to extending the activities of the working group, established at the last meeting for the consultation on the Lincolnshire Acute Services Review, to the Humber Acute Services engagement exercise)*	109 - 112

Debbie Barnes OBE
Chief Executive
2 November 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, 10th November, 2021, 10.00 am (moderngov.co.uk)

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
13 OCTOBER 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 and R Wootten.

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) and Mrs A White (West Lindsey District Council) and M A Whittington (South Kesteven District Council).

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

Charley Blyth (Director of Communications and Engagement, Lincolnshire Sustainability & Transformation Partnership), Katrina Cope (Senior Democratic Services Officer), Tom Diamond (Associate Director of Strategy, Lincolnshire Clinical Commissioning Group), Simon Evans (Health Scrutiny Officer), Sarah-Jane Mills (Chief Operating Officer (West Locality), Lincolnshire Clinical Commissioning Group), Dr Kieran Sharrock (Medical Director, Lincolnshire Local Medical Committee) and John Turner (Chief Executive, NHS Lincolnshire Clinical Commissioning Group)

The following officers/representatives joined the meeting remotely via Teams:

Tom Diamond (Associate Director of Strategy, Lincolnshire Clinical Commissioning Group) and Jody Clark (representative from Fighting 4 Grantham Hospital).

Councillor C Matthews (Executive Support Councillor NHS Liaison, Community Engagement, Registration and Coroners).

33 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors R P H Reid, G P Scalese (South Holland District Council) and R Kaberry-Brown (South Kesteven District Council).

It was noted that Councillor M A Whittington (South Kesteven District Council) had replaced Councillor R Kayberry-Brown (South Kesteven District Council) for this meeting only.

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

34 DECLARATIONS OF MEMBERS' INTERESTS

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

Councillor Mrs A White wished it to be noted that like other members of the Committee, she had received copy of information in relation to services at Grantham Hospital and District Hospital from two campaign groups in Grantham.

35 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 15 SEPTEMBER 2021

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 15 September 2021 be agreed and signed by the Chairman as a correct record.

36 CHAIRMAN'S ANNOUNCEMENTS

Further to the Chairman's announcements circulated with the agenda, the Chairman brought to the Committee's attention the supplementary announcements circulated on 12 October 2021. The supplementary announcements made reference to:

- The Covid-19 Update, a copy of the latest data compiled by Lincolnshire County Council Public Health Division was attached at Appendix A to the supplementary announcements;
- Cliff House Medical Practice, Lincoln - Contract extension; and
- Healthwatch Lincolnshire – Yourvoice@healthwatch public face to face event on 3 November 2021 from 10.00am to 1.00pm at the Boston United Football Club. The theme for the event was Community Wellbeing.

Some members expressed concerns at the increased number of Covid-19 cases in schools. The Chairman agreed that he would discuss the matter with Cllr R J Kendrick, Chairman of the Children and Young People Scrutiny Committee.

RESOLVED

That the Supplementary Chairman's announcements circulated on 12 October 2021 and the Chairman's announcements as detailed on pages 15 to 17 of the report pack be noted.

37 LINCOLNSHIRE ACUTE SERVICES REVIEW - INTRODUCTION TO CONSULTATION AND ARRANGEMENTS FOR RESPONSE

The Chairman advised the Committee that before he invited the representatives from the Lincolnshire NHS Clinical Commissioning Group to present the report, he had received a request from Jody Clark (Fighting 4 Grantham Hospital) to speak at the meeting. The Committee was advised that a time period of three minutes would be allotted to Jody to address the meeting via Teams.

The statement made reference to some of the following points: the opposition in Grantham to the overnight closure of Grantham A & E; the troubles with recruitment and retention of staff at Grantham Hospital; the travelling incurred by local patients due to the reduced service and the impact of travelling on families in the Grantham area; with no A & E provision, there was a need for a 24/7 Urgent Treatment Centre with walk in access, and access to medical and acute beds.

On behalf of the Committee the Chairman extended his thanks to Jody Clark for her statement.

The Chairman invited the following representatives from the Lincolnshire NHS Clinical Commissioning Group who were present in the Council Chamber to present the item to the Committee: John Turner, Chief Executive, Charley Blyth, Director of Communication and Engagement and Tom Diamond, Associate Director of Strategy (who attended the meeting via Teams).

The Chief Executive extended his thanks to the Committee for their continued interest and support shown over the last eighteen months.

The Committee was reminded that on the 21 September 2021 the Chairman had received notification from the Chief Executive of the Lincolnshire Clinical Commissioning Group (CCG) that the CCG would shortly commencing a formal public consultation exercise in relation to the four NHS service change proposals. It was noted that at the Lincolnshire CCG Board on 29 September 2021 had agreed to proceed with the consultation, which was then subsequently launched on 30 September 2021 for a period of twelve weeks up to 23 December 2021.

The Committee noted the four NHS services change proposals were in the following areas:

- Orthopaedic Surgery – the development of a 'centre of excellence' in Lincolnshire for planned surgery at Grantham and District Hospital and a dedicated day-case centre at County Hospital Louth, for planned orthopaedic surgery;
- Urgent and Emergency Care at Grantham and District Hospital – the establishment of a 24/7 Walk in Urgent Treatment Centre, in place of the current Accident and Emergency department;

- Acute Medical Beds at Grantham and District Hospital – The establishment of integrated community/acute medical beds, in place of the current acute medical beds; and
- Stroke Services – the development of a 'centre of excellence' in Lincolnshire for hyper-acute and acute stoke services at Lincoln County Hospital; which would be supported by the enhancement of the community stroke rehabilitation service to support stroke patients with more complex needs.

The Committee was advised that the vision was to provide the very best health care for the people of Lincolnshire and to continually improve services wherever possible. It was felt that the benefit of the proposed changes would improve the quality of care being provided; reduce waiting times; provide better outcomes for patients; increase the availability of staff to care for patients; and would be a better use of NHS funds, by reducing spending on temporary staff.

Detailed at Appendix A to the report was a copy of the Executive Summary of the Pre-Consultation Business Case for the Lincolnshire Acute Services Review; and Appendix B provided the Committee with a copy of the public consultation document relating to four of Lincolnshire's NHS Services.

It was reported that there was a programme of public consultation events happening around the County, some of which had already been held. It was noted that every effort was being made to publicise public consultation across the County. It was highlighted that flyers had been sent to every household, face to face events were being held, and that there was also the opportunity for members of the public to complete the questionnaire on-line.

Page 21 of the report provided a proposed timetable to allow the Committee to respond to the NHS service changes.

Whilst reviewing the report presented, the Committee raised the following comments:

- The views of Grantham residents with regard to the provision of A & E services at Grantham and District Hospital. Assurance was given that the views of residents of Grantham had been listened to. The Committee noted that over a number of years there had been several changes made to A&E services at Grantham Hospital and the services being provided were far closer to that of an Urgent Treatment Centre (UTC). It was reported that the vast majority of people needing care would be able to attend a UTC for their care and that making it a 24/7 walk in service would be an enhanced service. A question was asked whether members of the public had been using the UTC when it had been temporarily changed during the pandemic. The Committee was advised that during the temporary period, the UTC had been well used. Officers agreed to make the data available to members of the Committee;
- Members of the Committee welcomed the public consultation. A request was made for further information concerning the consultation and where that information could be found, so that it could be forwarded on to other organisations and members of the public;

- What the timetable was for the remaining four areas of service. The Committee noted that when the ASR commenced clinicians had initially looked at 35 services across the county; then as a result of due process, eight services had been identified for more detailed work. Following this, four areas had been selected for consultation, to implement these changes would require less capital expenditure (between £10 to £12million). The intention was to enhance care, help workforce issues and to actually make a difference in services being provided for the residents of Lincolnshire. It was highlighted for the four remaining areas more capital investment was required (between £50 to £60 million). Details relating to the financial impact of ASR following full impact of service changes were shown on page 52 of the report pack;
- Cross border services for those residents in the north and south and west of the County;
- Some concern was expressed regarding the rurality of East Lindsey and whether any engagement was being done in market towns. Reassurance was given that the responsibility of the CCG was for the whole population of Lincolnshire. It was further highlighted that whilst consulting on the four services, the NHS welcomed feedback on all aspects of the NHS. The Committee was advised that market day events were being held in all market towns during December and that there was also the opportunity to participate in virtual events;
- Whether the Lincolnshire Association of Local Councils (LALC) had been approached to help get the information out to town and parish councils. The Committee was advised that LALC had been contacted prior to the launch of the consultation on 30 September as had other stakeholders. The Committee was advised that 1,200 responses had already been received as of 12 October; and that this compared very well to a consultation in Gloucestershire, which had only received a total 715 responses for the whole consultation period. Emphasis was however made that it was not the quantity of responses; it was the quality of response that was very important. A further question asked was whether there was capacity for someone to visit parish councils. It was noted that there was a focus group and that as requests were received, visits could be arranged. The Committee requested details of who to contact in these instances;
- The issue of rurality for a patient experiencing a stroke and the prospect of a longer journey to a specialised unit;
- The emerging Humber Acute Services Review, and its potential impact on residents on the east of the county, and other neighbouring trust; and whether these changes had been taken into consideration with the planned Lincolnshire changes and the possible additional pressures on Lincolnshire trusts. Reassurance was given that the CCG linked in very closely neighbouring trusts; and that this was an on-going process;
- A request was made for the Committee to be kept updated regarding the number of responses received to the public consultation. Thanks were also extended to the CCG for arranging a flyer to be sent to every household in Lincolnshire. The Chief Executive agreed to make information available to the Committee regarding the number of responses received. A further question was asked as to how the despatch of the flyers was being monitored to ensure that each resident received a leaflet. The

Committee was advised that every effort was being made to ensure that a leaflet was delivered to every household;

- Whether Covid-19 would have any impact on proposed timetable for implementation. Reassurance was given that contingency plans were in place in the event of a further wave of Covid-19;
- What the proposed bed provision at Grantham hospital was going to be. It was reported that the bed provision would make provision for overnight inpatients and day case patients;
- Staff recruitment and retention in Lincolnshire. It was noted that this was an issue in Lincolnshire in primary care and nursing staff. It was noted that a recent successful recruitment exercise had managed to secure a number of health and care workers to key hospital services. The Lincoln Medical School had been successful in helping to recruit trainees. It was further noted that the focus on the east coast was to grow your own;
- Reference was made to a number of outstanding questions not being answered following the attendance at a recent council meeting in Boston. Reassurance was given that the questions raised would be answered;
- The positives of having Grantham and District Hospital as a centre of excellence for Orthopaedic surgery;
- Some concerns were expressed regarding some services being centralised. The Committee was advised of the significant investment that Pilgrim Hospital Boston had received. The Committee was advised that the CCG was happy to provide more detail if required;
- Whether financial constraints were the driving force for the proposed changes to services. The Committee noted that the changes were not about financial savings. The driving force was quality of care, services being reconfigured in the right way; reducing waiting lists; and ensuring the retention of staff;
- The need to ensure that communication provided ensured that people understood what services were available now and what was going to change. Particular reference was made to the Louth County Hospital site. The Chief Executive agreed to provide in collaboration with United Lincolnshire Hospitals NHS Trust and Lincolnshire Community Health Services NHS Trust a list of services currently provided at the Louth County Hospital and what the proposed changes would entail for the East Lindsey District Council representative. There was recognition that communication was key to the ensuring that the public were well informed of the proposed changes and the reasons for the changes;
- Whether a patient from the East Lindsey area who had attended Grantham Hospital for orthopaedic surgery would be able to have a follow up appointment in Louth. The Committee was advised that this would be checked and reported back;
- Transport issues for those attending the proposed centres of excellence;
- The need for members of the public to see the benefits of any change to service;
- The need to take into consideration the Chief Medical Officer's Annual Report 2021: Health in Coastal Communities. The Committee was advised that the CCG and the Council worked very closely together regarding equitable service provision across the County;

- Residents from Alford and Mablethorpe not being unable to attend breast and diabetic screening appointments as they had no transport available to them. The Chief Executive agreed to look into this issue; and
- A question was asked if a patient attended a proposed UTC had to be moved to an alternative site, would travel arrangements be made to bring the patient back to the original site. The Committee noted that as the UTC was a local service, the majority of patients would have their care needs met without the need for any further transportation.

The Chairman on behalf of the Committee extended his thanks to representatives for their presentation.

RESOLVED

1. That the introductory presentation on the public consultation on the Lincolnshire Acute Services Review be noted.

2. That the arrangements for responding to the NHS's consultation on the Lincolnshire Acute Services Review in line with the following timetable be confirmed:

   a) Detailed consideration of two specific elements of the Acute services Review at each Committee's next two meetings on 10 November and 15 December 2021;
   b) Consideration of the interim feedback report on the consultation from the Lincolnshire Clinical Commissioning Group on 15 December 2021;
   c) Establishment of one working group to draft the detailed response to the consultation;
   d) Finalisation of the Committee's response to the consultation on 19 January 2022, for submission prior to 31 January 2022.

3. That the working group be comprised of the following: Councillors Mrs S Harrison, C S Macey, S R Parkin; Mrs A White, M A Whittington, L Wootten and R Wootten,

38 GENERAL PRACTICE ACCESS

The Committee gave consideration to a report from the Lincolnshire Local Medical Committee, which provided an update on General Practice services.

The Chairman invited Dr Kieran Sharrock, Medical Director, Lincolnshire Local Medical Committee, to present the item to the Committee.

Also present for this item to help with questions was: John Turner, Chief Executive Lincolnshire Clinical Commissioning Group and Sarah-Jane Mills, Chief Operating Officer (West Locality) Lincolnshire Clinical Commissioning Group.

The Committee was advised that general practice nationally was overstretched, due to an increasing workload before the pandemic, and that the pandemic pressure had then exacerbated the issue. Also, due to hospital trusts being under pressure with long waiting lists, general practice was seeing an increase in the number of patients seeking support for their increasing health needs, which were not being managed by secondary care.

It was reported that the number of GPs had been falling consistently, in March 2016 there had been 51.5 GPs for every 100,000 patients, and that now in March 2021 the figure had fallen to 46.3 for every 100,000 patients. It was highlighted that since March 2021, the British Medical Association had seen a loss of a further 597 GPs and 920 general practice nurses. In order to compensate for the loss of GPs, Primary Care Networks were now employing other health professionals to manage patient conditions such as: clinical pharmacists, paramedic practitioners, first contact physiotherapists, social prescribers and mental health practitioners. It was highlighted further that these professionals were qualified to manage conditions in their sphere, but did not have the holistic skills that a GP would have.

The Committee was advised that to help ease the situation, practices had moved to a 'Total Triage' model of providing services. This allowed practices to navigate the patient to the most appropriate professional to manage their condition. Further details of relating to total triage was shown on page 100 of the report pack.

It was highlighted that Lincolnshire had always had difficulty recruiting and retaining clinical workforce. The Lincoln Medical School and other development at the University of Lincoln would help with recruitment in the long-term, but was unable to offer support to the short-term shortages. The report highlighted that by 2025 there would be a shortage of 220 "autonomous" practitioners.

In conclusion, as Lincolnshire's general practice were experiencing increasing workload and workforce shortages, Lincolnshire and other health systems were considering moving to a Primary Care Home model, which would require public and stakeholder engagement. It was also highlighted that self-care and prevention needed to be prioritised to alleviate further pressures on health and social care.

During discussion, the Committee raised the following points:

- The number of face to face appointments figures on page 100. The Committee was advised that the only figures that could be provided were those from the NHS Digital GP Appointment Data;
- The need for better communication to the public of the changes that had been made to mitigate the workforce problems and the increased workload issues, particular reference was made 'total triage', if people were advised how the system worked then there would be less concern from patients not having their expectations met. There was recognition that more communication needed to be done and that there needed to be a consistent message as to why the change had been made and why it

was needed to continue. It was also highlighted that there needed to be better communication between the GP and the hospitals. One member confirmed that following a consultant visit, a copy letter was sent to the practice and the patient, which was extremely useful;

- What plans were proposed for a recruitment campaign to fill the 220 practitioner gap. The Committee was advised that GPs had done an outstanding job over the last 18 months; and primary care as a whole had seen a lot of change as they moved to total triage and digital access, which in itself had caused some problems, as some patients still had expectations that the GP was the person they needed to see. It was recognised that there were challenges ahead with regard to recruitment and retention and that was an on-going discussion. The Committee noted that the workforce challenge was nationally as well as in Lincolnshire. The Committee noted that progress was being made in Lincolnshire; particular reference was made to retaining GPs who were nearing retirement; successful international recruitment, it was noted that over the last 12 months, 38 newly qualified doctors had been recruited; the presence of 15 Nurse Associates working in general practice; work was on going to secure paramedics to work in general practice; and the recruitment of 58 clinical pharmacists. There was recognition that there was still more to do. A request was made for the People Plan to be a future item for discussion for the Committee;
- One member from personal experience agreed that the system was working for long-term conditions, ordering prescription etc., but concern was expressed to conditions that were not picked up or diagnosed correctly, for example cold/flu like symptoms, which actually in one instance had turned out to be meningitis. The Committee was advised that systems were in place which allowed people to assess their own symptoms and to make contact if they were not getting any better; and 99 times out of a hundred assessments were correct, but unfortunately there would be rare occasions when symptoms were missed;
- Some concerns were raised regarding the difficulty of contacting general practices by telephone, patients having to wait half an hour to get through, some not getting through at all; and some actually after numerous tries just giving up. It was highlighted that there was a lot of variation across the county. The Committee noted that at the moment there were 86 practices and they all ran their practices in slightly different ways, and that discussions were on going as to how the variation across practices could be reduced. It was noted further that there were proposals for setting up a task force to promote good practice and offer support. The Committee was advised that the frustrating thing for practices was that some phone calls, some patients with access to IT could have actually used on-line facilities, freeing up more time for those without access to IT. It was highlighted that the two main problems attributed to telephones were: firstly infrastructure, it was highlighted that support was being given to a number of practices to replace their telephone systems; and secondly there was the issue of having enough workspace and workforce available to be able to answer calls. Reference was also mentioned to investment through funding from Section 106 funding to developing a telephone hub;
- The care navigation process, some concern was expressed that whether following training, care navigators would be able to pick up on serious illness. It was felt that care navigators needed clear instructions as to what they could do and what they

should not do; as it was felt that this was not happening at the moment. The Committee was advised that the role of the care navigator was purely to navigate people to the right person to deal with their problem;

- The Primary Care Home Model, the separating of long-term and short-term health management, which allowed for better management of each of the groups by focusing the skills of the professionals to the needs of the patients. The Committee noted that some parts of the country were already working to this model and that it was something that had been discussed, but it was just seeing how the model would work for the population of Lincolnshire. It was highlighted that over the last 12 months Primary Care Networks (PCNs) had established an enhanced Care Homes project, where each PCN had identified the care homes that sit within their area, and that the PCN were responsible for working with all professionals to support patients living in their own homes and care homes. The Committee was advised that at the moment care arrangements between general practice and community services were not as integrated as they could be, however, there were patches of great teamwork and proactive work, but there was not consistent integration in Lincolnshire;
- Thanks were extended to Healthwatch Lincolnshire, for their patient feedback;
- The regular referral by GPs for patients to visit the UTC. The Committee was advised that if patients were being sent inappropriately to the UTC, the CCG would receive feedback from the Lincolnshire Community Health NHS Trust. The Committee was advised that there was some testing going on in both the Skegness and Lincoln City area whereby GP practices could actually book patients into the UTC to have a face to face appointments in that facility, where that was appropriate for their needs;
- The need for better transport facilities in rural area;
- The need to promote self-care and to ensure that more was done from a public health perspective with regard to prevention, as it was felt that this was an area that needed further consideration;
- Whether there was a process of peer review between practices. The Committee was advised that peer reviews did occur across primary care, but not for things like how long does it take to get through on the telephone. It was hoped that the establishment of the task force would help share best practice;
- The fantastic role undertaken by nurse practitioners; and
- A member's personal experience of ringing three separate practices and that a different message and response was received from each one with regard to Covid-19, which highlighted the discrepancies across GP practices;

The Chairman on behalf of the Committee extended thanks to the representatives for their presentation.

RESOLVED

1. That the challenges affecting General Practice in Lincolnshire, in particular the shortfall of 220 autonomous practitioners, be noted; and the Committee's strong support for a recruitment campaign to encourage practitioners to work in Lincolnshire be recorded.

2. That the Committee's preference that as many in-person appointments as possible should be offered to patients, where there is a clinical need for them to be seen in person, be recorded.

3. That a further update on General Practice Access be received by the Committee in six months.

39 LINCOLNSHIRE CLINICAL COMMISSIONING GROUP - SUPPORT FOR GENERAL PRACTICE

The Committee gave consideration to a report from the Lincolnshire Clinical Commissioning Group, which provided an overview of the key areas of work being undertaken to support local GP services.

The Chairman invited John Turner, Chief Executive of Lincolnshire Clinical Commissioning Group (CCG), and Sarah-Jane Mills, Chief Operating Officer (West Locality) Lincolnshire CCG to present the item to the Committee. Dr Kieran Sharrock, Medical Director, Lincolnshire Local Medical Committee was also in attendance for this item.

As a lot of what was contained within the report had been discussed in the previous item, the Committee's attention was brought to section IV on page 6 of the report which made reference to Communication and Engagement, which highlighted that the CCG appreciated that there could never be too much communication and engagement and as such were investing additional capacity to support enhanced engagement with local communities, to ensure that patients were better informed of changes and developments.

It was highlighted that following feedback the CCG would be working jointly with Healthwatch to develop a programme to support people to understand the digital offer and provide a step by step guide on how to use it and that this would be ready early December 2021.

During discussion, reference was made to:

- The need to promote the NHS App as well as this linked primary and secondary care and that information should be provided as to how to set it up. Representatives agreed to take back the comments raised with regard to the NHS App.;
- One member asked for further information as to where the 14 Primary Care Networks were situated across the county; and how many GP practices were within each network. It was agreed that this information would be sent through to the Health Scrutiny Officer to circulate to members of the Committee;
- Whether the training hub was a physical building. The Committee noted that the training hub was a team who co-ordinated and supported training;
- Using County News to get important message out to the residents of Lincolnshire; and

- To what extent could the CCG intervene, using the GP contractual provisions, if the CCG were to feel a particular practice was not offering a good level of service. The Committee noted that the approach taken in Lincolnshire was to work with practices, primary care and the Local Medical Committee to provide additional support to deal with whatever issues they had. It was highlighted that contractual provisions would be an absolutely last resort.

RESOLVED

1. That the various support provided by Lincolnshire CCG to general practice in Lincolnshire be noted.

2. That the Committee's concerns that the shortage of practitioners not only impacts on general practice itself, but also on the wider health system be recorded.

3. That a further update on Lincolnshire CCG Support for General Practice be received by the Committee in six months.

40 ELIGIBILITY CRITERIA FOR NON-EMERGENCY PATIENT TRANSPORT - CONSULTATION

The Chairman invited Simon Evans, Health Scrutiny Officer, to present the item which invited the Committee to agree its response to the Eligibility for Non-Emergency Patient Transport – Consultation, for submission to NHS England by the consultation closing date of 25 October 2021. The Committee had received a copy of the response document circulated by email on 11 October 2021.

The Committee noted that it was the intention that new contracts from April 2022 would reflect the new criteria, and that this would be applied by the provider of the new contract for non-emergency patient transport from 1 July 2022.

RESOLVED

That the Committee's response to the NHS consultation on the eligibility criteria for non-emergency patient transport as circulated on the 11 October be approved.

41 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 108 and 109 of the report pack.

During consideration of the item, the Committee raised the following comments/suggestions:

- Clarification as to the remit of the Humber Services Review. The Committee noted the proposals would include Northern Lincolnshire and Goole NHS Foundation Trust, and that in terms of Lincolnshire residents it was mainly, but not exclusively changes to the Diana Princess of Wales Hospital in Grimsby;
- The NHS recovery Plan post Covid-19. It was agreed that due to the number of items on future agendas that an update would be provided as part of the Chairman's announcements. If it was then felt that the matter should be discussed further, it would then be added to the work programme.

RESOLVED

That the work programme presented be agreed subject to inclusion of the items agreed at minute numbers 37 2(a),(b),(c) and (d), 38(3), and 39(3).

The meeting closed at 1.28 pm

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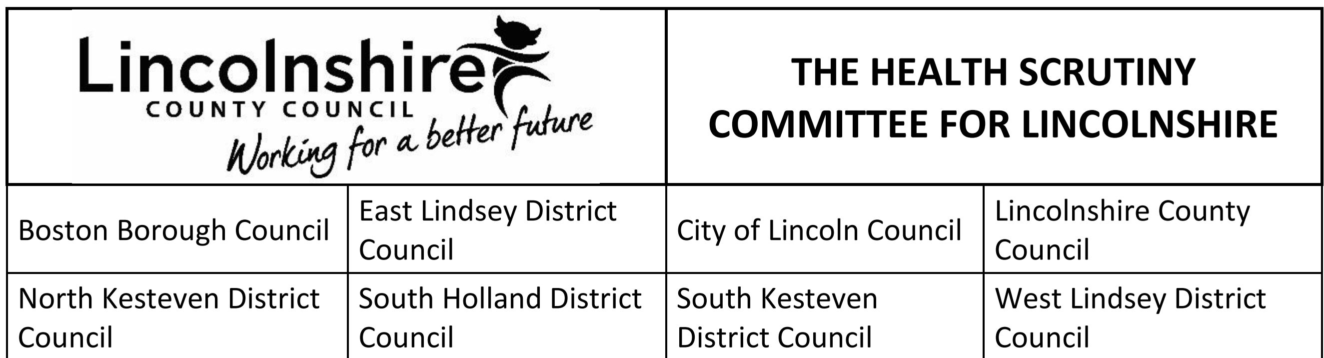
Agenda Item 4



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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**10 November 2021**
Subject:	**Chairman's Announcements**

1. Information Requested at the Last Meeting – 13 October 2021

Lincolnshire Acute Services Review

At the last meeting, details were requested on three aspects of the Lincolnshire Acute Services Review *(Minute 37 refers)*: -

(a) usage numbers for the Grantham Urgent Treatment Centre;
(b) follow-up appointments at Louth County Hospital for patients from the East Lindsey area, who had been treated at the proposed centre of excellence at Grantham; and
(c) a summary of all services provided at Louth County Hospital.

(a) can be covered by the relevant item on this agenda. The Committee is due to consider orthopaedic surgery on 15 December, when (b) will be considered. Information on (c) is set out in section 8 below.

Primary Care Networks

Information was requested on the fourteen Primary Care Networks in Lincolnshire *(Minute 39 refers)*. The Lincolnshire Primary Care Network Alliance annual report for 2019/20 has been circulated. The 2020/21 annual report will be circulated to members of the Committee when available.

The Local Recovery from the Impacts of Covid-19

Information was also requested on the local recovery from the impacts of Covid-19 *(Minute 41 refers)*. This is set out in section 9 below.

2. United Lincolnshire Hospitals NHS Trust – Nuclear Medicine

On 15 September 2021, the Committee considered an introductory item on Nuclear Medicine from United Lincolnshire Hospitals (ULHT) NHS Trust, whose Board is due to consider engagement proposals on 2 November 2021. Subject to the ULHT agreeing the proposals, the engagement exercise will be considered on 15 December 2021.

3. Humber Acute Services Review

The agenda for this meeting had planned an item on the Humber Acute Services Review. The Review Team has requested that this item be deferred to the Committee's next meeting on 15 December 2021. Additional details on the review are set out in Appendix A.

4. Plans for the Expansion of A&E Department at Pilgrim Hospital, Boston

On 26 October 2021, United Lincolnshire Hospitals NHS Trust announced more details on the plans for the expansion of the A&E Department at Pilgrim Hospital, Boston. These plans show how the department will:

- more than double in size;
- include state of the art innovations and infection prevention control measures;
- have a much bigger resuscitation zone for the sickest patients;
- have more cubicles in which to treat patients;
- have a separate area dedicated to providing emergency care for the hospital’s youngest patients and their families;
- have more training rooms for staff; and
- have a much better environment for patients and staff.

ULHT stated that the plans would soon be submitted to Boston Borough Council as part of the planning process. Once planning permission has been granted, the next step would be to get final approval from the Department of Health and Social Care so that work could begin.

ULHT has stated that this represented a major milestone in the transformation of the emergency department at Pilgrim Hospital, and it had taken a while to finalise the plans, but this was because it was important to get it right for our patients, their families and ULHT's staff.

5. NHS: Our Plan for Improving Access for Patients and Supporting General Practice

On 14 October 2021, the NHS published *Our Plan for Improving Access for Patients and Supporting General Practice*, which can be found at:

https://www.england.nhs.uk/coronavirus/publication/our-plan-for-improving-access-for-patients-and-supporting-general-practice/

The document refers to steps to (a) increase and optimise capacity; (b) encourage good practice; and (c) improve communication with the public, including tackling abuse and violence against NHS staff. These are briefly summarised below:

Increase and Optimise Capacity

For the period from 1 November 2021 to 31 March 2022, the Government has announced a new winter fund of £250 million, with two main uses:

(i) to improve access to urgent, same day primary care, by increasing capacity and GP appointment numbers; and
(ii) to increase the resilience of the NHS urgent care system during winter by expanding same day urgent capacity.

All local NHS systems were required to submit a plan by 28 October 2021.

Address Variation and Encourage Good Practice

All GP Practices were expected to complete by 31 October 2021 a review of whether they had the balance right for patients between remote and in-person consultations. In addition, NHS England and the Department of Health and Social Care have asked the Royal College of General Practitioners to consider providing a further update to its guidance by the end of November 2021.

Zero Tolerance of Abuse and Public Communications

The Government and NHS England will work with the trade unions and the Academy of Medical Royal Colleges to launch a zero-tolerance campaign on abuse of NHS staff. In addition, NHS England will work with the British Medical Association, the Royal College of General Practitioners and patient groups to to help people to understand how they can access the care in general practice.

6. Care Quality Commission Report: *The State of Health Care and Adult Social Care in England 2020/21*.

On 22 October 2021, the Care Quality Commission's report: *The State of Health Care and Adult Social Care in England 2020/21* was circulated to members of the Committee via e-mail and is available at the following link:

State of Care | Care Quality Commission (cqc.org.uk)

The **key points** in the report have been grouped under four headings:

- People's Experiences of Care;
- Flexibly to Respond to the Pandemic
- Ongoing Quality Concerns
- Challenges for Systems

These are set out in Appendix B.

7. Covid-19 Response – Autumn and Winter Plan 2021

I would like to take this opportunity to remind you of the Government's *Covid-19 Response - Autumn and Winter Plan 2021*, which was published on 14 September 2021, and includes details of the Government's Plan A and Plan B for the response to Covid-19. The plan is available at the following link: Covid-19 Response Autumn and Winter Plan 2021

Plan A includes the following measures: -

1. **Building defences through pharmaceutical interventions:** vaccines, antivirals and disease modifying therapeutics.
2. **Identifying and isolating positive cases to limit transmission:** Test, Trace and Self Isolation.
3. **Supporting the NHS and social care:** managing pressure and recovering services.
4. **Advising people on how to protect themselves and others:** clear guidance and communication.
5. **Pursuing an international approach:** helping to vaccinate the world and managing risks at the border.

The key points of the Government's contain framework are as follows:

1. Anyone with Covid-19 symptoms will be expected to self-isolate and take a PCR test.

2. Regular asymptomatic testing, using lateral flow devices, will be focused on those who are not fully vaccinated; those in education; and those in higher risk settings.

3. Community testing will continue to support local authorities to focus on disproportionately impacted and high-risk groups.

4. The legal requirement to self-isolate for 10 days if an individual tests positive, and for close contacts who are 18 and over and not fully vaccinated, will remain.

5. Contact tracing will continue throughout autumn and winter, with local authorities continuing to play an essential role in this through the local tracing partnerships.

6. People will continue to be encouraged to use the NHS Covid-19 App.

7. The Health Protection (Coronavirus, Restrictions) (England) (No.3) Regulations 2020, continue to give local authorities the power to impose restrictions on individual premises, events and public outdoor places.

8. The Government will continue to support and work with local authorities and areas facing particular challenges.

The Autumn and Winter Plan included a contingency plan, Plan B, which would be used if the NSH was likely to come under sustained pressure. The contingency measures envisage:

- communicating to the public that the risk level had changed;
- mandatory vaccine certification for Covid-19 in certain settings;
- mandatory face coverings in certain settings (to be specified by the Government); and
- consideration being given to asking people to work from home.

The Government published details on mandatory Covid-19 certification on 27 September 2021, which can be found at: details.

8. NHS Services at Louth County Hospital

There are two main NHS providers at Louth County Hospital: Lincolnshire Community Health Services NHS Trust (LCHS); and United Lincolnshire Hospitals NHS Trust (ULHT). In addition Northern Lincolnshire and Goole NHS Foundation Trust operates some clinics at the hospital.

A full up-to-date list is being compiled. In the interim the following are the main services:

LCHS provides:

- a 24/7 urgent treatment centre;
- Archer Assessment Centre, providing frailty assessment with eight assessment beds and six short stay assessment areas;
- Archer Ward, 16 GP-led in-patient rehabilitation beds and four palliative care beds; and
- Cawthorpe Suite, a six chair unit focusing on ambulatory care and treatment for patients on a day case basis.

ULHT provides:

- orthopaedic surgery for day case patients and in-patients, with in-patients staying on Fortherby Ward;
- an endoscopy unit;
- a urology suite; and
- various outpatient services at the Woldside Unit.

9. The Local Recovery from the Impacts of Covid-19

At the last meeting of the Committee, information was requested on the local NHS's plans for recovery, following the Covid-19 pandemic. An extract of a report to the Lincolnshire CCG Board on 27 October is set out below, together with the latest information on the Lincolnshire Resilience Forum.

Extract from a Report to the Lincolnshire CCG Board on 27 October 2021

Overview

"All NHS services in Lincolnshire are continuing to experience exceptional levels of patient demand. This is particularly noticeable in urgent and emergency care services, where GPs, Urgent Treatment Centres, A&E services and EMAS Ambulance Services are reporting continuous levels of demand beyond that experienced in the depths of winter with high levels of acuity in hospital admissions. NHS staff in Lincolnshire are therefore under ongoing and continuous pressure, and it is anticipated that this position will continue through to Spring 2022.

Elective Operations

"With regards to elective operations the increased pressure in hospitals of both Covid Inpatients combined with emergency demand has caused many nearby trusts to cancel routine electives and in Lincolnshire the trust is day by day assessing the ability to operate on patients who would require either an Intensive Care Bed (ICU) or High Dependency (HDU) bed post-surgery with a very small number of patients cancelled.

"In August 2021 the total waiting list size for Lincolnshire patients at all hospitals was circa 82,000 people, just over 1 in 10 of our population. This compares to 64,000 in August 2020.

"Whilst these patient numbers are a huge concern, Lincolnshire compares well with other systems in England, mostly because of the 'green site' arrangements at Grantham Hospital which meant that many elective procedures were still able to be undertaken in previous waves of Covid. Within Lincolnshire NHS our surgical teams are working exceptionally hard to improve our position for patients, and we are also supported by the Independent Sector.

Cancer Treatment

Cancer Waiting times are beginning to rise again due to the operational pressures felt in Acute Trusts and the impact that has on ICU/HDU beds post-surgery. The largest backlogs remain in surgical specialities that are the same regionally therefore mutual aid to support is constrained. Trusts continue to clinically prioritise patients with the focus on treating those cancer patients that are clinically urgent - these are Priority 1 patients who need surgery within 72 hours, and Priority 2 patients who need surgery within a month.

Primary Care

"Primary care is also seeing record numbers of patients compared to pre Covid levels. GP practices are open as they have been throughout the pandemic but are working differently in order to meet this rise in demand and protect the most vulnerable when they are attending appointments.

"The Lincolnshire Health Scrutiny Committee examined Primary Care and GP Access pressures when it met recently on 13th October, and fully discussed this important issue with John Turner, CCG Chief Executive, Dr Kieran Sharrock, LMC Medical Director and Sarah-Jane Mills, CCG lead for Primary Care. The Committee noted that across Lincolnshire GP Practices, 47% of patients who contact their GP are seen on the same day. Overall two thirds of all patient contacts in Lincolnshire are face-to-face, one third virtual.

"*Most surgeries operate a form of triage system (Total Triage) where patients contact their practice either by telephone or by using an online tool; they provide basic information that allows the practice care navigators to direct the patient to the right professional. The professional will receive the information to assess patients and consider who needs to be seen in person or when a telephone or video consultation may be appropriate. There are many issues can be effectively and efficiently dealt with working this way and many patients welcome this. However where patients have multiple clinical issues Total Triage does not make it easy for all of these to be addressed.*

"*On 14 October, the Government issued a national document titled 'Supporting General Practice and Improving Access for Patients', with £250m additional investment. There are a wide range of proposals within the document which are designed to increase capacity in Primary Care and improve access. This includes additional workforce, making better use of community pharmacy and improving telephony services. The CCG is working to submit a plan in line for how this will be progressed in Lincolnshire to NHS England NHS Improvement by 28 October.*"

Lincolnshire Resilience Forum

The Lincolnshire Resilience Forum (LRF) is now in the final stages of the 'oversight and assurance' phase of recovery. The LRF's Recovery Strategic Co-ordination Group has received assurance from the education; higher education; and community and voluntary sector representatives that, across the system, the direction of travel was positive and plans were in place at an organisational level to address risks, without the requirement for a wider LRF command structure being in place. This has built upon previous assurances provided by NHS and Public Health.

On that basis currently there is confidence that exit should proceed as planned with a target date of the end of the calendar year 2021. However, this timetable will be monitored and reviewed in line with any changes to either the local or the national position.

APPENDIX A

Humber Acute Services Review - Programme One – Interim Clinical Plan

Overview of Humber Acute Services Programme

Activity on the Humber Acute Services Review has been in three programmes, as set out below:

- 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 join up services across all aspects of health and social care.
- Building Better Places (Programme Three) – working with a wide range of partners in support of a major capital investment bid to government to develop our hospital estate and deliver significant benefits to the local economy and population.

The Committee's item on 15 December will focus on Programme Two, Core Hospital Services, as this programme is likely to include proposals for changes to services.

The Review Team has provided the following update on Programme 1 of the review, the interim clinical plan.

Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust have committed to working together to address challenges in the most vulnerable or fragile specialties – this work is being undertaken through Programme One of the Humber Acute Services Programme (or the Interim Clinical Plan). The Interim Clinical Plan is about pooling resources, skills and expertise to provide more resilient services that patients across the Humber can access equitably.

The Interim Clinical Plan is one of a number of programmes of work and improvement activities underway across the Humber, Coast and Vale Health and Care Partnership and within individual acute trusts. Others include:

- *Acute Care Collaborative – 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 sharing best practice between trusts.*
- *Elective Care Programme and COVID recovery – ensuring 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 – brings together all the organisations that commission and provide cancer services to improve patient experience, awareness and diagnosis, treatment and patient pathways.*

For the Interim Clinical Plan we have adopted a consistent framework to review all specialties and established joint governance arrangements across both Trusts to oversee the programme of work. The paper (available at the link below) provides an outline of progress specialty-by-specialty, with some more detailed examples of progress in Neurology and Cardiology.

Engagement work has been undertaken across those services impacted by temporary service changes (i.e. Oncology, Haematology, Ear, Nose and Throat (ENT) and Urology). The outcomes of the review of these temporary changes will be reported by the end of 2021.

More information is available at the following link:

https://humbercoastandvale.org.uk/humberacutereview/

APPENDIX B

The State of Health Care and Adult Social Care in England 2020/21

The Care Quality Commission has set out the following key points from the report *The State of Health Care and Adult Social Care in England 2020/21,* which was published on 21 October 2021:

People's Experiences of Care

- The impact of the pandemic on many who use health and social care services has been intensely damaging. Many people have struggled to get the care they need, and there is also evidence that some people have not sought care and treatment as a result of Covid-19.
- We have previously highlighted the ongoing issues that people from some groups have faced in accessing and receiving high-quality care. Over the last year, the pandemic has further exposed and exacerbated these inequalities.
- People with a learning disability have faced increased challenges as a result of the pandemic.
- The need for mental health care has increased, with children and young people particularly badly affected.
- The strain on carers has intensified. Carers UK estimated in June 2020 that an additional 4.5 million people had become unpaid carers since the pandemic began.
- Health and social care staff are exhausted and the workforce is depleted. People across all professions, and carers and volunteers, have worked tirelessly to help those who needed care. The negative impact of working under this sustained pressure, including anxiety, stress and burnout, cannot be underestimated.
- Despite the widespread disruption caused by the pandemic, surveys have shown that, when people were able to access the care they needed, they were often positive about that care.

Flexibility to Respond to the Pandemic

- After the initial prioritisation of urgent care, there was a gradual push to bring systems back in line with pre-pandemic levels. Of the NHS acute areas we examined (cancer, cardiovascular, A&E, and mental health services), cancer services have achieved the best response and recovery.
- The NHS was able to expand its critical care capacity to respond to the needs of the patient population at a time of crisis, although it put extra pressure on staff and other types of care and treatment.
- We have serious concerns about ambulance handover delays at hospitals, which put the safety of patients at risk.

- The ‘discharge to assess’ model for managing transfers of care has helped to support services in both health and social care. It has been a good step towards helping people after they leave hospital, although there needs to be greater consistency in how it is implemented.
- The vital role of adult social care was made clear during the pandemic, but urgent action is needed to tackle staffing issues and the increased pressures and stresses caused by staff shortages.
- GP practices had to rapidly move to a more remote model of care in the pandemic – this was welcomed by many people needing GP care, but it did not benefit everyone and some struggled to get the appointments they wanted.
- Access to NHS dental care was an issue since before Covid-19, and there are clear signs that this has been compounded by the pandemic.

Ongoing Quality Concerns

- Through our reviews of high-risk mental health services, we are concerned that people continue to be put at risk in a small number of services where there are warning signs of closed cultures.
- Improvements in maternity care are far too slow, with continuing issues around staff not having the right skills or knowledge, poor working relationships, and not learning from when things go wrong. Other concerns include a lack of engagement with local women by maternity services and limited action taken by these services to improve equitable access.
- While services have largely maintained levels of Deprivation of Liberty Safeguards during 2020/21, they need to have a continued focus on people subject to a deprivation of liberty. We continue to have concerns about delays in authorisations, which mean that individuals are deprived of their liberty longer than necessary, or without the appropriate legal authority and safeguards in place.

Challenges for Systems

- Collaborative working was varied among the local systems we reviewed. Cross-sector working was helped by good communication, information sharing and shared values.
- There was a lack of integration of adult social care providers into system-level planning and decision-making.
- Most systems had some understanding that inequalities in care that existed in their areas before the pandemic, as well as how they had worsened or changed due to the pandemic. But tackling these inequalities was often not a main priority for them.
- Workforce planning is a major priority and challenge for local systems and providers. Recruitment and staff retention continue to be severe problems.
- In adult social care, the situation is serious and deteriorating. There must be a sharp focus on developing a clearly defined career pathway and training, supported by consistent investment that will enable employers to attract and retain the right people.

		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:	**10 November 2021**
Subject:	**Lincolnshire Acute Services Review – Stroke Services**

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 two of the four strands of the review at this meeting, with the remaining two on 15 December 2021.

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 details on the Lincolnshire Acute Services Review of Stroke Services.

(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 the Committee considered an introductory item and agreed its approach to the consultation.

2. Stroke Services

Dr Abdul Elmarimi, a Consultant in Stroke Medicine, from United Lincolnshire Hospitals NHS Trust, is due to attend the meeting to present information on this topic. To facilitate the Committee's consideration, pages 37-41 of the consultation document, which relate specifically to Stroke Services, are attached as Appendix A to this report. Chapter 12 of the Pre-Consultation Business Case provides further detail and is attached at Appendix B. It should be noted that chapter 12 of the PCBC in turn refers to the following documents, all of which are available at: Pre-Consultation Business Case Appendices:

- Appendix F – Temporary Covid-19 Pathway (Update to United Lincolnshire hospitals NHS Trust Board on 6 July 2021.
- 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 37 – 41) from Lincolnshire NHS Public Consultation Document – Relating to Four of Lincolnshire's NHS Services – Stroke Services
Appendix B	Chapter 12 of the Pre-Consultation Business Case for the Lincolnshire Acute Services Review – Preferred Option for Stroke Services

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

Stroke services

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 hyper-acuteand acute stroke services at Lincoln County Hospital
- Which would be supported by enhancement of thecommunity stroke rehabilitation service across the county, so it can support stroke patients with morecomplex needs

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

Hyper-acute and acute stroke services are provided fromhospitals that treat the sickest of patients:

- Hyper-acute stroke services care for people in hospitalin the first 72 hours (it may be less) after their admission for a stroke, when more specialist 'critical' care is needed
- Acute stroke services care for people in hospital afterthe first 72 hours of having a stroke (including in- hospital rehabilitation) and until they are ready to bedischarged to another service and/or go home

These hospital stroke services are provided by highly trained and skilled doctors, nurses and therapists who specialise in looking after people who have had a stroke. They work as a multi-disciplinary team to provide the mostappropriate care tailored to the needs of individual people.

Two key hospital services for the treatment of strokes are:

- Thrombolysis: a 'clot busting drug'. Only strokes caused by blood clots (about 85% of all strokes) could be considered for thrombolysis, which is appropriate to under 20% of these strokes only. It istime critical, as can only be given within 4.5 hours ofstroke onset
- and

Mechanical thrombectomy: 'clot retrieval' througha procedure where a 'guide wire' is used to remove the clot causing the stroke, usually used inconjunction with thrombolysis. This is a relatively new procedure only available in a small number ofhospitals, the nearest of which is Queen's Medical Centre in Nottingham. It is not currently available in Lincolnshire

In addition, these hospital stroke service teams also run transient ischaemic attack (TIA) or 'mini stroke' clinics (in outpatient services), where patients whose symptoms have resolved but are still thought to be 'high risk' will be seen the next day by a stroke consultant and have appropriate investigation and results for the patient all in the same day.

Prior to the temporary changes made in response to COVID-19, United Lincolnshire Hospitals NHS Trust (ULHT) provided hyper-acute and acute stroke services,as well as TIA clinics from Lincoln County Hospital and Pilgrim Hospital, Boston. Grantham and District Hospital does not provide these services. If patients with a suspected stroke present at Grantham and District Hospital they are rapidly transferred to the most appropriate site.

A summary of stroke service provision at ULHT's hospital sites 'pre COVID-19' is set out below.

Site	Services
Lincoln County	• Hyper-acute stroke service including Thrombolysis • Acute stroke service • TIA clinics
Pilgrim Hospital	• Hyper-acute stroke service including Thrombolysis • Acute stroke service • TIA clinics

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

Working alongside the Lincolnshire hospital-based stroke services is the Lincolnshire community stroke rehabilitation service. This service aims to reduce the length of stay of patients within hospital stroke units, to improve the patient and carer experience followinga stroke, and to offer a seamless transfer of care for patients from hospital to home.

What are the challenges and opportunities for stroke services?

This section sets out the challenges and opportunitiesfor stroke services and what we hope to achieve by making changes.

Challenges

- The national best practice is that hyper-acute stroke units should admit a minimum of 600 patients a year - below this level doctors and nurses in hospital stroke services risk becoming deskilled. This in turn means patients may not get the best or safest care inthe future:
    - Lincoln County Hospital admits around 670 strokepatients a year and Pilgrim Hospital, Boston around 500 stroke patients a year
    - Even when considering growth in the size and theageing of the local population over the next five years, Pilgrim Hospital, Boston is highly unlikely toadmit 600 stroke patients a year, every year
- We need more doctors, nurses and therapists to deliver the existing hospital stroke services, but therearen't enough locally and nationally:
- This means there are significant problems staffingour hospital stroke services - and we have alreadyseen temporary closures of some of our services because there aren't enough doctors or nurses available

Both the Lincoln County Hospital and Pilgrim Hospital,Boston stroke services have struggled to consistently perform well in the national audit of service quality and performance, despite the skills and dedication of our staff. This is reflective of the challenges set out above

Opportunities

By making changes, we can look to ensure:

- High quality hyper-acute and acute stroke services aredelivered in Lincolnshire in a sustainable way for the long term, by:
    - Ensuring hospital stroke services are based onnational clinical evidence
    - We achieve a balance between access and ensuring the long term sustainability of services
    - Our hospital stroke services receive over 600 strokepatients a year so that our doctors and nurses here in Lincolnshire maintain and develop theirspecialist skills and expertise
    - Improving the ability of hospital stroke services toattract and retain talented and substantive staff by building a strong, high quality and successful service, reducing our reliance on temporary, expensive staffing solutions
    - Stroke patients spend the minimum time necessaryin a hospital bed, by ensuring community services have the right skills and capacity to support stroke patients at home, or as close to home as possible
- Patients are more likely to receive timely assessment,treatment and diagnosis when they arrive at hospital
- Patients are more likely to see the right specialist, firsttime, 24/7 and receive the best possible care
- Health outcomes and the overall patient experienceare improved

- Reduced burden of stroke on patients, families, carers and the wider health economy through better outcomes for patients

- More working age patients will be able to return to work, and lead more fulfilling lives

We know that this approach already works well in other services in the county. Through the establishment of the Lincolnshire Heart Centre at Lincoln County Hospital, Lincolnshire residents already have first-hand experience of the benefits to patient care that can be achieved by bringing together and consolidating highly specialist clinical expertise into a centre of excellence.

The feedback from engagement about stroke services 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 hospital stroke services, including some specifically related to those living in the Boston area, have been shared by the public and stakeholders throughout our engagement to date:

- Consolidation of hospital stroke services in order to provide specialist, expert standards of care is reasonable, however this needs to be balanced against the possible negative impacts of increased travel times, which needs to be mitigated

- It is important that patients should be able to undergo rehabilitation and ongoing care nearer their homes

- Specific to the Boston area:

    - Concerns about ambulance service response times to Lincoln County Hospital and treatment not being started within 60 minutes

    - Concerns about a loss of services at Pilgrim Hospital, Boston and overburdening the Lincoln County Hospital site

We have consistently looked to take into account all public and stakeholder feedback throughout our work.

What is our preferred proposal forchange?

Our preferred proposal for change is to establish a 'centre of 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. TIA clinics would be unaffected at Pilgrim Hospital, Boston.

This would mean hyper-acute and acute stroke services would be consolidated at Lincoln County Hospital and no longer be provided from Pilgrim Hospital, Boston.

It is anticipated the change would affect, on average, 1 to 2 patients a day. These patients would receive hyper- acute and acute stroke services at an alternative hospital.

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 Stroke Services two solutions remained following the shortlisting of options:

- Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service

- Provide hyper-acute and acute stroke services from Lincoln County Hospital and Pilgrim Hospital, Boston, supported by a combined medical on-call rota

Attendees at the workshop were asked to think about the advantages and disadvantages of the two proposalsagainst agreed criteria.

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

Support for options for hyper-acute and acute stroke services		
Support for change proposal	**Stakeholder Workshop**	**Public Workshops**
Consolidated on Lincoln site	61%	64%
Provided from twosites – Lincoln andBoston	27%	26%
No preference	12%	10%

Impact Analysis

As we have developed our proposals we have considered the quality and equality impact of the proposal for change for stroke services.

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 economically disadvantaged.

Our observations from these assessments are set out opposite. 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

1. Evidence that consolidating hyper-acute and acute stroke services on a smaller number of sites where specialised staff and equipment can be concentratedmeans patients are:
    - More likely to survive and recover more quickly.
    - More likely to have a reduced length of stay inhospital
    - More likely to continue to lead more fulfilling livesin the future, such as being able to return to work
2. Consolidating hospital stroke services helps address the significant workforce shortages and challenges experienced in these services by:
    - Concentrating specialist skills and expertise together to ensure clinical staff maintain and develop these to provide the safest and best possible care
    - Making hospital stroke services more attractive todoctors, nurses and therapists to work in
    - Reducing reliance on temporary, expensive staffingsolutions
3. Consolidation of hospital stroke services on the Lincoln County Hospital site allows more patientsto benefit from these services being located on the same hospital site as the highly successful Lincolnshire Heart Centre, which include:
    - Increased access to important time critical interventions
    - Increased access to acute imaging services, furtherreducing time to treatment
4. Consolidation of stroke services on the Lincoln County Hospital site ensures patients are closer to Nottingham's Queen's Medical Centre in the instancethey require mechanical thrombectomy.

Potential adverse impacts

1. For those patients who would previously have been admitted to Pilgrim Hospital, Boston with a stroke (1to 2 a day on average), treatment would be receivedat an alternative site with the facilities and skills to look after the most seriously ill patients.

   - Lincoln County Hospital is expected to be the alternative site for the majority of patients, witha minority going to Peterborough City Hospital,and Queen Elizabeth Hospital at Kings Lynn on occasion

   These patients would get the specialist input they require at the right time and receive the best possible care. However, it is acknowledged that needing to travel further for this care may be seenas 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 minutes by ambulance, the threshold set by the local health system for this type of activity.

   - 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.

12 Acute Services Review: Preferred option – Stroke Services

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-19pandemic and subsequent temporary service changes).

12.1 Case for change

12.1.1 Stroke is the third most common cause of death and most common cause of complex disability in the UK. A stroke can occur at any age; a quarter of stroke deaths occur in under 65 year olds, around 80% of strokes are attributable to high blood pressure, smoking, obesity, poor diet and lack of exercise.

12.1.2 Rates of death from stroke for under 75 year olds per 100k population in 2015-17 was lower forLincolnshire (12.6%) compared with East Midlands (13.0%) or England (13.1%). However, the prevalence of stroke (all ages) in 2018/19 was higher in Lincolnshire (2.3%) compared with both East Midlands (1.9%) and England (1.8%).

12.1.3 It has been estimated that c.3% of the Lincolnshire population will be living with the consequences of stroke by 2020. This will place a considerable burden not only on health services but on families and carers, and the workforce as a whole.

12.1.4 The United Lincolnshire Hospitals NHS Trust (ULHT) currently provides inpatient, hyper-acute(day 0 – 3 of the pathway) and acute stroke services (day 3- to discharge) at both Lincoln Hospital (2019/20: 670 strokes per annum) and Pilgrim Hospital (2019/20: 497 strokes per annum).

12.1.5 Grantham Hospital does not provide hyper-acute or acute stroke services, if strokes present at Grantham Hospital they are rapidly transferred to the most appropriate site (19/20: of 77 stroke patients attending at Grantham Hospital A&E, 18 were strokes and sent on to other sites. Of the remaining 59 mimics 7 were TIAs which also transferred to other sites, 19 were admitted to Grantham, 18 transferred elsewhere and 15 were discharged from A&E).

12.1.6 The NHS *Stroke Services: Configuration Decision Support Guide* recommends that whenassessing the case for change for stroke services the Sentinel Stroke National Audit Programme (SSNAP) analysis should provide the starting point.

12.1.7 The SNAP is comprised of 44 key indicators (KI) that are grouped into 10 domains, which highlight the pre-existing and upcoming national measures. Each domain has a performance level (A to E, with A being best performance) and a total key indicator score is calculated based on the average of the 10 domains. The combined total key indicator score is adjusted for case attainment and audit compliance to provide an overall SSNAP level.

12.1.8 ULHT continually strives to improve the SSNAP performance at Lincoln County Hospital and Boston Pilgrim Hospital, however this is challenging for the reasons set out in this case for change. ULHT's performance by site for the last 12 months is set out in the table below.

Figure 158 – ULHT SSNAP October 2019 to September 2020

SSNAP Level/Score	Jul-Sep20	Apr-Jun20		Jan-Mar20	Oct-Dec19
Lincoln County Hospital					
Team-Centred Total KI Level	B		A	B	C
Team-Centred Total KI Score	80.0		86.0	78.0	68.0
SSNAP Level	B		A	B	C
SSNAP Score	80.0		86.0	80.0	68.0
Boston Pilgrim Hospital		*Domains 5-10*	*All Domains*		
Team-Centred Total KI Level	A	A	D	C	C
Team-Centred Total KI Score	86.7	81.4	52.1	66.0	60.0
SSNAP Level	B		D	C	D
SSNAP Score	78.0		55.9	66.0	57.9

12.1.9 However, when comparing ULHT's SSNAP performance data consideration needs to be given to the changing context stroke services have been provided in and associated changed to pathways:

- December 2019 – March 2020: This period was in essence 'pre-Covid', when both LincolnCounty Hospital and Boston Pilgrim Hospital both classified as a 'Routinely Admitting Hospital' for hyper-acute stroke care. During this period SSNAP scores were:
    - Lincoln County Hospital - 'B' and 'C'; and
    - Boston Pilgrim Hospital - 'C' and 'D'.
- April 2020 – September 2020: In response to the COVID-19 pandemic and the additional pressures this put on the sustainability of the ULHT stroke services, Boston Pilgrim Hospital became a 'Non Routinely Admitting Hospital' (rather than a Routinely Admitting Hospital, which Lincoln County Hospital continued to be). Consequently, during this periodfor Pilgrim the emphasis should be placed on Domains 5 to 10 in the SSNAP data, rather than those which attribute to the first 72 hours). For Boston Pilgrim Hospital the SSNAP report for April – June 2020 reported on all Domains and was also amended to reflect Domains 5-10). The July – September 2020 SSNAP report only focused on Domains 5-10for Boston Pilgrim Hospital. During this period, SSNAP scores were (with the emphasis forBoston Pilgrim on Domains 5-10):
    - Lincoln County Hospital - 'A' and 'B'; and
    - Boston Pilgrim Hospital - 'B'

12.1.10 It should be noted that Lincoln County Hospital was 'A' for the first time in the April-June quarter of 2020. This coincided with the temporary service change to consolidate ULHT hyper-acute stroke services on the Lincoln County Hospital site in light of the challenges the service faced due to COVID-19.

12.1.11 This experience of service consolidation and improved performance aligns to the evidence presented later in this chapter for the concentration of stroke clinical expertise and capacity on to fewer sites.

12.1.12 In addition to SSNAP, 'pre-Covid' ULHT was not achieving the required performance in 1 of the 4 priority standards for 7-day services, for hyper-acute stroke.

Figure 159 – 7-day services and urgent network clinical services

Clinical Standard	ULHT
Clinical Standard 2 – All emergency admissions seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital	
Clinical Standard 5 – Hospital inpatients have scheduled 7-day access to diagnostic services, typically ultrasound, CT, MRI, echo, endoscopy and microbiology. Consultant-directed diagnostic tests and reporting available 7-days a week	
Clinical Standard 6 – Hospital inpatients have timely 24 hour access, 7-days a week to key consultant-directed interventions that meet relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear protocols	
Clinical Standard 8 – All patients with dependency needs should be seen and reviewed by a consultant twice daily. Once a clear pathway of care has been established, patients should be reviewed at least once every 24hrs, 7 days a week	

12.1.13 The NHS *Stroke Services: Configuration Decision Support Guide* also recommends that hyper-acute stroke units should see no less than 600 strokes per year, as activity below this is not sufficient to ensure staff have enough clinical and institutional learning experience to maintain their skills. The minimum of 600 strokes per year was also a threshold endorsed by the Midlands and East stroke review. Even when factoring in growth in demand the Boston Pilgrim Hospital Service is unlikely to see 600 strokes per year over the next 5 years.

12.1.14 In 2019/20 significant workforce gaps existed across the ULHT stroke services against recommended clinical standards:

- Both Lincoln and Pilgrim Hospitals should have six substantive consultant posts each, however there were only two substantive consultants in post in total with gaps covered byagency and locum doctors (however not always up to a total of 6 on each site) - to date ithas not been possible to recruit substantively to vacancies.
- Vacancy rate at Pilgrim Hospital for nursing was 50%, which led to a reduced number ofbeds being open on the Stroke unit from 28 to 24.

12.1.15 Between the start and end of 2019/20 the 12 month rolling average length of stay across ULHT for stroke patients reduced from 16.1 days to 13.6 days. At Lincoln Hospital the reduction was 16.5 days to 14.4 days, looking at individual months the lowest average length of stay was 10.6 days. At Pilgrim Hospital the rolling average length of stay reduced from 13.8 days to 12.1 days, the lowest average length of stay for an individual month was 11.5 days.

12.1.16 The current community stroke service provided in Lincolnshire was procured in 2010, prior to this there were no community based rehabilitation services for stroke survivors. It is a countywide service that has established excellent working relationships with all acute stroke units delivering care to Lincolnshire residents. It is delivered by Lincolnshire Community Health Services NHS Trust (LCHS) in partnership with Lincolnshire Adult Care Services and the Stroke Association. At present the service supports c.60% of stroke survivors to leave hospital.

12.1.17 To address these challenges, the preferred option for the future provision of stroke services across Lincolnshire identified through the options appraisal process once fully implemented comprises of two elements that fully align with recommendations in the NHS Long Term Plan:

- Consolidation of hyper-acute and acute stroke services (day 0-7 post stroke) at the Lincoln Hospital; and
- Provision of a much greater enhanced community-based stroke rehabilitation service with the aim to reduce the length of time patients stay in the acute hospital (best practice target 7 days).

12.1.18 It is proposed there are two main stages to the implementation of this preferred model:

- Phase 1: Enhancement of the community stroke services, this will act as an enabler to the consolidation of hospital stroke services. Following significant work to re-define and agree how an enhanced stroke rehabilitation service should function and what resources would be required, an initial investment was made and ongoing review and patient feedback will inform further development of the service.
- Phase 2: Public consultation on the consolidation of hyper-acute and acute stroke services at the Lincoln Hospital site followed by implementation (as appropriate).

12.1.19 It should be noted the case for change for stroke services developed for the first ASR ClinicalSummit in early 2018 has not changed, and the service's fragility was highlighted further through COVID-19. The case for change and preferred option are described in more detail inthe remainder of the chapter.

12.2 Consolidation of hyper-acute and acute services at Lincoln Hospital

Overview

12.2.1 The option to consolidate hyper-acute and acute stroke services at Lincoln Hospital was designed through a number of clinically led workshops headed by the Stroke Consultants at ULHT with support and contributions from Professor Rudd (the National Clinical Director for Stroke Services), and local acute, primary and community based health professional. A numberof influential factors for why the Lincoln Hospital site was identified to centralise acute stroke services as opposed to Pilgrim Hospital were identified.

12.2.2 Co-location of specialised services is very important. There is an established and highly successful heart centre on the Lincolnshire Hospital site. The cardiology team support the stroke team to deliver an optimal front door service as co-location with cardiology enables access to more important time critical interventions like bubble echocardiograms and implantable loop recorders. At Lincoln Hospital there is an established Advanced Care Practioner (ACP) service and pathway that was noted as a regional example of excellence by a Getting It Right First Time (GIRFT) review.

12.2.3 Co-location with the heart unit also has the benefit of using the Cath lab facilities to directly access acute imaging thus bypassing A&E and further reducing door to needle time. Moving these cardiac services from the Lincoln site to another hospital would require significant financial investment and is risky in terms of being able to transfer all staff for this service.

12.2.4 Mechanical thrombectomy is a relatively new treatment for strokes that is currently only carried out in tertiary stroke centres, the closest of which for Lincolnshire residents is Nottingham University Hospitals NHS Trust (NUH). Lincoln Hospital offers a shorter travel time to NUH than Pilgrim Hospital by c.30 minutes. Consolidation of stroke services at Lincoln hospital also provides an increased opportunity for the Lincoln site to provide mechanical thrombectomy in the future as there has been discussion at a national level that Cardiologists may be considered as being appropriate to deliver mechanical thrombectomy based on their experience with PPCI.

12.2.5 Vascular Surgery is currently provided from Pilgrim Hospital, and will be going forward. Co-location with Vascular Surgery is helpful, however the timeline for surgery is within 2 weeks andreserved for those with no disability or minor disability patients who are fit for surgery.

12.2.6 ULHT's stroke service faced a number of ongoing recruitment challenges. Experience has shown it is easier to recruit to the Lincoln Hospital compared to Pilgrim Hospital, and thereforethe current and future feasibility of the service would be better protected if services were consolidated on the Lincoln site.

12.2.7 More Lincolnshire residents would also receive their care out of the county if stroke services were consolidated on the Pilgrim Hospital site rather than at Lincoln Hospital. Based on strokepatients attending their nearest hospital it is estimated c.150 more patients per year would be treated outside of Lincolnshire if stroke services were consolidated at Pilgrim Hospital rather than Lincoln Hospital (this reduces to c.65 patients if a 15-minute travel time preference for Pilgrim hospital is applied). Lincoln Hospital is therefore a better solution for more of Lincolnshire's population on that basis.

12.2.8 When the model for consolidating hyper-acute and acute stroke services at Lincoln Hospital was presented to the East Midlands Clinical Senate it was praised by the panel and deemed to be well led clinically and from the evidence provided well researched. It was acknowledged that the proposed reconfiguration would reduce unwarranted variation in outcomes and would ensure a more consistent achievement of clinical standards and national guidelines.

12.2.9 The only question raised was how patients with Transient Ischaemic Attack (TIA) symptoms attending Pilgrim Hospital would be managed. All high risk patients will be offered an appointment in Lincoln the next day, as per national guidelines. There would be two follow-upstroke and TIA clinics a week at Boston Hospital for local patients (e.g. post-discharge) and some low risk patients attending with TIA symptoms could be seen in these.

12.2.10 These clinics will rotate for all clinicians, unless some express preferences for them. There is scope for more clinics if the demand is there. It is the intention that a once a month clinic in Louth, Skegness and Gainsborough will be established once the demand has been ascertained. Skegness is the highest priority.

12.2.11 Since this initial work on the future care model for acute stroke services the NHS Long Term Plan has been published that also recommended the consolidation of specialist acute stroke services to improve quality and outcomes.

Quality

12.2.12 The evidence is clear that centralising hyper-acute stroke treatment at a much smaller number of hospitals has considerable benefits as these units are more likely to provide more effective stroke treatment thereby saving lives, reducing the chances of disability and shortening the time spent in hospital.

12.2.13 Evaluation of the centralisation of hyper-acute stroke services in London and Greater Manchester have shown these models can reduce mortality, improve provision of evidencebased clinical interventions and reduce length of stay. The evaluations have shown these effects can be sustained over time.

12.2.14 Reconfiguration of hyper-acute stroke services in London and Greater Manchester has been shown to deliver unadjusted mortality decreases at 30 days of 2.8% and 1.6% respectively (estimated to be the equivalent of c.100 and c.70 extra lives saved per year respectively). These areas have also reported an absolute decline in risk adjusted length of hospital stay of 1.4 days and 2.0 days respectively.

12.2.15 A significant improvement in patient outcomes has also been seen through similar changes to hyper-acute services in Northumberland.

12.2.16 Evidence shows that stroke patients treated in dedicated and focused hyper-acute stroke units are more likely to survive and recover more quickly because these units are fully staffed and equipped, and set up to deliver specialist care 24/7. This also helps to address the significant workforce shortages and challenges in stroke by concentrating specialist stroke skills and expertise under one roof.

12.2.17 Performance against the SSNAP has required further improvement in stroke services at Lincoln Hospital and Pilgrim Hospital for some time. Through the consolidation of acute services on the Lincoln Hospital site it should be possible to drive improvements in these clinical standards and therefore the care that patients receive.

12.2.18 A key factor in achieving this will be not providing two acute stroke units; one that is borderline on the critical mass (600 strokes) for the minimum number of strokes per year and one that is below the recommended critical mass. For the latter, even when factoring in demand growth it is unlikely to achieve the critical mass over the next 5-10 years.

12.2.19 A single acute stroke service at Lincoln hospital would treat over 900 strokes a year, which would ensure staff have enough clinical and institutional learning experience to maintain their own skills and expertise. This in turn would make the service more attractive to doctors and nurses to work in and would support addressing some of the key workforce challenges faced.

12.2.20 Such an improvement in outcomes for patients by consolidating services is also seen in other services such as for heart attack patients. Lincolnshire residents have already experienced this through the establishment of the Lincolnshire Heart Centre at Lincoln Hospital.

12.2.21 In 2013 the Lincolnshire Heart Centre opened, underpinned by a £4.3m investment in a new facility. Since it opened 1000 lives have been saved by patients being treated at the specialistcentre. The latest statistics from the National Institute for Cardiovascular Outcomes Research(NICOR) show the centre outperforming all of the national targets.

12.2.22 Anyone suffering a heart attack caused by blockage of an artery is treated by using a balloon catheter called an angioplasty. The national target is 150 minutes for all patients to receive this treatment from first 999 call to when the balloon is inflated. Nationally, 75% of patients are treated within this window. In Lincolnshire, despite the large geographical area and road network, 85% of patients are treated within the timeframe.

12.2.23 On average it takes the specialist team just 32 minutes from the moment a patient arrives in the ambulance at hospital to open the artery – national average is 40 minutes. Patients spend on average 2 days at Lincoln County Hospital, whereas nationally it is 3 days.

12.2.24 30-day mortality for patients who have suffered a heart attack (STEMI/nSTEMI combined) has fallen from 13.8% to 5.4%.

12.2.25 Specifically in the context of the temporary changes made by ULHT to consolidate hyper-acute stroke on the Lincoln Hospital site in response to the additional pressures put on the ULHT stroke service by the COVID-19 pandemic, a number of useful insights have emerged (based on information April to September 2020):

- Patient feedback has been good with only 3 negative comments via Care Opinion in 6 months. Comments related to poor communication with patient regarding reason for transfer from Boston ED to Lincoln Hospital site for Stroke care.
- All eligible patients for Thrombolysis were treated within the clinical window.
- All eligible patient for mechanical thrombectomy met the travel times and onward transfer to a tertiary centre. Since April 2020 9 patient were sent for mechanical thrombectomy (3 of whom were from the Boston catchment area, in contrast to a single patient in the preceding period from the start of the service at Queens Medical Centre Nottingham).

Access

12.2.26 Pilgrim Hospital currently treats 497 strokes a year (19/20), those patients transported to Pilgrim Hospital by ambulance generally originate from Boston, Mablethorpe on the east coast and Spalding to the south.

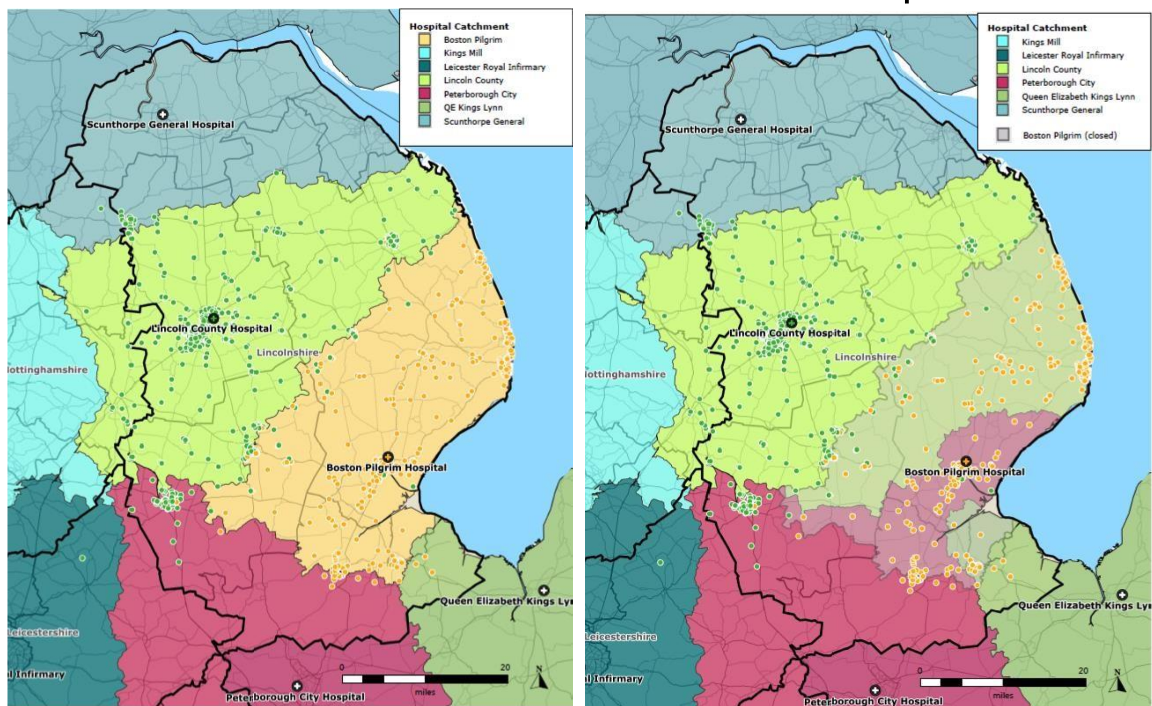
12.2.27 Once fully implemented the preferred option to consolidate stroke services at Lincoln Hospital will displace all 497 stroke patients currently seen at Pilgrim Hospital. In the proposed model of consolidated hyper-acute and acute stroke services at Lincoln Hospital, the patient pathway will see patients with FAST positive symptoms who would have previously gone to Pilgrim Hospital taken directly to the nearest A&E Department by the ambulance service.

12.2.28 For patients who self-present at the Pilgrim Hospital A&E department, they will be assessed and transferred to Lincoln Hospital by ambulance for treatment if their symptoms indicate a diagnosis of stroke.

12.2.29 The maps below show the current hospital catchment areas for stroke patients and what the hospital catchment areas would expected to be for stroke patients if hyper-acute and acute stroke services were consolidated at the Lincoln Hospital site, once fully implemented.

Figure 160 – Hospital catchment areas: current and proposed preferred option

Current | **Preferred Option**



12.2.30 These are derived from analysis and modelling completed by Operational Research in Health Ltd (ORH) on potential changes to stroke services at Pilgrim Boston Hospital in 2018. Approximately 50% of the Pilgrim Hospital patients would be taken to Lincoln Hospital and the others would be transported out of county, mostly to Peterborough.

12.2.31 ORH used a combination of East Midlands Ambulance Trust data and data on FAST-positive stroke patients from Lincolnshire. Travel time analysis was undertaken to quantify the base position for Pilgrim Hospital patients and how travel times would be expected to change if changes to services occur. Travel times were based on blue-light speeds.

12.2.32 Under the proposal of consolidating acute stroke services at Lincoln Hospital, it is estimated the average travel time by ambulance to an acute stroke unit for stroke patients who would have gone to Pilgrim Hospital will increase from 23m58s to 44m28s (increase of 20m30s on average). This is based on the assumption patients attend their nearest unit.

12.2.33 In 2015 the predecessor programme to ASR, LHAC, prescribed and agreed the level of activity which should be accessible within three different time thresholds. The three thresholds were 45 minutes (A&E, maternity and non-elective paediatrics), 60 minutes (all other non-electives and outpatients) and 75 minutes (elective paediatrics, day case surgery and elective surgery).

12.2.34 Stroke services fall into the 60-minute threshold, as other non-elective services, and the travel time analysis conducted estimated that under the proposal where stroke services are consolidated at Lincoln Hospital no patients would travel over 60-minutes. Assuming patients travel to their nearest acute stroke unit.

12.2.35 A sensitivity analysis was conducted on the number of patients travelling over 60-minutes if stroke services were consolidated at Lincoln Hospital. This estimated that even with patients travelling to their nearest acute stroke unit plus a 15-miunte threshold preference for Lincoln County Hospital, no patients would travel over 60-minutes (increase in average travel time of 22m53s). It is estimates around 75% of Pilgrim Hospital patients would attend Lincoln Hospital under this scenario.

12.2.36 The sensitivity analysis estimated patients would still not travel more than 60-minutes when the threshold was increased to 20-minutes. Under this scenario the average increase in travel time to hospital is 23m07s, compared to 20m30s if there is no preference.

12.2.37 The table below provides a summary of the estimated impact on the number of patients displaced and associated travel times by ambulance when the preferred option is fully implemented (based on 19/20 activity and forecast 23/24 activity). This includes a sensitivity analysis relating to patients not attending the nearest hospital.

Figure 161 – Displaced stroke activity and impact on travel times

	Lincoln Hospital		Pilgrim Hospital		Peterborough Hospital		QE Kings Lyn Hospital	
	19/20	23/24	19/20	23/24	19/20	23/24	19/20	23/24
Patients attend nearest hospital								
Stroke Activity	+236	+246	-497	-517	+226	+235	+35	+36
Travelling +60 mins.	0	0	0	0	0	0	0	0
Sensitivity Analysis – nearest hospital +5mins								
Stroke Activity	+277	+289	-497	-517	+185	+192	+35	+36
Travelling +60 mins.	0	0	0	0	0	0	0	0
Sensitivity Analysis – nearest hospital +10mins								
Stroke Activity	+338	+352	-497	-517	+124	+129	+35	+36
Travelling +60 mins.	0	0	0	0	0	0	0	0
Sensitivity Analysis – nearest hospital +15mins								
Stroke Activity	+376	+392	-497	-517	+86	+89	+35	+36
Travelling +60 mins.	0	0	0	0	0	0	0	0

NOTE: Forecast is based on average annual growth rate of 0.97% p.a.

12.2.38 A number of stroke patients currently transferred to Boston Hospital are from the most deprived wards, as defined by the Index of Multiple Deprivation (IMD), around Skegness and some areas of Boston. There are also pockets of demand in less deprived wards around Coningsby and Woodhall Spa.

12.2.39 The ORH analysis identified the majority of wards which account for the highest 10% of IMD scores in Lincolnshire currently have travel times of over 30-minutes, with an average of c.35m32s. ORH also modelled the scenario of Pilgrim Hospital stroke services being consolidated at Lincoln Hospital, which estimated all of these wards experience an increase in average travel time to hospital, with an average increase of c.21m39s (based on attending nearest hospital).

12.2.40 The ORH modelling identified that under the scenario where Boston Hospital stroke services are consolidated at Lincoln County Hospital, the change in travel time is generally similar regardless of the IMD group. But the most deprived wards still have the longest travel time.

12.2.41 The analysis and modelling completed by ORH on potential changes to stroke services at Pilgrim Boston Hospital in 2018 was re-run in 2021 with more recent data. The findings were very similar to the original analysis, including the modelling identifying no patients would travel over 60 minutes by ambulance (including when a threshold preference of 20 minutes is set for Lincoln County Hospital). The original report and more recent report, which includes a comparison of findings between the two reports, are included in Appendix F.

12.2.42 During the various public engagement exercises that have taken place a number of people, particularly in the Boston area, raised some concern about travel time for people with symptoms of a suspected stroke if the service was no longer provided at Pilgrim Hospital.

12.2.43 Something in particular that was raised was the ‘golden hour’. The conversations highlighted there were differing views amongst the public about what the ‘golden hour’ referred to, with many thinking of it in the context of the core principle of rapid intervention in trauma cases, rather than the specific golden hour for administering thrombolysis treatment.

12.2.44 The golden hour is often used to refer to the period of time following a traumatic injury during which there is the highest likelihood that prompt medical and surgical treatment will prevent death. While initially defined as an hour the exact time period depends on the nature of the injury, and can be more than or less than this duration. It is well established that the person’s chances of survival are greatest if they receive care within a short period of time after a severe injury; however, there is no evidence to suggest that survival rates drop off after 60 minutes.

12.2.45 The golden hour for stroke services refers to the door to needle time i.e. from the patient arriving in hospital to administering the thrombolysis treatment. It is a target and has no clinical significance to outcome. The sooner the treatment is given, the better the chance of a better outcome for those who are going to benefit from the treatment. Not everybody can have the treatment as it depends on the type of stroke, around 15% of all patients can receive this treatment and of these one third (5% of total) will benefit.

12.2.46 There is a 4.5-hour limit in the national clinical stroke guidance that refers to the time within which thrombolysis treatment can be administered with the current licence. This is more relevant to clinical practice, but it starts from the time of onset of stroke symptoms or from when the last time the patient was seen well. When discussing the preferred option for stroke services with the public this was explained.

12.2.47 In this context of the ’60-minute door to needle time’ and ‘4.5-hour limit for the time in which thrombolysis can be administered’ it is important to note the local experience of consolidating heart services on to the Lincoln Hospital site to create the Lincolnshire Heart Centre and what can be achieved:

- On average it takes the specialist team in Lincoln Hospital just 32 minutes from the moment a patient arrives in the ambulance at hospital to open the artery – national average is 40 minutes.
- The national target is 2.5 hours for all patients to receive angioplasty from first 999 call to when the balloon is inflated. Nationally, 75% of patients are treated within this window. In Lincolnshire, despite the large geographical area and road network, 85% of patients are treated within the timeframe.

12.2.48 The NHS Lincolnshire CCG fully recognises its duty to reduce inequalities in respect of access to health services and that the proposals will have an adverse impact on travel times for some people from areas of high deprivation.

12.2.49 Given the evidence of the impact of centralising hyper-acute stroke care (including the impact of temporary changes to ULHT’s stroke services in light of Covid on its SSNAP scores), it has been concluded the clinical benefits and outcomes outweigh the impact of increase geographical distance. However, it should be recognised that the travel time analysis identified that all patients displaced would still be within 60-minutes travel time of a hyper-acute stroke unit.

12.2.50 It should also be recognised that central to the preferred model for acute stroke services is an enhanced community service that will enable a shorter length of stay in hospital following a stroke. This would support patients to return back to their own communities much faster than they currently do.

12.2.51 This approach fully aligns with the feedback received from the public during the various engagement exercises. A common theme arsing in these discussions was the public thought it was important that patients should be able to undergo rehabilitation and ongoing care nearer their homes.

12.2.52 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.

12.2.53 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.

12.2.54 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

12.2.55 Currently there are 28 stroke beds in the Lincoln Hospital stroke unit and 28 in the Pilgrim Hospital unit, however only 24 beds are open at the latter due to nurse shortages.

12.2.56 To inform the number of stroke beds required at Lincoln Hospital under the preferred model to consolidate acute stroke services on that site an analysis has been conducted based on three key factors:

- Activity growth rate;
- Preference for hospital site; and
- Average length of stay

Figure 162 – Future stroke service bed requirement at Lincoln Hospital 2023/24

Lincoln Hospital bed requirement under preferred option				
	Current	Current av. LoS	10 day av. LoS	7 day av. LoS
Based on ONS all age growth (19/20-23/24: 2.17%)				
Nearest	*28*	*43*	28	20
Nearest + 5mins	*28*	*45*	30	21
Nearest + 10mins	*28*	*47*	32	22
Nearest + 15mins	*28*	*48*	33	23
Based on av. annual growth rate (19/20-23/24: 3.88%)				
Nearest	*28*	*44*	29	20
Nearest + 5mins	*28*	*46*	30	21
Nearest + 10mins	*28*	*48*	32	23
Nearest + 15mins	*28*	*49*	33	23
Based on ONS 65+ growth rate (19/20-23/24: 6.70%)				
Nearest	*28*	*45*	29	21
Nearest + 5mins	*28*	*47*	31	22
Nearest + 10mins	*28*	*49*	33	23
Nearest + 15mins	*28*	*51*	34	24

12.2.57 The factor that has the biggest impact on the required bed capacity for a consolidated acute stroke unit at Lincoln Hospital is average length of stay. The ambition is to move to an average length of stay of 7 days supported through an enhanced discharge service.

12.2.58 However, based on the evidence from Northampton and Peterborough that have implemented the enhanced community model a 7-day length of stay in the acute setting may not be achieved straight away. Therefore, the bed capacity for the proposed future model has been based on an average length of stay of 10 days.

12.2.59 Although care should be taken when comparing data between 2019/20 and 2020/21 given the impact Covid-19 had on peoples behaviours and the changes in patient pathways, the average length of stay at Lincoln County hospital reduced from c.15 days to c.13 days between these two years, which coincided with the consolidation of hyper-acute stroke services on the Lincoln Hospital site. With the average length of stay in some months below 10 days.

12.2.60 The factor that has the second largest impact on the required bed capacity for the proposed model of care is hospital site preference. Given within the 15-minute site preference scenario for Lincoln Hospital it is estimated patient travel times will not exceed 60 minutes, to strike the optimum balance of ensuring sufficient capacity at Lincoln Hospital and the impact on out of county hospitals this scenario has been used as the basis for the future bed capacity requirement.

12.2.61 The factor that has the least impact on the required bed capacity is the activity growth rate. The future bed capacity requirement has been based on the average annual growth rate.

12.2.62 Drawing the chosen assumptions for these three factors together gives a future bed requirement of 33 acute stroke beds on the Lincoln Hospital site to deliver the preferred model.

12.2.63 When giving consideration to the future capacity requirements for a consolidated acute stroke service at Lincoln Hospital, as well as the stroke activity consideration needs to be given to mimic activity.

12.2.64 It is estimated that currently at Lincoln Hospital mimics use around 2 beds a year and around 2.7 beds at Pilgrim Hospital. Under the proposed model for acute stroke services it is estimated that Lincoln Hospital would need an additional 1.3 beds for mimics if patients attend their nearest hospital and an additional 2 beds if a 15-minute preference for Lincoln Hospital is applied.

12.2.65 Based on mimics requiring 2 beds, this gives a total bed requirement of 35 beds for the proposed model to consolidate acute stroke services on the Lincoln Hospital site.

12.2.66 Currently significant workforce gaps also exist across ULHT stroke services against recommended clinical standards, In particular in stroke consultants across the whole service and in nursing at Pilgrim Hospital.

12.2.67 The proposed future model of acute stroke services supports a more sustainable and resilient workforce, particularly in the medical consultant and nursing groups, by:

- A reduction in a heavy reliance on locum and agency staff
- Increases the chances of recruiting to substantive roles if the service is based at Lincoln Hospital alongside other specialist services
- Avoids having to spread 6.0 consultants across two sites
- Supports a concentration (through service consolidation and the provision of fewer beds) of nursing staff at the Lincoln site, where there are currently fewer vacancies than at the Pilgrim site

12.2.68 The table below sets out the current hospital based stroke service workforce model (funded establishment) together with the workforce model under the proposed preferred option.

Figure 163 – Stroke services workforce model (funded establishment)

Staff Group	Current configuration		Preferred Option	
	Lincoln Hospital	Pilgrim Hospital	Lincoln Hospital	Pilgrim Hospital
Medical				.
• Consultants	3.0	3.0	6.0	-
• Associate Spec.	1.0	1.0	2.0	-
• F2 (Trust)	-	1.0	1.0	-
• F2 (Deanery)	1.0	-	1.0	
• F1 (Trust)	-	1.0	1.0	
• F1 (Deanery)	1.0	1.0	2.0	
• GPVTS (Deanery)	1.0	-	1.0	
• Core Trainee (Deanery)	-	1.0	1.0	
• Administration	2.0	2.66	4.66	
ACP				
• Nurse ACPs			5.80	-
Nursing				
• Registered	26.90	23.24	51.08	-
• Nursing Associate	2.00	4.0	-	-
• Non Registered	15.32	11.26	21.04	
• Ward Clerk	1.0	2.0	1.4	
AHP				
• Physio/OT/SALT	39.36		33.67	

12.2.69 As there will no longer be a stroke service at Pilgrim Hospital, staff will be offered the opportunity to transfer to Lincoln Hospital, or to be re-deployed within another department at the Pilgrim Hospital.

12.3 Stroke Early Supported Discharge (ESD) Service

12.3.1 Between the start and end of 2019/20 the 12 month rolling average length of stay across ULHT for stroke patients reduced from 16.1 days to 13.6 days. At Lincoln Hospital the reduction was 16.5 days to 14.4 days, looking at individual months the lowest average length of stay was 10.6 days. At Pilgrim Hospital the rolling average length of stay reduced from 13.8 days to 12.1 days, the lowest average length of stay for an individual month was 11.5 days.

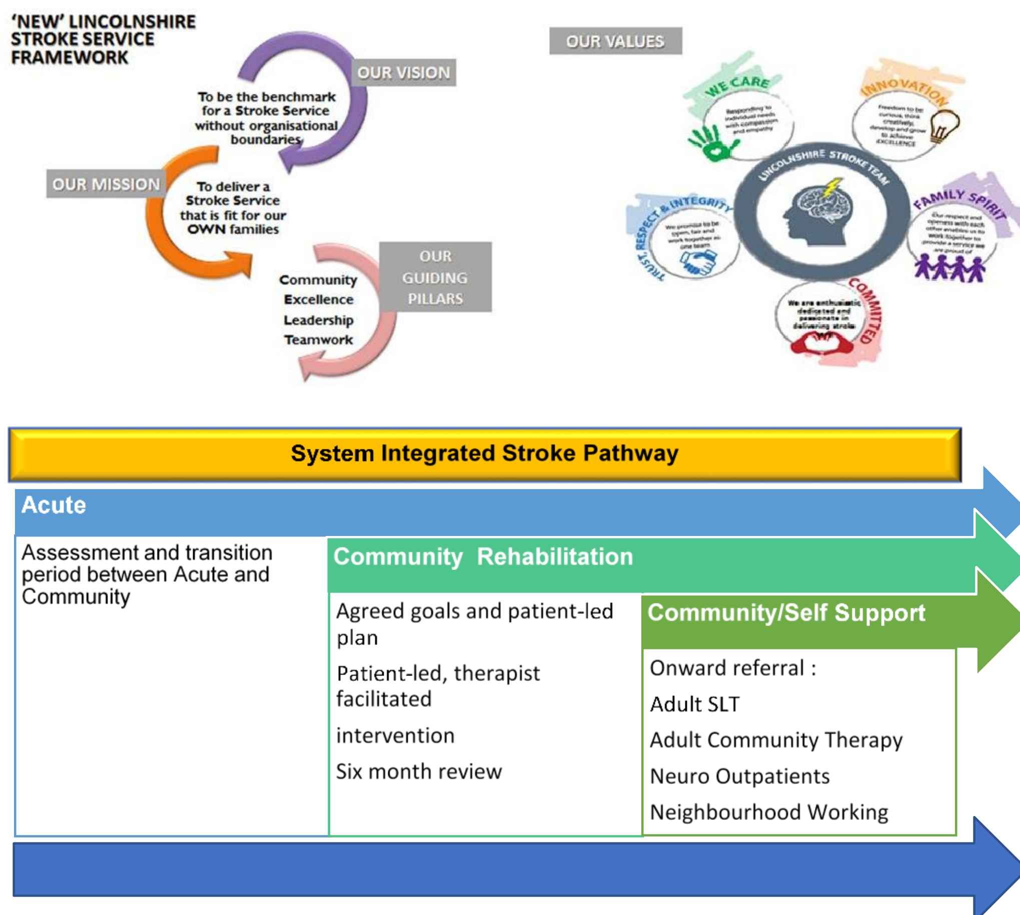
12.3.2 During 2019 significant work took place to re-define and agree how an enhanced stroke rehabilitation service should function and what resources would be required. This aligned to the national recommendations regarding enhanced community stroke services set out in the NHS Long Term Plan.

12.3.3 From the outset it was agreed that there should be an integrated stroke rehabilitation service that worked across both community and acute care with a multi-organisational/multi-professional project group established to drive the work forward.

12.3.4 Simultaneously Organisational Development (OD) work commenced to bring the separate teams together and agree how an integrated service would be established. The aim throughout has *been 'To establish an integrated, seamless pathway and a community based stroke rehabilitation service that is able to support ALL stroke survivors, operating 7 days a week'*.

12.3.5 As part of this process a clear vision, mission and guiding principles were collectively developed and agreed.

Figure 164 – Overview of proposed enhanced community stroke model



12.3.6 Towards the end of the OD work the teams were keen to 'test' out how the new, agreed stroke rehabilitation pathway would operate, thus it was agreed to utilise rapid improvement methodology, 100-day approach, to do this.

12.3.7 Between October 2019 and January 2020 three teams worked together across the pathway with the following change achieved:

- Supported a reduction in length of stay (LoS) on the Stroke Unit in Lincoln County
- Launched the Lincolnshire Stroke YouTube Channel
- Launched a Patient Handbook that travels with the patient from acute to community and beyond
- Initiated a dedicated Stroke Orthoptic clinic
- Started acute/community staff rotational work experience
- Begun the SAM2 trial linked to timely discharge
- Enabled (hospital) WebV access for Social Care colleagues
- Initiated a trial for single assessment and single transfer form
- Piloted 'Living Well After Stroke' Groups

12.3.8 This enhanced community service will:

- Support all stroke survivors across Lincolnshire to receive their rehabilitation within their local community wherever possible;
- Work with the hyper-acute/acute stroke service to deliver an average length of stay of 7 days;
- Ensure a clear route back into specialist care for patients once discharged from the service;
- Offer a 6-month review to all stroke survivors;
- Support new professions to the Lincolnshire Stroke pathway in a community setting e.g. dietetics and psychology;
- Embed the Stroke Association team into the new Lincolnshire Stroke Service; and
- Improve efficiencies in the system through improved outcomes e.g. reduced hospital utilization, reduced social care costs over the medium to long term.

12.3.9 The service will link in closely with the Neighbourhood Teams, who will provide the requisite nursing, social care support and on-going 'self-care' options and support for stroke survivors.

12.3.10 The service will support community hospitals, which will be health & wellbeing hubs providing different levels of care under one roof, making the most effective use of inpatient and ambulatory services offered locally, including rehabilitation, reablement and palliative care services.

12.3.11 At present between four and six stroke survivors per week are discharged into a community bed, which is expected to continue. However, the overriding principle for this work is 'home first' and as the enhanced community stroke service embeds and integrates into Neighbourhood working the ability to support complex survivors at home is expected to increase.

12.3.12 The increase in the community stroke service team to deliver this service is set out in the table below.

Figure 165 – Proposed staffing increase to community stroke team

Staff group	Current service	Proposed increase
Occupational Therapy	8.63	1.78
Physiotherapy	15.72	2.26
Speech and Language Therapy	3.90	2.25
Rehabilitation Assistants	17.70	6.00
Dietician	0	1.0
Clinical Psychologist (specialising in Stroke)	0	1.0
Assistant Psychologist	0	1.0
Total	*45.95*	*15.29*

12.4 East Midlands Clinical Senate recommendations and workforce improvements

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

12.4.2 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.

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

Figure 166 – East Midlands Clinical Senate recommendations and progress

EM Clinical Senate Recommendation	Progress
Ensure the clinical guidelines for the management of patients with a Transient Ischaemic Attack (TIA) are met	All high risk patients will be offered an appointment at Lincoln County Hospital the next day, as per national guidelines. There would be two follow-up stroke and TIA clinics a week at Boston Hospital for local patients (e.g. post-discharge) and some low risk patients attending with TIA symptoms could be seen there These clinics will rotate for all clinicians, unless some express preferences for them. There is scope for more clinics if the demand is there. It is the intention that a once a month clinics in Louth, Skegness and Gainsborough will be established one the demand has been ascertained. Skegness is the highest priority
The EM Clinical Senate reflected Lincolnshire is well placed on the East Coast for a clinical trial around early (in ambulance) stroke management – this could be explored further	The service is not aware of any work of this type locally

12.5 Quality and Equality Impact Assessments

12.5.1 A Quality Impact Assessment (QIA) has been completed for the proposed service change for stroke services to identify clinical risks to the reconfiguration. This has been completed using a standard template and assured by the Head of Nursing Services for Medicine.

12.5.2 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.

12.5.3 A summary of the QIA for the proposed changes to stroke services is set out below and the full version is included in Appendix I.

Figure 167 – Summary of QIA for proposed stroke service changes

Area	Summary Impact(+ve & -ve)	Summary Actions
1. Quality		
Duty of Quality	▪ Perceived reduction in access ▪ Quality of care is anticipated to improve ▪ Specialist centre should attract candidates from further afield ▪ Boston staff unable to relocate may seek alternative employment, but could also fill vacancies at Boston Hospital	▪ Comprehensive communication strategy and robust consultation ▪ Staff consultation ▪ Asses impact on future staffing numbers
Patient Safety	▪ Risk medics and nurses from Boston Hospital do not relocate to Lincoln.	▪ Staff consultation ▪ Assess potential impact on future staffing numbers ▪ Recruitment and retention strategy ▪ Supervised training time built into future rotas to rapidly upskill staff
2. Experience		
Patient Experience	▪ Quality of care not anticipated to be impacted at all ▪ Increase travel distance for relatives based on east coast may be negatively reflected in patient satisfaction surveys ▪ Lack of local in-patient service may cause dissatisfaction with residents local to Pilgrim Hospital. ▪ Limit choice of in-patient care to single ULHT site with potential for patients to wish to receive treatment in surrounding trusts	▪ Comprehensive communication strategy and robust consultation process regarding service changes ▪ Communicate benefits of a single site centre of excellence
Staff Experience	▪ Potentially positive impact being able to recruit to a specialist centre may make posts more attractive ▪ Staff who do not wish to transfer from Pilgrim Hospital could increase turnover rate ▪ Could establish a more robust workforce at Lincoln Hospital improving retention and sickness rates	▪ Strong recruitment campaign to market Trust and benefits or working in a specialist centre ▪ Communicate benefits of a single site centre of excellence
3. Effectiveness		
Clinical Effectiveness & Outcomes	▪ Build on evidence based proactive already in place to drive improvement in SSNAP ▪ May impact on very small numbers of patients who may not meet time critical element to support thrombolysis ▪ Proposed model assumes enhanced community rehab service will be in place ▪ A consolidated inpatient unit will be more cost effective ▪ Recruitment is anticipated to be easier, thus reducing reliance on agency locum cover at Boston	▪ Clear clinical messages for patients as part of a well-planned consultation process ▪ Ensure robust bed modelling of required acute and community capacity ▪ Development of robust recruitment plans ▪ Development of clear service/staff integration plans

12.5.4 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.

12.5.5 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 mainproviders (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.

12.5.6 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.

12.5.7 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 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.

12.5.8 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.

12.5.9 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.

12.5.10 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.

12.5.11 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.

12.5.12 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.

12.5.13 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 and Economically Disadvantaged

12.5.14 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.

12.5.15 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.

12.5.16 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.

12.5.17 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.

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

- Age:
    - Possible negative impacts of the stroke service change proposals on the older population include; concerns of greater reliance on family and friends for increased travel needs, longer travel requirements which is impractical, reliance on public transport, which is perceived to be limited in accessibility.
    - Possible negative impacts of this proposed change on the younger population include; negative impact on health, reliance on public transport, which is perceivedto be limited in accessibility
- 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 costsof return travel from hospital, especially at times of limited/no public transport.

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

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

12.5.21 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 168 – Summary of EIA for proposed stroke service changes

Impact / issue identified	Key actions or justification to address impact/issues	Anticipated outcome – will this remove negative impact
1. Longer travel requirements	▪ As an inpatient service longer travel times are likely to be only experienced upon admission and discharge. This specifically impacts on those patients who currently access stroke services at Pilgrim Hospital. ▪ Estimated c.500 patients a year displaced - travel analysis has modelled that under the preferred option no patients are estimated to travel over 60-minutes (the agreed threshold for this type of activity), assuming they travel to their nearest acute stroke unit by ambulance. ▪ The majority of patients who access acute stroke services are likely to arrive at hospital by ambulance. Upon discharge if the patient has a healthcare need or meets the ULHT transport support criteria transport support will be provided. ▪ Community care (including follow-up and routine appointments) will not be affected by this model, in fact they will be enhanced enabling patients to return home sooner.	• No. For some patients there may be longer travel times, but this is balanced against improved service quality. • For those with health needs on discharge or meet the ULHT transport support criteria transport support would be provided. • Patients would return home sooner.
2. Negative impact on health	▪ Evidence has shown that the centralisation of hyper-acute stroke services has a positive impact on health outcomes, including reduced mortality, improved provision of evidence-based interventions and reduced lengths of stay. ▪ The more sustainably staffed, multi-disciplinary care provided at the Lincoln site upon arrival will improve the care received immediately and throughout admission, with improved community care ▪ Temporary measures instigated due to Covid which include consolidation of hyper-acute stroke unit on the Lincoln Hospital site have demonstrated an improvement in care quality (SSNAP audit)	• Yes. Proposed service should have a positive impact on health and provide improved health outcomes across the county • Admission duration should also be reduced that has benefits to a patient's wider health and wellbeing.

3. Greater reliance on family and friends forincreased travel needs
4. Greater reliance on public transport, which is perceived tobe limited in accessibility
5. Concerns about costsof travel to and from hospital, especially attimes of limited/ no public transport
	▪ Acute stroke services will be consolidated on the Lincoln Hospital site. A service will no longer be provided from Pilgrim Hospital
	▪ People currently receiving care at Pilgrim Hospital will on average experience an increase in travel time to an alternative hospital
	▪ The vast majority of patients admitted into an acute stroke unit are through an unplanned attendance and admission, and are therefore likely to present at hospital in an ambulance, as opposed to using their own transport
	▪ Upon discharge, if the patient has a health care need or meets the ULHT transport support criteria then transport will be provided on their return journey home and there will be no need for reliance on friends and family or public transport:
	  ▪ 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.
		• 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 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.

12.6 Vignettes to demonstrate the positive impacts of the clinical model

Patient 1

12.6.1 A 65 years old male who lives with his wife in Sibsey suffers alarming symptoms whilst playing bridge at his local bridge club. An ambulance is called and arrives at the bridge club, the paramedic observes the patient displaying FAST (Facial dropping, Arm weakness, Speech difficulties, T; Time to call emergency services) positive symptoms, a sign that he may be having a stroke.

12.6.2 The ambulance takes the patient directly to the hyper-acute stroke centre at the Lincoln County Hospital where the patient immediately has diagnostic tests on arrival at the hospital, following which a diagnosis of stroke is confirmed and he is admitted to the Stroke Unit. Given the co-location of the hyper-acute stroke unit with the Cardiology team at Lincoln County Hospital, the patient benefits from use of the Cath Lab facilities to directly access acute imaging thus bypassing A&E and reducing the assessment time.

12.6.3 As the patient has a stroke with a blood clot involved, he is given an injection to thrombolyse the clot within one hour of the scan confirming his diagnosis.

12.6.4 The patient stays in the hyper-acute stroke part of the stroke unit for 72 hours, and is then moved to the acute stroke part of the stroke unit to start intensive therapy. The patient's wife visits him at Lincoln County Hospital every day. The patient's wife is unable to drive herself there or access public transport, however transport is provided by volunteer drivers.

12.6.5 After eight days of being in the Lincoln County Hospital stroke unit, the patient is discharged to the Lincolnshire Community Health Service enhanced rehabilitation service closer to his home in Sibsey, where all of his continuing therapy treatment is delivered.

12.6.6 Outcomes, following liaison with the ICT may be:

- The patient's diagnostic tests, treatment and therapy is delivered in line with national best practice and meets all of the national performance standards. The patient received a 7-day service / ward rounds from the Stroke consultants.
- The Stroke team at Lincoln County Hospital work together efficiently and effectively, drawing in support from the Cardiology team as required, to deliver the best care and outcomes for the patient.

Patient 2

12.6.7 A patient has a left partial anterior circulation infarct and is admitted to hospital, and subsequently repatriated to a local hospital for further rehabilitation.

12.6.8 The Multi-Disciplinary Team on the acute ward is unsure as to whether or not a care package is required, so an access visit is completed by the community team after arrival at the local hospital. Support is given to the patient's wife to familiarise her with the equipment required and the support available on discharge from the therapy team.

12.6.9 The patient and their wife agree to discharge with no care package, and the patient is discharged home with downstairs living initially as he is unable to use the stairs. An initialphysiotherapy review in the patient's home is completed within 24hrs and confirms no requirement for community team to support with personal care.

12.6.10 During this visit advice on strategies to reduce risk of falls, particularly in the night, is provided and a care plan for the patient is developed to work on strength, balance and mobility. A total of 44 face to face visits are provided, a combination of speech, occupational therapy and physiotherapy.

12.6.11 Outcomes:

- The patient's stamina in walking improves, they return to sleeping upstairs and explore options to return to driving.
- Onward referrals are made for neuro outpatient physiotherapy, regional driving assessment centre and Stroke Association for ongoing support.
- Care professionals give emotional support to the patient and their wife throughout anda good rapport is built. The patient gives positive feedback to the therapy staff.

Patient 3

12.6.12 A patient has a right total anterior circulatory infarct and spends time in intensive care, followed by a prolonged period of time in hospital and then a local community hospital before being discharged home.

12.6.13 A treatment plan is put in place for the patient that includes engaging more with transfers from lying to sitting, improving the quality of Sara Stedy transfer and being able to manage toileting, working on the management of clonus, supporting the care agency with the moving and handling plan, teaching carer techniques of stretches to left side to maintain soft tissue length and advising and supporting long term carers with moving and handling and equipment training, personal care and dressing techniques.

12.6.14 Outcomes:

- The patient's wife is taught to complete muscle stretches prior to transfers to reduce colonus, and the patient practices transfers using Sara Stedy with care agency staff.
- A referral is complete to spasticity clinic for assessment and a referral is made to the Stroke Association for ongoing support.
- The hospital stroke consultant is liaised with for medication review regarding high tone/pain management.

12.7 Assessment against tests for service change

12.7.1 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 be assessed against the Government's four tests for service change and NHS England and Improvement's test for reductions in hospital beds.

12.7.2 An assessment against these tests for the proposed change to consolidate acute stroke services at Lincoln Hospital has been conducted and is set out below. This assessment reflectsand aligns to the description and narrative for the preferred option for acute stroke services set out in this chapter.

Test 1: Strong public and patient engagement

12.7.3 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 stroke services.

12.7.4 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. The main themes that arose in relation to stroke services were:

- The provision of specialist care for stroke patients was seen as critical, however there were also concerns about journey times for patients experiencing a stroke, as well as queries around rehabilitation and recovery.
- The need to achieve a 'balance' between quality and travel times. In other words, although attendees felt that the quality of care received on arrival at hospital was extremely important, they also felt its value depended on patients being able to access the care quickly enough. For this reason, reassurances were sought that ambulance staff would be suitably equipped and trained to look after people on the journey to hospital.
- Concerns and queries were around rehabilitation, which was identified as a key area in the treatment of stroke patients. Specifically, many participants felt it was important that patients should be able to undergo rehabilitation and ongoing care nearer their homes.
- In summary there was a widespread view that the centralisation in order to provide specialist, expert standards of care is reasonable, albeit with a need to balance these advantages against the possible negative impacts of increased travel times. There was also a strong view that services should be backed up with improved rehabilitation and robust follow-up and outpatient services in the local community.

12.7.5 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 in relation to stroke services included:

- 31% or respondents were prepared to travel 0-15 minutes to a specialist stroke unit; 39% were prepared to travel 15-45 minutes; 17% were prepared to travel 45-60 mins;and 13% were prepared to travel over an hour.
- 64% or respondents said they would travel to a hospital appointment by car; 13% by public transport; 3% patient transport; 4% taxi; and 15% friend or family.
- When asked about a set of statements and which was most important in relation to stroke services:
    - 26% said 'I will be offered care closer to home when appropriate'
    - 22% said 'I will receive specialist care even if that means I will need to travelfurther'

12.7.6 In October 2018 four public options evaluation workshops were undertaken across Lincolnshire in Sleaford, Mablethorpe, Bourne and Gainsborough to enable members 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 this event two proposals for thefuture provision of acute stroke services were considered: consolidating acute stroke services at Lincoln Hospital and providing acute stroke services at Lincoln and Pilgrim Hospital.

- Overall the proposal to consolidate acute stroke services at Lincoln was felt to satisfythe criteria best (64% of respondents).
- It was felt the consolidation of acute stroke services at Lincoln Hospital best met the quality (92%) and deliverability (95%) criteria – this was the case in all four areas where events were held.
- However, views were fairly evenly split in relation to access and a very small majority (53%) felt providing acute stroke services at Lincoln Hospital and Pilgrim Hospital was better in terms of affordability.
- A majority in all four areas where the events were held felt consolidation of acute services at Lincoln Hospital best satisfied the criteria in terms of quality and deliverability.
- Those in the Bourne, Mablethorpe and Sleaford groups were concerned about whether patients would receive treatment within the 'golden hour'.
- Participants debated the issue of affordability to consolidate acute stroke services on the Lincoln Hospital site. It was also suggested consolidating services into one unit would attract more specialist staff, improve the quality of services and patient care andreduce the current reliance on and cost of using agency staff.

12.7.7 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 stroke service change proposals identified the following key themes:
    - 'Golden Hour' not achievable from some parts of the county
    - Consideration of population need by locality before determining locations of service – distance, accessibility and transport challenges
    - No mention of step down / rehabilitation and scope to link mental health support
    - Assurance is needed around ambulance response times
    - Overburdening the Lincoln Hospital site
    - Loss of services at Pilgrim
    - Transport issues need addressing before any services are relocated

- Feedback from a workshop held in Boston relating to stroke services highlighted themes relating to:
  - Travel times and ambulance transfers to Lincoln Hospital
  - Treatment times for patients suffering a stroke
  - Ambulance performance and targets
  - Stroke care in the community
- 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.

12.7.8 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 was set out. The Committee considered the proposal to consolidate acute stroke services on the Lincoln Hospital site on 12June 2019 and submitted initial comments on 4 July 2019. These were:

- Acceptance that the preferred option had been developed in line with the national clinical guidelines.
- Acknowledgement of significant workforce gaps against clinical guidelines for staffing levels and recruitment to a centre of excellence for acute stroke services aimed to recruit and retain staff.
- Welcome for proposal for enhanced community stroke rehabilitation service as part of the emerging option.
- Acceptance of the benefit of a centre of excellence, but concern recorded on the travelling times to the Lincoln Hospital site for patients across the county.
- Concern on that the patients from Pilgrim Hospital that would be displaced to North West Anglia NHS Foundation Trust.

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

12.7.9 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.

12.7.10 The guidance goes onto 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.

12.7.11 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 stroke service model.

12.7.12 Consolidating acute stroke services at Lincoln Hospital will reduce the number of locations fromwhich these services are provided (the number of providers is not reducing under the change proposals). However, there is a compelling case to reconfigure and centralise acute stroke services to improve the quality, safety and sustainability of services and make best use of available resources. Key drivers of change are the current performance in the national stroke audit, currently having two stroke units one slightly above the recommended yearly activity levels and one below and significant challenges in appropriate consultant and nursing workforce.

12.7.13 The consolidation of acute stroke services onto one hospital site would be supported by an enhanced community stroke rehabilitation service to enable more people to be discharged sooner from hospital and return to their home and communities earlier. Thereby improving access to care closer to home. Improved access to community rehabilitation services was a consistent message through the public engagement programme.

Test 3: Clear clinical evidence base

12.7.14 The development of the case for change for acute stroke services has been led by the ULHT stroke consultants supported by Professor Tony Rudd, National Clinical Director for Stroke Services:

- Sentinel Stroke National Audit Programme (SSNAP) performance has required improvement at Lincoln Hospital and Pilgrim Hospital for some time, this was highlighted again in the most recent audit for the period October-December 2019;
- ULHT is not achieving all of the required performance in priority standards for 7-day services, for hyper-acute stroke;
- Pilgrim Hospital does not meet the recommended minimum volume of 600 strokes per year set out in the NHS Stroke Services Configuration Decision Support Guide;
- Significant gaps exist in consultant and nurse workforce across the ULHT stroke services; and
- 'No change' would perpetuate the situation of unsustainable acute services across two hospital sites.

12.7.15 The options for service change to address the significant challenges faced by acute stroke services in Lincolnshire have also been developed by the ULHT stroke consultants supported by Professor Tony Rudd.

12.7.16 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 EastMidlands Clinical Senate.

12.7.17 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 stroke services at this event was led by a ULHT stroke consultant.

12.7.18 The identified preferred option for future reconfiguration of acute stroke services aligns to recommendations of the NHS Stroke Services: Configuration Decision Support Guide and to evaluation findings from London, Greater Manchester and Northumberland on the reconfiguration of hyper-acute stroke services improving outcomes. The identified preferred option also aligns to recommendations for stroke service provision set out in the NHS Long Term Plan.

12.7.19 The presentation of the preferred option for the future configuration of stroke services to the East Midlands Clinical Senate was led by local lead clinicians. East Midlands Clinical Senate panel deemed the proposal to be well led clinically and well researched. It acknowledged the proposed reconfiguration would reduce unwarranted variation in outcomes and would ensure a more consistent achievement of clinical standards and national guidelines.

Test 4: Support for proposals from clinical commissioners

12.7.20 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.

12.7.21 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.

12.7.22 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.

12.7.23 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.

12.7.24 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

12.7.25 Acute hospital bed capacity requirements under the preferred option for the future configurationof acute stroke services have been modelled considering three main factors:

- Stroke activity growth rate;
- Preference for hospital site; and
- Average length of stay.

12.7.26 Based on the analysis conducted and the sensitivity test completed an additional bed requirement of seven beds has been identified. If implemented this would increase the bed capacity at Lincoln Hospital from 28 to 35.

12.7.27 It is believed a relatively prudent approach has been taken to defining the required acute bed capacity for the proposed future configuration of acute stroke services, given the requirement has been modelled on average length of stay of 10 days where as the target and plan is for anaverage length of stay of 7 days.

12.7.28 In addition, the bed requirement has been modelled based on a 15-minute site preference forLincoln Hospital, to strike a balance between ensuring sufficient capacity at Lincoln Hospital and the impact of activity on out of county hospitals.

12.7.29 The estates solution to provide the additional stroke bed capacity (7 beds) is an extension to the existing unit, which has been scoped at a high level with support from external design andarchitectural consultants. ULHT has an area of land adjacent to the current stroke unit that allows for a 400 square meter build to be achieved.

12.7.30 At this stage, this is the preferred way forward in terms of feasibility and delivering the intended outcomes and benefits. It suggests that the current unit could continue to operate with little or no disturbance making the option also more affordable at this stage as a result of not having toconsider decant costs. This approach and the alternative options considered are set out in more detail in the Estates chapter.

12.7.31 Enhanced community stroke rehabilitation service capacity requirements under the preferred option have been modelled using the learning from the 100-day pilot (2019), on what it takes todeliver an average length of stay of 7 days.

12.7.32 Additional community stroke rehabilitation service capacity modelled as requiring an additional 15.29 wte.

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Agenda Item 6

		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:	**10 November 2021**
Subject:	**Lincolnshire Acute Services Review – Urgent and Emergency Care**

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 two of the four strands of the review at this meeting, with the remaining two on 15 December 2021.

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.

The following NHS representatives are due to attend to present to the Committee:

- Dr Dave Baker, South West Lincolnshire Locality Clinical Lead, Lincolnshire Clinical Commissioning Group
- Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services NHS Trust

Actions Requested:

(1) To consider the details on the Lincolnshire Acute Services Review of Urgent and Emergency Care.

(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 the Committee considered an introductory item and agreed its approach to the consultation.

2. Urgent and Emergency Care

Dr Dave Baker, South West Lincolnshire Locality Clinical Lead, Lincolnshire Clinical Commissioning Group, and Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services NHS Trust, are due to attend the meeting to present information on Urgent and Emergency Care. To facilitate the Committee's consideration, pages 27-31 of the consultation document, which relate specifically to Urgent and Emergency Care, are attached as Appendix A to this report. Chapter 10 [Acute Services Review: Preferred Option – Urgent and Emergency Care] of the Pre-Consultation Business Case (PCBC) provides further detail and is attached at Appendix B. It should be noted that chapter 10 of the PCBC in turn refers to the following documents, all of which are available at: Pre-Consultation Business Case Appendices:

- Appendix N - Grantham and District Hospital Urgent Treatment Centre, Ambulatory Care Unit and Emergency Assessment Unit exclusion criteria
- Appendix H – Access Impact Analysis by Neighbourhood Team
- Appendix I – Quality Impact Assessments
- Appendix J - Equality Impact Assessment (EIA) Stages 1 and 2

At the Committee's last meeting on 13 October, when an introductory item on the Acute Services Review consultation was considered, more information was requested on the usage data for the Grantham Urgent Treatment Centre.

3. Consultation and Conclusion

The Committee is invited to consider the presentation on the detailed elements of the Lincolnshire Acute Services Review and highlight any areas which the Committee's working group might wish to explore in further detail.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Extract (Pages 27 – 31) from Lincolnshire NHS Public Consultation Document – Relating to Four of Lincolnshire's NHS Services – Urgent and Emergency Care at Grantham and District Hospital
Appendix B	Chapter 10 of the Pre-Consultation Business Case for the Lincolnshire Acute Services Review [Acute Services Review: Preferred Option – Urgent and Emergency Care]

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

Urgent and emergency care at Grantham and District Hospital

What are we asking you to consider?

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

- A 24/7 Urgent Treatment Centre (UTC) at Granthamand District Hospital

What are the services and how are they currently organised?

The primary role of an Accident and Emergency (A&E) department is to assess and treat people with major trauma, serious injuries and those in need of emergency treatment.

United Lincolnshire Hospitals NHS Trust (ULHT) currently provides A&E departments at Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital.

The A&E departments at Lincoln County Hospital and Pilgrim Hospital, Boston are consultant-led 24 hour services that provide the full range of accident and emergency care, with support from 24/7 diagnostics and access to critical care.

However, the Grantham and District Hospital A&E department has for some time (since 2007/8) only dealt with a limited range of presenting emergency conditions. This is because of its small size, limited availability of specialist staff and limited range of 24/7support services to support very ill patients after they leave the A&E department.

This means the majority of patients treated at Grantham and District Hospital A&E department arrive with injuries or illnesses that can be safely treated at an Urgent Treatment Centre (UTC). As the service is supported by a skilled range of doctors, GPs, practitioners and nursing staff, it is able to provide an extensive range ofassessment and treatment that meets the needs of thelocal population.

The service available at Grantham and District Hospitalis well understood by the local healthcare system, including the ambulance service. If they assess a patientlocal 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 theright facilities and skills to care for them.

If patients do present at Grantham and District Hospital A&E department with conditions that the hospital is not able to deal with, the skills and experience are there to manage the patient whilst transfer is quickly arranged to a more specialist unit for the appropriate treatment.

Prior to 2016 the A&E department at Grantham and District Hospital was operating 24/7 (dealing with a limited range of presenting emergency conditions).

Since 2016 it has been operating on reduced hours (currently closed between 6.30pm and 8.00am) due to difficulties faced by ULHT in safely staffing its A&E departments. This change did not impact on the limited range of emergency conditions the service could deal with

A summary of the current provision at ULHT's A&E departments is set out below.

Hospital	Provision
Lincoln County Hospital	• Operates 24/7 • Services: Full A&E • Consultants: 24/7 • Doctors: 24/7 • Nurses: 24/7
Pilgrim Hospital, Boston	• Operates 24/7 • Services: Full A&E • Consultants: 24/7 • Doctors: 24/7 • Nurses 24/7
Grantham and District Hospital	• Operates 08:00-18:30 • Services: Not full A&E • Consultants: 14/7 • Doctors: 14/7 • Nurses: 14/7

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

In addition to the three A&E departments currently provided by ULHT, six Urgent Treatment Centres (UTC) are provided by Lincolnshire Community HealthServices NHS Trust (LCHS). These are located at:

- Lincoln
  located with A&E
- Boston
  located with A&E
- Louth
- Skegness
- Gainsborough
- Spalding

These urgent care services can treat a wide range ofconditions which are not critical or life threatening such as sprains and strains, suspected broken limbs and feverish illness in adults and children. They playa significant role in protecting A&E departments for those patients who really need them.

The Minor Injuries Unit service at Stamford Hospital (which is currently provided by North West Anglia NHS Foundation Trust is available to people in and around the Stamford area in the south of the county.

What are the challenges and opportunities for urgent and emergency Care at Grantham and District Hospital?

This section sets out the challenges and opportunities for urgent and emergency care and what we hope to achieve by making changes.

Challenges

- Nationally there is a shortage of emergency medicine (A&E) doctors, which means greater competition between hospitals for doctors and an over reliance on doctors employed on a temporary basis
- Emergency medicine doctors are very difficult to secure, which in turn can lead to medical staffing vacancies and risk to the quality of patient care. Ultimately this can lead to service and patient safety concerns – as experienced by Grantham and District Hospital A&E department when the opening hours were reduced
- There have been genuine efforts to recruit and retain staff to work in Lincolnshire's A&E departments but with limited success – the uncertainty over the future of the Grantham and District Hospital A&E has addedto the reluctance to join the county's team
- Independent clinically-led reviews have concluded that in the interests of safety the A&E department atGrantham and District Hospital should not re-open 24/7 unless sufficient staff can be recruited and retained on a long term and sustainable basis
- The A&E service at Grantham and District Hospital has, since 2007/8, only dealt with a limited range ofpresenting emergency conditions, and services are similar to that of an Urgent Treatment Centre (UTC) yet the description of the service as an A&E is still inplace
- Using a description of A&E for this service creates unrealistic expectations and misunderstandings aboutthe level of service that is and can be provided at Grantham and District Hospital

Opportunities

By making changes, we can look to ensure:

- High quality urgent care services are delivered at Grantham and District Hospital on a 24/7 basis in a sustainable was for the long term, by:
  - Making relatively small changes in the scope of safe and high-quality services, ensuring Granthamand District Hospital receives patients in line with its medical capabilities
  - Those few patients with the highest levels of needthat cannot be met at Grantham hospital receivecare in the most appropriate and safest place for them
  - Improve our ability to attract and retain talented and substantive staff to an effective, high quality,successful and sustainable service
- All patients see the right clinician for their needs, firsttime, 24/7, and therefore receive the best possible care, including not having to wait unnecessarily
- Patient health and the overall patient experience areimproved

The feedback from engagement about urgent and emergency care 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 urgent and emergency care have been shared by the public and stakeholders throughout our engagement to date:

- The need to improve urgent and emergency care services across the entire county to deliver the best possible care for everyone
- Concern that the variety of urgent and emergency care service options across the county, with different names and specifications, was confusing and contributing to inappropriate use of services
- A clear desire that people should only use specialist A&E services when they are appropriate, to protect them for those requiring them
- Specific to Grantham and District Hospital:
  - A wish for 24/7 walk in access
  - Some concerns about increased travel time for local people if an A&E was no longer provided at the hospital
  - Some concern that other services at the hospital would be affected by not having an A&E department

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

In light of the feedback received in relation to urgent and emergency care we have considered how we can deliver a sustainable 24/7 walk in service at Grantham and District Hospital.

What is our proposal for change?

Our proposal for change is to establish a 24/7 walk in Urgent Treatment Centre (UTC) at Grantham and District Hospital, in place of the current Accident and Emergency (A&E) department.

The UTC would be provided by a community health careprovider, with existing doctors retained as part of the team and consultant (senior doctor) oversight provided to the unit. The multi-disciplinary workforce would havethe ability to manage all presentations, including those requiring stabilisation and transfer to an alternative hospital with the right skills and expertise.

It is anticipated this change would affect around 3% ofthose patients currently attending the Grantham and District Hospital A&E. This is equivalent to 2 patients a day, on average. These are patients who require onwardtransfer for immediate specialist care.

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 urgent and emergency care, 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 opposite summarises the level of stakeholder and public support for the change proposal.

Support for change proposal to establish a UTC at Grantham and District Hospital in place of the A&E department		
Support for change proposal	**Stakeholder Workshop**	**Public Workshops**
Agree (strongly/ tend to)	98%	84%
Disagree (strongly/ tend to)	2%	11%
Neither agree nor disagree	0%	5%

Impact Analysis

As we have developed our proposals we have considered the quality and equality impact of the preferred option for urgent and emergency care at Grantham and District Hospital.

Through our equality impact assessment we identified three groups of people, two of which can be defined by protected characteristics, which 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 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. 24/7 walk in urgent care would return to Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term

2. The vast majority of patients (estimated to be around 97%) seen at the Grantham and District Hospital A&Edepartment would continue to be seen and treated at the 24/7 Urgent Treatment Centre (UTC)

3. The UTC would provide greater accessibility due to increased opening hours compared to the current A&E arrangements (currently closed between 6.30pmand 8.00am). Access to treatment would further improve for children because the UTC team would broaden to include community and primary care staff (eg. GPs) who are more experienced and familiar withtreating children than a traditional, non-paediatric A&E team.

4. Patients would spend less time in the UTC compared to an A&E department due to the different model of assessment and management it uses. Specialistfollow-up input would be arranged as required

5. The UTC would be provided by a community health service provider, which would support better integration with primary care and community servicesand the provision of care closer to home

6. For a small number of patients (estimated to be around 3%, which is equivalent to 2 patients a day on average) currently attending the Grantham and District Hospital A&E who wouldn't be able to have their care needs met by the UTC, care would be received at an alternative site with the right facilities and expertise to ensure better clinical care outcomes

Potential adverse impacts

1. For the small number of patients (estimated to be around 2 a day) with greater needs who wouldn't be able to have their care needs met by the UTC, treatment would be received at an alternative site with a full A&E service

   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 3% of patients seen at an alternative site with the required specialist (A&E) services, it isestimated that if travelling by car around 60% of them would travel over 45 minutes (the thresholdagreed by the local health system for this type of activity). This equates to less than 9 patients a week. It is estimated there will be no increase in the number of patients travelling more than 60 minutes by car

   However, given the serious nature of the conditions these patients are expected to have, most are likely to travel by ambulance. This is whathappens now for those patients requiring a level ofemergency care that cannot be met by Grantham and District Hospital A&E

   - Of those attending an alternative site it is estimated around a third would attend Lincoln County Hospital and the remainder would attendhospitals out 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 if they require specialist in-patient care

10.Acute Services Review: Preferred option – Urgent & Emergency Care

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 changes).

10.1 Case for change

10.1.1 The United Lincolnshire Hospitals NHS Trust operates three Accident and Emergency (A&E) Departments: Lincoln Hospital (c.73,000 attendances per year) provides a full A&E, Pilgrim Hospital (c.55,000 attendances per year) which is also a full A&E and Grantham Hospital (c.29,000 attendances per year prior to the temporary closure) that has an exclusion criterion. Major trauma cases go to Queens Medical Centre in Nottingham.

10.1.2 The Grantham A&E department sees both adults and children, however because of its small size and availability of specialist staff exclusion criteria have been put in place. The A&E Department at Grantham Hospital has for some time only dealt with a limited range of presenting conditions.

10.1.3 The exclusion criteria have been in place for some time, since 2007/08, and following its introduction patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions have been taken by the ambulance service straight to neighbouring hospitals (Lincoln, Pilgrim, Nottingham or Peterborough) where more specialised services are located.

10.1.4 This exclusion list is well understood by the local healthcare system including primary care, community providers and the ambulance service. If patients do present at Grantham A&E with conditions the hospital is not able to deal with the capabilities and systems exist to manage the patient pending transfer to a bigger unit.

10.1.5 In the summer of 2016 concern was expressed by the emergency departments at Lincoln Hospital and Pilgrim Hospital about their ability to fill middle-grade medical rotas. A report to the ULHT Board described a number of reasons for this – a national shortage of emergency medicine doctors, insufficient doctors in training choosing to work at ULHT, an increasing reliance on locums and difficulty in securing the number of locums required to fill gaps in rotas consistently.

10.1.6 The report also stated that (at the time) there were four substantive consultants in post out of 15 funded whole time equivalent (wte) posts, with vacancies being filled by locums. Furthermore, there were 11.6 wte middle-grade doctors against the 28 funded posts. The reduced emergency staffing levels, combined with a reduction in skill mix of substantive staff, compromised the on-going provision of safe 24 hours, seven days per week A&E care across three sites. Although efforts were continuing to recruit additional staff, and various steps had been taken to mitigate staff shortages it was felt further action was required.

10.1.7 The ULHT Board agreed the additional risk to patients was too great to continue without further action and considered potential options to how best manage this situation. The Board agreed to implement a temporary overnight service closure at Grantham Hospital to support the staffing at the Lincoln and Pilgrim A&E departments, as releasing middle-grade doctors to work at these two sites would provide safer services for the Lincolnshire population as a whole. Prior to the temporary closure attendances there were on average 11 attendances between the hours of 23.00 and 07.00.

10.1.8 In August 2016 an initial three-month overnight closure of the Grantham A&E Department was introduced by ULHT taking it from a 24/7 service to 09.00 to 18.30 hrs seven days a week. In addition, an agreed threshold plan for recommencing services was agreed. The Lincolnshire A&E Delivery Board assumed responsibility for undertaking the monthly reviews with effect from September 2016 against a threshold of:

- No deterioration in the current consultant position; and
- Fill rate of at least 75 per cent (21) of the middle-grade establishment (28) on an eight-week prospective basis.

10.1.9 Representatives of Lincolnshire East CCG (the lead commissioner of services from ULHT) and NHS Improvement undertook a quality visit of the Grantham Hospital A&E and reported no concerns. Quality impact and equality assessments were undertaken and the Trust's decision was supported by NHS Improvement.

10.1.10 The ULHT Board met on 1 November 2016 and considered an updated report on the position regarding emergency care services. A number of expressions of interest in vacancies had been received but no appointments made while a further two-middle grade doctors were leaving the Trust. The Board considered options on how to proceed and decided to extend the period of closure to the end of February 2017.

10.1.11 The ULHT Chief Executive and Medical Director attended the Lincolnshire Health Scrutiny Committee again on 23 November 2016. It was reported that reducing the A&E department opening hours at Grantham Hospital had enabled the A&E department at Lincoln Hospital to be supported by up to an additional 85 hours per week by middle-grade and consultant staff from Grantham Hospital. No serious issues had been reported. A recruitment drive had indicated the potential to reach the necessary threshold but it was unlikely that sufficient new doctors would be in employment before January or February 2017.

10.1.12 The Health Scrutiny Committee concluded that the closure of A&E services between 18.30 and 09.00 at Grantham Hospital represented a substantial variation in the provision of health services for the area. It recorded it was not reassured that the required threshold of consultant and middle-grade doctors would be recruited by February 2017 and hence that A&E services would not be reinstated by this date, and therefore the closure between those times would be permanent. The Committee decided that the matter should be referred to the Secretary of State and letter of referral was sent on 15 December 2016.

10.1.13 The Secretary of State for Health passed the matter onto the Independent Review Panel (IRP) to undertake an initial assessment in accordance with its agreed protocol for handling contested proposals. The IRP responded to the Secretary of State on 22 March 2017 with the following advice:

- The IRP was content the closure of A&E services at Grantham Hospital between 18.30 and 09.00 represents a substantial variation in health care provision.
- The changes agreed by the ULHT Board in August 2016 and implemented in relation to the temporary closure at Grantham Hospital were done so on the grounds of safety.
- The situation raised a number of questions in relation to the true nature of emergency care provision at Grantham Hospital.
- The A&E service at Grantham Hospital has for some time (since 2007/08) only dealt with a limited range of presenting emergency conditions.
- The level of emergency service provided from Grantham Hospital prior to August 2016 was already more akin to that of an urgent care centre. Yet description of the service as an A&E or ED by the NHS and Health Scrutiny Committee continues today.
- This is not just about the appropriate use of terminology or signage but that unrealistic expectations and misunderstanding may have been allowed to develop about the level of service that can and should be provided at Grantham Hospital.
- Genuine efforts to recruit and retain staff to work in ULHT's departments continue but, thus far, with limited success. The IRP agreed that after six months (to date at the time) the closure of the A&E service at Grantham Hospital can no longer be regarded as a temporary measure and considered that it is not in the interests of patients that future discussions be conducted on this basis.
- The Grantham A&E service is demonstrably the smallest of the three A&E services provided by ULHT and deals with a limited range of presenting conditions. Consequently, taking account of the low level of activity through the night, the actual numbers of patients affected in terms of accessing A&E elsewhere is relatively small.
- That said the IRP accepts the issues that gave rise to the issue did not originate in Grantham and that there is considerable disquiet about the uncertainty among the residents of Grantham and the surrounding areas.

10.1.14 The IRP concluded that in the interests of safety the A&E service at Grantham Hospital should not re-open 24/7 unless sufficient staff defined by the threshold can be recruited and retained. It also stated that the time has come for an open and honest appraisal, both of the options for future emergency care delivery at Grantham Hospital and more widely across Lincolnshire.

10.1.15 Following the referral to the IRP, ULHT continued its effort to recruit staff and the closure of A&E services between 18.30 and 09.00 at Grantham Hospital was reviewed. A review in February 2017 concluded that the threshold to re-open the service full time had not been met but acknowledged there had been significant improvement in staffing levels.

10.1.16 It was agreed to increase opening hours by one hour (08.00-18.30) with effect from 27 March 2017 and to introduce a direct to admission pathway for selected medical patients conveyed by the ambulance service from 3 April 2017. These changes aside the closure would remain in place for a further three months. NHS Improvement confirmed that it had received assurance regarding the decision.

10.1.17 In November 2017, the ULHT Board considered re-opening the A&E at Grantham Hospital on a 24/7 basis. NHS Improvement requested the Board delay its final decision on whether to re-open the department for a period of one month to allow time for a safety review to take place.

10.1.18 This review was undertaken by the East of England Clinical Senate, with a final report being submitted to the relevant organisations on 14 December 2017. Key findings from the East of England Clinical Senate review were:

- The extensive list of exclusions currently in place would not be subject to any change should the decision to extend or change opening hours be implemented;
- The Trust advised that over half its emergency medicine consultant workforce were locums with most currently not on the GMC Specialist Register, and only a small proportion with specialist qualifications.
- Since the original workforce thresholds were set to inform whether the service could revert back to being 24/7, ULHT had reviewed its workforce requirements resulting in a significant uplift in its target establishment. This was supported by additional funding.
- It was acknowledged that if the original workforce calculation threshold (c.75% of the required minimum number of medical staff across all three sites) was applied to the new establishment of 38 middle-grade doctors across ULHT (rather than the historical figure) around 30 middle-grade doctors would be required (as opposed to the original 21). ULHT also had plans to increase middle-grade staffing to 44 across all three sites in April 2018.
- The current number of 22 middle grades (at the time), including locums, therefore only met 50% of the Trust's target establishment for April 2018 (44). It was also acknowledged that the heavy proportion of locums amongst the 22 middle-grade doctors meant this was a relatively unstable position.
- The panel advised the Royal College of Emergency Medicine provided a 'rule of thumb' guide for 'Medical and Practitioner Staffing in Emergency Department'. Using that guide would indicate that ideally 36 middle-grade medical staff would be needed (i.e. 12 middle grades at each of the three sites) to maintain safe, sustainable 24/7 cover.
- The panel learned that although there were currently around ten nursing vacancies across the three sites, an additional 20 nurses would be needed to reach the new uplift level, including 24/7 opening at the Grantham site.
- Despite having reached the previously agreed threshold of 21 middle-grade doctors, the Trust acknowledged that there was still significant performance challenge across the Trust's three A&Es, with particularly poor performance compliance to the four-hour performance standard and Friends and Family results.
- ULHT confirmed there had been no reported patient harm as a result of the closure; the CCG also confirmed that it was unaware of any harm resulting from the reduction of opening hours. The Trust also reported that there had not been any significant change in activity, nor had overall admissions increased. The data provided showed that since August 2016 there had been an average decrease in attendance to Grantham Hospital A&E or around 100 attendances a week, with no correlating increase at Lincoln or Pilgrim A&E.

- The panel heard that the Trust considered that having reached the 21 middle-grade doctors threshold across the three sites, it may be able to support three 24/7 rotas for A&E but had no certainty or confidence in how long it could be safely sustained. The Trust agreed that given the considerable vacancy gaps it may not be able to sustain sucha rota for longer than three to four months, and the dependencies for the sustainability were outside the Trust's control, including staff being maintained.
- The panel agreed that as middle-grade staff from Grantham Hospital were currently covering some of the workload created by middle-grade vacancies at Lincoln and Pilgrim Hospitals; re-opening Grantham Hospital A&E 24/7 would mean that this additional support to Lincoln and Pilgrim Hospitals would no longer be available.
- Evidence showed that the majority of patients presenting at Grantham Hospital A&E were 'type 3' patients, the department did not support patients of higher acuity. Althoughthe department did have a resuscitation area, any critical patients would always need tobe transferred. The panel heard the department had two beds in the Emergency Admission Unit 'ring fenced' for patients requiring transfer for more specialist care, or to another site, after the department had closed. The panel heard that although formal recording of number of transfers ceased in March 2017, bed managers reported the activity as low.
- The CCG had made reference to the potential to extending the opening hours at Grantham Hospital A&E to 21.00. ULHT reported that this would require new staff rotas to be extended to midnight or beyond that could be challenging to achieve on current staffing and rotas. ULHT advised that historically there were typically around 11 patientspresenting between 23.00 and 08.00 hours at Grantham Hospital A&E.
- Both the Trust and CCG agreed that, having taken a year or more to adjust to the change in opening hours, to temporarily reinstate 24/7 opening would likely result in confusion among the public, patients and staff. There was agreement that there was insufficient demand for a full medically led overnight A&E service and that until there wasa full establishment across ULHT, services were not stable on any of the three sites.
- The panel noted there had been no mention or reference to any discussion with other parts of the system such as out of hours, community care providers, GPs and primary care on managing the impact of change in opening hours. The panel found that Grantham Hospital hosted an Enhanced Out of Hours service (Kingfisher Suite) taking walk in minor injuries from 18.30 until 23.30hrs seven days a week and an Out of Hoursservice for minor illnesses with appointments accessed via 111 from 18.30 to 08.00hrs,although no mention had been made of this.
- The panel heard that there had been ongoing engagement and discussion with the CCG and local stakeholders including community group leaders and that there was a broad agreement that a 24/7 medically led A&E at Grantham Hospital was not a sustainable model, nor a model that was justified in view of the small number of patients per hour that previously attended overnight.
- The panel agreed that the terminology 'A&E Centre' could imply a full A&E facility and be confusing for patients. The panel noted the IRP had made comment that *"the level of emergency service provided from Grantham and District Hospital prior to August 2016 was already more akin to that of an urgent care centre"*. It made reference to use of appropriate terminology *and "unrealistic expectations and misunderstanding about the level of service that can and should be provided at Grantham hospital"*. The East Midlands Clinical Senate panel reiterated those concerns, although it did agree that Grantham Hospital did currently provide more than an Urgent Care Centre which tendedto be Primary Care led, but significantly less than an A&E would usually be expected to provide.

10.1.19 The panel concluded that there was no evidence that any extended opening, over and above the current level of provision of the A&E Department at Grantham Hospital would improve outcomes for patients. The panel also agreed extending the opening hours at Grantham Hospital would put further pressure on the ULHT's A&E nursing staff when there are already vacancies – this could further impact on the quality and safety of care provided.

10.1.20 Therefore, the recommendation was ULHT should continue to provide an A&E service at Grantham Hospital on the opening hours of 08.00-18.30, seven days a week. The panel also recommended that in order to make it clear for patients and the public the type of services available at Grantham A&E ULHT look to re-naming the department, and that the terminology 'A&E Centre' is not applied.

10.1.21 Since the time of the unplanned temporary closure at Grantham A&E ULHT has continued to work hard to shore up its A&E departments. This has included significant uplifts in target establishments of medical and nursing workforce supported by additional funding and significant recruitment activity including a variety of initiatives.

10.1.22 Despite this hard work and some success, significant issues in the medical and nursing workforce still exist today resulting in challenges with rota coverage, high vacancies and high agency usage across ULHT's A&E services (2019/20):

- Consultants: currently funded for 26 posts - 3 filled substantively
- Middle grades: currently funded for 52 posts – 27 filled substantively
- Remainder are either filled with locums or underqualified clinicians, or left vacant
- Vacancy rates, turnover and sickness are high.

10.1.23 These ongoing workforce challenges have continued to drive quality and performance challenges across ULHT's urgent and emergency services:

- 4-hour A&E performance - through 2019/20 ULHT performance did not go above 68%
- Poor performance against time to triage at Lincoln Hospital and Pilgrim Hospital;
- Poor performance against time to treatment across all three hospital sites;
- Poor performance against proportion of patients who left before being seen across all three sites
- Worsening picture of ambulance handover delays at Lincoln and Pilgrim Hospitals.
- Lincoln Hospital and Pilgrim Hospital urgent and emergency care services rated as 'Inadequate' in the most recent CQC inspection in 2019.

10.2 Grantham A&E service re-designated as a 24/7 Urgent Treatment Centre and 24/7 A&E services provided from Lincoln Hospital and Pilgrim Hospital

Overview

10.2.1 At the time of the ASR Programme commencing in early 2018 the partners in the Lincolnshire health and care system were already engaged in a significant dialogue in relation to the provision of urgent and emergency care across ULHT's three hospital sites (as set out in the case for change above).

10.2.2 This work was supported by a substantial amount of analysis, particularly in relation to the workforce. The conclusions and recommendations from this work were fed into the ASR programme and its option appraisal process.

10.2.3 The preferred option identified through the ASR options appraisal process for urgent and emergency care is to re-designate the Grantham A&E service as an Urgent Treatment Centre (UTC) and maintain 24/7 A&E services provided from Lincoln Hospital and Pilgrim Hospital.

10.2.4 The Urgent Treatment Centre would be developed in line with the nationally-defined criteria for UTCs, offering improved accessibility and pre-booking via NHS 111. As a minimum, the eight priority standards sought by NHSE would be delivered.

10.2.5 The UTC would incorporate the existing A&E service (currently operating 08.00 – 18.30) and the Out of Hours on-site provision. The unit would be a community-led service, however a medical workforce would be retained as part of the team and consultant oversight would be provided to the unit for governance and training purposes.

10.2.6 The multi-disciplinary workforce would have the ability to manage all presentations, including those requiring stabilisation and transfer. The workforce mix would be expected to include GPs, urgent care practitioners, middle grade doctors, medical trainees, nurses and clinical support. The mix and level of input will be reviewed and refined once the service is operational.

10.2.7 The ULHT Emergency Medicine consultant team would provide ten sessions (40 hours a week) to the unit from commencement. Their primary function would be to provide clinical oversight, training and governance in addition to providing supervision to the medical trainees in the unit. Cover would be provided on a rotational basis from across appropriate members of the permanent ULHT team, facilitating improved working relationships across all urgent care services in the county. The volume of consultant input to the service would be reviewed at three, six and 12 months post-commencement.

10.2.8 Ambulance arrivals would continue to be accepted. The clinical criteria for conveyance to Grantham by East Midlands Ambulance Service have been reviewed against the planned clinical acuity model for the Grantham Hospital site (described in the Preferred Option - Acute Medicine chapter). See Appendix N for revised exclusion criteria.

10.2.9 In response to feedback received from the public during the *Healthy Conversation 2019* engagement events, the proposed UTC at Grantham Hospital would be open 24 hours a day, 7 days a week and accommodate walk-ins throughout the opening hours (though the preferred route of access will be via NHS 111, supporting early triage and pre-booked appointments – as per national UTC standards).

10.2.10 Home visiting through the Out of Hours service would also be offered by this team, supporting improved consistency of care.

10.2.11 Radiology access will be x-ray and CT over a 24-hour period and MRI access will be available Monday to Friday 09.00-17.00. Diagnostics would be supported by full laboratory access.

10.2.12 The table below sets out a comparison of the 24/7 Grantham A&E service as it was before the temporary closure and the proposed 24/7 Urgent Treatment Centre.

Figure 142 – Comparison of Grantham 24/7 A&E service and proposed 24/7 UTC

	24/7 A&E (as was)	24/7 UTC
Opening hours	• 24hrs a day 7 days a week *Av. 80 attendances per day (24hrs)* *Av. 11 attendances between 23.00-07.00*	• 24hrs a day 7 days a week
Acuity	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E • Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E • Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals • Refinement of exclusion criteria to allow a larger proportion of frail and elderly patients from the geographic locality to receive inpatient care at Grantham and a small volume of higher acuity cases currently managed at Grantham to receive specialised treatment elsewhere
Workforce	• Consultants: 80hrs/week plus on-call evenings & weekends • Middle Grades: 24/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours	• Consultants: 40hrs/week no on-call evenings & weekends • Middle Grades: 16/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours *Planning assumptions: All subject to review and change once service is fully operational*
Diagnostics	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7

Quality

10.2.13 Concerns have been expressed for a number of years regarding the clinical sustainability of ULHT delivering three 24/7 A&E medical and nursing rotas, one in each of its hospitals. This culminated in the implementation of a temporary service closure at Grantham Hospital to support the staffing at the Lincoln Hospital and Pilgrim Hospital A&E departments, as releasing middle-grade doctors to work at these two sites would provide safer services for the Lincolnshire population as a whole. In parallel there have been growing concerns regarding these services delivery and achievement of clinical standards.

10.2.14 The preferred option for urgent and emergency care provision across Lincolnshire is seen to provide a number of quality improvement opportunities:

- Given the medical workforce challenges and heavy reliance on locum doctors who are likely to represent a less stable workforce, will minimise additional pressures across the A&E system in Lincolnshire and patient risk.
- Minimise the pressure on ULHT's nursing staff, where there are already significant vacancies, and therefore impact on the quality and safety of care provided.
- Support a more consistent achievement of clinical standards, i.e. the NHS constitutional four-hour standard, time to triage at the Lincoln Hospital and Pilgrim Hospital sites and time to treatment across all three ULHT hospital sites.
- Redefining and refining the scope of safe and high quality services, ensuring Grantham Hospital receives an appropriate mix of patient acuity in line with its capabilities.
- Encourages integrated service delivery between primary care, community care and acute care providers.
- Aligns with NHS England and Improvements vision for urgent and emergency care patients, with more serious life threating emergency needs treated in centres with the very best expertise and facilities in order to reduce risk and maximise chances of survival and recovery.
- Promotes positive volume versus service provision balance in urgent care provision at Grantham Hospital between 23.00 and 08.00 hrs, compared to a 24/7 A&E service.

10.2.15 When the preferred option for urgent and emergency care was presented to the East Midlands Clinical Senate as part of the ASR programme's options evaluation process, the panel praised the Lincolnshire health system for its exclusion protocol, which was considered 'clear, comprehensive and excellent'.

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.

10.2.18 A comparison of the performance of the temporary UTC at Grantham Hospital as part of the 'Green' site in August 2020 and March 2021 has been carried out, due to the length of time the temporary service was in place it is not possible to use comparable months. However, there is an assumption that given similar levels of isolation and lockdown that overall performance should not differ between months:

- August 2020
  - 90% of patients seen within their 15 minute clinical triage, of those averagingaround a 9 minute assessment
  - 98% of UTC attendances are discharged within the 4 hour target, of those averaging 102 minute attendance.
  - 5% referral rate to A&E

- March 2021
  - 91% of patients seen within their 15 minute clinical triage, of those averaging around a 9 minute assessment
  - 98% of UTC attendances are discharged within the 4 hour target, of those averaging 112 minute attendance.
  - 5% referral rate to A&E.

10.2.19 A comparison of the Friends and Family test performance showed:

- August 2020:
  - 357 responses
  - Recommended Score= 90%
  - Non Recommended Score = 4%
- February 2021:
  - 314 responses
  - Recommended Score = 93%
  - Non Recommended Score = 3%

10.2.20 A range of positive and negative feedback was received during the months of August 2020 and February 21:

- Positive:
  - "I honestly don't think you could have done better. Everyone was so understanding supportive and helpful. I never felt they were in a rush. They took time to talk to me help me relax and of course talked about what I should do etc the doctor who looked after me. Who I cant remember the name of was absolutely brilliant and the nurse Sally was as well"
  - "Just wanted to thank all the everyone involved from my visit to Grantham UTC this afternoon, from the Reception staff, to all the doctors, nurses and Healthcare assistants who treated and looked after me."
  - "It was my first experience using a UTC so had doubts but everything that was required was there, specialists were on hand, it was a good experience (that might have been the Entonox!!)".
- Negative
  - "A choice of hospital to travel to would of been better. Also I had arrived at Boston & Grantham hadn't released me. The notes didn't include everything as Id said been sent for a CT scan & they were not in the notes that I took with me"
  - "Staff excellent but the service they can offer has been stripped to nothing. Whats been done to Grantham A&E is criminal"
  - "The facility was great but the judgement or expertise was lacking. I needed to be admitted to hospital and drs at A and E where shocked I had been sent home two days before by Grantham. Bring back proper A and E at Grantham please I nearly died"

10.2.21 Based on both months of the Friends and Family Test it highlighted the following:

- Positive experience of UTC service, but mixed reviews as expected around the loss of an A&E.
- Lack of confidence or uptake in using the 111 service, but unlikely to use the service where a walk in option is available.
- A mixed understanding around how services operate and integrate in Lincolnshire, proving that there is still further work and collaboration to be made in the local area.

These insights will be taken forward into any final decision making.

Access

10.2.22 In 2019/20 Grantham Hospital A&E saw 23,134 attendances (opening hours 08.00-18.30), these patients largely came from Grantham and the surrounding area. The highest volumes of attendances per hour are first thing in the morning when the service opens at 8.00am, volumes per hour then steadily reduce through the day to when the service closes.

10.2.23 Under the proposed model of a 24/7 UTC at Grantham Hospital (and integrated community/acute medicine beds described later) the exclusion criterion for the Grantham Hospital site would be refined, meaning a relatively small number of patients currently attending the A&E, would not in the future. This would mean more patients going to the right place for care first time and minimising subsequent patient transfers.

10.2.24 It is estimated that with the refinement of the exclusions criteria, once fully implemented the preferred option to establish an UTC at Grantham Hospital will displace c.600 patients per year who are currently seen at Grantham Hospital A&E (based on 2019/20 activity). This is equivalent to c.2.5-3.0% 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. It is anticipated the majority of these patients will have a NEWS ≥7 with a low frailty score (<5), fractured neck of femur/femoral fractures or acute coronary syndrome.

10.2.25 Under the proposal it is estimated that the number of additional patients travelling over 45 minutes for non-elective care, the travel time threshold set by the local health system for activity of this type, is c. 375 (based on 2019/20 activity, c.435 forecast to 2023/24 - see Appendix H for breakdown by neighbourhood team). This is based on the assumption they travel to their nearest appropriate hospital by car and against a baseline of c.21,500 patients across Lincolnshire who currently travel more than 45 minutes to attend urgent and emergency care services by car.

10.2.26 However, in reality given the existing exclusion criteria and the acuity of patients who would no longer be seen at Grantham Hospital many are likely to travel by ambulance to an alternative site and therefore their travel time could be less than 45 minutes. 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.

10.2.27 Approximately 33% of the patients would attend Lincoln Hospital and the remainder would attend hospitals out of county, the majority of these would attend North West Anglia NHS FT (58%) followed by Nottingham University Hospitals NHS Trust (9%).

10.2.28 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).

Figure 143 – Estimated displaced Grantham urgent and emergency care activity andimpact on travel times

	Grantham Hospital		LincolnHospital		Out of county hospital	
	19/20	23/24	19/20	23/24	19/20	23/24
UEC activity	-600	-694	197	228	403	466*
Travelling +45 mins.	+376	+435	16	16	360	419

** (19/20 c.350 to NWAFT and c.50 to NUH; 23/24 c.400 to North West Anglia NHS FT, c.65)*

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

10.2.30 However, it is not widely understood by the public that exclusion criteria have successfully existed for some time (since 2007/08) for the Grantham Hospital site to ensure the care it provides aligns to its size and the 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.

10.2.31 When necessary, under the current model patients are already taken by ambulance to alternative hospitals in line with the current exclusion criteria to ensure patients are treated at the most appropriate location to their needs. In addition, if patients self-attend at Grantham Hospital who fall into the exclusion criteria they are transferred to Lincoln Hospital to ensure they receive the clinical input they need.

10.2.32 Through the ASR programme public engagement events a common theme of feedback was a desire from the public for the Grantham A&E service to return to a 24/7 service following its temporary closure. In the original scoping of the Urgent Treatment Centre (UTC) option its planned opening hours were to be in line with the national principles and standards set for UTCs (open for at least 12 hours a day seven days a week).

10.2.33 However, in light of the feedback from the public further consideration was given to the opening hours of the proposed Urgent Treatment Centre at Grantham Hospital and the decision was reached for this proposed model to operate 24 hours a day, seven days a week. Therefore, implementation of the preferred model would increase overall access to patients compared to the reduced hours A&E service currently in operation.

10.2.34 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.

10.2.35 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.

10.2.36 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 is 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

10.2.37 In 2015/16, the last full year the Grantham Hospital A&E Department operated as a 24/7 service, it saw 29,297 patients. In the same year the Out of Hours service based at Grantham Hospital saw 15,675 patients (70% from NHS 111, a further 17% from walk-ins and the remainder from other sources). Giving a total activity in 2015/16 of 44,972.

10.2.38 Based on historic growth rates in accident and emergency activity seen at Grantham Hospital it is estimated that if the A&E department was still operating 24/7 the activity levels in 2019/20 would be c.33,900. In 19/20 the activity volumes seen by the Out of Hours service on the Grantham Hospital site had reduced to 7,603 (70% of which was from NHS111, a similar proportion to 2015/16 just a smaller absolute number). If the estimated volume of activity in 2019/20 assuming the Grantham A&E was operating 24/7 is combined with the 2019/20 actual Out of Hours activity this would give an estimated total urgent and emergency activity of c.41,500.

10.2.39 To estimate the activity that would be seen at the proposed 24/7 UTC in 2023/24 an analysis has been conducted based on two scenarios:

- Scenario 1 – Demographic growth applied to 2019/20 A&E activity (assuming operating 24hrs/day) and Out of Hours Activity = 42,700
- Scenario 2 – Historic growth applied to 2019/20 A&E activity (assuming operating 24hrs/day) and assume 50% of drop in Out of Hours activity seen between 2015/16 and 2019/20 returns = 49,900

10.2.40 Through the ongoing planning and implementation of the Lincolnshire Integrated Community Care (ICC) clinical model a set of 'left shift' assumptions were developed to inform the system's planning. In relation to accident and emergency services a reduction of 10% of attendances has been assumed. This has been used as an additional sensitivity analysis on the expected number of attendances at the Grantham UTC.

10.2.41 The table below provides a summary of the estimated volume of activity at the proposed 24/7 UTC on the Grantham Hospital site when the preferred option is fully implemented. This includes a sensitivity analysis relating to the number of patients that would attend if the full impact of the 'left shift' occurs.

Figure 144 – Estimated future Grantham UTC attendance analysis

Attendees at the proposed Grantham Urgent Treatment Centre				
	15/16	**19/20**	**23/24** Scenario 1	**23/24** Scenario 2
Grantham 24/7 A&E attendances *Assuming 24/7 operation in 19/20*	29,297	33,900	-	-
Grantham OOH service	15,675	7,600	7,800	11,600
Grantham 24/7 UTC attendances	-	-	34,900	39,000
Total	44,972	41,500	42,700	50,600
Adjusted for displaced patients	-	-	42,000	49,900
Sensitivity analysis – reduction in 10% of attendances through ICC				
Grantham 24/7 UTC attendances	-	-	37,800	44,910

10.2.42 Within the original ASR PCBC and identified capital requirement, moderate capital investment was identified to address backlog maintenance and improve the functional suitability of the environment.

10.2.43 This would include some expansion into adjoining departments which are deemed underutilised, enabling a rationalisation of back office accommodation and increase in the amount of clinical floor space which enables a greater degree of privacy and dignity for patients.

10.2.44 These changes are still the longer term ambition, however they are not an immediate necessity to enable the transition from an A&E to UTC and this change can still happen without them. The activity forecast in 2023/24 under the higher activity growth scenario (Scenario 2) does estimate a level of activity greater than that seen when the A&E operated 24/7. If required there is the option to relocate the fracture clinic to provide additional capacity (supported through virtual fracture clinics and telemedicine) ahead of the expansion planned for the longer term.

10.2.45 A comparison has been made between this forecast activity and that seen by the temporary UTC implemented as part of the Lincolnshire health systems response to the COVID-19 pandemic. However, as previously highlighted this should be treated with caution due to the differences in the service provided and context it was operating.

10.2.46 The temporary UTC saw on average 72 patients a day, which would equate to 26,280 for a full year. This is below the forecast set out above, which could be expected given the proposed model will be able to treat more patients with higher acuity needs and provide more pathways such as 111 attendance.

10.2.47 The temporary UTC showed a consistent demand throughout the hours of 07:00-23.00, with small numbers of use in the remaining hours. Between the hours of 23.00-07.00 (included) the average attendance was:

- September 2020: c.5 patients
- March 2021: c.5 patients

10.2.48 Recruitment and retention of urgent and emergency staff has been a long-standing concern for ULHT, although Grantham Hospital has not had as many issues as Lincoln and Pilgrim Hospitals.

10.2.49 Historically there have been two A&E consultants who provide day-time cover to the A&E department. Under the proposed Urgent Treatment Centre model there would still be consultant support and input to provide vital leadership, clinical governance and training to all UTC staff, however this would reduce to 1.2 whole time equivalents.

10.2.50 The retention of Emergency Medicine Consultants is additionally required to provide supervision for medical trainees, who are to be retained as part of the UTC workforce. The consultant workforce will be ULHT employed and will undertake sessions at Grantham UTC on a rotational basis.

10.2.51 Initially a total of ten sessions of Emergency Medicine Consultant cover will be provided (equivalent to 40 hours a week). This will be reviewed at three, six and 12 months. Any future reduction would only be agreed if clinically appropriate, and where it would not adversely impact on overall service model delivery. In particular, the ability to retain middle grade staff and training placements.

10.2.52 During its review of whether the temporary closure of the Grantham A&E should be lifted and it go back to being a 24 hour 7 day a week service, the East of England Clinical Senate identified that using the Royal College of Emergency Medicine ‘rule of thumb’ guide 36 middle grade medical staff would be needed (i.e. 12 middle grades at each of the three sites) to maintain safe, sustainable 24/7 cover.

10.2.53 When the Grantham Hospital A&E operated 24 hours a day, seven days a week the service operated with six whole time equivalent middle grades providing the 24/7 middle grade cover. Under the proposed model it would operate with five whole time equivalent middle grades.

10.2.54 Given the workforce pressures and heavy reliance on locum doctors facing all medical grades in emergency medicine it would be very difficult to sustainability staff up to the ‘rule of thumb’ number identified by the Royal College of Emergency Medicine.

10.2.55 The proposed model being led by a community provider should also minimise the pressure on ULHT’s nursing staff, where there are already significant vacancies.

10.2.56 By implementing the proposed model of an Urgent Treatment Centre at Grantham Hospital it is believed the optimum balance of patient volumes, acuity, outcomes and resource will be achieved. Medical middle grades will support the UTC between 08.00 and midnight when activity is known to be at its highest and will not need to staff an on-call rota at night. When the A&E operated as a 24/7 service on average 11 patients a day attended between 23.00 and 07.00.

10.2.57 The table below sets out the workforce (funded establishment) of the Grantham Hospital A&E when it operated 24/7 together with the Out of Hours workforce, what the workforce currently is and the workforce for the proposed 24/7 Urgent Treatment Centre developed for planning purposes. The workforce model for the 24/7 UTC will be subject to ongoing review and refinement once the service is fully operational.

Figure 145 – Grantham UTC model workforce compared to A&E & Out of Hours model (funded establishment)

	A&E 24/7 & Out of Hours (WTE) *2015/16*	A&E (08.00-18.30) & Out of Hours (WTE) *2019/20*	UTC 24/7 (WTE)***
Medical			
• Consultants	2.0*	2.0	1.2
• Middle/Trust Grade	6.0**	5.0	5.0
• Foundation/Trainee	7.0	6.0	6.0****
• Admin	0.6	0.6	0.6
• GPs	10 sessions/week	10 sessions/week	10 sessions/week + OOH
ACP			
• Nurse ACPs	4.5	4.0	4.0
Nursing			
• Registered	24.5	19.0	25.5
• Nursing Associate	2.5	1.0	1.0
• Non Registered	10.0	7.5	14.0
• Receptionist	4.0	2.5	2.5
Out of Hours			
• GP	2.0	2.0	*Out of Hours will be integrated with UTC*
• Registered	6.5	6.5	
• Non Registered/ Clark	7.0	6.5	

** Consultants provided on-call cover overnight and at weekends*
*** Middle grades covered the whole out of hours rota between them – 'rule of thumb' guidance suggests should be 12.0*
**** Planning assumptions: All subject to review and change once service is fully operational*
***** Junior training posts will be retained, proposed model will offer a valuable and interesting environment. Ongoing engagement of HEE to ensure they remain supportive and posts will need to be considered in the context of the overall requirement/ need for these posts across the whole of ULHT*

10.3 East Midlands Clinical Senate recommendations and workforce improvements

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

10.3.2 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.

10.3.3 Through this review the East Midlands Clinical Senate supported the proposal for Urgent and Emergency Care and made no further recommendations other than not use the term 'UTC Plus'.

10.4 Quality and Equality Impact Assessments

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

10.4.2 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.

10.4.3 A summary of the QIA for the proposed changes to urgent and emergency care services is set out below and the full version is included in Appendix I.

Figure 146 – Summary of QIA for proposed urgent and emergency care service changes

Area	Summary Impact(+ve & -ve)	Summary Actions
1.Quality		
Duty of Quality	▪ Presenting symptoms for a small no. of patients would indicate full A&E department required at a different site – resulting improved quality of care received ▪ Population need to understand what symptoms are appropriate for a UTC	▪ Comprehensive communication strategy and robust consultation process
Patient Safety	▪ Improve patient safety as ensures those with highest acuity needs go to right hospital first time ▪ Workforce capability/skills - Staff working in existing A&E Department as staff may need to transfer employment to a new provider	▪ Support offered to staff to facilitate the change
2. Experience		
Patient Experience	▪ Quality of service will remain high, and access will only change for a small proportion of current service users on the basis of appropriate clinical care ▪ Greater accessibility (opening hours) and a direct link with Primary Care and Community Services ▪ Positive impact on time spent by patients within department due to UTC model of assessment and management compared to UTC.	▪ Comprehensive communication strategy and robust consultation
Staff Experience	▪ Changes should make some roles more attractive to staff ▪ Stability and a confirmed long term service model should reduce anxiety among staff	
3. Effectiveness		
Clinical Effectiveness & Outcomes	▪ Optimise balance of access, cost and outcomes	

10.4.4 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.

10.4.5 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.

10.4.6 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.

10.4.7 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.

10.4.8 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.

10.4.9 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.

10.4.10 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.

10.4.11 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.

10.4.12 As well as a QIA, a Stage 1 and Stage 2 Equality Impact Assessments (EIA) has also been completed for the proposed urgent and emergency care service changes.

10.4.13 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, Disability and Economically Disadvantaged.

10.4.14 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.

10.4.15 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.

10.4.16 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.

10.4.17 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.

10.4.18 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 impacton 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 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
    - Negative impact on health and anxiety levels
- Economic Disadvantaged:
    - The specific engagement from The People's Partnership did not receive feedbackfrom 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 negative impact on health and stress levels, 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.

10.4.19 A summary of the EIA for the proposed changes to urgent and emergency care services is set out below and the full version is included in Appendix J.

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

10.4.21 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 147 – Summary of EIA for proposed emergency and urgent care 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.600 patients per year who are currently seen at Grantham A&E will be displaced to an alternative site.
	• This is equivalent to c.2.5 – 3.0% 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 of these displaced patients 375 will travel over 45 minutes by car for A&E services, the travel time threshold set by the local health system for this type of activity. It is estimated that currently 21,500 people in Lincolnshire travel over 45 minutes to access A&E by car.
	• Given the acuity of patients who would no longer be seen at Grantham Hospital many are likely to travel by ambulance to an alternative site and therefore travel time could be less than 45 min.
		• 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	• The majority of patients currently seen at the Grantham A&E will continue to be seen at the Grantham UTC. • Only a small number of patients will be seen at an alternative site and the basis for this is to ensure people get to the right hospital with the right facilities first time to ensure the best outcomes	• Yes. Proposed service should have a positive impact on health

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
	• If a patient is concerned about their health but it is not an emergency, patients should call NHS 111 or 'walk in' to the UTC. There is no change to this service. The proposed UTC will remain on the same site.
	• If a patient is concerned because they are clearly very ill, patients should call 999 and an ambulance will be sent and their condition will be assessed, so they are taken to the most appropriate place for treatment, meaning no increased demand for friends and family.
	• 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.
	• If a patient goes to the proposed UTC and needs to be moved to an alternative hospital site travel arrangements will be made to transfer the patient, meaning no increased demand upon family and friends.
	• 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 an 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.
		• 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.

Note: 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.

10.5 Vignettes to demonstrate the positive impacts of the clinical model

Patient 1

10.5.1 A 62 year old male is brought to Grantham UTC by his wife with sudden onset of slurred speech and a left sided weakness in his arm. He has a history of hypertension and angina.

10.5.2 An immediate assessment reveals an irregular pulse, raised BP, dysarthria and paresis of the left arm. Capillary blood glucose is 7.8.

10.5.3 An immediate call is made to the Stroke Team at Lincoln. While awaiting ambulance transfer, the patient is given an immediate dose of clopidogrel and the GP record is accessed to establish past history, medication history and a log of any recent attendances. Blood samples are taken and if available, a CT brain is carried out on site at Grantham for review by the Stroke Team while awaiting arrival of the patient at Lincoln. Performing a CT should not delay transfer if an ambulance is immediately available.

10.5.4 Support is provided to the patient's wife to ensure she is aware of what is happening and she can either travel home herself or can be collected by a family member or friend.

10.5.5 Outcomes:

- This patient is either transferred back to Grantham Hospital for rehabilitation immediately following his specialist acute stroke intervention; or
- Receives assisted discharge home with support from the stroke discharge service.

Patient 2

10.5.6 A 44 year old male is brought to the UTC by his brother with worsening asthma following a lower respiratory tract infection.

10.5.7 The patient is triaged by a senior nurse, and immediately assessed as category 4 due to severe breathing difficulties.

10.5.8 The patient is transferred to an examination room and attended by a middle grade doctor. Treatment is commenced with oxygen and nebulisers. The patient fails to improve and a 999 ambulance is called, and due further rapid deterioration, a Same Day Emergency Care consultant is called to review the patient and on site anaesthetist is called to assist with airway management.

10.5.9 Outcomes:

- The patient is stabilised and an anaesthetist accompanies the patient in the ambulance transfer to Lincoln County Hospital Emergency Department.

Patient 3

10.5.10 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.

10.5.11 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.

10.5.12 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.

10.5.13 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 4

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

10.5.15 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.

10.5.16 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.

10.5.17 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: Patient 3 and 4 vignettes reflect full proposed acute medicine pathway at Grantham Hospital, which is described further in Chapter 11.

10.6 Assessment against tests for service change

10.6.1 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.

10.6.2 The proposed change to re-designate the Grantham A&E service as an Urgent Treatment Centre (UTC) has been assessed against these tests. This assessment reflects and aligns to the description and narrative for the preferred option for urgent and emergency services set out in this chapter.

Test 1: Strong public and patient engagement

10.6.3 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 urgent and emergency care services.

10.6.4 During July 2018 a series of nine engagement events to discuss hospital service in Lincolnshire were held, each in a different area of 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 points made in relation to urgent and emergency care at these events were:

- The discussions around urgent and emergency care were largely focused on how best to relieve pressure on existing A&E departments.
- Although there was some initial uncertainty about the difference between emergency and urgent care, it was generally accepted that A&E is often used incorrectly, and that more education is required to guide patients to the most appropriate place. There was confusion around, for example, exactly how an Urgent Treatment Centre differs to an A&E, and when to call 111 rather than 999. Participants also wanted to see more education on opening hours to assist the public.

- Some thought the burden on A&E might be relieved by more accessible GP services with longer opening hours; more widespread use of Advanced Nurse Practitioners, pharmacists and paramedics to assess patients; or through the development of 'hubs' containing multi-disciplinary teams. Many participants supported the idea of accelerating the process of assessing, 'filtering' or triaging patients.
- There were also suggestions for streamlining and improving 'pathways' between primary and secondary care, for example, allowing GPs more opportunity to refer patients directly to a specialist ward (where appropriate), completely bypassing the need for the patient to attend a walk-in centre or A&E.
- Existing locations such as Lincoln and Boston were widely identified as preferred sites for the provision of A&E services, with either Grantham or Stamford as a third location (to give coverage to North, South and East). Although the appropriate number of A&Es for Lincolnshire was not discussed in detail, a few participants stated one site would not be enough.
- Participants in Grantham felt their local A&E had been penalised at the expense of Boston's and Lincoln's, wanted a return to a 24-hour service, and were resistant to services being concentrated in Lincoln. Elsewhere participants asked for the seasonal and tourist pressure on coastal areas (e.g. around Skegness) to be considered as part of any service design. There was also support for Gainsborough offering an MIU or urgent care. Some participants had a negative perception of current services and said they would rather travel out of the county to Nottingham or Peterborough.

10.6.5 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 in relation to urgent and emergency services included:

- 72% of respondents were prepare*d* to travel under 45 minutes for urgent care (e.g. suspected broken arm); 22% were prepared to travel 45-60 mins; and 6% were prepared to travel over an hour.
- 92% of respondents were prepared to travel under 45 minutes for emergency care (e.g. suspected heart attack); 5% were prepared to travel 45-60 mins; and 3% were prepared to travel over an hour.
- When asked about a set of statements and which was most important in relation to urgent and emergency services 38% said 'I can access care when I need it and not just Monday – Friday 9am-5pm'.

10.6.6 In October 2018 four public options evaluation workshops were undertaken across Lincolnshire in Sleaford, Mablethorpe, Bourne and Gainsborough to enable members 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 for Lincoln Hospital and Pilgrim Hospital to provide 24/7 A&Es and Grantham to be re-designated as an Urgent Treatment Centre were discussed.

- Overall, a substantial majority of participants (84%) agreed with the proposed changes to emergency and urgent care.
- Across all four of the groups, a majority of participants agreed with the proposed changes – although it is worth noting that a third (3 out of 9) participants disagreed in Bourne.
- A number of participants expressed support for a two-site model, suggesting that this would lead to a more streamlined service. However, they felt for the model to work successfully, the CCGs should undertake a campaign to improve public awareness of where to present, as there is currently much confusion that could worsen if the model changes.
- Furthermore, it was felt this should be accompanied by education over the term used: for instance, if Grantham is re-designated as an Urgent Treatment Centre without a clear explanation of its purpose, this could lead to some people continuing to treat it as an A&E.

10.6.7 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 preferred options coming out of the ASR programme:

- In relation to urgent and emergency care services, and specifically relating to Grantham Hospital, key themes related to:
  - Distance and accessibility – treatment may be outside 'Golden Hour'
  - Transport – without a car access is difficult from other areas of the county
  - Grantham is on major road and rail links and needs an A&E open 24/7
  - New housing developments with increasing local population
  - Poor road networks and lack of public transport, especially in rural villages
  - Ambulance availability and response time concerns
  - Capacity issues – overburden on Lincoln Hospital
  - Inability to get back from hospital if taken by ambulance
  - Lack of transport to attend another A&E during the night
  - Service and staffing provision within the proposed Urgent Treatment Centre and how this may impact other hospitals
  - 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'.
- Suggestions to overcome challenges included:
  - Upgrade other local community hospitals to provide urgent and emergency care
  - Urgent and emergency care services required 24 hour a day 7 days a week
  - Offer walk in service 24/7 with full resuscitation and imaging
- 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 and the challenges this could bring. This also 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.

10.6.8 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 urgent and emergency care services on 15 May 2019 and submitted initial comments on the 23 May 2019.

10.6.9 These were:

- Acceptance that the introduction of urgent treatment centres (by autumn 2020) is a national initiative
- Need for 24/7 walk in access and proposals for Grantham Hospital should reflect this
- Concerns over continued absence of A&E facilities in Grantham and surrounding area overnight
- Need for list of services undertaken currently at Grantham A&E and proposed Grantham urgent treatment centre

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

10.6.10 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.

10.6.11 The guidance goes onto 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.

10.6.12 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 urgent and emergency care model.

10.6.13 Implementing the preferred option for urgent and emergency care will reduce the number of hospital sites with a service called an 'Accident and Emergency Department' from three to two (the number of providers is not reducing under the change proposals). However, in terms of the services provided and available to patients from each of the three hospital sites there will be minimal change.

10.6.14 This is due to the exclusion criteria that has existed at Grantham Hospital since 2007/08 due to its size and level of specialist services available. Under the proposed change to re-designate Grantham A&E to an Urgent Treatment Centre, the exclusion criteria will be refined, however it is estimated this will only impact on a small number (c.600 patients per year equivalent to 2.5-3.0% of the current activity seen) of higher acuity cases that clinically should receive specialist treatment elsewhere.

10.6.15 It should also be noted that given the proposal is for a 24/7 Urgent Care Treatment, more patients will be able to access the service than are currently able to under the reduced opening hours of the current A&E service.

Test 3: Clear clinical evidence base

10.6.16 The development of the case for change and preferred option for urgent and emergency care has had substantial clinical consideration and input from across the Lincolnshire health system:

- Concerns regarding sustainability of three 24/7 A&E services at each of ULHT's hospital sites expressed by clinical leads at Lincoln Hospital and Pilgrim Hospital.
- Development of options to address challenges faced in sustainability of A&E services led by ULHT Medical Director, supported by ULHT lead clinicians.
- In its review the Independent Reconfiguration Panel (IRP), which is supported by clinical experts, identified the A&E service at Grantham Hospital has for some time (since 2007/08) only dealt with a limited range or presenting emergency conditions and that the level of emergency service provided from Grantham Hospital is more akin to that of an urgent care centre.
- The IRP concluded that in the interests of safety the A&E service at Grantham Hospital should not re-open 24/7 unless sufficient staff defined by the threshold can be recruited and retained.
- The East of England Clinical Senate identified that based on the Royal College of Emergency Medicine 'rule of thumb' guide for 'Medical and Practitioner Staffing in Emergency Department', 36 middle-grade medical staff would be needed (i.e. 12 middle grades at each of the three sites) to maintain safe, sustainable 24/7 cover.
- The East of England Clinical Senate also identified the evidence showed that the majority of patients presenting at Grantham Hospital A&E were 'type 3', although it did agree that GDH did currently provide more than an Urgent Care Centre which tended to be Primary Care led, but significantly less than an A&E would usually be expected to provide.
- The East of England Clinical Senate panel concluded that there was no evidence that any extended opening, over and above the current level of provision of the A&E Department at Grantham Hospital (08.00-18.30 hours); would improve outcomes for patients.

10.6.17 The case for change and proposals for the future configuration of urgent and emergency care were tested through two ASR Clinical Summits with over 55 leads from across the system, facilitated by the East Midlands Clinical Senate.

10.6.18 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 conversations on urgent and emergency care services at this event were led by a ULHT urgent and emergency care consultant. At this event there was overwhelming support for this option with 98% of attendees either strongly or tending to agree it was the right way forward.

10.6.19 The identified preferred option for urgent and emergency care aligns with NHS England and Improvements vision for urgent and emergency care patients, with more serious life threating emergency needs treated in centres with the very best expertise and facilities in order to reduce risk and maximise chances of survival and recovery.

10.6.20 The presentation of the preferred option for urgent and emergency care services to the East Midlands Clinical Senate was led by local lead clinicians. The East Midlands Clinical Senate panel considered the exclusion criteria to be ‘clear, comprehensive and excellent’.

Test 4: Support for proposals from clinical commissioners

10.6.21 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.

10.6.22 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, community and acute care will continue into the public consultation meetings.

10.6.23 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.

10.6.24 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.

10.6.25 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

10.6.26 It is widely acknowledged that the current Accident & Emergency (A&E) department at Grantham Hospital is underutilised and the proposed re-designation of this service into an Urgent Treatment Centre (UTC) can be achieved within the current footprint.

10.6.27 The total activity forecast to attend the proposed 24/7 UTC on the Grantham Hospital site by 2023/24 is c.42,000-49,900. In 2015/16 when the A&E operated 24/7 the total urgent and emergency care activity seen between the A&E and Out of Hours service on the site was 44,972, which is in between the forecast estimate.

10.6.28 When the sensitivity analysis of a 10% reduction in activity is applied, which is the aspiration of the impact of the Integrated Community Care (ICC) model the forecast activity at the 24/7 UTC in 2023/24 c.37,800 - 44,910.

10.6.29 Within the original ASR PCBC and identified capital requirement, moderate capital investment was identified to address backlog maintenance and improve the functional suitability of the environment.

10.6.30 This would include some expansion into adjoining departments which are deemed underutilised, enabling a rationalisation of back office accommodation and increase in the amount of clinical floor space which enables a greater degree of privacy and dignity for patients.

10.6.31 These changes are still the longer term ambition, however they are not an immediate necessity to enable the transition from an A&E to a UTC and this change can still happen without them. The activity forecast in 2023/24 under the higher activity growth scenario (Scenario 2) does estimate a level of activity greater than that seen when the A&E operated 24/7. If required there is the option to relocate the fracture clinic to provide additional capacity (supported through virtual fracture clinics and telemedicine) ahead of the expansion planned for the longer term.

		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 NHS England and NHS Improvement (Midlands)

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**10 November 2021**
Subject:	**Update on NHS Dental Services in Lincolnshire**

Summary:

The purpose of this report is to provide an update to the Committee on the provision of NHS dental services commissioned in Lincolnshire. The report will include an overview of the continuing effects of the Covid-19 pandemic and the steps being taken to restore and recover service provision.

Actions Requested:

To consider and comment on the information provided by NHS England and NHS Improvement (Midlands) on Dental Services in Lincolnshire.

1. Access to Services

1.1 It is important to clarify that NHS dental care, including that available on the high street (primary care), through Community Dental Services or through Trusts is delivered by providers who hold contracts with NHS England and NHS Improvement. All other dental services are of a private nature and outside the scope of control of NHSEI. The requirement for NHS contracts in primary and community dental care has been in place since 2006.

1.2 There is no system of patient registration with a dental practice. People with open courses of treatment are practice patients during the duration of their treatment, however once complete; apart from repairs and replacements, the practice has no ongoing responsibility. People often associate themselves with dental practices. Many dental practices may refer to having a patient list or taking on new patients, however there is no registration in the same way as for GP practices and patients are theoretically free to attend any dental practice that will accept them. Dental statistics are often based on numbers of patients in touch with practices within a 24-month period and this in many cases be based on repeat attendances at a "usual dentist".

1.3 General Dental Practices within Lincolnshire offer a range of routine dental services; some of these generalist providers also provide less complex orthodontic services. In addition, there are specialist orthodontic practices; the orthodontists in these practices are specialists and provide more complex care. Extended or out of hours cover is provided by five '8-8 contracts', services which provide access to patients between 8 am and 8 pm, 365 days of the year. Secondary care is provided by United Lincolnshire Hospitals Trust (ULHT) and community dental services for special care adults and children is provided from five clinics in the area by CDS-CIC.

1.4 Around 50% of the population are routinely in touch with NHS high street dental services; the numbers of people attending private services is not known; but is not expected to be the remaining 50% of the population. Many people with less structured lifestyles or who are vulnerable may not engage with routine care and may instead use out of hours dental services. Individuals are free to approach practices to seek dental care and further information on NHS dental practices is available on the NHS website: https://www.nhs.uk/service-search/find-a-Dentist.

Timeline of National Pandemic Response and Impacts upon Dentistry

1.5. A timeline of the key decisions taken nationally and the impact upon dentistry is included below:

23 March, 2020

Routine dental services in England were required to close. Providers continue to receive contractual payments as previously (with a 16.75% abatement to mitigate cost savings of closure). All staff are required to be paid as per previous arrangements and providers instructed to operate remote telephone access for any patient contacting the practice.

April 2020

NHS England and NHS Improvement (NHSEI) commissions and mobilises urgent dental centres (UDCs) to ensure that patients with urgent needs can continue to access treatment. Dental practices are obliged to provide remote triage and Advice, the prescription (where appropriate) of analgesia and antibiotics despite being 'closed' as per an urgent care standard operating procedure (SOP).

UDCs are mobilised in Lincoln, Boston, Louth, Spalding and Sleaford. The UDCs remain open and operational and continue to operate at the time of writing to provide urgent care access and treatment for patients across Lincolnshire.

8 June, 2020
NHS Dental practices are allowed to reopen, with strict Infection Prevention Control (IPC) and social distancing protocols outlined and implemented. NHSEI supports practices to reopen as swiftly as possible.

20 July, 2020
All dental practices are expected to reopen and recommence provision of face-to-face services. Any practice advising that they are unable to reopen are contacted to understand the barriers to reopening and to support the development of an action plan to reopen as soon as possible.

January – March 2021
General dental providers are required to deliver a minimum threshold of 45% of their pre-Covid units of dental activity (UDA) or 70% of their pre-Covid units of orthodontic activity (UOA) in order to continue to receive 100% payment of their contract.

The minimum thresholds are not designed as 'targets' and are based upon the impact of providers adherence to the IPC and social distancing guidance imposed nationally.

Providers advised to inform NHSEI immediately as to any circumstances which may limit their achievement of these minimum thresholds so that arrangements can be put into place to support service recovery. Failure to achieve the minimum threshold of activity to result in a clawback of funding paid to providers upon reconciliation and review of activity.

April 2021 – September 2021
Required minimum thresholds for contract delivery are increased to a minimum of 60% of UDAs for general dental providers and 80% of UOAs for orthodontic providers, in order for providers to continue to receive 100% payment of their contract.

The thresholds are to remain constant for Quarters 1 & 2 of 2021/22 to provide stability to providers as they continue to recover services. Failure to achieve the minimum threshold of activity results in a clawback of funding paid to providers upon reconciliation and review of activity.

October 2021 – December 2021
Required minimum thresholds for contract delivery are increased to a minimum of 65% of UDAs for general dental providers and 85% of UOAs for orthodontic providers in order to continue to receive 100% payment of their contract.

Minimum thresholds are increased owing to some flexibility in IPC guidance which allows practices to treat patients with less 'downtime' between appointments.

IPC guidance and contractual minimum thresholds are to be revisited and reassessed in the coming weeks, with the minimum thresholds for January 2022 – March 2022 communicated in due course.

2. Continuing Impact and Effects of the Covid-19 Pandemic.

2.1 The continuing Covid-19 pandemic has had a considerable impact on dental services and the availability of dental care. The long-term impact on oral health is as yet unknown but forms a key component of recovery and restoration work being undertaken by NHSEI.

2.3 A significant constraint, that has limited practices in their ability to offer increased patient access and treatment, has been the introduction of 'downtime' – a period of time for which the surgery must be left empty following any aerosol-generating procedure (AGP). An AGP is a procedure that involves the use of high-speed drills or instruments and would include fillings, root canal treatment or surgical extractions. This has had a marked impact on the throughput of patients.

2.4 The constraints on the amount of activity that practices are able to safely deliver has dictated that NHS dental care remains prioritised towards those in greatest need. Primarily, during the pandemic, this has referred to patients with an urgent need for dental assessment and treatment.

2.5 NHSEI has worked closely with providers and other stakeholders to develop an Outbreak Standard Operating Procedure for practices to report any staff members that are self-isolating or have received positive Covid-19 tests. NHSEI is committed to supporting practices where incidents occur but can confirm that service delivery impacts have been minimal and are being well managed by practices across Lincolnshire.

3. Urgent Dental Centres (UDCs) and the Urgent Care pathway

3.1 Urgent and emergency oral and dental conditions are those likely to cause deterioration in oral or general health and where timely intervention for relief of oral pain and infection is important to prevent worsening of ill health and reduce complications. Urgent dental care problems have been defined previously into three categories. The table below shows current national information about the three elements of dental need and best practice timelines for patients to receive self-help or face to face care.

Triage Category	Time Scale
Routine Dental Problems	Provide self-help advice. Provide access to an appropriate service within seven days, if required. Advise patient to call back if their condition deteriorates

Triage Category	Time Scale
Urgent Dental Conditions	Provide self-help advice and treat patient within 24 hours. Advise patient to call back if their condition deteriorates
Dental Emergencies	Contact with a clinician within 60 minutes and subsequent treatment within a timescale that is appropriate to the severity of the condition

3.2 UDCs and Out of Hours services have been set up to operate to provide care in line with the standards described above. Practices also apply the same criteria but routine dental problems (those not associated with significant pain or swelling) are unlikely to be deliverable currently within 7 days due to the need to prioritise those in pain.

3.3 The availability of routine check-ups remains likely to be limited to those who are vulnerable or who have continuing dental issues, however the number of providers 'recalling' patients for routine check-ups and treatments continues to increase across the Midlands.

3.4 Many patients with generally good oral health would not be expected to require six monthly check-ups under normal circumstances and these remain safe to be deferred at this time. Treatment options may be more limited than usual. This is due to the need for AGP (aerosol generating procedures) for restorative dentistry (e.g. fillings and root canals), which are limited due to the extended 'downtime' necessary between patients.

3.5 At the outset of the pandemic response, the dental team engaged with stakeholders (including the Local Dental Committee (LDC), Local Dental Network (LDN) and Public Health England colleagues) to agree suitable sites for urgent dental care centres.

3.6 Across Lincolnshire UDC sites were mobilised in Lincoln, Boston, Louth, Spalding and Sleaford. The majority of these sites were established 8-8 practices, which offered the optimum combination of geographical coverage, contracted hours of opening and staffing.

3.7 In addition, sites were mobilised to provide care for those vulnerable patients that were "shielding" and for symptomatic patients. The local Community Dental Service was mobilised to provide these services, with enhanced infection prevention control measures in place for patients attending the symptomatic site.

3.8 The local Community Dental service continues to provide care for those with special care needs including some children.

3.9 The UDCs remain operational and continue to support other local practices in providing care to local patients – in particular those who do not have a “usual” dentist or are new to NHS dental care.

3.10 There remains no direct access into the UDCs; they are required to follow distancing and appointment only face to face contacts. Referral to a UDC is via a general dental practice or via 111.

3.11 The optimum pathway for accessing dental services (whether urgent or routine) remains for patients to contact a local dental practice (when attempting to access care during working hours) or to contact NHS 111 outside of working hours.

4. Vulnerable Patients

4.1 NHSEI, the Office of the Chief Dental Officer (OCDO), the Department of Health and Social Care (DHSC) and Public Health England have all written to providers to try and ensure that patients from vulnerable groups are not detrimentally impacted by the continued reduced levels of dental service provision.

4.2 Practices are expected to prioritise vulnerable patients (including children and those most ‘at-risk’ of dental disease and oral health problems) when recommencing routine care and recalls for check-up appointments.

5. Lincolnshire Dental Service Performance

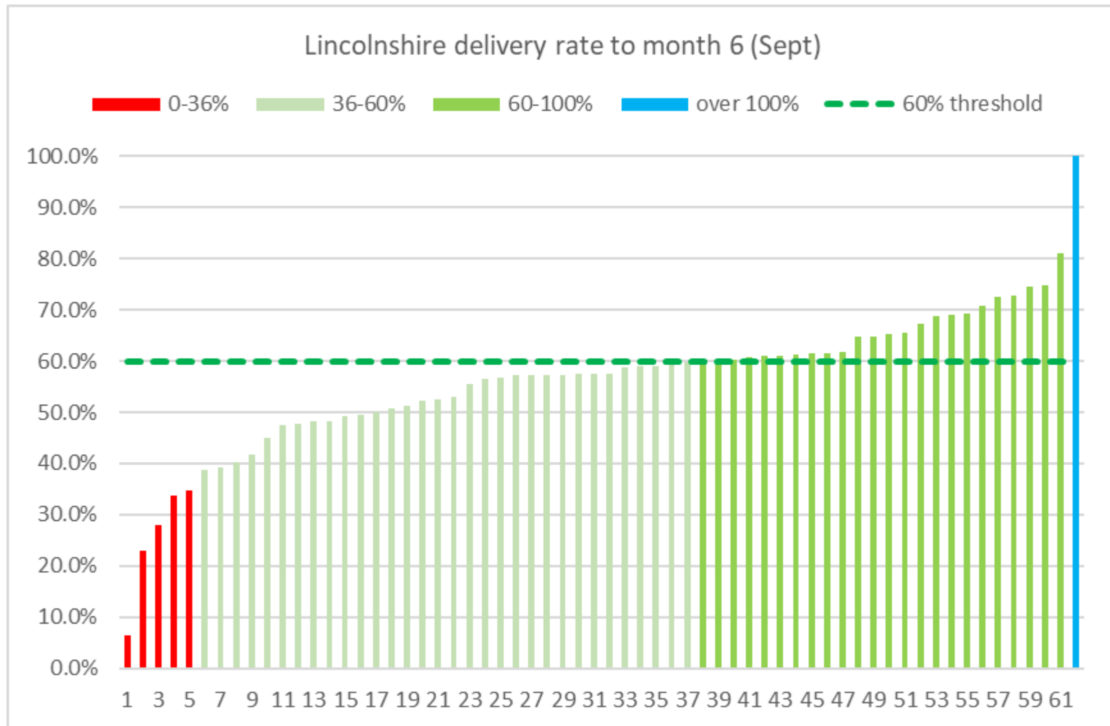
5.1 Across Lincolnshire during the first six months of the financial year 2021/22, 60.4% (vs. a minimum threshold of 60%) of pre-Covid contracted UDAs was delivered.

5.2 This represents a ‘loss’ of over 230,000 Units of Dental Activity (UDAs) during this period against the levels of pre-Covid activity commissioned by NHSEI and illustrates the level of service impact that the pandemic continues to have upon dental services.

However it is also important to note that one UDA does not equate to one appointment of course of treatment as different treatments attract different levels of UDAs (i.e. the more complex a course of treatment, the more units the course of treatment attracts to ensure that providers are compensated for the increased amount of time and resource required for that treatment).

5.3 During April-September 2021 (Q1 & Q2) providers were required to deliver a minimum of 60% of their pre-COVID contractual activity, in order to continue to receive 100% payment. Figure 1 (below) illustrates this achievement for all Lincolnshire providers during this time period.

Figure 1: Lincolnshire Provider Delivery Apr-Sep 2021



5.4 Of the 62 contracts in Lincolnshire providing general dental services:

- five contracts (red) delivered less than 36%
- 32 contracts delivered between 36% - 60%
- 24 contracts delivered between 60% - 100%
- one contract delivered greater than 100% (i.e. greater than the level of activity commissioned by NHSEI)

5.5 For Orthodontic providers the minimum threshold is higher (owing to less complex IPC guidance and less frequent use of AGPs) at 80%. During Q1 and Q2 across Lincolnshire providers delivered 94.4% of contracted orthodontic activity.

5.6 All providers delivering less than 60%/80% of activity are subject to contractual action by NHSEI. NHSEI will reclaim the appropriate proportion of monies paid to under-performing providers and reinvest these monies in schemes designed to support service recovery.

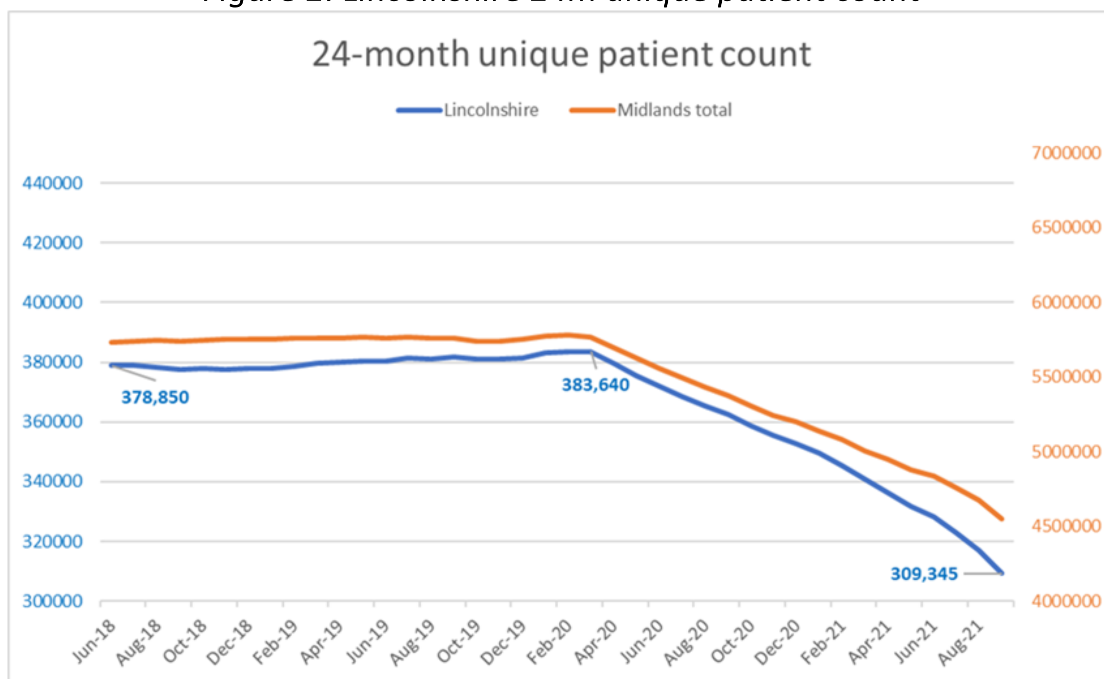
6. Recovery and Restoration of Services

6.1 Outlining a timeframe for full service recovery remains difficult, owing to the continued requirement for enhanced IPC measures and the impacts upon providers and their staff of the pandemic thus far.

6.2 The most appropriate objective measure to illustrate the 'loss' of activity is in the shape of 24-month unique patient access figures. These figures show the number of patients accessing NHS dental services over a two-year period. While this measure is not perfect (as some patients may be more likely to visit a dentist in this timeframe and others may not ordinarily visit at all) it does provide a proxy measure for 'lost appointments' and demonstrates the scale of the service backlog that exists.

6.3 Figure 2 (below) shows the impact of the COVID-19 pandemic on the 24-month unique patient count for both Lincolnshire and the Midlands region:

Figure 2: Lincolnshire 24m unique patient count



6.4 Broadly speaking, the above chart illustrates that, across Lincolnshire, there are approximately 74,295 patients that would ordinarily visit a dentist that have been unable to do so during the last eighteen months or so. Before dentistry can be fully 'restored' to pre-pandemic levels, this backlog will need to be addressed.

7. NHS England and Improvement Initiatives

7.1 To support the recovery and restoration of dental services, NHSEI has commissioned additional initiatives across the Midlands to attempt to mitigate the detrimental impact upon dental access and the limitations upon providers in delivering maximum numbers of appointments.

<u>Weekend Access Scheme</u>

7.2 NHSEI opened an expression of interest to all dental providers across the region to provide additional sessions of activity outside of contractual hours at weekends. This initiative was designed to encourage providers to open for additional sessions and appointments and increase patient provision.

7.3 Criteria were developed to ensure that activity commissioned was additional and that providers were only eligible if they were able to deliver their contracts in line with national minimum thresholds. Providers were also required to pass clinical checks to ensure that activity commissioned was of a high and safe standard for patients.

7.3 The initiative was initially offered to providers during January – March 2021 and successfully offered additional access to patients.

7.4 Following the success of the scheme it was repeated with providers able to deliver sessions during the period July 2021 – March 2022. Providers expressed an interest to provide sessions, but noted significant issues in their doing so, such as staff burnout, reluctance (having worked increased hours and in extremely difficult circumstances throughout the pandemic) of staff to commit to additional working hours and capacity limitations as a result.

Ventilation Schemes

7.5 A key input towards the restoration and recovery phase of NHS Dental services is the ability to increase patient access and treatment by reducing post AGP 'downtime' by supporting NHS dental practices to understand their air changes per hour (ACH) and 'downtime' whilst meeting the Workplace (Health, Safety and Welfare) Regulation.

7.6 To assist providers in operating as efficiently as possible NHSEI commissioned support via a contribution to practices to undertake a basic ventilation and filtration survey. This helped providers to understand their current building ventilation and filtration and how this can be enhanced to maximise throughput.

7.7 Across Lincolnshire three providers have received funding to improve the ventilation in their practice and to reduce the required 'downtime' between AGP appointments.

Dedicated 111 Slots

7.8 NHSEI recognises the impact of the pandemic on dental access and particularly the accessing of care by vulnerable groups. Many vulnerable groups access services infrequently and only when their needs are of an urgent nature.

7.9 To support this cohort of patients, NHSEI engaged with providers and NHS 111 to secure an additional 56 appointments per week across Lincolnshire, to be accessed and booked via NHS 111, for patients that do not regularly attend a dental practice.

7.10 Providers are required to reserve these appointments and to ensure that they are utilised only for the patients in this cohort, who access the dental pathway via 111 and meet the criteria for urgent treatment.

7.11 Review of the initiative is ongoing but all parties have reported a good level of usage and treatment of patients that fit the vulnerable criteria, with no slot wastage as any unused slots are offered for patients who contact the practice directly should a slot not be booked by 111.

7.12 It is hoped that this ongoing initiative will ensure access to services for those patients that do not ordinarily engage with dental services, via a direct and expedited route.

New Appointments

7.13 To ensure that NHS Dental services are at the forefront of the new Integrated Care Systems NHSEI has newly appointed Kenny Hume as the Local Dental Network (LDN) Chair for Lincolnshire. Kenny's role will be ICS-facing and provide a direct senior clinical link between NHSEI and the ICS and other stakeholders, including the HOSC meeting.

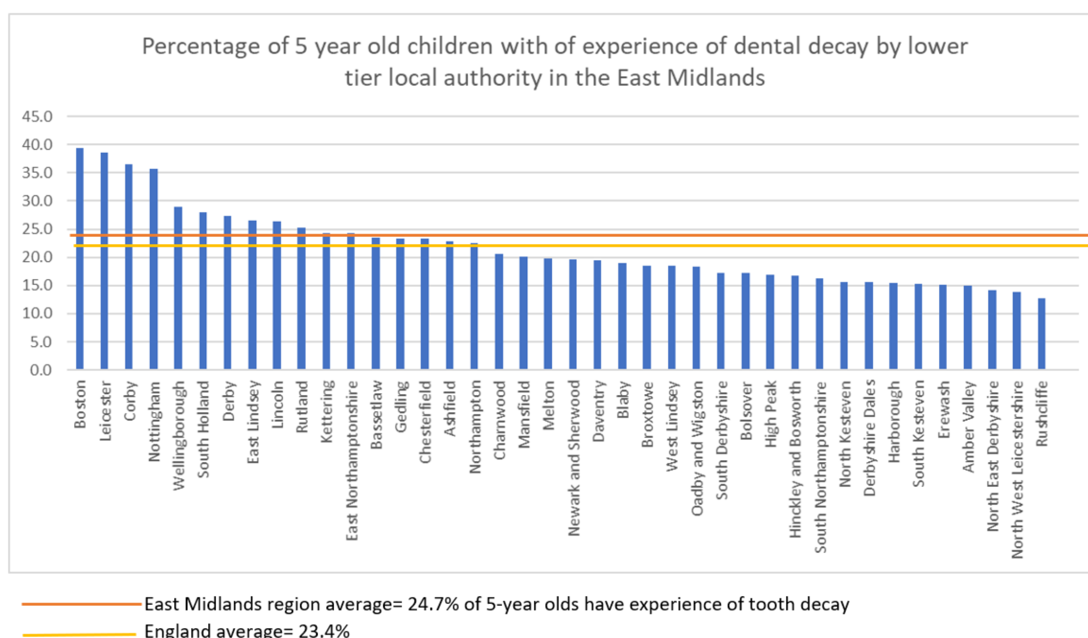
7.14 In addition, Adam Morby has been appointed as the Midlands Regional Chief Dental Officer, to provide senior clinical leadership for dentistry across the region and a greater link to the Chief Dental Officer for England and the Department of Health and Social Care.

8. Oral Health in Lincolnshire

Child Oral Health

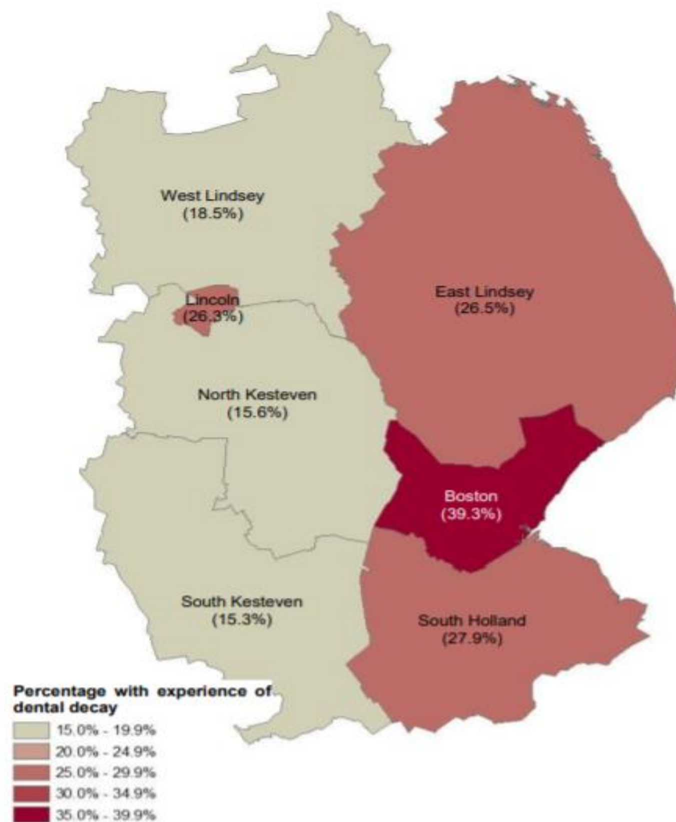
8.1 The national child dental epidemiology programme conducts a survey of the dental health of 5-year-old state school pupils every two years. The most recent survey published at the start of 2021 shows that in Lincolnshire average levels of dental decay are higher than the average for England, however, within Lincolnshire there are areas where there are higher than average levels of experience of dental decay.

Figure 3: Percentage of 5-year-old children with an experience of dental decay



8.2 At lower-tier local authority level, children living in Boston have the highest levels of experience of dental decay in the region. South Holland, East Lindsey and Lincoln also have child dental decay that places them in the top ten lower tier local authorities in the region.

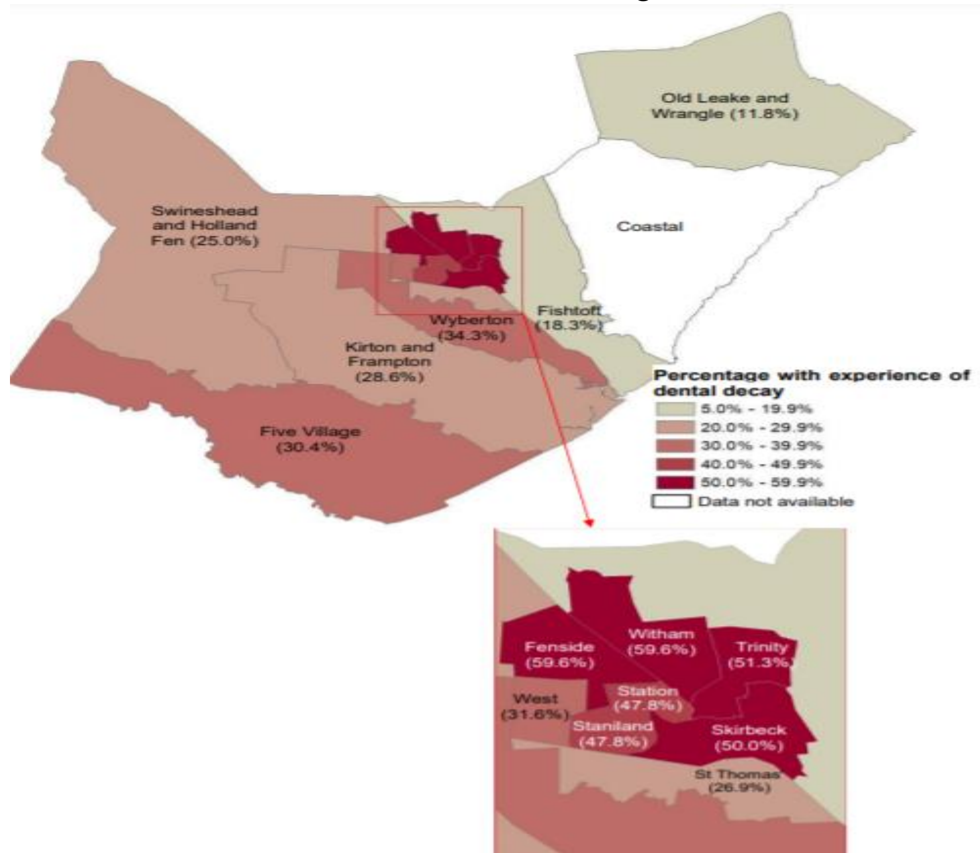
Figure 4: Prevalence of experience of dental decay in 5-year-olds in Lincolnshire, by lower-tier local authority, 2019



8.3 There is effectively a clear East/West divide in childhood tooth decay experience in Lincolnshire with children living in the east of the county experiencing poorer oral health and higher levels of tooth decay. This disparity is due to the fact that the West of the county's water supply is fluoridated under an existing water fluoridation agreement. The east of the county does not receive fluoridated water. Fluoride in the water to the level of one part per million is highly evidenced to be protective against the risk of tooth decay. The difference is tooth decay levels in children as a result of this west/east water fluoridation divide is stark with a 10%-20% absolute increase in the proportion of children experiencing tooth decay between moving from west to east.

Within Boston, the highest levels of experience of dental decay are clustered around Fenside, Skirbeck, Trinity and Witham wards, with tooth decay rates around 50% and above of children affected.

Figure 5: Percentage with Experience of Tooth Decay in Boston and Surrounding Area.



8.4 The risk of tooth decay in children in the east of the county is compounded by the fact that dental services are in less supply in the more remote, coastal areas influencing the attraction and retention of the dental workforce. Therefore, there is a situation of higher levels of need and lower levels of services. This makes the prevention of dental disease all the more important in these areas

<u>Prevention of Childhood Dental Disease in Lincolnshire</u>

8.5 Lincolnshire has a well-established and very active Oral Health Advisory Group consisting of system-wide partners across health and social care, with the input of specialist dental public health advice through the former Public Health England (recently transitioned into NHS England).

8.6 This multiagency partnership group develop strategic plans around oral health improvement for all Lincolnshire citizens across the lifecourse. This is informed by undertaking a joint oral health needs assessment of the population, which is regularly updated as new data becomes available.

8.7 The local authority commission a dedicated oral health promotion service who engage with and visit schools across the county to deliver oral health promotion and prevention.

8.8 Priorities and actions for the group in tackling child dental decay include:

- increasing access to supervised tooth-brushing in nursery and school settings, and increasing access to fluoride across the region (via toothpaste distribution and topical varnish applications), particularly targeted to those areas in the east of the county that do not enjoy the benefits of water fluoridation
- working with health visitors and community workers to better identify children and their families who are at high risk of tooth decay and poor oral health, so that preventative advice, support and signposting to available services can be actioned, thus contributing to a reduction in the number, and associated financial, social and personal burden, of children having to attend hospital for tooth extractions under general anaesthetic; and
- working with NHSE dental commissioners to improve access to child dental services, both at primary and community dental care levels across the county, targeted at areas of highest need wherever possible.

8.9 NHSE dental commissioning, public health and the local authority co-design and fund a range of evidence-based prevention interventions and initiatives to improve child and adult oral health and mitigate against the recognised risks to oral health

8.10 Further funding has been made available to mitigate against the effects of the pandemic on dental services. With the recent government White Paper of healthcare reform plans to take central government control in relation to the future expansion of community water fluoridation schemes in order to help remove some of the existing barriers to this, we would recommend wider political advocacy and support at a local level for expansion of water fluoridation across the whole of Lincolnshire, as this would have a significant positive effect in reducing the inequalities in child dental health across the county.

Adult Oral Health in Lincolnshire

8.11 In 2017/18 the National Dental Epidemiology Programme undertook an oral health survey of adults attending general dental practices in England. It provided data to inform joint strategic needs assessments and oral health needs assessments to plan and commission oral health improvement interventions and services for adults.

Adults attending general dental practices for any reason, aged 16 years and over, were recruited to take part in the survey. The survey consisted of a questionnaire on the impact of oral problems on individuals, use of dental services and barriers to receipt of care and a brief clinical examination conducted by trained local epidemiology teams under standardised conditions.

8.12 Summary of adults' oral health:

- The oral health of adults has improved significantly over the last 40 years with more of the population retaining their natural teeth throughout life.

- In Lincolnshire 20.7% of adults had tooth decay and 2% had severe gum disease. 45% of adults in Lincolnshire had an identified dental treatment need, with just under 2% classed as urgent need. This compares favourably with regional and national levels
- Men from materially deprived backgrounds were more likely to experience higher levels of tooth decay and gum diseases but least likely to visit a dentist.

Epidemiology of Oral Diseases in Vulnerable Groups

8.13 Vulnerable groups are those people whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services. This includes people who are old and frail, have physical or mental disabilities, homeless, children who are, or who have been in care.

8.14 These groups often require special treatment or treatment in a special setting to accommodate their needs. The 2015/16 Oral Health Survey of Older People presented the results of a questionnaire and standardised dental examination of older people (aged 65 years and older) with mild dependency who live in "extra care" housing establishments. This is the first oral health survey of this population group and the method was implemented as a pilot. There is therefore no directly comparable data to use which could help to show trends.

8.15 Summary of vulnerable groups' oral health:

- 49% of those older vulnerable adults surveyed in Lincolnshire reported having not visited a dentist in the last two years, with 32% saying they have difficulty travelling to and from a dentist compared with 13% nationally.
- 21% of older vulnerable adults in Lincolnshire reported having current dental/oral pain, far higher than the national figure of 9.5%.
- A higher number of vulnerable adults require domiciliary dental care in Lincolnshire than nationally (9% versus 5%)
- Children with learning disabilities are more likely to have teeth extracted than filled and have poorer gum health
- Adults with learning disabilities are more likely to have poorer oral health than the general population
- Adults with learning disabilities living in the community are more likely to have poorer oral health than their counterparts living in care
- Homeless people are more likely to have greater need for oral healthcare than the general population

8.16 As with Lincolnshire's prevention work in dental/oral health for children, priority and investment is provided to improve adult oral health and to mitigate against oral health risks. An example of this is Lincolnshire's improving oral health in care home initiative. This programme, called SONA (Swallowing, Oral Health and Nutrition Ambassadors) aims to upskill care homes around the delivery and improvement of evidence based and systematic daily mouth care to their residents which is shown to reduce pain, discomfort and treatment need as well as favourable impact on general health and care use.

9. Equalities and Human Rights Implications

The report author acknowledges the impact upon access to dental services for population of Lincolnshire, particularly vulnerable patient groups, and the mitigating actions taken.

10. Consultation

This is not a direct consultation item.

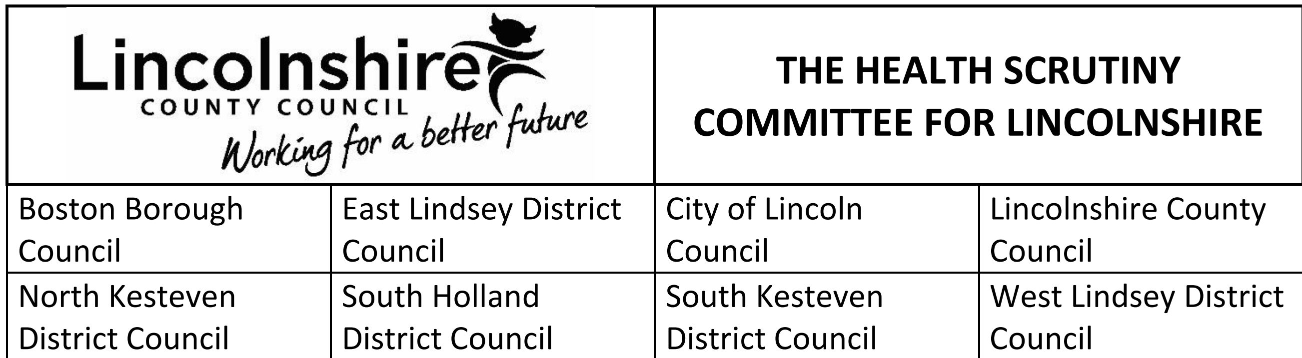
11. Conclusion

The Committee is requested to consider the information presented in this report by NHS England and NHS Improvement (Midlands) on the impact of the Covid-19 pandemic on dental services in Lincolnshire; the plans for recovery; and the overview of oral health in the county.

12. Background Papers

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

The contact officer for this report is Carole Pitcher, Senior Commissioning Manager,
NHS England and Improvement (Midlands), who can be contacted via
Carole.Pitcher@nhs.net



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:	**10 November 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

(1) To consider and comment on the Committee's work programme.

(2) To extend the activities of the working group, established at the last meeting for the consultation on the Lincolnshire Acute Services Review, to the Humber Acute Services engagement exercise.

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: -

10 November 2021		
	Item	*Contributor*
1	Lincolnshire Acute Services Review: Stroke Services	Representatives from United Lincolnshire Hospitals NHS Trust: • Dr Abdul Elmarimi, Consultant in Stroke Medicine • Management Representative
2	Lincolnshire Acute Services Review: Urgent and Emergency Care 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
3	Dental Service Update – NHS England (Midlands)	Representatives from NHS England NHS Improvement (Midlands): • Carole Pitcher, Senior Commissioning Manager • Tom Bailey, Senior Commissioning Manager

3. Future Work Programme

Scheduled Items

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 • Management Representative
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

15 December 2021		
	Item	*Contributor*
3	Humber Acute Services Review – Core Hospital Services Programme	Representatives from the Humber Acute Services Review Team
4	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

19 January 2022		
	Item	*Contributor*
1	Lakeside Medical Practice Stamford – Update on Response to the Inspection Report of the Care Quality Commission.	Representatives from Lincolnshire Clinical Commissioning Group
2	East Midlands Ambulance Service Update	Representatives from East Midlands Ambulance Service
3	Consultation on Lincolnshire Acute Services Review (Finalisation of Response)	Simon Evans, Health Scrutiny Officer
4	Humber Acute Services Review – Engagement Activity (Finalisation of Response to Engagement Exercise)	Simon Evans, Health Scrutiny Officer
5	Continuing Healthcare	Representatives from Lincolnshire Clinical Commissioning Group

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

16 March 2022		
	Item	*Contributor*
1	Community Pain Management Service (CPMS) Update	Representatives from Lincolnshire Clinical Commissioning Group

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.

- **Non-Emergency Patient Transport –** The Committee has requested an update on the outcomes of the current procurement exercise for a new contract for non-emergency patient transport which is due to begin from 1 July 2022.

- **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.

- **Lessons Learned from Lakeside Healthcare Stamford** – The Committee has requested details on the lessons learned from Lakeside Healthcare Stamford.

- **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. Working Group – Acute Services Review

On 13 October 2021, the Committee established a working group comprising Councillors Carl Macey, Linda Wootten, Mrs Sandra Harrison, Sarah Parkin, Mrs Angela White, Mark Whittington and Ray Wootten. The role of the working group is to consider the detail of each proposal of the Lincolnshire Acute Services Review and to draft the Committee's response to the consultation document. As the Humber Acute Services Review reaches its engagement phase, it is proposed that the working group also consider any relevant details, and also draft a response to this document.

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