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

Direct Dialling: 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, 13 October 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
5	**Lincolnshire Acute Services Review - Introduction to Consultation and Arrangements for Response** *(To receive a report from John Turner, Chief Executive Lincolnshire Clinical Commissioning Group, which provides an introduction on the content of the consultation for the Lincolnshire Acute Services Review and invites the Committee to agree its arrangements for responding to the consultation)*	19 - 98
6	**General Practice Access** *(To receive a report from the Lincolnshire Medical Committee (LMC), which provides the Committee with an update on access to general practice services. Dr Kieran Sharrock, Medical Director, Lincolnshire Local Medical Committee will be in attendance for this item)*	99 - 102
7	**Lincolnshire Clinical Commissioning Group - Support for General Practice** *(To receive a report from the Lincolnshire Clinical Commissioning Group, which advises the Committee of the support for general practice. Sarah-Jane Mills, Chief Operating Officer (West Locality), Lincolnshire Clinical Commissioning Group will be in attendance for this item)*	To Follow
8	**Eligibility Criteria for Non-Emergency Patient Transport - Consultation** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to approve the Committee's response to the NHS consultation on the eligibility criteria for non-emergency patient transport)*	103 - 106
9	**Health Scrutiny Committee for Lincolnshire - Work Programme** *(To receive a report from Simon Evans, Health Scrutiny Officer, which invites the Committee to consider and comment on its forthcoming work programme)*	107 - 114

Debbie Barnes OBE
Chief Executive
5 October 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, 13th October, 2021, 10.00 am (moderngov.co.uk)

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
15 SEPTEMBER 2021

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors L Wootten (Vice-Chairman), M G Allan, R J Cleaver, S R Parkin and R Wootten.

Lincolnshire District Councils

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

Healthwatch Lincolnshire

Dr B Wookey.

Also in attendance

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

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

Simon Evans (Chief Operating Officer, United Lincolnshire Hospitals NHS Trust), Wendy Martin (Associate Director of Nursing & Quality, Lincolnshire Clinical Commissioning Group), Sarah-Jane Mills (Chief Operating Officer (West Locality), Lincolnshire Clinical Commissioning Group), Anna Richards (Associate Director of Communications and Engagement), Caroline Walker (Chief Executive, North West Anglia NHS Foundation Trust), Nick Blake (Head of Transformation and Delivery (South Locality), Lincolnshire Clinical Commissioning Group) and Laura White (Head of Nuclear Medicine, ULHT) and Laura White (Head of Nuclear Medicine, ULHT).

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

24 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors Mrs S Harrison (East Lindsey District Council), Mrs L Hagues (North Kesteven District Council) and Dr M E Thompson.

It was noted that Councillors S Devereux (East Lindsey District Council) and T Boston (North Kesteven District Council) had replaced Councillors Mrs S Harrison (East Lindsey District Council) and Mrs L Hagues (North Kesteven District Council) respectively, 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).

25 DECLARATIONS OF MEMBERS' INTERESTS

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

26 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING ON 21 JULY 2021

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 21 July 2021 be agreed and signed by the Chairman as a correct record.

27 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 the 14 September 2021. The supplementary announcements made reference to:

- Build Back Better – Our Plan for Health and Social Care document which had been published by the government on 7 September 2021, which provided an overview of how the elective care backlog in the NHS will be tackled;
- Covid-19 Statistics for Lincolnshire. It was noted that Lincolnshire's Local Outbreak Engagement Board (LOEB) was due to meet on the 15 September 2021 at 10.00am. The Board would be considering the latest Covid-19 statistics for Lincolnshire. The Committee was advised that the information would be circulated to members of the Committee following the LOEB meeting;
- Health Infrastructure Plan: Future New Hospitals Programme. It was noted that the Lincolnshire NHS system had prepared an expression of interest as part of the latest phase of the government's *Health Infrastructure Plan: Future New Hospital's Programme*, which had to be submitted by 9 September 2021; and
- Appointment of Chief Executive – Lincolnshire Partnership NHS Foundation Trust (LPFT). The Committee noted that LPFT had appointed Sarah Connery as its new Chief Executive.

During a short discussion, the following matters were raised:

- Whether the *Health Infrastructure Plan: Future New Hospital's Programme,* included the building of new hospitals. The Committee noted that details had yet been received regarding the new programme and that once information had been received, it would be shared with members of the Committee;
- The need to ensure that United Lincolnshire Hospitals NHS Trust Urology Services, (Item 4 of the Chairman's Announcements) was kept on the Committee's Work Programme for further consideration in six months' time; and
- Concern was also expressed to the centralisation of services by United Lincolnshire Hospitals NHS Trust, particular reference was made to the effect on Pilgrim Hospital, Boston. The Chairman confirmed that this would be monitored by the Committee.

RESOLVED

That the Supplementary Chairman's announcements circulated on 14 September 2021 and the Chairman's announcements as detailed on pages 17 – 46 of the report pack be noted.

28 LAKESIDE MEDICAL PRACTICE, STAMFORD

The Chairman invited the following presenters from the Lincolnshire Clinical Commissioning Group (CCG): Wendy Martin, Associate Director of Nursing and Quality,) and Nick Blake, Head of Transformation and Delivery (South Locality), to remotely present the report to the Committee. The Committee was advised of an apology from Andy Rix, Chief Operating Officer (South Locality).

The report advised of the actions taken both in advance of and following the publication of an inspection report by the Care Quality Commission (CQC) on 2 August 2021 on the Lakeside Medical Practice (Stamford). It was noted that the CQC report had found Lakeside Stamford to be 'inadequate' and as a result had put the practice into special measures.

The report also provided the Committee with details of the mitigating actions taken by Lakeside, Stamford, plus assurance and support activity for Lakeside by the Lincolnshire Clinical Commissioning Group.

Summary details relating to the response of Lakeside, Stamford to address all areas of concern were shown on pages 50 and 51 of the report pack.

It was highlighted that the CCG was satisfied with the progress of the practice to date and the Committee was advised that the CCG would be continuing to meet with the practice at regular intervals to receive on-going assurance on the improvement actions and to provide support and guidance when required.

It was reported that Patient Participation Group (PPG) chair would be gaining feedback from patients, through an email address, online survey and from postcards left at the surgery.

It was also reported that CQC representatives had also been satisfied with the progress made by the practice. The Committee noted that the CQC had carried out a re-inspection in the week commencing 30 August and that a update on progress and any issues identified following the re-inspection were expected to be received in the near future.

The Committee was invited to review and consider the report to improve care provision from Lakeside Healthcare General Practice (Stamford). During discussion, the following comments were raised:

- The CQC Inspection Regime. The Committee noted that when the practice had been inspected previously, it had been rated as 'good'. As a result of issues raised by patients and patients groups the CQC had made an inspection on 8 June 2021 and found the practice to be 'inadequate' and as a result had placed the practice into special measures. Some concern was expressed that action should have been taken sooner;
- Whether there was a monitoring process that checked that the concerns highlighted by patients had been addressed. The Committee was advised that the PPG would be obtaining feedback from patients through an on-line survey and from postcards left at the surgery. Reassurance was given by the Healthwatch representative that some improvements had already been made, but there was still some concerns as to whether the local voice was being listened too; and whether there were communication problems, as the practice was part of a larger group;
- Whether lessons had been learnt which could assist other practices? Confirmation was given that lessons had been learnt and that these would be shared with other practices. Some Committee members felt that further information concerning the lessons learnt should have been included in the report, and that a further report should be made available to the Committee advising of the lessons learnt to help ensure that the situation did not happen in other GP practices;
- That further information needed to be made available regarding the workings of the telephony system; and the advice available to patients on the website;
- Some concern was also expressed regarding contractual obligations and whether these were being adhered to. The Committee noted that the contracts were standard national contracts and that clauses and penalties were part of the said contracts;
- Reassurance was sought that the action plan identified timeframes by which the highlighted actions needed to be completed by. A summary of the required main actions and their current status was provided on pages 50 and 51 of the report pack. The Committee noted that the practice was still within the period set by the CQC for improvements. It was noted further that if it was found that insufficient progress had been made and a practice was still deemed inadequate, the CQC could de-register a practice;
- When the outcome of the re-inspection would be made available. The Committee noted that indications were that improvements had been made, but that the practice still had some further work to do. It was highlighted that the practice had been very

receptive to help and would be receiving additional support to help them improve; and

- What the biggest challenges were for Lakeside in the coming months. The Committee was advised that the biggest challenge was gaining back patient trust; and making sure that staff at the practice were well informed, trained and supported.

The Chairman on behalf of the Committee extended thanks to the presenters; and their best regards were extended to Andy Rix, Chief Operating Officer (South Locality).

RESOLVED

1. That the Committee's concerns be recorded concerning the standards of care provided by the Lakeside Medical Practice, which had led to the Care Quality Commission's rating of 'inadequate'.

2. That a request be made for a copy of the practice action plan to address all areas of concern highlighted by the CQC; and information relating to lessons learnt.

3. That the actions taken by Lakeside Medical Practice to date in response to the inspection be noted and that a further update be received at a future meeting.

29 COMMUNITY PAIN MANAGEMENT SERVICE - UPDATE

The Committee gave consideration to a report from NHS Lincolnshire Clinical Commissioning Group, which provided the Committee with an update on the Community Pain Management Service (CPMS).

The Chairman invited Sarah-Jane Mills, Chief Operating Officer (West Locality), to remotely present the report to the Committee.

The Committee had previously received an update on the Community Pain Management Service at its March 2021 meeting.

It was reported that the CPMS had made good progress in the last six months in improving referral to assessment waiting time performance, whilst continuing to operate in a Covid-19 safe working environment.

The Committee was advised that the CPMS expected to have 100% of clinic locations operating face to face appointments by the end of September, improving capacity and convenience for patients, where it was clinically appropriate to do so, or at the wish of the patient.

It was highlighted that the Care Quality Commission (CQC) had rated Connect Health, the organisation which provided the CPMS in May 2021 as 'good' overall.

The Committee noted that the latest CPMS Quarterly Quality Report up to June 2021 had not highlighted any areas of concern. It was highlighted that the report had shown an improvement as positive feedback had been received by patients completing and returning a patient satisfaction survey and that there had been a reduction in negative feedback compared to the previous quarter.

The report also provided a summary of the time taken for the CCG to make decisions where pain management treatment had been requested through the CCG individual Funding request process and further commentary on the use of opioids, a medicine which traditionally had been used for the treatment of chronic pain.

Appendix A to the report provided a Key Performance Indicator Performance Summary for the period January to June 2021 for the Committee's consideration.

The Committee was asked to consider the information presented. During discussion, the following comments were raised:

- The impact of chronic pain on an individual. Some concern was expressed to the length of time patients were waiting to be seen and to the minimum targets. The Committee was advised that the targets were national targets. Reassurance was given that Connect Health would ensure that patients were signposted to other support services to help them manage their pain. The Committee noted that it was the aspiration of the service to exceed the national targets;
- Some concern was expressed that delays in obtaining a GP appointment were also an issue for patients accessing the service;
- Whether the service was effective in dealing with pain management. Reassurance was given that the treatment prescribed matched the needs of the individual. It was noted that the use of the public health management system, would enable the service to better understand needs at a local level, highlight trends and help shape the service to meet needs better;
- Some concern was raised at to how pain management services were provided in Lincolnshire compared with other areas. Particular reference was made to the pathway into the CPMS; and to the service's reluctant use of opioids. The Committee was advised that the model adopted in Lincolnshire was in line with NICE guidance and the British Pain Society recommendations, which had been adopted as best practice. The Committee was advised further that it was the case in Lincolnshire that patients were able to receive injections. Injections would be administered where it was clinically appropriate to do so. It was noted that the pain management service looked at the whole person, as opioids were very addictive, and that clinicians worked with patients to find other ways of managing their pain;
- Clarification was sought as to the start of the assessment process. The Committee as advised that the start of the process was when the patient was review and assessed;
- Clarification as to the provision of the CPMS to Stamford residents. The Committee was advised that Stamford had not been omitted from the initial commissioning of

the service. Due to closeness of Stamford to the border, it had been originally agreed that both Peterborough and Stamford should have their own local clinic;

- Concern was expressed that the follow up system did not appear to be working very effectively and needed to be reviewed. The representative agreed to look into this matter further;
- Referral into the service – The Committee was advised that referrals could be made by consultants as well as primary care;
- Some concern was expressed that there would be no provision for a pain management clinic in Louth until October. Reassurance was given that the clinic would be open as soon as possible; and
- The problems encountered by some patients accessing the CMPS via their GP. The Committee was advised that the CCG could review this information, to identify if some practices were not accessing the service via the clinical pathway, or not utilising the service, as their referral rates would be lower.

The Chairman extended thanks on behalf of the Committee to Sarah-Jane Mills for her presentation.

RESOLVED

1. That the information presented on the Community Pain Management Service, including the rating of good by the Care Quality Commission in June 2021 and the actions taken to the high level review of complaints in June 2021 be noted.

2. That the positive direction of travel of the service be noted, but with three of the key performance indicators still not reaching their targets, a further report be received in six months' time, and that a copy of the action plan also be made available for consideration by the Committee.

30 UPDATE ON KEY DEVELOPMENTS AT NORTH WEST ANGLIA NHS FOUNDATION TRUST

The Chairman invited Caroline Walker, Chief Executive North West Anglian NHS Foundation Trust, to remotely present the report to the Committee.

The Committee was advised that the report provided a clinical and strategic update on the activities of the North West Anglia NHS Foundation Trust, which managed Peterborough City Hospital, and Stamford and Rutland Hospital, as well as Hinchingbrooke Hospital in Huntingdon.

The update made reference as to how the Trust had adapted and responded to manage patient care during the Covid-19 pandemic. It was noted that patients requiring treatment for Covid-19 were being cared for in dedicated 'red' areas at Peterborough City and Hinchingbrooke Hospitals. The Trust had maintained 'green' status at its Stamford and Rutland Hospital site, where outpatient and day care services continued as normal alongside the John Van Geest in patient ward.

It was reported that the Trust were supporting their staff, regularly reminding them of the range of services available to them to help with their emotional wellbeing; and that the Trust had held a week-long focus on staff health and wellbeing in mid-August to further support colleagues.

The Committee was made aware of the Stamford and Rutland Redevelopment; the impact of the shortage of midwifery staff, which had resulted in the temporary suspension of the Trust's home birth service. It was hoped that the service would be resuming during September; and the Urgent and Emergency Care Reconfiguration at Peterborough City Hospital.

During consideration of the report, the Committee raised the following comments:

- Return of mobile breast screening. The Committee was advised that during the pandemic the service had been centralised to the Peterborough City Hospital; and that it was the intention to keep the service on the Peterborough site;
- Whether there was scope for expansion of primary care on the Stamford Site. The Committee noted that there was no plan at the moment for Lakeside to expand on to the site. It was noted however, that there had been interest from a company to develop a nursing home on an unused part of the site;
- What plans were in place to reduce A&E waiting times at Peterborough Hospital. The Committee was advised that discussions had been undertaken with the two ambulance services, so as to avoid too many ambulances arriving all at the same time, which would improve the ambulance waiting time. The reconfiguration of urgent and emergency care at Peterborough City Hospital had provided an integrated front door for all urgent care needs for the Greater Peterborough community. This had now enabled clinical staff to assess patients quickly and start them on the most appropriate pathway for their care;
- Whether the Trust had any major plans for development in the coming year. Reference was made to the development of the Hinchingbrooke Site; improving patient flow through the hospital; and the reconfiguration of neighbourhood work with GP's;
- What the current level of staff vacancies was across the Trust and the Trust's recruitment plan. The Committee was advised that the vacancy rate was currently at 5%. It was noted that the Trust had hard to recruit areas for example maternity. The Committee was advised further that the Trust had managed to recruit 20 midwifes. It was highlighted that nurse vacancies were at the lowest in the region. It was noted that the Trust worked hard to support staff with their health and wellbeing; and the Trust encouraged talent management, which had helped retain staff;
- A request was made for the Committee to view the Trusts two year recovery plan. The Committee was advised that once the plan was completed, the Trust was happy to share with members of the Committee.

On behalf of the Committee the Chairman extended thanks to Caroline for her presentation.

RESOLVED

1. That the information presented by North West Anglia NHS Foundation Trust be noted and that thanks be extended to all the staff at the Trust for their efforts in response to the Covid-19 pandemic over the last year.

2. That a further update on the North West Anglia NHS Foundation Trust be received in 12 months.

31 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST - NUCLEAR MEDICINE

The Committee gave consideration to a report from United Lincolnshire Hospitals NHS Trust (ULHT) concerning Nuclear Medicine.

The Chairman invited the following representatives from ULHT to remotely present the report to the Committee: Simon Evans, Chief Operating Officer, Laura White, Head of Nuclear Medicine and Anna Richards, Associate Director of Communications and Engagement.

It was reported that nuclear medicine was a specialist imaging technique involving the administration of radioactive substances in the diagnosis and treatment of disease. The service was provided by the Trust at Grantham and District Hospital, Lincoln County Hospital and Pilgrim Hospital, Boston. Details relating to the current reconfiguration of the nuclear medicine service and the number of studies performed were shown on page 67 of the report pack. The second table on page 67 provided information relating to staffing levels and the geographical demands on the service.

The Committee was advised that as nuclear medicine involved radiation, the technique was highly regulated and that all staff had to undergo extensive training. Details of the challenges faced by the service nationally and in particular with workforce were shown on page 68 of the report for the Committee to consider.

It was highlighted that Lincolnshire had struggled to recruit and retain clinical technologists over the last five years. This had been further impacted by the national training service for nuclear medicine clinical technologist's ceasing, which had resulted in a national shortage of trained specialist in the country. Attempts had been made to recruit abroad, but these had been protracted and unsuccessful in a couple of instances.

In order to ensure continuity of the service, the Committee was advised that the Trust had taken the decision to convert one of the full time posts to an apprentice post. Further information regarding the experts required to provide the service were shown on page 69 of the report pack.

It was highlighted that the workload demand was only enough for three cameras within the county, but currently there were five. The five gamma cameras in Lincolnshire were all over ten years old and as such were considered to need replacing.

In conclusion, the Committee was advised that the challenges faced by the Lincolnshire nuclear service included a shortage of skilled workers; the removal of specialist training programmes, which had resulted in an aging workforce, which meant that the department had to look at training staff internally, which in itself posed a challenge. In addition to this the equipment used was over ten years old, and was not properly utilised.

With these challenges, it was highlighted that the service could not continue to guarantee a well-led service, and therefore the Trust was seeking support from the Committee in its development of a proposal for a future service model; and for a public engagement exercise on the proposal to begin no later than 2021.

During discussion, the Committee raised the following comments:

- The qualifications required for the role. The Committee was advised that the area of work was very specialised and required extensive training over a number of years to become fully trained;
- The Committee was advised that the Trust was trying to work with colleagues in the East Midlands to train people. Lincolnshire was planning to have contingency measures in place for the next 10 to 15 years;
- Whether the Trust planned to go out for engagement for a two site model or a one site model. The Committee was advised that at this stage all options would be kept on the table; and
- What the impact was on stopping the service on other services at any one of the hospitals. The Committee noted that the services impacted would be those at Lincoln, due to the concentration of cancer services. The Committee was advised that the engagement details would be presented to the Trust Board in October and then to the Health Scrutiny Committee for consideration in October, prior to start of the engagement process.

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

RESOLVED

That any future engagement exercise by United Lincolnshire Hospitals NHS Trust on the configuration of nuclear medicine be presented to a future meeting of the Committee.

32 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 74 and 75 of the report pack.

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

- Update from Northern Lincolnshire and Goole Hospitals NHS Foundation Trust regarding services provided to residents at the north of the county. The Committee was advised that an item was expected later in the year regarding the Humber Acute Services Review;
- Some concern was expressed regarding the quality of service provided by some GP practices. It was highlighted that an item concerning GP Practice – Developments and Challenges would be considered by the Committee at the 13 October 2021 meeting;
- Lessons learnt by the CCG with regard GP services; and contract management by the CCG of GP Services. As the forthcoming agendas were already concentrating on the Lincolnshire Acute Service Review, the Chairman agreed to speak to the CCG regarding the issues highlighted by the Committee.

RESOLVED

That the work programme presented be agreed, subject to the inclusion/consideration of the items listed above and the inclusion of the items agreed at minutes numbers 28 (3), 29 (2) and 30 (2).

The meeting closed at 12.54 pm

This page is intentionally left blank

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

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**13 October 2021**
Subject:	**Chairman's Announcements**

1. Information Requested at the Last Meeting – 15 September 2021

Lakeside Healthcare, Stamford, Action Plan *(Minute 28)* – The Committee's request for action plan from Lakeside Stamford in response to the Care Quality Commission's report remains outstanding.

North West Anglia NHS Foundation Trust Two Year Recovery Plan *(Minute 31)* – At this stage the two year recovery plan by North West Anglia NHS Foundation Trust is still in development and will be circulated when it becomes available.

Health Infrastructure Plan: Future New Hospitals Programme (Minute 27) – It is not expected that any detailed information will be published before the Department of Health and Social Care moves from the expressions of interest stage to the long-listing stage of its decision-making process, which is due to take place later this year.

2. Decisions of Lincolnshire Partnership NHS Foundation Trust Board

On 30 September 2021, Lincolnshire Partnership NHS Foundation Trust (LPFT) Board approved two service changes, which had previously been considered by this Committee on 21 July 2021:

Child and Adolescent Mental Health Services – Crisis and Enhanced Treatment Team

The LPFT board approved the Crisis and Enhanced Treatment Team as the permanent model of care, a decision which was also supported by NHS England. This Committee had given its in-principle support to this and had requested that LPFT continue to monitor the number of young people treated at out-of-county general adolescent units; and to report any significant increases in their use to the Committee.

Older Adults Mental Health Services

This Committee supported a proposal for make the closure of the Rochford Ward at Pilgrim Hospital permanent, with the continuation of the Home Treatment Service. A request was made for monitoring of demand for in-patient beds, particularly form the east of the county. The KLPFT Board made its decision as set out in the proposal.

3. Covid-19 Recovery

The Committee has previously recorded information on the recovery of the local NHS from the impacts of Covid-19. On 29 September, the Lincolnshire Clinical Commissioning Group Board received the following summary information on the impacts of Covid-19:

Demand for NHS Services

"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. It is anticipated that this position will continue through to Spring 2022."

Elective Operations and Waiting Lists

"With regards to elective operations the increased pressure in hospitals of both Covid Inpatients combined with emergency demand is starting to impact upon elective operations. Many NHS hospital trusts have had to take decisions to cancel routine electives and in Lincolnshire United Lincolnshire Hospitals NHS 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.

a. In July 2021 the total waiting list size for Lincolnshire patients at all hospitals was 80,800 people. This compares to 61,300 in July 2020.

b. Prior to the pandemic Lincolnshire only had 7 patients waiting longer than 52 weeks for an elective procedure, all of which was for a specialist operation out of county. Today the number of Lincolnshire patients waiting over 52 weeks is more than 2,200 across all providers of which 768 are at Lincolnshire hospitals.

c. 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.

d. 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.

e. We have recently launched a communications initiative aimed at supporting patients who are waiting for appointments at hospital guiding them to the most appropriate place for queries."

Cancer Waiting Times

"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.

a. 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.

b. We currently have no Priority 1 patients waiting, and Priority 2 patients are treated within an average of 4.1 weeks which is slightly above the regional average.

c. The NHS locally is exploring further with Independent Sector Providers to give additional support to assist with cancer patients."

Mental Health

"Within mental health, both 24/7 mental health helplines (one for adults, and one for children) continue to be available to our population across the county. In addition, we are supporting Primary Care with funding to support patients with Severe Mental Illness and along with the County Council have launched a series of engagement workshops to support the delivery of the National Autism Strategy."

4. Department of Health and Social Care Ministerial Team

Following the recent cabinet reshuffle the Secretary of State for Health and Social Care (The Rt Hon Sajid Javid MP), and the Minister of State for Health (Edward Argar MP) continue in their roles. Gillian Keegan MP has been appointed as the Minister of State for Care and Mental Health. There are three other new ministers (parliamentary under-secretaries): Maria Caulfield MP (Patient Safety and Primary Care); Maggie Throup MP (Vaccines and Public Health); and Lord Kamall (Technology, Innovation and Life Sciences).

5. Lincolnshire Community Health Services NHS Trust – Appointment of Chief Executive

On 17 September 2021, Lincolnshire Community Health Services NHS Trust (LCHS) announced that Maz Fosh had been appointed as its permanent Chief Executive with immediate effect, following a national recruitment process. Maz had been acting in an interim capacity for the last two years.

This page is intentionally left blank

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

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**13 October 2021**
Subject:	**Lincolnshire Acute Services Review – Introduction to Consultation and Arrangements for Response**

Summary:

On 30 September 2021, the NHS in Lincolnshire launched a public consultation on the Lincolnshire Acute Services Review. John Turner, the Chief Executive of Lincolnshire Clinical Commissioning Group, is due to attend to give an introductory presentation on the content of the consultation.

In addition to receiving the presentation, the Committee is invited to agree its arrangements for responding to the consultation. The closing date for the public consultation is 23 December 2021. The Committee has been offered a final submission date of 31 January 2022 for its response. It is proposed to accept this offer, so that the Committee is using all the time available to consider the detail and prepare its response and consider any interim feedback reports on how the public has been responding.

Actions Requested:

(1) To consider the introductory presentation on the public consultation on the Lincolnshire Acute Services Review.

(2) To confirm the arrangements for responding to the NHS's consultation on the Lincolnshire Acute Services Review, in line with the following timetable: -

(a) detailed consideration of two specific elements of the Acute Services Review at each of the 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 (or more working groups) to draft the detailed response to the consultation; and

(d) finalisation of the Committee's response to the consultation on 19 January 2022, for submission prior to 31 January 2022.

1. Background

Notification of Intention for Formal Consultation

On 21 September 2021, the Chairman received a notification from the Chief Executive of the Lincolnshire Clinical Commissioning Group (CCG) that the CCG would shortly be commencing a formal public consultation exercise in relation to four NHS service change proposals. This notification was issued in accordance with Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013. This public consultation exercise on the service change proposals would run for twelve weeks from 30 September until 23 December 2021. The Lincolnshire CCG Board decided at its public meeting on 29 September 2021 to proceed with the consultation which was launched on 30 September 2021.

This Committee has been offered a further month to finalise its response by 31 January 2022. It is proposed to accept this offer, so that the Committee is using all the time available to consider the detail and prepare its response and consider any interim feedback reports on how the public has been responding.

Service Change Proposals

The four NHS service change proposals are summarised as follows:

(1) *Orthopaedic Surgery*:

- development of a 'centre of excellence' in Lincolnshire for planned orthopaedic surgery at Grantham and District Hospital; and
- a dedicated day case centre at County Hospital, Louth, for planned orthopaedic surgery.

(2) *Urgent and Emergency Care at Grantham and District Hospital*: establishment of a 24/7 walk in Urgent Treatment Centre, in place of the current Accident and Emergency department.

(3) *Acute Medical Beds at Grantham and District Hospital*: establishment of an integrated community/ acute medical beds, in place of the current acute medical beds.

(4) *Stroke Services*: development of a 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services at Lincoln County Hospital; which would be supported by enhancement of the community stroke rehabilitation service so it can support stroke patients with more complex needs.

There is extensive background information on each of the above on the NHS Lincolnshire website:

What is this public consultation about? :: Lincolnshire STP

It is proposed in this report that the detailed elements will be considered at the Committee's next two meetings in November and December. For the Committee's initial consideration, executive summary of the pre-consultation business case is attached at Appendix A; and the consultation document is attached at Appendix B.

2. Approaches to Responding to the Consultation

As a key role of this Committee is responding to NHS service change proposals which affect Lincolnshire residents, the Committee is invited to make arrangements to respond to the consultation, in the with the following timetable: -

Committee Meeting Date	Activity
13 October 2021	• Introduction / Background to the Consultation • Confirmation of the Arrangements for Responding to the Consultation
11 November 2021	• Two Specific Elements of the Acute Services Review
16 December 2021	• Two Specific Elements of the Acute Services Review: • Consideration of Interim Report from CCG on Feedback to the Consultation to date.
19 January 2022	• Finalisation of the Committee's Response Prior to the 31 January 2022 deadline

In addition to consideration at the Committee one (or more working group) is proposed to consider the detail of each proposal. For example, it may be appropriate for one working group to consider items (2) and (3) in the list above, as there is a link between them; with another working group considering items (1) and (4), although there is no direct link and they could be considered separately.

3. Consultation and Conclusion

The Committee is invited to consider the presentation on the Lincolnshire Acute Services Review and make arrangements for consideration of the elements of the consultation and the finalisation of the Committee's response.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Executive Summary of the Pre-Consultation Business Case for the Lincolnshire Acute Services Review
Appendix B	Public Consultation Document – Relating to Four of Lincolnshire's NHS 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

1 Executive Summary

1.1 Introduction and background

1.1.1 This business case takes the form of a Pre-Consultation Business Case (PCBC) to be presented to NHS England and Improvement (NHSEI) for assurance prior to the Lincolnshire CCG launching a public consultation.

1.1.2 This PCBC is a revised version of the Acute Services Review (ASR) PCBC submitted to NHS England (NHSE) in November 2018.

1.1.3 This revised PCBC continues to set out the context, process and conclusions of the whole ASR programme as they were in the original PCBC submitted to NHSE in 2018 i.e. in relation to all eight services originally agreed within the programme's scope. These services being:

- Acute Medicine
- Breast
- General Surgery
- Haematology & Oncology
- Orthopaedics
- Stroke
- Urgent & Emergency Care
- Women's & Children's

1.1.4 This approach has been taken with the aim of being as transparent as possible in the approach and decision making throughout the whole course of the ASR programme, both up to the submission of the original PCBC to NHSE in 2018 and then afterwards through to the development of this revised PCBC.

1.1.5 The amendments made to the original PCBC submitted to NHSE in 2018 to create this revised version reflect:

- The feedback provided by NHS England following the assurance checkpoint panel in December 2018;
- The Lincolnshire health system's agreement to an ASR PCBC 'production-line' approach to progress the preferred option for the future configuration of the eight services within the scope of the programme as set out in the original PCBC. The reason for this approach being:
  - It has not been possible to secure the capital required to enable the full implementation (all eight services) of the preferred option set out in the original PCBC submitted to NHS England; and
  - An ongoing need to ensure the clinical and operational sustainability of the acute services within the scope of the ASR programme and deliver the benefits set out in the PCBC.
- In light of the revised PCBC 'production-line' approach, a specific focus on the change proposals relating to four of the eight services within the scope of the ASR programme. These being the focus of the first ASR PCBC under the 'production-line' approach to be included in an initial consultation with the public as they require no/minimal capital investment or their sustainability is at greatest risk:
  - Orthopaedics (elective and non-elective)
  - Urgent & Emergency Care
  - Acute Medicine
  - Stroke Services
- The impact of the Covid-19 pandemic on health services in Lincolnshire.

An introduction and background to the ASR are set out in more detail in Chapter 2.

1.2 Strategic context: Local demographics and acute services case for change

1.2.1 The strategic context for the reconfiguration of acute services across Lincolnshire has not changed since the original PCBC was submitted to NHSE in 2018. In addition, the recent COVID-19 pandemic has brought further insights to the provision of services across the county.

1.2.2 A strong case for change for the reconfiguration of acute services has been widely articulated for a number of years, not just through the ASR but also its predecessor programmes. There is a broad recognition that the current configuration of acute hospital services is not meeting the needs of the Lincolnshire population.

1.2.3 Lincolnshire is one of the largest counties in England with one of the most dispersed populations. The county council is made up of seven districts that have a diverse geography, comprising large rural and agricultural areas, urban areas and market towns and a long eastern coastline.

1.2.4 The population density in Lincolnshire is approximately 125-150 persons per square kilometre, which is around a third of the average for England. There is a registered population of 783,080, based on the General Practitioner (GP) registered population (April 2019).

1.2.5 Acute service provision across Lincolnshire needs to find the optimum balance between accessibility across a large diverse geographical area whilst addressing the particular health needs of the local population. In addition, this needs to be done whilst ensuring acute services are clinically and financially sustainable.

1.2.6 The Lincolnshire population is served by a number of acute hospital trusts, however the United Lincolnshire Hospitals NHS Trust (ULHT) is by far the largest provider in terms of the number of residents covered. The viability and long-term sustainability of services within ULHT is therefore critical to the provision of acute care services to the residents of Lincolnshire.

1.2.7 ULHT provides inpatient acute services from hospital sites located in Lincoln, Boston and Grantham, which it owns, plus a fourth smaller site at Louth owned by Lincolnshire Community Health Services NHS Trust.

1.2.8 The geographical distance is considerable between these hospital sites, and the acute services provided at each have evolved over many years to try to best meet the needs of their local population.

1.2.9 It is widely acknowledged that acute hospitals serving rural areas face a common set of challenges, specifically high staff turnover, competition to attract and retain staff, service sustainability, public perception of the scope of services provided, and a lack of modern infrastructure. Many of these were exacerbated during the COVID-19 pandemic.

1.2.10 These issues are interlinked, act in a reinforcing manner, and can have a significant impact on the key performance measures of quality, performance and finances.

1.2.11 It is also widely acknowledged that there is an over-reliance on hospital treatment in Lincolnshire, rather than on prevention and the interventions to keep people well at home. In other words, services deal with the consequences of ill health rather than on preventing it. If the current model of healthcare provision does not change, there will be increasing demand for hospital services which will become unsustainable in the long term.

1.2.12 Despite the best endeavours of local clinicians, professionals and staff to keep pace with the changing needs of the population, keep pace with specialisation, tackle significant workforce challenges and deliver services within increasingly constrained budgets, it is widely recognised that some services are delivered in a sub-optimal way and not fit for the future.

1.2.13 A lack of change and innovation, as seen in other geographies, has led to outdated models of care that are no longer fit for purpose.

1.2.14 The table below summarises the key challenges facing ULHT as a result of the rurality of Lincolnshire, the current demand for acute hospital care and the configuration of its services across multiple sites. Although the analysis is broken down into individual areas it should be noted that each cannot be considered in total isolation as they are inter-related. For example, staff shortages will impact on the quality of services and result in higher operating costs through the use of more agency and bank staff.

Figure 1 – Summary of ULHT's key challenges

Summary of key challenges facing ULHT
Quality
Struggle to meet national quality standards
"Requires improvement" Care Quality Commission (CQC) inspection rating
Systemic staff recruitment or retention challenge due to: • Difficulty attracting the best staff due to physical location of trust and hospital sites – geographically less desirable • High local competition for staff / staff 'poached' by other providers in the county • Perceived culture of poor quality care in the trust • Services not specialised as unable (without consolidation) to get to critical mass to support appropriate care so not attractive to clinicians
Performance
18-week, Urgent & Emergency Care and Cancer constitutional standards not being achieved
Crowding out of elective services by non-elective activity
More patients referred than can be seen and treated within the national timeframes
Delays in discharging patients who are medically fit to be discharged
Time delay between implementing system wide out of hospital initiatives and seeing the impact
Finance
Year-end deficit in 2019/20 of £93m (majority of total system deficit of £101m)
Reliance on expensive locum and agency staff
Inefficiency versus peers; position of not driving savings and poor cost control
Geographic isolation • Diseconomies of scale and scope • National and local expectations of what a District General Hospital should be • Cost of replication of sub-optimal services across multiple sites
Higher estates costs than peers, and underutilised estate

The ASR strategic context is set out in more detail in Chapters 3 and 4.

1.3 Acute Services Review (ASR) overview

1.3.1 The configuration of acute services within Lincolnshire must be clinically, operationally and financially sustainable and underpin the safe, efficient and effective delivery of quality services to the local population.

1.3.2 The Acute Services Review (ASR) is the programme for ensuring acute service provision across Lincolnshire is adequate to address the quality, performance and financial challenges facing hospital services as well supporting the outcomes of the Lincolnshire Integrated Care System (ICS) as a whole.

1.3.3 The aim of the ASR Programme has been to develop a set of recommendations on the optimal configuration of acute hospital services across Lincolnshire to maximise clinical, operational and financial sustainability.

1.3.4 A five-step approach to progressing the Acute Services Review was adopted, which stressed the importance of strong engagement with stakeholders and senior buy-in across Lincolnshire, particularly with clinicians.

1.3.1 This approach ensured senior leadership agreement on the design principles that have then guided the design of the future state; and structured engagement with stakeholders throughout. Both current state assessment and design of options for the future state, have been based on five key drivers for change: quality, workforce, performance, accessibility and affordability.

1.3.2 At the same time as adopting the five step approach a clear set of design principles were adopted for this major change programme. These principles were agreed by both the Lincolnshire Co-ordinating Board (LCB) and the System Executive Team (SET). These principles are set out below:

- Compliance with relevant clinical standards/guidelines including those from relevant Medical Colleges and Advisory Bodies, NHS England, The National Institute for Clinical Excellence (NICE) and The Care Quality Commission (CQC) is critical.
- Services which remain too specialised or small to provide locally should be consolidated to maintain quality, patient safety, and patient experience – this consolidation may be within ULHT/Lincolnshire or result in moving services to other providers outside of the County.
- Patient travel will be minimised where possible but balanced with the need for services to be clinically, operationally and financially sustainable as well as safe, efficient and effective. Patient travel limits as agreed by LHAC in 2015 will be used as the benchmark.
- Residents will be offered choice but seen and treated in Lincolnshire as far as it is safe and practicable to do so.
- Services must be sustainable from a workforce perspective. Services must have suitable working patterns and not be over-reliant on temporary staff or non-substantive staff.
- The configuration of services must support apprenticeships, undergraduate and postgraduate education and training within the County.
- Changes must be achievable within 5 years and the constraints which exist, they will therefore seek to make best possible use of the existing estate footprint, and minimise investment in estates, given the limited capital and transitional funding available.

An overview of the Acute Services Review is set out in more detail in Chapter 5

1.4 Clinical services prioritisation

1.4.1 In January 2018 an assessment of 32 individual specialties provided by ULHT was carried out by joint clinical and managerial teams from across the Lincolnshire health system to determine the priority areas to be addressed by the Acute Services Review (ASR). This assessment was conducted against a framework of quality, workforce, performance and finance.

1.4.2 Following this review three categories of specialty were identified:

- Strong case for change
- No case for change
- Some case for change but not currently prioritised

1.4.3 The priority specialties with the strongest cases for change were:

- Acute Medicine
- Breast
- General Surgery
- Haematology & Oncology
- Orthopaedics
- Stroke
- Urgent & Emergency Care
- Women's & Children's

1.4.4 A common thread across all of the services identified with a strong case for change was a lack of suitably qualified staff in key areas. Although in many cases this was consistent with a national shortage.

1.4.5 The issues in each specialty as identified were shared and presented at a Clinical Summit on 1 February 2018 with over 70 key stakeholders and clinical leaders agreeing there is an unequivocal case for change in these areas. This session was facilitated by the East Midlands Clinical Senate. This group agreed a need to further explore configuration options, interdependencies and impacts of potential change.

The clinical services prioritisation is set out in more detail in Chapter 6

1.5 Options appraisal

1.5.1 The Acute Services Review option appraisal process ran throughout the majority of the 2018 calendar year.

1.5.2 If local clinicians considered every possible combination of reconfiguration options to address the challenges identified, the 'exhaustive' list would be too long to be meaningful. This is due to the potential infinite number of combinations of all the service delivery models on all the existing sites and, theoretically on any number of new sites.

1.5.3 Therefore, the overarching options appraisal process for the ASR Programme looked to move through a 'funnel' from an initial full range of possibilities down to a preferred option(s) that the Lincolnshire CCGs (as was – now the NHS Lincolnshire CCG) could take to public consultation.

1.5.4 Following wide spread acceptance of the case for change (Clinical Summit 1 February 2018), potential options for reconfiguration across each priority specialty area (i.e. Breast, Orthopaedics, General Surgery, Stroke, Acute Medicine, Women's & Children's, Urgent & Emergency Care and Haematology & Oncology) were considered by joint clinical and managerial teams.

1.5.5 This included impact on capacity, activity, financials, as well as other external factors, such as alignment to wider Sustainability and Transformation Partnership (as was, now Integrated Care System) aims, specialised commissioning, health inequalities and patient travel.

1.5.6 This exercise identified a list options for change across the eight specialties identified as having a strong case for change by the joint clinical and managerial teams.

1.5.7 Following identification of these options for change at specialty level, possible combinations of options were considered, with the aim of establishing scenario-based options to test.

1.5.8 A long-list of nine overarching scenario-based options was agreed, posing combinations of consolidation of activity and closures of sites. This long-list presented a view of significant change possibilities, providing a sense of what could be achieved.

Figure 2 – Long list of scenario-based options

Option 1a	Consolidate complex and high-acuity services in Lincoln as far as is possible. Low-acuity elective and day case activity transferred to Grantham which will become a centre of excellence for diagnostic, day case and short stay elective work. Louth and Pilgrim activity to remain as is otherwise.
Option 1b	As for Option 1a except for Breast services where the Centre of Excellence will be located at Grantham instead of Lincoln.
Option 2a	Consolidate complex and high-acuity services in Lincoln and Pilgrim. Low-acuity elective and day case activity transferred to Grantham. Grantham will become a centre of excellence for diagnostic, day case and short stay elective work. Louth and Pilgrim to remain as is otherwise.
Option 2b	As for Option 2a except for Breast services where the Centre of Excellence will be located at Grantham instead of Lincoln.
Option 3	Consolidate complex high-acuity services in Lincoln whilst retaining emergency and urgent care and acute medicine on all three sites. All other activity remains as is on current sites.
Option 4	Consolidate complex and high acuity services in Lincoln and Pilgrim whilst retaining emergency and urgent care and acute medicine on all three sites. All other activity remains as is on current sites.
Option 5	Close the Grantham site. All services at Grantham cease and Grantham activity goes to the next nearest provider. All other activity remains as is on current sites.
Option 6	Close the Pilgrim site. All services at Pilgrim cease and Pilgrim activity goes to the next nearest provider. All other activity remains as is on current sites
Option 7	Close the Lincoln site completely. All services at Lincoln cease and Lincoln activity goes to the next nearest provider. All other activity remains as is on current sites
Option 8	Close the Louth site completely. All services at Louth cease and Louth activity goes to the next nearest provider. All other activity remains as is on current sites
Option 9	Single site solution. All services at 3 of the 4 ULH sites to cease. All activity to go to the next nearest provider.

1.5.9 The anticipated impacts of change associated with each of the nine overarching scenario-based options was modelled. These were presented at a second Clinical Summit on 14 February 2018, which had over 55 key stakeholders and leaders present.

1.5.10 This session was also facilitated by the East Midlands Clinical Senate.

1.5.11 Each of the long list of options was evaluated at the Clinical Summit workshop on the 14 February 2018 where key stakeholders and clinical leaders discussed the options alignment and impact on four criteria (Quality, Access, Affordability/Sustainability, Deliverability – which originated from the predecessor Lincolnshire Health and Care (LHAC) Programme). These were aligned to the seven ASR design principles.

1.5.12 This evaluation was clinically led and undertaken through the lens of quality, safety and sustainability to collectively review and assess the scenario based options impact on the whole system, identifying clinical opinion for which option is the best fit to meet the need of the Lincolnshire population. Options 1a, 1b and 2a emerged as preferences during the 14 February 2018 Clinical Summit.

Figure 3 – RAG rating of options by Clinical Summit attendees

1.5.13 Across the three shortlisted options that emerged from the Clinical Summit on 14 February 2018, differences between them were focussed in Women's and Children's, Breast and Stroke services. This shortlist of three scenario-based options is summarised below.

Figure 4 – Shortlist of scenario-based options

	Option 1A	Option 1B	Option 2A
Breast	Centre of Excellence - Lincoln	Centre of Excellence - Grantham	Centre of Excellence - Lincoln
Stroke	Consolidate hyper-acute and acute stroke at Lincoln only; with enhanced rehab in community	Consolidate hyper-acute and acute stroke at Lincoln only; with enhanced rehab in community	Combined on-call rota at Lincoln and Pilgrim
W&C	Consolidate consultant-led maternity services and neonatology at Lincoln and open midwife led unit at Lincoln and Pilgrim Consolidate EL and NEL (>23 hrs) Paediatrics at Lincoln, provide PAU at Pilgrim	Consolidate consultant-led maternity services and neonatology at Lincoln and open midwife led unit at Lincoln and Pilgrim Consolidate EL and NEL (>23 hrs) Paediatrics at Lincoln, provide PAU at Pilgrim	Retain obstetric-led maternity services across Lincoln and Pilgrim; retain two neonatal units Consolidate EL and NEL (>23 hrs) Paediatrics at Lincoln, provide PAU at Pilgrim
T&O	Consolidate to make Grantham hub for elective short stay, day case surgery; to retain Lincoln, Pilgrim as non-elective sites		
Gen Surg	Consolidate to make Grantham hub for elective short stay, day case surgery; to retain Lincoln, Pilgrim as non-elective sites with small elective workload		
Acute Med	Cease acute medical inpatient services in Grantham		
Urgent & Emergency	Re-designate Grantham as a GP-led Urgent Treatment Centre (no acute medicine on-call provision		
Haem/Onc	To be consolidated at Lincoln		

1.5.14 The clinical view was a consensus of support for Options 1a, 1b and 2a, with a strong preference for 1a; it was acknowledged these options had a high level of alignment with the design principles; support the four criteria; support an improved financial position; have minimal impact on activity; and are projected to decrease the bed requirement across the county.

1.5.15 The concluding preference for Option 1a over 1b emerged due to concerns over locating Breast activity at Grantham and the subsequent impact on breast radiology. Other key comments from the session include:

- Both options show strong alignment to improving quality and sustainability
- Hot and cold activity split improves patient experience and makes services more robust
- Recruitment and workforce sustainability still remains a challenge in both options

1.5.16 Option 9 (single site solution) was not assessed at the Clinical Summit on the 14 February as the supporting analysis was not available at the time.

1.5.17 The ASR programme modelled a new build scenario and analysed the consequences of closing Lincoln County Hospital, Pilgrim Hospital Boston and Grantham & District Hospitals and a new hospital site established in the centre of Lincolnshire. This hypothetical hospital site is unknown and identified as the postcode NG34 which is in Sleaford.

1.5.18 In light of the immediate quality, financial and workforce challenges, the System Executive Team concluded not to progress further work on this single site new build scenario and to revisit this decision in three years. This future review was incorporated into the Lincolnshire's Estates and Capital Strategy submitted to NHS England in July 2018.

1.5.19 Following the two clinical summits there was largely agreement across the System Executive Team that the majority of Option 1a was becoming the preferred way forward, however, there was not full conformity to the components of the option for:

- Acute Medicine beds at Grantham; or
- Women's and Children's.

1.5.20 In light of this position the Lincolnshire health system worked together to review these two components and develop an alternative option for provision, known as Option 1a+. This option was developed and refined through work by local clinicians and managers and input from the East Midlands Clinical Senate (see below). Within this option:

- Grantham would provide integrated community/acute beds; and
- Lincoln would provide consultant-led obstetrics, mid-wife led unit, Local Neonatal Unit (LNU), inpatient paediatrics, day case paediatrics and non-elective admissions and Pilgrim would provide consultant-led obstetrics, midwife-led unit, Special Care Baby Unit, day case paediatrics and a Paediatric Assessment Unit (PAU) for non-elective stays of less than 23 hours.

1.5.21 In addition, it was agreed that in relation to the Orthopaedic (elective and non-elective) service change proposal to make Grantham the hub for elective and day case surgery, that the evaluation of the planned care pilot at Grantham Hospital that was due to conclude in March 2019 should be used to shape the extent of non-complex non-elective activity that would continue on the Grantham site.

1.5.22 The East Midlands Clinical Senate had been involved in the two clinical summits in February, and on the 11 July 2018 a session was held with them to discuss Option 1a+. The clinical senate were asked to consider whether there is a clear clinical evidence base underpinning proposals. Presentations to the clinical senate were led by clinicians from the Lincolnshire health system.

1.5.23 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.

1.5.24 The panel recommended that the Lincolnshire health system proceed with the proposals set out in Option 1a+ for Breast Services, General Surgery, Orthopaedics, Stroke Services and Haematology & Oncology. However, they were of the opinion that further work needed to be completed for the Acute Medicine and Women's & Children's proposals.

1.5.25 Following further work in these two areas the East Midlands Clinical Senate was engaged for a second time to review the proposed developments to Acute Medicine and Women's and Children's. This supplementary clinical review took place on 12 September 2018.

1.5.26 The clinical review team was impressed by the amount of work that had taken place on the medical beds at Grantham Hospital proposal. For the evolved Acute Medicine proposal the panel considered it to be not only clinically acceptable but to represent an excellent example of the value of a team approach to finding solutions to the inevitable issues that result from service redesign. The panel recommended proceeding with the proposal.

1.5.27 The panel acknowledged the ambition the system had to deal with the challenges it faces in relation to Women' and Children's Services, striving to balance access and inequalities with long term clinical outcomes. It was clear the concerns and suggestions raised by patients and the public had been listened to in the development of the proposal. In relation to Women's and Children's the East Midlands Clinical Senate recommended:

- Obstetric input into the community hubs needs to increase.
- A plan for outcome based strategies should be developed, clearly articulating how clinical outcomes at Boston Pilgrim Hospital will be improved.
- A head of nursing for paediatric should be appointed to join the senior leadership team at ULHT with a major brief to develop the ethos of a 'single team'.
- The opportunities that exist for the trainees needs to be considered and a holistic approach considered to address transport, remuneration and professional development issues to produce attractive posts an significantly reduce the reliance on locum positions.

1.5.28 In conclusion, the East Midlands Clinical Senate recommended that the change proposals as set out in the revised Option 1a+ should proceed for Breast Services, Stroke Services, Acute Medicine, Orthopaedics, General Surgery and Haematology & Oncology. For Women's and Children's they set out a specific set of recommendations.

1.5.29 To ensure completeness and transparency in the evaluation of this new Option 1a+, the developments in the clinical models for Acute Medicine and Women's and Children's services were also reflected across the original shortlist that came out of the Clinical Summit on 14 February 2018, thus creating a revised shortlist of six options.

Figure 5 – Revised short list of six options

	Option 1A	Option 1A+	Option 1B	Option 1B+	Option 2A	Option 2A+
Breast	Centre of Excellence - Lincoln	Centre of Excellence - Lincoln	Centre of Excellence - Grantham	Centre of Excellence - Grantham	Centre of Excellence - Lincoln	Centre of Excellence - Lincoln
Stroke	Consolidate HASU and acute at Lincoln	Consolidate HASU and acute at Lincoln	Consolidate HASU and acute at Lincoln	Consolidate HASU and acute at Lincoln	HASU and stroke at Lincoln & Pilgrim – combined on call rota	HASU and stroke at Lincoln & Pilgrim – combined on call rota
Acute Med	Cease acute medial inpatient services at Grantham	Integrated community/acute provision at Grantham	Cease acute medial inpatient services at Grantham	Integrated community/acute provision at Grantham	Cease acute medical inpatient services at Grantham	Integrated community/acute provision at Grantham
W&C	Consolidate consultant-led maternity services and neonatology at Lincoln and open midwife led unit at Lincoln and Pilgrim Consolidate EL and NEL (>23 hrs) Paediatrics at Lincoln, provide PAU at Pilgrim	Retain obstetric-led maternity services across Lincoln and Pilgrim; retain two neonatal units Consolidate EL and NEL (>23 hrs) Paediatrics at Lincoln, provide PAU at Pilgrim	Consolidate consultant-led maternity services and neonatology at Lincoln and open midwife led unit at Lincoln and Pilgrim Consolidate EL and NEL (>23 hrs) Paediatrics at Lincoln, provide PAU at Pilgrim	Retain obstetric-led maternity services across Lincoln and Pilgrim; retain two neonatal units Consolidate EL and NEL (>23 hrs) Paediatrics at Lincoln, provide PAU at Pilgrim	Retain obstetric-led maternity services across Lincoln and Pilgrim; retain two neonatal units Consolidate EL and NEL (>23 hrs) Paediatrics at Lincoln, provide PAU at Pilgrim	Retain obstetric-led maternity services across Lincoln and Pilgrim; retain two neonatal units Consolidate EL and NEL (>23 hrs) Paediatrics at Lincoln, provide PAU at Pilgrim
T&O	Consolidate to make Grantham hub for elective and day case surgery, and Lincoln and Pilgrim to provide some day case surgery and elective care for complex patients with significant co-orbidities and all complex non elective and trauma services. Evaluation of planned care pilot at Grantham that is due to conclude in March 2019 to be used to shape the extent of non-complex trauma that continue on the Grantham site.					
Gen Surg	Consolidate to make Grantham hub for elective short stay, day case surgery; to retain Lincoln, Pilgrim as non-elective sites with small elective workload					
Urgent & Emergency	Development of UTCs at Lincoln, Boston and Grantham. Lincoln and Boston will continue to have an ED department, Grantham will not.					
Haem/Onc	To be consolidated at Lincoln					

1.5.30 In parallel with the discussions with the East Midlands Clinical Senate, the revised shortlist of options underwent a more detailed appraisal, led through the ASR Steering Group. Once again this was based on the LHAC criteria, but also reflective of the feedback received from the public on the criteria during engagement events in July 2018.

1.5.31 In light of the conclusions of the East Midlands Clinical Senate and the further detailed appraisal of the revised shortlist of options, the Lincolnshire health system's leaders preferred way forward evolved to Option 1a+.

1.5.32 In line with the published guidance from NHS England relating to the four tests and the involvement of wider stakeholders, including patients and the public in the consideration of options, the next step was to run options appraisal exercises with a wider group of people.

1.5.33 The purpose being to provide a 'confirm and challenge' to the system leaders preferred option and provide additional insights and consideration of the options ahead of any final conclusions being made by the appropriate decision making bodies.

1.5.34 It was agreed one workshop was to be held with wider NHS stakeholders and four workshops held with the public. The evaluation criteria and weightings used at the options appraisal events were based on the criteria developed through the LHAC programme, but also reflected the feedback received from the public when the criteria was discussed with them through the engagement events (in line with the criteria used for the detailed appraisal of the short list of options).

1.5.35 The stakeholder option evaluation workshop was held on the 4 October 2018 and attended by over 60 stakeholders from across the Lincolnshire health system. Attendees represented a broad range of stakeholder groups including general practitioners, acute hospital clinicians, nurses, hospital managers, mangers from clinical commissioning groups, and the third sector.

1.5.36 In addition, in the week commencing 8 October 2018, four option evaluation workshops were undertaken with randomly selected members of the public across Lincolnshire. In total there were 37 participants across the four groups. The purpose of these was to get early views (ahead of a formal public consultation) on the change proposals being considered and to consider these views against the outputs of the Stakeholder Option Evaluation workshop held a few days earlier.

1.5.37 Attendees at these events were asked to consider the specific service change proposals at a specialty level (e.g. Breast, Stroke, Acute Medicine etc.) that when combined in various ways made up the revised shortlist of six-scenario based options (set out in the diagram above).

1.5.38 Where there was more than one alternative option attendees were asked to think about *'the advantages and disadvantages of the two proposals against each of the four criteria, to what extent do you consider that either Proposal 1 or Proposal 2 would satisfy the criteria better, or do you consider that both proposals would satisfy the criteria equally well?'*.

1.5.39 Where only one option exists for a specialty, attendees were asked *'to what extent do you agree or disagree that the changes proposed would help to improve the current situation and meet the challenges identified?'*

1.5.40 The outcomes of the evaluation in terms of the percentage of attendees that showed a preference for a proposal are set out below.

Figure 6 – Stakeholder options evaluation workshop

Breast	**Consolidate at Lincoln**	**No preference**	**Consolidate at Grantham**
Stakeholder workshop	64%	27%	10%
Public workshops	51%	26%	24%
Stroke	**One site at Lincoln**	**No preference**	**Two sites at Lincoln and Pilgrim - one rota**
Stakeholder workshop	61%	12%	27%
Public workshops	64%	9%	26%
Women's and Children's	**One site at Lincoln**	**No preference**	**Two sites at Lincoln and Boston - one team**
Stakeholder workshop	20%	22%	58%
Public workshops	25%	20%	56%
Acute Medicine	**No acute medical beds at Grantham**	**No preference**	**Integrated community/acute beds at Grantham**
Stakeholder workshop	9%	7%	85%
Public workshops	11%	8%	81%
T & O Consolidate day-case and Elective care at Granrtham	**Agree**	**Neither agree nor disagree**	**Disagree**
Stakeholder workshop	98%	2%	0%
Public workshops	84%	3%	14%
General Surgery Consolidate day-case and Elective care at Granrtham	**Agree**	**Neither agree nor disagree**	**Disagree**
Stakeholder workshop	97%	3%	0%
Public workshops	86%	5%	8%
Urgent and Emerg. Care Re-designate Grantham as a UTC	**Agree**	**Neither agree nor disagree**	**Disagree**
Stakeholder workshop	98%	0%	2%
Public workshops	84%	5%	11%
Haematology and Oncology Consolidate at Lincoln	**Agree**	**Neither agree nor disagree**	**Disagree**
Stakeholder workshop	97%	3%	0%
Public workshops	81%	11%	8%

Note: figures have been rounded to nearest whole number

1.5.41 The preference identified through the workshops with stakeholders and the public for each speciality aligned to Option 1a+.

1.5.42 Having considered the detailed analysis of the shortlist of options, the feedback from the East Midlands Clinical Senate and the outcomes of the stakeholder and public workshops the leaders of the Lincolnshire health system confirmed Option 1a+ as the preferred option.

The ASR options appraisal is set out in more detail in Chapters 7

1.6 The preferred option

1.6.1 The conclusion of the options appraisal process identified Option 1a+ as the preferred option for the future configuration of acute services across Lincolnshire.

1.6.2 An overview of the proposed changes, by specialty, for Option 1a+ once fully implemented is set out in the table below.

Figure 7 – Overview of Preferred Option changes

Service	Current configuration	ASR preferred option reconfiguration
Breast	Screening is provided at static screening sites at Lincoln Hospital, Pilgrim Hospital and Grantham Hospital and mobile units operate across the county Outpatient, day case and elective services are provided mainly from Lincoln Hospital and Pilgrim Hospital, with low volumes provided from Grantham Hospital.	Screening mammography, follow-up outpatients and community support will stay the same and continue to be provided locally. Lincoln Hospital becomes a centre of excellence providing all first outpatient appointments (including the assessment appointment for patients who have received an abnormal breast screening result), day case and elective procedures.
Orthopaedics (Elective and non-elective)	Outpatient, day case, elective and non-elective services are provided from Lincoln Hospital, Pilgrim Hospital and Grantham Hospital.	Consolidate to make Grantham Hospital the hub for elective and day case surgery. Lincoln Hospital and Pilgrim Hospital retained as non-elective sites and provide some day case and elective care for complex patients. Day cases to be distributed across the Louth and Grantham sites Evaluation of pilot to be used to shape extent of non-complex non-elective orthopaedic activity that continues on Grantham site Outpatient services remain at Lincoln Hospital, Pilgrim Hospital and Grantham Hospital
General Surgery (Adult)	Outpatient, day case and elective services are provided from Lincoln Hospital, Boston Hospital and Grantham Hospital. Non-elective services are provided from Lincoln Hospital and Pilgrim Hospital.	Consolidate to make Grantham Hospital the hub for elective short stay and day case surgery. Lincoln Hospital and Pilgrim Hospital provide some day case and elective surgery for complex patients with co-morbidity and those on a cancer pathway Outpatient services remain at Lincoln Hospital, Boston Hospital and Grantham Hospital.
Stroke	Hyper-acute and acute stroke services at Lincoln Hospital and Pilgrim Hospital (two separate rotas)	Consolidate hyper-acute and acute stroke at Lincoln Hospital; with enhanced rehabilitation to be performed in the community
Acute Medicine	Acute medical beds provided at Lincoln Hospital, Pilgrim Hospital and Grantham Hospital. Grantham Hospital already operates with exclusion criteria for high acuity patients i.e. restricted non-elective medical attendance and admissions	Acute medical beds provided at Lincoln Hospital and Pilgrim Hospital. Grantham Hospital provides integrated community/acute beds provided as part of an extension of the neighbourhood team
Women and Children's	Consultant-led maternity services at Lincoln Hospital and Pilgrim Hospital. Local Neonatal Unit (LNU) at Lincoln Hospital and Special Care Baby Unit at (SCBU) at Pilgrim Hospital. Antenatal and post-natal appointments provided at Grantham Hospital Paediatric outpatient, day case, elective and non-elective services provided at Lincoln Hospital and Pilgrim Hospital. Paediatric outpatient appointments	A One Service – Two Site model Consultant-led obstetrics services and Midwife-Led Units at Lincoln Hospital and Pilgrim Hospital. Local Neonatal Unit (LNU) at Lincoln Hospital and Special Care Baby Unit at Pilgrim Hospital Antenatal and post-natal appointments provided at Grantham Hospital Paediatric Elective Care and non-elective admissions requiring a stay greater than 23 hours provide from Lincoln Hospital only

Service	Current configuration	ASR preferred option reconfiguration
	provided at Grantham Hospital	Paediatric Assessment Unit at Pilgrim Hospital Paediatric outpatients and day cases provided at Lincoln Hospital and Pilgrim Hospital Paediatric outpatient appointments provided at Grantham Hospital
Urgent and Emergency Care	24/7 A&E services are provided from Lincoln Hospital and Pilgrim Hospital. Grantham Hospital operates an A&E service between 9.00am and 6.30pm with high selected admissions and no admissions overnight (this is a temporary change from the original 24/7 service)	24/7 A&E services are provided from Lincoln Hospital and Pilgrim Hospital. Re-designate Grantham A&E as an Urgent Treatment Centre For the majority of urgent care needs, patients will continue to be able to access their local hospital as all options include an Urgent Treatment Centre on each site
Haematology / Oncology	Haematology outpatients, day case and inpatient units at Lincoln Hospital and Pilgrim Hospital. Haematology outpatient and day case services provided at Grantham Hospital. Oncology outpatients, day case and inpatient units at Lincoln Hospital and Pilgrim Hospital Oncology day case at Grantham Hospital.	Haematology outpatients, day case and inpatient units at Lincoln Hospital. Haematology outpatients and day case at Pilgrim Hospital and Grantham Hospital. Oncology outpatients, day case and inpatient units at Lincoln Hospital. Oncology outpatients and day case at Pilgrim Hospital. Oncology day case at Grantham Hospital utilising the mobile chemotherapy service.
Louth Hospital	No change to elective activity	

1.6.3 On 19 November 2018 a PCBC was submitted to NHS England that set out the preferred option (Option 1a+) for the future configuration of all eight services within the scope of the ASR Programme, which identified a capital requirement of £52m (2018 prices) to enable the changes. On 5 December 2018, representatives from the Lincolnshire health system attended a regional assurance checkpoint panel to undertake formal assurance of proposals to reconfigure acute services in Lincolnshire.

1.6.4 At the regional panel assurance meeting it was confirmed that the service change assurance process was not a capital process. At the time of the panel meeting Lincolnshire had submitted its Wave 4 capital bid, which did not contain capital requirements of the ASR programme, and anticipated making an application for the funding to enable ASR in the Wave 5 capital process.

1.6.5 In spring 2019 the Lincolnshire Wave 4 capital bids were confirmed as unsuccessful (as they were for the majority of the country) and the availability of capital in future processes to enable the proposed ASR service changes looked evermore unlikely.

1.6.6 In light of the availability of capital becoming the biggest barrier to progressing the ASR programme a review of the capital requirement for implementing Option 1a+ was undertaken through the summer of 2019, with a revised capital ‘ask’ of £19m identified.

1.6.7 The System Executive Team (SET) considered this revised cost and rejected it as it was felt not to be a viable option due to derogation not achieving estate standards. Lincolnshire subsequently reconfirmed the capital ask of c.£52m with the regional NHSEI team in September 2019.

1.6.8 In addition, during 2019 the Lincolnshire health system held an engagement exercise with the public, ‘Healthy Conversation 2019'. This went wider than the ASR programme; however it did include pre-consultation engagement on the programme.

1.6.9 Through this exercise and in response to feedback received from the public the preferred option for Urgent and Emergency Care was developed so 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.

1.6.10 In late 2019 the Lincolnshire Coordinating Board agreed to go into a 'production line' approach to developing ASR Pre Consultation Business Cases (PCBCs), where each of these PCBCs would focus on a sub-set of the eight service change proposals that made up Option 1a+ (the ASR preferred option). This approach was adopted so as to not delay potential service reconfiguration, and associated benefits, that can happen in line with the identified preferred option with no/minimal capital.

1.6.11 To inform the scope of the initial PCBC to be completed under the 'production-line' approach, in the context of the overall scope of the ASR Programme, consideration was given to each of the eight proposed changes that make up Option 1a+. This identified four services to be included:

- Orthopaedics (elective and non-elective);
- Urgent & emergency care;
- Acute medicine; and
- Stroke services

1.6.12 The rationale for each of these four services to be included in the initial focus is set out below.

Figure 8 – Scope of first business case under production line approach

Service	ASR preferred option reconfiguration	Rational for inclusion in scope
Orthopaedics (elective and non-elective)	Consolidate to make Grantham Hospital the hub for elective and day case surgery. Lincoln Hospital and Pilgrim Hospital retained as non-elective sites and provide some day case and elective care for complex patients. Day cases to be distributed across the Louth and Grantham sites Evaluation of pilot to be used to shape extent of non-complex non-elective orthopaedic activity that continues on Grantham site Outpatient services remain at Lincoln Hospital, Pilgrim Hospital and Grantham Hospital ***NOTE: Evaluation of the pilot has further refined this proposal as planned – this is described further below***	• Does not require additional estate initially – currently being delivered in part through the Orthopaedic Pilot • Technically still a temporary change, pilot has evaluated well and change needs to be made permanent through public consultation • Can continue without additional capital initially (i.e. as pilot has done) • Longer term to deliver full vision would require an estates expansion and upgrade, to be included in Wave 5 bids (or equivalent) and other funding opportunities
Urgent and Emergency Care	24/7 A&E services are provided from Lincoln Hospital and Pilgrim Hospital. Re-designate Grantham A&E as an Urgent Treatment Centre For the majority of urgent care needs, patients will continue to be able to access their local hospital as all options include an Urgent Treatment Centre on each site	• Does not require additional estate • No risk to delivery however significant ongoing reputational damage with public and stakeholders as service has had restricted opening hours as a temporary measure for 3 years • Can be done without additional capital initially, longer term would benefit from an estates upgrade • Upgrade capital to be included in Wave 5 bids (or equivalent) and other funding opportunities
Acute Medicine	Acute medical beds provided at Lincoln Hospital and Pilgrim Hospital. Grantham Hospital provides integrated community/acute beds provided as part of an extension of the neighbourhood team	• Does not require additional estate • Can be done without additional capital initially, longer term would benefit from an estates upgrade • Upgrade capital to be included in Wave 5 bids (or equivalent) and other funding opportunities
Stroke Services	Consolidate hyper-acute and acute stroke at Lincoln Hospital; with enhanced rehabilitation to be performed in the community	• Requires additional estate • However, stroke services identified as the most fragile out of the eight services within the scope of the ASR Programme • Emerging preferred estates solution will require additional capital.

1.6.13 Since February 2020 the Lincolnshire health system has developed this revised PCBC, the first in the 'production-line' approach.

1.6.14 Given the time that has elapsed since the original PCBC was submitted to NHSE in 2018, for the four services areas that form the focus of this revised PCBC the specialty level cases for change and preferred options have been validated and where appropriate information and analysis updated.

1.6.15 This included updating the activity and finance baseline data for 2019/20 and forecasts to 2023/24, the latter being in line with the local five-year strategic plan, and 'out of hospital assumptions' being based on impact already evidenced in the system or confirmed investment in an agreed community based care model and service.

1.6.16 It should also be noted that in March 2020 NHS England & Improvement issued operational guidance to reflect the requirements of organisations and systems in response to COVID-19. Following this the Lincolnshire health and care system placed its management as its priority.

1.6.17 It was agreed to continue to progress the revised ASR PCBC in recognition that the challenges faced by the services within the scope of the revised PCBC would likely deteriorate through the COVID-19 crisis. This has subsequently been borne out by some of the temporary changes the system has had to make.

1.6.18 In agreeing to progress the revised ASR PCBC, the health and care system has taken the conscious decision to ensure that the change proposals defined through the ASR programme are kept separate to those related to COVID-19.

1.6.19 However, it is acknowledged that where there is alignment between temporary service changes in response to COVID-19 and ASR service change proposals learning should be used to inform the longer term proposals. Where information is available it is reflected in the PCBC.

1.6.20 Of the four services in the scope of the initial PCBC to be produced under the 'production-line' approach there are two where temporary changes made in response to COVID-19 strongly align with the ASR proposals. These are UEC - Grantham A&E and Stroke Services.

Figure 9 – Alignment between COVID-19 temporary changes and ASR change proposals

Service	COVID-19 temporary change	ASR service change
Orthopaedics (elective and non-elective)	• Grantham Hospital to become 'green' site • Initial focus on cancer and high priority surgery • Elective orthopaedic activity likely to reduce in short term until additional capacity is established on Grantham and Independent Sector sites ***Temporary changes still in place at time of writing***	• Consolidate to make Grantham Hospital the hub for elective and day case surgery. Lincoln Hospital and Pilgrim Hospital will be retained as non-elective sites. • Lincoln Hospital and Pilgrim Hospital provide some day case surgery and elective surgery for complex patients with significant co-morbidities and all complex non-elective and trauma services.
UEC – Grantham A&E	• A&E to 24/7 UTC • Reduced complexity of patients seen compared to current A&E due to only ambulatory unit and no acute bed provision on the site • Provided by LCHS ***Temporary changes still in place at time of writing***	• A&E to 24/7 UTC • Higher complexity of patients seen (more in line with current A&E) as acute medicine bed provision on site • Provided by community provider
Acute Medicine – Grantham Medical beds	• No beds provision on site other than ambulatory unit • Provision moved to alternative ULHT site ***Temporary changes still in place at time of writing***	• Integrated community/acute bed provision • Provided by community provider
Stroke Services	• Hyper-acute stroke services consolidated on the Lincoln Hospital site ***Temporary changes still in place at time of writing***	• Hyper-acute and acute stroke services consolidated on the Lincoln Hospital site • Enhanced community stroke reablement service

The ASR preferred option is set out in more detail in Chapter 8.

1.7 Orthopaedics service change proposal

1.7.1 The Orthopaedics services preferred option identified through the ASR Programme is 2018 was:

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

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

1.7.3 In parallel with the ASR Programme progressing ULHT volunteered to be involved with the National Getting it Right First Time (GIRFT) programme.

1.7.4 This meant being one of a small number of trusts across England to pilot a 'hotter' (emergency/unplanned non-elective care) and 'colder' (elective/planned care) site for orthopaedic services. The ULHT Orthopaedic Pilot commenced in August 2018.

1.7.5 The Orthopaedic Pilot arrangements aligned to the preferred option identified through the ASR programme. However, it should be noted that the preferred ASR option was based on additional theatre and bed capacity being provided on the Grantham site to enable the full planned activity shift, whereas the pilot utilised existing capacity.

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

1.7.7 At the end of February 2020 the evaluation of the orthopaedics pilot was showing very positive results. The experience of the pilot has reaffirmed the preferred option for the future provision of orthopaedic services identified through the ASR options appraisal (to consolidated elective orthopaedic services at Grantham Hospital and Lincoln and Pilgrim to provide some day case surgery and elective care for complex patients with significant co-morbidities and all complex non-elective and trauma services) and allowed it to be refined.

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

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

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

1.7.10 The table below provides an overview of the care, quality and outcomes benefits of the proposed services changes for Orthopaedics against the current model of care (i.e. that provided pre-pilot and before the COVID-19 pandemic and subsequent temporary service changes).

Figure 10 – Overview of Orthopaedics service change proposal

Orthopaedics	
Current model **Elective activity provided from all sites (pre-pilot)**	**Proposed model** **Consolidate elective activity at Grantham Hospital**
• Declining performance against 18-week target • Limited separation of elective and non-elective activity makes attainment/sustainment of 18-week target a challenge • There is a need for ring fenced orthopaedic beds across all sites, given the high volumes of medical emergencies all year round is placing significant pressures on elective beds • On average 10 patients a month cancelled on the day due to a lack of beds • Distance between sites and the poor transport infrastructure limits opportunities for economies of scale and networked working • Over 3,000 patients each year receive their procedure in the independent sector (funded by the NHS) • NHS Long Term Plan supports split of urgent and planned care work on different sites • High medical (c.10%) and nursing (c.15%) vacancies exist in Orthopaedics	• The orthopaedic pilot has evaluated very positively • Reduced trust-wide cancellation rate on the day due to a lack of beds (to 3 patients a month on average) – cancellations on the day due to a lack of beds reduced to 0 at Grantham Hospital • Reduced waiting times for operations/ procedures • Improved overall patient experience and satisfaction including reduced length of stay • Reduction in average length of stay at Grantham Hospital from 2.7 days to 1.7 days. • ULHT performing significantly better than peer trusts and national median for primary total hip replacement length of stay • Increased theatre utilisation at Grantham Hospital • Length of stay at Grantham Hospital for primary knee replacements has outperformed all other pilot Trusts within the GIRFT programme • Reduced number of patients going out of county to receive treatment • Established a centre of excellence – thereby improving patient care and increasing appeal to doctors and nurses to work at the site • On-call is reduced and surgeons spend more time operating and treating patients making jobs more attractive • The Orthopaedic pilot workforce model has successfully removed all agency and doctor usage ULHT wide

1.7.11 The table below provides a summary of the equality impact assessment for the proposed Orthopaedics service change.

Figure 11 – Orthopaedics summary EIA

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

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

2. Negative impact on health	• Patients will have fewer cancellations, be seen quicker, receive a better quality service and achieve better outcomes. • The pilot has shown these improvements are possible	• Yes. Proposed service should have a positive impact on health • This has been demonstrated through the evaluation of the orthopaedic pilot.

3. Greater reliance on family and friends for increased travel needs
4. Greater reliance on public transport, which is perceived to be limited in accessibility
5. Concerns about costs of travel to and from hospital, especially at times of limited/ no public transport
	• Patients may potentially have a greater reliance on public transport for travel support. However:
	  • ULHT currently provides a patient transport service based on eligibility criteria; and
	  • Volunteer services currently provide patient transport services where confidence or mobility issues can make it difficult to attend hospital
	
	The NHS is not responsible for the public transport infrastructure in the county (Lincolnshire County Council controls this), however the NHS is undertaking partnership working with LCC and others in order to review and improve travel and transport in the county.
		• Yes. For some there may be a greater reliance on family and friends for transport. However, NHS and voluntary sector patient transport services already exist to help in certain situations.
		• The proposed service changes do not make any changes to these patient transport services.
		• The Grantham pilot has evaluated very well and these issues were not observed in the feedback.

1.7.12 The table below provides a summary of the assessment against the five service change tests for the proposed Orthopaedics service change proposal.

Figure 12 – Orthopaedics summary of assessment against five service change tests

Orthopaedics	
1. Strong public and patient engagement	• Strong ongoing engagement through life of ASR and predecessor programmes – incl. Healthy Conversation 2019. • Public: Some concerns about distances needed to travel but overall support given reduced cancellations/waiting times and improved outcomes; support evidenced through evaluation of pilot. • HOSC[1]: Support proposal given pilot has seen a reduction in waiting list and cancelled operations; welcome the fact model has been highlighted as good practice nationally; concerns from staff as to future of orthopaedic service at Louth County Hospital needed to be addressed.
2. Consistency with patient choice	• Once fully implemented will reduce number of sites from which certain procedures are provided (the number of providers is not reducing under the change proposals). • However, cancellations and waiting lists should reduce and outcomes and patient satisfaction increase (as demonstrated through the pilot). • More patients should be able to choose to have their operation /procedure in Lincolnshire rather than go out of county.
3. Clear clinical evidence base	• Case for change and future proposals led by ULHT consultants, supported by Professor Briggs, National Clinical Director for GIRFT[2]. • Case for change and future proposals tested through two Clinical Summits with over 55 leads from across system. • Overwhelming support at clinically led options appraisal event for this option (98% strongly/tended to agree). • EM Clinical Senate recommended to proceed with it • Proposed changes trialled since August 2018 – evaluation shown reduced cancellations, waiting times and length of stay and increased patient satisfaction.
4. Support from clinical commissioners	• The four NHS Lincolnshire CCGs have been the main sponsors of the ASR programme since its inception. Members of all the Governing Bodies of four predecessor CCGs recognised the case for change and accepted doing nothing was not an option. • Clinical leads from CCGs have played a key role in developing and refining clinical models working closely with colleagues in acute setting. • The four CCG Governing Bodies, as they were at the time, agreed the original PCBC that set out the preferred option for this area. • Most recently newly formed single Lincolnshire CCG GB gave support.
5. Capacity implications	• Theatre and bed capacity existed on the Grantham Hospital before the pilot started, this has been utilised through the pilot. • Phase 1 is to make the pilot a permanent change (optimising productivity and efficiency of current capacity), which does not require additional capacity – focus of this PCBC • Phase 2 to increase the volume of activity consolidated at Grantham Hospital including the repatriation of more patients currently seen out of county in the private sector through additional theatre and bed capacity.

The change proposal for Orthopaedics is set out in more detail in Chapter 9.

[1] Local Authority Health Overview Scrutiny Committee (HOSC)
[2] Getting it Right First Time (GIRFT) programme

1.8 Urgent and Emergency Care service change proposal

1.8.1 The preferred option identified through the ASR programme is to re-designate the Grantham A&E service as an Urgent Treatment Centre (UTC). The UTC would be developed in line with the nationally-defined criteria for UTCs, offering improved accessibility and pre-booking via NHS 111.

1.8.2 The UTC would incorporate the existing A&E service (currently operating 08.00 – 18.30) and the Out of Hours on-site provision.

1.8.3 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. The multi-disciplinary workforce would have the ability to manage all presentations, including those requiring stabilisation and transfer.

1.8.4 The workforce mix would be expected to include GPs, urgent care practitioners, middle grade doctors, medical trainees, nurses and clinical support. Given exclusion criteria has existed at the Grantham site since 2007/08, by adopting this approach the vast majority of patients (97%) currently seen by an A&E service at Grantham Hospital would continue to be seen if the service operated as a UTC.

1.8.5 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.

1.8.6 The table below provides an overview of the care, quality and outcomes benefits of the proposed services changes for Urgent and Emergency Care against the current model of care (i.e. that provided before the COVID-19 pandemic and subsequent temporary service changes).

Figure 13 – Overview of Urgent and Emergency Care service change proposal

Urgent and Emergency Care	
Current model **A&E provided from 3 sites, exclusion criteria at Grantham Hospital and temporary closure**	**Proposed model** **Grantham Hospital A&E to become a 24/7 UTC (run by community provider)**
• Across ULHT ongoing challenges relating to poor 4-hour performance, time to triage, time to treatment and hand over delays • Ongoing concerns regarding sustainability of all 3 ULHT A&E services in totality – heavy reliance on locum doctors and nursing pressures • Heavy locum usage across ULHT in this speciality, particularly at Lincoln and Pilgrim Hospitals • Ongoing concerns regarding sustainability of 24/7 A&E rota at Grantham – average of 11 attendances a day between 23.00-08.00 when open 24/7 • Temporary arrangements at Grantham Hospital have been in place since 2016 • Level of activity provided at Grantham Hospital A&E already more akin to a UTC and unrealistic expectations and misunderstanding allowed to develop about level of service that can and should be provided at Grantham by public (as reported by Independent Review Panel) – exclusion criteria in place since 2007/08 • View of Independent Review Panel supported by East of England Clinical Senate during their review in 2017	• Minimise additional pressures across Lincolnshire A&E system • Minimise pressure on ULHT's nursing staff, where there are already significant vacancies • Support more consistent achievement of clinical standards • Encourages integrated service delivery between primary care, community care and acute care providers • Redefines and refines the scope of safe and high quality services, ensuring Grantham Hospital receives patients in line with its medical capabilities – ensuring patients are seen at right place at the right time • Reduces need for ambulance transfers from Grantham Hospital to other sites with an A&E Department • Promotes positive volume versus service provision balance at Grantham Hospital, particularly between 23.00-08.00 • Improves service ability to attract and retain talented and substantive staff through building a strong and successful service that offers opportunities to work in a centre of excellence. • Aligns with NHSE/I vision for urgent and emergency care

1.8.7 The table below provides a summary of the equality impact assessment for the proposed Urgent and Emergency Care service change.

Figure 14 – Urgent and Emergency Care summary EIA

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 c2.5-3.0% 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 c.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 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.

1.8.8 The table below provides a summary of the assessment against the five service change tests for each of the four areas.

Figure 15 – UEC summary of assessment against five service change tests

Urgent and Emergency Care	
1. Strong public and patient engagement	• Strong ongoing engagement through life of ASR and predecessor programmes – incl. Healthy Conversation 2019. • Public: Agreed clarity required regarding where it was appropriate for public to present. Some concerns about increased travel times and impact changes would have on other services currently provided at Grantham Hospital. Support for a 24/7 service. • HOSC: Acceptance introduction of UTCs is a national initiative, however concerns over continued absence of A&E facilities in Grantham and surrounding area over night; support for a 24/7 walk-in basis.
2. Consistency with patient choice	• Once implemented will reduce number of hospital sites in Lincolnshire 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 services provided and available to patients from each of the three hospital sites there will be minimal change due to the exclusion criteria that has been in place at Grantham Hospital since 2007/08. • It is estimated refinement of the exclusion criteria under this proposal will impact c.2.5-3% (c.600 patients per annum) of current total activity, these being higher acuity cases that clinically should receive specialist treatment elsewhere.
3. Clear clinical evidence base	• Concerns regarding sustainability of three 24/7 A&E services at each of ULHT's hospital sites expressed by clinical leads at Lincoln and Pilgrim Hospitals. • Development of options to address challenges faced in sustainability of A&E services led by ULHT Medical Director, supported by lead clinicians. • Review by the IRP[3] identified the A&E service at Grantham Hospital for some time (since 2007/08) has only dealt with a limited range of presenting emergency conditions and level of activity is more akin to a UTC. • East of England Clinical Senate also identified the evidence showed the majority of patients presenting at Grantham Hospital A&E were 'type 3' although it did acknowledge the service provided more than a UTC but significantly less than an A&E would usually be expected to provide. • Case for change and future proposals tested through two Clinical Summits with over 55 leads from across system. • Overwhelming support at clinically led options appraisal event for option (98% strongly/tend to agree). • East Midlands Clinical Senate panel considered the Grantham Hospital exclusion criteria to be 'clear, comprehensive and excellent'.
4. Support from clinical commissioners	• The four NHS Lincolnshire CCGs have been the main sponsors of the ASR programme since its inception. Members of all the Governing Bodies of four predecessor CCGs recognised the case for change and accepted doing nothing was not an option. • Clinical leads from CCGs have played a key role in developing and refining clinical models working closely with colleagues in acute setting. • The four CCG Governing Bodies, as they were at the time, agreed the original PCBC that set out the preferred option for this area. • Most recently newly formed single Lincolnshire CCG GB gave support.
5. Capacity implications	• Existing estate footprint is sufficient to support forecast activity seen by the service under the proposed model with minimal adaptation. Therefore, change can happen without additional capital investment.

The change proposal for Urgent and Emergency Care is set out in more detail in Chapters 10.

[3] Independent Reconfiguration Panel (IRP)

1.9 Acute Medicine service change proposal

1.9.1 Through the ASR options appraisal process the preferred option identified for Acute Medicine is the provision of integrated community/acute beds at Grantham Hospital as part of the neighbourhood team.

1.9.2 This conclusion was reached following a detailed audit of patients within acute medicine beds at Grantham Hospital that combined National Early Warning Score (NEWS) and Frailty Scores.

1.9.3 This innovative integrated community/acute model has been developed through extensive discussions by local clinicians, commissioners and provider organisations and reflects feedback received from the East Midlands Clinical Senate. The East Midlands Clinical Senate recommended the Lincolnshire STP proceeds with its proposal for the future of medicine at Grantham Hospital.

1.9.4 Key components of the model are Same Day Emergency Care (SDEC), Complex Frailty Assessment Service, Short Stay Assessment Unit (SSAU), high acuity medical wards and lower acuity medical wards.

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

1.9.6 The table below provides an overview of the care, quality and outcomes benefits of the proposed services changes for Acute Medicine against the current model of care (i.e. that provided before the COVID-19 pandemic and subsequent temporary service changes).

Figure 16 – Overview of Acute Medicine service change proposal

Acute Medicine	
Current model **Provided from 3 sites, exclusion criteria at Grantham Hospital**	**Proposed model** **Grantham Hospital medical beds to become integrated acute/community beds (community/acute provider partnership)**
• ULHT Acute Medicine services experience significant workforce challenges in their ability to deliver a safe, quality service. • It is widely recognised the ULHT Acute Medicine service is clinically and operationally unstable in its current form. • Across ULHT Acute Medicine service there is significant recruitment and agency spend challenges. • 40% vacancy rate for respiratory consultants across ULHT. • Key specific issue relating to Grantham is sustainability of the acute medicine service as it has a selected take (exclusion criteria in place since 2007/08) • Clinical audit of patients in acute medicine beds in Grantham Hospital identified 80% of patients could be supported in the beds by a community provider. Only c.10% were seen as requiring specialist acute hospital support. Remainder of the admissions could have been avoided if appropriate alternative community service were available at time of admission. • Long lengths of stay on acute medicine wards at Grantham Hospital.	• Delivers a balance between access and sustainable long term outcomes for acute medicine services – as articulated by the East Midland Clinical Senate. • Majority of patients currently receiving Acute Medicine care at Grantham Hospital would do so in future, only c.10% of high complexity patients would be cared for at another hospital. • Enables Grantham Hospital to offer services which may not be offered elsewhere and build a centre of excellence for integrated multi-disciplinary care, particularly for frail patients. • Delivers a more comprehensive service provision at Grantham Hospital, specifically in relation to the 'frail' population, thereby reducing pressure on acute sites in Lincoln & Boston • Grantham Hospital acts as a hub for supporting community teams and community services across the county – improved accessibility to specialist advice for primary care and community-based teams • Supports improved community-based management of LTCs and reduced length of stay in hospital beds • Supports a more sustainable medical and nursing workforce through new and innovative care models that offer sustainability, role variety and greater integration across pathways.

1.9.7 The table below provides a summary of the equality impact assessment for the proposed Acute Medicine service change.

Figure 17 – Acute Medicine summary EIA

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

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

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

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

1.9.8 The table below provides a summary of the assessment against the five service change tests for each of the proposed Acute Medicine service change.

Figure 18 – Acute Medicine summary of assessment against five service change tests

Acute Medicine	
1. Strong public and patient engagement	• Strong ongoing engagement through life of ASR and predecessor programmes – incl. Healthy Conversation 2019 • Public: The public very much focused on Accident and Emergency provision when engaged on how non-elective care should be provided, rather than acute medicine. • HOSC: Preference for this option over having no medical beds on the Grantham Hospital site, although have concerns around how it would be funded; view is medical admissions to Grantham Hospital should continue on a 24/7 basis; more detail requested on how it would work in practice
2. Consistency with patient choice	• Implementing the preferred option for acute medicine will not reduce the number of hospital sites from which acute medicine is provided from (the number of providers is not reducing under the change proposals). • However, for a small number of patients (c.385 patients per year) with higher acuity needs they will receive care specialist treatment elsewhere. • It should also be noted that the under this proposed model Grantham Hospital will be able to see a larger proportion of frail and elderly patients from the geographic area to receive inpatient care at Grantham.
3. Clear clinical evidence base	• Case for change and future proposals tested through two Clinical Summits with over 55 leads from across system. • Subsequent to ASR Clinical Summits a specific Grantham Clinical Summit was convened to specifically look at the provision of acute medicine services on the Grantham Hospital site – this was comprised of professionals from acute, community and primary care including Clinical Chair for South West Lincolnshire CCG, local GP lead, Medical Director LCHS, Medical Director ULHT, Consultant Nurse Cardiology/Associate Chief Nurse ULHT and Transformation Lead from EMAS. In addition, external independent clinical expertise was provided by the Chair of the Royal College of Emergency Medicine SIG in Geriatric Medicine. • Overwhelming support at clinically led options appraisal event for this option (85%). • Presentation of the preferred option for acute medicine services to the East Midlands Clinical Senate was led by the clinicians who had led the Grantham Clinical Summit. Two presentations were given to the East Midlands Clinical Senate on the proposals, following the second presentation the clinical senate panel confirmed they were left with the impression that all system partners are engaged and cohesive with a clear vision for the future of medicine for Grantham Hospital. • The East Midlands Clinical Senate panel described the proposal as innovative and achieved an excellent balance between access and sustainable long term outcomes.
4. Support from clinical commissioners	• Lincolnshire CCG(s) have been main sponsors of ASR programme since its inception. Members of all the Governing Bodies recognised the case for change and accepted doing nothing was not an option. • Clinical leads from CCGs have played a key role in developing and refining clinical models working closely with colleagues in acute setting. • The four NHS CCG Governing Bodies, as they were at the time, agreed the original PCBC that set out the preferred option for this area. • Most recently newly formed single Lincolnshire CCG GB gave support.
5. Capacity implications	• Activity seen by the service under the proposed model is expected to be broadly in line with the activity currently seen, therefore no additional capacity is required.

The change proposal for Acute Medicine is set out in more detail in Chapter 11.

1.10 Stroke Service change proposals

1.10.1 The preferred option identified through the ASR programme for Stroke Services is to:

- Consolidate hyper-acute and acute stroke services (day 0-7 post stroke) at Lincoln County Hospital; and
- Provide 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).

1.10.2 The preferred option was designed through clinically led workshops lead by the Stroke Consultants at ULHT with support from Professor Rudd (National Clinical Director for Stroke Services), and local acute, primary and community based health professionals.

1.10.3 Key influential factors of why Lincoln Hospital site has been identified as the location to centralise acute stroke services rather than Boston Hospital are:

- Larger 'catchment population' of NHS Lincolnshire CCG population (i.e. more patients per annum treated by ULHT based on patients attending nearest hospital).
- Co-location with Cardiology:
  - Cardiology teams support stroke team to deliver optimal front door service as col-location with cardiology enables access to more important time critical interventions like bubble echocardiograms and implantable loop recorders.
  - Established ACP service and pathway (noted as a regional example of excellence by GIRFT review)
  - Benefit from using the Cath Lab facilities to directly access acute imaging thus bypassing A&E and further reducing door to needle time
  - Provides increased opportunity for Lincoln Hospital to provide mechanical thrombectomy in the future as cardiologists may be considered appropriate to deliver this service
- Access to mechanical thrombectomy currently only provided at Nottingham University Hospital (c.30 mins shorter travel time compared to Pilgrim Hospital)
- Experience has shown recruiting to Lincoln Hospital is generally more successful than Pilgrim Hospital.

1.10.4 When the preferred option 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 the proposed reconfiguration would reduce unwarranted variation in outcomes and would ensure a more consistent achievement of clinical standards and national guidelines. The East Midlands Clinical Senate recommended the Lincolnshire STP proceeds with its proposal for stroke services to be consolidated at Lincoln County Hospital.

1.10.5 Since this initial work the NHS Long Term Plan has been published that also recommends the consolidation of specialist acute stroke services to improve quality and outcomes.

1.10.6 The proposed acute model for stroke services will be supported by an enhanced community service that will:

- Support all stroke survivors across Lincolnshire to receive their rehabilitation within their local community wherever possible;
- Work with the acute stroke service to deliver an av. 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 and the Stroke Association to embed in the Lincolnshire Stroke pathway in a community setting; and
- Improved efficiencies in the system through improved outcomes e.g. reduced hospital utilization, reduced social care costs over the medium to long term.

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

1.10.8 The table below provides an overview of the care, quality and outcomes benefits of the proposed services changes for Stroke services against the current model of care (i.e. that provided before the COVID-19 pandemic and subsequent temporary service changes).

Figure 19 – Overview of Stroke Service change proposal

Stroke Services	
Current model **Hyper-acute and acute stroke services provided from Lincoln and Pilgrim Hospital**	**Proposed model** **Consolidate hyper-acute and acute stroke at Lincoln Hospital supported by enhanced community service**
• Sentinel Stroke National Audit Programme (SNAP) shows ULHT need to continue to improve performance at Lincoln County Hospital and Boston Pilgrim Hospital. • In addition, ULHT is not achieving required performance in 1 of 4 priority standards for 7-day services, for hyper-acute stroke: 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* • Recommended hyper-acute stroke units see no less than 600 strokes per year, as activity below this is not sufficient to ensure staff have enough clinical and institutional experience to maintain skills; Lincoln sees just over this, Pilgrim does not and is unlikely to over next 5-10 years • Currently significant gaps exist in workforce – both Lincoln and Pilgrim should have six substantive consultant posts however each only has one. Has not been possible to recruit substantively. • Current nursing vacancy at Pilgrim is 50% which has led to a reduction in open beds • Average length of stay is c.13.5 days against a best standard target of 7-10 days	• Evidence shows centralising hyper-acute stroke treatment on a smaller number of sites has considerable benefits including reduced mortality, faster recovery, shorter length of stay and improved workforce sustainability • Evidence shows patients treated in dedicated hyper-acute stroke units are more likely to survive and recover more quickly as 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. • Supports improved performance against Sentinel Stroke National Audit Programme domains and priority standards for 7-day services • Enables a critical mass for stroke units well above recommended levels, which will support the delivery of improvements in quality and outcomes • Supports reduction in length of stay in acute hospital • Enables a concentration of multi-disciplinary teams on one hospital site to support performance and quality improvement • Supports reduction in heavy reliance on locums - increases chances of recruiting to substantive roles and having to spread limited staff across two sites

1.10.9 The table below provides a summary of the equality impact assessment for the proposed Stroke Service change.

Figure 20 – Stroke Services summary EIA

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 will be displaced from where they currently receive care - travel analysis has estimated that under the preferred option no patients would travel over 60-minutes (the agreed threshold for this type of activity), based on 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 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
	▪ 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
		• 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.

1.10.10 The table below provides a summary of the assessment against the five service change tests for the proposed Stroke Services change.

Figure 21 – Stroke services summary of assessment against five service change tests

Stroke services	
1. Strong public and patient engagement	• Strong ongoing engagement through life of ASR and predecessor programmes – incl. Healthy Conversation 2019. • Public: 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 – concerns those experiencing an increase in travel times are from some of the more deprived areas in the county to the east. • HOSC: Acceptance preferred option had been developed in line with national clinical guidelines; acknowledgement of significant workforce gaps and recruitment to a centre of excellence for stroke services would aid this; welcome proposal for enhanced community stroke service as part of option; acceptance of benefit of a centre of excellence but concern on travelling times to Lincoln Hospital; concern patients from Pilgrim Hospital would be displaced to North West Anglia NHS Foundation Trust.
2. Consistency with patient choice	• The number of sites from which acute stroke services will be provided will be reduced, however there is a compelling case to reconfigure and centralise these services to improve quality, safety and sustainability of services and make best use of resources (the number of providers is not reducing under the change proposals). • Key drivers are current performance in national stroke audit, having two acute stroke units one slightly above recommended yearly activity levels and one slightly below and significant doctor and nurse shortages • Consolidation of acute stroke services onto one hospital site would be supported by an enhanced community stroke rehabilitation service to enable people to discharge sooner from hospital and return to their home/communities earlier.
3. Clear clinical evidence base	• National stroke audit programme has shown improvement is required across ULHT's service for some time; ULHT not achieving all required performance priority standards for 7 day working; one site (Pilgrim) does not meet minimum recommended volume of strokes per year; significant gaps exist in medical and nursing workforce • Case for change and future proposals led by ULHT consultants, supported by Professor Rudd, NHS England's Clinical Director for Stroke - tested through two Clinical Summits with over 55 leads from across system • Support at clinically led options appraisal event for this option (61%) - Overwhelming support to consolidate the hyper-acute and acute stroke service at Lincoln Hospital in relation to improved quality (90%) and deliverability (93%) of the service; Recognition that consolidation will potentially impact on access, and there is therefore a trade off with significantly improved quality and deliverability • 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.
4. Support from clinical commissioners	• Lincolnshire CCG(s) have been main sponsors of ASR programme since its inception. Members of all the Governing Bodies recognised the case for change and accepted doing nothing was not an option. • The four NHS CCG Governing Bodies, as they were at the time, agreed the original PCBC that set out the preferred option for this area. • Most recently newly formed single Lincolnshire CCG GB gave support.
5. **Capacity implications**	• Capacity modelling has identified a requirement for an additional 7 beds at Lincoln Hospital to enable the consolidation. • Emerging preferred estates solution will require additional capital. • Capacity modelling is based on an average length of stay of 10 days (target is 7 days) and assumes a '15 minute preference' for Lincoln Hospital.

The change proposal for Stroke services is set out in more detail in Chapter 12.

1.11 Financial case

1.11.1 Essentially the ASR is about maximising the clinical, operational and financial sustainability of acute services for the residents of Lincolnshire. The current acute services model of delivery deployed by United Hospitals Lincolnshire NHS Trust (ULHT) is both clinically unsustainable and expensive.

1.11.2 A key driver of ULHT's clinical and financial sustainability problems is it provides acute services across multiple sites on a hospital estate that is inadequate and in need of fundamental investment.

1.11.3 In the evaluation of the short list of six-scenario based options (that covered the eight services in the full scope of the ASR programme) affordability was one of the criteria applied. The difference in the impact on the ULHT income and expenditure (I&E) between the shortlist of six options was minimal, with a range of +£3.90m to +£6.50m (2018 prices) across the options (a difference of £2.6m between the option with the largest and smallest contribution).

1.11.4 When the cost of capital and investment in services out of hospital to support the change was considered the contribution of the short-list of six options to the system I&E had a range of £3.07m to -£0.51m (a difference of £3.58m). In the original affordability evaluation of the shortlist of options the preferred option, Option 1a+, gave an impact on the ULHT I&E of +£5.60m and +£1.2m on the system I&E position.

1.11.5 The financial case in this revised PCBC, the first under the 'production line approach', focusses on the financial impact of the Orthopaedic, Urgent and Emergency Care, Acute Medicine and Stroke service changes that were part of Option 1a+.

1.11.6 Since the original affordability analysis on the shortlist of options was completed the Lincolnshire health system has moved away from payment by results to more 'block' based contracts and therefore the financial analysis has focused on cost of service provision.

1.11.7 The recent finance allocations provided to Lincolnshire health system as part of the 2020/21 'Phase 3' recovery planning round has more closely aligned financial resource to the cost of service delivery. This has eliminated Lincolnshire's circa £100m underlying deficit. However, this is not expected to be the case when the NHS financial region returns to 'business as usual' following the COVID-19 pandemic.

1.11.8 The four services in the scope of this initial PCBC under the 'production line' approach is forecast to deliver a modest financial benefit of c.£1.9m by the time all the service changes are in place.

1.11.9 One of the four service change proposals, Stroke Services, requires capital funding to enable its implementation. The current cost estimate of the estates solution that is the preferred way forward at this stage is £7.5m, which the system is committed to meeting. The revenue consequences of this are included in the overall financial impact.

1.11.10 In addition to the financial impact attributable to the four service change proposals a contingency has been set aside to cover the cost of additional Patient Transport Services (PTS) to reduce the impact on patients who may be required to travel to different ULHT sites for their services. A breakdown of the financial impact summary by service is set out below.

Figure 22 – Financial impact of ASR following full impact of service changes

Service	Cost of Current Service £k	Cost of Proposed Service £k	Difference £k
Orthopaedics	32,358	28,320	4,038
A&E/UTC	4,540	3,878	662
Acute Medical Beds (Inc Ambulatory Care)	8,620	8,875	-255
Stroke Pathway	11,662	13,219	-1,557
Financial Impact of Service Change	**57,180**	**54,292**	**2,888**
Contingency for additional Patient Transport	-	1,000	-1,000
Overall ASR Financial Impact	**57,180**	**55,292**	**1,888**

1.11.11 The Lincolnshire System recognises the importance of progressing the proposed changes identified as part of the Acute Services Review. The revenue consequences resulting from the proposed changes in the four service areas have been communicated clearly to finance and planning leads within Lincolnshire's four constituent NHS organisations.

1.11.12 In some circumstances these costs are already being incurred where there was a 2020/21 component. In examples where the cost will be incurred from 2021/22 onwards the organisational impact is already being reflected in 2021/22 financial baseline calculations and will be provided for from within the financial allocations the Lincolnshire System receives as part of the 2021/22 funding settlement. This is in accordance with the investment principles Lincolnshire STP applies to all its service transformation priorities.

The financial case for the four service change proposals is set out in more detail in Chapter 13.

1.12 Enablers

1.12.1 Lincolnshire's Integrated Community Care (ICC) model has a key role to play in supporting and enabling the delivery of the preferred option for the future configuration of acute services identified by the Acute Services Review. This includes:

- Specialist community services that support the provision of accessible, high quality care with local hospital teams working in a locality with neighbourhood teams;
- Intermediate, unplanned and crisis services that provide a network of urgent and emergency care services and facilities that balance accessibility and sustainability, ensuring patients are treated at the right place at the right time; and
- Resilient communities that look to equip communities with the necessary tools and resources to improve the health and wellbeing of their population by addressing the wider determinants of health and the long term management of lifestyle factors that contribute to strokes.

1.12.2 The Lincolnshire People Plan will be another key enabler to deliver change in our acute services. It aims to deliver a patient and service user centred workforce that will provide high quality care within the available finances. Its vision is of one of working with our people to improve productivity and deliver a unified culture, modelled on new systems of care and exemplar leadership and behaviours that will drive improved workforce engagement and satisfaction using business intelligence relating to our workforce, activity and finance.

1.12.3 Given the four services that are the focus of this revised PCBC were identified following it becoming clear is was not possible to secure the capital to enable all the changes identified in the preferred option, the requirement for estates changes has been minimised. The one service that will require a significant estates development is Stroke, where the preferred option is to build an extension to the existing unit.

1.12.4 The final key enabler to the proposed acute service changes is digital. We have identified specific opportunities against each of the four service change proposals where a digitally enabled workforce can work more flexibly, reduce the burden of bureaucracy, support direct care and support a better understanding of health needs. Where the Lincolnshire health system's response to the COVID-19 pandemic has accelerated these developments these have been identified.

The enablers for the four service change proposals are set out in more detail in Chapters 14, 15, 16 and 17.

1.13 Stakeholder engagement and governance arrangements

1.13.1 From the very start this work has been led by local clinicians. Through an ongoing process we have engaged with the residents and stakeholders of Lincolnshire to identify ways we can improve these services.

1.13.2 The conversation has been continuous since prior to the publication of the first Sustainability and Transformation Partnership (STP) five-year plan in 2016, and has played a pivotal role in developing the case for change, guiding and shaping the vision and underpinning the ASR planning process.

Figure 23 – Evolving ASR programme engagement

Lincolnshire Sustainability Services Review / Lincolnshire Health and Care (LHAC)		
2013-2017		
• Views and input from the public informed both of these programmes		
Acute Services Review (ASR)		
Broad Engagement	***Options Engagement***	***Pre-consultation Engagement***
2018	***2018***	***2019***
• *Raising awareness and seeking views*	• *Consideration of options for future service delivery*	• *Ongoing shaping of options for future service delivery*

1.13.3 Any decision to proceed with one or more of the proposed service changes is dependent on the completion and evaluation of a consultation with the public and any subsequent decisions taken by the NHS Lincolnshire CCG Board together with their partners. This will take the form of a Decision Making Business Case (DMBC).

1.13.4 The position set out within this PCBC is contemporaneous with the planned approach to consulting with the public. This will be kept under constant review given the constantly evolving situation in relation to COVID-19 and the Lincolnshire system's response.

1.13.5 The implementation phase will only begin following final approval of the Decision Making Business Case by the NHS Lincolnshire CCG.

The ASR programme stakeholder engagement and governance arrangements are set out in more detail in Chapters 18 and 19.

1.14 Conclusion

1.14.1 The constituent organisations of the Lincolnshire Sustainability and Transformation Partnership (STP), and more recently Integrated Care System (ICS), through the Acute Services Review (ASR) programme have developed a number of proposals for changing the configuration of acute hospital services for the population of Lincolnshire.

1.14.2 These proposed changes will both improve the quality and safety of care for the whole population and increase the health and care system's sustainability into the next generation.

1.14.3 The ASR programme has taken over two years to get to this point, which is longer than anticipated and to the frustration of some including the public.

1.14.4 During this time some services have become more fragile, however the Programme has been able to develop during this time additional assurances around its approach that give confidence to the public and regulators that it is time to proceed to public consultation.

1.14.5 This fragility has been further emphasised by the temporary service changes the Lincolnshire health system has had to make in response to COVID-19.

1.14.6 In conclusion, the Lincolnshire health system believes it has:

- Set out a clear and demonstrable case for change for the provision of acute services across the county;
- Conducted a robust appraisal of the potential options for improving the quality, safety and sustainability for the future;
- Identified a preferred option that is supported by clinical leaders and wider stakeholders from across the system
- Met sufficiently the Government's and Department of Health's tests for significant service change.

1.14.7 Lincolnshire CCG believes the time is now right to ask the public and all other stakeholders its views on these options through a public consultation.

NHS
Lincolnshire

Public Consultation Document

Relating to four of Lincolnshire's NHS Services

Orthopaedic surgery
Urgent and emergency care at Grantham and District Hospital
Acute medical beds at Grantham and District Hospital
Stroke services

From 30th September until 23rd December 2021

Contents

This document is available in other languages and formats. To request alternative formats or if you require the services of an interpreter, please contact us on 01522 421860 Monday – Friday 9am – 5pm or email us at **lccg.asr-enquiries@nhs.net**

Bulgarian
По заявка този документ е наличен на други езици и в други формати. За да заявите друг формат или ако имате нужда от услугите на устен преводач, молим да се свържете с нас.

Czech
Pokud bysta požadovali informance v jiném jazyce nebo formátu, kontakuje nás.

Italian
Se desiderate ricevere informazioni in un'altra linua o in un'altra lingua o in unaltro format, siete pregati di chiedere.

Latvian
Šis dokuments pēc pieprasījuma ir pieejams citās valodās un formātos. Lai pieprasītu to citā formātā vai ja jums ir nepieciešami tulka pakalpojumi, lūdzu, sazinieties ar mums.

Lithuanian
Jei norėtumėte gauti informaciją kita kalba ar formatu, kreipkitės į mus.

Polish
Jeżeli chcieliby Państwo uzyskać informacje w innym języku lub innym formacie, prosimy dać nam znać.

Portuguese
Se deseja obter informação noutro idioma ou formato, diga-nos.

Romanian
Acest document este disponibil la cerere și în alte limbi și formate. Pentru a cere alte formate, sau în cazul în care aveți nevoie de serviciile unui interpret, vă rugăm să luați legătura cu noi.

Russian
Этот документ доступен на других языках и в других форматах по запросу. Для того чтобы запросить альтернативные форматы, или если вам требуются услуги переводчика, свяжитесь с нами.

Some photos were taken before the COVID-19 pandemic

What is this consultation about?

The NHS belongs to us all. It is undoubtedly one of the most important and treasured institutions in our country.

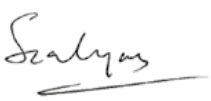
In Lincolnshire, the NHS serves a population of almost 800,000 people, 15,000 of whom use it every day. Over 14,000 people work in our NHS in the county.

We are rightly proud of many things about our local NHS. The efforts and dedication of staff throughout the coronavirus pandemic have been widely praised, and our standards of care and delivery in many areas are often outstanding. However, in some services we have problems to resolve in order to ensure that we can provide the highest quality of patient care possible to the people of Lincolnshire. This will require changes to some of the health services we provide.

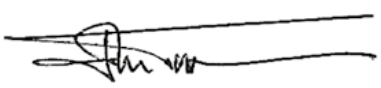
This consultation document explains the review process undertaken so far of four NHS services provided by United Lincolnshire Hospitals NHS Trust (ULHT). It also describes the challenges these services face and how they might change in the future to deliver some of that much needed improvement. Most importantly, it asks for your views on the proposed changes. The four NHS services are:

- Orthopaedic surgery across Lincolnshire
- Urgent and emergency care at Grantham and District Hospital
- Acute medical beds at Grantham and District Hospital
- Stroke services across Lincolnshire

We welcome your views on these services as they will help us in our decision making process. Please complete the questionnaire and tell us what you think about the proposed changes.



Sean Lyons
NHS Lincolnshire CCG, Chair



John Turner
NHS Lincolnshire CCG, Chief Executive

What is public consultation?

Public consultation in the NHS is a formal process through which the NHS listens to the views of the public relating to service change proposals.

In this particular process, the authority consulting is the NHS Lincolnshire Clinical Commissioning Group (CCG). The review work leading to consultation has been undertaken in partnership with senior clinicians from the NHS in Lincolnshire.

Why are we consulting?

Our vision is to deliver the very best in health and care for people across Lincolnshire, and we seek to continuously improve services wherever we can.

This consultation is focused on these four NHS services because we believe that significant and permanent improvement is required to them. Such change would ensure that the highest possible standards of patient care are provided in line with clinical evidence and best practice, giving the best possible outcomes for patients. We are consulting to understand the potential impact of these changes on you before we make a decision.

We believe that the benefits of changing will include:

- Improved quality of care
- Reduced waiting times
- Better outcomes for patients
- Increased availability of staff to care for patients
- Better use of NHS funds, reducing spend on temporary staff

If we don't improve these services, there is a continued risk that the quality of care the services provide to patients would deteriorate. In addition there is a risk that the staffing levels and expertise needed to provide the service would not be sufficient to provide high standards of care. If these issues are not addressed, these services will remain unsustainable.

Who are we consulting?

We are consulting with the people of Lincolnshire. This includes patients who have used, are currently using or could use in the future, services in Lincoln, Boston and Grantham hospitals. It also includes their families and carers; NHS staff; people who live or work in Lincolnshire; people in neighbouring areas; partner organisations; the community and voluntary sector and elected representatives.

We are also working closely with the Lincolnshire County Council Health Scrutiny Committee with regard to their oversight responsibilities in relation to public consultation exercises.

As well as consulting widely across our county, we are particularly interested in hearing from groups (often defined by protected characteristics) who might be most affected by the proposals. The Equality Impact Assessments we have done to date tell us these are:

- People who are economically disadvantaged
- People with a disability
- People who may be affected due to their age (i.e. they are in the older or younger age brackets)
- Carers (specifically of those in the above groups)

All the responses that we receive will be valued and will inform any formal decisions which will be made by NHS Lincolnshire CCG.

The public consultation of these four Lincolnshire NHS services will run for 12 weeks, from 30 September until 23 December.

Detailed information on all of the sections within this consultation document, and further reading can be found at www.lincolnshire.nhs.uk

Does Lincolnshire NHS have a preferred way of improving?

Yes. Later in this document (in each of the service sections) we describe each of the four NHS services and how they are structured now, as well as how we believe they should be structured in future. Our senior clinicians have been heavily involved in designing our preferred service models.

What this consultation includes and what it does not

✖ The consultation does not cover any other NHS services, such as mental health, hospital or primary care services (those based in and around GP surgeries, pharmacies, opticians and dentists). Lots of work continues to happen to ensure these services keep improving, which will support any changes we make to our hospital services. Whilst we are only consulting on the four NHS services, we continuously welcome feedback on all NHS services in the county.

To give us your feedback on any other services, go to www.lincolnshire.nhs.uk

This consultation includes:

✔
- Orthopaedic surgery
- Urgent and emergency care at Grantham and District Hospital
- Acute medical beds at Grantham and District Hospital
- Stroke services

Why we need to change

There is a widely publicised, national case for change regarding why the NHS across the country must improve and transform. Key national challenges are well known: recruiting and retaining staff; increased demand for services and patients living longer and with more complex conditions.

Within Lincolnshire, United Lincolnshire Hospitals NHS Trust (ULHT) provides a wide range of acute hospital services to our population.

This consultation relates to four NHS services currently provided by ULHT. Some people in Lincolnshire receive their hospital care from NHS Trusts in a neighbouring area (eg. North West Anglia NHS Foundation Trust, Peterborough and Northern Lincolnshire and Goole NHS Foundation Trust).

The quality and long-term sustainability of services within ULHT is critical to Lincolnshire's community. To support ULHT to address the national challenges and improve services we need to change the way they are currently delivered. This public consultation is focused on improving this quality of care, and retention and recruitment of staff, rather than on financial savings. If we improve these four NHS services, we believe there will be:

- Shorter waiting times for planned orthopaedic procedures in Lincolnshire
- Fewer cancellations of planned orthopaedic procedures in Lincolnshire
- Better urgent and emergency care for patients across Lincolnshire
- Clinically optimum hospital stays for recovering stroke patients
- Better hospital care for recovering stroke patients
- More integrated community and hospital medical services
- Quicker access to specialist staff across these four NHS services
- Reduced risk that Lincolnshire would lose these services if they become unsustainable
- Increased ability for the NHS in Lincolnshire to attract new staff to work in the county
- Better retention of staff already in the county, as they would be working for more sustainable and progressive services
- Reduced spend on temporary and locum staff to fill gaps in the rota, caused by too few permanent staff to fill them

How to get involved

We want people across Lincolnshire to get involved and to have their say. If you live in or use these services in Lincolnshire, we would really welcome your views on their future because the final decision about these four NHS services may affect you.

A detailed public consultation strategy and plan, as well as full event listings and contact information, can be found on our website: www.lincolnshire.nhs.uk

How can I get involved in this consultation?

We will be offering a mix of 'virtual' methods of consultation, such as on-line discussion forums, as well as face-to-face events, where appropriate and safe. We will continue to adapt our consultation activities in line with any changes to national or local guidance regarding the COVID-19 pandemic during the consultation period.

We are publicising this consultation widely to encourage as many people as possible to provide their views. This includes those people we know are usually less likely to engage with such a process. We have developed a dedicated online resource at www.lincolnshire.nhs.uk where all information about this consultation, including the online questionnaire, can be found. We are also sending an information leaflet to households across the county.

This consultation will run for 12 weeks from 30 September until 23 December. There are lots of ways you can find out more about it:

- Visit our website for further detail about all sections of this document, films, FAQs and much more at www.lincolnshire.nhs.uk
- The website also has the full Pre Consultation Business Case document that contains the full detail behind the proposals and their selection
- Look through the consultation materials distributed to local outlets e.g. consultation booklet, Easy Read booklet, awareness flyer to local households
- Attend one of our events, either online or face-to-face. If you can't make one of the events listed on our schedule, you can watch our event film to learn what is discussed at www.lincolnshire.nhs.uk
- Talk to us when you see us out and about in market places, supermarkets and community venues
- NHS staff can attend one of our staff engagement events to learn what this might mean for them. Your line manager will have more information

You can respond to the consultation by:

- Completing the questionnaire included in this document and sending it back to us at Opinion Research Services, FREEPOST SS1018, PO Box 530, Swansea, SA1 1ZL (no stamp required) OR
- Completing the same questionnaire online on our website www.lincolnshire.nhs.uk

This document is available in other languages and formats. To request alternative formats or if you require the services of an interpreter, please contact us on 01522 421860 Monday – Friday 9am – 5pm.

What will happen with feedback?

We will carefully record and review all of the feedback we receive. Individual responses to the questionnaire will remain anonymous and confidential and all responses will be analysed by an independent organisation. All the analysis will then be made publicly available. Hearing the views of people throughout the consultation process is an important part of the decision making and will be fully taken into account alongside other essential factors such as clinical, financial and practical considerations. Any decision to proceed with one or more of the preferred service changes will be informed by the feedback from the consultation and any subsequent decisions taken by the NHS Lincolnshire CCG Board.

The feedback from the public consultation is really important but does not represent a vote on, or a veto over, any form of change. The independent report of the results will be published on our website and the decision-making process will be assured by NHS England.

The CCG has appointed ORS, an independent social research company, to manage the consultation questionnaire and responses and will faithfully report the outcomes. All information you provide will be processed by ORS in accordance with the latest Data Protection regulations. Information will only be used to inform this consultation and any personal information that could identify you will be kept for no more than one year after any decisions have been made.

The views of individual members of the public in a personal capacity will be anonymous. However, where feedback is from representatives of organisations or someone acting in an official capacity, it may be attributed to them.

All the questions are optional, and all information you provide will be processed by ORS in accordance with the Data Protection Act and GDPR. Please visit **www.ors.org.uk/privacy** and/or our CCG website **www.lincolnshireccg.nhs.uk/contact/freedom-of-information/privacy-notice-your-information-and-how-we-use-it/** for more information.

For further details on how to get involved please visit www.lincolnshire.nhs.uk

How have we involved the public so far?

Our review work over the past few years has been led by Lincolnshire's senior clinicians, who have experienced working in the services which are being considered.

As well as benefiting from the expertise of these clinical leaders, we have undertaken significant engagement with the public across Lincolnshire. This has involved explaining the challenges, discussing the possible solutions and ensuring their views have also influenced the developing ideas for improvement. A full overview of this process and associated timeline prior to developing into the 'Acute Services Review' in 2017, can be found on our website, and is summarised here:

- **Phase 1** – 2013: the first public engagement on this review occurred, via Lincolnshire Sustainable Services Review (LSSR) programme
- **Phase 2** – 2014-2017: Our Lincolnshire Health and Care Programme (LHaC) programme included stakeholder engagement events, task and finish groups, and Clinical Senate reviews to develop and design models of care
- **Phase 3** – 2017-2021: LHaC transitioned into the Acute Services Review (ASR), which continued to engage with clinicians, stakeholders and the Clinical Senate to develop these initiatives

The latest engagement programme that has fed into this review was Healthy Conversation 2019. During this six-month exercise we asked the public and many other stakeholders to tell us their views on a range of NHS services, and contributory factors such as access and workforce issues. Feedback from this helped us develop the review process into possible solutions that NHS Lincolnshire CCG could take to public consultation. Similarly, the public feedback helped develop our understanding of public concerns, such as the importance of 24/7 walk in access to urgent care services in Grantham.

Focus on four NHS services

Those who took part in Healthy Conversation 2019 will note that there are only four of the services which were discussed at that point included in this consultation. This is because we are not currently able to progress improvements to all of the eight original services discussed at that time, due to not having sufficient capital funding. This means that there is not enough 'one-off' funding available to, for example, adapt the buildings to accommodate all of the potential service changes we are proposing.

The reason we are focusing on the current four NHS services is either because we can take the proposed changes forward without significant capital funding, or because the service is extremely fragile in its current state, and must therefore be prioritised for improvement in order to continue caring for Lincolnshire's population.

What impact has the public involvement had so far?

The public and stakeholder feedback which has been received through the review process included:

- Most members of the public understand why changes need to be made
- Some members of the public have concerns about consolidating some services (especially emergency care) but many agree that a specialised service might improve quality and safety standards and reduce the number of cancelled operations
- Some members of the public were happy to travel further for better care but some felt that other people (for example in our most rural areas or on a lower income) might be disadvantaged by having specialised services in fewer locations
- Some members of the public were concerned about a potential increased burden on the East Midlands Ambulance Service

Our most recent pre-consultation engagement, Healthy Conversation 2019, which ran for six months from March of that year, provided us with greater detail about the public's views on the four services in this consultation. Specifically:

We heard that people in the Grantham area:

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

We heard that people in the Boston area:

- Are concerned about travel time for people with symptoms of a suspected stroke if the service is consolidated at Lincoln County Hospital

We heard that people across Lincolnshire as a whole:

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

As Healthy Conversation 2019 closed, we produced a full and final report. This can be found on our website and details all that we heard throughout this extended engagement exercise through completed questionnaires, face to face sessions and focus groups, visits to market days, freshers' fayres and community groups and much more.

Since receiving this feedback, Lincolnshire's NHS has continued to progress activity and improvements where possible, including:

- We have increased our collaborative working with local government to align NHS services with other locality plans, as demonstrated for example, through NHS support to the successful Town Fund
- We have invested in the digital delivery of health services, particularly GP access, to improve the availability of appointments and advice
- We have established a county-wide programme focused on the recruitment, retention and wellbeing of health and care staff in the county

- We have invested in the resourcing and development of 'primary care networks' to further improve general practice services in the county. It was this structure that played such a key role in enabling Lincolnshire to so successfully deploy our COVID vaccination programme

- Online recruitment events this year facilitated almost 250 health care support worker roles in Lincolnshire's hospitals being offered to new staff and since lockdown guidelines eased, we have welcomed over 50 international nurses into the county, with more cohorts coming in the months ahead.

Equally important is the feedback from engagement work we undertook with communities who are seldom heard in traditional engagement activity. Also on our website is a report of the feedback received by The People's Partnership, a specialist in this area of engagement, who engaged with a number of communities on behalf of Lincolnshire NHS. Key concerns reported were:

- Potential cost increase of travel if services move further away

- Limited public transport options for patients and family members who do not have access to a car

- The significant impact of greater travel time and distance to those who are disabled or frail

It is clear that the proposed changes may have more of an impact on certain age groups, people with a disability or those who are economically disadvantaged

Details of the potential impact of proposed improvements identified by these Equality Impact Assessments are included in each service section, later in the document.

This consultation document provides a summary of the engagement responses received so far. It does not attempt to describe every point made. A full report of the Healthy Conversation 2019 exercise and feedback, as well as the full Stage 1 and Stage 2 EIAs is available on our website www.lincolnshire.nhs.uk

We really welcome members of the public and other stakeholders continuing to share their views via this consultation, so that this feedback can continue to feed into the ongoing review and decision-making process.

How we developed our change proposals

Identifying NHS services for improvement

Following a review led by senior clinicians and managers from across the Lincolnshire health system, eight NHS services provided by United Lincolnshire Hospital NHS Trust (ULHT) were identified as priority areas for improvement.

This assessment was conducted using a framework of quality of care, workforce, performance and finance. The priority services identified through this review were:

- Acute medical beds
- Breast
- General surgery
- Haematology & oncology
- Orthopaedic surgery
- Stroke services
- Urgent and emergency care at Grantham and District Hospital
- Women's and children's services

A common thread across all of the services identified as a priority was a lack of enough suitably qualified staff in key areas. In many cases this was consistent with a national shortage.

The issues identified in each of these services were presented and discussed at a meeting of clinical leaders and key stakeholders from across the Lincolnshire health system. It was agreed that change was needed in each of them to improve quality of patient care in line with best clinical practice and advice.

How potential solutions for improving NHS services were developed and considered

To develop and consider potential solutions for improving the prioritised hospital services, we followed a process whereby we developed an initial full range of possible solutions. We carried out a thorough analysis on each of them and identified a preferred proposal for change to be taken to public consultation.

Throughout this process we ensured we had independent clinical best practice input by:

- Involving national clinical leaders in the development of the change proposals; and
- Asking the independent East Midlands Clinical Senate to review our change proposals

The steps we followed in this process are set out below.

Step one: Developed a 'long list' of options

Following widespread agreement by senior clinicians of the need for change in the prioritised services, potential solutions for improving care provision were considered.

This exercise identified a list of options for change at a service level which were put together in different combinations to develop a 'long list' of nine overarching scenario-based options.

This long list of options presented a view of significant change possibilities, thereby providing a sense of what could be achieved.

Step two: Developed a 'shortlist' of options

Each of the long list of options was evaluated at a clinically led workshop where clinical leaders and key stakeholders discussed the options alignment and impact against four criteria.

This evaluation was clinically led and focused on quality, safety and sustainability to collectively review and assess the impact of the scenarios on the whole Lincolnshire heath system. This identified clinical opinions on which of the options were the best fit to meet the needs of the Lincolnshire population. A shortlist of six scenario-based options was identified.

Step three: Appraised the 'shortlist' of options

Each of the shortlisted options underwent a more detailed appraisal, using the evaluation criteria. This included running one options appraisal workshop with local clinical leads and key stakeholders and four option appraisal workshops with randomly selected members of the public from across Lincolnshire.

Attendees at the events were asked to consider the specific service change proposals at a specialty level (e.g. acute medicine, stroke etc.) that when combined made up the scenario based options in the shortlist.

Following a review of the outcomes of the clinical leads and key stakeholder options appraisal workshop, the public option appraisal workshops and the recommendations of the East Midlands Clinical Senate, a preferred change proposal was identified from the shortlist.

Option evaluation criteria

The evaluation criteria used to appraise the options for improving the prioritised hospital services was based on a framework developed as part of a previous programme of work, known as the Lincolnshire Health and Care Programme (LHaC).

During its development as part of the LHaC programme, the evaluation criteria were subject to a significant amount of stakeholder consultation and involvement.

As part of this programme of work the evaluation criteria underwent further testing with the public and were developed further.

The evaluation criteria used to appraise the shortlist of options are set out below.

Quality	• Does the option maintain or improve clinical quality and outcomes? • Does the option maintain or improve patient experience?
Access	• Does the option maintain or improve equality of access to care? • Does the option minimise activity seen or treated at a different site or provider?
Affordability	• Does the option minimise the requirement for capital? • Is the implementation of the option achievable?
Deliverability	• Does the option have an achievable workforce requirement?

Progressing the preferred option

Due to the limited capital funding available to the NHS, both nationally and locally, it is not currently possible to progress all the proposed service level changes that make up the preferred overall option at once.

In light of this, so as not to delay the benefits to patients of service change proposals, four NHS services were identified where the proposed changes could be taken forward without significant capital funding and / or the service is extremely fragile in its current state.

These areas are:

- Orthopaedic surgery
- Urgent and emergency care
- Acute medical beds
- Stroke services

The change proposals relating to these four hospital services are the focus of this public consultation.

Impact assessments

An impact assessment is a formal process to understand and consider the implications of any proposed changes on people or their environment.

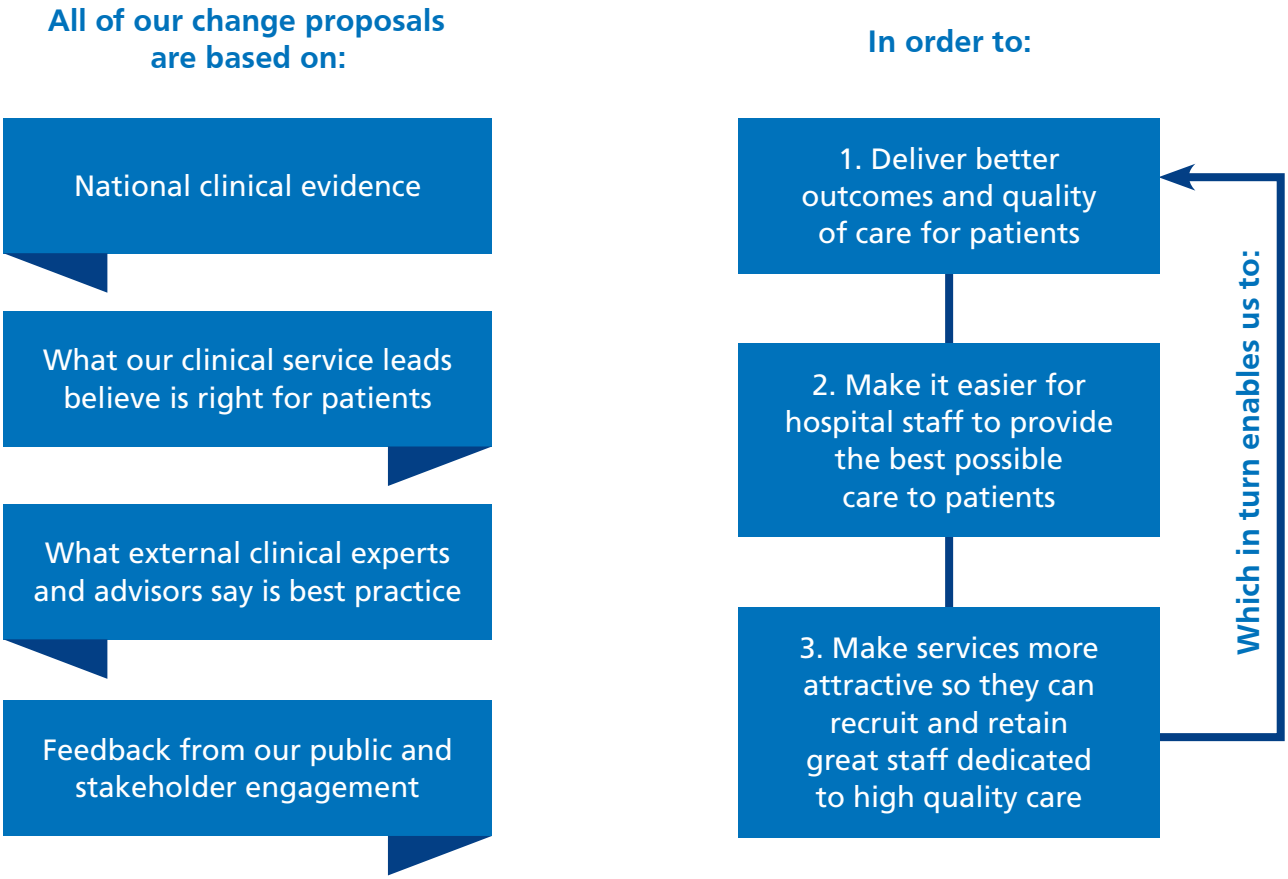
For each of the four service change proposals we have conducted a Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA).

Our findings from these are set out in each of the service change sections later in this document.

A key focus during the public consultation will be to seek out the views of those groups of people identified through the EIAs who may be more likely to be impacted by the change proposals. This is described further in the next section.

We will continue to review and develop these EIAs, with independent support, throughout our public consultation in light of the feedback we receive. They will play a key part in informing the decision making process.

Overview of our change proposals



Summary of our change proposals

For each of the four NHS services within the scope of this consultation, the tables below set out the options considered at the shortlist stage, the preferred change proposal identified following the appraisal of the shortlist and a summary of the preferred change proposal.

Orthopaedic surgery

Options appraised at shortlist stage	Change proposal identified following appraisal
1. Consolidate planned orthopaedic surgery at Grantham and District Hospital *Other options were considered initially, however these did not progress to the shortlist stage following the clinically led evaluation of the long list of options*	Consolidate planned orthopaedic surgery at Grantham and District Hospital A dedicated day case centre at County Hospital Louth (developed through the pilot which is described on p22)

Overview of preferred change proposal

- A 'centre of excellence' in Lincolnshire for planned (only) orthopaedic surgery would be established at Grantham and District Hospital
- A dedicated day case centre at County Hospital Louth for planned orthopaedic surgery
- All unplanned orthopaedic surgery delivered by dedicated, specialist staff at ULHT will take place at Lincoln County Hospital and Pilgrim Hospital, Boston
- A pilot of these services has demonstrated:
  - Reductions in the number of patients who have their planned orthopaedic surgery cancelled due to a lack of beds
  - Care provided in line with national best practice and care standards
  - A reduction in the amount of time patients wait for their planned orthopaedic surgery
  - A reduction in the amount of time patients spend in hospital after their planned surgery
  - An improvement in patient satisfaction and experience
  - A reduction in the number of patients receiving their care in the private sector, funded by the NHS

Urgent and emergency care at Grantham and District Hospital

Options appraised at shortlist stage	Change proposal identified following appraisal
1. Grantham and District Hospital A&E department to become an Urgent Treatment Centre (UTC) *Other options were considered initially, however these did not progress to the shortlist stage following the clinically led evaluation of the long list of options*	Grantham and District Hospital A&E department to become an Urgent Treatment Centre (UTC)

Overview of change proposal

Feedback from the public received during Healthy Conversation 2019 engagement further developed this proposal into a 24/7 walk-in UTC

- 24/7 walk-in urgent care services at Grantham and District Hospital would be provided by a sustainable and permanent Urgent Treatment Centre (UTC)
- The vast majority (estimated to be around 97%) of patients currently seen by the A&E department at Grantham and District Hospital would continue to be treated by the proposed 24/7 Urgent Treatment Centre (UTC)
- Compared to the current Grantham and District Hospital A&E Department, access overall would increase as the UTC would be open 24/7. Greater access would also be provided for children
- The 24/7 UTC would be provided by a community health service provider, which will support better integration with primary care and community services and the provision of care closer to home
- For the small number of patients who wouldn't be able to have their care needs met by the 24/7 UTC in Grantham, care would be received at an alternative site with the right facilities and expertise to ensure the best patient care
- The Mental Health Liaison Service currently provided at Grantham and District Hospital would not be impacted by the proposed service changes and would continue to provide services as it does now

Acute medical beds at Grantham and District Hospital

Options appraised at shortlist stage	Change proposal identified following appraisal
1. No acute medical beds at Grantham and District Hospital OR 2. Integrated community/acute medical beds at Grantham and District Hospital	Integrated community/acute medical beds at Grantham and District Hospital

Overview of change proposal

- Acute medical beds would be retained locally at Grantham and District Hospital in a sustainable way
- The majority (estimated to be around 90%) of patients currently receiving care in the acute medical beds at Grantham and District Hospital would continue to be treated in the integrated community/acute medical beds
- Compared to the current Grantham and District Hospital acute medical beds, a more comprehensive service would be delivered, particularly for frail people, which enables greater integration with community health and care services
- Maintaining a local service at Grantham and District Hospital would reduce pressure on Lincoln County Hospital, Pilgrim Hospital, Boston and Peterborough City Hospital
- For the small number of patients who would not be able to have their care needs met by the integrated community/acute medical beds in Grantham, care would be received at an alternative site with the right facilities and expertise to ensure the best patient care

Stroke services

Options appraised at shortlist stage	Change proposal identified following appraisal
1. Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service OR 2. Provide hyper-acute and acute stroke services from Lincoln County Hospital and Pilgrim Hospital, Boston, supported by a combined medical on-call rota	Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service

Overview of change proposal

- A 'centre of excellence' in Lincolnshire for hyper-acute and acute stroke services would be established at Lincoln County Hospital – Pilgrim Hospital, Boston would no longer provide hyper-acute and acute stroke services
- Hospital stroke service provision would be based on national clinical evidence, which has demonstrated stroke patients are more likely to survive, recover more quickly and spend less time in hospital
- Hospital stroke services in Lincolnshire would be in a stronger position to attract and retain talented staff through building a strong, high quality and successful service – making it sustainable for the long term
- More patients would benefit from hospital stroke services being located on the same hospital site as the highly successful Lincolnshire Heart Centre, with benefits including increased access to important time critical interventions and acute imaging services, further reducing time to treatment
- Stroke patients would spend the minimum time necessary in a hospital bed, by ensuring enhanced community services have the right skills and capacity to provide high quality rehabilitation to stroke patients as they return home, or as close to home as possible

The sections that follow in this document provide more detail on the individual services that form part of this consultation.

How these four NHS services are currently organised and how they could look in the future

Each of the tables below outline how the services which are part of this public consultation are currently organised (pre COVID-19 temporary changes). They also outline how services have temporarily been changed in response to COVID-19, changes which were necessary for multiple reasons during the pandemic, such as staff isolating, and the need to separate patients with COVID-19 from other patients. And finally, they outline how services would be organised in the future if our change proposals are agreed and implemented.

It can be seen in some areas there are similarities between the temporary COVID-19 changes and the preferred proposals for change. These temporary changes have therefore provided the Lincolnshire health system with additional insights into the proposed change.

Orthopaedic surgery

	Services pre COVID-19 ***(after the pilot changes in August 2018)***	**Temporary changes in response to COVID-19** ***(in place between March 2020 and May/June 2021)***	**Preferred option for change proposal**

Lincoln County Hospital	• Planned surgery
	  ○ Day case
	  high risk patients
	  ○ Inpatient
	  high risk patients
	• Unplanned surgery
		• Planned surgery
		  ○ Day case
		  based on priority level
		  ○ Inpatient
		  based on priority level
		• Unplanned surgery
			• Planned surgery
			  ○ Day case
			  high risk patients
			  ○ Inpatient
			  high risk patients
			• Unplanned surgery

Pilgrim Hospital, Boston	• Planned surgery
	  ○ Day case*
	  high risk patients
	  ○ Inpatient
	  high risk patients
	• Unplanned surgery
	**some non-high risk patients also seen to manage day to day operational demands*
		• Unplanned surgery	• Planned surgery
			  ○ Day case
			  high risk patients
			  ○ Inpatient
			  high risk patients
			• Unplanned surgery

Grantham and District Hospital	• Planned surgery
	  ○ Day case
	  non-high risk patients
	  ○ Inpatient
	  non-high risk patients
		• No service provision	• Planned surgery
			  ○ Day case
			  non-high risk patients
			  ○ Inpatient
			  non-high risk patients

County Hospital Louth	• Planned surgery
	  ○ Focused on day cases
	  non-high risk patients
		• No service provision	• Planned surgery
			  ○ Focused on day cases
			  non-high risk patients

Urgent and emergency care at Grantham and District Hospital

	Services pre COVID-19	Temporary changes in response to COVID-19 *(in place between June 2020 and July 2021)*	Preferred option for change proposal
Lincoln County Hospital	• 24/7 full A&E department • Co-located Urgent Treatment Centre (UTC)	• 24/7 full A&E department • Co-located Urgent Treatment Centre (UTC)	• 24/7 full A&E department • Co-located Urgent Treatment Centre (UTC)
Pilgrim Hospital, Boston	• 24/7 full A&E department • Co-located Urgent Treatment Centre (UTC)	• 24/7 full A&E department • Co-located Urgent Treatment Centre (UTC)	• 24/7 full A&E department • Co-located Urgent Treatment Centre (UTC)
Grantham and District Hospital *A&E operating reduced hours since 2016*	• A&E department (08.00-18.30 since 2016) • Limited range of presenting conditions dealt with by A&E department since 2007/8	• 24/7 Urgent Treatment Centre (UTC)	• 24/7 'walk in' Urgent Treatment Centre (UTC) (full range of services)

Acute medical beds at Grantham and District Hospital

	Services pre COVID-19	Temporary changes in response to COVID-19 *(in place between June 2020 and July 2021)*	Preferred option for change proposal
Lincoln County Hospital	• Acute medical beds	• Acute medical beds	• Acute medical beds
Pilgrim Hospital, Boston	• Acute medical beds	• Acute medical beds	• Acute medical beds
Grantham and District Hospital	• Acute medical beds – level of provision reflective of the specified range of presenting emergency conditions	• No acute medical beds	• Integrated community/ acute medical beds – level of provision reflective of specified range of presenting conditions

Stroke services

	Services pre COVID-19	Temporary changes in response to COVID-19 *(commenced April 2020, still in place)*	Preferred option for change proposal
Lincoln County Hospital	• Hyper-acute stroke service including thrombolysis • Acute stroke service • Transient Ischaemic Attack (TIA) clinics	• Hyper-acute stroke service including thrombolysis • Acute stroke service • TIA clinics	• Hyper-acute stroke service including thrombolysis • Acute stroke service • TIA clinics
Pilgrim Hospital, Boston	• Hyper-acute stroke service including thrombolysis • Acute stroke service • TIA clinics	• Acute stroke service • TIA clinics	• TIA clinics

Orthopaedic surgery

What are we asking you to consider?

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

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

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

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

Planned surgery can be provided:

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

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

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

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

	Before the pilot in August 2018	After the pilot changes in August 2018

Lincoln County Hospital	• Planned surgery
	  ○ Day case
	  ○ Inpatient
	• Unplanned surgery
		• Planned surgery
		  ○ Day case *high risk patients*
		  ○ Inpatient *high risk patients*
		• Unplanned surgery

Pilgrim Hospital, Boston	• Planned surgery
	  ○ Day case
	  ○ Inpatient
	• Unplanned surgery
		• Planned surgery
		  ○ Day case *high risk patients**
		  ○ Inpatient *high risk patients*
		• Unplanned surgery
		**some non-high risk patients also seen to manage day to day operational demands*

Grantham and District Hospital	• Planned surgery
	  ○ Day case
	  ○ Inpatient
	• Unplanned surgery
		• Planned surgery
		  ○ Day case *non-high risk patients*
		  ○ Inpatient *non-high risk patients*

County Hospital Louth	• Planned surgery
	  ○ Day case
	  ○ Inpatient
		• Planned surgery
		  ○ Focused on day cases *non-high risk patients*

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

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

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

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

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

What are the challenges and opportunities for orthopaedic surgery?

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

Challenges (pre pilot)

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

Opportunities

By making changes, we can look to ensure:

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

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

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

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

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

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

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

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

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

What is our proposal for change?

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

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

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

It is anticipated the change would affect on average:

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

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

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

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

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

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

Impact Analysis

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

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

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

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

Potential positive impacts

Evaluation of the pilot pre COVID-19 identified:

1. A reduction in waiting times for planned orthopaedic surgery, which means patients were getting treated quicker

2. Cancellations on the day of planned orthopaedic surgery due to a lack of beds reduced:

    - From 10 a month to 3 a month across United Hospital Lincolnshire NHS Trust (ULHT)

    - To 0 at Grantham and District Hospital

3. Length of stay reduced:

    - From 2.9 days to 2.3 days across ULHT

    - From 2.7 days to 1.7 days at Grantham and District Hospital

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

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

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

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

Potential adverse impacts

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

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

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

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

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

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

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

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

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 our preferred change proposal to develop:

- A 24/7 Urgent Treatment Centre (UTC) at Grantham and 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 24/7 support 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 of assessment and treatment that meets the needs of the local population.

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

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.

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 changes in 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 Health Services 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 of conditions which are not critical or life threatening such as sprains and strains, suspected broken limbs and feverish illness in adults and children. They play a 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 added to the reluctance to join the county's team
- Independent clinically-led reviews have concluded that in the interests of safety the A&E department at Grantham 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 of presenting 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 in place
- Using a description of A&E for this service creates unrealistic expectations and misunderstandings about the 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 way for the long term, by:
    - Making relatively small changes in the scope of safe and high-quality services, ensuring Grantham and District Hospital receives patients in line with its medical capabilities
    - Those few patients with the highest levels of need that cannot be met at Grantham hospital receive care 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, first time, 24/7, and therefore receive the best possible care, including not having to wait unnecessarily
- Patient health and the overall patient experience are improved

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 care provider, with existing doctors retained as part of the team and consultant (senior doctor) oversight provided to the unit. The multi-disciplinary workforce would have the 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% of those 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 onward transfer 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 they agreed 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 feedback we 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&E department 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 6.30pm and 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 with treating 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. Specialist follow-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 services and 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 possible care. 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 is estimated that if travelling by car around 60% of them would travel over 45 minutes (the threshold agreed 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 what happens now for those patients requiring a level of emergency 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 attend hospitals 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

Acute medical beds at Grantham and District Hospital

What are we asking you to consider?

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

- Integrated community/acute medical beds at Grantham and District Hospital

What are the services and how are they currently organised?

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

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

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

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

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

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

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

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

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

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

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

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

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

Challenges

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

Opportunities

By making changes, we can look to ensure:

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

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

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

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

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

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

What is our proposal for change?

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

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

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

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

For acute medical beds two solutions remained following the shortlisting of options:

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

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

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

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

Impact Analysis

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

Through our equality impact assessment we identified two 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 below. We will continue to review and develop these, including the impact on different groups of people within our population, with independent support, through our public consultation in light of the feedback we receive.

Potential positive impacts

1. Acute medical beds provision would continue to be delivered at Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term – including a more sustainable medical and nursing workforce

2. The majority of patients (estimated to be around 90%) cared for in the acute medical beds at Grantham and District Hospital would continue to be cared for in the integrated community/acute medical beds

3. The preferred proposal for change would deliver a more comprehensive local service provision at Grantham hospital, specifically in relation to the 'frail' population, thereby reducing pressure on acute hospital sites at Lincoln and Boston

4. The preferred proposal for change would enable Grantham and District Hospital to build a centre of excellence for integrated multi-disciplinary care (particularly for frail patients), which supports both improved community-based management of long term conditions and reduced lengths of stay in hospital beds

5. An estimated 10% of patients (equivalent to 1 a day on average) currently cared for in the acute medical beds at Grantham and District Hospital would not be able to have their care needs met in the integrated community/ acute medical beds. Instead, they would receive their care at an alternative site with the right facilities and expertise to ensure the best outcomes

Potential adverse impacts

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

   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 seen as an adverse impact by some people.

- Of those patients seen at an alternative site, it is estimated that there would be no increase in the number of patients travelling more than 60 minutes by car, the threshold set by the local health system for this type of activity. However, given the serious nature of the conditions these patients are expected to have, most are likely to travel by ambulance
- Of those attending an alternative site, it is estimated around 40% would attend Lincoln County Hospital. The remainder would attend hospitals closer to them, but outside of the county, with the majority going to Peterborough City Hospital.
- The friends and family of those patients receiving treatment at an alternative hospital, which better meets the patients care needs, may have to travel further to see them

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-acute and acute stroke services at Lincoln County Hospital
- Which would be supported by enhancement of the community stroke rehabilitation service across the county, so it can support stroke patients with more complex needs

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

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

- Hyper-acute stroke services care for people in hospital in 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 after the first 72 hours of having a stroke (including in-hospital rehabilitation) and until they are ready to be discharged 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 most appropriate 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 is time critical, as can only be given within 4.5 hours of stroke onset

and

- Mechanical thrombectomy: 'clot retrieval' through a procedure where a 'guide wire' is used to remove the clot causing the stroke, usually used in conjunction with thrombolysis. This is a relatively new procedure only available in a small number of hospitals, 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.

Lincoln County Hospital	• Hyper-acute stroke service including Thrombolysis • Acute stroke service • TIA clinics
Pilgrim Hospital, Boston	• Hyper-acute stroke service including Thrombolysis • Acute stroke service • TIA clinics

Please see earlier section for description of temporary changes in 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 following a 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 opportunities for 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 in the future:
    - Lincoln County Hospital admits around 670 stroke patients a year and Pilgrim Hospital, Boston around 500 stroke patients a year
    - Even when considering growth in the size and the ageing of the local population over the next five years, Pilgrim Hospital, Boston is highly unlikely to admit 600 stroke patients a year, every year
- We need more doctors, nurses and therapists to deliver the existing hospital stroke services, but there aren't enough locally and nationally:
    - This means there are significant problems staffing our hospital stroke services – and we have already seen 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 are delivered in Lincolnshire in a sustainable way for the long term, by:
    - Ensuring hospital stroke services are based on national clinical evidence
    - We achieve a balance between access and ensuring the long term sustainability of services
    - Our hospital stroke services receive over 600 stroke patients a year so that our doctors and nurses here in Lincolnshire maintain and develop their specialist skills and expertise
    - Improving the ability of hospital stroke services to attract 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 necessary in 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, first time, 24/7 and receive the best possible care
- Health outcomes and the overall patient experience are 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 for change?

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 proposals against agreed criteria.

The table below summarises the level of stakeholder and 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 two sites – Lincoln and Boston	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 identified two 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 concentrated means patients are:
    - More likely to survive and recover more quickly.
    - More likely to have a reduced length of stay in hospital
    - More likely to continue to lead more fulfilling lives in 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 to doctors, nurses and therapists to work in
    - Reducing reliance on temporary, expensive staffing solutions
3. Consolidation of hospital stroke services on the Lincoln County Hospital site allows more patients to 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, further reducing 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 instance they require mechanical thrombectomy.

Potential adverse impacts

1. For those patients who would previously have been admitted to Pilgrim Hospital, Boston with a stroke (1 to 2 a day on average), treatment would be received at 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, with a 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 seen as an adverse impact by some people.

    - Of those patients seen at an alternative site, it is estimated that there would be no increase in the number of patients travelling more than 60 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.

Have your say

Our vision is to deliver the very best in health and care for people across Lincolnshire, and we seek to continuously improve services wherever we can.

We believe that these four NHS services need significant improvement to ensure that the best quality of care and outcomes for patients are in place here in Lincolnshire for the future. We believe that the benefits of changing will include:

- Improved quality of care
- Reduced waiting times
- Better outcomes for patients
- Increased availability of staff to care for patients
- Better use of NHS funds, reducing spend on temporary staff

We want people across Lincolnshire to get involved and to have their say. If you live in, or use these services in Lincolnshire, it is important that you share your views on their future because the proposed options for change outlined in this document may affect you.

You can respond to the consultation by:

- Completing the consultation questionnaire and sending it back to us at Opinion Research Services, FREEPOST SS1018, PO Box 530, Swansea, SA1 1ZL (no stamp required)

OR

- Completing the same questionnaire online on our website www.lincolnshire.nhs.uk
- This consultation will run for 12 weeks from 30 September until 23 December

We will also be hosting virtual events and many face to face events around the county throughout the consultation. To find an event near you, visit our website at www.lincolnshire.nhs.uk

Thank you for taking the time to read this information.

For further details on how to get involved please visit www.lincolnshire.nhs.uk

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

Open Report on behalf of Lincolnshire Local Medical Committee (LMC)

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**13 October 2021**
Subject:	**General Practice Access**

Summary:

The Health Scrutiny Committee for Lincolnshire has requested that Lincolnshire Local Medical Committee provide a report on access to general practice services.

General practice services are now accessed by "total triage" as instructed by Department of Health and Social care during the pandemic. However, 63% of general practice contacts in Lincolnshire are face-to-face, with 47% occurring on the same day that the patient requests the appointment.

Lincolnshire's general practices continue to struggle with workload and reduced workforce, and thus access for some patients is affected.

Actions Required:

The Committee are invited to review the work being undertaken to support the system.

1. Background

General practice nationally is over-stretched. An older population with more long-term conditions was already increasing workload before the pandemic, and pandemic pressures have exacerbated this.

Hospital trusts are also under pressure and have long waiting lists due to the pandemic. This has an impact on general practice as patients seek support from their general practice and have increased health needs which cannot be managed by secondary care.

General practice workforce has also changed. The number of GPs has been falling consistently despite promises that there will be 6000 extra GPs. In March 2016 there were 51.5 GPs for every 100,000 patients, this has fallen to 46.3 in March 2021[1]. Since March 2021 the British Medical Association reports a loss of a further 597 GPs and 920 general practice nurses.

To compensate for the reduced numbers of GPs and nurses practices and Primary Care Networks (PCNs) now employ other health professionals who can manage patient conditions: clinical pharmacists, paramedic practitioners, first contact physiotherapists, social prescribers, mental health practitioners, and more. These professionals are qualified to manage conditions in their sphere of practice, but do not have the holistic skills of a GP.

Total Triage

To cope with this mismatch general practices have moved to a "Total Triage" model of providing services. Total Triage is the method by which practices navigate the patient to the most appropriate professional to manage their condition.

When using Total Triage patients who have a health concern contact their general practice, either by telephone or by using an online tool, and provide some basic health information so that the practice's care navigators can direct the patient to right professional. It is important that the patient provides adequate information to facilitate this.

Health professionals will receive the information that the patient has provided and will then manage the patients concern in various ways: offer a face-to-face consultation, offer a telephone consultation, provide management advice and support by electronic means.

Total Triage enables the professional most suited to the patient's problem to manage the concern. However where patients have multiple clinical issues Total Triage does not make it easy for all of these to be addressed.

In July 2021 in Lincolnshire 63% of triaged contacts resulted in face-to-face appointments, 47% on the same day, and 73% within seven days of request.[2] In the past patients often waited weeks to be seen.

Will Total Triage continue?

Total Triage was being introduced gradually prior to the Covid-19 pandemic and was accelerated as a result of the pandemic.

Total Triage allows general practices to protect patients and staff from risks of exposure to infection, and thus whilst Covid-19 remains we must continue to use Total Triage.

Total Triage also enables practices to manage the workload and workforce mismatch and thus will remain until this is addressed.

[1] NHS Digital Workforce Data
[2] NHS Digital GP Appointment Data

Addressing workforce shortages

Lincolnshire has always had difficulty recruiting and retaining clinical workforce. Lincoln Medical School and other developments at University of Lincoln will help this, though this does not support short-term shortages.

In the short to medium term practices and PCNs are developing workforce strategies and trying to recruit non-medical workforce to improve workforce levels. Non-medical clinicians though do not provide the holistic service that a GP can.

The Lincolnshire Clinical Commissioning Group, working with the Whole Systems Partnership, have modelled the clinical workforce and this indicates that there will be a shortage of 220 "autonomous" practitioners by 2025. This needs to be addressed.

In 2018 Lincolnshire LMC in partnership with NHS England and NHS Improvement, and Health Education England recruited 26 GPs from Europe, 80% of whom remain in Lincolnshire's workforce. A similar recruitment campaign may be required to fill this 220 practitioner gap.

Managing Workload Differently

Historically, general practices manage 90% of contacts with the NHS. General practices manage patients with long-term conditions and patients who have a short-term health need. Often the demand for short-term interventions reduces the capacity for practices to properly manage long-term conditions, which results in patients' health deteriorating and thus increased dependence on social care and increased hospital admissions. This is bad for patients and bad for the health and social care economy.

Some health systems separate long-term and short-term health management. This allows better management of each of these groups by focusing the skills of the professionals to the needs of the patient. One model known as "Primary Care Home"[3] identifies patients who fall into the different levels of need and manages their care in different ways. This model relies upon an integrated model of care providing tailored care to populations of about 50,000 patients.

PCNs have brought general practices into groups with populations which would fit well with the Primary Care Home model, however integration and reorganisation takes both time and political will.

This model will also require patient acceptance. For instance, a patient requiring health support for a new short-term condition may have to travel further and be managed by a different health professional. Services for most patients would not be provided by "my GP" anymore, but would be provided at a population level by larger groups of clinicians.

[3] https://napc.co.uk/primary-care-home/

Reducing Workload

Ideally the population would be healthier without the need to seek health advice. This is the remit of public health, to prevent people becoming unwell. This must be a focus of health and non-health providers. Better housing, better jobs, better education, better transport all lead to better health. Society has a responsibility to reduce the workload for health and social care by investing in these to reduce workload long-term.

In the short to medium term empowering patients to self-care is essential. Most conditions do not require medical intervention and will get better on their own.

2. Consultation

This is not a consultation item.

3. Conclusion

Lincolnshire general practice is under dual pressures of increasing workload and workforce shortages. This has led to a mismatch between demand and access to GP services.

Total Triage helps with both workload management and prevents infection so will continue to be utilised.

Recruitment campaign is likely to be required to fill the projected clinical shortfall.

Lincolnshire and other health systems are considering moving to a Primary Care Home model, which will require public and stakeholder engagement.

Self-care and prevention must also be prioritised alleviate future pressures on health and social care.

4. Background Papers

[1] NHS Digital Workforce Data
[2] NHS Digital GP Appointment Data
[3] https://napc.co.uk/primary-care-home/

This report was written by Dr Kieran Sharrock, who can be contacted on 01522 576659 or k.sharrock@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:	**13 October 2021**
Subject:	**Eligibility Criteria for Non-Emergency Patient Transport - Consultation**

Summary:

The NHS is consulting on the eligibility criteria for non-emergency patient transport, with a view to standardising access to this service across England. The Committee is invited to agree a response to the consultation, for submission to NHS England by the consultation closing date of 25 October 2021. This response will be circulated prior to the meeting.

Actions Requested:

To approve the Committee's response to the NHS consultation on the eligibility criteria for non-emergency patient transport.

1. Background

Review of Non-Emergency Patient Transport Services

As reported to the Committee on 15 September 2021, a national review of non-emergency patient transport was published in August 2021. This review highlighted several challenges for the commissioners and providers of patient transport, which included a commitment to update and clarify the national criteria for eligibility, which have been in place since 2007.

The 2007 Eligibility Criteria for Patient Transport Services are set out below and were described by the national review as 'high level':

> *"Eligible patients should reach healthcare (treatment, outpatient appointment or diagnostic services i.e. procedures that were traditionally provided in hospital, but are now available in a hospital or community setting) in secondary and primary care settings in a reasonable time and in reasonable comfort, without detriment to their medical condition.*
>
> *"Similarly, patients should be able to travel home in reasonable comfort without detriment to their medical condition. The distance to be travelled and frequency of travel should also be taken into account, as the medical need for PTS may be affected by these factors. Similarly, what is a 'reasonable' journey time will need to be defined locally, as circumstances may vary.*
>
> *"Eligible patients are those*
>
> *(1) Where the medical condition of the patient is such that they require the skills or support of Patient Transport Service staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.*
> *(2) Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.*
> *(3) Recognised as a parent or guardian where children are being conveyed.*
>
> *"Patient transport services could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with a physical or mental incapacity, vulnerable adults or to act as a translator. Discretionary provision such as this would need to be agreed in advance, when transport is booked.*
>
> *"A patient's eligibility for patient transport services should be determined either by a healthcare professional or by non-clinically qualified staff who are both: clinically supervised and/or working within locally agreed protocols or guidelines, and employed by the NHS or working under contract for the NHS."*

Since 2007, local areas have developed more detailed criteria, as they sought to translate the national criteria for their local populations. This, as the national review noted, in turn has led to variations in eligibility from place to place. In response to the local variations and other issues, a national consultation is underway on more detailed criteria, which would be applied in each area in England.

2. Response to the Consultation Questions

Set out in Appendix A to this report are the proposed criteria, together with a proposed draft response for the Committee to consider. The full consultation document on is available at the following link:

https://www.engage.england.nhs.uk/consultation/eligibility-for-non-emergency-patient-transport/

3. Impact of New Criteria on Lincolnshire Non-Emergency Patient Transport

As previously reported, Lincolnshire Clinical Commissioning Group (CCG) is currently undertaking a procurement exercise for non-emergency patient transport, as the contract with the existing provider expires on 30 June 2022. As stated in the consultation document it is the intention that new contracts from April 2022 will reflect the new criteria, so this means they will be applied by the provider of the new contract from 1 July 2022. The CCG has advised that the specifications issued to the prospective providers had referred to the imminent publication of the national review. NHS England had also provided the CCG with prior knowledge of the main findings of the review prior to publication, and these were covered in the market engagement event with potential bidders.

4. Consultation and Conclusion

The Committee is being invited to approve a response to the national consultation on the proposed eligibility criteria for non-emergency patient transport.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A **(TO FOLLOW)**	Draft Response of the Health Scrutiny Committee for Lincolnshire to *Eligibility Criteria for Non-Emergency Patient Transport: A Consultation*

6. 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

This page is intentionally left blank

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

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**13 October 2021**
Subject:	**Health Scrutiny Committee for Lincolnshire - Work Programme**

Summary

This report sets out the Committee's work programme, and includes items listed for forthcoming meetings, together with other items, which are due to be programmed. The Committee is required to consider whether any further items should be considered for addition to or removal from the work programme.

Actions Required

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

1. Background

At each meeting, the Committee is given an opportunity to review its forthcoming work programme. Typically, at each meeting three to four substantive items are considered, although fewer items may be considered if they are substantial in content.

2. Today's Work Programme

The items listed for today's meeting are set out below: -

13 October 2021		
	Item	*Contributor*
1	Consultation on Lincolnshire Acute Services Review (Initial Consideration)	John Turner, Chief Executive Lincolnshire Clinical Commissioning Group
2	General Practice Access	Dr Kieran Sharrock, Medical Director, Lincolnshire Local Medical Committee
3	Lincolnshire Clinical Commissioning Group – Support for General Practice	Sarah-Jane Mills, Chief Operating Officer (West Locality), Lincolnshire Clinical Commissioning Group
4	Response to National Consultation on Non-Emergency Patient Transport Eligibility Criteria	Simon Evans, Health Scrutiny Officer

3. Future Work Programme

Scheduled Items

10 November 2021		
	Item	*Contributor*
1	Consultation on Lincolnshire Acute Services Review (Consideration of Two Specific Elements)	Representatives from Lincolnshire Clinical Commissioning Group and Other NHS Colleagues
2	Humber Acute Services Review – Introductory Item	Representatives from the Humber Acute Services Review Team
3	Nuclear Medicine – Engagement on Future Configuration of Service	Representatives from United Lincolnshire Hospitals NHS Trust: • Simon Evans, Chief Operating Officer • Laura White, Head of Nuclear Medicine
4	Dental Service Update – NHS England (Midlands)	Representatives from NHS England (Midlands)

16 December 2021		
	Item	*Contributor*
1	Consultation on Lincolnshire Acute Services Review (Consideration of Two Specific Elements)	Representatives from Lincolnshire Clinical Commissioning Group and Other NHS Colleagues
2	East Midlands Ambulance Service Update	Representatives from East Midlands Ambulance Service
3	Continuing Healthcare	Representatives from Lincolnshire Clinical Commissioning Group

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

16 February 2022		
	Item	*Contributor*
1	United Lincolnshire Hospitals NHS Trust – Urology Services	Representatives from United Lincolnshire Hospitals NHS Trust

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** – This item has been included in the Committee's work programme following a request from one of its members. As reported to this Committee on 23 June 2021, the Care Quality Commission published its report on this topic on 18 March 2021, which contained eleven recommendations. Three of these recommendations 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 for Lincolnshire patients, particularly in the light of the impact of the Covid-19 pandemic.

- **Staffing Challenges in Hospitals –** At the meeting on 21 July 2021 the Committee requested inclusion of an item on staff shortages, particularly at Grantham and District Hospital.

- **Lessons Learned from Lakeside Healthcare Stamford** – On 15 September 2021, the Committee requested more information on the lessons learned from Lakeside Healthcare Stamford, in terms of support for GPs and contract management.

4. Items Previously Considered

Set out in Appendix A to this report is a summary of the outcomes of the items previously considered by this Committee since June 2021.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Items Previously Considered by the Health Scrutiny Committee for Lincolnshire

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

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

PREVIOUS ACTIVITY

A summary of the previous activity of the Health Scrutiny Committee for Lincolnshire since June 2021 is set out below:

23 June 2021		
Item		*Summary of Outcomes*
1	United Lincolnshire Hospitals NHS Trust General Update	The Committee recorded its thanks to staff for their efforts during the pandemic and in restoring services and agreed that in future reports would be focused on specific services, such as cancer care, as requested by the Committee.
2	United Lincolnshire Hospitals NHS Trust – Consultation on Hospital Urology Services	Proposals for inpatient urology services included all emergency admissions being received at Lincoln County Hospital; with increases in planned activity at Pilgrim Hospital and Grantham and District Hospital. The Committee agreed that its draft response would be approved on 21 July 2021.
3	Update on Pilgrim Hospital, Boston, Paediatric Service	The Committee noted the development of the paediatric service at Pilgrim Hospital, Boston over the last three years and thanked staff for their efforts in maintaining and restoring services over the last year. The Committee also authorised the Chairman to respond to United Lincolnshire Hospitals Trust, outlining the views of the Committee on: (a) the substance of the proposal for a short stay paediatric assessment; and (b) to support the proposal by the Trust for a twelve-week engagement period.
4	Lincolnshire Community Health Services NHS Trust Update	The Committee recorded its thanks to all staff involved in the Trust for their continued involvement in responding to Covid-19. The Committee welcomed the establishment of new urgent treatments centres in Gainsborough and Spalding during the last year. However, the Committee recorded its concerns about overnight medical cover at Louth and Skegness urgent treatment centres and requested a further report on this matter.
5	National General Practice Data for Planning and Research - Data Collection	NHS Digital was changing the way it collected data from GPs and although the changes related to the process, the issue had caused some concern among the media. The Committee noted this report and requested a further progress report be received at an appropriate future date.

21 July 2021		
Item		*Summary of Outcomes*
1	Lincolnshire Partnership NHS Foundation Trust: Lincolnshire Child and Adolescent Mental Health Services (CAMHS) Crisis and Enhanced Treatment Team	The Committee noted the information presented and requested certain additional information from the Trust. The Committee supported in principle the proposal that the CAMHS Crisis and Enhanced Treatment Team become the permanent model of care in Lincolnshire, with a recommendation to the NHS: (a) to continue to monitor the number of Lincolnshire young people treated at out-of-county general adolescent units, with reference to any increases in demand for places arising from the pandemic; and (b) to report any significant and sustained increases in demand for out-of-county general adolescent units to the Committee.
2	Lincolnshire Partnership NHS Foundation Trust: Older Adults Mental Health Services	The Committee noted the information presented and supported the proposal to make the closure of Rochford Ward at Pilgrim Hospital permanent, with the continuation of the Home Treatment Service, with a recommendation to the NHS to continue to monitor the demand for older in-patient beds, particularly from the east of the county.
3	Lincolnshire Partnership NHS Foundation Trust: General Update	The Committee noted the information presented and thanked all the staff at the Trust for their continued efforts during the Covid-19 pandemic and agreed that in future, rather than receive general updates, the Committee would focus on specific mental health topics.
4	Lincolnshire Pharmaceutical Needs Assessment	The Committee made arrangements to respond to the consultation, which was planned for the autumn of 2021. However, following the meeting the Government had deferred the timetable, with consultation expected between April and June 2022.
5	United Lincolnshire Hospitals NHS Trust – Finalising Response to Consultation on Urology	The Committee approved its response to proposals: the Committee did not believe that it was in a position to support the proposal for the reconfiguration of the Trust's non-elective hospital urology services.

15 September 2021		
Item		*Summary of Outcomes*
1	Lakeside Medical Practice Stamford – Response to the Inspection Report of the Care Quality Commission (CQC), which was published on 2 August 2021.	The Committee recorded its concerns with the care provided by the Lakeside Medical Practice, which had led to the CQC's rating of inadequate. The Committee requested a copy of the Practice's full action plan and a report on the lessons learned by the Clinical Commissioning Group to prevent similar circumstances elsewhere. The Committee noted the actions taken by the Practice to date and requested a further update at its January 2022 meeting.
2	Community Pain Management Service (CPMS)	The Committee noted the information presented on the CPMS, including the rating of good by the Care Quality Commission in June 2021, and the actions taken in response to the high level review of complaints in June 2021. The Committee also noted the positive direction of travel of the CPMS, but with three of the key performance indicators not reaching their targets, requested a copy of the action plan and a further report in six months.
3	North West Anglia NHS Foundation Trust Update *(Responsible for Peterborough City Hospital and Stamford and Rutland Hospital)*	The Committee noted the information presented by North West Anglia NHS Foundation Trust; thanked all the staff at the Trust for their efforts in response to Covid-19 pandemic over the last year; and requested a further update in twelve months.
4	United Lincolnshire Hospitals NHS Trust (ULHT) - Nuclear Medicine Introductory Item	Nuclear medicine usually involves an injection of a radioactive 'tracer', followed by a imaging by a scanner. ULHT currently provides this at three hospitals and the Committee noted ULHT's intention to undertake engagement on its future provision.

This page is intentionally left blank