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

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A Meeting of the Health Scrutiny Committee for Lincolnshire will be held on Wednesday, 24 January 2024 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, R J Kendrick, P M Martin, S R Parkin and T J N Smith

District Councillors: S Welberry (Boston Borough Council), E Wood (City of Lincoln Council), J Makinson-Sanders (East Lindsey District Council), Mrs L Hagues (North Kesteven District Council), G P Scalese (South Holland District Council), C Morgan (South Kesteven District Council) and 1 Vacancy (West Lindsey District Council)

Healthwatch Lincolnshire: Liz Ball

AGENDA

Item	Title	Pages
	NHS Trust, which provides the Committee with an update on current EMAS performance in the Lincolnshire Division and provides further assurance on progress made since June 2023. Sue Cousland, EMAS Lincolnshire Divisional Director will be in attendance for this item)	
6	**Non-Emergency Patient Transport** *(To receive a report from NHS Lincolnshire Integrated Care Board and East Midlands Ambulance Service NHS Trust, which provides the Committee with an update on the Non-Emergency Patient Transport Service. Tim Fowler, Assistant Director of Contracting and Performance, NHS Lincolnshire Integrated Care Board, Sue Cousland, East Midlands Ambulance Service (EMAS) Lincolnshire Divisional Director and Joy Weldin, Head of Non-Emergency Trasport Services EMAS will be in attendance for this item)*	119 - 124
7	**Health Care Provision at the Proposed Home Office Development of Accommodation for Asylum Seekers at the former RAF Scampton** *(To receive a report from NHS Lincolnshire Integrated Care Board, which provides the Committee with a summary of the proposed health care service provision to support the residents who would be living at RAF Scampton. David Harding, Deputy Director - Asylum and Detention Accommodation Programme from the Home Office will be in attendance for this item)*	125 - 128
8	**Response of the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee to the NHS Consultation on Hospital Services in Grimsby and Scunthorpe** *(To receive a report from Simon Evans, Health Scrutiny Officer, which provides the Committee with a copy of the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee's response to the consultation by the NHS Humber and North Yorkshire Integrated Care Board on services at Scunthorpe General Hospital and Diana Princess of Wales Hospital in Grimsby)*	129 - 176
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 the content of its forthcoming work programme)*	177 - 184

Debbie Barnes OBE
Chief Executive
16 January 2024

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, 24th January, 2024, 10.00 am (moderngov.co.uk)

HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE
6 DECEMBER 2023

PRESENT: COUNCILLOR C S MACEY (CHAIRMAN)

Lincolnshire County Council

Councillors L Wootten (Vice-Chairman), M G Allan, R J Cleaver, R J Kendrick, P M Martin, S R Parkin and T J N Smith.

Lincolnshire District Councils

Councillors E Wood (City of Lincoln Council), J Makinson-Sanders (East Lindsey District Council), C Morgan (South Kesteven District Council) and J Pessol (North Kesteven District Council).

Also in attendance

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

Remote attendees via Teams

Eve Baird (Associate Director of Operations – Specialist Services LPFT), Nick Blake (Programme Director – Primary Care), Katrina Cope (Senior Democratic Services Officer), Simon Evans (Health Scrutiny Officer), Christopher Higgins (Director of Operations, Lincolnshire Partnership NHS Foundation Trust) and Sarah-Jane Mills (Director for Primary Care and Community and Social Value)

County Councillor C Matthews (Executive Support Councillor NHS Liaison, Integrated Care System, Registration and Coroners) attended the meeting as an observer.

49 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor Mrs L Hagues (North Kesteven District Council), D Rodgers (West Lindsey District Council), G Scalese (South Holland District Council), S Welberry (Boston Borough Council) and Liz Ball (Healthwatch Lincolnshire).

It was noted that Councillor J Pessol (North Kesteven District Council) had replaced Councillor Mrs L Hagues (North Kesteven District Council) for this meeting only.

An apology for absence was also received from Councillor S Woolley (Executive Councillor NHS Liaison, Integrated Care System, Registration and Coroners).

50 DECLARATIONS OF MEMBERS' INTEREST

Councillor R J Kendrick wished it to be noted that he was one of the Council's representatives on the Lincolnshire Partnership NHS Foundation Trust – Council of Governors Stakeholders Group.

Councillor T J N Smith declared a non-pecuniary interest in relation to agenda item 6, as a member of the East Midlands Veteran Advisory and Pension Committee.

51 MINUTES OF THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE MEETING HELD ON 8 NOVEMBER 2023

RESOLVED

That the minutes of the Health Scrutiny Committee for Lincolnshire meeting held on 8 November 2023 be approved and signed by the Chairman as a correct record.

52 CHAIRMAN'S ANNOUNCEMENTS

Further to the announcements circulated with the agenda, the Chairman brought to the Committee's attention the supplementary announcements circulated on 5 December 2023, which referred to the following:

- The outcome of the consultation of Paediatric Services at Pilgrim Hospital, Boston. The Committee noted that the NHS Lincolnshire Integrated Care Board had approved the service change; and
- Primary Care System Level Access Improvement Plan. The Committee noted that the document (found on pages 29 -78 of the agenda) had been approved by the NHS Lincolnshire Integrated Care Board on 28 November 2023.

During consideration of this item, some support was extended to the investment being made into a national prostate screening trial. One member enquired as to how much funding would be allocated to Lincolnshire. The Health Scrutiny Officer agreed to forward any available information on to members of the Committee.

RESOLVED

That the supplementary announcements circulated on 5 December 2023 and the Chairman's announcements as detailed on pages 17 to 20 of the report pack be noted.

53 GENERAL PRACTICE PROVISION

Consideration was given to a report from the NHS Lincolnshire Integrated Care Board (ICB), which provided the Committee with an overview of current general practice care delivery

and provided an update on mental health care provision within primary care, and summarised progress on local delivery of Primary Care Access Recovery Plan.

(Note Councillor S R Parkin joined the meeting at 10.05am).

The Chairman invited Nick Blake, Programme Director, NHS Lincolnshire Integrated Care Board and Sarah-Jane Mills, Director of Primary Care, Community & Social Value, NHS Lincolnshire Integrated Care Board, to remotely present the item to the Committee.

Attached to the report at Appendix A was a copy of the Lincolnshire Primary Care System Level Access Improvement Plan for the Committee to consider.

In conclusion, the Committee noted that GP care across Lincolnshire continued to be good and reflected the hard-work and dedication of GP's, their practices, and Primary Care Networks. It was noted that progress had been made regarding access, but there was more to do to ensure that people could get the care they needed.

It was reported that the development and implementation of the System Level Access Improvement Plan would improve patient access and experience and help to mitigate some of the pressures on GP practices.

During consideration of this item, some of the following comments were noted:

- Clarification was sought regarding the methodology in place to tackle the 8am rush and to the statement that patients would no longer be asked to call back another day to book an appointment. The Committee was advised that if a patients need was clinically urgent it would be assessed on the same day by a telephone or face-to-face appointment. If a patient contacted a practice in the afternoon, they might be assessed the next day, where clinically appropriate. If a patients need was not urgent, but it needed a telephone or face-to-face appointment, then this would be scheduled within two weeks. It was also noted that where appropriate, patients would be signposted to self-care or other local services. Some members observed that they had not experienced any improvements in the 8.00am access to GP practices issues;
- The Committee was advised that receptionist training was down to each GP practice, as each practice had slightly different operating models, and receptionists had different roles within each practice. It was highlighted that support was available through the system to support a practice support their staff including the receptionists, which included care navigation support. The Committee noted that the 8.00am rush was really supported by the expertise of those at first point of contact. It was noted further that there was a national training programme, funded through the Primary Care Access Recovery Plan, for staff to develop their skills and expertise. Some support was also extended to the service provided by care navigators as their expertise and guidance was crucial in a GP practice;
- It was reported that that some practices had not received a Care Quality Commission (CQC) inspection for some time, but it was highlighted that the CQC did however

monitor practice data, and they did risk assess practices, where certain thresholds had been passed. Representatives presenting agreed that a list of practices showing when they had last been inspected and the outcome of the last inspection would be made available to members of the Committee;

- That the amount of enhanced access was mandated through the primary care network direct enhanced service. Reassurance was provided that the ICB did work with Primary Care Networks (PCN's) to ensure that capacity was available and was being used. The report highlighted that in September 2023, PCN's had provided an average of 67.8 minutes of enhanced access provision per 10,000 patients, which was above the 60-minute target, and 76% of Enhanced Access appointments had been face-to-face. Representatives present agreed to provide further details in this regard to members of the Committee after the meeting. Reassurance was provided that from an ICB perspective all the PCN's were meeting national requirements in relation to enhanced appointments. It was also noted that the availability of enhanced access appointments would be different in each PCN area, for example in different practices on different days;

Note: Councillor C Morgan (South Kesteven Dostrict Council) joined the meeting at 10.34am).

- The need for more publicity regarding self-referral. The Committee noted that the primary care access recovery plan had several different initiatives that would cumulatively start to create capacity. There was recognition that communication was vital to help members of the public understand that service models were changing, especially hard to reach groups and that this would be covered by the Communication strategy. Some concern was expressed that patients did not know what services had changed and what options were now open to them. Further concerns were expressed that with self-referral there needed to be interconnectivity to make sure that patients were dealt with holistically. The Committee noted that some of the work being carried out around multidisciplinary teams working across primary care into other community services would help develop this further. Confirmation was provided that self-referral would only be available for non-urgent services;
- One member enquired how long after March 2024, when the options appraisal for the self-referral pathway for Musculo-skeletal services had been developed was it expected the pathway would be in place. The Committee was advised that it was hoped to have a new contract in place for April 2024, but this had now been extended, and that further information would be provided to the Committee when it was available;
- Whether the number of people accessing 111 was being monitored. The Committee was advised that the challenge was that there had been an increase in demand from members of the public for access to urgent care services, which had resulted in an increased demand across general practice, 111 and in urgent treatments, and that increase in demand would not be mitigated by improving access to general practicer. One member enquired whether self-referral information would be included on a patients record, which could be accessed by the GP;

- Whether access improvement plans were signed off by PCN's and whether these would be published, and who measured the outcomes of the plans. The Committee was advised that plans were reviewed and signed off by the ICB Executive team. Representatives agreed to speak to PCN's regarding the publishing of their plans;
- Whether unfortunate misdirection by pathway coordinators was being monitored. Reassurance was provided that mechanisms were in place to deal with such an occurrence, as part of the quality assurance work and also the CQC, who looked at processes within a practice to supervise staff and make sure they are dealing with patients appropriately;
- A request was made for further information pertaining to how many times people attended GP appointments across the county. The Committee noted that people's needs become more complicated because of long term conditions, (80 contacts each year) the number of contacts with primary care increased, compared to someone who was mildly frail (40 contacts each year), hence that was why there was an average of 6 appointments. It was highlighted that the number of GP appointments was based on a nationally set baseline. Presenters agreed to provide further information around GP appointment data based on the baseline set nationally;
- Some concern was expressed to the KPI information detailed on pages 77 and 78 of the report pack and to the fact that some of the KPI's were under target. Particular reference was made to the fact that 10 GP practices still did not have high quality on-line consultation workflow tools. The Committee noted that the ICB would be looking to see improvements across all of the indicators;
- It was reported that PCN's had been able to recruit Mental Health Practitioners (MPHs) through the Additional Roles Reimbursement Scheme to support population health management. The Committee noted that currently there were 26 whole time equivalents MHPs across the county, and that these were evenly distributed across PCN's. It was noted further that MHP's would provide service and support to all the practices within the PCNs, and would be available at those practices throughout the week, depending on the caseload required;
- Confirmation was provided that health visitor services were not managed by the ICB, but by the local authority. The Committee noted that health visiting would come under the remit of the Children and Young People Scrutiny Committee, as the Chairman of the Children and Young People Scrutiny Committee was also a member of the Committee, he agreed to speak to the member outside of the meeting;
- Same day access hubs were cited as being one in the east of the county and one south of Lincoln and a third one was being looked into for the Gainsborough area. Representatives agreed to provide Committee members with details of the site's actual locations. The Committee noted that transportation to the hubs was still being looked at, but it was highlighted that there was potential support available, with some GP practices offering transport schemes;
- Confirmation was provided that all the 81 practices in Lincolnshire were part of a PCN;
- The Committee was advised that the Primary Care Access Recovery Plan sat alongside recovery plans for elective and unplanned, and emergency care. It was noted that coordinating the work on the three plans was critical to improving health care for the

Lincolnshire population and that this was being delivered through the Lincolnshire Joint Forward Plan 2023-2028;

- It was reported that there was an ongoing relationship between community pharmacies and general practice and that this was being strengthened through the primary care access recovery plan. It was noted that access to over-the-counter medications had increased, so had the range of services offered through a community pharmacy. Representatives advised that a more detailed overview of the pharmacy first scheme might be useful for the Committee to consider at a future meeting;
- Reference was made to page 23, paragraph 4 of the report which stated that 71% of appointments were face to face in Lincolnshire. Further information was sought for a breakdown against each individual practice, and what lessons were being learnt on how to improve outcomes further. Confirmation was given that breakdown information was available, and that there was variation across practices, which was partly due to varying operating models. The Committee was advised that work was underway with practices to understand the variations and where there was a warranted variation, work would be undertaken with the practice to improve on-line consultation or face to face consultation; and
- The Committee was advised that currently it was forecasted that there would be an underspend in the Additional Roles Reimbursement Scheme for 2023/24, based on current information of approximately £1.5 million, which was a significant improvement on the previous year.

RESOLVED

1. That the presenters from the NHS Lincolnshire Integrated Care Board be thanked for their presentation, and that a further update be requested in six months' time.

2. That the NHS Lincolnshire Integrated Care Board's Primary Care Improvement Plan be supported, and a report be received in twelve months on its progress and implementation.

54 SPECIALIST MENTAL HEALTH SERVICES IN LINCOLNSHIRE - UPDATE

The Committee considered a report from Lincolnshie Partnership NHS Foundation Trust (LPFT), which provided the Committee with an update on the learning disability and autism services provided by LPFT in the county and the specialist mental health services available for armed forces veterans.

The Chairman invited Chris Higgins, Director of Operations ULHT and Eve Baird, Associate Director of Operations for Specialist Services ULHT, to remotely present the item to the Committee.

During consideration of this item, the following comments were noted:

(Note: Councillor R J Kendrick left the meeting at 11.30am).

- Thanks were extended to the increase in the amount of signposting for patients requiring specialist mental health services in Lincolnshire;
- The Committee was advised there had been significant improvements in the autism waiting list, but in was noted that some people were waiting up to a year for assessment. There was recognition that this was not acceptable, the Committee was advised there had been a recurrent funding increase to increase capacity within the diagnostic team, and that outsourcing and additional partners were helping to reduce the waiting list to a more manageable level. The Committee noted that the 18-month trajectory plan was for no-one to be waiting more than 12 weeks for an assessment;
- In terms of the gap for 16 to 18-year-olds, the Committee noted that a piece of work was being led by the Integrated Care Board (ICB) in collaboration with the Autism Partnership Board to look at the autism diagnostic pathway across the age range;
- The Committee noted that the virtual autism hub would offer the same level of navigation and support to individuals who believed they might be autistic or were waiting for a diagnosis, or believed they were autistic but did not want to go through a diagnostic process, but still wanted the support that the hub might be able to offer;
- In terms of the Op COURAGE, the Committee was advised that this programme allowed for the service to step into the space of lead provider, across health and social care. The Committee noted that the programme was specially commissioned to provide specialist care and support for service personnel, reservists, armed forces veterans, and their families. The Committee noted further that there was currently a gap in who provides that holistic care, and that steps were being undertaken by the ICB to look at health and social care to mirror what happens in the children and young people service, as veterans required a whole system commitment. The Committee was advised that self-referrals and referrals from professionals were accepted, with consent of the individual;
- The Committee was advised that the average waiting time for accessing speech and language therapy was within eighteen weeks, but it was noted that this was too long, and the service was working towards a four week wait. The Committee noted that cases with a dysphagia element would tend to be prioritised, and those individuals would be seen within a week for urgent cases or four weeks for non-urgent referrals;
- The Committee was advised that at the moment it was not known when self-referrals or referrals from other agencies for children and young people would be accepted by the mental health assessment unit in Lincolnshire. It was indicated that this could possibly be sometime from the spring of 2024 onwards, and that it would be a phased approach to make sure that the service could operate effectively;
- Members of the Committee were advised that there was not a national standard for autistic waiting times. The Committee noted that Lincolnshire was performing better than other regions in terms of autism waiting times, and that the ambition was for a four week wait for the service;
- The Committee was advised that LPFT provided support for people as they came out of prison with their mental health needs. The Committee noted that within each

prison there were commissioned healthcare services who provided mental health support and specialists in neuro diversity; and

- The Committee noted that there was a prioritisation system in place in the children's diagnostic service, which was led by community paediatrics from the adult diagnostic assessment. Reassurance was given that there was a prioritised system and that was based around risk to the individual and others as well as impact on quality of life, so there would be priority given to people where there was significant risk to them maintaining relationships or education.

RESOLVED

1. That the Lincolnshire Partnership NHS Foundation Trust be thanked for their report and presentation on Specialist Mental Health Services, in particular the level of detail in the report.

2. That the Committee be advised of any future developments in these services.

3. That a letter be written to John Turner, Chief Executive, Lincolnshire Integrated Care Board recording the Committee's support for the introduction of a national standard for autism assessment waiting times, which would facilitate the early diagnosis of autism.

55 RESPONSE TO CONSULTATION BY HUMBER AND NORTH YORKSHIRE INTEGRATED CARE BOARD: YOUR HEALTH, YOUR HOSPITALS - LET'S GET BETTER HOSPITAL CARE

Consideration was given to a report from Simon Evans, Health Scrutiny Officer, which invited the Committee to consider a draft response, and subject to any further amendments approve the draft response as the Committee's final response to the Humber and North Yorkshire Integrated Care Board Consultation entitled *Your Health, Your Hospital – Let's Get Better Hospital Care,* which had been compiled from the comments made at the 8 November 2023 meeting.

The Committee were reminded that the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee (H&LJHOSC) was the statutory consultee for the purpose of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations) 2013. It was highlighted that a meeting of the H&LJHOSC was scheduled to be held on 18 December, at which its response to the consultation was due to be finalised.

Thanks were extended to the Health Scrutiny Officer for capturing the comments raised by Committee during debate of this item at the meeting held on 8 November 2023.

During consideration of this item, the Committee highlighted their dismay at the overall consultation process, and the potential impact of some of the proposals for residents in Lincolnshire, the impact on neighbouring trusts, and transportation implications. As a result of the Committee's concerns, there was agreement that the tick boxes would not be used and that text boxes inserted in the document should remain. It was also suggested that local

MP's affected by the proposals should be made aware of the Committees concerns. Members of the Committee were reminded that the Committee was only responding as a non-statutory consultee.

RESOLVED

1. That the response (as circulated as Appendix A) be approved, as the Committee's final response to the consultation on *Your Health, Your Hospitals – Let's Get Better Hospital,* being undertaken by NHS Humber and North Yorkshire Integrated Care Board.

2. That the Committee's response to the consultation be shared with the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee, with a view to it being considered for inclusion in the Joint Committee's response.

3. That a copy of the Committee's response to the consultation be passed onto the RT Hon Sir Edward Leigh MP and the Rt Hon Victoria Atkins MP, as their constituencies would be mostly affected by the proposals.

56 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 97 and 98 of the report pack.

Attached at Appendix A to the report was a schedule of items covered by the Committee since the beginning of the current Council term, May 2021.

The Health Scrutiny Officer briefed the Committee on the items for consideration at the 24 January 2024 meeting.

The Committee also considered the list of items to be programmed and guidance was sort regarding:

- Item 2 - NHS Planning for Demographic Change. It was noted that most of the demographic modelling was undertaken by NHS England who used the latest available Office for National Statistic projections to factor in population changes into their models. It was noted that at a strategic level the responsibility for funding lay with the government, who set out the levels of funding for each government department, including Health and Social Care. Each department then agreed their priorities, which then brought in resource allocations for NHS England and ultimately for each Integrated Care Board (ICB). It was then up to each ICB to determine its strategy to use the resources allocated to best meet the health needs of the local population. The Committee noted the Lincolnshire Acute Services Review had

evaluated projected activity growth over the next five years for the services forming part of that review. The Committee was advised that evaluation had been done on an individual basis, and it was therefore suggested that the Committee might want to have such information when items were presented, rather than have an overall item. A suggestion was made for further information relating to the older persons demographics across the county. It was also highlighted that the east coast had a large concentration of caravans and that this impacted health provision along the coast, and therefore needed to be included within the demographics;

- Item 4 - Third Sector Support for the NHS. The Committee was advised that as this topic was so extensive, a suggested approach was for the Committee to request an overview from the Lincolnshire Voluntary Engagement Team, which was a collective of voluntary groups and organisations who had an interest in working with health and care partners to develop and deliver services. One member advised that voluntary groups were struggling and that an overview would be useful for the Committee to consider; and
- Item 5 – Local Strategic Planning of Integrated Health Provision. The Committee was advised that two items focusing on strategies were scheduled for the 21 February 2024 meeting. It was further clarified that the request for an item on Local Strategic Planning for Health Provision related to strategic planning at a Primary Care Network level. It was requested that further information be provided either as part of the two items in February or subsequently as to how the strategies worked at a Primary Care Network level, in particular on integration with secondary care and other services.

During discussion relating to the work programme, the following comments/suggestions were noted:

- Patient Data, to include the confidentiality of patient data, integration of data within the NHS, to make sure that data was being fully used to achieve the required outcomes;
- Further to the discussion above on a potential item on demographic change, it was requested that an item should be added to the work programme on NHS requests for contributions from developers as it was felt that health services appeared at times to be missing out on this funding. One member advised that usually GP facilities were looked at as part of the developer contribution process, but not the impact on hospital beds or acute care; and
- A request was made for more information as to how the East Midlands Ambulance Services and NHS Lincolnshire worked in partnership with the Local Resilience Forum with regard to Emergency Planning.

RESOLVED

That the work programme presented on pages 97 and 98 of the report be agreed, subject to the inclusion of the suggestions put forward by the Committee as detailed above and the request made at Minute number 53(1) and (2).

The meeting closed at 12.31 pm.

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Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**24 January 2024**
Subject:	**Chairman's Announcements**

1. Information Requested at the Last Meeting – GP Provision

The information requested at the last meeting is set out in Appendix A.

2. Brant Road and Springcliffe GP Surgery, Lincoln

The Brant Road and Springcliffe GP Surgery in Lincoln, which has 9,000 registered patients, has submitted a proposal to the NHS Lincolnshire Integrated Care Board to close the Springcliffe branch surgery located at 42 St Catherine's, Lincoln.

The GP practice has stated that one of the reasons for the proposed closure is the decreasing number of patients using the branch surgery, with most patients preferring to access the main site on Brant Road, due to the wider range of services and better facilities available. The GP practice has analysed the use of the branch site and believes the closure will only impact a few patients per week. The practice hopes that by closing the branch site it will be able to focus on improving services at the main site. The closure would also see all services and staff currently operating from the branch site relocate to the main site. If the proposals to close the branch site are approved, patients would have full access to services from the main site and would not be required to register as a patient.

Patients have been encouraged to share their feedback on the proposals by completing a survey or by attending one of three planned patient engagement events. Two of these events took place on 14 December and 12 January. The remaining event is planned for Wednesday 14 February, 10 am - 12 noon (drop in anytime) at Springcliffe Surgery.

The closing date for responses is on 22 February 2024. The final decision regarding the proposal will be made by the NHS Lincolnshire Integrated Care Board later in 2024.

3. Bourne Gellatly Medical Practice, Care Quality Commission Inspection

On 8 December 2023, the Care Quality Commission (CQC) published an inspection report on the Bourne Gellatly Practice, following an inspection which took place on 30 August 2023. The CQC has rated the practice as *outstanding* overall, which has been based on an *outstanding* rating for three of the CQC's domains (caring, responsive, and well-led); and a *good* rating for the remaining two CQC domains (safe and effective). This inspection was undertaken in line with the CQC's inspection priorities, as the practice had not been inspected since December 2014, when it had received an overall rating of *good*.

The CQC's full report and evidence table is available on its website: Bourne Gellatly - CQC (cqc.org.uk)

4. Psychiatric Intensive Care Unit – Hartsholme Centre, Lincoln

On 12 January 2024, Lincolnshire Partnership NHS Foundation Trust (LPFT) issued an update on the temporary closure of the Hartsholme Centre, Lincolnshire's male psychiatric intensive care unit (PICU), based in Lincoln. The PICU closed temporarily in October 2022, and LPFT had announced during the summer of 2023 of a plan for a re-opening on a phased basis from the autumn of 2023. However, this was delayed as legionella bacteria were found on site during November 2023. LPFT has announced that there has been substantial work to clear the bacteria, but they have not yet been fully removed from the systems. Cleansing work continues and a further set of test results are due at the end of January.

LPFT adds that out of area care for male patients requiring psychiatric intensive care has risen over the last month and it is far from ideal for patients. LPFT states that this continues to be very disappointing, as it remains operationally ready to start the re-opening. A further update will be issued by LPFT in February.

5. Industrial Action by Junior Doctors

Since the last meeting of the Committee, junior doctors have held two periods of industrial action: from 7 am on 20 December until 7 am on 23 December 2023, and from 7 am on 3 January until 7 am on 9 January 2024.

During these periods, the NHS Lincolnshire Integrated Care Board (ICB) advised the public to continue to come forward for NHS care, but asked the public to use NHS services wisely. It was stated that some hospital appointments would have to be rescheduled. However, patients were advised to attend any appointments during the period of industrial action, unless specifically asked not to do so.

The ICB reminded the public that GP practices and local pharmacies continued to be open to offer advice and help, as well as the ICB's Stay well and choose well this winter advice. The ICB urged people to be aware of diarrhoea and sickness, particularly those who are vulnerable and/or who have long-term health conditions. Whilst most people make a full recovery within one or two days from norovirus, this is not the case for everyone and for patients ill in hospital or those with long-term conditions the virus can cause complications.

On 12 January 2024, United Lincolnshire Hospitals NHS Trust (ULHT) stated that all parts of the Lincolnshire system remained under significant operational pressure, which had been exacerbated by the two periods of industrial action. ULHT also stated that the focus now remained on ensuring patients were treated in the right place, at the right time, by the right people, including minimising ambulance handover delays, ensuring as much capacity as possible was available and maximising flow through the system. All of this, stated ULHT, continued to be addressed in partnership across the health and social care system.

6. United Lincolnshire Hospitals NHS Trust – Teaching Hospital Status

On 12 January 2024, United Lincolnshire Hospitals NHS Trust announced that it had recently submitted a full application for Teaching Hospital status to the Department for Health and Social Care. A decision on this is now awaited.

7. Primary Care Network Alliance – Annual Report for 2022/23

The Lincolnshire Primary Care Network Alliance produces an annual report each year. Notification of the publication of the Annual Report for 2023/23 has been received.

The report's headlines refer to 81 GP practices organised into 14 primary care networks (PCNs). There are 2,700 staff employed in these GP practices, representing 17% of the NHS workforce in Lincolnshire. During 2022/23, there were 4.7 million appointments in Lincolnshire's GP practices, representing an increase of 9% compared to 2021/22.

A feature of the Annual Report are innovation stories from PCNs:

- The employment of six cancer co-ordinators by Boston PCN, who support patients from suspected cancer through to remission or end of life.
- The introduction of a high intensity use service by the Trent Health PCN, which targets the most vulnerable socio-economic groups, affected by challenges such as poverty, co-morbidities, and disabilities. This is an 18 month project aimed at informing a county-wide service.
- Meridian PCN undertook a falls prevention and wellbeing pilot project at Fotherby House Care Home, which saw a reduction in falls from an average of nine to ten per month to one per month.
- Pop up blood pressure clinics were held by East Lindsey PCN (in conjunction with One You Lincolnshire) to provide support to those in a very rural community.

- South Lincoln Healthcare PCN established a partnership board to determine how to make the best use of resources to address the health and care needs of the local population.
- Pop up falls prevention sessions were held in village halls across the area covered by Imp Healthcare PCN. In all, 325 people attended the events, with positive feedback given.
- Both practices in the Spalding Care PCN now operate a branch site, which has thus provided facilities in the north, east, south and west of Spalding.
- Lincoln Healthcare PCN has reviewed falls in care homes, with an assessment made after each fall. This had led to reduction in the number of falls, and those that occur are less severe.
- K2 Healthcare Sleaford PCN has developed a virtual multi-disciplinary team focused on the treatment of chronic heart failure, and as a result has managed more patients in primary care, without the need for referral to secondary care.
- South Lincs Rural PCN's social prescribing team has trebled its workload over the last year. The team typically supports people suffering from bereavement, loneliness and isolation, or 'low-level' mental health.
- Nurses based in K2 Healthcare Sleaford PCN have assessed whether patients with severe asthma would benefit from 'biologic' therapies.
- Apex PCN has been working with *One You Lincolnshire* to develop a targeted weight management clinic at one of its practices. Following its success, the clinic is being rolled out to other practices in the PCN.
- First Coastal PCN has gained a further four practices, which has led to the recruitment of further occupational therapists and care co-ordinators. This has facilitated the further development of social prescribing across the PCN.

The Annual Report is available in full at the following link:
https://lpcna.nhs.uk/application/files/8017/0203/2319/LPCNA_-_Annual_Report_2223.pdf
LPCNA webpage: https://lpcna.nhs.uk/

8. Amendments to the Health Overview and Scrutiny Regulations and Revised Guidance

Power of Referral to Secretary of State

On 9 January 2024, the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving Provisions) Regulations 2024 were laid in Parliament and will come into force on 31 January 2024.

The effect of these amendments to the regulations is that the power of referral to the Secretary of State by health overview and scrutiny committees ceases with effect from 31 January 2024. This power has applied in instances where an NHS commissioner or provider is considering a proposal for a local substantial development of the health service or for a local substantial variation in the provision of a such a service, and the local health overview and scrutiny committee disagrees with the proposal.

There is a saving provision in the regulations, but this is limited to instances where a health overview and scrutiny committee has made a referral prior to 31 January 2024.

New Duties on NHS Commissioners

A new Schedule 10A to the National Health Service Act 2006 also comes into force on 31 January 2024 and places a duty on any commissioner of NHS services to notify the Secretary of State when they propose a 'notifiable' reconfiguration of local services. A 'notifiable' reconfiguration is not defined, but in effect will be a reconfiguration comprising a proposal for a local substantial development of the health service or for a local substantial variation in the provision of a such a service.

The statutory guidance states that making a notification to the Department of Health and Social Care is the sole responsibility of the relevant NHS commissioning body. However, the NHS commissioning body should consider the local health overview and scrutiny committee's views on a proposal when deciding when to notify and should make it clear to the Secretary of State of the local health overview and scrutiny committee's view of whether the reconfiguration is notifiable.

Secretary of State Call-in Powers

Schedule 10A to the National Health Service Act 2006 also provides a new 'call-in' power to the Secretary of State, who may issue a direction to an NHS commissioning body to call in any proposal. The Secretary of State's powers include:

- deciding whether a proposal should, or should not, proceed, or should proceed in a modified form;
- whether particular results should be achieved by the NHS commissioning body in taking decisions in relation to the proposal;
- whether procedural or other steps should, or should not, be taken in relation to the proposal; and
- whether to retake any decision previously taken by the NHS commissioning body.

Health overview and scrutiny committees and other interested parties may request that the Secretary of State consider calling in a proposal. The Department of Health and Social Care expects that requests would only to be used in exceptional situations where local resolution has not been reached.

Next Steps

It is proposed that a full report be submitted to the next meeting of the Committee to consider how the new working arrangements will impact on the Committee in the future. This could include revising the existing protocol on consultation between the Committee and the NHS Lincolnshire Integrated Care Board.

Link to Documents

The new provisions have been summarised above. Full details may be found in the following documents:

- The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving Provision) Regulations 2024 (legislation.gov.uk)
- Local authority health scrutiny - GOV.UK (www.gov.uk)
- Reconfiguring NHS services - ministerial intervention powers - GOV.UK (www.gov.uk)
- Schedule 10A NHS Act 2006 (legislation.gov.uk)
- The National Health Service (Notifiable Reconfigurations and Transitional Provision) Regulations 2024 (legislation.gov.uk)

9. Appointment of Group Chair for Lincolnshire Community Health Services NHS Trust and United Lincolnshire Hospitals NHS Trust

On 10 January 2023, Lincolnshire Community Health Services NHS Trust (LCHS) and United Lincolnshire Hospitals NHS Trust (ULHT) announced the appointment by NHS England of Elaine Baylis as Group Chair of LCHS and ULHT with effect from 1 April 2024. Elaine has served as Chair of ULHT since December 2017, and was previously Chair of LCHS from April 2015 until March 2023.

LCHS and ULHT have stated that Elaine's appointment means that recruitment can now begin to the substantive Group Chief Executive role, as the two organisations introduce shared decision-making arrangements and progress further on coming together as a group.

APPENDIX A

INFORMATION REQUESTED AT THE LAST MEETING ON GP PROVISION

The following information has been provided by NHS Lincolnshire Integrated Care Board

1. An Overview of How Old Care Quality Commission Inspections / Ratings Are

The Care Quality Commission (CQC) inspection report publication dates range from November 2015 to December 2023, in summary:

- Inspection report published in 2023 – 8 practices
- Inspection report published in 2022 – 8 practices
- Inspection report published in 2019, 2020 & 2021 – 11 practices
- Inspection report published in 2018 – 6 practices
- Inspection report published in 2017 – 20 practices
- Inspection report published in 2016 – 27 practices
- Inspection report published in 2015 – 1 practice

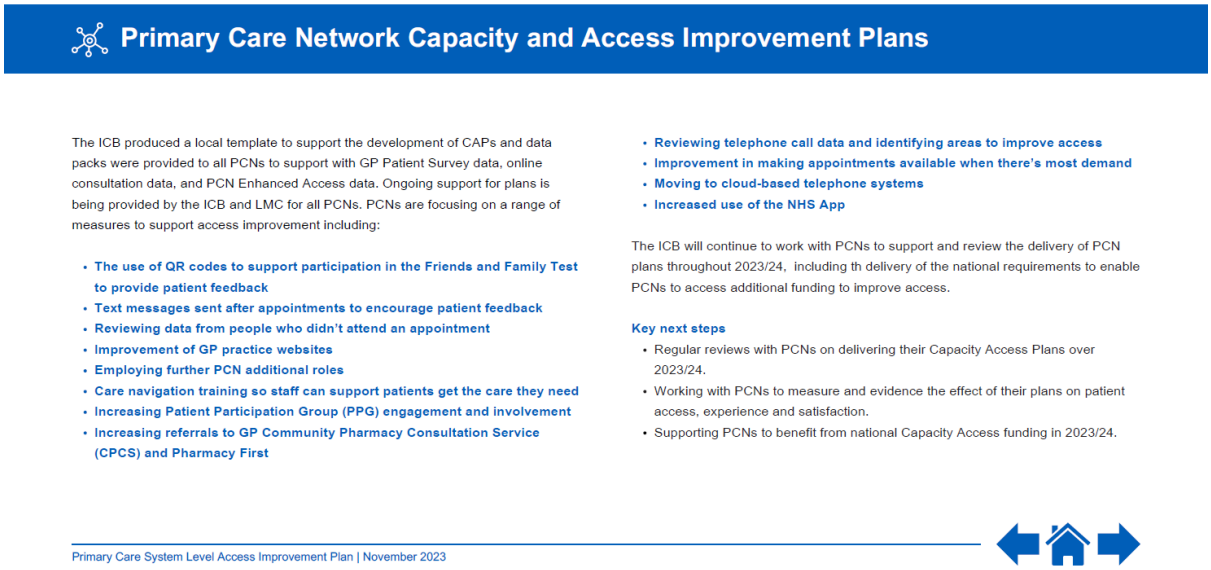
2. Enhanced Access Appointments

The Committee requested more Details Requested on how they worked in each Primary Care Network (PCN) area.

A separate detailed document will be emailed to members of the Committee. Appointments are available by the person contacting their GP practice. PCNs are required to provide 60 minutes of enhanced access appointments per 1,000 patients (adjusted) per month. For Lincolnshire in October 2023 - 86.84 minutes of appointments per 1,000 patients were provided with a utilisation rate of 76%. The amount of appointment offered in October was higher than usual due to some vaccination appointments being offered through Enhanced Access clinics. The average amount of appointment time offered per month per 1,000 patients is 62 minutes which equates to a total 14,822 appointments per month for the population.

3. Availability of PCN Improvement Plans

PCN Capacity Improvement Plans are internal working documents and not available publicly – a summary of themes within the plans is provided in the ICB's Primary Care System Level Access Improvement Plan which was shared with the Committee in November (please see the key slide below). These included improving telephone access through implementation of digital telephone systems and using patient feedback to monitor access and identify opportunities for improvement.



Primary Care Network Capacity and Access Improvement Plans

The ICB produced a local template to support the development of CAPs and data packs were provided to all PCNs to support with GP Patient Survey data, online consultation data, and PCN Enhanced Access data. Ongoing support for plans is being provided by the ICB and LMC for all PCNs. PCNs are focusing on a range of measures to support access improvement including:

- **The use of QR codes to support participation in the Friends and Family Test to provide patient feedback**
- **Text messages sent after appointments to encourage patient feedback**
- **Reviewing data from people who didn't attend an appointment**
- **Improvement of GP practice websites**
- **Employing further PCN additional roles**
- **Care navigation training so staff can support patients get the care they need**
- **Increasing Patient Participation Group (PPG) engagement and involvement**
- **Increasing referrals to GP Community Pharmacy Consultation Service (CPCS) and Pharmacy First**
- **Reviewing telephone call data and identifying areas to improve access**
- **Improvement in making appointments available when there's most demand**
- **Moving to cloud-based telephone systems**
- **Increased use of the NHS App**

The ICB will continue to work with PCNs to support and review the delivery of PCN plans throughout 2023/24, including th delivery of the national requirements to enable PCNs to access additional funding to improve access.

Key next steps

- Regular reviews with PCNs on delivering their Capacity Access Plans over 2023/24.
- Working with PCNs to measure and evidence the effect of their plans on patient access, experience and satisfaction.
- Supporting PCNs to benefit from national Capacity Access funding in 2023/24.

Primary Care System Level Access Improvement Plan | November 2023

4. <u>Average Number of GP Appointments per person</u>

The Committee requested more details on this topic for example average numbers per age band.

GP appointment data should be viewed with some caution – work is ongoing to address technical data collection issues alongside improving data quality and consistency. Data on the average number of appointments by patient cohort (age, specific conditions etc) is not available through GP appointment data sets.

A specific report could be developed to produce appointment data using the Lincolnshire linked data set but would be require some capacity to develop and need to be fitted in to the performance team's work programme.

Based on November 2023 data:

- UK – average of 5.2 appts per patient
- Lincolnshire – average of 6.4 appts per patient

The ratio of appointments seen in person (face-to-face) in November 2023 was 71% for Lincolnshire, this in line with the Midlands region (71%).

5. <u>Locations of Same Day Access Hubs</u>

All three PCNs offer 35 appointments per day (Monday-Friday):
South Lincoln PCN (all sites offering appointments Mon-Fri):

- Navenby Cliff Villages Surgery
- Branston & Heighington Family Practice
- The Heath Surgery

- Washingborough Surgery
- Church Walk Surgery
- Brant Road & Springcliffe Surgery
- The Bassingham Surgery

East Lindsey PCN
- Market Rasen (Mon-Wed)
- Wragby (Thu)
- Woodhall Spa (Fri)

Lincoln Health Partnership:
- Newland Health Centre

Acute Respiratory Infection hubs are also available at the following locations seven days per week:

South Lincolnshire Rural PCN:
- Market Deeping (Mon and Tue)
- Bourne (Wed and Thu)
- Holbeach (Fri and Sat – alternating with Swineshead on Saturdays)
- Gosberton (Sun)

LADMS:
- Skegness (Mon)
- Sutton-on-Sea (Tue-Thu)
- Louth (Fri)
- Ingoldmells (Sat and Sun)

Welby Medical Group:
- Gainsborough (Mon-Sun)

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

Open Report on behalf of the East Midlands Ambulance Service NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**24 January 2024**
Subject:	**East Midlands Ambulance Service Performance**

Summary:

The purpose of this report is to provide an update on current EMAS performance in the Lincolnshire Division and to provide further assurance on progress made since the last visit to the Committee in June 2023.

This report includes information:

- a Vision for the NHS Ambulance Sector, created by the Association of Ambulance Chief Executives;
- performance improvement, including activity for Greater Lincolnshire, resourcing and hours lost as a result of delays at hospital emergency departments;
- recruitment and retention; and
- emergency preparedness, resilience and response, for example in relation to Storm Babet.

Actions Requested:

The Committee is asked to note the contents of this report.

1. Background

The last update to this Committee in Q1 2023/24 was during a period of intense local, regional and national hospital delays, leading into one of the most challenged post winter periods experienced by the NHS and Social Care, which included a period of intense national Industrial Action.

At the last attendance of the Health Scrutiny Committee in June 2023 continued concerns were raised in particular respect to the Division's ability to:

a) Perform to national ambulance standard targets
b) Improve hospital handover times
c) Sustain adequate levels of recruitment, particularly related to qualified staff
d) Retain experienced members of staff

The following report highlights local and national performance trends over the last six months as well as work being undertaken to mitigate some of the unique challenges faced by the Division in Lincolnshire.

2. Extracts from Chief Executive's Trust Board Report – 9 January 2024

2.1 Introduction

Reflecting on 2023, it brought new challenges, as well as those which have caused issues for some time. The pressure on the NHS throughout the year has been immense, however, we have also experienced significant successes during the year. We know that the challenges for ambulance trusts and others across the health sector will continue into 2024.

2.2 National Vision

A new national ambulance sector vision, contained as Appendix A, has been created by the Association of Ambulance Chief Executives (AACE). It has been published to focus attention, discussions, and action in response to the issues faced by ambulance services. It links very closely to work underway at EMAS to meet our own ambitions and objectives included in our new Clinical Strategy, contained as Appendix B.

The national vision recognises the two clear remits for the ambulance sector:

1. To be the lead co-ordinator and navigator for access to Urgent and Emergency Care and support agencies, making efficient use of multi-professional, integrated clinical hubs and assessment services at system level.
2. To respond to patients needing out-of-hospital care, with more direct referral pathways to other parts of the system, and advanced skill sets and paramedicine models to safely keep more patients at home.

Lincolnshire Division has employed a number of Clinical Pathway Leads who have been working with system colleagues to improve the number of appropriate alternative pathways available for patients in Lincolnshire – a summary of their work is contained in Appendix C.

AACE believes that:

- by targeting investment into the ambulance workforce, infrastructure, and digital innovations this will play a significant, and efficient, part in improving trajectories within the NHS;

  Lincolnshire Division has received additional funding as part of the national funding stream and detail is contained within this paper in section 5.

- expanding our digital infrastructure and advanced practitioner roles will mean more patients can be appropriately treated, monitored and cared for out of hospital, especially older people and those living with frailty;

  Lincolnshire is recruiting further Specialist Practitioners (SP's) in Q1 of 2024 to support more complex pre hospital care. Front line clinicians now all have individual iPads in order to support pre hospital clinical care delivery.

- investment to rapidly increase recruitment to, and development of, our highly skilled paramedics and multi-professional clinical workforce in emergency operations centres and clinical assessment services will support decision-making and reap the rewards in getting patients access to the most appropriate care first time; and

  Lincolnshire recruitment continues to increase with training for SP's to work remotely alongside warm transfer of C3 and C5 calls to community care partners

- future strategy (which sets direction on what organisations will and will not do) should better co-ordinate resources to bring improvements for patients, staff and systems.

Further work is being undertaken by AACE in collaboration with membership organisations to produce a broader discussion document setting out the case for change.

2.3 Performance Influencers – Use of Additional National Funding

2.3.1 Increasing Capacity

Figures 1 to 3 outline in pictorial format the overall Trust expenditure plan to improve performance and efficiency.

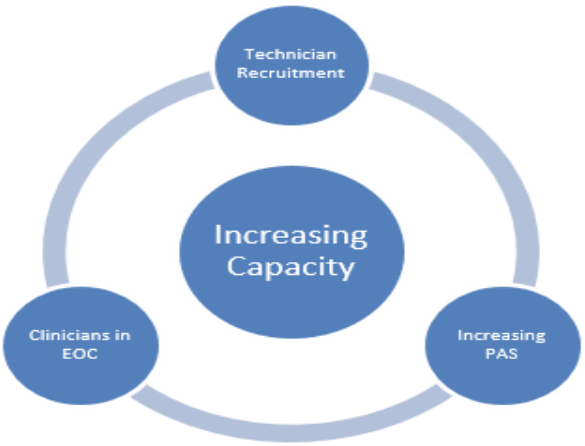

Figure 1

2.3.2 Managing Demand

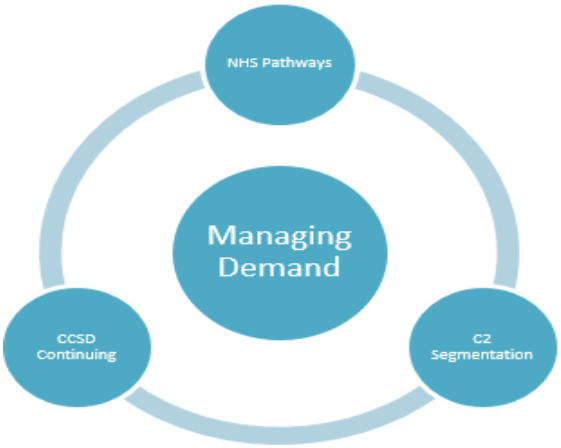

Figure 2

2.3.3 Supporting Staff

Figure 3

3. Performance Improvement

3.1 National Modelling Tool

EMAS have been working in collaboration with NHS England (regional and national teams) to implement a national tool being used to more accurately model resource requirements to achieve national ambulance standards. A revised regional trajectory has been re-modelled and agreed nationally for EMAS – the revised trajectory for C2 is 39 mins 49 secs.

This tool is now being used to calculate realistic trajectories at Divisional level taking into account resourcing, abstraction and hospital handover performance. These trajectories will be provided to the system in early 2024.

3.2 Performance Categories

Category	Response
Category 1	An immediate response to a life threatening condition, such as cardiac or respiratory arrest
Category 2	A serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport
Category 3	An urgent problem, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting
Category 4	A non-urgent problem, such as stable clinical cases, which requires transportation to a hospital ward or clinic

3.3 Divisional Performance - Greater Lincs July 2023 – December 2023

Lincolnshire Division Category 2 performance is shown historically for comparison – Nov 2023: 65 minutes versus Dec 2022: 176 minutes.

Category 2 Mean Time (mins)		
	Lincolnshire Division	**Lincolnshire ICB Area**
Jul 2023	49:09	49:47
Aug 2023	47:10	47:46
Sep 2023	61:14	59:38
Oct 2023	73:24	72:01
Nov 2023	41:60	42:33
Dec 2023	50:45	50:18

Figure 4

3.4 Activity – Greater Lincolnshire

At the beginning of December, we escalated to Resource Escalation Action Plan Level 4, meaning more actions are being taken in response to the pressures faced.

Volume of Incidents NHS Lincolnshire Area (Q2/Q3 2023-24) is detailed below in Figure 5

Date	Incident ASI	Response
July	10608	9024
August	10655	9194
September	10138	9044
October	10261	8565
November	9990	8817
December	10563	9045

Figure 5

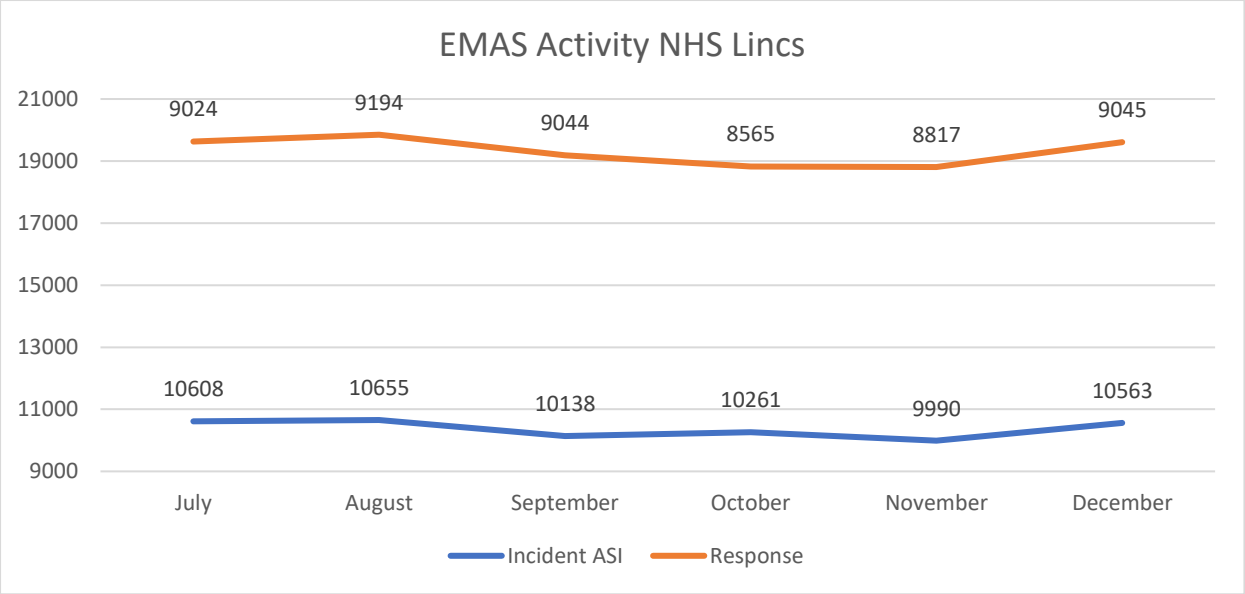

Figure 6

Whilst EMAS has little control of the activity, which is referred via 999, the Trust does have the ability to manage activity in a variety of ways including *Hear and Treat*, *See and Treat* or *See and Convey*, depending on what is clinically safe and appropriate for the patient and what pathway options are available. Please refer to Figure 7 below for further information.

Date	Incident ASI	HT ASI	% Hear & Treat ASI to Inident ASI	ST	% See & Treat to Incident ASI	STC	% See Trat & Convey to Incident	See Treat & Convey to ED	% ED Conveyance to Incident ASI	See Treat & Convey to Non-ED	% Non ED Conveyance to Incident ASI
October 2023	10261	1696	16.53%	3417	33.30%	5148	50.17%	4774	46.53%	374	3.64%
Grand Total	**10261**	**1696**	**16.53%**	**3417**	**33.30%**	**5148**	**50.17%**	**4774**	**46.53%**	**374**	**3.64%**

Date	Incident ASI	HT ASI	% Hear & Treat ASI to Inident ASI	ST	% See & Treat to Incident ASI	STC	% See Trat & Convey to Incident	See Treat & Convey to ED	% ED Conveyance to Incident ASI	See Treat & Convey to Non-ED	% Non ED Conveyance to Incident ASI
November 2023	9990	1173	11.74%	3414	34.17%	5403	54.08%	4857	48.62%	546	5.47%
Grand Total	**9990**	**1173**	**11.74%**	**3414**	**34.17%**	**5403**	**54.08%**	**4857**	**48.62%**	**546**	**5.47%**

Date	Incident ASI	HT ASI	% Hear & Treat ASI to Inident ASI	ST	% See & Treat to Incident ASI	STC	% See Trat & Convey to Incident	See Treat & Convey to ED	% ED Conveyance to Incident ASI	See Treat & Convey to Non-ED	% Non ED Conveyance to Incident ASI
December 2023	10560	1516	14.36%	3535	33.48%	5509	52.17%	4857	45.99%	652	6.17%
Grand Total	**10560**	**1516**	**14.36%**	**3535**	**33.48%**	**5509**	**52.17%**	**4857**	**45.99%**	**652**	**6.17%**

Figure 7

3.5 Demand / Activity

The table below (Figure 8) shows the percentage of activity managed as a conveyance to Emergency Departments. The rest of the activity is dealt with by remote or on scene management away from an Emergency Department – July 2023 – December 2023 across Lincolnshire. The regional and national position are shown for comparison.

	Lincolnshire Division	EMAS Regional	National
Jul 2023	48%	49%	53%
Aug 2023	49%	49%	52%
Sep 2023	49%	49%	52%
Oct 2023	46%	47%	51%
Nov 2023	49%	49%	52%
Dec 2023	46%	46%	51%

Figure 8

Despite fluctuations in performance and demand, the protective nature of Emergency Department conveyance in Lincolnshire has remained stable and better or equal to regional and national peers.

3.6 Resourcing

Ambulance output hours have grown over the course of the year as the staff recruited have developed into patient-facing roles following initial education and induction, please see figure 9 below. Additionally, the growth of private ambulance provision to provide gap fill while we recruit and train new staff over months/years has continued to grow in tandem.

	Lincolnshire Division Ambulance (Output Hours)	Private Ambulance Provision in Lincolnshire (Output Hours)
Jul 2023	27,886	5,352
Aug 2023	27,333	5,938
Sep 2023	27,731	5,905
Oct 2023	28,020	6,308

	Lincolnshire Division Ambulance (Output Hours)	Private Ambulance Provision in Lincolnshire (Output Hours)
Nov 2023	28,475	6,669
Dec 2023	29,698	6,801

Figure 9

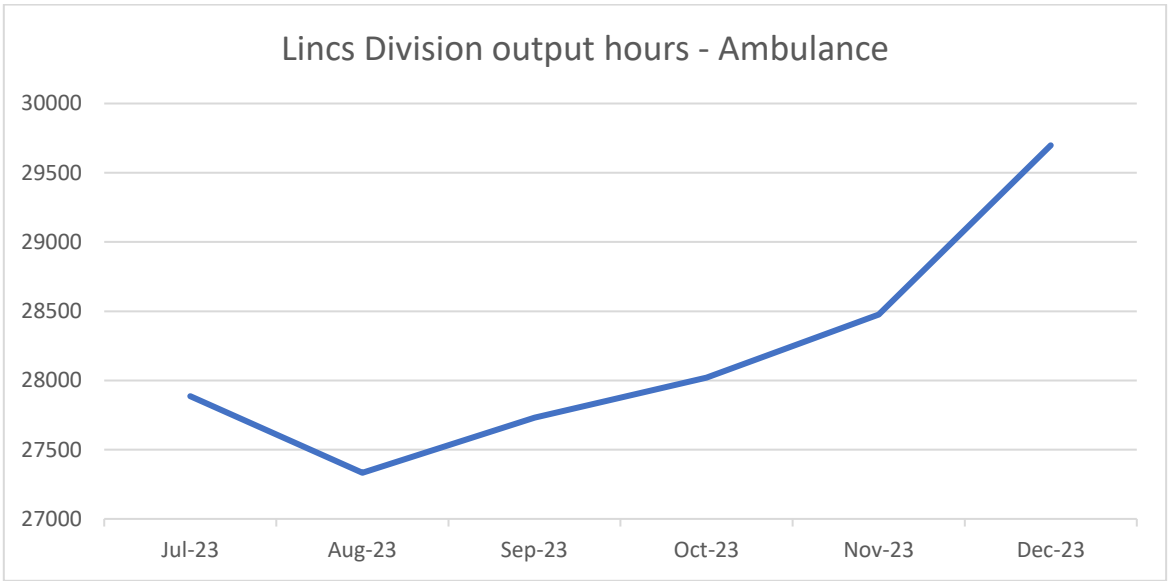

Figure 10

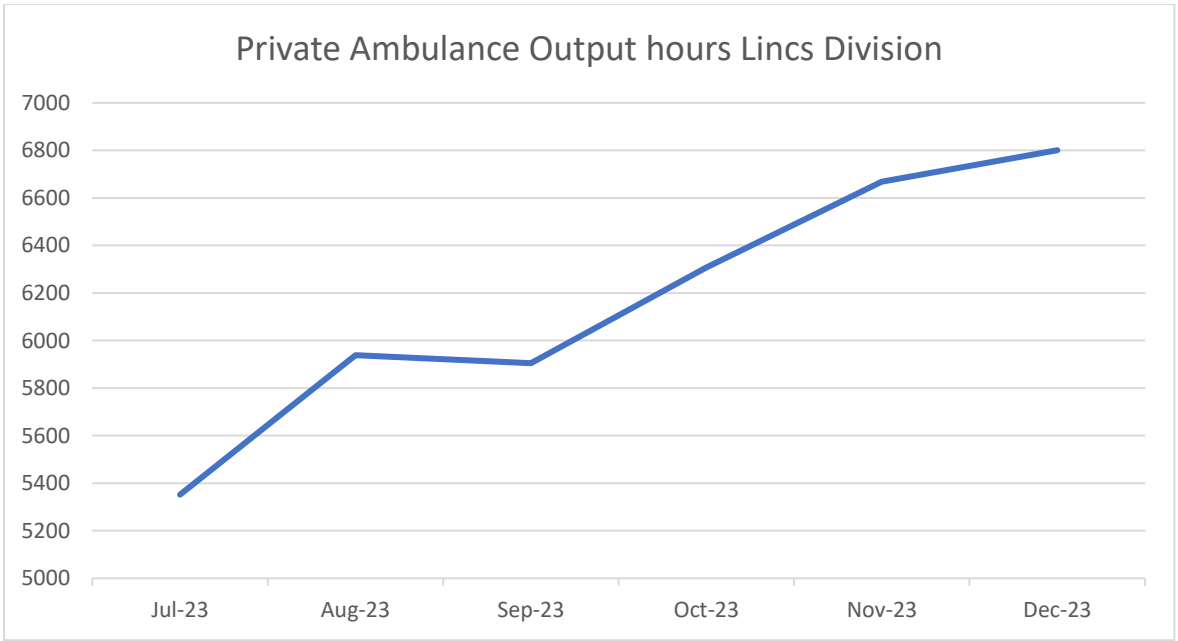

Figure 11

3.7 Sickness / Absence Management

Sickness 2023	April %	May %	June %	July %	Aug %	Sept %	Oct %	Nov %	Year To Date
EMAS Trust	7.35	7.89	7.36	7.65	8.00	7.86	7.39	7.83	7.6
A&E Ops	7.65	8.24	7.66	7.95	8.6	8.39	7.41	7.98	7.98
Lincs Division	6.85	6.5	6.18	6.05	5.81	7.8	6.77	6.38	6.5

Figure 12

3.8 Lincolnshire Division Lost Hours Pre-Handover

The tables below (Figures 13-14) detail the hours lost pre-handover at hospital emergency departments, including those for United Lincolnshire Hospitals NHS Trust (ULHT) specific lost hours for response. In addition, it is worthy of note that the Division also manages significant delays across Northern Lincolnshire and Goole NHS Foundation Trust, Peterborough City Hospital and Queen Elizabeth's Hospital in Kings Lynn. The planning of 'cohort' crews has now become the norm at shift end to release crews who may still be waiting to pass on their patients.

<u>2023 Whole of Lincolnshire Division</u>

In figure 13 'HO Pre over 60' refers to the number of handovers taking more than 60 minutes.

Date	Lost Hours Pre Handover >15min	Lost Hours Post Handover >15min
April	2348:38:48	454:47:21
May	2807:34:12	447:28:36
June	2261:08:03	361:51:39
July	2344:36:14	333:02:33
August	2950:08:37	326:01:41
September	4272:48:16	314:35:11
October	6401:34:23	1290:36:14
November	3371:34:18	1597:12:36
December	3940:43:26	1578:06:20

Hospitals	HO Pre Over 60
2023	**10514**
April	785
May	929
June	737
July	788
August	1024
September	1467
October	2273
November	1114
December	1397

Figure 13

2023 ULHT Lincoln and Boston sites only

In figure 14 'HO Pre over 60' refers to the number of handovers taking more than 60 minutes.

Date	Lost Hours Pre Handover >15min	Lost Hours Post Handover >15min
April	1395:28:24	190:59:33
May	1728:07:07	177:55:42
June	1296:59:38	140:49:40
July	1343:47:11	129:39:45
August	2033:26:42	137:41:42
September	2511:30:26	141:00:40
October	3631:54:42	526:49:20
November	1626:11:00	693:36:25
December	1521:39:43	753:34:49

Hospitals	HO Pre Over 60
2023	5468
April	425
May	535
June	385
July	393
August	705
September	831
October	1231
November	489
December	474

Figure 14

Pre and Post Lost Hours – Whole of Lincolnshire Division

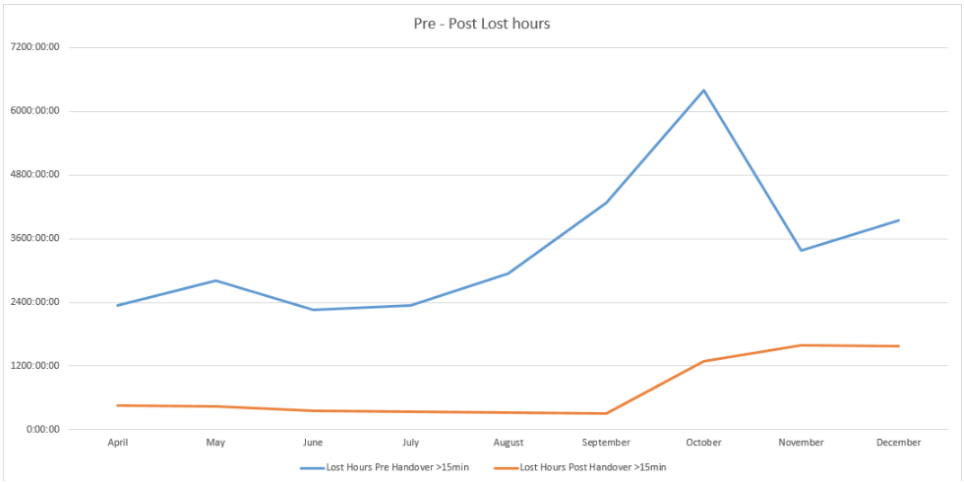

Figure 15

Pre and Post Lost Hours – Lincoln and Boston hospitals only

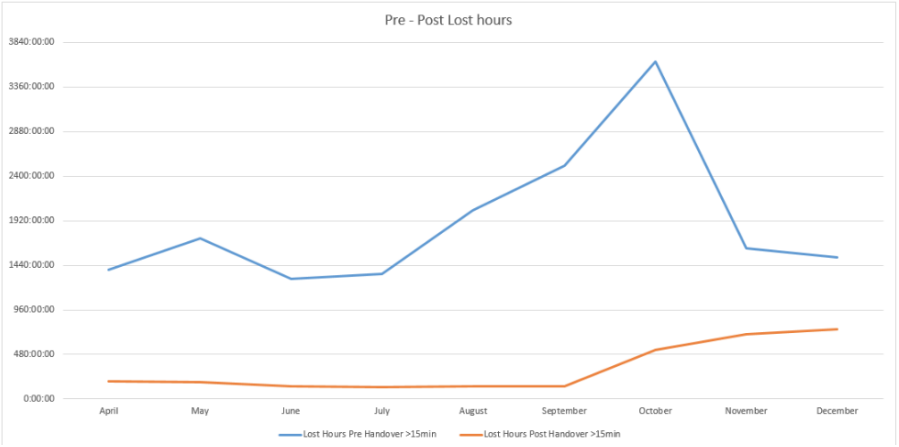

Figure 16

*The way that post-handover is recorded undertook a process change in October 2023 creating an exception data point.

3.9 Recent Lincolnshire C2 Performance Quarter 3 2023

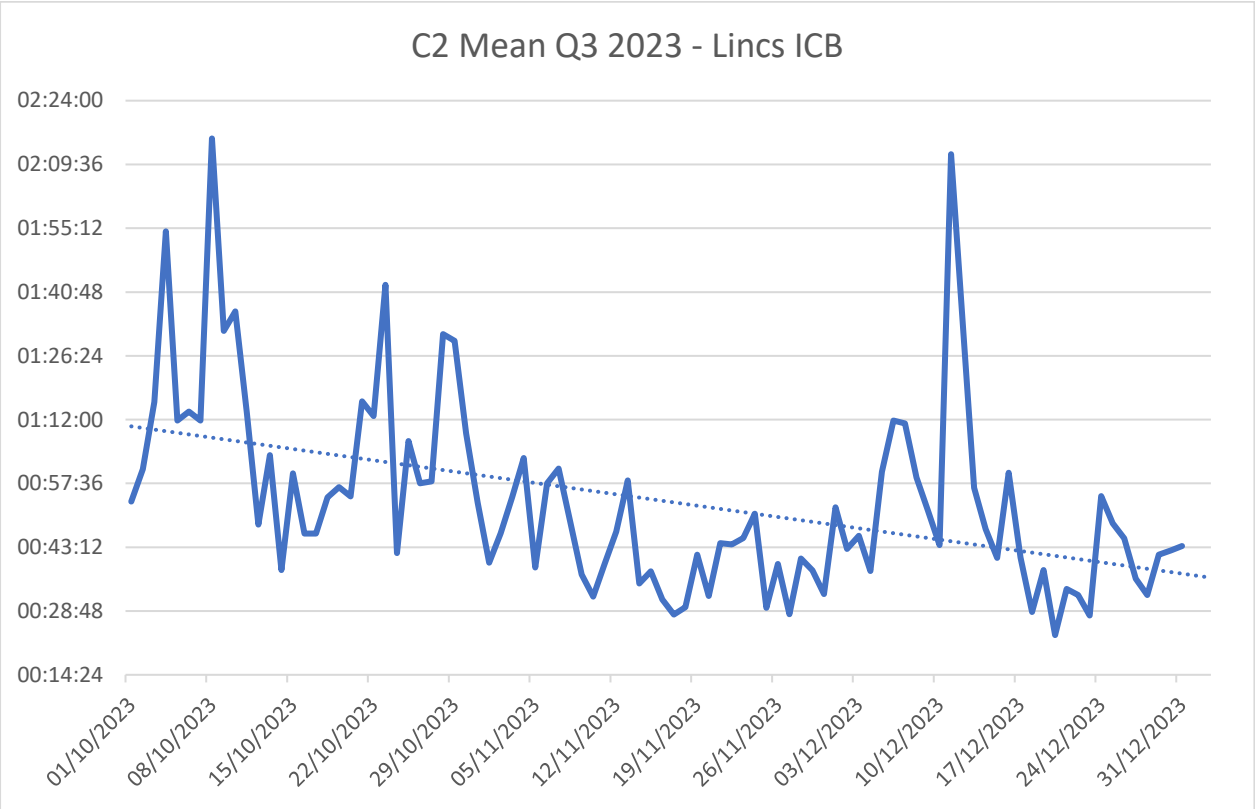

Figure 17

The sustained period of ULHT handover stabilisation (Nov 23) detailed in Figure 17, in conjunction with resource output increase during November shows the impact of all variables working together to improve performance. Figure 18 below is an extract of ULHT handover in detail.

Colleagues across the Urgent and Emergency Care (UEC) system have been working extensively over recent months to improve the position of patient safety and response both within healthcare premises and in the initial emergency arena. The focus of all has been on the goal of reducing the risk and improving the quality and timeliness of care provision. Specifically the work that ULHT and LCHS have undertaken to both risk share and increase capacity has significantly aided de-escalation and reduction in ambulance waits. This is visible in the periods of stabilisation seen recently as well as a comparison of winter 2022/23 to winter 2023/24.

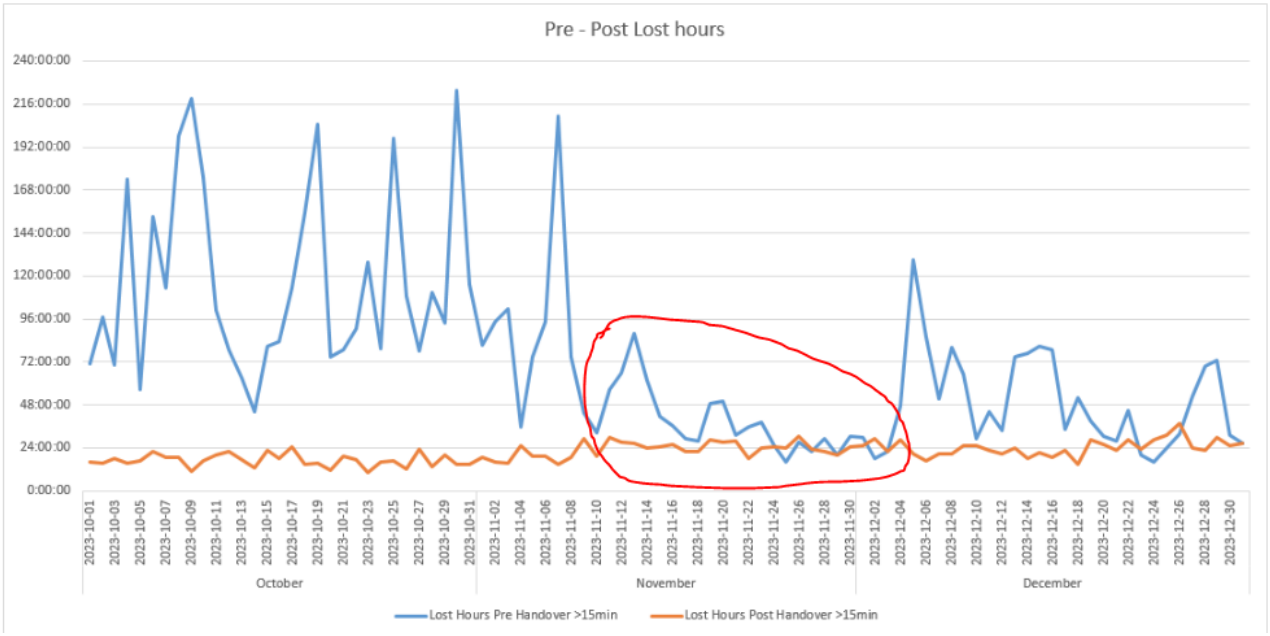

Figure 18

4. Quality Initiatives

4.1 Divisional Senior Manager for Workforce

With the additional funding received by EMAS, Lincolnshire Division has secured a two year dedicated Workforce position aimed at improving our overall workforce plan and working with system partners on initiative solutions to the overall workforce challenge being experienced in the county.

4.2 Efficiency and Effectiveness Initiatives

With the additional funding received by EMAS, Lincolnshire Division has secured an additional temporary position to improve our overall Call Cycle efficiency.

4.3 Clinical Leadership

The Division has been a leader in providing enhanced clinical leadership across the county. A development role of Associate Clinical leader which was trialled in Lincolnshire has proved so effective, the role is now being rolled out across the Trust.

The Divisional Clinical Leadership team have produced an Annual Report, and work is ongoing to refine further delivery of Education and Clinical Supervision across the Division. We are keen to trail more local delivery of Statutory Education and are working closely with colleagues on a plan to implement from 2025.

5. Recruitment and Retention

5.1 Skill Mix

The table below (Figure 19) details the skill mix of staff within the Division which poses a challenge when managing more complex patients. Frontline clinical staff have access to additional expertise via staff in EMAS Operations Centre, (Nurses, Paramedics, Doctors and Mental Health Clinicians), Clinical Assessment Service (Lincolnshire Community Health Services NHS Trust) and single points of access in the N and NE of the county.

Lincolnshire	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	avg
Operational Skill Mix Qualified/Unqualified	77.52%	76.38%	76.32%	74.55%	74.46%	72.72%	72.92%	71.37%	69.87%	68.42%	68.44%	67.03%	72.42%
Operational Skill Mix Registered/ Unregistered	37.24%	36.49%	36.38%	35.46%	35.35%	34.44%	35.04%	34.51%	34.00%	33.50%	33.72%	33.23%	34.92%

Figure 19

5.2 Attrition

Lincolnshire													
Leaver/movers	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2023/24 workforce plan	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	6.1	73.7
2023/24 actual/projection	5.01	4.00	6.25	4.05	5.00	5	4						33.18
Variation from plan	-1.13	-2.14	0.11	-2.09	-1.14	-1.14	-2.27						

Figure 20

Attrition detailed in Figure 20, has been less than predicted which is a positive for the Division as this retains staff. Further analysis of exit interviews indicates that a range of reasons for leaving, and the spread is across all grades.

5.3 Recruitment Trajectory

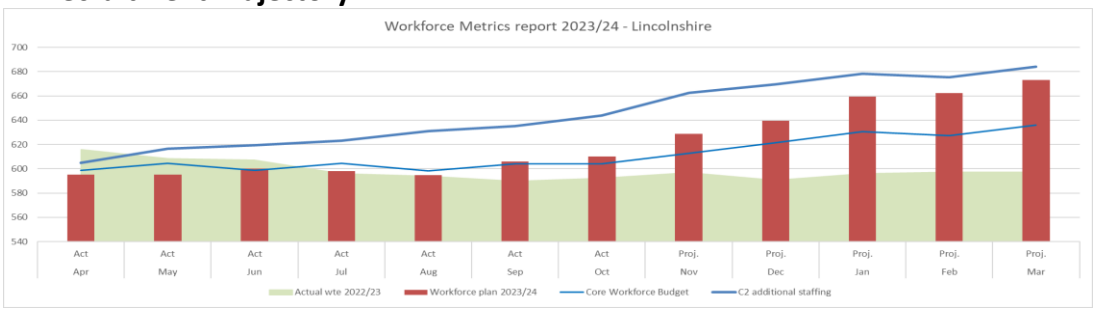

Figure 21

A more streamlined approach to internal career progression is being explored by the Trust and Lincolnshire Division has expressed a keen interest to pilot schemes in support of enhanced recruitment / retention opportunities in what is a challenged environment for the entire health and care system in Lincolnshire.

Our Workforce Lead will focus on recruitment and retention strategies for the next two years to enable the Division to be in a more stable position in future years. An overall Workforce Plan is being developed that will encompass internal career progression alongside plans to work with system partners on career portfolio options for all staff.

Figure 21 demonstrates that the Division are significantly above the 2023/24 recruitment trajectory which will continue into 2024.25. There are plans to hold open days on stations throughout the Division to encourage local residents to join the ambulance service alongside working with military establishments to actively recruit personnel who wish to explore alternative career opportunities. Recruitment Ambassadors will follow up grass route engagement session at schools and colleges in support of a five year plan to recruit locally.

Work has continued with Lincoln University and the next cohort of Paramedics, due out in August have all been offered a role within Lincs Division to help with the skill mix. Open adverts are out to attract qualified Paramedics and Technicians into the County as well as the first cohort of Australian Paramedics due to arrive in early February. A second cohort is planned for May 2024.

It has been agreed that the Division will trial a development role of Associate Specialist Practitioner and at the end of their training staff will have the opportunity to move to a fully qualified Band 7 role.

Additional roles of Advanced Practitioner, Ambulance Nurse and are also being considered by the Trust to ensure additional front line specialised skills are available to meet the expanded clinical need.

6. Staff Engagement

6.1 'Chatty Cafes' and Locality PMRs

As part of the continued drive to have local representation and accountability we are actively seeking the views of our staff at a local level. The local Conversation Cafés continue in parallel with a Regional Corporate Conversation Café tour attended by EMAS Executives.

From a management accountability point of view, we are devolving oversight of performance from a Lincolnshire divisional viewpoint to a locality level – to aid first line management accountability and understanding of the important issues to performance, efficiency and service delivery.

6.2 Staff Opinion Survey

We have recently completed the national NHS Staff Opinion Survey. The results for this will be available for review and outcome planning towards the end of Q4.

With the introduction of the Station Manager role, meetings are now scheduled to take place on a regular basis with options for staff to attend in person or remotely via their personal issue iPads.

7. Emergency Preparedness, Resilience and Response (EPRR)

7.1 Category 1 Responder Responsibilities

The Civil Contingencies Act is a single framework used for civil protection in the UK. The Act is split into two substantive Parts:

1. Civil Protection (Part 1)
2. Emergency Powers (Part 2)

Under Part 1 agencies are split into two categories:

Category 1 – includes but not exclusively Emergency Services and Local Authorities
Category 2 – Health and Safety Executive, Utilities and Transport companies.

As a Category 1 Responder EMAS has a statutory obligation under law to:

- assess the risk of emergencies occurring and use this to inform contingency planning.
- put in place emergency plans.
- put in place business continuity management arrangements.
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- share information with other local responders to enhance co-ordination.
- co-operate with other local responders to enhance co-ordination and efficiency.

7.2 Storm Babet Overview

During Storm Babet October 2023 EMAS, Lincolnshire took part in 13 Tactical Coordinating Group (TCG) meetings both in person, at the Country Emergency Centre or remotely via MS TEAMs. While the storm had minimal impact on our ambulance service delivery in Lincolnshire the shared situational awareness gathered by attending the multi-agency TCGs was invaluable.

The frequency of these weather events is increasing and by the end of the first week in January 2024 we had provided attendance at eight TCGs and three SCGs in relation to Storm Henk, which is part of our statutory obligation as a Category 1 under the Civil Contingency Act.

7.3 EMAS Relationships with Local Resilience Forum (LRF)

Lincolnshire Division has a good working relationship with the Local Resilience Forum. We are an active member of the LRF and participate in several multi-agency exercises at all levels of command (Strategic, Tactical and Operational). We continue to collaboratively provide staff from our Emergency Preparedness Resilience and Response Department to support with

the delivery of education courses to wider partner agencies such as local authorities and our own commander cadre.

As Strategic Commanders we are mandated to undertake the Multi-agency Gold Incident Command course – all training is compliant locally.

Of the six staff who are required to completed Multi-agency TCG training, five have already completed mandated training locally with the LRF and the sixth member of the team is booked on a course in April 2024. All six staff have completed yearly Continual Professional Development (CPD) with Lincolnshire LRF within the last twelve months.

7.4 Training Figures for Staff

Our commanders are required to undertake training provided by the National Ambulance Resilience Unit (NARU) however, EMAS as a trust, are only provided with a set number of places per course, this can impact on the number of commanders we are able to put through this national course. To mitigate this, our EPRR Department have developed a course that furnishes the commander with the underpinning knowledge and skills required to bridge the gap until they're allocated a place on the national course. Figure 22 outlines the current training figures for Lincolnshire Tactical Commanders

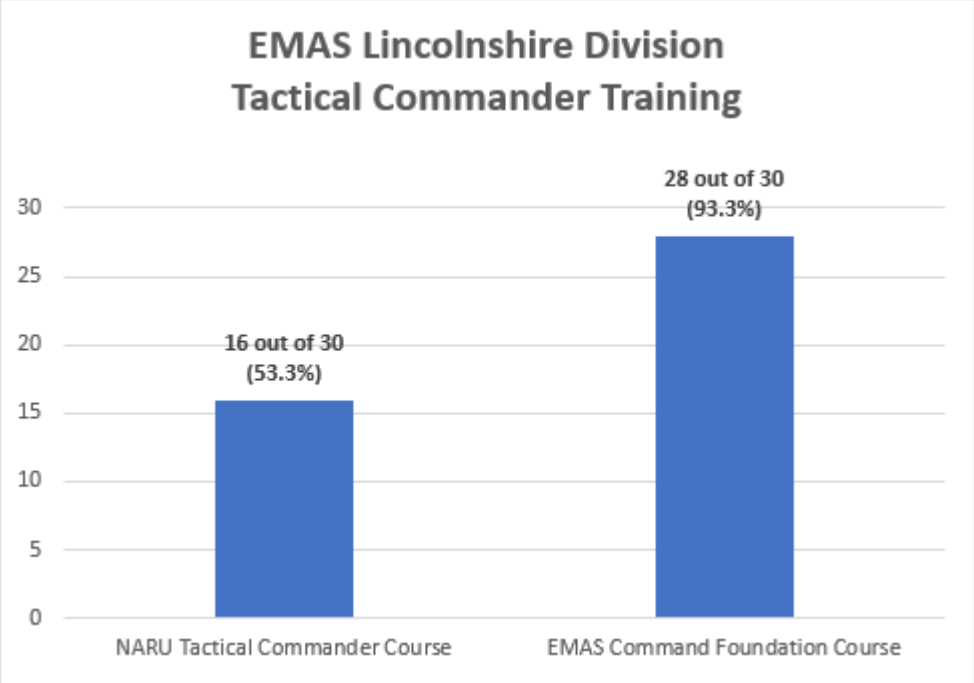

Figure 22

8. Appendices

These are listed below and attached at the back of the report	
Appendix A	A Vision for the NHS Ambulance Sector in Co-Designing Urgent and Emergency Care Provision (Association of Ambulance Chief Executives)
Appendix B	East Midlands Ambulance Service NHS Trust – Clinical Strategy 2023-2028
Appendix C	East Midlands Ambulance Service NHS Trust – Pathways 2023 Summary

9. 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 the by the East Midlands Ambulance Service NHS Trust Lincolnshire Senior Management Team

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ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Bringing together skills, expertise and shared knowledge in UK ambulance services

A vision for the NHS ambulance sector in co-designing urgent and emergency care provision

Introduction

The purpose of this paper is to prompt and guide conversations at national, regional and system level, about the potential that could be realised by developing the future role of ambulance services in co-designed urgent and emergency care (UEC) provision.

The core remit of any NHS ambulance service will *always* be to provide emergency response, to those who have a life-threatening health need, and to major incidents. This will not change, but it could be better. As a relatively small proportion of what ambulance services do (circa 10-11%), this remit is often 'squeezed' by the increase in demand for everything else provided by ambulance services in out-of-hospital care. In many cases they 'fill the gaps' for other sectors, where there are unmet urgent care needs, whilst suffering, like other providers, the impinging effects on resources resulting from the wider challenges affecting all systems.

Some of the detail in our long-term vision (described just in outline below), is already happening, but mostly by default rather than by planning and design – and where it is being done by design and concepts have been proven, it is happening in pockets rather than at scale. This might provide certain benefits at local levels but is missing out on the real possibilities of embedding sustainable value for money and meaningful change in UEC equitably across the country.

We believe that by targeting investment into the ambulance workforce, infrastructure, and digital innovations this will play a significant, and efficient, part in improving trajectories within the NHS. We cannot continue to do more of the same and hope that things will get better. We owe it to patients, as health and care systems, to work together for them, and we have a moral duty to our people to improve on their current working conditions so they have fulfilled careers and can provide the best possible care. By doing things differently we have the opportunity to fix for tomorrow many of the things that are not working well today.

We need commissioners and partner providers to purposefully discuss with their ambulance service their potential to do more for patients. In doing so, they can proactively support other sectors and relieve some of the seemingly intractable system pressures by providing more expansive and responsive out-of-hospital care, as well as contributing to preventative care. System leaders need to consider collectively with all UEC partners a roadmap to achieve this re-design in a realistic timescale to begin making sustainable improvements for patients.

The case for change

> ***"Anyone who has had recent contact with the NHS knows it is in crisis. Patients suffering long waits and hard-pressed staff working in a system which is not delivering deserve better…The NHS has more money and staff than ever before but has made poor use of it to improve access for patients when they are in urgent need."***
> ***(House of Commons Public Accounts Committee HC1336)***

Health and care systems across the UK have been facing increasing demands and pressures over the last decade, and post-pandemic these have risen to unprecedented levels where avoidable harm is frequently occurring. We know that for many patients their experiences of NHS services are often frustrating, and they have poorer outcomes than could be expected; public satisfaction in the NHS is waning, and exhausted staff are leaving their vocations.

Health and social care provision currently faces:

- a growing, ageing population, living longer with a range of complex conditions;
- workforces stretched beyond limits in terms of capacity and poor morale in many sectors, leading to increasing absence levels and problems retaining staff;
- access to, and resources in, primary, community and mental health services remaining significantly challenged;
- increasing elective waiting lists, with resulting knock-on effects for UEC;
- growing delays for discharges from hospital, affecting flow across systems;
- crowding in emergency departments, resulting in ambulances queued outside for long periods; and
- patients waiting unacceptable lengths of time for an appropriate response to their 999 calls.

Ambulance services are at the heart of strained UEC systems and hold some of the biggest risks for patient safety, particularly when there are no resources to send to someone who has called 999 needing emergency or time-critical urgent care. Being available 24/7, patients may contact 999 or 111 because they have been unable to access care through a route they would normally use for their condition (whether in hours or out-of-hours), or because they are unsure of what they need. They see the ambulance service as a 'trusted brand' and know they will get a response. Sometimes, the ambulance service is not what they need, and nor might they need to go to hospital, but there may be no alternative.

Despite best efforts and additional short-term funding for recovery plans there is **little evidence for any significant sustained improvement** for health and care provision on the horizon.

We need radical re-design for UEC and long-term planning, with a stronger focus on prevention and a shift in balance of investment to out-of-hospital services. We also need to be better prepared for the emerging impacts of advancing technologies and medical developments, climate change, global conflicts, and the potential for pandemics of any nature. We cannot, as a health service, continue to do more of the same. We all need to do things differently.

> ***"The pressures on every part of the system across the board just feel to me to be more challenging than they've ever been. That doesn't mean that there isn't a possible way through this, but it does mean that we really do have to start thinking very differently… the NHS needs to rebalance… sadly, most investment in health care in the last decade, has tended to focus on hospitals, because that's where the noise is."***
> ***Sir David Haslam - Does the NHS need to be rebooted?***

Long-term vision of an enhanced role for ambulance services in UEC

Despite the current challenged position described above, ambulance services have great potential to help solve some of the key system pressures, reduce the risks for patients and address inefficiencies within their health systems. They can make better use of scarce clinical resources across wider footprints, working with their systems to implement the models of care that make most sense for their particular population needs.

In an NHS that is truly focussed on:

- provision of high quality, timely and integrated UEC;
- keeping patients out of hospital when they do not need to be there;
- reducing inequalities in access to healthcare, patient experience and outcomes; and
- preventing ill health,

We see greater potential for **ambulance services to develop with two clear remits as trusted assessors,** to be:

1. the lead coordinator and navigator for access to UEC and support agencies, making efficient use of multi-professional, integrated clinical hubs and assessment services at system level; and
2. responders to patients needing out-of-hospital care, with more direct referral pathways to other parts of the system, and advanced skill sets and paramedicine models to safely keep more patients at home.

By developing UEC strategy collaboratively within their systems, listening to patients and their communities, ambulance services, with the support of their commissioning bodies, could become the system leaders in implementing those strategies, joining all the elements up cross-sectors.

The potential for ambulance services to play a leading and coordinating role in UEC lies in the fact that they already have:

- ✔ **24/7 regional/national infrastructure** (unlike any other NHS provider) enabling them to see issues, gaps, and connections that others cannot, and to exploit the efficiency this offers at a system or regional level;
- ✔ **highly skilled, increasingly multi-professional workforces,** with a range of skill sets able to triage and operate autonomously in all environments;

- the **trust of the public** and interaction with patients in their own environments, and the ability to engage with 'hard to reach' patients;
- **little difficulty in recruiting** to the clinical workforce (unlike other sectors) and the ready ability to expand, develop and up-skill our clinicians to specialised and advanced practice levels;
- **interoperable telephony and connectivity infrastructure** (ripe for increased commonality and digital advancements), supporting the interface with all parts of UEC across primary, secondary, community and mental health care;
- **data insight in real time** that can provide early-warning intelligence to systems;
- **longitudinal data insights** to support population health management and planning of services;
- **standardised national capabilities and resilience** to support each other when mutual aid is needed.

Investment to rapidly increase recruitment to, and development of, our highly skilled paramedics and multi-professional clinical workforce in emergency operation centres and clinical assessment services at scale, **represents good value for money** and will reap the rewards in getting patients access to the most appropriate care first time. Expanding our digital infrastructure and advanced practitioner roles will mean more patients can be appropriately treated, monitored, and cared for out of hospital, especially older people and those living with frailty. The **return on investment,** just in terms of creating increased bed capacity in hospitals alone, would be tangible.

Paramedics are sought-after professionals, for good reason, and increasingly work in different sectors such as primary care and emergency departments. Future strategy needs to better coordinate these resources, with the ambulance service as the main employer, able to provide rotational roles within local systems where advantageous for career development and retention of staff.

We can bring improvements for patients, staff and systems by:

a) being the entry point to UEC services where **patients can be triaged *once*** and navigated to the most appropriate service for their needs;
b) co-ordinating appropriate face-to-face and remote responses to 999 and 111 calls through seamlessly joined-up **multi-professional clinical assessment services at scale,** making efficient use of scarce clinical resources;
c) providing **timely emergency response** to life-threatened 999 calls and major incidents;
d) delivering **more extensive and specialised urgent care,** providing paramedicine models with extended mobile diagnostics and prescribing capabilities, able to safely **close more episodes of care in the patient's home** and in our communities;
e) **supporting primary care and out-of-hours services** in coordinating same-day access to urgent care, by providing telephony and triage support capabilities and infrastructure, ensuring patients receive or are navigated to the most appropriate response to their needs;
f) extending the application of regional Computer Aided Dispatch infrastructure to provide **dynamic sight of other out-of-hospital UEC resources** such as for mental health and community teams, and provide early warning when demand is likely to exceed capacity;
g) co-ordinating non-emergency transport for patients needing scheduled care and discharge or transfer from hospital, to **better support patient flow** through systems;
h) being system players and anchor institutions in population health management, prevention and **reducing health inequalities**;
i) being the NHS lead in our collaboration with other emergency services and resilience fora, to provide **greater assurance in our preparedness for major incidents** and protracted, challenging events.

Consolidating the role of ambulance services in urgent care coordination and provision in a planned and integrated way, (e.g. linking with same-day-emergency care and urgent community response teams) will allow ambulance services to more effectively meet some of the unmet needs, where other out-of-hospital sectors struggle with resourcing same-day urgent care provision (i.e. primary, community and mental health). We can reduce pressures on these sectors so they can focus on their non-urgent provision. By safely closing more episodes of care in our communities we can shift the balance away from secondary care, releasing capacity for elective work. This in turn will remove the experience of ambulances being held for long periods outside hospitals, with all the adverse effects for both patients and staff. By having ambulance resources available where and when they need to be we can improve not only our emergency responses, but the out-of-hospital responses from all providers and join up the wrap-around care that patients expect and will benefit from.

By acknowledging the potential for change and co-designing system UEC strategies with all of our partners, the ambulance sector can play a pivotal part in helping to alleviate many of the system pressures and capacity issues, rather than contributing to them. Rebalancing the focus of resources in more efficient and effective ways within systems, will mean we can improve the out-of-hospital offering and experience for patients. This would also facilitate the development of a more positive culture, supportive and productive working environments for our people. We could create attractive and fulfilling remits and cross-sector career paths for the UEC workforce, and address many of the challenges that are leading to the current levels of dissatisfaction and attrition of the NHS's most valuable asset.

The Association of Ambulance Chief Executives is confident that this sector has much more to offer the rest of the NHS in improving UEC provision in the UK. We would like to engage with national, regional and system leaders, and our partner providers, to explore the possibilities of enhancing the ambulance role within UEC and promote collaborative cross-sector planning and implementation of a long-term strategy to deliver meaningful change for patients and our people.

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East Midlands Ambulance Service NHS Trust

CLINICAL STRATEGY

2023 - 2028

Author: Nicole Atkinson, Medical Director

Date: 16/11/2023

Version Control: V3

Document Location

The source of the document will be found in

Revision History

Revision date	Previous revision date	Summary of changes	Version

Approvals

This document requires approval from the following:

Name	Title	Distribution Y/N	Date of issue

Summary

Our clinical strategy forms one of five enabling strategies through which our 2023-2028 trust strategy will be delivered. We are committed to delivering improved outcomes through implementing and embedding our new clinical operating model.

Clinical Strategy 2023 to 2028

Our commitment

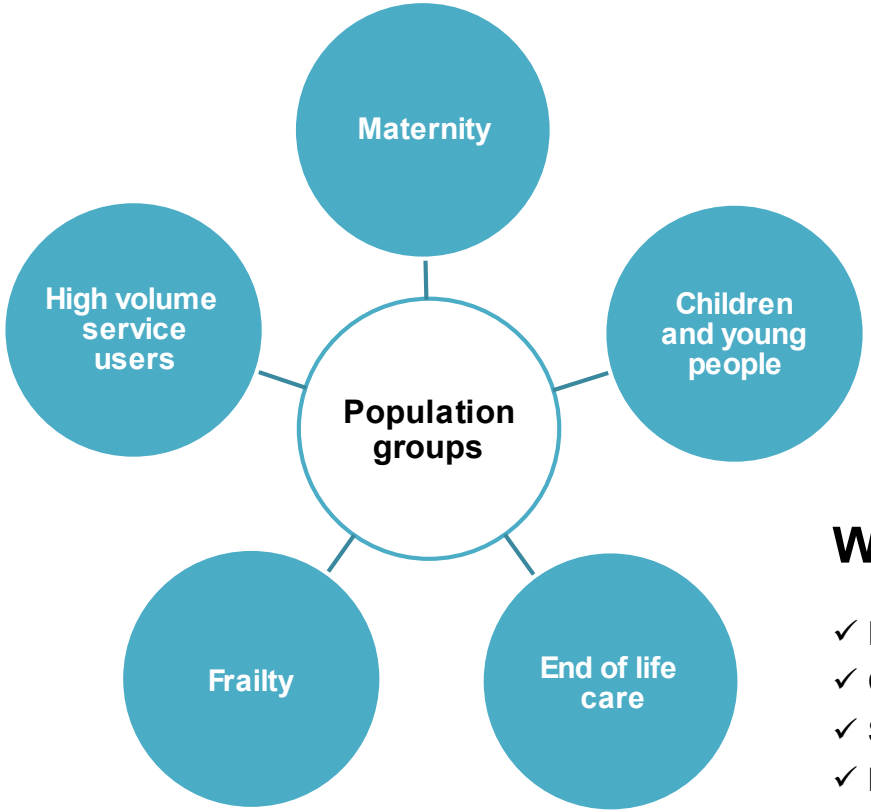
	Major incidents	Emergency care	Urgent care	Non-emergency patient transport
Our clinical aims	Deliver critical clinical response in collaboration with urgent response partners	Deliver the best possible life chances for patients	Support patients with complex care needs, delivering a clinically appropriate and timely response in collaboration with local organisations	Meet patients needs in a safe, timely and compassionate manner
Our clinical model	• collaborate with other category 1 providers • respond to the incident appropriately and with the resources required • deliver the best possible outcomes for surviving patients	• rapidly assess critical health needs and use most appropriate resources to respond • deliver rapid intervention • make safe for transport to most appropriate location	• determine the most appropriate response • signpost to/work in partnership with services • support access to personalised care closer to home	• assess patient eligibility • plan and book appropriate transport to ensure the needs of the patient are met • transported in a timely manner

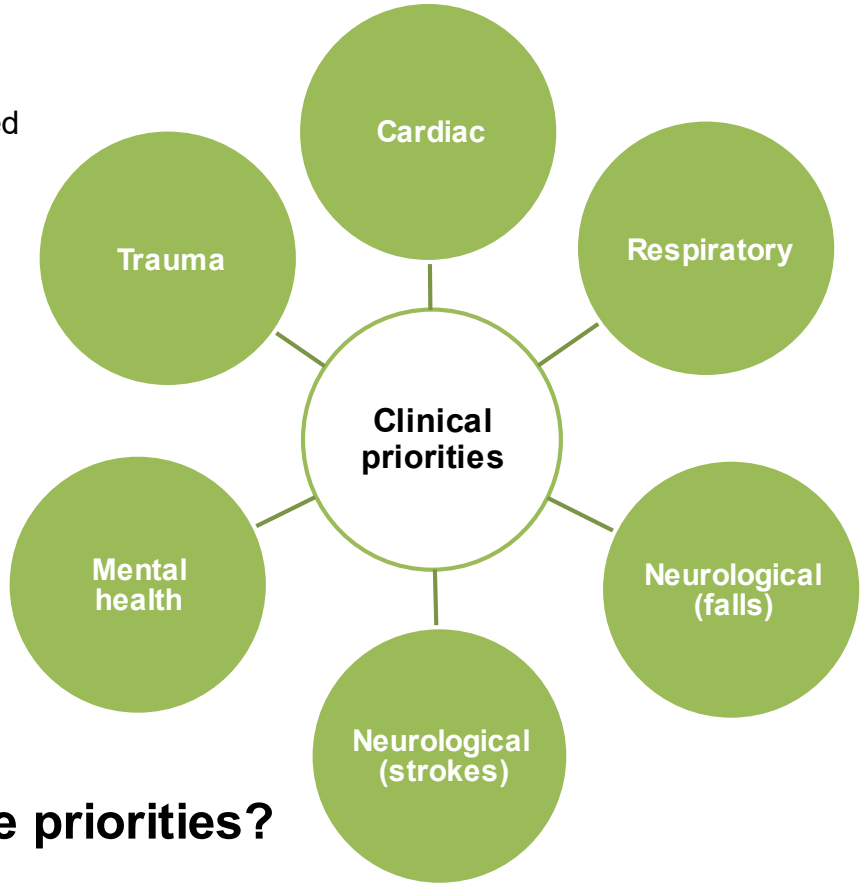
Fundamental principles	Equity	Care closer to home	Joined up care	Consistent and Timely	Improved clinical outcomes	Safe and effective care	Reducing health inequalities	Personalised care

Our approach and how we will deliver this

To develop this strategy we built on the engagement feedback that informed our EMAS Strategy for 2023 -2028.

We also reviewed our clinical data and the current national and local context to inform our clinical and population group priorities.





Why these priorities?

- ✓ Further improve patient outcomes and experience
- ✓ Conditions are high clinical risk
- ✓ Substantial amount of activity we undertake
- ✓ Partnership working opportunities

Clinical priorities – our commitment

Cardiac

- via 999 triage process, rapidly identify patients experiencing critical cardiac events
- dispatch appropriate clinical resources to provide swift expert care and transport
- pre-alert hospital to ensure timely treatment
- ensure the patient arrives at the right place first time
- give frontline staff 24/7 access to senior clinical advice to support decision making and manage risks
- ensure teams are trained to identify and treat range of cardiac conditions
- educate the public to perform cardio-pulmonary resuscitation and use automated external defibrillator

Respiratory

- ensure our teams have necessary equipment, training and resources to undertake high-quality respiratory assessments
- remotely and/or in person triage and signpost patients to the most appropriate individualised care setting for them
- use effectively the clinical pathways available eg communitybased care, virtual respiratory wards or hospital at home, sharing self-care options, or emergency care
- streamline our handover and referral processes
- make every contact count (eg smoking cessation advice, flu support, improving patient inhaler techniques)

Mental health

- ensure patients experiencing mental health crisis will be treated and appropriately referred to remain safe from harm
- develop care pathways to reduce avoidable hospital admissions
- give all frontline staff knowledge and skills to support provision of high-quality care
- use our data to build better understanding of NHS mental health outcomes to inform service developments

Clinical priorities

Trauma

- send most appropriately skilled resource to scene
- give staff 24/7 access to specialised trauma support and advice
- embed learning from incidents using data to support future responses
- work with regional trauma networks to support effective data sharing and develop more collaborative approach to joint training and education

Neurological (Falls)

- where appropriate, proactively prevent fall related hospital admissions, focussing on reducing the time a person is on the floor
- where people have spent extended time on the floor, work with NHS partners to appropriately reduce hospital admissions
- utilise our Community First Responders for timely and appropriate falls responses
- patient referrals to falls prevention services to avoid future falls
- use data to identify care homes requiring support to reduce falls risk and reduce inappropriate 999 calls
- support the development of alternative pathways for hospital falls management

Neurological (Strokes)

- develop our evidence-based response to strokes focusing on timely response
- improve our on-scene assessment and remote consultation capabilities
- enhance timely access to the right specialist care first time to improve patient stroke outcomes
- additional staff education and clinical supervision supporting rapid detection of suspected stroke
- reduce on scene times
- work with NHS partners to promote public awareness and education to identify early signs of stroke and associated preventative risk factors

Population groups – our commitment

Maternity

- develop maternity decision support tools for frontline staff
- buildin toour clinical operating model a remote clinical maternity support offer for crews to support clinical decision making and improve clinical outcomes
- appointment of consultant midwife to provide specialist clinical leadership and expertise to develop our maternity ambitions
- ensure patient need is supported by most appropriate clinical response
- reduce inequality and improve access to maternity services
- collaborate and share learning with maternity services, ensuring pathways are safe and effective

End of life care

- deliver high quality compassionate care through the delivery of six national endof-life care framework ambitions
- reduce avoidable admissions, considering the personal needs and wishes of the patient and their families/carers
- collaborate with partners to increase completion and sharing of RESPECT forms (end of life care plans) to inform staff of the patient's wishes prior to ambulance arrival
- deliver specific education and training to staff to enable them to deliver person centred, compassionate care with confidence
- provide specialist equipment and medication to support dignified dying
- collaborate with health and care providers and hospices to improve delivery of coordinated patient care and shared learning

Children and young people

- develop access to specialist clinical advice for assessment and decision making on scene, and increase hear and treat and see and treat responses where appropriate
- patients who require treatment will be taken to the most appropriate treatment facility, ensuring parents/carers accompany them to support a compassionate approach
- support work to improve health outcomes and reduce health inequalities
- use our data and collaborate with partners to develop services, promote wellbeing, and reduce avoidable harm (including physical and psychological)

Population groups

Frailty

- proactively assess patients for frailty risk factors to ensure early identification and intervention
- using the clinical frailty scale and additional staff training and education, support proactive, consistent, early identification of frailty, and effective prevention and management of frailty
- develop advanced practitioner roles to further support clinical and complex care decision making
- work with health and care partners on public frailty prevention and early identification campaigns
- where clinically appropriate, collaborate with partners to develop and enhance pathways to support and increase the number of patients with frailty (and their carers) to remain at home

High volume service users

- work collaboratively with other health and care providers to support high volume service users to access appropriate services (general practice, community or mental health services) to support their needs
- develop a more effective joined up care plan approach across health and care organisations
- use data and intelligence to ensure proactive identification and ensure a more holistic joined up care approach for these patients
- appropriately increase our hear and treat response, reducing unnecessary and inappropriate deployment of emergency ambulances
- train and develop staff to manage on scene patients and to access support and advice through our enhanced clinical assessment

Why are we proposing these changes in our clinical strategy?

The Clinical Strategy is aligned to these EMAS ambitions:

The case for change:

- Growing prevalence of long -term health conditions
- Impact of COVID -19 pandemic on mental health
- Pressure on acute hospital beds
- Longer ambulance response times nationally
- Elective care backlogs
- Concerns for staff wellbeing
- High staff vacancy rate
- Growing health inequalities gap
- Need for proactive and preventative support

Our key measures – what our clinical strategy will deliver

↑ Safe, effective, and compassionate care

↑ Right care, right place, right person

↑ Co-ordinated care

↑ Patient outcomes

↑ Preventative healthcare

↓ Health inequalities

↓ Response times

↓ Inappropriate ambulance dispatch

How is the Clinical Strategy different to our current provision?

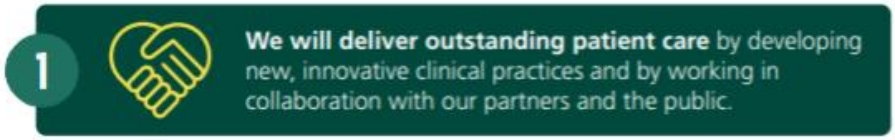
- increase our ‘hear and treat’ and ‘see and treat’ contacts, shifting away from always providing an ambulance and taking patients to hospital
- increase the skill mix of our workforce to achieve better patient outcomes for all clinical and population groups
- increased proactive, preventative approach to support the demand on the whole health and care system
- Increased focus on improving clinical outcomes

Contents

Purpose of our Clinical strategy

Our clinical strategy forms one of five enabling strategies, through which our 2023-2028 trust strategy will be delivered.

The clinical strategy aims to describe how we will **shift the balance towards delivering outstanding patient care by working in collaboration with system partners to support keeping patients safe and healthy at home.**



The Clinical Strategy is aligned to our trust ambition;

And associated strategic objectives;

1.1 We will ensure that patients are cared for in the most appropriate setting.

1.2 We will develop emergency and urgent/ non-emergency ambulance models ensuring we right size our capacity to enable delivery of the most appropriate response and meet ambulance response targets.

1.3 We will connect our services as seamlessly as possible with our partners and deliver our non-emergency ambulance offer in partnership with local systems maximising use of local pathways.

1.4 We will support effective system flow, recognising our role, working with partners, in supporting both admission avoidance and effective hospital discharge.

1.5 We will continually develop our emergency preparedness, resilience and response to major incident/ mass casualty events working in collaboration with national and local resilience partnerships and other national bodies to protect staff and public, minimising disruption to services and maintaining response to other emergencies.

And supports delivery of our ambitions;

And associated strategic objectives:

5.1 We will promote an organisational culture that champions reducing health Inequalities and preventative healthcare as core business.

5.2 We will work in partnership with our local health and care systems to better understand the needs of our communities through improved engagement, insight, and patient experience.

The clinical strategy describes our new clinical operating model and our strategy for responding to specific, high priority, clinical conditions, and patient groups, taking an

innovative and collaborative approach to ensuring the right care is delivered, by the right person, at the right time and in the right place.

Developing our Clinical strategy

Strategic Context

The case for change

- Whilst on average we now live for longer, many these additional years are not lived in good health. The growing prevalence of long-term health conditions, the impact of the COVID-19 pandemic on mental health and elective care backlogs for instance, places increasing strain on our current health and care services.
- The pressure on acute hospital beds remains persistently high and in 2022, 19 out of 20 beds across the NHS were occupied, impacting on the flow of patients within hospitals. This subsequently impacts on ambulance handovers and response times.
- 10.6 million calls were answered by ambulance services in England between April 2021 and March 2022. Around 7.9 million of these required a face-to face-response, which equates to around one per year for every seven people in England. With demand at times outstripping ambulance capacity this impacts on average wait (response) times for ambulances.
- In England, people are waiting longer than ever for ambulances to arrive. The number of the most serious ambulance callouts has at times been up by one third on pre-pandemic levels. Alongside increasing ambulance hospital handover delays, this has led to a marked deterioration in ambulance response times, impacting on patients' clinical outcomes.
- The impact of Covid-19 on NHS staff has been substantial and wide-ranging, with growing concerns regarding staff well-being, stress, and burnout. The number of vacancies in the ambulance sector almost doubled in 2021-22 along with increasing sickness absence rates. A fully staffed and healthy ambulance workforce, supported and enabled to do the job they are trained and want to provide is critical, and must remain a priority.
- A growing health inequalities gap in our East Midlands population, forecast to increase because of the recent cost-of-living crisis, is further widening the gap across local communities and impacting upon on-going health and care provision.
- Greater focus is needed on increasing proactive and preventative support to our communities to improve their overall health and well-being and enable them to live full and independent lives for as long as possible. This will not only have huge benefits for individuals, but it will also help to solve many of the demand and capacity problems the health and care sector is facing.

The NHS Long Term Plan

The Long-Term plan, published in 2019, set out the key ambitions for the health care system over the next 10 years. The plan focuses on delivering an NHS that is:

- More joined up and co-ordinated in its care.
- More proactive in the services it provides.
- More differentiated in its support offer to individuals.

Pertinent to the development of the EMAS clinical strategy is the focus to deliver a new NHS service model with the focus on 'out of hospital care' to allow patients to access more options, better support, and properly joined-up care at the right time in the optimal care setting.

It is this focus on 'out of hospital' care and providing services at the right time, in the right place and by the right person that underpins our new clinical operating model and overarching clinical strategy.

By achieving these ambitions, it will enable us to respond in a timelier fashion to those patients who clinically require a face-to-face ambulance response.

Integrating care: Next steps to building strong and effective integrated care systems (ICS) Guidance – NHSE November 2020

This national guidance focuses on the development of integrated care systems and sets out four core purposes of an ICS:

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience, and access.
- Enhance productivity and value for money.
- Help the NHS support broader social and economic development.

As a healthcare organisation spanning and embedded within six ICS', we will consider in our clinical strategy the part EMAS is able to play in delivering on these aims and look to understand where working in collaboration and partnership with others will have most benefit for our patients, communities and workforce.

2023/24 National Priorities and Operational Planning Guidance – NHSE January 2023

As part of recovering services and productivity following the COVID-19 pandemic, this national guidance sets out the need to improve patient safety, outcomes and experience through improving ambulance waiting times, with a specific focus on improving category 2 response times. Actions to achieve this include, reducing ambulance hand over times and increasing the capacity in the ambulance service.

Our clinical strategy aims to support the delivery of these national ambitions.

Delivery Plan for Recovering Urgent and Emergency Care Service's – NHSE January 2023

The national delivery plan further details the actions urgent and emergency services need to take to support recovery following COVID-19. The direction of our EMAS clinical strategy is aligned to the intent set out within this plan, towards keeping more patients in the community where possible, better integration and partnership working with other services including 111, and a focus on our EMAS workforce and their health and wellbeing.

The delivery plan sets out the ambition to:

- Increase the clinical assessment of calls in Emergency Operation Centres (EOC), prioritising ambulances and increasing triage to other alternative services.
- Improve forecasting of demand and intelligent routing of 999 calls.
- Increase mental health expertise and provision within ambulance services.
- Provide access to clinical advice for paramedics through a single point of access.

In addition, the NHSE plan sets out five key areas of focus:

- **Increase capacity** – investing in more hospital beds and ambulances and making better use of existing capacity by improving patient flow.
- **Growing the workforce** – not just increasing the size but the ability of staff to work flexibly to support patients.
- **Improving discharge from hospital** – which should lead to an improvement in hospital ambulance handovers.
- **Expanding and better joining up of health and care outside hospital** –to enable people to be better supported at home for their physical and mental health needs.
- **Deliver the right care, in the right place, in a timely way**.

The expectation within this plan is for ambulance trusts to improve Category 2 response times to 30 mins on average over the 2023/24 period, and back to the 18-minute standard during 2024/25.

Local Context

EMAS delivers clinical care to 4.8 million people, across 6,452 square miles and six integrated care systems.

We provide an extensive range of clinical services. From major incident, emergency, and urgent care, through to non-emergency patient transport services and emergency medical cover at events. We take nearly 3,500 calls a day and provide nearly 2,000 face-to-face ambulance responses daily.

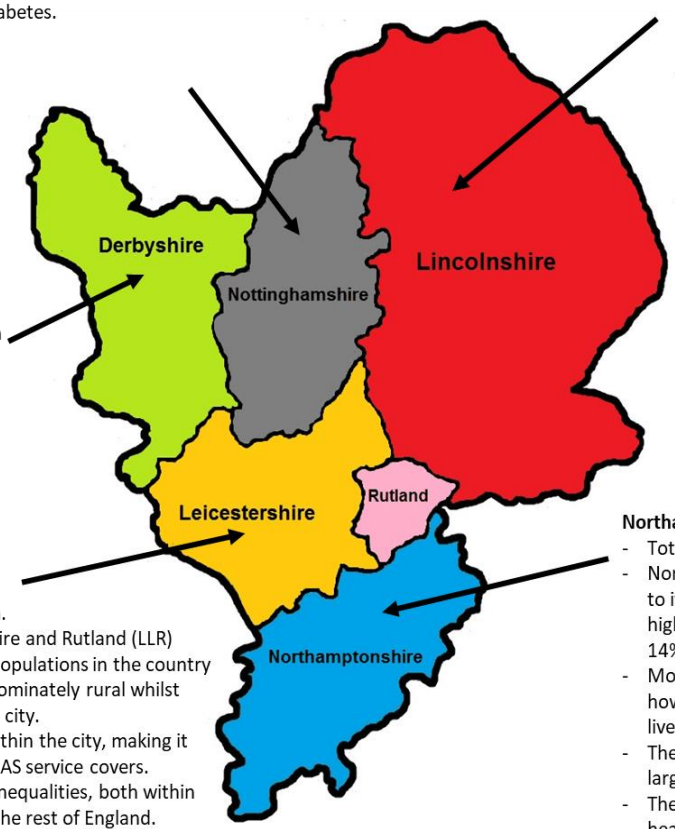
Delivering care across a vast geography is not without its challenges, especially when the different population health needs are considered, and there is variation in local infrastructures. To flex and adapt to local urgent and emergency care ambulance response requirements, EMAS operates out of five geographical divisions: Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, and Nottinghamshire.

Our Populations:

Nottinghamshire
- Total population of 823,126.
- Over the next 10 years, there is predicted to be a significant growth in the older population with a 38% increase in people over the age of 85
- The area is geographically diverse from a busy city centre, through to numerous rural ex- mining villages intersected by connecting roads and the M1 motorway.
- The area has large variations in levels of deprivation.
- As the older population grows, we can expect more people with moderate and severe frailty, heart failure, stroke, congestive heart disease, chronic obstructive pulmonary disease (COPD), cancer, hypertension and diabetes.

Lincolnshire
- Total population size is 768,364.
- Lincolnshire has an ageing population with 23% of residents over the age of 65
- Lincolnshire is the second largest county in England covering an area of 2,687 square miles.
- It is predominantly rural, with no motorways and little dual carriageway and 50 miles of coastline. Residents are dispersed across the city, market towns, rural and coastal areas
- Although the general pattern of deprivation in the county is in line with national levels, the towns and coastal strip have higher levels of deprivation than the rest of the county, with Skegness and Mablethorpe in the most deprived 10% neighbourhoods in the country.

Derbyshire
- Total population over 1 million people.
- By 2033, 27.5% of population will be over 65, number of over 75s will be more than 40% higher than today.
- Physical geography in Derbyshire can make providing ambulance care challenging with more limited access in rural areas
- There is high deprivation in Derby City and the Northeast which contrasts with the affluence of the Dales and South West
- The area faces challenges from an increasing ageing population and a growing number of the population requiring support for mental health needs.



Leicestershire
- Total population of LLR is 1.1 million.
- The people of Leicester, Leicestershire and Rutland (LLR) represent one of the most diverse populations in the country
- Leicestershire and Rutland are predominately rural whilst Leicester city is a densely populated city.
- High deprivation levels are found within the city, making it the most deprived area that our EMAS service covers.
- The area is marked by stark health inequalities, both within the area and when compared with the rest of England.
- Deprivation is considered one of the biggest health challenges for the ICB.

Northamptonshire
- Total population is 715,000.
- Northamptonshire has had a significant increase to its population over the past 10 years with the highest increase in England. A further increase of 14% is expected over the next 20 years
- Most of the population live in urban areas, however the majority of the over 65 population live in rural areas.
- The majority of poverty and income deprivation is largely concentrated around Northampton town.
- The diseases that are responsible for most ill health and early deaths in the area include: cancers, heart disease, chronic lung disease, musculoskeletal conditions, and poor mental health.

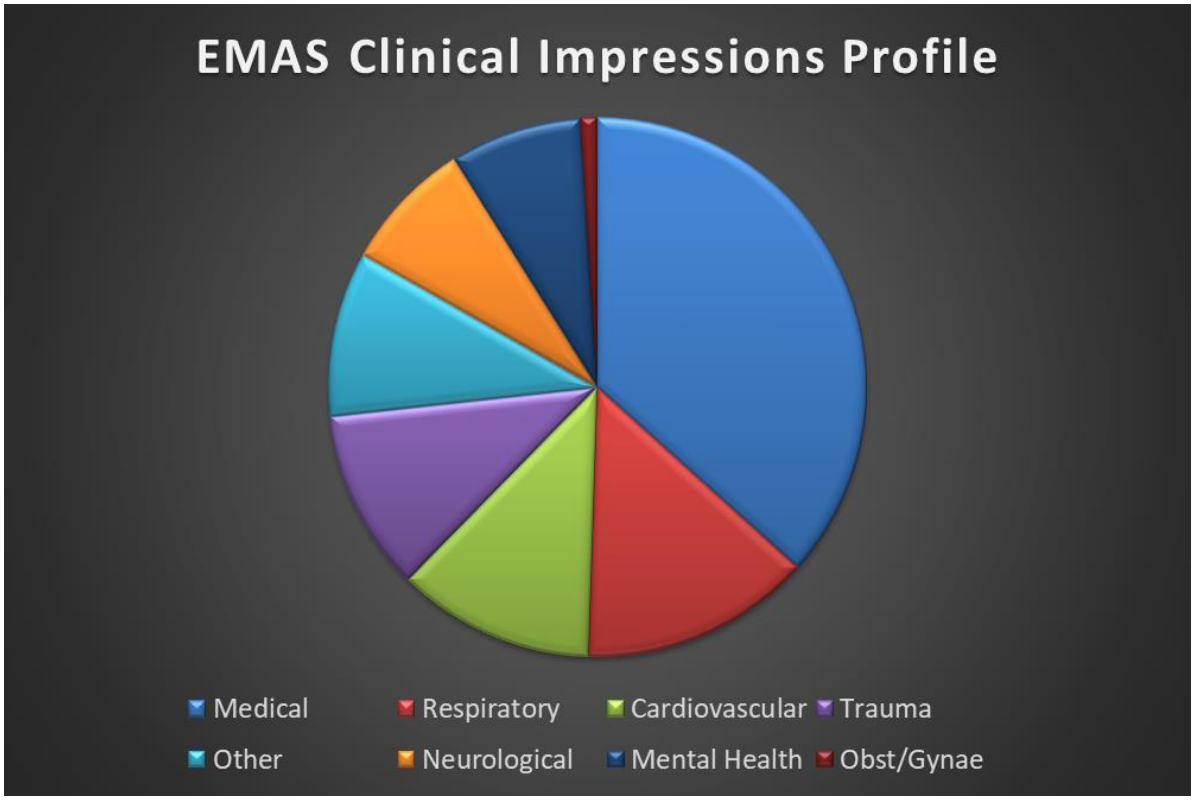
Our Clinical Data

Despite the differences seen across our EMAS footprint, consistency remains in the clinical conditions our patients are experiencing, and to which our clinical workforce is therefore supporting or responding to.

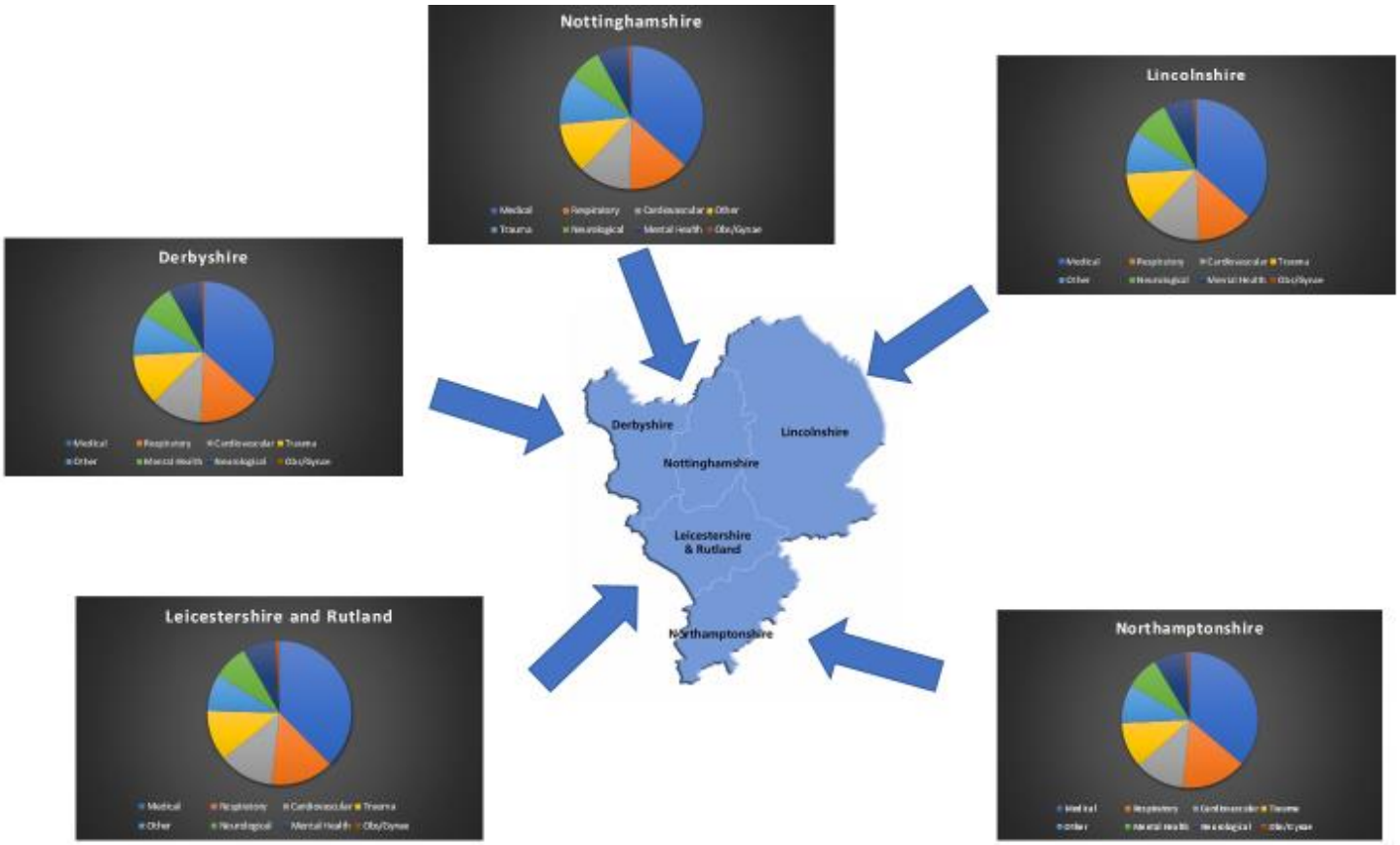
Analysing our 2022 EMAS clinical impressions data, the key clinical conditions can be categorised into eight clinical groups: medical, respiratory, cardiovascular, trauma, other, neurological (including strokes and falls), mental health and obstetrics and gynaecology conditions.

Despite the population variations seen across our five EMAS geographical delivery divisions, this top eight remains consistent, as seen below.

EMAS Top Eight Clinical Conditions Profile 2022:



2022 Clinical Conditions Data Broken Down to Local Divisional Footprints:



As part of our EMAS plan to support the national "Delivery Plan for Recovering Urgent and Emergency Care Service's" we are already focusing our energies on developing targeted improvements related to the "medical" group, identified by our data.

We have developed divisional data dashboards highlighting clinical areas where variation is evident. This analysis is being used to inform local clinical conversations and facilitate sharing of best practice across our divisions and within EMAS. We have already started to see positive impacts of these improvements on recent data, and plan to adopt this approach and methodology (data driven and clinically led) going forward to underpin and support our clinical strategy.

The views of our people, public and partners

Our clinical strategy has been developed in collaboration with staff, system partners and patients to ensure that it reflects the needs and ambitions of the systems we operate in and the populations we serve.

The views of our public

We engaged with the public on what matters most to them. The following themes were reported and have been considered in our clinical strategy development.

- Response times
- Compassionate care
- Investing in, developing, and supporting staff
- Using technology and digital opportunities
- Patient and public education and collaboration

The views of our partners

We spoke to our partners across our integrated care systems to collect feedback and ensure that our strategy aligns with our wider health care system strategies.

Priority areas highlighted by our partners are detailed below and have helped to shape our strategy development.

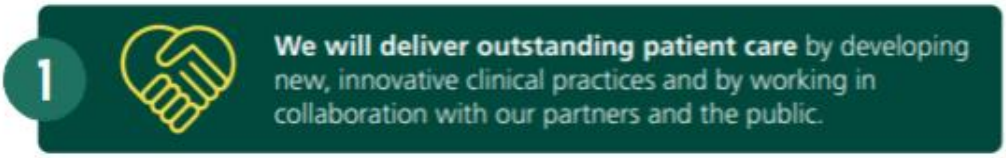
- A more patient centred, holistic approach with a key focus on reducing health inequalities.
- Supporting staff and the public to understand that not all patients need to be taken to hospital.
- Ambulance crews with the skills and confidence to support a patient to stay at home.
- Timely response, clinical assessment and transportation of those patients who do need to be taken to hospital.
- Rotational role opportunities, and joint training opportunities, with progression for staff within the health and care system, enabling better joined up care and sharing of best practice.
- Ongoing EMAS engagement in system working groups to ensure alignment with local priorities and better communication across the systems.
- Local alignment where appropriate, recognising the challenge EMAS faces in working across multiple integrated care systems.
- Shared patient records, better data sharing and collaborative data collection.
- Better integration between EMAS and other teams, including senior clinical decision making to support crews on scene.

The views of our staff

We engaged with staff from across the trust to find out what challenges they face day-day, what areas of future improvement and development they think are the most important and what they think about the proposed clinical operating model and areas of focus.

Our Clinical Strategy

The overarching ambition of the clinical strategy is:



The overarching objectives is:

We will ensure that patients are cared for in the most appropriate setting for their needs by *suitably trained staff and using an (evidence-based and/or effective) practice approach)*

Principles

Our clinical strategy is underpinned by six guiding principles.

- Putting the **patient at the centre** of all we do, and ensuring we take a **holistic approach** to providing clinical care.
- Developing a **personalised care** approach by enabling patient choice, **shared decision making,** and **community-based support** approaches
- **Clinical collaboration** and **integration** by default
- To strive for **equity in all we do**, to **reduce health inequalities** and **improve clinical outcomes** for all.
- Design and **deliver clinical care as close to our local populations** & patients as is possible.
- A culture of **Trust, psychological safety, and civility,** to support patient care and colleague wellbeing.

Clinical operating model

Our vision

Our clinical operating model is designed to ensure that patients receive the right care, at the right time, from the right person in the most appropriate location for their clinical needs. This covers the full spectrum of our services from major incident, through to urgent and emergency and planned care (i.e., non-emergency patient transport services).

EMAS services can be accessed through a variety of mechanisms: 999 calls, referrals from 111 calls, digital access, or referrals from health care professionals. At the point of access, non-clinical and clinical assessment takes place, using a multi-disciplinary clinical assessment approach and the NHS pathways triage tool, supported by a directory of wider services.

This is to support clinically prioritising patients to ensure the most appropriate response for the patient is achieved, proportionate to their clinical needs. These principles of prioritisation will also underpin our planned care delivery model.

The model reverses the assumption that every patient needs an ambulance. Instead, it will support a wider range of responses, matched to the patient's needs, and ensure we utilise the most appropriate services for the patient from across our health and care systems (including the options of supporting patient self-care).

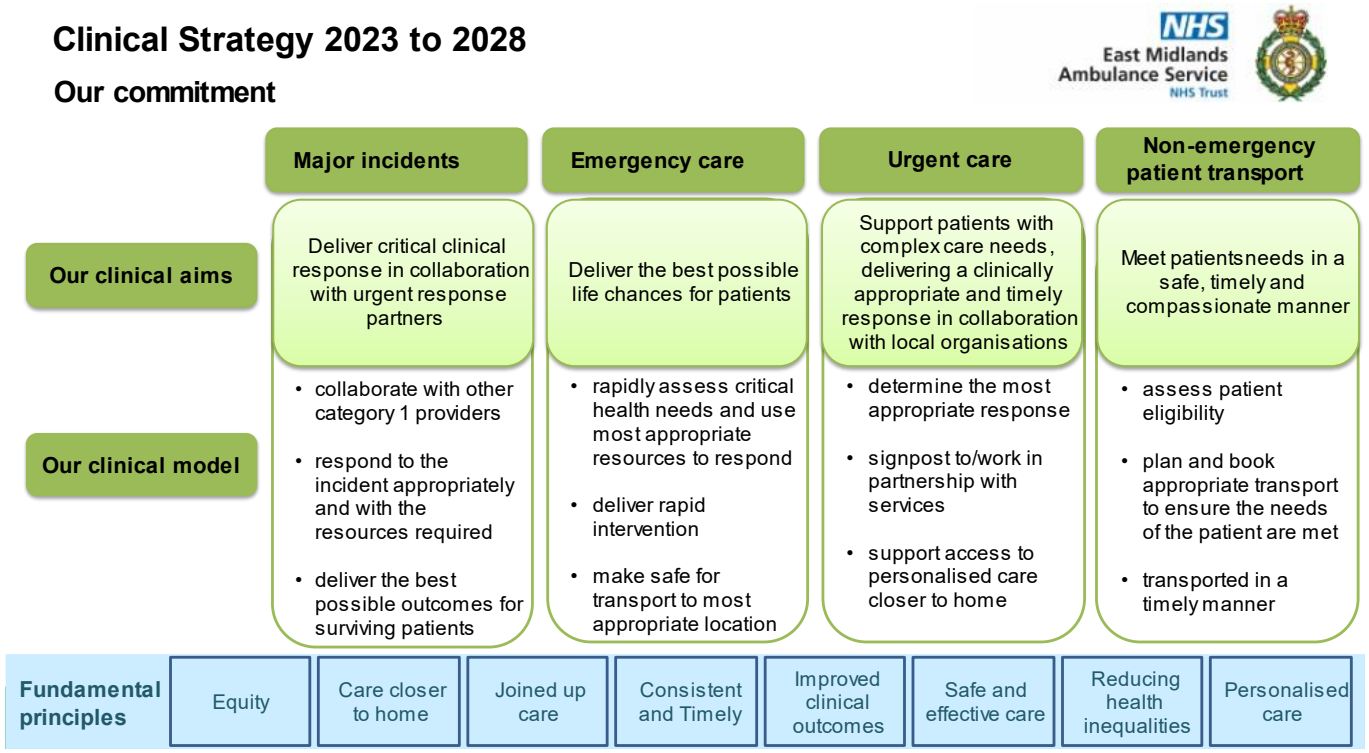
We will ensure a personalised response with appropriate assessment, response, and transport (if needed) dependant on the nature of the patients' clinical needs.

In **an emergency**, life threatening, time critical situation, patients will be rapidly assessed, and the most appropriate ambulance resource sent immediately. The responding clinical support will have the correct skill sets and training to respond to the critical health needs, deliver rapid intervention and make the patient safe for conveyance (transportation). We will ensure an efficient and effective conveyance of patients, to the most appropriate destination first time, and in a timely way to improve patients' clinical outcomes.

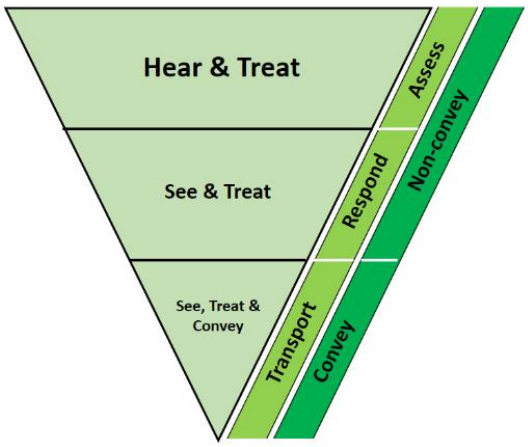
In **an urgent** situation, that requires an intervention from a health or social care professional, we will determine the most appropriate response through assessment. During assessment, calls will be clinically triaged, and an appropriate clinical response will be decided which may be in the form of onward signposting outside of EMAS (matched to the patient's clinical needs), self-care or further EMAS clinical involvement. The response will be appropriate, effective, and personalised, in or as close to the patients home as possible and in partnership with other community services. For these patients, we will minimise the need for ambulance conveyance (where clinically appropriate), focusing on improving outcomes outside of the hospital.

Where a **response is planned** for a known patient transport need, we will assess the eligibility of the patient and enable planning and booking of appropriate transport. The response will be personalised to the needs of the patient, ensuring they can be transported to

medical appointments, to a variety of care settings or home after discharge. Transportation will be within an agreed timeframe.



Our new model will aim to increase hear and treat (patients offered support, advice and onward referral or signposting to other services without need for an ambulance to attend) and improve our ability to match clinical need with the appropriate clinical response (including signposting and self-care). We will only send an ambulance response to those deemed to clinically need this (therefore improving our ambulance response times). This model can be considered as "inverting the pyramid", with fewer of our calls resulting in a see, treat and convey response (deployment of an ambulance).



To support a model that delivers more hear and treat and see and treat, we will operate a more comprehensive multi-disciplinary team (MDT) within the clinical assessment hub. This will increase our clinical assessment capabilities and ensure more effective utilisation of clinical triage as well as the MDT's currently operating within our ICS' (i.e., becoming a trusted referrer into ICS's Clinical Assessment Services). By using technology solutions this will enable us to view patient records and safely pass patients between services.

Our enhanced and expanded clinical assessment function will provide further clinical triage following the initial non-clinical NHS pathways triage. This MDT will be made up of a variety

of specialists, for example, pharmacists, advanced practitioners, mental health practitioners, social care professionals, and be able to offer specialist clinical advice over the phone and signpost callers to the most appropriate services. This team will also provide clinical support to crews on scene to help manage risk and support clinical decision making. This function will support the full spectrum of clinical conditions from critical and enhanced patient care issues (including trauma), through to less urgent clinical care needs, ensuring we can support physical and mental health needs in equal measures. We will explore the effectiveness of delivering this through a "hub and spoke" approach with more localised clinical teams, as well as the ability to deliver some of this function remotely and/or virtually.

To support our enhanced assessment, we will need to continue to work with key system partners to ensure we have optimised the interfaces between us, to ensure the right services are assessing the patients' needs first time (i.e., collaboration with NHS 111, ICS clinical assessment services, urgent community response services).

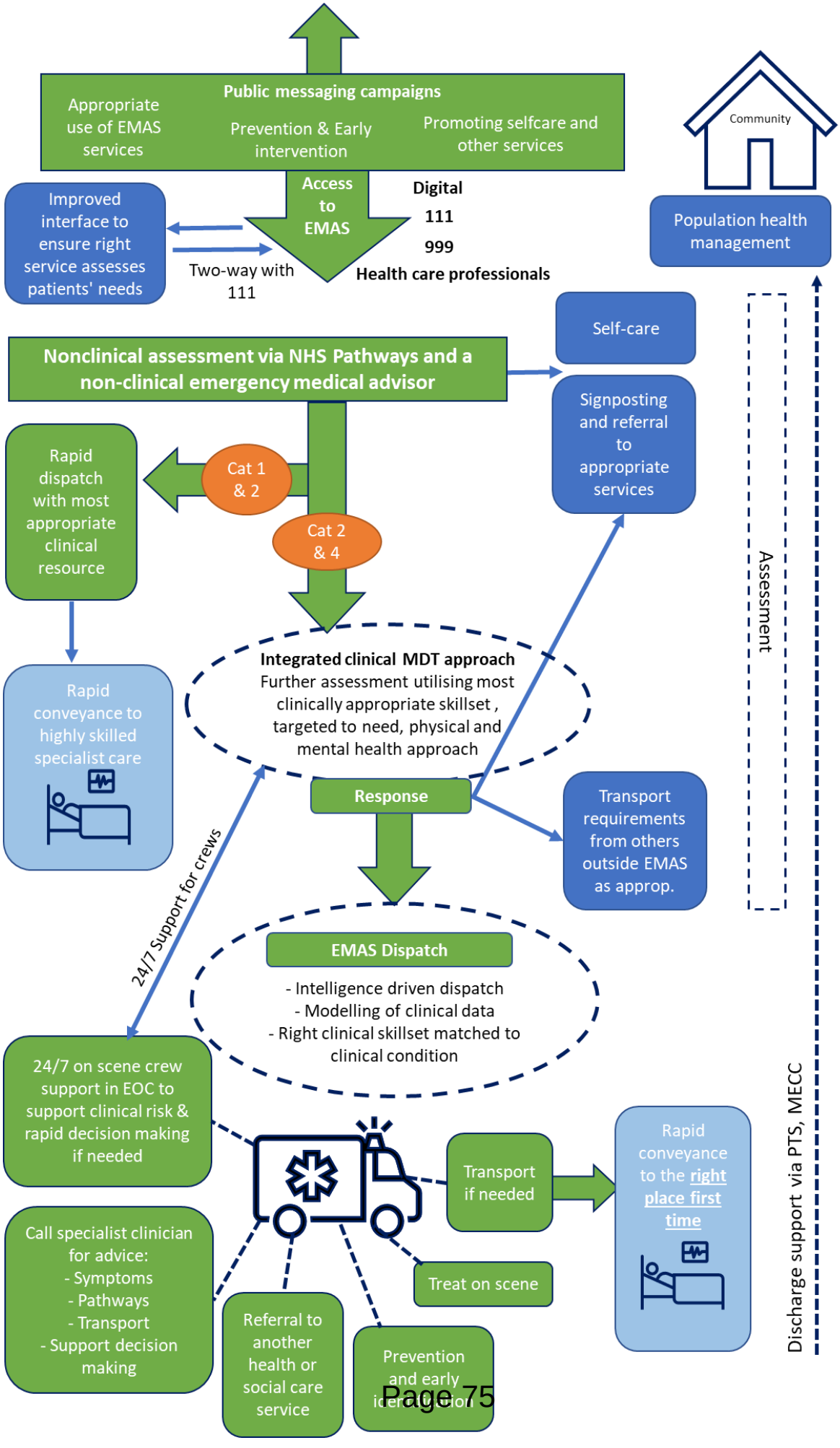
When an ambulance response is required due to a clinical need, ensuring the most effective and efficient ambulance dispatch process will be critical. We will explore the options around developing an intelligence driven despatch system to help support our ability to match and dispatch the right clinical skill set with the patient's clinical condition and needs. This will ensure clinical crews with the skills and confidence to support a patient with complex health conditions to stay at home are dispatched accordingly, as well as a timely response, and transportation of those patients who do need to be taken to hospital by alternative skill sets.

We will scope and develop, alongside our integrated care systems and staff, an offer to flex and more effectively integrate our emergency and urgent services with our planned care (NEPTS) offer considering areas such as patient discharge and the ability to support the urgent and emergency care system during periods of high demand.

We will support our planned care teams through wider education of certain clinical conditions (e.g., end of life care to support fast-track hospital patient discharges) to ensure they feel confident and enabled to support people's health and care needs and are supported to make every contact count.

For our clinical operating model to be successful we will need to continue to work alongside our public, our communities, our systems, and our staff to engage and communicate how we will adapt the way we work across EMAS to support and deliver urgent, emergency care and planned care in the future.

Clinical operational model in practice:



Clinical Operating Model Objectives

- We will ensure that patients are cared for in the most appropriate setting based on their health and care needs.
- We will implement a new decision support tool platform (NHS pathways) and integrated multidisciplinary clinical triage approach to enable effective triage of 999 calls and prioritising patient's needs based on clinical risk, using a population health management approach.
- We will embed signposting to the most appropriate setting (ensuring we support more effective and appropriate use of other resources within systems or supporting patient self-care)
- We will develop our education and communication offer to improve public awareness and understanding of 999 services and when to use them.
- We will identify and implement opportunities for better integration and collaboration between 999 and 111.
- We will explore and develop collaborative clinical assessment workforce models (e.g., rotational roles and joint training), enabling sharing of clinical workforce and best practice across providers and within systems.
- We will connect our services as seamlessly as possible with our partners and deliver our non-emergency ambulance offer in partnership with local systems maximising use of local pathways and resources.
- We will work with our ICS' urgent care hubs to ensure optimal utilisation of available resources to support patients' health and care needs and develop a more integrated MDT approach working across our divisions and local communities.
- We will work towards (when an ambulance response is required) ensuring the right clinical skill set is deployed to support the patient's health and care condition and needs.
- We will further develop and optimise our resource deployment model, including people, vehicles, and equipment, to reflect any shift from "acute" conveyance/transportation of patients, towards community based urgent care. As implementation of this model progresses, we will need to continue to calibrate the optimal clinical skill set, vehicles and equipment required to keep pace and reflect changing patient's needs.
- We will explore and consider the capabilities needed to develop and deliver an Intelligence driven dispatch function.
- We will develop a consistent 24/7 clinical on-scene support function for crews to utilise (across the spectrum of clinical conditions) within our EOCs to support clinical risk and on-scene decision making.

- We will work in partnership with other health and care providers to develop (where clinically appropriate) more specialized clinical support and expertise offers to support crews on scene with decision making.

Clinical operating model in practice

Joan's story

Joan is a 74-year-old lady who lives alone and has been feeling a bit wobbly on her legs for the last few weeks. On waking up and getting out of bed her legs give way and she ends up on the floor.

This is her second fall of the week. She feels shaky, disorientated and anxious, but fortunately has an alert pendant to hand. After pressing this, carers are unable to establish Joan's condition so call 999, as they feel she needs to be checked over and is at home alone.

Our call handlers ask a series of questions which identify that she has sustained a non-injury fall. Instead of sending an emergency ambulance, a Specialist Paramedic is sent who conducts a thorough and holistic assessment.

They find her blood pressure on standing is low which accounts for her symptoms and arrange for her blood pressure medications to be reviewed by her GP. They also arrange for the community urgent care response team to assess her case and they arrange to visit Joan that day. They also notice her walking is unsteady and arrange a follow up appointment through the falls team to provide ongoing physiotherapy support which improves Joan's mobility.

Following this Joan is no longer falling, having had her tablets changed and she feels much more confident to cope and manage at home.

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Major Incident Response (Emergency Preparedness, Resilience and Response (EPRR))

Major incident management is another critical element of our overall clinical operating model provision. This covers not only how we respond to a major incident, but how we manage an incident's impact on delivery of our other services. Because of the critical nature of this response and its priority within the Trust, we have set out several specific objectives for this element of our operating model to ensure continued focused improvements.

Overarching ambition statement

We will work collaboratively with other Category 1 responders to ensure an integrated response to Major Incidents, Mass Casualty events and Marauding Terrorist Attacks.

During a major incident, our five key objectives are to,

1. Ascertain the medical treatment capacities required by those at scene and liaise with potential receiving hospitals to clarify their capability and capacity and potential expansion of the site facilities.
2. The identification, cohorting and repatriation of surviving patients.
3. To ensure safe systems of work are in place to maximise staff safety for responders at any EPRR related event or incident.
4. To coordinate deployable medical assets in the affected area and establish off-site treatment facilities.
5. To ensure effective command and control arrangements, co-ordination and communications are established.

To ensure we can respond effectively to a major incident, our priorities over the next five years are to:

- Embed learning and recommendations from the Manchester Arena Inquiry.
- Work collaboratively with other Category 1 responders to conduct regular training and exercising for all commanders, senior clinicians, specialist, and non-specialist resources.
- Conduct regular training for all staff.
- Implement the new Major Incident Triage Tool (MITT) and ten second triage tool.
- Ensure appropriate equipment on all front-line vehicles e.g., increased stretcher capacity and provision of triage packs.
- Develop our major incident response based on updated national guidance from NHS England (NHSE), National Ambulance Resilience Unit (NARU), Joint

Organisation Learning (JOL) and the joint decision model to support effective joint decision making between organisations (JESIP).

- Achieve full compliance status in relation to the NHSE EPRR Assurance standards.

To achieve our ambitions, we will work in collaboration with partners to ensure a co-ordinated response. This will include:

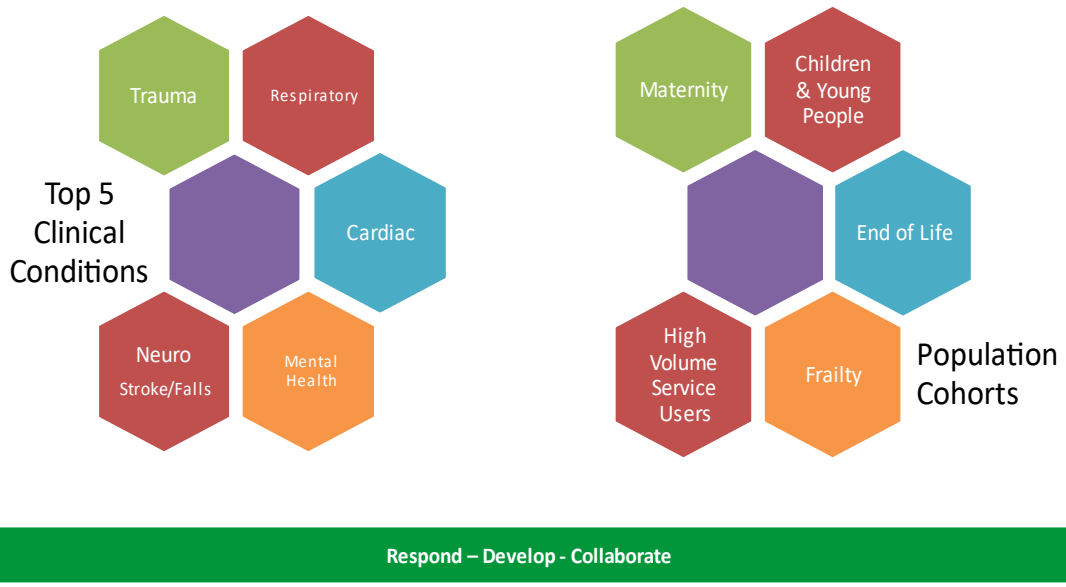
- Regular training and exercising with other Category 1 responders, including NHSE, ICB's, police, fire and the military.
- Participation at a senior level in all Local Resilience Forums and Local Heath Resilience Partnerships.
- Working closely with other partner organisations such as air ambulance services, voluntary groups, and specialist responders, which will include training and exercising.
- Engaging with National EPRR related Groups (and partners) to advance the National EPRR strategy.

Clinical Conditions and Population Cohorts

Using our data and views from our people, patients, and partners we have identified five evidence based clinical conditions and five population cohorts on which we wish to focus our improvements over the next five years.

These have been chosen for the following reasons.

- They make up a high proportion of the activity we undertake.
- It is an area with high clinical risk potentially associated with it.
- There are partnership working opportunities to collectively improve pathways of care.
- There is an opportunity to further improve patient outcomes and experience.



Overarching ambition statements for conditions and populations

For each area of focus we have defined a 5-year ambition statement to guide our decision making and direction through this clinical strategy.

Clinical Conditions

Trauma . We will ensure our workforce are skilled and prepared to respond to trauma and have 24/7 access to specialised trauma support and advice. This will occur alongside a continued focus on working in partnership with local providers to improve patient outcomes.

Cardiac- We will rapidly identify patients experiencing time critical cardiac events via our 999 remote triage processes, and dispatch appropriate clinical resources without delay to

provide swift and expert care and transport utilising acute pathways with partner NHS Trusts to ensure the patient arrives at the right place first time.

Respiratory - We will triage, remotely and in person, and signpost patients experiencing respiratory symptoms to the most appropriate individualised care setting for them. Be that community-based care with partner agencies, patient self-care, or emergency care delivered by our skilled clinicians and partner acute trusts.

Mental Health- We will ensure that patients experiencing mental health crisis will be treated and referred appropriately, whilst ensuring that the least restrictive options are used.

Neurological (Falls) – We will proactively prevent fall related hospital admissions where appropriate, with a focus on trying to reduce the time a person is on the floor. Where people have spent extended time on the floor, we will work with system partners to reduce admissions where appropriate by supporting the development of alternative pathways to support and further assess out of hospital.

Neurological (Strokes) – We will develop our evidence-based response to strokes focusing on timely response, improving our on-scene assessment and remote consultation capabilities, and enhance timely access to the right specialist care first time to improve patient stroke outcomes.

Population Cohorts

Maternity - We will deliver high quality compassionate care for individuals with maternity care needs, recognising the need to reduce inequality and improve access to maternity services.

Children and young People - We will work towards improving the health outcomes and reducing healthcare inequalities for service users who are Children and Young People. We will develop our services to meet the needs of patients and staff to reduce avoidable harm (including physical and psychological) and promote wellbeing.

End of life care - We will deliver high quality compassionate care for those individuals with end-of-life care needs through the delivery of the 6 national ambitions set out in the end-of-life care framework.

Frailty - We will support effective prevention, identification and management of frailty supporting appropriate clinical decision making on scene.

High volume service users - We will work collaboratively with systems and other health and care providers to support high volume service users to access appropriate services to support their needs, including patient signposting and developing a more effective joined up care plan approach across organisations.

Trauma

We will ensure our workforce are skilled and prepared to respond to trauma and have 24/7 access to specialised trauma support and advice. This will occur alongside a continued focus on working in partnership with local providers to improve patient outcomes.

Why?

- Every year across England and Wales, c10,000 people die after injury (TARN 2000)
- Trauma is recognised as being a leading cause of severe disability and loss of independence thus the reduction of injury and appropriate management is paramount.

Our Vision

Assessment - We will promote the adoption of a harmonised Major Trauma Triage tool to align with other local ambulance services and ensure an evidence-based approach to assessment.

Response - We will introduce a 24/7 complex care remote clinical support team, providing support to crews, improving identification, clinical triage, and improving the deployment of an enhanced care team support. We will ensure that the most appropriately skilled resource is sent to the scene.

Transport - We will ensure that patients are transported to the most clinically appropriate location, first time, pre alerting the hospital.

Enabling the work force - We will deliver an enhanced package of training to enable staff to have the knowledge and confidence to manage trauma.

Data - We will embed learning from incidents across the organisation using data to support our future actions and support health promotion strategies.

Partnership working – We will continue to work through our regional trauma networks to support more effective data sharing and learning from incidents and develop a more collaborative approach to joint training and education.

Case study example

Dad Aamir phones 999 in a panic as his son, Ravi is unconscious after falling off a climbing frame in the park and looks to have sustained a nasty leg injury. A category One call is made and a Paramedic double crewed ambulance, Specialist Practitioner and Air ambulance is deployed, with the first ambulance at Aamir and Ravi's side in 6 minutes.

The Crew and Specialist Paramedic assess Ravi who is now awake and although has serious injuries is able to be managed without the requirement of the air ambulance. The air ambulance is subsequently cleared to be available for other critically ill patients and Ravi is now pain free having been prescribed enhanced medications by the Specialist Practitioner and subsequently taken to the most appropriate hospital. Dad Aamir travels with Ravi to hospital and is grateful that despite his son's broken leg he is now awake and receiving timely treatment in their local hospital and most importantly pain free.

What does success look like?

- All front-line staff will feel confident and well equipped to manage a major trauma.
- A consistent approach to triaging trauma patients across the region, driving out clinical variation and ensuring a standardised approach across providers
- Senior specialist clinical advice and decision making available within the Trust 24/7 to support front line crews' decision making and ensuring the most appropriate and timely clinical resources are sent to support
- Improved patient outcomes by working in partnership with key local providers of trauma care.

Cardiac Conditions

We will rapidly identify patients experiencing time critical cardiac events via our 999 remote triage processes, and dispatch appropriate clinical resources without delay to provide swift and expert care and transport utilising acute pathways with partner NHS Trusts to ensure the patient arrives at the right place first time.

Why?

- Heart disease covers a range of conditions that affect the heart: including blood vessel disease, irregular heartbeats, congenital heart defects, disease of the heart muscle and/or valves and is one of the main causes of death and disability in the UK.
- Cardiac chest pain is the second most frequent clinical conditions responded to across EMAS.
- Sudden cardiac death remains a major cause of death and morbidity in the UK. The incidence of out-of-hospital cardiac arrest (OHCA) is approx. 55 per 100,000 people. 72% of these occur at home. Resuscitation is attempted in about 45% of cases, of which approximately 20% achieve a return of spontaneous circulation (ROSC) by the time they arrive at hospital, and around 5% survive to leave hospital (Survival to Discharge).
- Improving outcomes & survival for OHCA remains a top clinical priority for EMAS & our 2021-2026 EMAS Resuscitation strategy "Saving more lives from out of hospital cardiac arrests" actions need to continue be implemented. This specific strategy must remain a core component within our future clinical strategy.
- Treatment of cardiac conditions can be time dependant and requires rapid identification, intervention, and conveyance for further time critical treatment.
- Many types of heart disease can be prevented or treated with healthy lifestyle choices.

Our Vision

Assessment - We will ensure rapid identification of critically ill cardiac patients and support improved coordination of the correct clinical skills and resources to scene, through the development of a complex care clinical support team.

Response – Educate the public to perform cardio-pulmonary resuscitation (CPR) and use an automated external defibrillator (AED) to support out-of-hospital cardiac arrests and ensure where appropriate community first responder volunteers are deployed to commence timely resuscitation, with front line crews and volunteers being supported by Cardiac Arrest Leader (CAL) trained clinical leads.

Transport - We will ensure the patient is transported to the most appropriate hospital setting, first time and use an early pre alert to ensure timely access to treatment on arrival.

Enabling the work force – We will ensure our teams are appropriately trained to identify, manage, and treat a range of cardiac conditions and ensure our front-line staff will have 24/7 access to senior clinical advice to support decision making and management of risk.

We will continue to increase, support, and adequately train our growing network of community first responders across our footprint to support out of hospital cardiac arrest outcomes.

We will continue to increase our Cardiac Arrest Leader (CAL) numbers.

Data - We will continue to work towards on-going improvements in our national ambulance clinical quality indicator (ACQI) cardiac outcomes measures and review the clinical outcome variations across of divisions. Where these occur, we will develop a specific local action plan to reduce cardiac outcome inequalities.

We will look to share our clinical data with systems where appropriate, to help with the identification of specific risk factors for heart disease (for example, blood pressure measurements)

Partnership working - We will work with partner organisations, the public, and our community first responder schemes to increase the numbers of people trained to provide effective CPR and use of AEDs to support out of hospital cardiac arrests.

We will work with local healthcare providers to ensure our front-line staff have access to appropriate and adequate cardiac pathways to ensure the patient is taken to the right place first time.

We will support public awareness campaigns highlighting the signs and symptoms of heart disease and its associated risk factors and healthy lifestyle choices.

Maya's cardiac journey

Maya called 999 when she felt pressure in her chest and pain in her left arm. Her call was answered by EMAS' emergency operations centre, where her symptoms are recognised as a potential heart attack. The nearest available ambulance is immediately dispatched.

On their arrival, the ambulance crew acts promptly, recognising that Maya's symptoms could indicate that she is having a heart attack. They record a heart trace reading, which confirms that Maya is indeed experiencing a heart attack. The heart trace reading is sent electronically to the specialist cardiac centre, whilst the paramedic initiates emergency drug treatment in her home.

Maya is transported in the ambulance with blue lights and sirens. When they arrive at the hospital, the specialist cardiac team are on standby, waiting to take Maya directly to the operating theatre where she will receive an operation to unblock the artery in her heart that is causing the heart attack. Less than 45 minutes ago Maya was calling 999, now she is in the right place, receiving treatment that will save her Life.

What will success look like?

- Increased rates and confidence by individuals to undertake bystander CPR and use public accessible defibrillators (AED) – prior to the arrival of our frontline crews.
- More rapid identification by EMAS of a working cardiac arrest / active resuscitation, ensuring rapid response by the right clinicians and resources to improve out-of-hospital cardiac outcomes, with staff feeling appropriately skilled and supported to ensure delivery of high-performance CPR.
- Reduction in cardiac inter-hospital transfers where patients have not been transported to the right place first time.
- On-going improvements in our EMAS metrics across our cardiac clinical and quality indicators, leading to better clinical outcomes and a reduction in outcome variations currently evident across our footprint.
- Patients with acute coronary syndrome and STEMI (a type of heart attack) will receive swift identification and rapid transportation to a specialised PPCI (primary percutaneous coronary intervention) facility for life-saving intervention.

Respiratory Conditions

We will triage, remotely and in person, and signpost patients experiencing respiratory symptoms to the most appropriate individualised care setting for them. Be that community-based care with partner agencies, patient self-care, or emergency care delivered by our skilled clinicians and partner acute trusts.

Why?

- Respiratory disease affects one in five people and is the third biggest cause of death in England. Lung cancer, pneumonia and chronic obstructive pulmonary disease (COPD) are the biggest causes of death.
- Hospital admissions for respiratory disease have risen at three times the rate of all admissions in the last seven years.
- During winter, respiratory disease admissions double in number and are a major contributing factor in the winter pressures the NHS experiences every year.
- Incidence and mortality rates from lung conditions are higher in areas of deprivation and in disadvantaged groups, leading to worsening health inequalities and poorer outcomes. Our more deprived areas tend to have higher smoking rates and exposure to higher levels of air pollution, poorer housing conditions and greater exposure to occupational hazards.

Our Vision

Assessment - We will develop a patient centred triage and assessment approach to patient's experiencing respiratory conditions, supporting enhanced clinical prioritisation to determine the timeliness of intervention needed and helping to identify the right clinical skill set required to support, be that within EMAS or in the wider health and care services, or through self-management strategies.

Response - Our enhanced clinical assessment will support a wider range of responses, from deploying the most appropriate clinical resource within EMAS or the wider health and care setting, through to appropriate utilisation of virtual wards and patient self-care.

Transport - We will ensure those patients requiring further acute intervention are taken to the right place first time, streamlining our handover and referral processes to ensure patients receive prompt and efficient care.

Enabling the work force – We will ensure our workforce has the necessary equipment, training, and resources to undertake high-quality respiratory assessments, to not only support patients' emergency and urgent care requirements, but also provide appropriate prevention and future self-care management support.

Data - We will improve our data capture capabilities to be able to analyse and monitor wider aspects of respiratory care within EMAS to drive improved respiratory clinical outcomes.

Partnership working - We will work with partners to improve direct access to emergency and urgent respiratory pathways and specialist advice for our crews, so they are supported in clinical decision making, and we can ensure our patients arrive at the right setting to manage their care in a timely and effective manner.

We will work with systems to further develop our ability to support and effectively utilise virtual respiratory wards or hospital at home services, to support patients to stay at home where this is clinically appropriate.

We will work with systems to develop our respiratory prevention offer, utilising a making every contact count approach (e.g., smoking cessation advice, flu and covid vaccination support, improving patient's inhaler techniques)

Matthew's Respiratory Journey

Matthew's day took an alarming turn when he suddenly found himself struggling to breathe due to an exacerbation of his asthma. Panic set in as he gasped for air, and his concerned partner immediately dialled 999, recognising the urgency of the situation.

The call reached the emergency operations centre, where a clinician skilfully assessed the situation. Providing tailored advice, they worked to calm Matthew's partner while identifying that this call might be appropriately managed by a Specialist Practitioner. This decision was made in alignment with the goal of optimising patient care and resource allocation.

Swiftly, the Specialist Practitioner was dispatched to the scene, arriving promptly. With a thorough assessment, they confirmed that Matthew was indeed experiencing an acute episode of asthma. Their expertise came into play as they administered appropriate treatment on-site, including supplying essential medications to support Matthew's recovery.

The Specialist Practitioner also referred Matthew to the community respiratory team for follow-up, ensuring that his asthma management was comprehensive and sustainable, avoiding the need for hospital admission.

Thanks to the collective efforts of the healthcare staff, Matthew's asthma was managed comprehensively, and he could look forward to continued support towards better health.

What does success look like?

- Crews feeling more confident and educated to support patients who are clinically appropriate to stay at home, reducing unnecessary hospital admissions.
- Increased ability to directly access respiratory pathways and specialist advice.
- Increasing utilisation across systems of respiratory virtual wards, where appropriate to do so.
- Greater uptake of flu and covid vaccinations in our populations and reduction in smoking rates, with a greater focus on upstream prevention.
- Patients feeling more confident to appropriately manage their respiratory long-term conditions resulting in less need for emergency and urgent support, and in more control of their own health needs.

Mental health

We will ensure that patients experiencing mental health crisis will be treated and referred appropriately, whilst ensuring that the least restrictive options are used.

Why?

- Every year, one in four of us experiences mental health problems. The covid-19 pandemic has impacted this further with more people than ever requiring mental health services and support.
- Mental health is now one of the top reasons for 999 calls, and our patient transport services facilitate conveyance of patients requiring movement between facilities.
- When experiencing a mental health problem, access to timely, effective support and treatment can change your life.
- The ambulance sector has a key role to play in ensuring patients, especially those in crisis, receive timely assessment and appropriate treatment or referral.

Our Vision

Assessment - We will provide 24/7 clinical support, access, and signposting to other pathways through Mental Health clinician capacity in our Emergency Operations Centre as part of expanding our mental health clinical capabilities. We will ensure there are strong links with our high-volume service user team for frequent 999-callers with mental health concerns, to provide a more comprehensive care planning approach.

Response - We will deliver the right care, right person model, working with partner organisations to ensure patients continue to receive the care and support they need to remain safe from harm.

In partnership we will identify and develop appropriate care pathways to reduce avoidable hospital admissions, with specific response pathways for priority groups including children and young people, dementia patients and patients with learning disabilities and autism.

Transport - We will mobilise mental health vehicles driven by suitably trained mental health clinical teams for patients in mental health crisis to enable triage and treatment at home where local vehicles have been procured via ICS partners.

Enabling the workforce - All front-line staff will have the knowledge and skills required to provide or support provision of high-quality care for patients presenting with a mental health condition or presentation.

Data - We will strengthen our capacity and capabilities to develop and monitor key mental health clinical metrics and outcomes within EMAS and work with systems to share this intelligence to build a better understanding of wider system mental health outcomes.

Partnership working- We will work with partners across our systems to deliver against the NHS long term plan (2019) ambitions.

Leah's journey

EMAS call handlers receive a 999 call from Ethan who says his partner, Leah is experiencing shortness of breath. An ambulance is sent to Leah's house. On arrival, the crew undertake a clinical assessment and examination and find Leah's physical observations are normal. However, Leah is highly anxious and admits to experiencing suicidal thoughts. Her shortness of breath symptoms have been a sign of her underlying anxiety and distress.

Because of the EMAS crews training they are able to support Leah to reduce her anxiety levels and undertake a mental health risk assessment, using skills learnt from the Mental Health training they have received.

The crew identify Leah does have some coping strategies and support networks currently in place, predominantly her partner, Ethan and her teenage son, Aiden. Ethan says that he feels he can support her in the immediate term to keep her safe, but that she does need some intense support more urgently to manage her suicidal thoughts.

The crew contact the local mental health crisis team, who agree that Leah is safe to be left at home with her partner with a plan for the Crisis Team to take over her care. This onward referral is made and the crew leave scene. Following the urgent referral the crisis team undertake a further phone call assessment with Leah that day and a subsequent visit the following morning to more fully assess her needs.

Leah is able to undertake her recovery journey at home with the expertise and support of her local mental health team. She understands the physical symptoms that she may experience as someone who suffers anxiety, and feels better able to cope with these and her on-going mental health needs moving forwards.

What does success look like?

- Patients can access appropriate clinical support via hear and treat and signposting.
- Staff members will be better equipped to respond to mental health crisis managing risk on scene and reducing conveyance.
- Patients will be able to access mental health support through the no wrong door approach and will only have to tell their story once.

Falls

We will proactively prevent fall related hospital admissions where appropriate, with a focus on trying to reduce the time a person is on the floor. Where people have spent extended time on the floor, we will work with system partners to reduce admissions where appropriate by supporting the development of alternative pathways to support and further assess out of hospital.

Why?

- 40% of ambulance callouts to homes for people aged 65+ are falls related.
- In 2021, EMAS received 58,743 calls for falls, half of these patients were conveyed to hospital.
- Being in a hospital setting combined with inactivity can lead to deconditioning and increasing likelihood of recurrent falls in the future.
- To give people the best chance to stay mobile after a fall, hospital admissions should be avoided where safe to do so.

Our vision

Assessment - We will adopt and deliver a consistent clinical approach to telephone triage for patients who have fallen to ensure the most appropriate resources from within our health and care system is mobilised to support them, thereby reducing the time a person may be on the floor (long lies).

Response - Where appropriate, and other system services are not clinically indicated, we will utilise our Community First Responders to ensure a timely response and prevent patients lying on the floor for prolonged periods.

We will complete onward referrals to falls prevention services to prevent future fall occurrences.

We will develop point of care testing to rule out clinical complications because of people lying on the floor for prolonged periods.

Transport - We will utilise frailty virtual wards and other community pathways, enabling EMAS to safely transfer the care of the patient to another healthcare provider without the need for a hospital admission.

Enabling the workforce - We will utilise the Urgent Care Assistants teams to assist with simple falls pickups (where there is no additional clinical complexity), in the approach of ensuring the right resource is sent to support the right clinical condition.

Data - We will review and analyse data to identify care homes who may require additional support and advice proactively, who are calling 999 for non-injury falls.

Partnership working - We will support community initiatives such as iStumble in care homes, with the aim to reduce inappropriate 999 calls.

Selina's journey

Selina called 999 after she had a fall. She has rheumatoid arthritis and often her knees give way. She struggles to get up as they are painful and don't bend very easily.

The clinician in the Emergency Operations Centre assessed Selina over the telephone to determine who would be best to go and help her.

A local community first response service volunteered to go to assist Selina from the floor, they used a lifting cushion to help her up and she was able to walk some steps.

When chatting to Selina they discovered that she is falling at least once a month and has become nervous about going out and has stopped going into town on the bus.

They updated the clinician and discussed what services were available in the local area to help Selina. She was referred to a strength and balance class to improve her strength in her knees and give her more confidence to go to town and help prevent further falls.

What does success look like?

- A reduction in the number of patients who experience prolonged periods on the floor following a fall, leading to reduced clinical complications and need for hospital admission
- The number of 999 calls for non-injury falls will reduce, with community providers and further pathway developments providing support to prevent further falls.
- Fall risk factors will be identified early, and preventative measures put in place to reduce further incidents and support patients to remain independent and as mobile as possible in the future.

Stroke

We will develop our evidence-based response to strokes focusing on timely response, improving our on-scene assessment and remote consultation capabilities, and enhance timely access to the right specialist care first time to improve patient stroke outcomes.

Why?

- Stroke is the 4th leading cause of death in the UK, and its prevalence is predicted to a rise by 59% between 2019 and 2025.
- In 2021, EMAS attended 2,332 people who were experiencing a stroke.
- There is variation in response times and clinical outcomes for stroke across geographical divisions in EMAS.
- Treatment for stroke is time critical, so improved response times, early identification by crews and ensuring patients are transported to the right place first time significantly improves longer-term patient outcomes.

Our vision

Assessment - We will improve rapid and early identification of stroke through implementing supporting tools for our emergency operations call handlers and on scene crews.

Response - Where stroke is suspected, we will ensure a timely clinical assessment is undertaken by suitably trained front-line clinical staff, with a focus on reducing on scene time to ensure patients are admitted to hospital as quickly as possible.

Transport - We will ensure the patient is transported to the appropriate hospital setting first time (to avoid subsequent inter-hospital transfers) and use an early pre alert to ensure timely access to treatment on arrival.

We will work with system partners to explore the development of an innovative mobile stroke unit to support assessment and treatment closer to the patient's home, with subsequent transport to the right hospital setting.

Enabling the work force - Our staff will have additional education and clinical supervision to support rapid detection of a suspected stroke and reduce on scene time.

We will work with local specialists to enable access to an on-call stroke consultant to aid with decision making and appropriate transport to hospital.

Data - We will ensure current stroke data continues to inform and shape on-going improvements in appropriate ambulance deployment, with effective and consistent completion of Electronic Patient Records to support with safe and high-quality hospital handovers.

Partnership working - We will work in partnership with systems to promote public awareness and education related to identifying early signs of a stroke and associated preventative risk factors.

We will work with systems to develop pathways to support our teams with onward referral for patients whose stroke symptoms have resolved (i.e. Transient ischaemic attacks).

What does success look like?

- Patients who are experiencing a stroke will receive a timely emergency ambulance response and will be conveyed rapidly to an appropriate facility to improve their outcomes.
- Staff will feel confident and supported when making decisions on scene.
- EMAS will play an active role in public education and awareness.

Population Cohorts

Maternity

We will deliver high quality compassionate care for individuals with maternity care needs, recognising the need to reduce inequality and improve access to maternity services.

Why?

- EMAS provides care to over 8,000 patients annually who present with maternity related healthcare issues.
- Little focus has been paid within national agendas to the care provided to woman and babies outside of planned maternity and obstetric care, but this is of equal importance to ensure high-quality care is provided at every point of contact with equitability in access to services for pregnant, postpartum, and neonatal patients being equally critical.
- A recent CQC report "key areas for improvement in maternity services" highlighted that every pregnant woman wants a positive birth experience and every staff member working in this area wants to provide safe, high-quality care. That said when things go wrong the consequences for mothers, babies, their families, and staff can de devasting.

Our Vision

Assessment - We will improve our maternity remote assessment, co-ordination, and support functions to improve recognition of maternity associated risks, develop a patient centred care approach to mothers, birthing persons, and their babies and ensure their needs are supported by the most appropriate clinical responses.

Response - We will develop maternity decision support tools for front line staff and build in a remote clinical maternity support offer for crews into our clinical operating model to support clinical decision making on scene and improved clinical outcomes.

We will strive to ensure we have appropriate equipment, medications and wider treatment options related to maternity care available to ensure our clinicians can deliver best practice evidenced base care.

Transport - We will develop direct and consistent access to specialist maternity teams and hospital pathways ensuring our mothers, birthing persons and babies go to the right place first time.

Enabling the work force – All front-line staff will have the knowledge and skills required to provide or support provision of high-quality care for patients requiring maternity care.

We will support our maternity improvement work through the appointment a Trust Consultant Midwife to provide specialised clinical leadership and expertise to deliver our maternity objectives.

For those clinical staff most likely to be involved in more complex maternity care cases we will consider and scope further maternity training requirements i.e., PROMPT programme.

Data - We will enhance our maternity data capture to support the development of a range of maternity clinical outcomes to help monitor and evaluate our on-going improvements.

Partnership working - We will work in collaboration with local maternity services to ensure our maternity pathways are safe and effective and with other ambulance trusts to ensure we continue to share best practice and learning across the sector.

Emily's Journey

Emily is 38 weeks pregnant when she experiences at sudden onset of labour symptoms at work and a colleague calls 999. During the call a senior clinician screens the call and identifies that Emily has a known breech (baby not lying with its head presenting first) presentation with risk factors and this is recorded in her patient held electronic notes. The senior clinician contacts the responding clinicians to highlight that there is a significant risk factor and ensures they are aware of the need to prioritise early transport, if safe to do so and also ensures that they are aware the senior clinician is available for guidance if needed. The clinical team arrive and rapidly assess Emily's needs and calmly explain their plan and ensure that her wishes are heard and met. The crew convey Emily to an obstetric unit with a clear pre-alert to ensure that they are aware of the incoming case and can prepare for her arrival.

The receiving team meet the crew on arrival and a structured handover is provided ensuring that key information is provided and also that Emily's wishes regarding birthing support are clearly stated and understood.

What does success look like?

- A reduction in the number of maternity related incidents on scene and during conveyance as staff feel confident and appropriately trained to manage maternity care.
- Appropriate conveyance of mothers, birthing persons, and babies to the right location, first time, ensuring if speed is of the essence that this is timely to improve clinical outcomes.
- Mothers, birthing persons and their families having an overall improved patient experience if they have required our help and support.

Children And Young People

We will work towards improving the health outcomes and reducing healthcare inequalities for service users who are Children and Young People. We will develop our services to meet the needs of patients and staff to reduce avoidable harm (including physical and psychological) and promote wellbeing.

Why?

- Ambulance call outs to children and young people (CYP) are rising. In 2022/23 EMAS attended 103,281 calls to this group, up 15% more than in 2017/18
- Mental health presentations, stabbings and overdoses have risen significantly in this group following the COVID-19 pandemic.
- Ensuring children and young people have the best start to life in their health, development and education is a priority in many of the local health and care systems. Appropriate emergency and urgent care services to support children and young people will be important to help support this priority.

Our Vision

Assessment - We will look to develop access to specialist children and young people's clinical advice to support our clinical assessment function as well as to support our clinical decision making on scene.

Our assessment process will identify critically ill children and young people, and support and coordinate the most appropriate clinical resource and skillset to support their needs.

Response - We will look to improve our access to advanced and specialist children and young people practitioner expertise to increase hear and treat and see and treat and support crews with decision making and clinical risk on scene.

Transport - Where we need to transport, we will convey children and young people to the most appropriate facility for their needs ensuring inclusion of parents/ carers to accompany them to ensure a compassionate approach.

Enabling the workforce - We will work in collaboration with our partner organisations to offer enhanced children and young people's specific training and use feedback from incidents to inform learning and improve clinical outcomes.

Data - We will review and analyse our children and young people's data to identify if there are variations in clinical conditions and presentations across our footprint.

Partnership working – We will work in partnership with system partners to share our data and intelligence to help inform and tailor further development in services to support this patient group.

Case study example

Ola is 'generally unwell, with a lethargy and a high temperature'. Her mum calls 999 because she is worried about her not being her usual self. The Emergency Medical Advisor asks questions about Ola's symptoms and advises that a clinician will call her back within 2 hours to further assess her condition.

The EMAS Clinical Assessment Team within the ambulance emergency operations centre call Ola's mum to determine the most suitable course of action. The senior clinician completes a remote video triage assessment with them and discusses with mum, that they feel an ambulance is not necessary at this time due to the clinical nature of her condition and provides further reassurance and advice.

A referral is made to GP services locally where a GP assesses Ola and diagnoses her with a viral throat infection and provide mum with advice and support on how to manage this condition symptomatically.

What does success look like?

- All front-line staff will feel confident in clinically managing children and young people needs.
- Front-line staff being able to access specialist children and young people advice to support with decision-making.
- Better joined-up services and pathways across ICS' for children and young people to help us access the right support for them at the right time in the right place.

End of life (EOL) care

We will deliver high quality compassionate care for those individuals with end-of-life care needs through the delivery of the 6 national ambitions set out in the end-of-life care framework.

- ***Each person is seen as an individual.***
- ***Each person gets fair access to care.***
- ***Maximising comfort and wellbeing***
- ***Care is co-ordinated.***
- ***All staff are prepared to care.***
- ***Each community is prepared to help.***

Why?

- It is nationally recognised, exacerbated by the Covid-19 Pandemic, that end of life (EOL) care must be a priority for action for health and care systems.
- The 2008 National strategy for EOL care in England provided 3 key insights: that people don't die in their place of choice, we need to prepare for larger number of people dying (due to our ageing population) and that not everyone at their end of life receives high-quality care.
- Focus should be placed on reducing avoidable admissions, considering the personal needs and wishes of people receiving end of life care and their families or carers.

Our Vision

Assessment - We will work with systems and community services to promote and increase completion and sharing of RESPECT (EOL care plans) forms to inform our staff of the patient's wishes for clinical assessment and prior to any ambulance crew arrival.

Response - Care will be person centred and individualised, taking the patient's needs and requests into consideration and working with other partners to ensure timely wrap round support is provided as needed to support the patient and any carers, for the person to remain at home (where this is their wish).

Transport - Our non-emergency patient transport service will respond to EOL journey requests in a timely manner to ensure patient's wishes are upheld and supported when they wish to receive end of their life support in their own home. In addition, we will support our NEPTS staff with further EOL training to ensure they feel enabled to support patients and their families and carers, in end-of-life situations.

Enabling the work force - We will deliver specific education and training to front line staff to enable them to deliver person centred, compassionate end of life care with confidence.

We will provide specialist equipment and medication to support dignified dying.

Data - We will support the system to improve data quality and information sharing so that patient's needs and desires are being recorded and communicated effectively with EMAS teams.

Partnership working - We will work in collaboration with local palliative care teams, providers, and hospices to improve delivery of co-ordinated care for our patients and shared learning and training opportunities.

What does good look like?

- Achieve the six national ambitions for EOL care.
- All front-line staff will be confident in delivering EOL care and will have access to appropriate support during and after.
- Systems and community services will work together to increase appropriate identification of people who would benefit from completing a proactive care plan and RESPECT form to ensure any future care can be delivered in line with their wishes

Frailty

We will support effective prevention, identification and management of frailty supporting the appropriate decision making on scene.

Why?

- Frailty refers to a person's mental and physical resilience, or ability to bounce back and recover from events like illness and injury.
- Frailty (rather than age) helps us identify people at greater risk of future hospitalisation, care home admission or death.
- In the UK approximately 14% of people over the age of 60 may be frail, and about 65% of those aged over 65.
- Frail patients are likely to decondition through reduced movement whilst in hospital reducing their independence on discharge. For this reason the national ageing well programme focuses on preventing unplanned admissions for frail and elderly patients.

Our Vision

Assessment - We will proactively assess patients for risk factors for frailty to ensure early identification and intervention.

Response – We will support identification of frailty using the clinical frailty scale, additional frailty training and education for our staff and through more effective use of our EMAS clinical data.

We will implement a decision support framework for crews to support decision making and risk management.

We will support crews to access alternative pathways for frail patients where staying at home is clinically appropriate e.g., such as frailty virtual wards and urgent community response teams.

Transport - Where possible and clinically appropriate, we will aim to reduce conveyance to hospital to prevent inactivity related decline associated with hospital stays for frail patients.

Enabling the work force – we will ensure appropriate training of our workforce to support frailty.

We will develop advanced practitioner roles to further support management of frailty to support complex care decision making and management.

Data - We will use our data to help identify patients at risk of frailty associated illness and share this with systems and other health and care partners.

Partnership working - We will work with system partners on frailty prevention and early identification campaigns.

we will work with systems to enhance and develop further pathways to support patients (and their carers) with frailty to remain at home, where clinically appropriate.

What does success look like?

- All front-line staff will feel confident and well equipped to identify and provide person-centred care for those with frailty or at risk of frailty.
- A consistent approach to identifying and recording those with frailty across the region and ICS', supporting front-line staff to access accurate and up-to-date information on a person's risk of frailty.
- System partners supporting the development of specialist frailty advice and decision-making support tools to ensure the most appropriate support is provided in the most appropriate place for the person's needs.
- A reduction in clinically unnecessary hospital admissions for patients with frailty and an increase in the support available to patients to allow them to remain at home where possible.

High Volume Service Users (HVSU)

We will work collaboratively with systems and other health and care providers to support high volume service users to access appropriate services to support their needs, including patient signposting and developing a more effective joined up care plan approach across organisations.

Why?

- As part of the 2019/20 operational planning and contracting guidance, all health systems in England must implement a High Intensity User Service.
- By supporting high volume service users to access the most appropriate services, we will enable these patients have their needs supported whilst reducing inappropriate use of ambulance service and wider health and care resources.

Our Vision

Assessment - We will take a holistic approach to assessing high volume service user needs, working in collaboration with the national frequent caller network and system partners.

Response - We will ensure high volume service users are supported and signposted to the most appropriate service for their on-going needs. This may involve supporting the patient to access wider provision such as a general practice, community, or mental health services.

Transport - We will work with system partners to better support these patients in a more proactive joined up way within the community.

Enabling the work force – Staff will have the skills and training for managing on scene patients identified as high-volume service users and be able to access wider clinical support and advice through our enhanced clinical assessment support function.

Data - We will work with systems to share data and intelligence on high volume service user patients to ensure effective proactive identification and ensure a more holistic joined up care approach is delivered to this group of people.

Partnership working - We will actively engage with system partners to collectively understand and address the issues and potential care gaps facing high volume service user patients and ensure we provide appropriate management in line with the national guidance[1]

[1] *Supporting High Frequency Users (HFU)through proactive personalised care, delivered by Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Coordinators – October 2022*

What does success look like?

- High volume service users will be supported to access community services and resources.
- We will shift our response towards hear and treat, reducing unnecessary deployment.

Proactive Care – Prevention, Personalisation & Supporting Health Inequalities.

We will promote an organisational culture that champions reducing health inequalities and supporting preventative healthcare as core business.

The East Midlands is home to a diverse population. Whilst the average deprivation levels seen across the east midlands is lower than the national average, this doesn't reflect the more localised health inequalities patterns experienced in certain parts of the region. An earlier section in the strategy illustrates the unique challenges faced by each of our EMAS Divisions and integrated care systems.

Prevention and health inequalities are part of everyone's role at EMAS.

As an ambulance service, our staff are uniquely placed to deliver effective primary prevention. By entering the homes of patients, our staff have the privileged opportunity of observing the day-day behaviours and living conditions of our patients that can impact their overall health and wellbeing. Where risk factors are observed, our staff need to be supported and enabled to respond to these issues and consider what maybe the most appropriate preventative measures that need to be put in place. As part of a newly developed association of ambulance chief executives (AACE) health inequalities self-assessment tool, we will be able to assess and benchmark ourselves as a trust in year one of this strategy.

To enable us to realise our ambition to be an organisation that champions reducing health inequalities and supporting preventative healthcare, we will:

1. Provide training to our staff to enable them where appropriate, to deliver preventative health care (including self-care support) and consider ways to address health inequalities confidently and proactively.
2. Look to "Make every contact count" by asking patients "what matters most" to them, identifying and responding to risk factors and delivering preventative health care interventions opportunistically.
3. Support broader public health campaigns and initiatives in collaboration with our local health and social care systems.
4. Improve our data collection and capture to improve our Trust understanding of how health inequalities and equity issues are experienced in our divisional populations.
5. Enhance our data sharing capabilities to help inform wider system health inequality and prevention approaches and priorities.

What does success look like?

- Staff will proactively promote preventative healthcare and champion reducing health inequalities, using their unique position to assess a patient's wider health and social care needs outside of the primary presenting issue. (e.g., this may look like encouraging those at higher risk to obtain a seasonal flu vaccine, complete a referral to the fall's prevention team where a risk has been identified or promote access to local social prescribing networks).
- Patients will receive a patient centred response from the ambulance service, where we will have considered and understood their individual needs and desires. These individual patient considerations will be communicated effectively at the point of referral / transfer of care, improving the patient experience and ensuring they only have to tell their story once.
- EMAS will look to enhance our ability to capture health inequalities and protected characteristic data, where appropriate. This intelligence will be shared with the integrated care system to further understand where there are care gaps and areas of unmet needs in communities and identify risk and vulnerability.

In the medium to long term, if this approach is effective and implemented successfully, we should see:

- Reduced demand on ambulance services and the wider NHS
- More equitable health outcomes across the East Midlands

Enablers

Our clinical strategy is one of 5 supporting strategies to our overarching trust five-year strategy. It provides further detail on how our clinical delivery will support the realisation of the trust strategy vision and ambitions.

The clinical strategy underpins the other 4 supporting strategies as it describes the way in which we deliver our services. For the clinical strategy to be successful there are several critical enabling functions that will need to be considered, developed, or strengthened if we are serious about achieving our level of ambition as detailed in this strategy.

Critical Enablers

- Data, Analytics, Information and Technology
- Workforce, including our volunteers
- Estates, fleet, equipment
- Optimising medicines
- Research & Innovation
- Culture for change, alongside the right capacity & capability to deliver this

Clinical Workforce Development

Our people are our greatest asset, and our priority is to ensure we can deliver high quality care through our staff and volunteers (our people).

Our People Strategy details our overarching vision, which is to ensure that ***we can deliver safe, effective, compassionate care to our patients through our people.*** To do this we must: ensure the right number of people are in post within our organisation, with the right mix of skills, knowledge, and training to respond flexibly to meet patients' health and care need.

The modelling illustrated in the NHS Long Term Workforce Plan, (June 2023), illustrates that with no intervention, the workforce shortfall across all NHS organisations will be 260,000-360,000 full time equivalents by 2036/37. The biggest short falls expected across staffing groups includes paramedics.

To deliver on our Clinical Strategy, in alignment to our new people strategy, we will need to grow our current workforce, expand our clinical skill mix, and consider new clinical roles that will provide expertise, leadership, and enhanced care options to a range of clinical conditions. In addition, we will need to match our clinical roles more effectively to patients' clinical needs and define the skill set for each level in the context of our new clinical operating model and priority clinical conditions. Alongside this, we will need to ensure we create a culture of trust, psychological safety, and civility to support patient care and colleague wellbeing.

Growing the workforce

We will strive to right size our clinical workforce capacity to build in sufficient people to support increasing demand for our services and calibrate future capacity needs in line with our new clinical operating model.

Right care, right patient, right clinical skills

For our new clinical operating model to be successful, it will require us to more effectively match the right clinical skillset with the patients' needs, through our expanded clinical assessment function and ensuring the most appropriate clinical skill set is sent to the patient. Our strategy implementation plan, we will describe this future clinical workforce model in more detail.

We will develop a wider multi-disciplinary clinical workforce to deliver enhanced clinical support, including advanced clinical support for complex care, as well as access to specialist maternity, children and young people and mental health expertise.

We will increase our access to mental health clinical expertise within the Trust, either through increasing our own staff numbers or working in collaboration with local mental health providers.

We will continue to support our existing clinical roles which are crucial to providing the right level of patient care as part of our operating model and all our roles enable clinical skill progression, from non-patient emergency service roles and volunteers, through to paramedic technicians up to advanced practice.

Creating new clinical roles & rotational posts

Working alongside our current clinical roles, we will develop Advanced practitioner roles to provide advanced clinical skills and expertise (e.g., non-medical prescribing) to support enhanced clinical assessment in our new clinical operating model. These roles can provide clinical leadership and support crews on scene with more complex clinical decision making and play a pivotal role in our integrated MDT function. These roles, while predominantly supporting assessment, will respond to specific clinical conditions and patient cohorts.

These roles will have the clinical skill set requirements to be able to rotate into posts within the wider health and care system. We will explore how collaborative clinical posts between EMAS and different part of our system benefit individuals, develop greater understanding of clinical care delivered in other settings and provide opportunities for learning to enhance care within EMAS.

Our volunteers

Our volunteers are an invaluable part of our workforce, supporting patients with a range of conditions from falls to out-of-hospital cardiac arrests, as well as supporting our non-emergency patient transport offer. As part of our clinical strategy, our aim is to enhance our Community First Response (CFR) 999 response model and introduce two new dedicated roles, in addition to our current model, with a focus on clinical quality:

The roles will be:

- Community Resilience Volunteer Trainer - to support the trust's out of hospital cardiac arrest and clinical quality strategy.
- Volunteer Operations Support Worker – to support A&E and PTS (Patient Transport Services) increased demand and capacity pressures across EMAS.

These roles will focus on optimising the use of volunteers in cardiac arrests and increasing bystander CPR rates. They will work with local communities to support CPR awareness and increase our support in the community through falls recovery services and challenging isolation.

Developing and supporting our workforce

Education and training

To support our staff to deliver safe, effective, and compassionate care, we will provide further training and education opportunities.

Our clinical strategy highlights five training and education areas which we will need priority in the next 5 years

- Clinical groups (Trauma, Cardiac, Respiratory, Mental health, Neurological)
- Population cohorts (Maternity, CYP, EOL, Frailty, HVSU)
- Major incident training and exercising
- Prevention, personalisation, and Health inequalities training
- Medicines optimisation and safety training

We will work with our systems and partner organisations to consider and build joint clinical training and education opportunities for our teams.

We will review our education and training digital platform offers to ensure an integrated and co-ordinated approach to providing a broad range of clinical education options, and an ability for individuals to maintain a portfolio training record.

Clinical supervision and reflective practice

We will improve and develop our offer of clinical supervision to patient facing clinicians. Recognising that supervision can have different forms and functions (e.g., day to day support for issues arising in practice, regular support to promote high clinical standards, educational support etc)

We will look to offer a range of activities that create safe space for reflection, problem solving and learning that reflects what our workforce would find helpful. These in turn will be delivered, monitored, and evaluated by and with front line staff.

Development

We need to ensure development and clinical career progression opportunities are available to all and provide greater clarity to people on how they can move up the clinical career skill set ladder in the context of our clinical operating model and new role developments.

Supporting clinical portfolio opportunities will help EMAS to retain more staff and bring wider knowledge and skills into existing teams.

Clinical Outcomes

We are committed to continuing improvement in our clinical outcomes through the delivery of our Clinical Strategy, ensuring we also build our understanding of what happens to our patients post ambulance intervention. To enable this, we must improve our use and understanding of clinical data, as well as growing our capabilities and capacity to measure a wider range of clinical outcomes measures as a trust, and in collaboration with local health and care systems.

Our current key clinical outcome measures are:

Nationally identified ambulance quality Indicators:

- Return of spontaneous Circulation after cardiac arrest (ROSC) at hospital
- Survival at 30 days after a cardiac arrest
- Utstein Subcategories for ROSC and Survival
- Post ROSC care
- Outcome from segment elevation myocardial infarction (STEMI), a type of heart attack
- Outcome from stroke
- Falls

The following data is also helps us determine the impact of our response:

- Conveyance rates - numbers of patients transported to hospital and other settings vs the numbers we support to stay at home and access other care.
- Serious incidents - acts or omissions in care that result in unexpected or avoidable death, or Unexpected or avoidable injury resulting in serious harm.
- Response times - the time taken for us to arrive with the patient following their 999-call based on national standards defining response speed.

From these foundations, we are keen to expand and develop further EMAS clinical outcome measures so we can monitor and evaluate our clinical effectiveness and on-going improvements to ensure these truly improve patients' clinical outcomes. We will need to build and grow our analytical and intelligence capabilities and capacity to achieve our ambitions to go further than the current national NHS clinical quality indicators.

For this to be achievable we will need to:

- Improve and ensure consistency of approach to our clinical coding across EMAS and our third-party provider organisations.
- Enhance our analytical support and underpinning infrastructure to ensure we can make sense of the information we are capturing.
- Develop our future Electronic Patient Record system in line with these ambitions.

- Work in partnership with local health and care partners to enable data sharing between us for us to develop patient clinical outcome measures post-handover and greater system visibility across the full spectrum of a patient pathway.

Research, Evaluation, and Innovation

Research is the cornerstone of developing an evidence-based medicine approach within the NHS.

The recent NHSE National Research Plan identified that 'Research is vital in providing the evidence we need to transform services and improve outcomes e.g., in developing new care models, redesigning urgent and emergency care". It noted that, 'By fully integrating research into our organisation we can outperform organisations that do not, leading to better quality care and improved use of resources.' Research and innovation are also an essential part of 'Next steps on the NHS five-year forward view'.

Within EMAS, we see research as not just an added extra, but as an essential component in developing an evidence-based approach to learning and future clinical development.

Our ambition is that EMAS will be at the forefront of pre-hospital care improvements and innovation by making "research everyone's business". Allowing healthcare professionals within the organisation access to the most recent clinical care evidence, whilst at the same time leading the way and working in collaboration with others to investigate and research areas which may benefit future patient care.

As a trust we will:

- Continue to develop our EMAS Clinical Audit and Research Unit, providing a supportive and professional environment to enable continued professional development through research and evaluation.
- Ensure the latest evidence is used to develop guidelines and pathways within EMAS and wider health and care partners to ensure "the patient gets the right care, at the right time, in the right place".
- Develop a model of "Research Champions" throughout the organisation, who will support dissemination of evidence-based learning internally and proactively support the development of research, innovation, and evaluation within the organisation.
- Continue to develop and enhance the Clinical Analytics function within the trust to provide timely data and intelligence to support wider decision making and evaluation within the trust and ensure this function is linked in with systems and other partners to enable us to share and learn more broadly.
- Embed a consistent evaluation approach towards any service changes or new innovations that are introduced within the trust and ensure learning is shared not just within EMAS but more widely across systems.

- Foster a culture of innovation and "curiosity" across the whole organisation, ensuring that everyone feels able to suggest improvements and new ideas.

Clinical and Quality Governance

In the future, a fully integrated clinical and quality approach to our Trust Clinical Governance will allow for our clinical and quality improvement strategies to become intertwined and reliant on each other to succeed.

We need to ensure we have the right Quality assurance processes in place, allowing us to assess our services against a set of essential standards across the domains of quality. This will require robust governance arrangements and leadership commitment at all levels of the organisation to achieve. We plan to ensure our overarching clinical governance processes are fit for purpose, not duplicated, and will have an agreed "one version of the truth" approach to help us assess our success.

The importance of medicines optimisation in clinical care

As medicine advances and health needs change, we are seeing more complex clinical care with the need to access the right medicines and skills at the point of care. It is important that we carry the right medicines to meet patient's urgent and emergency care needs whilst empowering patients and staff in the safe use of medicines. Reducing our medicines waste and the impact on our carbon footprint needs to remain a priority.

We need to consider future medical advances and digital solutions. This will help us to provide more joined up care as well as deliver treatments in a mobile setting. In parallel, we will need to ensure staff have the right knowledge and skills to support this. To achieve these ambitions, we will develop a medicines optimisation improvement plan to ensure this critical enabler to our overarching strategy is given the priority focus it requires.

What will success look like?

Specific measures of success will be developed for each of the clinical strategy objectives aligned to the trust strategy measures and the integrated board report. These will include the measures shown below.

- ↑ Safe, effective, and compassionate care
- ↑ Right care, right place, right person
- ↑ Co-ordinated care
- ↑ Patient outcomes
- ↑ Preventative healthcare
- ↑ Patient experience
- ↑ CQC rating
- ↑ Ambulance Clinical and Quality Indicators

- ↓ Health inequalities
- ↓ Response times
- ↓ Inappropriate ambulance dispatch

How is the Clinical Strategy different to our current provision?

- increase our 'hear and treat' and 'see and treat' contacts, shifting away from always providing an ambulance and taking patients to hospital.
- increase the skill mix of our workforce to achieve better patient outcomes for all clinical and population groups.
- increased proactive, preventative approach to support the demand on the whole health and care system.
- Increased focus on improving clinical outcomes

Delivering this strategy

The Clinical Strategy launch is a key deliverable in the 2023/2024 EMAS Business Plan under the ambitions of 'Delivering outstanding patient care' and 'Safe, effective, compassionate care'.

Beyond this, the Quality and Governance Committee will have oversight of Clinical Strategy delivery with quarterly reports based on the objectives outlined in the Clinical Strategy and associated action plans. Sub strategy delivery will also be included in the six-monthly strategy updates to the Board.

Summary

We are delighted to have been able to work together developing our new clinical strategy. This has been a collaborative endeavour involving colleagues from across our organisation as well as input from patients and our wider health and care systems. This work has helped us define our strategic ambitions around three key areas, our future clinical operating model, our ten clinical and population group priorities and how these will impact on our clinical workforce. Our future ambition (supported by our new clinical operating model) will see a shift from a purely ambulance response approach to working with systems and partners to support patients to receive the right care, at the right time, by the right person in the right setting as defined by their clinical need.

Thank you to everyone who supported its development and shared their thoughts and ideas, whether that be from within our EMAS team or more broadly across our patients and our health and care partners.

We look forward to the next phase of this clinical strategy where we need to put these words into action. For this to be successful we will all need to continue working together to create and build the future we want to see.

We look forward to continuing this journey together and bringing this strategy to life.

Nicole Atkinson, Medical Director **Ben Holdaway, Director of Operations**

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Pathways 2023 Summary

NHS East Midlands Ambulance Service NHS Trust

In 2023 there were a total of:

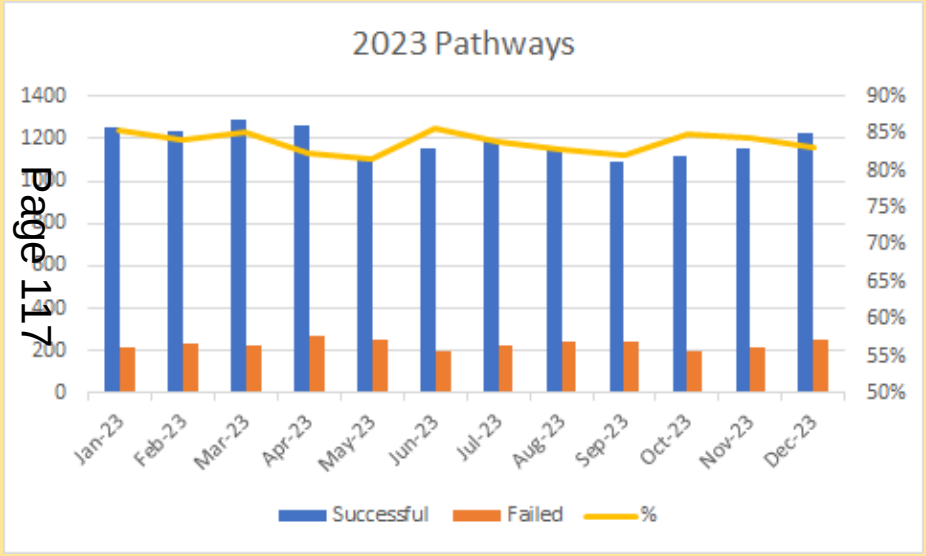
14,499 Successful pathway referrals

2,816 Unsuccessful pathway referrals (including pathway refused, no capacity, pathway closed & patient refused)

With a success rate of **84%**

The most used pathway was **GP Surgery** with **4,067** referrals/signposting

The most successful pathway was **Consultant Advice** with **97%** success rate



Conveyance Rates:

Lincolnshire received **202,027 999 calls** with **146,124** receiving a response.

93,969 patients were conveyed to hospital (**64%**)

85,969 patients were conveyed to ED (**59%**)

8,000 patients were conveyed to a Non-ED destination, meaning a pathway was used for **9%** of all patients conveyed.

Pathway Usage:

Pathways were used during **11%** of all incidents, up from 8% in 2022.

Top 5 stations for highest pathway use:

Bourne = 20%

Grantham = 16%

Louth, **Mablethorpe** & **Skegness** = 15%

(individual station data to follow via email)

What we did:

- Age UK Falls Response Service for CAT Team
- UCR Falls Response Service for CAT Team
- Call Before Convey for PCH
- Frailty Assessment Unit at Grantham
- Grantham UTC 24/7
- Head Injury Pathway for ULHT
- Oncology Pathway for NLAG & HUTH
- Worked with other healthcare providers to improve pathway access & referral rates
- Worked with community providers to directly refer incidents to them from our waiting calls (e.g. UCR, falls teams, CAS/SPA)
- Regular reviews with all pathway providers and ICBs to work collaboratively and maximise improvement

This data comes from the Pathways questions you complete on your ePR so please continue to document your pathway use accurately.

Contact **lincolnshirepathways@emas.nhs.uk** with any queries or issues

What's coming:

- Working with Lincs CAS, North & North East SPA to increase the number of calls automatically transferred to them to avoid inappropriate ambulance responses.
- Development of new pathways in all areas of Lincolnshire, both within the community & at acute sites
- Continue to review existing pathways to measure effectiveness
- Continue to monitor referral data and highlight barriers to the pathway providers to improve interprofessional relationships and encourage collaborative working

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

Open Report on behalf of NHS Lincolnshire Integrated Care Board and East Midlands Ambulance Service NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**24 January 2024**
Subject:	**Non-Emergency Patient Transport**

Summary:

This report provides an update from NHS Lincolnshire Integrated Commissioning Board (ICB) and Non-Emergency Patient Transport Service (NEPTS) for the period since the previous report considered by the Committee in February 2023 to date.

The NEPTS contract for Lincolnshire is now operated by the East Midlands Ambulance Service NHS Trust. All NEPTS services included in the contract are managed by EMAS. The new contract for NEPTS in Lincolnshire was awarded to East Midlands Ambulance Service with the service commencing on 1 July 2023.

EMAS NEPTS and Lincolnshire ICB have been asked by the Committee to return following the go live date to provide an update on the current service provision.

Actions Requested:

The Committee is asked to note the contents of this report.

1. Background

On the 15 February 2023 the Committee noted a previous paper, presented by the NHS Lincolnshire Integrated Commissioning Board (ICB) in relation to the Non-Emergency Patient Transport Service (NEPTS). The report updated the committee that from the 1 July 2023 East Midlands Ambulance Service NHS Trust (EMAS) would be the new NEPTS provider for Lincolnshire. The Committee requested a further update from the ICB and EMAS once the service provision was in place and had embedded for a short period of time.

Following the contract award and a period of planning, EMAS NEPTS successfully mobilised and went live on schedule and without any break in service provision for patients and healthcare stakeholders. All staff eligible through TUPE were transferred to EMAS. Routine ICB contract management processes are also in place.

The ICB have undertaken a modified approach within areas of the contract by transforming the traditional threshold penalty Key Performance Indicators (KPIs) within the contract to overarching aims and objectives focused on timely transport with no excessive waits, in particular, fast track and care home journeys, reducing late night journeys, minimum aborted and cancelled journeys, signposting for patients not meeting eligibility criteria and working with the wider system to deliver emerging new care models. In addition, there is a Local Incentive Scheme (LIS), which is designed to continuously improve delivery in three key outcome areas over the period of the contract:

- Zero re-beds
- Delivery of a social value plan
- Patient and Healthcare professionals' satisfaction and partnership working

Alongside the contractual requirements EMAS has a set of Service Delivery Principles for internal monitoring and measuring to inform continuous improvement of service delivery, this information is shared with the ICB on a monthly basis to inform improvement discussions.

The Lincolnshire NEPTS mobilisation has been undertaken in two phases. The initial phase was designed to support NEPTS staff, patients HCPs with the minimal amount of change or disruption to service, giving the opportunity for all stakeholders to adapt to the change of provider and any system and process change that was required from the 1 July. An example of this being the number of NEPTS base locations and staff rotas across the county remaining the same as the previous NEPTS provider.

Phase two has commenced earlier than anticipated due to the positive response to change from both staff and healthcare system partners, this phase will see changes to rotas to improve resource alignment to activity levels and an increase in base locations across the county, creating opportunities for people wishing to undertake a career in EMAS, reducing staff travel from home to base locations and providing more accessibility of NEPTS to patients in more rural areas and increase collaborative working with Accident and Emergency colleagues.

Current contract performance

Appendix B demonstrates the current Service Delivery Principles performance each month from the commencement of the contract.

EMAS NEPTS have become established as members of the Lincolnshire healthcare system and have links to the local resilience forum. This being particularly beneficial during the recent flooding. The robust Business Continuity Plans within EMAS supported patient flow with minimal service delivery impact ensuring essential patients received their treatments.

Relationship building and collaborative working have been key in identifying improvements in service delivery and continue to be the focus of NEPTS as part of the LIS. Patient, HCP surveys and face to face meeting with groups such as patient voice have commenced. The feedback has already been influential in some areas of service design.
Volunteers continue to be a part of the service delivery model with continual adverts for new recruits live within NHS jobs and new recruits joining training in January 2024. EMAS NEPTS are members of the Association of Ambulance of Chief Executives Volunteer group which supports a consistent approach across the Ambulance Trusts with regards to training and policy. NEPTS Volunteer lead is also undertaking initial stages of collaborations with our Community First Responder team.

2. Consultation

This is not a direct consultation item.

3. Key Strategy Documents

The key NHS guidance for non-emergency patient transport services is set out in the documents *non-emergency patient transport services eligibility criteria*, and *NEPTS: Commissioning, contracting and core standards* which were published in May 2022 and July 2022 respectively. These documents relate to the recommendations in the *Report of the non-emergency patient transport review* published in August 2021 and provide a direction for the future operation of non-emergency patient transport services. The guidance documents are reflected in the ICB approach to the commissioning of patient transport and early insights into this guidance were available prior to their formal publication and were considered in the development of the ICB non-emergency patient transport procurement.

There are no explicit references to non-emergency patient transport in the NHS Long Term Plan, the Lincolnshire Joint Strategic Needs Assessment or the Lincolnshire Health and Wellbeing Strategy. It is, however recognised that the provision of non-emergency patient transport supports eligible patients to access hospital and other healthcare services and, in this way, contributes to the delivery health and well-being in Lincolnshire. The EMAS five-year Clinical strategy embeds NEPTS within the plan along with Emergency and Urgent Care.

4. Conclusion

EMAS NEPTS services in Lincolnshire have seamlessly mobilised and are continuing to develop in line with the mobilisation plan and contractual requirements, EMAS NEPTS are working responsively with the ICB and hospital and community partners in the delivery of their service. Within EMAS the Divisional Director for both NEPTS and the Divisional Director for Lincolnshire Accident and Emergency Ambulance Services have approached and developed their strategic aims with consistency to create a responsive and cohesive transport provision across Lincolnshire.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Service Delivery Principles -Key
Appendix B	Service Delivery Principles - Performance

6. Background Papers

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

Appendix A

Service Delivery Principles

KPI/Principle	Summary
Principle 1	No re-beds/failed discharges due to transport failure
Principle 2.1	A timely service for renal dialysis patients - arrival no earlier than one hour before
Principle 2.2	A timely service for renal dialysis patients - collection no later than 60 minutes
Principle 2.3	A timely service for all patients - arrival no earlier than one hour before
Principle 2.4	A timely service for all patients - collection no later than 80 minutes
Principle 3.1	Timely discharges / No Excessive waits two hours after booked collection time
Principle 3	Timely discharges / No Excessive waits - four hours after booked collection time
Principle 4.1	Fast Track - collected no more than 60 minutes after booked collection time
Principle 4.2	Fast Track - mean response minutes

Appendix B

Performance of Service Delivery Principles

KPI	Internal Target	Jul23	Aug23	Sep23	Oct23	Nov23
Principle 1	**0**	**0**	**0**	**0**	**0**	**0**
Principle 2.1	**90%**	**76%**	**82%**	**85%**	**79%**	**81%**
Principle 2.2	**90%**	**90%**	**95%**	**94%**	**95%**	**92%**
Principle 2.3	**90%**	**63%**	**70%**	**68%**	**71%**	**68%**
Principle 2.4	**90%**	**84%**	**88%**	**88%**	**86%**	**85%**
Principle 3.1		**56%**	**60%**	**52%**	**56%**	**54%**
Principle 3.2	**90%**	**84%**	**85%**	**81%**	**83%**	**84%**
Principle 4.1	**100%**	**20%**	**67%**	**67%**	**71%**	**0%**
Principle 4.2	**60**	**115**	**60**	**71**	**55**	**132**

Principle 1 – Reporting will commence February 2024 (data from 1 January) in line with the LIS requirements.

Principle 2.1 – 96% renal dialysis patients arrived before or within 30 minutes of their agreed arrival time.

Principle 2.3 - 99 patients (5%) arrived earlier than the measure. 91% of patients arrived early or within 30 minutes of their agreed arrival time.

Principle 2.4 - to achieve the measure of 90% a further 52 patients would have been required within the parameters. Of the 52 required, there were 50 collected within 90 minutes, only 10 minutes outside the parameter.

Principles 3.1 & 3.2 - 54% discharges collected within 2 hours and 84 % within 4 hours. An average of 7 discharges per day out of 64 discharges in total each day, fell outside of the principle measure.

Principle 4.1 - There were three fast track journeys undertaken, one collected within 80 minutes and two collected between 150-180 minutes.

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Open Report on behalf of Lincolnshire Integrated Care Board

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**24 January 2024**
Subject:	**Health Care Provision at the Proposed Home Office Development of Accommodation for Asylum Seekers at the former RAF Scampton**

Summary:

The Home Office is currently planning to utilise the former RAF Scampton site to provide accommodation for up to 2000 asylum seekers.

This report provides a summary of the proposed health care service provision to support the residents who would be living in this accommodation.

Actions Required:

The Committee is asked to note the information submitted.

1. Background

In early 2023, the Home Office outlined plans to utilise the former RAF Scampton site to provide accomadation for up to 2,000 Asylum seekers.

At present, there are ongoing legal challenges in progress between West Lindsey District Council and the Home Office with regards to the Scampton development and as such there is no confirmed date for when the site will be ready for occupation. Clearly, it is imperative to respect that these legal challenges are underway.

In intiating the development, the Home Office engaged with NHS England and the NHS Lincolnshire Integrated Care Board (ICB) to request support in planning health care service provision for the residents who would be living at the site.

As part of this process it was agreed that the approach would be to develop plans such that Scampton site residents could access health care, whilst ensuring that there would be no material adverse impact on access to health care services for the wider Lincolnshire population, particularly those living in the local vicinity. The Home Office confirmed that additional funding would be made available to the NHS to facilitate the development of services

2. Outline Approach to Health Provision

Informed by feedback from the Home Office, other providers of health care for asylum seekers elsewhere in the country, and local experience in Lincolnshire of supporting asylum seekers in hotel accommodation, the Home Office approved the development of services to address the three main areas of need namely:

- Reducing the Risk of Transmittable Disease
- Primary Care
- Mental Health Support

The Home Office has committed to providing facilities and revenue funding to support the establishment and provision of the following:

- Comprehensive Health Checks for All Residents on Arrival
- Isolation Accommodation
- On-site Medical Centre
- On-site Primary Care Provision provided by a Dedicated General Practice Team
- On-site Mental Health Support provided by a Dedicated Mental Health Team
- Monitoring of utilisation of other health provision to ensure that there is no adverse impact on access to services for the Lincolnshire population.

3. Current Situation

The NHS Lincolnshire ICB is continuing to work closely with the Home Office, NHS England and a range of partners to ensure that healthcare services can be available to meet the needs of the residents of the Scampton site, if the scheme progresses.

In terms of the healthcare facilities and services to be available on site, significant progress has been made in terms of the equipping of the medical centre, and in terms of general practice team services and mental health team services which will be provided on site. These are now at an advanced stage of development and could be mobilised at short notice.

By ensuring that these primary medical services will be available to meet the needs of Scampton site residents, this means that nearby local GP services and their practice services to their registered populations will not be impacted in any way.

Experience from elsewhere indicates that, with GP and mental health services being available on the site, that any impact on other NHS services (for example, hospital services) will be very modest and not at any material level.

The Home Office and the NHS Lincolnshire ICB have agreed an indicative overall funding arrangement, which will mean that the additional healthcare support required will be met from an additional Home Office allocation to the ICB, and as such there will be no negative impact on NHS funding for healthcare in Lincolnshire.

4. Conclusion

The NHS Lincolnshire ICB has worked closely with the Home Office, NHS England and other partners in relation to the Scampton site development. If the scheme progresses, the ICB is confident that health services will be able to be available to meet the needs of the Scampton site residents in line with the approach described above, without any material impact on NHS services to the local population and services, and supported by the additional Home Office funding. The ICB currently does not envisage any significant problems in satisfactorily meeting the requirements of the Home Office, and will continue to work closely under the guidance of the Home Office as matters progress.

This report was written by Sarah-Jane Mills, Director of Primary Care, Communities and Social Value, NHS Lincolnshire Integrated Care Board

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

Open Report on behalf of Andrew Crookham,
Deputy Chief Executive and Executive Director of Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**24 January 2024**
Subject:	**Response of the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee to the NHS Consultation on Hospital Services in Grimsby and Scunthorpe**

Summary

The response of Humber and Lincolnshire Joint Health Overview and Scrutiny Committee to the consultation undertaken by the NHS Humber and North Yorkshire Integrated Care Board on services at Scunthorpe General Hospital and Diana Princess of Wales Hospital in Grimsby has been submitted.

The Joint Committee's response is attached at Appendix A, and was finalised following a meeting of the Joint Committee on 18 December 2023. As previously advised, the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee was the statutory consultee for the purposes of this consultation.

Actions Requested

The Committee is invited:

(1) To note the response of the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee to the consultation undertaken by the NHS Humber and North Yorkshire Integrated Care Board on hospital services in Grimsby and Scunthorpe (as set out at Appendix A to this Report).

(2) To identify if any further action can be taken at this stage.

1. Background

On 25 September 2023, the NHS Humber and North Yorkshire Integrated Care Board (ICB) launched a consultation on acute hospital services at Diana Princess of Wales Hospital in Grimsby and Scunthorpe General Hospital. The consultation document was entitled: *Your Health Your Care – Let's Getter Better Hospital Care* and the main elements can be summarised as follows:

- **trauma** – for people with injuries requiring specialist care and who might need observation by a trauma team;
- **overnight emergency surgery** – for people who need an emergency operation in the middle of the night or who need to stay in hospital overnight and be looked after by teams with surgical expertise;
- **some inpatient medical specialities –** for people who need a longer stay in hospital (more than 72 hours) and need to be looked after by a specialist team for their heart, lung or stomach condition; and
- **overnight paediatric inpatient care –** for children and young people who need to stay in hospital for more than 24 hours.

It was proposed in the consultation that urgent and emergency care would continue to be provided at both Grimsby and Scunthorpe, including 24/7 accident and emergency departments.

Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee considered the consultation document, which was presented by representatives of the NHS Humber and North Yorkshire Integrated Care Board on 8 November 2023. The Committee's response was approved on 6 December 2023 and submitted to the NHS Humber and North Yorkshire Integrated Care Board on 12 December 2023.

2. The Humber and Lincolnshire Joint Health Overview and Scrutiny Committee

Establishment of the Joint Committee

Regulation 30(5) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations) 2013 requires that where commissioners of NHS-funded services are consulting on substantial changes or substantial developments to NHS-funded services affecting more than one local authority area, there is a requirement on the local authorities concerned to establish a joint committee for the purposes of the consultation exercise.

This regulation was invoked on 16 May 2022 by the Humber and North Yorkshire Heath and Care Partnership, which indicated at that time consultation on proposals was expected to begin 'no earlier than September 2022'. The Humber and North Yorkshire Heath and Care Partnership stated that the proposals would affect the following five local authorities:

- East Riding of Yorkshire Council
- Hull City Council
- Lincolnshire County Council,
- North East Lincolnshire Council
- North Lincolnshire Council.

In response, a decision was made by the five local authorities to appoint three members to serve on the Joint Committee, and Lincolnshire County Council duly appointed Councillors Carl Macey, Tom Smith and Stephen Bunney in September 2022.

The effect of the above is that the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee would be the statutory consultee for the purposes of these regulations. This did not, however, preclude local health overview and scrutiny committees from making responses to the consultation as 'non-statutory' consultees. As stated above, the Health Scrutiny Committee for Lincolnshire approved its response on 6 December 2023.

Delay of 2022 Consultation

In November 2022, it was announced that the planned consultation would be delayed until after the local government elections in May 2023. As a result, no meetings of the Joint Committee would be necessary until the consultation period began.

Reports of Yorkshire and Humber Clinical Senate

Clinical Senates are independent non-statutory advisory bodies, established under the Health and Social Care Act 2012 'to provide clinical advice to commissioners, systems and transformation programmes to ensure that proposals for large scale change and service reconfiguration are clinically sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care'. There is a clinical senate in each of NHS England's regions.

In November 2022, a detailed report (dated September 2022) by the Yorkshire and Humber Clinical Senate was published. This was the first time that any details of the proposals had been released into the public domain. The Clinical Senate had been asked to review the models of care at Diana Princess of Wales Hospital in Grimsby and Scunthorpe General Hospital, with a view to changing to a model, where there would be:

(1) an acute hospital on one site and a local emergency hospital on the other site; or
(2) an acute hospital with trauma unit on one site and an elective hospital on the other site.

It was not clear at this stage in (1) or (2), which of the two hospitals would remain as the acute hospital, and which would be the local emergency hospital or elective hospital. The Clinical Senate concluded that it was difficult to provide clinical assurance on the models, given the current uncertainty around the potential impacts on patients and staff, and the ability of the whole local health and social care system to be aligned and to adequately support the acute care plans.

The Clinical Senate also concluded that there would be a need to broaden the detail of the various options and their potential impact on neighbouring trusts. The Clinical Senate's recommendations covered areas such as models of care; workforce; and digital support.

In response to the Clinical Senate's report, NHS Humber and North Yorkshire Integrated Care Board worked on reducing the number of options, together with further clinical modelling, with a view to re-submitting its proposals to the Clinical Senate by February 2023.

The subsequent report by the Clinical Senate, dated May 2023, found that significant progress had been made since the previous review and the Clinical Senate was reassured that most of the recommendations had been considered and robustly addressed. The Clinical Senate concluded that it supported the development of an acute hospital and a local emergency hospital, as a 'widely accepted model of modern healthcare and with appropriate supporting infrastructure and robust system wide clinical pathways including operating procedures, this would offer safe and sustainable services for patients and staff'.

<u>Decision of NHS Humber and North Yorkshire Integrated Care Board – July 2023</u>

On 3 July 2023, the NHS Humber and North Yorkshire Integrated Care Board announced that maternity and neonatal services had been 'decoupled' from the Humber Acute Programme, so that a more comprehensive review could be undertaken of these services to reflect current provision and national developments.

On 12 July 2023, the NHS Humber and North Yorkshire Integrated Care Board approved the Pre-Consultation Business Case, subject to assurance being received from NHS England. The Pre-Consultation Business Case focused on urgent and emergency care; and paediatric services.

On 17 August 2023, the NHS Humber and North Yorkshire Integrated Care Board reiterated the requirement for a joint committee in line with the regulations, and indicated that the consultation would begin on 25 September 2023.

<u>Launch of the Consultation Period</u>

The consultation period began on 25 September 2025. This in effect activated the need for a meeting of the Joint Committee to consider and make a response to the consultation.

First Meeting of the Joint Committee – 17 October 2023

The Joint Committee held its first meeting on 17 October 2023, at the council offices of North Lincolnshire Council in Scunthorpe, with Lincolnshire's three members (Councillors Carl Macey, Tom Smith and Stephen Bunney) present. Representatives from the NHS Humber and North Yorkshire Integrated Care Board presented the consultation. The Joint Committee made comments on the following issues:

- the impact on waiting times;
- centralisation and the future sustainability of the two hospitals; and
- the greater use of community facilities.

The Committee resolved:

(1) That each local authority's health overview and scrutiny committee continue their work on the proposals as they fit.

(2) That a future meeting of the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee be convened to agree common conclusions and a joint response to the consultation.

The effect of this decision was that a draft response from the Joint Committee would be prepared comprising:

(a) the responses of individual councils, including verbatim the wording of these statements; and
(b) 'joint elements' such as the common conclusions and summary.

Second Meeting of the Joint Committee – 18 December 2023

The second meeting was arranged for 18 December 2023 in Scunthorpe, with an agenda issued on 8 December 2023. On 14 December 2023, a draft response was circulated to members of the Joint Committee. Section 3 of this draft comprised (a) above, the responses of individual councils – at that time only the responses from the health scrutiny committees in the East Riding of Yorkshire and Lincolnshire. Sections 1 [Introduction], 2 [General Overview], 4 [Common Conclusions] and 5 [Summary] were in effect the 'joint elements' of the draft response.

Councillors Carl Macey, Tom Smith and Stephen Bunney were present on 18 December and reiterated the concerns expressed in the Health Scrutiny Committee's response. Lincolnshire's statements on the quality of the consultation were not shared by other members present, who indicated that the consultation had been adequate.

Representatives from all five local authorities outlined their own views, and there was a wide-ranging discussion. The Joint Committee approved Sections 1, 2, 4 and 5 of the draft response as circulated on 14 December, without any additional wording to reflect the discussion which had taken place during the course of the meeting. In effect, the only changes the Joint Committee approved would be to the statements provided by individual health scrutiny committees (Section 3 of the response).

Submission of Final Response

Appendix A to this report contains the response as submitted to the NHS Humber and North Yorkshire Integrated Board on 5 January 2024 on behalf of the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee. This contains individual statements from each of the five local authorities.

The Next Steps

NHS Humber and North Yorkshire Integrated Care Board has indicated that a decision on the consultation will be made by its Board on 13 March 2024. If for any reason there is a delay, the next scheduled meeting of the Board is 8 May 2024. There may be a need to convene a meeting of the Joint Committee following the Board's decision.

3. Consultation

This report outlines the development and finalisation of the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee's response to the consultation on paediatric services and urgent and emergency care at Diana Princess of Wales Hospital in Grimsby and Scunthorpe General Hospital, which took place between 25 September 2023 and 5 January 2024.

4. Conclusion

The Committee is requested to note the response of the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee to the consultation undertaken by the NHS Humber and North Yorkshire Integrated Care Board on hospital services in Grimsby and Scunthorpe (as set out at Appendix A to this Report). The Committee is also requested to identify if any further action can be taken at this stage.

5. Appendices

These are listed below and attached to this report:

Appendix A	Response of the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee to the consultation entitled: *Your Health, Your Hospitals – Let's Get Better Hospital Care,* undertaken by the NHS Humber and North Yorkshire Integrated Care Board

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 via 07717 86893 or via Simon.Evans@lincolnshire.gov.uk

APPENDIX A

HUMBER AND LINCOLNSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE.

FORMAL RESPONSE TO THE 'HUMBER ACUTE SERVICES PROGRAMME' CONSULTATION BY HUMBER AND NORTH YORKSHIRE INTEGRATED CARE BOARD.

1. Introduction

1.1 The Humber and Lincolnshire Joint Health Overview and Scrutiny Committee (JHOSC) is the statutory, democratic body responsible for scrutinising substantial development and variations to local NHS services. The JHOSC was formally constituted on 17 October 2023 to undertake this work.

1.2 The JHOSC is comprised of non-executive elected members of the following local authorities.

- East Riding of Yorkshire Council,
- Hull City Council,
- Lincolnshire County Council,
- North East Lincolnshire Council, and
- North Lincolnshire Council.

1.3 The JHOSC has undertaken this role by speaking to senior members of the Integrated Care Board, local NHS leaders, and clinicians. The JHOSC has also reviewed a large number of supporting documentation.

1.4 The JHOSC would like to place on record its sincere thanks to the above NHS representatives, who have acted in a responsive, open and productive manner throughout.

1.5 This response will take the form of a general overview, followed by short submissions from each of the above local authorities, and ending with commonly held conclusions, and a summary.

2. General Overview

2.1 The JHOSC fully understands the rationale for the proposals, both in terms of the challenges that the health and care system face, and the desire to provide the best possible services for the residents of the Humber and Lincolnshire. These have been articulated eloquently by the ICB, and reviewed by external specialists, and we are confident that the ICB are genuine in their attempts to ensure safe and quality care.

2.2 Despite this, we do have a number of concerns about the implications of the proposals, some of which are acknowledged by the ICB, or have been identified as areas for further work. These are discussed in section four (the JHOSC's views) and summarised in section five, along with our collective view.

3. Responses from Constituent Scrutiny Committees

A. East Riding of Yorkshire Council's Health, Care and Wellbeing Overview and Scrutiny Committee

EAST RIDING OF YORKSHIRE COUNCIL HUMBER ACUTE SERVICES RESPONSE	
Quality of Care - How does the authority feel patient outcomes, safety measures, equalities and patient satisfaction be affected by the HASR?	Some disquiet was raised regarding the impact to the convenience of family and friends to visit patients now being treated further away and how this would impact on the patient experience, particular for paediatric care. Transport more generally was a point of contention for Members, with some concerned that the issue had not yet been given adequate consideration. As the proposals progressed towards implementation, Members hoped these issues would be revisited.
Consultation - Does the authority feel the extend of consultation has been sufficient for the HASR?	Though the reception to the extent of consultation was generally positive, there were some concerns that there were no realistic alternatives presented beyond that of those proposed within the Humber Acute Services Review. Moreover, Members were pleased to see that community groups were directly engaged with however were aware that responses from service users would likely only be received from those currently affected and not future user.
Long Term Sustainability - How does the authority feel overall quality improvements, changing patient demographics, and growing patient volume be affected by the HASR?	While supportive, East Riding of Yorkshire Council were enthusiastic to see how the changes proposed in the Humber Acute Services review would affect work force planning to ensure long term sustainability of acute services moving forward. Some Members feared that the changes proposed could lead to service reduction creep and an overall move to centralisation of more secondary care services.

Summary and Conclusions	Despite the fact some impacts to patient amenity were observed, a net gain to the quality of care was the consensus of the Members of East Riding of Yorkshire Council. This was however subject to effective implementation and appropriate forward work force planning. Members of East Riding of Yorkshire Council took repeated assurance that no changes acute service provision in Goole was planned. East Riding of Yorkshire Council presented no significant objections to the scoped changes affected by the Humber Acute Services Review and cautiously gave their endorsement.

B. Hull City Council's Health and Social Wellbeing Overview and Scrutiny Committee

Hull City Council welcomes the opportunity to take part in this consultation, acknowledging and appreciating the difficulties faced by the NHS and all public sector organisations at this time. Whilst the planned changes being consulted upon may currently only touch on the peripheral of the Hull and East Riding services, Hull may be impacted by the same issues in the future and therefore supports our fellow Humber authorities in their concerns.

Our primary concerns are outlined below:

1. Map 2.2 on Page 65 of the consultation document shows that a number of staff commute from north of the River Humber to the Scunthorpe and Grimsby hospitals, and also across the south bank region. Has enough consideration been given, especially as recruitment is emphasised as being difficult, to those whose roles move / change? They may consider leaving to secure a job closer to home and therefore exacerbate the staffing situation.

2. Engagement table on page 82 shows that this process has been ongoing since 2018, with impacts being evaluated since Oct 2022. It is disappointing that the local authorities, whose Councillors are elected to represent those affected, have been engaged so late into this process.

3. It is questioned as to whether an ambulance crew responding to an emergency at the west of the region would choose the longer journey to Grimsby, or choose for patient care needs to use instead Lincoln, Doncaster or Hull, which may be shorter journey times, resulting in a knock-on effect to those hospitals. We would seek assurances that in the case of this resources will be made available to the Hull hospitals to ensure no degradation of service.

4. We are disappointed to see that the only way forward being considered involves the withdrawal of services from these hospitals, and are highly concerned that should these proposals be implemented only the statistical results will be considered and not the real impact on real people in their real lives. Losing health services in your community contributes to poorer wellness which contributes to deprivation.

5. We also join colleagues from the affected areas in voicing our concerns that patient outcome and recovery from in-patient stays will be negatively impacted by the additional difficulty of having family visit. Some journeys across the catchment area are difficult to complete using public transport, and the cost of additional travel at a time of a cost-of-living crisis could hit the most deprived residents hardest. This could also impact on out-patients travelling regularly to appointments. In addition we are concerned that consideration of transport issues for patients and their families seems to be an after-thought, introduced at a very late stage of the process.

C. Response from the Health Scrutiny Committee for Lincolnshire

Introduction

This document sets out the response of the Health Scrutiny Committee for Lincolnshire to the consultation *Your Health, Your Hospitals – Let's Get Better Hospital Care*, undertaken by the NHS Humber and North Yorkshire Integrated Care Board. This response was approved by the Committee on 6 December 2023.

The Committee would like to record its thanks to representatives of the NHS Humber and North Yorkshire Integrated Care Board and Northern Lincolnshire and Goole NHS Foundation Trust who attended a meeting of the Committee on 8 November 2023, to present the consultation materials and respond to questions.

The Health Scrutiny Committee for Lincolnshire has noted the role of the Humber and Lincolnshire Joint Health Overview and Scrutiny Committee as the statutory consultee on *Your Health, Your Hospitals – Let's Get Better Hospital Care* for the purposes of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. On this basis, this response is submitted by the Health Scrutiny Committee for Lincolnshire as a non-statutory consultee for the purposes of these regulations.

The response is in three parts:

A. Response to the Consultation Questions
B. Other Comments
C. Summary and Conclusion

A. Response to Consultation Questions

Questions 1-4

> The Committee does not wish to use the 'tick-boxes' in response to questions 1 to 4, but has included a brief statement on each question. More details on the views of the Committee are found in the responses to questions 5 and 6.

Question 1

To what extent do you agree or disagree that NHS Humber and North Yorkshire Integrated Care Board needs to make changes to respond to the challenges (as set out pages 4 – 5 of the consultation document)?

> The Committee does not fully accept the rationale for change, and furthermore is not convinced by the proposals put forward. Please refer to the Committee's response to question 5.

Question 2

To what extent do you agree or disagree with the proposal to keep most urgent and emergency care services for the majority of patients, at both Scunthorpe and Diana Princess of Wales Hospital in Grimsby?

> Although the Committee accepts that most urgent and emergency care services for the majority of patients would remain at each hospital, it is not convinced by the proposals put forward. Please refer to the Committee's response to question 5.

Question 3

To what extent do you agree or disagree with the proposal to bring the four specific services (trauma unit, emergency surgery, paediatric (children's) and complex medical inpatient services at one hospital?

> The Committee does not fully accept the rationale for change, and furthermore is not convinced by the proposals put forward. Please refer to the Committee's response to question 5.

Question 4

If the four specific services were brought together in one hospital, to what extent do you agree or disagree that this should be Diana Princess of Wales Hospital in Grimsby?

The Committee is aware that one of the key drivers in the proposal to consolidate these services at Diana Princess of Wales Hospital was the substantial capital funding required for improvements at Scunthorpe General Hospital. This is an example of the NHS providing a service within its available resources, rather than a better service, as factors such as staff availability and building costs are the key determinants.

Question 5

Please explain the reasons for your answers and tell us if you have particular concerns about:

- keeping most urgent and emergency care services on both hospitals;
- bringing the four specific services together at one hospital, including if you have specific concerns or comments about any particular service;
- the hospital site, where the four specific services are proposed to be brought together.

Heart Patients at Weekends

The Committee welcomes the fact that cardiology patients will receive an improved service, including at weekends, where patients attending Scunthorpe General Hospital would have access to cardiologists sooner than currently.

Step-Down Services

The Committee has been advised that step-down services for cardiology patients would be similar under the proposals to those for existing stroke patients. Essentially, local facilities, such as those in Lincolnshire, would be used where this was appropriate for patients to undertaken rehabilitation, and this would be nearer to home, where possible.

Sharing Patient Records

The Committee would like to be re-assured that efforts will continue to ensure that patient records held by one part of the NHS remain or become accessible to other parts of the NHS, so that essential information about a patient is not lost or overlooked.

Waiting Lists

The Committee accepts that these proposals are likely to have minimal impact on waiting lists, as the proposals relate to urgent and emergency care, rather than elective care.

Impact on Neighbouring Trusts

The Committee is not convinced that these proposals will have limited impact on the services provided by neighbouring trusts. For this reason, the Committee intends to request monitoring information on their impact on United Lincolnshire Hospitals NHS Trust, in particular on its accident and emergency department.

NHS Planning Across the Greater Lincolnshire Area

The Committee recognises that for NHS purposes, Greater Lincolnshire has always been divided into two separate NHS regions, currently the North East and Yorkshire Region, and the Midlands Region. This approach has not always helped the overall planning for NHS services. For example, in 2014 there was a public consultation on proposals to consolidate hyperacute stroke services at Scunthorpe General Hospital, discontinuing these services at Diana Princess of Wales Hospital in Grimsby. These proposals were supported by the Health Scrutiny Committee for Lincolnshire at that time, on the basis that this approach had been recommended in the 2013 Keogh Review of Urgent and Emergency Care, which highlighted a reduction in London from 32 to eight stroke units and improved patient outcomes as a result.

In 2021, there was a consultation to consolidate acute stroke services at Lincoln County Hospital, in effect reducing these services at Pilgrim Hospital Boston. This was not supported by the Health Scrutiny Committee for Lincolnshire, but was approved by the former NHS Lincolnshire Clinical Commissioning Group in May 2022; and as of December 2023, the decision continues to be implemented.

The effect of these two separate consultations is a movement of services away from the east coast to hospitals in the west of the county: in Lincoln and Scunthorpe. This remains a concern for the Committee. Although stroke services do not form part of this consultation, the Committee would like to record its view that the decisions on the proposals should take account the wider impacts on the NHS, across NHS regional boundaries, as well seeking workable solutions, not just fit for purpose for the next five to ten years, but for the next thirty to fifty years.

Again, although not the subject of this consultation, the Committee would also like to cite the use of the accident and emergency department at Diana Princess of Wales Hospital in Grimsby by residents in Lincolnshire, particularly on the east coast, including as far south as Skegness. This is another example of how changes to NHS services impact over NHS regional boundaries.

Question 6

Are there any particular groups or people that you believe might be positively or negatively affected by any of the possible changes to services being considered? If so, what groups are these and how might any positive impacts be enhanced or negative impacts reduced?

Use of Virtual Wards and Virtual Appointments

The Committee recognises that the proposals relate to trauma, emergency admissions overnight or for longer than three days, patients would continue to be seen in person.

The Committee would like to refer to initiatives such as virtual wards and virtual appointments, which are much wider than this consultation and form part of national policies for the NHS. The Committee would like to put on record its support for each patient to be treated in an appropriate way, including recognition that virtual appointments in several circumstances would not be appropriate. Furthermore, virtual treatments rely on patients having both accessible IT equipment and adequate broadband coverage in their areas, as well as the means to subscribe to a household broadband provider. Where patients are affected by the proposals, there is the potential for a negative impact on deprived communities.

Transport

The Committee recognises that the proposals relate to trauma, emergency admissions overnight or for longer than three days, and patients would often be transported to hospital by ambulance, rather than using personal or public transport. However, when patients are discharged, they will need transport. Thus, the Committee is concerned that many people in Gainsborough and the surrounding area, who currently use Scunthorpe General Hospital, do not have access to private transport, and rely on public transport will be adversely affected. This makes journeys from Diana Princess of Wales Hospital in Grimsby to Gainsborough area, both for patients and their friends and families, more difficult and expensive than existing journeys from Scunthorpe. This will have a negative impact on deprived communities.

The Committee understands that the high level transport action plan, which was included in the Pre-Consultation Business Case, would be developed into a series of actions for discussion with partners. The Committee looks forward to these actions forming part of a more detailed action plan in response to the transport issues. The Committee would like to be advised of progress with the detailed action plan for transport, and subsequently its implementation.

B. Other Comments from the Committee

Consultation Arrangements

The Committee would like to record its disappointment and concerns over the arrangements for the consultation events, and the extent to which these were adequate, as no event was initially planned in the administrative county of Lincolnshire. The Committee acknowledges that two events were subsequently arranged and took place in Lincolnshire: a community roadshow at Louth Library; and an exhibition event at Morton Village Hall, Morton. The Committee feels that the 'last-minute' arrangement of these two events may have limited the overall number of responses to the consultation from these areas, as individuals may have had questions, which might not have been answered in the consultation period. Furthermore, the Committee queries the extent to which these events engaged with the public, rather than simply provided an opportunity to circulate questionnaires and other information.

The Committee also suggested that a leaflet be delivered to every household in the affected areas drawing attention to the consultation. This was the approach taken by the former NHS Lincolnshire Clinical Commissioning Group on its Lincolnshire Acute Services Review proposals in 2021. As above, the absence of a leaflet delivered to each household raises a question over the adequacy of the consultation.

The Committee is mindful of the specific health needs of armed forces veterans, and the duties, which are placed on commissioners and providers of NHS services. Further to the above, a leaflet delivered to each household in the affected area would include these groups.

C. Summary and Conclusion

The Committee acknowledges the case for change, but is not convinced by the rationale put forward in the consultation document and the Pre-Consultation Business Case for the proposed changes to hospital services at Scunthorpe General Hospital and Diana Princess of Wales Hospital in Grimsby. The Committee's concerns regarding transport and travel, and the likely impact on patients using neighbouring hospital trusts, as stated above, are key considerations in reaching this conclusion.

In the event of the proposals being implemented, the Committee would like to consider the details of the transport plan, and intends to review the impact of the changes on patients using the hospitals of neighbouring trusts, as well as those Lincolnshire patients treated at Scunthorpe General Hospital, and at Diana Princess of Wales Hospital in Grimsby.

D. North East Lincolnshire Council's Health and Adult Social Care Scrutiny Panel

NORTH EAST LINCOLNSHIRE COUNCIL HUMBER ACUTE SERVICES RESPONSE	
Quality of Care - How does the authority feel patient outcomes, safety measures, equalities and patient satisfaction have been addressed by the HASR	The panel respects that the proposals are trying to get better outcomes for patients by going to seven days a week service. Accepts that the trust will be able to retain staff, keep developing their skills, and maintaining competences, which the panel see as a positive. Patients will be seen at weekends; therefore, this will shorten hospital stays and enable people to return back to their own homes where outcomes are better for individuals in certain cases. The panel recognises the importance of treating people seven days a week and is pleased this incorporates the weekends. The panel wanted to seek reassurance that at worst there will be no detriment to patient flow and at best an improvement to flow due to the seven days working with senior decision makers. Given current performance of the ambulance service the panel were concerned about the impact of the changes to the service and response times. Work should be in collaboration with the ambulance services, to make sure that there isn't a decline in outcomes for all transport patients due to the proposed changes. The panel are seeking reassurance that

	the capacity of the ambulance services is in place before any of the proposed changes takes place. Within the process, ensure that there is clarity around which patient transport is used, to transfer people in-between sites and back to their homes. How this will work efficiently, to ensure there is no impact on the patients and the ambulance service. The panel is concerned about the impact of family and friends of the extra travel in terms of cost. The panel understands that outcomes are better for patients, when they have people visiting and that provision within the car parks is made. For those people who don't have cars the panel hope to see support for them to be able to make the journey to DPOW.
Consultation - Does the authority feel the extent of consultation has been sufficient for the HASR	The panel welcomed the consultation documents and the impact it would have on people e.g., the case studies. They found the sessions by the team useful and informative at both at the JHOSC meetings and scrutiny panel meetings.
Long Term Sustainability - How does the authority feel overall quality improvements, changing patient demographics, and growing patient volume be affected by the HASR	The panel recognises it is a five year programme, however after each proposed change has been up and running, an update would be welcome within the first year. This update should include any impacts for patients, staff and hospitals also if possible, the ambulance service. Need to make sure patients are being treated within in good time and seek reassurance and that a review of this is undertaken over time.
Other Considerations -	The panel is not convinced by the rationale to move children to DPOW, especially as maternity is staying on both sites.
Summary and Conclusions -	Overall, the panel welcomes the proposals in the consultation, which attempts to mitigate staff shortages, improve patient outcomes and improve services.

E. North Lincolnshire Council's Health, Integration and Performance Scrutiny Panel

As voted through as Chair of the collective arrangement, the document and its commentary represent fully the views of the Health, Integration and Performance Scrutiny Panel on behalf of key stakeholders.

4. Common Conclusions

4.1 Travel Implications and Health Inequalities

The ICB has adopted four values to govern its activity. One of these is to 'tackle inequalities in outcomes, experience and access'. This is aligned to the requirements of the Health and Care Act (2022) which states "Each integrated care board must, in the exercise of its functions, have regard to the need to —

(a) reduce inequalities between persons with respect to their ability to access health services, and

(b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

As part of the documentation supporting the consultation, the ICB published an Integrated Impact Assessment. This identifies "Potential increased stress and anxiety for both patients and family members from North Lincolnshire" if services were transferred to the Diana, Princess of Wales (DPoW) site in Grimsby. The Assessment states that "modelling indicates this will impact approx. 5,059 people per year (including paediatric patients)"

The Assessment also reports a "potential negative impact on families/carers living in North Lincs and/or Goole area in being able to visit, as DPoW is further away" The ICB's modelling "indicates that 3,714 patients per year would have more than 30mins additional travel".

The JHOSC raised this issue with the ICB as part of their work, and were told that the ICB acknowledge that the proposals represented a 'least worst' model. The ICB highlight that the alternate model of centralising some services at Scunthorpe General Hospital (SGH) rather than DPoW would result in higher number of people travelling (and presumably increased stress and anxiety). Whilst this is supported by the modelling figures within the Assessment, the JHOSC cannot support proposals which, by design, increase health inequalities around accessibility; a move that we believe is in direct contradiction of the ICB's stated value (above) and potentially their legal responsibilities under the 2022 Act.

The Integrated Impact Assessment which supports this consultation is, in the JHOSC's view, wholly incomplete. Whole sections including 'how will these impacts be monitored', 'how often will actions be monitored' and the identification of leads for each action/risk are blank. See examples in Appendix 1.

The JHOSC notes the creation of a 'multi-agency transport working group' to address the issues that the proposals inevitably create. However, our strong view is that this work should have been developed prior to consultation, so solutions were clear to all, rather than to simply assign this work to a group to seek solutions in the future.

4.2 Long Term Sustainability of Services

The JHOSC, in general terms, does not fully accept the rationale for the proposed changes, and is concerned that the proposals will impact on the long-term sustainability of both Scunthorpe General Hospital and local acute care generally. The future model of care for residents is largely unclear.

In addition, we note that the ICB are clear that these proposals will not resolve the financial or infrastructure issues that we face locally.

4.3 Consultation Process

The JHOSC is concerned that the consultation process was launched prior to a range of issues being resolved. Whilst we acknowledge that the relatively lengthy implementation period will allow for this work to be completed, it would have been better, in our view, to complete this work and allow for a fully informed consultation, where the implications are clearer. We therefore cannot support the ICB's view that 'this is the beginning of a journey'.

During the discussions both at the JHOSC and in our respective councils, we note that the following issues were highlighted as either 'work in progress' or 'future work'. Some of this included working with other partners, including local authorities. However, we have yet to see any substantial evidence of this within our respective councils.

Some of the issues highlighted include:

- The development of multi-agency transport solutions, arising from the additional need to travel for many patients and visitors, including funding implications,
- The increased need for ambulance provision, given the pressures to the service, and the suggestion that this be funded by efficiencies,
- The need for a long term, funded plan for the capital estate,
- The outlined steps to move some acute services into the community, including a sustainable clinical model for some outpatient care and diagnostics,
- The implications of the above on the capital sites at SGH, DPoW and other acute sites, with associated funding.
- A joint, integrated workforce and development plan,
- The safeguarding implications of centralisation of services,
- As above, the detrimental impact on health inequalities for residents accessing services, particularly for North Lincolnshire patients, but also for those who live in areas around Goole, Gainsborough, and surrounding towns and villages.

Given this list of unresolved issues, we have serious concerns that the consultation is premature and not fully informed, and could result in implications which have not been made clear to residents and stakeholders.

5. Summary of the Response from the JHOSC.

5.1 The JHOSC fully understands the rationale for the proposals submitted by the ICB. The JHOSC generally welcomes proposals that improve services to residents, and can certainly see the merit in some aspects. For example, moving to a genuine 24/7 model for emergency surgery and some inpatient clinical specialisms is very welcome.

5.2 Despite this, the JHOSC strongly believes that, as outlined above, these proposals are unequal, will inevitably increase health inequalities for residents, and will do nothing to address either the financial or capital estate situation.

5.3 The JHOSC also does not agree with the ICB's position that the many other unresolved issues described at paragraph 4.3 are matters for future discussion. Many of these will require a fundamental shift of resources, primarily from acute to community settings. There is very little clarity of what these changes may look like, or what they mean for the future of the hospital site, or for services that local people rely on, pay for, and have a right to expect.

5.4 In summary, we believe the proposals to be significantly premature, potentially damaging to local healthcare services, and widely unsupported by informed representatives, including many clinicians. The changes will increase health inequalities and reduce choice and accessibility for patients, including worried families with sick children. We believe this is may breach the requirements of the Health and Social Care Act 2012, the NHS Constitution, and potentially all four of the still-extant 'Lansley Tests'. These are:

- There must be clarity about the clinical evidence base underpinning the proposals,
- They must have the support of the GP commissioners involved,
- They must genuinely promote choice for their patients,
- The process must have genuinely engaged the public, patients and local authorities".

5.5 Given the fundamental concerns outlined in this document, we reserve the right to take further action as deemed necessary.

Extracts from the Integrated Impact Assessment

Page 7 Clinical Effectiveness Impact Assessment - Positive Impacts

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Urgent and Emergency Care	
Introduction/development of UCS co-located within an ED department could reduce ED attendance by 35-48% each year	
An improved SDEC and Acute Assessment will support a 4% reduction in admissions and improve efficiency by enabling teams to assess treat and discharge more quickly	
Reduction in those people who attend and ED 5 times or more per year	
This proposed model of care for urgent and emergency services will improve compliance with constitutional and clinical standards and will meet the national set criteria of activity numbers	
The proposed new pathway of urgent and emergency services will improve performance on waiting time standards	
Fewer cancelled operations and reduction in waiting times for treatment	
Working as multi-disciplinary teams across pathways creates opportunities for different staff *(GPs, specialty doctors, allied health professionals, and advanced clinical practitioners)* to develop their skills and provide effective and efficient care for our population	
By concentrating the workforce in fewer locations for the most specialist care, those delivering specialist services will have more opportunities to develop their skills, treating a higher number of complex cases and a wider variety of experiences.	
Competency of staff in dealing with more complex cases improves	
The proposed model of care will improve the quality of specialist care and ensure everyone across the Humber can access the most highly skilled professionals when they need them	
Better utilisation of theatres and more efficient workflow	
Swifter discharge of patients by working more closely with local authorities and social care	
Work in a joined up way with ambulance services to ensure patients who need hospital care are directed to a specified area in the most appropriate local, acute or specialist hospital and/or supported by 'hear and treat' / ' see	

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Urgent and Emergency Care	
and treat' - ensuring as far as possible patients get to the right place for their care needs first time	
This proposed model of care for emergency services will reduce the number of handovers within and between services, help to improve the flow of patients through the hospital, **reduce ambulance handover delays** and ensure that patients do not stay in hospital any longer than they have to.	
Ambulance services, GPs, primary care practitioners and consultants will be able to send patients directly through to AAU referring via a single point of access or following clinical advice and guidance. Where appropriate this will reduce the delay to handovers and improve flow within the Emergency Department	
Direct booking into UCS, SDEC, AAU and other diversionary pathways will result in better outcomes - patients get to the right place, first time	
Patients can get directly to the service the need and by-pass the Emergency Department	
This proposed model of care is built on a digitally delivered support infrastructure, providing remote assessments, monitoring, shared care planning and diagnostics access	
H@H/ Virtual wards could reduce the number of clinical contacts	
People will be able to manage their own conditions better and go to hospital less often for check-ups.	
Reduction in emergency admissions as more frail or elderly patients would be seen in a community service e.g. Integrated Frailty service	
Integrated frailty services and other proposed pathway changes would improve outcomes and support faster recovery for patients	

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Paediatric Care	
Through H@H children can get home more quickly or avoid an admission to hospital in the first place *The impact of Hospital @ Home on paediatric ED attendances and admissions was not included in the activity modelling due to the pilot being in a very early stage when this work was undertaken. Further modelling will be*	

Description of positive impacts (must include rationale and be evidence based)	How will these impacts be monitored
Paediatric Care	
undertaken as part of the development of the Decision-Making Business Case (DMBC) to quantify the impact of H@H on paediatric activity in ED, PAU and inpatients.	
Re-designing pathways for paediatric care will improve the safety, quality and effectiveness of services	
By concentrating the workforce into a single location for the most specialist care, those delivering specialist services will have more opportunities to develop their skills, treating a higher number of complex cases and a wider variety of experiences.	
This proposed model will develop improved advice and guidance so that hospital-based, specialist teams can support parents, carers, GPs and community staff, to aid prevention and self-management and reduce the need for children to attend hospital unnecessarily	
Consolidation of paediatric inpatient services onto the acute site will help to improve the quality of care and ensure long-term safety and sustainability of inpatient care ensuring everyone across the Humber can access the most highly skilled professionals when they need them	
This proposed model of care for paediatric care will improve compliance with constitutional and clinical standards and will meet the national set criteria of activity numbers	

Page 7 Clinical Effectiveness Impact Assessment – Negative Impacts

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Urgent and emergency care				
It is not guaranteed that this model will enable all college guidelines, constitutional standards and clinical standards to be fully met.	*Review as part of planning for implementation*			

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Urgent and emergency care				
If Trauma and emergency surgical needs are not identified at Source *(e.g. at the scene by ambulance)* and patients are taken to LEH (SGH) site this increases the potential of time to treatment standards being breached.	*Extensive work has been undertaken to develop clear transfer conditions and close working with ambulance providers will continue to ensure patients who are likely to need more specialist input at taken directly to the Acute Hospital wherever possible.*			
Potential for delays in transferring patients from LEH (SGH), affecting patient flow and clinical effectiveness	*Inter-hospital transport working group established to develop options for inter-hospital transport services which will be right-sized to meet anticipated demand.*			
Potential for delays if insufficient capacity at the acute site to accept transfers	*Right-sized services*			

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Paediatric care				
It is not guaranteed that this model will enable college guidelines, constitutional standards and clinical standards to be fully met.	*Review as part of planning for implementation*			
If Trauma and emergency surgical needs are not identified at Source (e.g. at the scene by ambulance) and patients are taken to LEH (SGH) site this increases the potential of time to treatment standards being breached.	*Extensive work has been undertaken to develop clear transfer conditions and close working with ambulance providers will continue to ensure patients who are likely to need more specialist input at taken directly to the Acute Hospital*			
Potential for delays in transferring children from LEH (SGH), affecting patient flow and clinical effectiveness	*Inter-hospital transport working group established to develop options for inter-hospital transport services which will be right-sized to meet anticipated demand.*			
Potential for delays if insufficient capacity at the acute site to accept transfers to paediatric inpatient ward	*Right-sized services*			

Page 8 Patient Experience – Positive Impacts

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Urgent and Emergency Care	
The proposed model of care retains local urgent and emergency care services at each of the three existing sites and enables the NHS across the Humber to continue to operate three ED in the three main localities; Hull, Grimsby and Scunthorpe	
The proposed model of care would reduce waiting times for patients in the Emergency Department (ED)	
Integrated Acute Assessment model to improve flow through the hospital will provide a better experience for patient (quicker diagnosis and treatment and fewer handoffs)	
The development of an AAU and SDEC would ensure patients can get directly to the service they need and by-pass the Emergency Department	
Better integration of urgent and emergency care across all health and social partners *(including mental health)* would enable patients to be treated and discharged more quickly.	
Improvements to NHS 111 and implementation of 'any-to-any' booking could benefit patients as they would get directed to the service they need and by-pass the Emergency Department.	
Improved continuity of care and patient experience	
Services will be easier to navigate for the public, helping to reduce inequalities and barriers to access	
Developing centres of excellence for acute medical specialties will also build confidence in patients, many of whom have told us through our engagement that they would prefer to be treated where the specialists are and have full specialist team wrapped around them *(Reference: Accident and Emergency - Feedback Report / Healthwatch ED Enter and View - Feedback Report / What Matters to You -Feedback Report).*	
A UCS co-located within an ED woud improve patient experience as it is easier to navigate and signpost to the most appropriate service *(right place, first time)* - public feedback has shown local people are confused about where to go for what care *(Reference: Accident and Emergency - Feedback Report / Healthwatch ED Enter and View - Feedback Report / What Matters to You -Feedback Report).*	

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Urgent and Emergency Care	
More services provided within the patients home (e.g. virtual wards/hospital@home/pathway changes) would allow patients to be supported at home and recover faster.	
It would be easier for family, friends and loved ones to provide support to the patient if more care was provided at the patient's home.	
People will be able to manage their own conditions better and go to hospital less often for check-ups.	
Integrated frailty services and other proposed pathway changes would improve outcomes and support faster recovery for patients	
Improved discharge processes and investing in social care workforce will help to reduce the length of stay for particularly frail or elderly patients	
Improved use of digital support remote monitoring, more responsive services *(e.g. patient-initiated follow-up)* , and reduce the overall need for patients to travel to hospital	

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Paediatric Care	
The proposed model of care retains local paediatric services at each of the three existing sites and enables children to be seen and treated initially at their local hospital in the Paediatric Assessment Unit (PAU)	
A 24/7 PAU provides better care and a better experience for patients than a time limited PAU	
A 24/7 PAU will enable children to be seen, treated and discharged more quickly	
A 24/7 PAU will reduce hospital admissions. CYP told us that they don't like staying in hospital. *(Source: What Matters to You: Children and Young People)*	
Hospital at Home - Could support a reduction of paediatric inpatients by enabling children to get home more quickly or avoid admission to hospital in the first place, improving experiences and outcomes for patients and their families.	
Hospital at Home improves continuity of carer as the needs of the child and family are known	
Hospital at Home improves mental and emotional wellbeing for children and their families as they feel more comfortable and at ease in their own environment	

Page 8 Patient Experience – Negative Impacts

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Urgent and Emergency Care				
Potential increased stress and anxiety for both patients and family members from North Lincolnshire area if there is a need for the patient to be transferred from the LEH (SGH) to the acute site (DPoW), which is likely to be further away from their home. *modelling indicates this will impact approx 5,059 people per year (including paediatric patients) - this is compared to 5,604 people per year in the option where SGH is the Acute site*	*Extensive work has been undertaken to develop clear transfer conditions and close working with ambulance providers will continue to ensure patients who are likely to need more specialist input at taken directly to the Acute Hospital wherever possible.*			
Potential delays for patients in transferring from LEH (SGH) site to the acute site (DPoW) could negatively impact patient experience.	*Inter-hospital transport working group established to develop options for inter-hospital transport services which will be right- sized to meet anticipated demand.*			
Potential negative impact on families/carers living in North Lincs and/or Goole area in being able to visit as DPoW is further away *modelling indicates that 3,714 patients per year would have more than 30mins additional travel in this model - this is compared to 4,635 people per year in the option where SGH is the Acute site*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
NL has high levels of deprivation and areas of low car ownership so families may not be able to afford to travel to visit the patient at the acute site (DPoW) *In North Lincs 18.5% of households do not own a car, and 20% of neighbourhoods are in the most income deprived quintile in England (Compared with 26.9% of households do not have a car and 40% of neighbourhoods are in the most income deprived quintile in North East Lincolnshire)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Potential delay in recovery and/or if admitted to a hospital further away or in another local authority from home with reduced access to relatives to support recovery.	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Poor, expensive and unreliable public transport links between hospital sites would impact patients/families and carers being able to visit	*Work is ongoing with local authority partners to review and potentially redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff.*			
Patients and service users have told us that availability of parking and cost of parking makes travelling to hospital difficult. Consolidating specialist and inpatient care onto one site could reduce the availability of parking event more. *Source: Travel and Transport Feedback Report*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Paediatric Care				
Children from North Lincs needing to be admitted will have to be transferred from the LEH (SGH) to DPOW (acute), this could have a negative impact on their experience and that of their families.	*Continued development of the Hospital at Home model to support reduction in admissions and length of stay*			
Children and young people told us that being at home, with their family and toys would help them to feel better more quickly, being in a hospital further from home and family is contrary to this. *Reference: What Matters to You: Children and Young People*	*Continued development of the Hospital at Home model to support reduction in admissions and length of stay*			
18.5% of households in North Lincs do not own a car or have access to a car so would potentially find it difficult to visit the young person in hospital at the acute site as alternative travel options could be expensive. *Car ownership rates are lowest in the central wards of Scunthorpe where deprivation is highest - in North Lincs 18.5% of households do not own a car (Compared with 26.9% of households in North East Lincolnshire)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Harder to arrange child care for other dependents if a child is admitted into a hospital further away from home				

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
The young person may not know any of the nurses or clinical teams looking after them at the acute site (DPoW), this could have a negative impact on their experience				

Page 9 Patient Safety – Positive Impacts

Description of positive impacts (must include rationale and be evidence based)	How will these impacts be monitored
Paediatric Care	
24/7 PAU will continue to improve safety for paediatric patients because a paediatrician would be available 24/7.	
Children and young people will continue to be assessed at their local hospital, treated and discharged within 24 hours in the Paediatric Assessment Unit (PAU).	
Consolidating paediatric inpatient services onto the Acute site enables CYP with more complex needs to access the specialist care they need from well- supported, experienced teams of highly skilled professionals where the needs of the child and their family are known	
Children can have shorter hospital stays or avoid them all together and be investigated and treated at home instead	
Re-designing pathways for paediatric care will improve the safety, quality and effectiveness of services	

Page 9 Patient Safety – Negative Impacts

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Paediatric Care				
Potential risk to CYP patients needing to be transferred from the LEH (SGH) to the acute (DPoW) or specialist hospital (HRI) due to travel time/distance if any delays are incurred *(e.g. lack of staff/ambulances)* - their condition could deteriorate whilst waiting for the transfer or on route.	*Safe transfer & inreach*			
This proposed model of care may deter clinicians and nurses living near the LEH (SGH) from remaining within the Trust and look for alternative employment, putting the sustainability of services at risk.	*Development of rotational posts and new career pathways to ensure strong pipeline of new staff coming through*			
Potential risk if no beds available at the acute/specialist hospital resulting in delays and the patient not receiving a quick responsive service for more serious or life-threatening emergencies in the right place with the right skilled staff and facilities available.	*Right-sized services Inreach*			
Increased risk that North Lincs parents may discharge the patients themselves before they are clinically ready to be discharged to get home quicker if transferred to the acute site, especially if they have other dependants at home.	*pathways of care /support of clinical teams*			

Page 10 Equality Impact – Positive Impacts

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Socio-economic background	
Improved pathways to provide more holistic care, that is more responsive and better at supporting people with multiple co-morbidities to stay well.	
Freeing up staff to improve outreach provision and support *(e.g. outreach clinics, virtual wards, hospital @ home)*	
Reducing waiting times for care and prioritising those most in need	
Improving opportunities for local people to access well-paid jobs and rewarding career pathways *(supporting workforce strategy will develop local workforce of the future in partnership with local education partners, industry etc.).*	
Continued investment in the two major towns *(Grimsby and Scunthorpe)* – keeping money in the local economy.	
When considering the travel impact as a whole, the proposed model (where DPoW is the acute hospital) does not have a disproportionate impact on people living in the most deprived quintile (IMD 1 and 2) - the travel time impact broadly follows the aggregate pattern of deprivation across Northern Lincs	
Age	
Improved experience for CYP due to better joined-up services *(H@H, properly staffed PAU, better quality of care)*	
CYP said that it was really important to them that could be in a place that they feel safe *(toys/home comforts)* H@H will deliver this. *(Reference: What Matters to You: Children and Young People)*	
PCG told us that it was really important that there was well trained staff treating their children. The proposed model supports improved workforce for paeds, specialists in one place. *(Reference: What Matters to You: Parents, Carers and Guardians)*	
Improved frailty services. Enhanced care in care homes and OOH enablers *(falls prevention)*	
Disability	
More care closer to home – reduces overall need to travel *19% of the population in North Lincs are disabled - compared with 20% in North East Lincolnshire*	
Virtual wards will allow for more accessible care – reduces overall need to travel	
People with LD – co-located UCS, easy access to local services. Easier to navigate system and find where they need to be	

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Standardising pathways across the Humber – same type of care will make it easier for people with disabilities to navigate	
Ethnicity	
Having a co-located UCS on-site would make it easier for people from BAME backgrounds to access to local services.	
Standardising pathways across the Humber will make it easier for people from BAME backgrounds, and people where English is not their first language to navigate the system . Ethnicity: Asian - 3.3%, Mixed/Multiple Ethnic Group - 0.5%, Black/African/Caribbean/Black British - 1.1% Other Ethnic Groups - 0.8%. Language: Cannot speak English well - 0.8%, cannot speak English -0.1%	
Improve opportunities for staff training *(unconscious bias/awareness/equality/disability etc)* – *Patients/Members of the public told us they want this through our engagement. Source: Equality Groups - Combined Feedback Report*	
Religion or Belief	
Improve opportunities for staff training (unconscious bias/awareness/equality/disability etc) – *Patients/Members of the public told us they want this through our engagement. Source: Equality Groups - Combined Feedback Report*	
Sex	
Sexual Orientation	
Of the LGBTQ+ people we have engaged with so far nobody has identified any barriers to accessing care based on their sexual orientation - in relation to the proposals	*We would like to engage with more members of the LGBTQ+ community as part of the consultation to help provide assurance that this feedback is reflective of the wider experiences of the LGBTQ+ community.*

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Gender Reassignment	
Of the LGBTQ+ people we have engaged with so far nobody has identified any barriers to accessing care based on their gender identity - in relation to the proposals	*We would like to engage with more members of the LGBTQ+ community as part of the consultation to help provide assurance that this feedback is reflective of the wider experiences of the LGBTQ+ community.*
Carers	
More care closer to home – reduces overall need for carers to travel *Approximately 3.1% of the population in North Lincs provides 50+ hours of unpaid care per week*	
Virtual wards will allow for more accessible care – reduces overall need to travel	
Care closer to home will reduce the financial strain on carers, particularly unpaid carers	
Any other Groups	
Sex Workers - The proposed model of care would reduce waiting times for patients in ED. Sex workers in North East Lincs told us during our engagement with them that waiting times are one of the main barierrs when accessing care as they feel judged in waiting rooms, so if waiting for any length of time will get up and leave. This proposed model could reduce this barrier for this group of people. *(Source: Equality Groups - Combined Feedback Report)*	
Sex Workers - This proposed model of care allows for increased opportunities for improved joined up working with primary, secondary and community providers and allow sex workers to be looked after by people they trust and who support them on a day-to-day basis *(Source: Equality Groups - Combined Feedback Report)*	
Asylum Seekers - Have told us that they have a lack of knowledge and/or accessible information about what services do exist, what they may be eligible for and what rights they have to access healthcare. Standardising pathways across the Humber will make it easier for people from BAME backgrounds, and people where English is not their first language to navigate the system .	

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
North Lincs Ethnicity: Asian/Asian British - 3.3%, Mixed/Multiple Ethnic Group - 1.1%, Black/African/Caribbean/Black British - 0.5%. White 94.3% North Lincs Language: Cannot speak English well - 1.5%, cannot speak English -0.2% *Migrant Indicator: 0.5% of people living in NL were living at an address outside the UK one year ago (Source: Census Data 2021)*	

Page 10/11 Equality Impact – Negative Impacts

Description of negative impacts	**Mitigating actions of negative impacts**	**How will this action be monitored**	**How often will this action be reviewed**	**Lead**
Socio-economic background				
Some people in North Lincs and Goole would have to travel further to access care. The proposals increase travel times for some patients, service-users, families and staff members.	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
NL has high levels of deprivation and areas of low car ownership so families may not be able to afford to travel to visit the patient at the acute site (DPoW) *In North Lincs 18.5% of households do not own a car, and 20% of neighbourhoods are in the most income deprived quintile in England (Compared with 26.9% of households do not have a car and 40% of neighbourhoods are in the most income deprived quintile in North East Lincolnshire)*	*Work is ongoing with local authority partners to review and potentially redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff.*			

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Low-income families from North Lincs would find it more difficult to afford the additional travel. *(In North Lincs 13.3% of the population are classed as being income deprived and 1 in 5 children in North Lincs are classed as living in poverty .) (Source: Fingertips Data)*	*Work is ongoing with local authority partners to review and potentially redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff.*			
Looking only at maternity and paediatric activity only, both site options (DPoW as the Acute site or SGH as the Acute site) have a disproportionate impact on people living in the most deprived communities, compared with the overall spread of deprivation across the region. This could be accounted for when considering the age profile of deprivation across our region - notably that those living in the most deprived communities are more likely to be younger.				
Age				
Consolidation of paediatric inpatient services would have an impact on people below the age of 18 from North Lincs *Activity modelling tells us that this is approximately 935 paediatric patients per year (compared with 990 in the scenario where these services are consolidated at Scunthorpe)*				

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Consolidation of specialist medical inpatient services (Cardiology, Respiratory and Gastroenterology) is likely to have a higher number of impacted patients age 65+ *Activity modelling tells us that this is approximately 1,069 patients per year (compared with 1,584 in the scenario where these services are consolidated at Scunthorpe)*				
Disability				
Disabled people in North Lincolnshire and Goole could face longer journeys to visit relatives or loved ones in hospital, if they are admitted for care at DPoW 19% of the population in North Lincs are disabled - compared with 20% in North East Lincolnshire	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Disabled people have told us that wheelchairs are not able to travel with patients and that they have no independence when they get to the hospital site	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Disabled people could face more barriers being discharged from hospital if they are admitted to DPoW when this is not their local hospital				

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Disabled people from North Lincs have further to travel and may experience difficulties parking *(feedback has told us that there is a lack of accessible parking on sites - Reference: Combined Equalities Group Feedback Report / Transport Survey - Feedback Report)*	*Transport working group to include estates team members to explore potential options to improve car parking*			
Ethnicity				
There is strong evidence that people from Black, Asian and Minority Ethnic (BAME) backgrounds face greater health inequalities. This was highlighted through the COVID-19 pandemic, which had a disproportionate impact on BAME populations in terms of incidence of disease and mortality.	*Ongoing engagement to increase understanding of potential impacts on BAME (in particular Asian/Asian British) communities and develop mitigations*			
The neighbourhoods with the largest concentration of Asian/Asian British Population in the Humber are all in North Lincolnshire, in the areas close to Scunthorpe Hospital - people living in these communities could be impacted if they or a family member is admitted to DPoW.	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Feedback with the BAME and Eastern European community have told us that translation services are currently a barrier - it is unclear whether the proposed model would improve this or not				

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Religion or Belief				
Feedback from the Muslim community: Muslim women are less likely to drive or have access to a car, making it more difficult if they have an ill child admitted as an inpatient at DPoW (Acute)	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Feedback from Muslim community: women often chaperoned by male member the family, which could be more difficult if care was further away	*Ongoing engagement to increase understanding of potential impacts on Muslim communities and develop mitigations*			
Sex				
In North Lincs men have a shorter life expectancy than women. *(England Average - Men = 78.7 years, Women = 82.8 years)* *Men = 78.9 years Women = 83.3 years* *(Source: Census Data 2021 - Life expectancy at birth)*				
Sexual Orientation				
Of the LGBTQ+ people we have engaged with so far nobody has identified any barriers to accessing care based on their gender reassignment.	*We would like to engage with more members of the LGBTQ+ community as part of the consultation to help provide assurance that this feedback is reflective of the wider experiences of the LGBTQ+ community.*			

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Gender reassignment				
Of the LGBTQ+ people we have engaged with so far nobody has identified any barriers to accessing care based on their gender reassignment.	*We would like to engage with more members of the LGBTQ+ community as part of the consultation to help provide assurance that this feedback is reflective of the wider experiences of the LGBTQ+ community.*			
Carers				
Some carers in North Lincs would have to travel further so that the people/person they look after could access care and/or to visit the person they care for should they be admitted to the acute site (DPoW) *Approximately 3.1% of the population in North Lincs provides 50+ hours of unpaid care per week, broadly similar to North East Lincolnshire (3.2%)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Low income carers / unpaid carers from North Lincs would find it more difficult to afford the additional travel. *(In North Lincs there are approximately 19,000 carers. 13.3% of the population are classed as being income deprived and 1 in 5 children in North Lincs are classed as living in poverty) (Source: Census Data 2021)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Any other Groups				
Sex Workers - We engaged with sex workers in North East Lincs. A key barrier for them when trying to access services is ease of access, for example if the appointment is too difficult to get too, they wont attend. By consolidating specialist/maternity services onto one site further away from where they live could create further health inequalities for this group as they will find getting to an appointment too difficult so wont go and get the medical care/treatment they need. *(Source: Equality Groups - Combined Feedback Report)*				
Sex Workers - Many sex workers won't get in an ambulance as they feel it resembles a police car and they are going to be judged by people in uniform. If these women are needing to be transferred to from the LEH (DPoW) to the Acute site (SGH) this could have a negative impact on them and create further barriers and health inequalities. *(Source: Equality Groups - Combined Feedback Report)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Asylum Seekers - Many asylum seekers don't have the right paperwork to access means-tested benefits. Many don't drive or have access to a car. By consolidating services onto the acute site (DPoW) could create further barrier for access and health inequalities for this group as they are unable to travel to the appropriate site and cannot afford public transport. *(Source: Equality Groups - Combined Feedback Report)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			
Asylum Seekers - Fear often prevents people from accessing services and/or asking for help – particularly, fear that doing so might impact on asylum status or application process. Lack of knowledge and/or accessible information about what services do exist and where they are may only compound that fear and inhibit them from accessing services at all. *(Source: Equality Groups - Combined Feedback Report)*	*Multi-agency transport working group established to develop innovative transport solutions for families, carers and loved ones.*			

Page 12 Workforce Impact – Positive Impacts

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
Paediatric Care	
The proposed model of care has embraced the concept of joint appointments where retiring staff from paediatrics and children's services could return to provide education support, advice and guidance.	
The proposed pathway re-design will ensure staff working in paediatric services have the opportunities they need to keep their skills up to date and have the confidence to handle more complex cases when they arise.	
Consolidation will enable more effective deployment of our skilled and specialist staff by concentrating teams in one location rather than spreading them across multiple units.	
The proposed staffing model for paediatrics has been developed considering the requirements set out in the *National Quality Board on Safe Staffing* and *Facing the Future* standards to deliver their services	
Opportunities for new roles and ways of working across paediatrics, including rotational induction/preceptorship programmes, dedicated apprenticeship programmes, retire and return mentorship/educational support, young person's nurse specialist roles	
Staff will be able to work in larger teams, which improves resilience and enables us to design rotas to cover services that will be more attractive to current and future workforce. Improved retention and recruitment of staff ensures the sustainability of services over the long term.	

Page 12 Workforce Impact – Negative Impacts

Description of negative impacts	**Mitigating actions of negative impacts**	**How will this action be monitored**	**How often will this action be reviewed**	**Lead**
Paediatric Care				
Still requires multiple rotas for some specialties, paediatrics/neonatal and ED				

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Additional workforce would be needed to support the additional transfers	*Development of transport solutions for inter- hospital transfers*			
Can the staff working at the LEH sufficiently maintain skills and experience	*Development of rotational posts and new career pathways to ensure strong pipeline of new staff coming through*			
Additional travel and financial impact for staff rotating between sites, staff with young families would be particularly impacted	*Work is ongoing with local authority partners to review and potentially redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff.*			
Potential for dissatisfaction/low morale amongst staff at the LEH whose site base may change. These existing staff members may choose an alternative role or organisation rather than travel to the acute site, this could potentially have a negative impact on staff vacancy rates	*Development of rotational posts and new career pathways to ensure strong pipeline of new staff coming through*			
Potential for reduced career opportunities/progression for specialist, paediatric workforce at the LEH and/or perception of reduced opportunities. This could make the LEH a less attractive place to work, and make recruitment difficult.	*Development of rotational posts and new career pathways to ensure strong pipeline of new staff coming through*			
Vacancy rates in NLaG could continue to rise if recruitment/retention initiatives aren't successful making it unsustainable to maintain services.				

Description of negative impacts	Mitigating actions of negative impacts	How will this action be monitored	How often will this action be reviewed	Lead
Staff have told us that parking and lack of spaces makes travelling to work difficult for them, consolidating some staff/services onto one site could reduce the availability of parking event more. *(Source: Travel and Transport Feedback Report)*	*Transport working group to include estates team members to explore potential options to improve car parking*			
Staff have told us that poor public transport links make it difficult for them when travelling to work, and public transport between hospital sites is poor. This could have a negative impact on staff who rely on public transport if required to work at alternative sites as a result of the changes proposed within this model of care. *(Source: Travel and Transport Feedback Report)*	*Work is ongoing with local authority partners to review and potentially redesign bus routes, exploring the possibility for direct transport between the hospital sites for patients, visitors and staff.*			

Page 13 Sustainability Impact – Positive Impacts

Description of positive impacts (must include rationale and be evidence based)	How will these impacts be monitored
Urgent and Emergency Care	
Improves financial sustainability by reducing the cost of using agency and locum staff to fill vacancies *(In 2022/23 - HUTH spent £18million and NLaG spent £37.7 million)*	
Design and build 'smart buildings' promoting increased environmental sustainability and efficiency. This will also support the delivery of the ICS's Green Plan.	
Improved use of digital to support remote monitoring, more responsive and efficient services will help to reduce the overall need for patients to travel to hospital.	
Digital Infrastructure - systems that interact with each other /providing remote assessments, monitoring, shared	

Description of positive impacts (must include rationale and be evidence based)	**How will these impacts be monitored**
care planning and diagnostics access	
Boost economic and productivity growth across the Humber's thriving industries, leveraging the benefits of Freeport status and working with a range of partners to support investment in the region. Our investment plans are backed by a strong "Anchor Network" across the region and integral to the delivery of regional regeneration strategies, Local Authority Master Plans and Town Deals. Planning has been undertaken collaboratively with Local Authorities and wider partners (Universities, LEPs), adopting a "One Public Estate" approach, to ensure maximum return on investment, leveraging wider economic benefits through increased private sector investment in allied industries.	
Raise the Humber's prominence as the UK's Energy Estuary within the emerging green energy sector and generate solutions to help meet the NHS Zero Carbon goals	
Built on a digitally delivered support infrastructure, providing remote assessments, monitoring, shared care planning and diagnostics access.	
Put in place virtual wards to achieve a sustainable shift from hospital to home-based care when safe to do so	
Paediatric Care	
Put in place virtual wards to achieve a sustainable shift from hospital to home-based care when safe to do so	

Page 13 Sustainability Impact – Negative Impacts

Description of negative impacts	**Mitigating actions of negative impacts**	**How will this action be monitored**	**How often will this action be reviewed**	**Lead**
Urgent and emergency care				
Our current buildings are not flexible and cannot easily by adapted to deliver new models of care.				
Paediatric Care				

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

Open Report on behalf of Andrew Crookham,
Deputy Chief Executive and Executive Director of Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**24 January 2024**
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 requested to consider whether any further items should be considered for addition to or removal from the work programme.

Actions Requested

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

1. Items to be Programmed.

(1) Pressures on Services at Lincoln County Hospital (*Added to List on 14 June 2023*)

(2) Use of Planning Gain Funding for NHS Facilities (*Added to List on 6 December 2023*)

(3) Stamford and Rutland Hospital Minor Injuries Unit (*Added to List on 19 July 2023*)

(4) Planning of Integrated Health Provision at Primary Care Network Level (*Added to List on 6 December 2023*)

(5) Cancer Care and Living with Cancer Programme (*Added to List on 13 September 2023*) – *NO EARLIER THAN SEPTEMBER 2024*

(6) Nuclear Medicine at United Lincolnshire Hospitals NHS Trust - (*Added to List on 13 September 2023*) – *NO EARLIER THAN OCTOBER 2024*

(7) Stroke Services at United Lincolnshire Hospitals NHS Trust (*Added to List on 8 November 2024*) - NO EARLIER THAN NOVEMBER 2024.

2. Items Already Programmed

24 January 2024		
	Item	*Contributor*
1	East Midlands Ambulance Service Performance	Sue Cousland, Lincolnshire Divisional Director, East Midlands Ambulance Service
2	Non-Emergency Patient Transport Service	East Midlands Ambulance Service: • Sue Cousland, Lincolnshire Divisional Director, • Joy Weldin, Head of Non-Emergency Patient Transport NHS Lincolnshire Integrated Care Board: • Tim Fowler, Assistant Director of Contracting and Performance
3	Health Care Provision at the Proposed Home Office Development of Accommodation for Asylum Seekers at the former RAF Scampton	David Harding, Deputy Director, Asylum and Detention Accommodation Programme, Home Office
4	Humber and Lincolnshire Joint Health Overview and Scrutiny Committee Response to Consultation on Humber Hospitals	Simon Evans, Health Scrutiny Officer

21 February 2024		
	Item	*Contributor*
1	Annual Report of the Director of Public Health	Derek Ward, Director of Public Health, Lincolnshire County Council
2	North West Anglia NHS Foundation Trust Update	Hannah Coffey, Chief Executive, North West Anglia NHS Foundation Trust

21 February 2024		
	Item	*Contributor*
3	Joint Health and Wellbeing Strategy	Michelle Andrews, Assistant of Public Health, Lincolnshire County Council Alison Christie, Programme Manager Strategy and Development Lincolnshire County Council
4	Integrated Care Strategy	Michelle Andrews, Assistant of Public Health, Lincolnshire County Council Pete Burnett, Director of Strategic Planning, Integration and Partnerships, NHS Lincolnshire Integrated Care Board

20 March 2024		
	Item	*Contributor*
1	NHS Dental Services, including Lincolnshire Dental Strategy	Representatives from NHS Lincolnshire Integrated Care Board
2	Voluntary Sector Support for the NHS / Health Services	To be confirmed.
3	Quality Accounts 2024	Simon Evans, Health Scrutiny Officer

17 April 2024		
	Item	*Contributor*
1	Urgent and Emergency Care Update, including the Outcomes of the Review of Urgent Treatment Centres	Clair Raybould, Director for System Delivery, NHS Lincolnshire Integrated Care Board
2	Lincolnshire Suicide Prevention Strategy	Lucy Gavens, Consultant in Public Health at Lincolnshire County Council

15 May 2024		
	Item	*Contributor*
1		
2		

12 June 2024		
	Item	*Contributor*
1	(a)	•
2		

17 July 2024		
	Item	*Contributor*
1	GP Provision on Lincolnshire, including: (a) NHS Lincolnshire Integrated Care Board (b) Lincolnshire Local Medical Committee	• Sarah-Jane Mills, Director for Primary Care and Community and Social Value, NHS Lincolnshire Integrated Care Board • Dr Reid Baker, Medical Director, Lincolnshire Local Medical Committee
(c)	Implementation of the Mental Health Community Rehabilitation Service	Representatives from Lincolnshire Partnership NHS Foundation Trust

3. Previous Work

Set out at Appendix A is a schedule of the items covered by the Committee since the beginning of the current Council term in May 2021, as well as planned work for the coming months.

4. Background Papers

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

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

APPENDIX A

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

KEY TO COLOURS	
	Previous Item
C	Previous Consultation Item
	Concluded Topic
	Chairman's Announcement
	Future Item

	2021						2022										2023											2024		
	23 Jun	21 Jul	15 Sept	13 Oct	10 Nov	15 Dec	19 Jan	16 Feb	16 Mar	13 Apr	18 May	15 Jun	13 July	14 Sept	12 Oct	9 Nov	14 Dec	18 Jan	15 Feb	15 Mar	19 Apr	17 May	14 Jun	19 Jul	13 Sept	4 Oct	8 Nov	6 Dec	24 Jan	21 Feb	20 Mar
Meeting Length – Hours : Minutes	3:04	2:44	2:54	3:28	3:30	2:53	3:12	2:54	2:35	3:52	2:05	3:46	3:05	0:07	3:32	3:02	3:17	3:03	2:36	2:19	1:25	2:43	3:41	3:48	3:10	1:33	2:37	2:32			
A&E Pilgrim Hospital (ULHT)																														
Acute In-patient Mental Health, Boston															C															
Armed Forces Covenant Duty																														
Ashley House, Grantham															C			C	C											
Branston and Heighington Family Practice																														
CAMHS		C																												
Cancer Care and Living with Cancer																														
Cancer Screening – Lung Cancer																														
Care Quality Commission National Reports																														
Care Quality Commission Working Arrangements																														
Caskgate Street Surgery, Gainsborough																														
Chief Medical Officer's Annual Report																														
Cliff House Medical Practice, Lincoln																														
Clinical Care Portal Data Sharing																														
Community Diagnostic Centres												C																		
Community Emergency Medicine Services																														
Community Pain Management Service																														
Continuing Healthcare																														
Covid-19 Data, Updates and Vaccinations																														
Critical Incidents																														
Defibrillators –Fund for Community Organisations																														
Dementia – Enhanced Home Treatment																														
Dementia Services - General																														
Dental Services																														
DPH - Annual Report																														
DPH – Greater Lincolnshire Arrangements																														
Early Mental Health Support Hubs																														
Elective Recovery Plan																														
Emergency Ambulance Services (EMAS)																														
Fluoridation of Water Supplies																														
Glebe Park GP Surgery, Lincoln																														
GP Patient Survey																														
GP Provision – Lincolnshire CCG / ICB																														
GP Provision – Lincolnshire LMC																														
GP Data for Research																														
Government Announcements for NHS																														
Government New Hospitals Programme																														

	2021						2022										2023										2024		
	23 Jun	21 Jul	15 Sept	13 Oct	10 Nov	15 Dec	19 Jan	16 Feb	16 Mar	13 Apr	18 May	15 Jun	13 July	14 Sept	12 Oct	9 Nov	14 Dec	18 Jan	15 Feb	15 Mar	19 Apr	17 May	14 Jun	19 Jul	13 Sept	4 Oct	8 Nov	6 Dec	24 Jan	21 Feb	20 Mar
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Grantham A&E / UTC					C		C																							
Grantham Medical Beds (Lincolnshire ASR)						C	C																							
Grantham Theatre Capacity																														
Hartsholme Psychiatric Intensive Care Unit																														
Hawthorn Medical Practice, Skegness																														
Health and Care Bill 2021 / Act 2022																														
Healthwatch Lincolnshire Annual Report																														
Healthwatch Lincolnshire Forward Vision Event																														
House of Commons Select Committee - Dentistry																														
Humber Acute Services Programme						C	C						C														C	C			
Humber and Lincolnshire Joint Scrutiny																														
Influenza Vaccination Programme																														
John Coupland Hospital, Gainsborough																														
Joint Forward Plan (NHS)																														
Joint Health and Wellbeing Strategy																														
Lakeside Healthcare, Stamford																														
Lincolnshire Acute Services Review				C			C																							
Lincolnshire Integrated Care Board																														
Lincolnshire Integrated Care Partnership																														
Lincolnshire Integrated Care Strategy																														
Lincolnshire Integrated Care System																														
Lincolnshire System Recovery Support Programme																														
Lincoln Medical School																														
Lincolnshire NHS Strategy																														
Lincolnshire People Board Update																														
LCHS - General Update																														
LPFT – General Update																														
Louth County Hospital																														
Mablethorpe Campus for Future Living																														
Mablethorpe Dental Services																														
Manthorpe Ward, Grantham and District Hospital																														
Maternity Wards, Lincoln County Hospital CQC																														
Mental Health Adult In-patient Wards																														
Mental Health Urgent Assessment Centre																														
Mental Health Service Developments																														
Mental Health Rehabilitation Service																														
NHS Backlogs and Waiting Times Report																														
NHS Discharge Fund																														
NHS England Announcements / Guidance																														
NHS Free Prescriptions – People Aged 60 - 66																														
NHS Joint Forward Plan																														
NHS Support for Victims of Sexual Assault																														
NHS Workforce Plan																														
Newark Road Surgery, Lincoln																														
Night Light Cafes																														
Non-Emergency Patient Transport Service				C																										
NLAG – Breast Oncology																														
NLAG – CQC Reports																														
North West Anglia NHS Foundation Trust																														
Norton Lea Mental Health Unit, Boston																														
Nottinghamshire Health Services																														
Nuclear Medicine (ULHT)																														
Older Adults Mental Health Services																														
Ophthalmology																														

	2021						2022										2023										2024		
	23 Jun	21 Jul	15 Sept	13 Oct	10 Nov	15 Dec	19 Jan	16 Feb	16 Mar	13 Apr	18 May	15 Jun	13 July	14 Sept	12 Oct	9 Nov	14 Dec	18 Jan	15 Feb	15 Mar	19 Apr	17 May	14 Jun	19 Jul	13 Sept	4 Oct	8 Nov	6 Dec	24 Jan	21 Feb	20 Mar
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Opioids																															
Orthopaedics (Lincolnshire ASR)						C	C																								
Paediatric Services (ULHT)	C																						C	C							
Peterborough City Hospital Maternity Services																															
Peter Hodgkinson Centre, Lincoln County Hospital																															
Pharmaceutical Needs Assessment												C																			
Pharmaceutical Services																															
Portland Medical Practice, Lincoln																															
Prescriptions – People Aged 60 - 66																															
Prostate Cancer Screening National Trial																															
Psychiatric Intensive Care Unit (Hartsholme)																															
Richmond Medical Centre, North Hykeham																															
Quality Accounts																															
Queen Elizabeth's Hospital, King's Lynn																															
Rochford Ward, Pilgrim Hospital Closure		C																													
Spalding GP Surgery																															
Stamford Minor Injuries Unit																															
Steps2Change – Talking Therapies																															
Storm Babet																															
Stroke Services (Lincolnshire ASR)					C		C																								
Suicide Prevention																															
Suicide Prevention and Mental Health WG																															
Talking Therapies - Steps2Change																															
ULHT - CQC Inspection																															
ULHT – Clinical Strategy 2024-29																															
ULHT - General Update																															
ULHT – Patient Flow and Discharge																															
ULHT – Recovery and Waiting Lists																															
Teaching Hospital Status (ULHT)																															
Urgent and Emergency Care Recovery Plan																															
Urgent Community Response Service (LCHS)																															
Urology Services (ULHT)	C	C																													
Water Supply Fluoridation																															
Woolsthorpe Branch Surgery																															

KEY TO ABBREVIATIONS	
ASR	Acute Services Review
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
DPH	Director of Public Health
EMAS	East Midlands Ambulance Service
ICB	Integrated Care Board
LCHS	Lincolnshire Community Health Services NHS Trust
LMC	Local Medical Committee
LPFT	Lincolnshire Partnership NHS Foundation Trust
NEPTS	Non-Emergency Patient Transport Service
NLAG	Northern Lincolnshire and Goole NHS Foundation Trust
ULHT	United Lincolnshire Hospitals NHS Trust
UTC	Urgent Treatment Centre

KEY TO ABBREVIATIONS	
WG	Working Group