Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Lincolnshire Health and Care prepared by Nigel Gooding, Head of Portfolio and Programme Office

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**22 July 2015**
Subject:	**The Critical Path to Developing Options for Future Healthcare Delivery in Lincolnshire**

Summary:

The purpose of this report is to inform and update the Health Scrutiny Committee on the evaluation of options and timelines for the future of Health and Care in Lincolnshire.

Actions Required:

To consider and comment on the information presented.

1. Background

1.1.1 The Objective

To address the challenges facing Lincolnshire, and to deliver a sustainable and safe Health and Social Care economy, commissioning and provider organisations across the county have established a joint programme of work known as Lincolnshire Health and Care (LHAC).

In the last 18 months the programme has developed a number of work streams and each is currently developing a range of service change options. We will be consulting publicly on some of these work streams from the winter of 2015.

In 2014 LHAC produced a blueprint plan for future health and care in Lincolnshire. This was widely shared with Lincolnshire residents, stakeholders and councillors. We had over

11,800 responding to that blueprint and the vision of health and care in Lincolnshire. The blueprint acknowledged financial pressures, access and quality of service provision in Lincolnshire and there was general acceptance that the current service is not sustainable in the longer term.

At the last meeting of the Health Scrutiny Committee on 11 June 2015, a paper and presentation was made which showed the progress and plan for the implementation of Neighbourhood Teams. As discussed Neighbourhood Teams are fundamental to the delivery of the programme of Health and Care change in Lincolnshire.

1.2 Neighbourhood Teams

Neighbourhood Teams are a key component of the Proactive Care Programme and is absolutely core to the delivery of the LHAC Vision.

- LHAC aspires to a population-based model of health where wellbeing is maximised through communities, voluntary and statutory services working together. The aspiration is to develop of services from “cradle to grave”.

- The Neighbourhood Team approach reflects a desire to move care closer to home whenever possible. In delivering health and care through Neighbourhood Teams there may be fewer situations where a patient journey to an acute hospital is required.

- It is common for those admitted to hospital to report their poor experiences due to high demand, stretched resources and low number of step up and step down beds available, whilst support in their community is currently fragmented.

- Neighbourhood Teams will address such issues by working in a multidisciplinary way to provide increasingly more joined up care and for information to be better shared, enabling people to be treated and cared for closer to home where possible and avoiding lengthy hospital stays and readmission.

The LHAC vision of provision of healthcare closer to home, working in partnership with Community Hospitals, the Third Sector and Community groups, is fundamental to the success of proposals the healthcare community.

1.3 Work streams

Neighbourhood Teams are only a component of a wider reconfiguration of health and care provision. The LHAC programme has five major work streams within it:

1. **Urgent Care:** A programme of work that reviews how urgent care is provided in Lincolnshire

2. **Elective Care:** A programme of work that reviews and make recommendations how we carry out acute hospital services in Lincolnshire and identify and plan for those that could be provided within the community and closer to home, including GP surgeries, Community Hospitals and other local providers

3. **Proactive Care:** This work stream develops Neighbourhood teams, self care and links to Adult Social Care so people can be treated within a community setting

4. **Woman and Children:** This work stream develops proposals around how we propose to deliver Woman and Children services including maternity services in the future

5. **Adult Specialist Services:** This work stream links all the programmes to proposals around adult specialist services such as community mental health provision.

1.4 Phase 2 Development of Work Streams

In summer 2014 the Blueprint was developed together with LHAC partners, stakeholders and providers. This work was taken one step further at that time to 'Phase 2'

This work built on the Blueprint and started to look at the development of a set of future service configuration proposals. You will be aware some have been implemented, e.g. Neighbourhood Teams. Due to the nature of other changes proposed in the Blueprint and Phase 2 health and care commissioners will need to consult publically. This will last a minimum of 12 weeks and will commence from winter 2015.

The proposals contained in Phase 2 have now been developed and we are now in a position to start preparing a Strategic Outline Case, (SOC). The SOC will require further work to enable us to arrive at a position where we can ask the public for their views in the formal public consultation.

Work completed in Phase 2 allowed clarification of how services could be configured, benefits to patients and how savings and efficiencies can be made. These are subject to the final short list that follows from criteria measurement of long list plans, governance and NHS assurance prior to formal public consultation. The work to date includes:

Women & Children's
The six interventions deliver a more effective, proactive service at a reduced cost, but no change in activity. The cost saving comes from doing the same things more efficiently through service consolidation and economies of scale.

Proactive and Urgent Care
There are ten Proactive Care initiatives shown combined with Urgent Care initiatives. This grouping reflects the fact that they are closely linked. Investment in Proactive Care is required to enable the benefits in Urgent Care. Additional work is ongoing to consider reduction in urgent care activity for children so that this becomes proactive rather than reactive.

The key headline objectives over five years are reduction in:

- A&E attendances of 17,800
- Non-elective admissions of 26,000
- Length of stay from 7 to 5 days for 75+ population admitted non-electively equal to 152 beds
- Beds in the residential care setting: 393 beds
- Acute care elective beds: 37 beds in five years.
- Note that elective system objectives need to be updated to reflect the updated assumptions.
- The total reduction in acute beds for due to the reasons above is 382 beds

Elective/Planned Care

Benefits for referral facilitation apply to all elective activities and specialties. Benefits for end-to-end integration of services are shown by specialty, as the intervention saving for each is variable.

Over the period to 2017-18 we are anticipating the number of people using hospital services to grow by c.7% and the proportion of those over 65 to grow from a 25% to 33%.

1.5 Impact

We have described interventions in the context of this expected new pattern of demand and the figures that follow summarises the assumptions for each intervention, but do not include quality benefits.

Service change area	Assumption	Assumed Reduction in an Acute Hospital Setting (Phase 2)
Reduction activity from referral facilitation	Reduction in Elective Activity	20%
Reduction in acute activity from community provision of elective procedures	Dermatology Rheumatology Pain management Gastroenterology Respiratory medicine Ophthalmology Clinical haematology Cardiology ENT Urology Gynaecology General surgery Orthopaedics Cost savings across ALL specialities	75% 90% 45% 40% 30% 45% 80% 40% 40% 33% 33% 33% 15% 25%

The LHAC Programme proposes to improve health and care services for a population of 718,000 people living in urban and rural environments in Lincolnshire

The Programme will impact on the lives of patients and staff, and aims to

- Deliver outcomes as fairly as possible, within the resources we have
- Put people, i.e. patients, customers and our staff, at the heart of what we do
- Evidence and ensure that the services meet customers' needs
- Fulfil our duties under the Equality Act 2010

An impact assessment will provide a formal measure of the changes proposed within the Programme to ensure that it does not inadvertently cause adverse impacts on any groups

of people. The consultation plan and rollout will also include the broadest range of groups, including protected characteristics groups.

Patients

It is recognised that the Lincolnshire population is aging and the programme addresses this with a proposal list that considers long-term conditions.

- Increasing the number and type of services delivered in the community, including some that are currently delivered in acute settings, will also have an impact on the travel needs of patients, where travel use will be reduced

- Patients in hospital will benefit from increased safety where staff are more accessible to meet their clinical and non-clinical needs

- Neighbourhood Teams will further provide patients with a wrap around service that reduces their need to attend A&E and a continuity of longer term care post-hospital where this is necessary.

- The development of a Clinical Assessment Service (CAS) from November 2015 aims to tackle the immediate need to address recovery within the system, but also to provide a single point of contact where patients can be triaged remotely and directed to the most appropriate service – so reducing the impact on A&E attendances and non-elective admissions

The impact of CAS on reducing patient numbers in these areas has been calculated:

A&E ATTENDANCES*

Overall reduction of 11,910 from November 2015

November – December 2015	496 fewer patients / month
January - February 2016	596 fewer patients / month
March 2016	794 fewer patients / month
April 2016 onwards	100% on a monthly basis, i.e. 992 (11,910/12) **

* These figures have been calculated in conjunction with ULHT

NON-ELECTIVE ADMISSIONS

Overall reduction of 5,420 from November 2015

November – December 2015	226/month
January - February 2016	271 fewer patients / month
March 2016	361 fewer patients / month
April 2016 onwards	100% on a monthly basis, i.e. 451 (5,420/12)**

** Figures will be distributed to reflect seasonal variances

Staff

The impact on staff will be three-fold.

i. A reduction in the number of patients attending A&E unnecessarily will enable staff to deal with the most critical cases.
ii. This will result in the need for fewer staff rotations where patients are otherwise served in community settings rather than in long waiting situations in hospitals/emergency units
iii. A consolidation through the Programme will also impact on estates and the need for reduced staff interventions, e.g. maintenance

Consultations with staff are managed through the Workforce enabler work stream.

1.6 Consultation

Work is now at a point whereby the Lincolnshire healthcare community wishes to get this work to a stage where we can publically consult on a range of options for the future service offering of those services that substantially change.

To deliver a robust consultation we must:

- Develop a strategic outline case (SOC) and consultation plan.
- Undertake a commissioner requested services (CSR) analysis
- Consult and agree that SOC and plan with our stakeholders and partners, the Health Scrutiny Committee playing a key role.
- Agree the proposals with the clinical senate & NHS England.

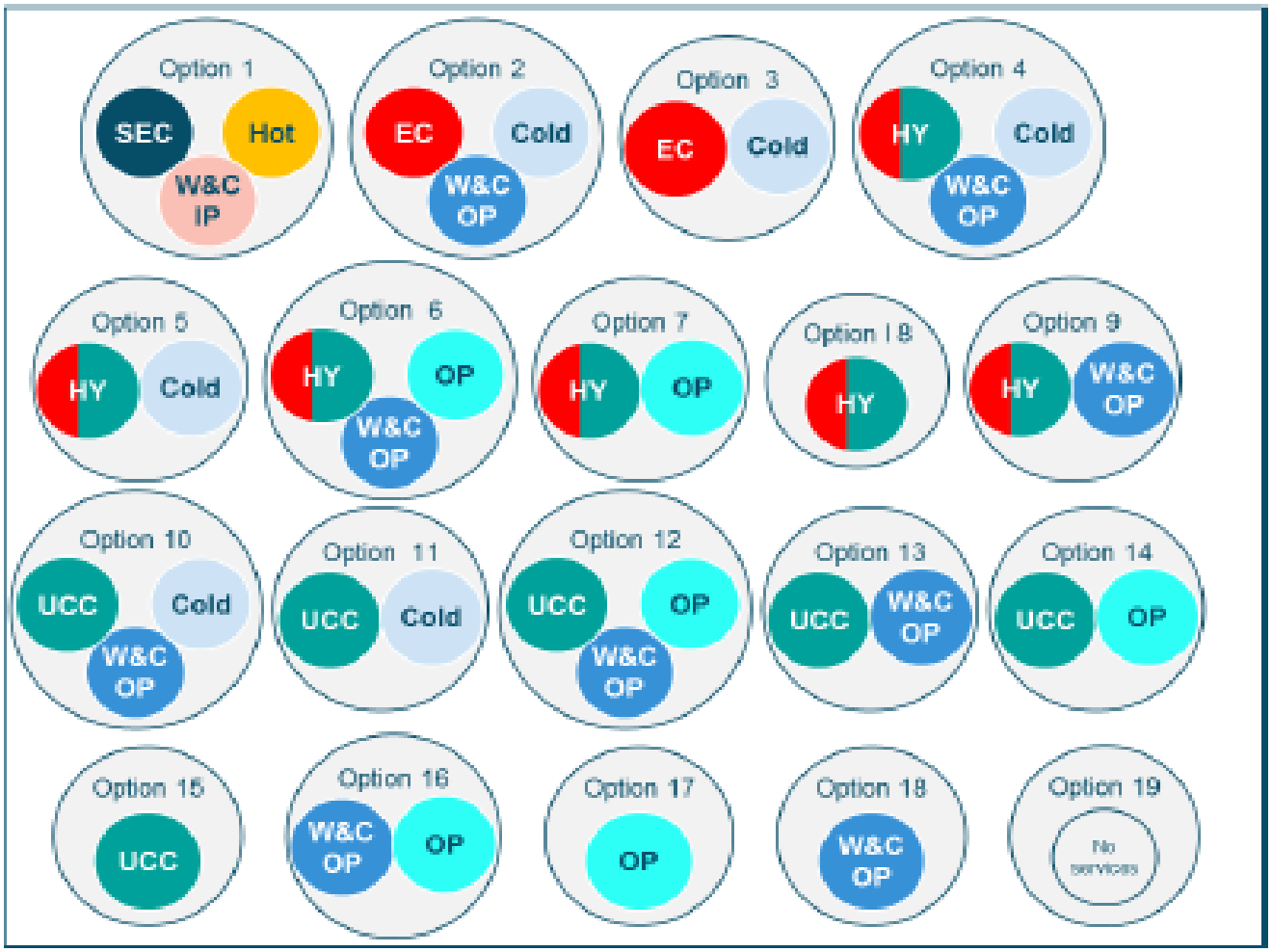
The timelines to deliver this strategic outline case and consultation is:

Deliverables for assurance – and consultation	Timeline 2015
Options Appraisals and Commissioner Required Services completed	June
Completion of service model development for the Strategic Outline Case	July
Development of services that do not need consultation, e.g. NT, CAS	July
Development of final options for consultation	August
Agreement of final Strategic Outline Case (SOC)	9 Sept
Lincolnshire Health Scrutiny Committee	16 September
Stakeholders and Partner Governing Bodies sign offs	Commences September
Health & Well Being Board	29 September
Lincolnshire County Council Executive	6 October
Public consultation starts (min 12 weeks) post NHS Assurance	November

1.7 Delivering proposals

To deliver a Strategic Outline Case we have to develop a set of proposals that have been through an objective process of evaluation. The Blueprint stated that there was a "long list" of options for service provisions.

The diagram below presents the complexity of work required to develop the "long list" outlined within the Blueprint and Phase 2.



MTC – Major Trauma Centre

SEC – Special Emergency Centre
EC – Emergency Centre
UCC – Urgent Care Centre
W&C OP – women's and children's outpatients

HY – Hybrid (small EC, with primary urgent care at front door)
Hot – highly acute elective care
Cold – low acuity elective care
OP – outpatient diagnostic centre
W&C IP – women's and children's inpatient

This "long list" of 19 different service configurations cannot go forward as a proposal to the public consultation stage, as it is simply too long.

Therefore work has developed throughout 2015 to establish a range of criteria that will allow an evaluation process to take place in order that we can include a short list of options.

The two stage process involves: -

- The reduction of the "long list" to a set of proposals - for the purpose of this proposal known as the "medium list". This is achieved by using Binary Criteria.

- The application of an evaluation process using a more detailed evaluation of each proposal to produce a "short list" of options that we can include within the Strategic Outline Case.

What are the Binary Criteria?

The Binary Criteria consider three aspects, which are also reflected in LHAC principles: Safety, Access and Affordability. The criteria do not consider deliverability, which is considered in the detailed evaluation criteria.

Criterion	Tests	Symbol
Safety *Does the option support safe and sustainable services?*	• Does the option have critical mass to deliver safe services under national guidance • Does the option meet minimum national safety standards? • Does the option consider clinical interdependencies? • Does the option meet Royal College guidelines and national / international best practice standards?	*x*
Access *Does the option prove appropriate access to essential services for the local population?*	• Does the CRS analysis show appropriate access levels?	Δ
Affordability *Does the option reduce costs of providing care relative to maintaining the status quo?*	• Does the option being considered cost no more than the current health provision?	+

The binary grid mentions the term Commissioner Requested Services (CRS). This is an activity that all commissioners of acute services in England have to undertake.

CRS is an analysis led by commissioners to provide an evidence base on what minimum services must be maintained should a healthcare trust or independent provider get into financial difficulty. This provides a safeguard and protects services and is enshrined in law.

What are the Evaluation Criteria?

Having first applied the tests of safety, access and affordability, the Evaluation Criteria, then go onto develop further analysis. The criteria we are proposing are as follows:

Criteria	Proposed Tests	Proposed Weighting
Quality of Care • Clinical quality and outcomes should be maintained and where possible improved • Patient experience should be maintained and where possible improved • Care should be integrated and focus on prevention and early intervention.	• Assess attainment and compliance of clinical outcomes against standards referenced in Phase 2 • Assess combined friends and family test for preferred service • Assess options against national guidance on safety requirements such as nurse to patient ratio	30
Access to care • Care should be provided into closer to home / better value care settings wherever possible • Ease and availability of care should be taken into consideration • There should be at least as much patient choice as current provision	• Undertake analysis of incremental increase in travel time • Choice criteria built into the CRS analysis • Inequality tests from CRS analysis	20
Affordability (Value for Money) • Long-term costs to the system (costs across the system in different domains must be considered) • Better value settings should be provided where possible • Ease of release costs needs to be taken into consideration	• Assess costs of provision • Assess income and expenditure benefit • Assess impact on other organisations	25
Deliverability • Ease of achieving transition towards new model of care • Feasibility of obtaining required transition funding • Ease of achieving workforces requirement (recruitment, retention, upskilling) • Alignment with national and local political agenda	• Assess the level of public and staff support with key stakeholders • Review the expected estates and recruitment risks • Estimate expected time to deliver and transition costs • Assess long term and financial sustainability • Assess alignment of options to other strategies	25

The current model of service provision is currently being reviewed for the future service configuration using the vision of delivering services locally. The current service going through the appraisal process is indicated below:

		Urgent and Emergency		Elective	Women's and Children's			
Provider	**Hospital**	A&E	UCC	Elective	Maternity: birth	Maternity: outpatient	Paediatric inpatients	Neonatal
ULHT	Lincoln	✓	✓	✓	✓	✓	✓	✓
	Boston	✓	✗	✓	✓	✓	✓	✓
	Grantham	✓	✗	✓	✗	✓	✗	✗
LCHS	Louth	✗	✓	✓	✗	✓	✗	✗
	Gainsborough (John Coupland)	✗	✓	✓	✗	✓	✗	✗
	Spalding (Johnson)	✗	✓	✓	✗	✓	✗	✗
	Skegness	✗	✓	✓	✗	✓	✗	✗

The blueprint and subsequent work to allow evaluation sees the following emerging options for review include:

Proactive Care

- Neighbourhood Team x 12 roll-out in 2015
- Possibly commissioned by January 2016
- Self care

Urgent Care

- Single Point of Contact
- Major Emergency Care Centre
- Urgent Care Centre
- Integration into Neighbourhood Team of acute setting activity

Elective Care

- Increased elective/planned care in community hospitals and primary settings
- Redesign pathway for clearer patient journeys
- Diagnostic services delivered where possible in a community setting

Women & Children

- Consolidation
- Care through Neighbourhood Team outreach
- Local consultation
- Day cases/in-patient only at main sites
- Community Hospital provision

These plans are being developed through the work stream programmes and those services that see significant change will be included with the Strategic Outline Case, which will be discussed at the September meeting of the Health Scrutiny Committee.

Those services which do not need consultation include Neighbourhood Teams, Self Care and the new CAS single point of access.

2. Conclusion

The Health Scrutiny Committee is requested to consider and comment on the information presented on the developing options for Lincolnshire Health and Care

3. Consultation

A formal consultation plan will accompany the Strategic Outline Case in September 2015.

4. Background Papers

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

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