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

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**17 June 2020**
Subject:	**Lincolnshire NHS - Restoration of Services**

Summary

This item focuses on the plans for the 'restoration' phase for NHS services, following the letter to all NHS Chief Executives from NHS England / Improvement on 29 April 2020.

Actions Required

To consider the information presented as the NHS moves into the 'restoration' phase.

1. Background

On 29 April 2020, Sir Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer, wrote to all local NHS Chief Executives, setting out the second phase of the response to covid-19, where the focus is on restoring NHS services.

2. Reports Considered by NHS Boards

Three reports to NHS Boards are attached. The first report to the Lincolnshire Clinical Commissioning Group Board on 27 May takes an overview of services in Lincolnshire. This report, entitled *Update – NHS Lincolnshire Response to and Management of COVID-19 Pandemic*, is attached at Appendix A. The report includes the letter from NHS England / Improvement on 29 April 2020.

The second report to the United Lincolnshire Hospitals NHS Trust (ULHT) Board on 2 June, entitled *ULHT Covid-19 Restore Phase Plan – Executive Summary*, is attached at Appendix B.

The final report is due to be considered by the ULHT Board on 12 June, entitled *Temporary Service Changes as a response to Covid-19*. This is attached at Appendix C.

3. Consultation

This is not a direct consultation item.

4. Conclusion

The Committee is requested to consider the information presented on the restoration of NHS services for Lincolnshire residents.

5. Appendices

These are listed below and attached to the report.

Appendix A	Report to Lincolnshire Clinical Commissioning Group Board (27 May 2020) Update – NHS Lincolnshire Response to and Management of COVID-19 Pandemic, including: Appendix 1 Daily Update – COVID-19 in Lincolnshire (as at 20/05) Appendix 2 Letter of 29 April from Simon Stevens and Amanda Pritchard 'Second Phase of NHS Response to COVID-19' Appendix 3 Slides – Second Phase Lincolnshire Response
Appendix B	Report to United Lincolnshire Hospitals NHS Trust Board (2 June 2020) - ULHT Covid-19 Restore Phase Plan – Executive Summary
Appendix C	Report to United Lincolnshire Hospitals NHS Trust Board (12 June 2020) - Temporary Service Changes as a response to Covid-19, including: Appendix 1 IPC Assurance Framework Appendix 2 Green Site Clinical Model Appendix 3 Quality Impact Assessment Appendix 4 Equality Impact Assessment

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 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

NHS
Lincolnshire
Clinical Commissioning Group

BOARD MEETING – PUBLIC

Date of Meeting:	27 May 2020	Agenda item:	4.1

Title of Report:	Update – NHS Lincolnshire Response to and Management of COVID-19 Pandemic
Report Author and Title:	John Turner, Chief Executive NHS Lincolnshire CCG
Appendices:	1. Daily Update – COVID-19 in Lincolnshire (as at 20/05) 2. Letter of 29 April from Simon Stevens and Amanda Pritchard 'Second Phase of NHS Response to COVID-19' 3. Slides – Second Phase Lincolnshire Response

1. Purpose of the Report (including link to objectives)

The purpose of this paper is to update the CCG Board in relation to:

i. The latest position in terms of the COVID-19 pandemic in Lincolnshire; and
ii. The NHS Lincolnshire System response and actions in relation to the 'Second Phase'

2. Recommendations

The Board is asked to note and consider all of the information in this report and the actions being taken.

3. Executive Summary

1. <u>NHS Lincolnshire and CCG Approach</u>

i. The NHS Lincolnshire approach to managing COVID-19 in the county has been one of joint working, partnership and support in the NHS between the CCG, Trusts, EMAS, and General Practice – and commitment to all work closely together to do the best we can for our patients, workforce and partners, whilst at the same time respecting the individual responsibilities which each has.

ii. In similar terms, the NHS in Lincolnshire is working closely through the Local Resilience Forum (LRF) structure with our wider partners in local government, the care sector, police, etc, to support and enable the best possible response to the Lincolnshire population as a whole.

iii. The NHS Lincolnshire System discipline previously described to the Board continues and includes:

a) Daily 0800 Chief Executives calls

b) Full participation in LRF calls and cells

c) Twice weekly Executive calls with Midlands Region NHSEI team, led by Dale Bywater, Regional Director

d) Weekly Chair calls with Dale Bywater, Regional Director

e) Weekly update briefings for Lincolnshire MPs/Leader of County Council

f) Regular ongoing liaison between CCG Chief Executive, Chief Executive of Lincolnshire County Council and Director of Adult Social Services

g) Regular briefings and meetings of the Lincolnshire Coordinating Board.

2. The Board will be aware of the changes recently introduced to the 'lockdown' measures by the Government as per the Prime Minister's national announcement on Sunday 10 May; the focus that there now is on reducing the 'R' number; that England is over the peak; and that numbers of new cases and hospital deaths in England currently is reducing. This position is also reflected locally in Lincolnshire.

3. <u>COVID-19 Case Numbers in Lincolnshire</u>

i. Lincolnshire continues to have comparatively low levels of COVID-19 cases and deaths. At the time of writing the transmission rate of 137/100,000 is third lowest in England; death rate in hospitals are fourth lowest; and excess deaths in Care Homes is the lowest in England.

ii. Appendix 1 shows the latest daily COVID-19 activity numbers update. This is updated daily and sent to Lincolnshire MPs and Leader of the County Council.

iii. Whilst Lincolnshire continues to have much lower transmission rates than most of the rest of the country, the rates at lower tier local authority (district) level are now being published, and show significant difference across the county. Rates per 100,000 (at 18/05) are:

England Average	256
Lincolnshire Average	137
Boston	302
East Lindsay	108
Lincoln	118
North Kesteven	112
South Holland	210
South Kesteven	108
West Lindsey	82

iv. The reasons for the higher rates in Boston are currently unclear. Points for consideration include:

a) Boston is one of the more densely populated areas of Lincolnshire and has a higher proportion of more deprived areas than average for the county (and compared to Lincoln). Urbanisation and deprivation are associated with statistically significantly higher rates of mortality (and potentially by inference infection)

b) The higher proportion of non-British born population, working in certain settings which could lead to an increased risk, plus language barriers, may result in lack of compliance to government advice and recommendations

c) Lack of comprehensive data about testing activity

d) Police advise there has been no significant increase in the use of powers to enforce social distancing in the Boston area.

v. Whilst there remains a huge amount of work going on, there are no significant immediate concerns to highlight to the Board in relation to:

a) PPE supply

b) The testing regime

c) Staffing sickness or availability

vi. The Workforce Cell remains particularly active, leading our approach to staffing support across the wider health (including primary care) sector, and extending a support offer to partners. Areas of ongoing focus include:

a) Support for staff from a Black and Minority Ethnic (BAME) background

b) Continued support to all staff and colleagues and the further development of Staff Wellbeing offers

4. 'Second Phase'

i. The NHS in Lincolnshire has continued to work closely together in progressing actions relating to the 'Second Phase' (up to approximately six weeks, focussed on essential non-COVID-19 services) of the NHS's response to the pandemic, in line with the attached 29 April letter from Simon Stevens and Amanda Pritchard.

ii. The CCG and Trusts have each progressed plans and actions for services which are their own responsibility whilst working very closely together as a System and ensuring a coordinated approach. On Thursday 14 May the NHS Lincolnshire System submitted its return to NHSEI, and key elements of that are highlighted in the attached slides.

iii. We await feedback from NHSEI, but all of the actions either have been, or are being, progressed in line with the plan.

iv. The Lincolnshire System Mental Health Recovery Cell, led by Brendan Hayes and with support and input from a range of partners, met initially on 12 May 2020, and is meeting on a weekly basis going forward. This will likely be a main feature of our response for a long period of time.

5. Third and Fourth Phases

i. As above, the NHS is currently in the Second Phase (approximately six weeks) of its response to the pandemic – restoring essential non-COVID-19 services.

ii. The Third Phase "recovery" will follow for the remainder of the 20/21 year, and the Fourth Phase "reset" from April 2021. Further details and national guidance about these will come from NHSEI in due course.

iii. We will continue to keep close to, and where possible influence, the developing Regional response to the two future phases, and will ensure that the Board is updated as thinking evolves.

6. Conclusion

i. The NHS in Lincolnshire, and across England, has now entered the 'second phase'. We will continue to work closely together to do the best we can for our patients, workforce and partners.

4.	Management of Conflicts of Interest
Not applicable to this paper.	

5.	Finance, QIPP and Resource Implications
Any implications will be identified in the main part of the paper.	

6.	Legal/NHS Constitution Considerations
Any considerations will be identified in the main part of the paper.	

7.	Analysis of Risk including Assessments

This section should identify known or potential risks and how these are being mitigated, including conflicts of interest.

Please state if the risk is on the CCG Risk Register.

Yes		No	

8.	Outline engagement – clinical, stakeholder and public/patient
Not applicable to this paper.	

9.	Outcome of Impact Assessments
Not applicable to this paper.	

10.	Assurance Departments/Organisations who will be affected have been consulted

Insert details of the departments you have worked with or consulted during the process:

Finance	
Commissioning	
Contracting	
Medicines Optimisation	
Clinical Leads	
Quality	
Safeguarding	
Other	

11.	Report previously presented at:
A previous update was presented to the April Board meeting.	

12.	For further information or for any enquiries relating to this report, please contact

John Turner, John.turner19@nhs.net

NHS
Lincolnshire
Clinical Commissioning Group

APPENDIX 1

DAILY COVID-19 SUMMARY for 20/05/20

Date	No. of COVID 19 cases in Lincolnshire	No. of COVID 19 cases in hospital (ULHT, LCHS, LPFT)	No. of COVID 19 Deaths in Lincolnshire Hospitals	Cumulative ULHT COVID 19 discharges
1 Apr	104	46	6	
2 Apr	133	55	7	
3 Apr	153	65	11	
4 Apr	223	77	11	
5 Apr	252	94	24	
6 Apr	275	87	24	
7 Apr	275	89	25	
8 Apr	277	108	28	
9 Apr	319	112	33	
10 Apr	363	96	36	
11 Apr	392	91	42	
12 Apr	412	90	45	
13 Apr	413	97	53	
14 Apr	464	92	58	
15 Apr	480	87	62	
16 Apr	503	93	65	
17 Apr	531	87	69	
18 Apr	551	80	70	129
19 Apr	579	70	72	133
20 Apr	584	68	74	134
21 Apr	585	66	76	136
22 Apr	593	69	83	142
23 Apr	669	59	85	147
24 Apr	712	59	86	151
25 Apr	725	58	91	157
26 Apr	748	59	92	162
27 Apr	759	59	94	162
28 Apr	781	55	94	172
29 Apr	804	51	97	179
30 Apr	804	46	101	184

NHS
Lincolnshire
Clinical Commissioning Group

Date	No. of COVID 19 cases in Lincolnshire	No. of COVID 19 cases in hospital (ULHT, LCHS, LPFT)	No. of COVID 19 Deaths in Lincolnshire Hospitals	Cumulative ULHT COVID 19 discharges
1st May	828	47	102	187
2nd May	834	53	107	194
3rd May	855	58	109	197
4th May	870	53	109	202
5th May	879	57	112	205
6th May	884	54	114	211
7th May	896	49	116	215
8th May	903	49	117	219
9th May	908	42	119	224
10th May	916	44	120	229
11th May	917	43	120	230
12th May	917	49	121	232
13th May	977	53	122	234
14th May	996	44	125	238
15th May	1002	42	126	240
16th May	1015	38	126	245
17th May	1036	35	128	248
18th May	1040	35	129	250
19th May	1042	37	130	252
20th May	1043	31	130	256

APPENDIX 2

Skipton House
80 London Road
London SE1 6LH
england.spoc@nhs.net

From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

29 April 2020

Dear Colleague,

IMPORTANT - FOR ACTION - SECOND PHASE OF NHS RESPONSE TO COVID19

We are writing to thank you and your teams for everything you have achieved and are doing in securing the remarkable NHS response to the greatest global health emergency in our history.

On 30th January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. Then in the light of the latest SAGE advice and Government decisions, on 17th March we wrote to initiate what has been the fastest and most far reaching repurposing of NHS services, staffing and capacity in our 72-year history.

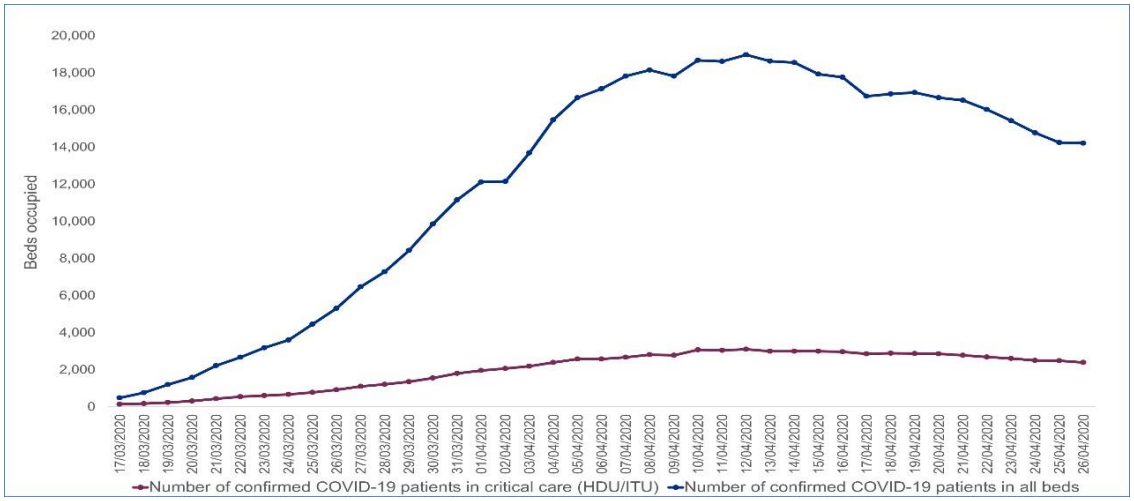
This has enabled us in the space of the past six weeks to go from looking after zero such patients to caring for 19,000 confirmed Covid19-positive inpatients per day, many of whom have needed rapidly expanded critical care support. Alongside this, the majority of patients the Health Service has continued to look after have been receiving care for other important health conditions. Despite real concern going in to the pandemic – following difficult international experience – every coronavirus patient needing hospital care, including ventilation, has been able to receive it.

This has largely been possible as a result of the unparalleled commitment and flexibility of NHS staff, combined with the public's 'social distancing' which remains in

place to cut the spread of the virus. We have also been greatly strengthened by over 10,000 returning health professionals; 27,000 student nurses, doctors and other health professionals starting their NHS careers early; 607,000 NHS volunteers; and the work of our partners in local government, social care, the military, the voluntary sector, hospices, and the private sector.

Sadly coronavirus looks set to be with the us for some time to come, so we will need continuing vigilance. We are, however, now coming through this peak of hospitalisations, as seen by the drop of nearly 5,000 in the daily number of confirmed Covid19-positive patients in hospitals across England over the past fortnight.

Patients with confirmed Covid19 in hospital beds, England



As the Prime Minister set out on Monday, we are therefore now entering the second phase in the NHS's response. We continue to be in a Level 4 National Incident with all the altered operating disciplines that requires. NHS organisations therefore need to fully retain their EPRR incident coordination functions given the uncertainty and ongoing need. The purpose of this letter is to set out the broad operating environment and approach that we will all be working within over the coming weeks.

Based on advice from SAGE, we still expect to be looking after several thousand **Covid19-positive patients**, though hopefully with continuing weekly decreases. This means:

- Ongoing and consistent application of PHE/NHS Infection Prevention and Control guidance in all NHS organisations, with appropriate cohorting of Covid/non-Covid patients (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control).

- In response to the global shortage, DHSC and the Cabinet Office together with BEIS (for UK manufacture) and DIT (for international suppliers) continue to expand the sourcing and procurement of HSE/PHE-recommended PPE for the NHS, social care and other affected sectors of the UK economy, but it is likely that current Covid-specific logistics and distribution arrangements will need to continue for the time being.

- Increased lab capacity now enables testing of all non-elective inpatients at point of admission, the introduction of pre-admission testing of all elective patients, testing prior to discharge to a care home, as well as expanded testing for staff. The corollary is the operational importance of fast turnaround times for test result reporting.

The pressure on many of **our staff** will remain unprecedented, and they will need enhanced and active support from their NHS employers to ensure their wellbeing and safety.

- Increased testing capacity means that we will now be able to extend the offer of regular testing to asymptomatic staff, guided by PHE and clinical advice. This approach is being piloted in a number of acute, community and mental health providers this week, which will inform further roll out from next week.

- As set out in our letter of 17th March, NHS organisations should continue to assess staff who may be at increased risk - including older colleagues, pregnant women, returnees, and those with underlying health conditions - and make adjustments including working remotely or in a lower risk area. Educational material, training and appropriate protection should be inclusive and accessible for our whole workforce, including our non-clinical colleagues such as cleaners and porters.

- Emerging UK and international data suggest that people from Black, Asian and Minority Ethnic (BAME) backgrounds are also being disproportionately affected by Covid19. Public Health England have been asked by DHSC to investigate this. In advance of their report and guidance, on a precautionary basis we recommend employers should risk-assess staff at potentially greater risk and make appropriate arrangements accordingly.

- Now more than ever a safety and learning culture is vital. All our staff should feel able to raise concerns safely. Local Freedom to Speak Up Guardians are able to provide guidance and support with this for any concerned member of staff. As we know, diverse and inclusive teams make better decisions, including in the Covid19 response.

- Employers are also asked to complete the process of employment offers, induction and any necessary top-up training within the next fortnight for all prospective ‘returners’ who have been notified to them.

We are going to see increased demand for Covid19 aftercare and support in **community health services, primary care, and mental health.** Community health services will need to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing health support. High priority actions for mental health providers in this next phase are set out in the Annex. General practice will need to continue to stratify and proactively contact their high-risk patients with ongoing care needs, including those in the ‘shielding’ cohort to ensure they are accessing needed care and are receiving their medications.

Given the scale of the challenges they face, we must also continue to partner with **local authorities** and Local Resilience Forums (LRFs) in providing mutual aid with our colleagues in **social care**, including care homes. This includes:

- Continuing to ensure that all patients safely and appropriately being discharged from hospital to a care home are first tested for Covid19; care homes can also check that these tests have been carried out.

- Under the direction of the LRF, local authority public health departments and CCG infection control nurses can help 'train the trainers' in care homes about PHE's recommended approach to infection prevention and control - particularly focusing on those care homes that lack the infrastructure of the bigger regional and national chains.

- To further support care homes, the NHS will bring forward from October to May 2020 the national roll out of key elements of the primary and community health service-led Enhanced Health in Care Homes service. Further detail will be set out shortly.

- Opportunities to support care homes should also be provided to younger health professional 'returnees' and public volunteers who have offered to help (subject to appropriate personal risk assessment, as described above).

As also seen in a number of other countries, **emergency activity** has sharply reduced in recent weeks. Last week emergency hospital admissions were at 63% of their level in the same week last year. This is likely due to a combination of: a) changed healthcare seeking behaviour by patients, b) reductions in the incidence of some health problems such as major trauma and road traffic accidents, c) clinical judgements about the balance of risk between care in different settings, and d) some NHS care being provided through alternative access routes (eg ambulance 'see and treat', online appointments).

There is therefore considerable uncertainty as to the timing and extent of the likely rebound in emergency demand. To the extent it happens, non-elective patients will potentially reoccupy tens of thousands of hospital beds which have not had to be used for that purpose over the past month or so.

This means we need to retain our demonstrated ability to quickly repurpose and **'surge' capacity** locally and regionally, should it be needed again. It will also be prudent, at least for the time being, to consider retaining extra capacity that has been brought on line - including access to independent hospitals and Nightingale hospitals. The national Nightingale team will work with Regions and host trusts to develop and assure regional proposals for the potential ongoing availability and function of the Nightingale Hospitals. Independent hospitals and diagnostics should be used for the remainder of the current contract which runs to the end of June. Please also start now to build a plan for each STP/ICS for the service type and activity volumes that you think could be needed beyond the end of June, which can inform discussions during May about possible contract extensions with the independent sector.

Over the next six weeks and beyond we have the opportunity to begin to release and redeploy some of the treatment capacity that could have been needed while the number of Covid19 patients was rising so sharply.

This means we are now asking all NHS local systems and organisations working with regional colleagues fully to step up **non-Covid19 urgent services** as soon as possible over the next six weeks, including those set out in the Annex. This needs to be a safe restart with full attention to infection prevention and control as the guiding principle.

In addition, you should now work across local systems and with your regional teams over the next 10 days to make judgements on whether you have further capacity for at least some **routine non-urgent elective care**. Provisional plans will need to factor-in the availability of associated medicines, PPE, blood, consumables, equipment and other needed supplies. We will continue to provide new ventilators to trusts over the coming weeks so as to sustain critical care 'surge' capacity should it again be needed in future, while progressively returning operating theatres and recovery suites to their normal use.

We should also take this opportunity to **'lock in' beneficial changes** that we've collectively brought about in recent weeks. This includes backing local initiative and flexibility; enhanced local system working; strong clinical leadership; flexible and remote working where appropriate; and rapid scaling of new technology-enabled service delivery options such as digital consultations.

In terms of wider action that will also be underway, DHSC will be designing and establishing its new 'Test, Track & Trace' service. The leadership and resourcing of local authority public health departments will be vital. Trusts and primary care networks should continue to support clinicians to enrol patients in the three major phase III clinical trials now underway across the NHS, initially testing ten potential Covid19 treatments. In addition, at least 112 Covid19 vaccines are currently in development globally. We also expect an expanded winter flu vaccination campaign alongside a school immunisation 'catch up programme'.

Looking forward, at the right time and following decision by Government, we will then need to move into the NHS's phase three 'recovery' period for the balance of the 2020/21 financial year, and we will write further at that point.

In the meantime, please accept our personal thanks and support for the extraordinary way in which you and your staff have risen to this unprecedented global health challenge.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX

ACTIONS RECOMMENDED FOR URGENT CLINICAL SERVICES OVER THE NEXT SIX WEEKS

Urgent and routine surgery and care

- Strengthen 111 capacity and sustain appropriate ambulance services 'hear and treat' and 'see and treat' models. Increase the availability of booked appointments and open up new secondary care dispositions (SDEC, hot specialty clinic, frailty services) that allow patients to bypass the emergency department altogether where clinically appropriate.
- Provide local support to the new national NHS communications campaign encouraging people who should be seeking emergency or urgent care to contact their GP, go online to NHS 111 or call 999 if necessary.
- Provide urgent outpatient and diagnostic appointments (including direct access diagnostics available to GPs) at pre-Covid19 levels.
- Ensure that urgent and time-critical surgery and non-surgical procedures can be provided at pre-Covid19 levels of capacity. The Royal College of Surgeons has produced helpful advice on surgical prioritisation available at: (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf)
- In the absence of face-to-face visits, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.
- Solid organ transplant services should continue to operate in conjunction with the clinical guidance developed and published by NHS Blood and Transplant.
- Where additional capacity is available, restart routine electives, prioritising long waiters first. Make full use of all contracted independent sector hospital and diagnostic capacity.
- All NHS acute and community hospitals should ensure all admitted patients are assessed daily for discharge, against each of the Reasons to Reside; and that every patient who does not need to be in a hospital bed is included in a complete and timely Hospital Discharge List, to enable the community Discharge Service to achieve safe and appropriate same day discharge.

Cancer

- Providers have previously been asked to maintain access to essential cancer surgery and other treatment throughout the Covid19 pandemic, in line with guidance from the Academy of Medical Royal Colleges and the NHS (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf and https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf). An exception has been where clinicians consider that for an individual patient the risk of the procedure at the current time outweighs the benefit to the patient.

- Local systems and Cancer Alliances must continue to identify ring-fenced diagnostic and surgical capacity for cancer, and providers must protect and deliver cancer surgery and cancer treatment by ensuring that cancer surgery hubs are fully operational. Full use should be made of the available contracted independent sector hospital and diagnostic capacity locally and regionally. Regional cancer SROs must now provide assurance that these arrangements are in place everywhere.
- Referrals, diagnostics (including direct access diagnostics available to GPs) and treatment must be brought back to pre-pandemic levels at the earliest opportunity to minimise potential harm, and to reduce the scale of the post-pandemic surge in demand. Urgent action should be taken by hospitals to receive new two-week wait referrals and provide two-week wait outpatient and diagnostic appointments at pre-Covid19 levels in Covid19 protected hubs/environments.
- High priority BMT and CAR-T procedures should be able to continue, where critical care capacity is available.

Cardiovascular Disease, Heart Attacks and Stroke

- Hospitals to prioritise capacity for acute cardiac surgery, cardiology services for PCI and PPCI and interventional neuroradiology for mechanical thrombectomy.
- Secondary care to prioritise capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.
- Primary care clinicians to continue to identify and refer patients acutely to cardiac and stroke services which continue to operate throughout the Covid19 response.
- Hospitals to prioritise capacity for stroke services for admission to hyperacute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.

Maternity

- Providers to make direct and regular contact with all women receiving antenatal and postnatal care, explaining how to access maternity services for scheduled and unscheduled care, emphasising the importance of sharing any concerns so that the maternity team can advise and reassure women of the best and safest place to receive care.
- Ensure obstetric units have appropriate staffing levels including anaesthetic cover.

Primary Care

- Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.
- Complete work on implementing digital and video consultations, so that all patients and practices can benefit.
- Given the reduction of face-to-face visits, stratify and proactively contact their high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams. In

particular, proactively contact all those in the ‘shielding’ cohort of patients who are clinically extremely vulnerable to Covid19, ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary.

- To further support care homes, the NHS will bring forward a package of support to care homes drawing on key components of the Enhanced Care in Care Homes service and delivered as a collaboration between community and general practice teams. This should include a weekly virtual ‘care home round’ of residents needing clinical support.
- Make two-week wait cancer, urgent and routine referrals to secondary care as normal, using ‘advice and guidance’ options where appropriate.
- Deliver as much routine and preventative work as can be provided safely including vaccinations immunisations, and screening.

Community Services

- Sustain the Hospital Discharge Service, working across secondary care and community providers in partnership with social care. Includes daily reviews of all patients in a hospital bed on the Hospital Discharge List; prompt and safe discharges when clinically and in line with infection control requirements with the planning of ongoing care needs arranged in people’s own homes; and making full use of available hospice care.
- Prepare to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing community health support.
- Essential community health services must continue to be provided, with other services phased back in wherever local capacity is available. Prioritise home visits where there is a child safeguarding concern.

Mental Health and Learning Disability/ Autism services

- Establish all-age open access crisis services and helplines and promote them locally working with partners such as local authorities, voluntary and community sector and 111 services.
- For existing patients known to mental health services, continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding.
- Ensure that children and young people continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school.
- Prepare for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan.
- Annual health checks for people with a learning disability should continue to be completed.
- Ensure enhanced psychological support is available for all NHS staff who need it.
- Ensure that you continue to take account of inequalities in access to mental health services, and in particular the needs of BAME communities.

- Care (Education) and Treatment Reviews should continue, using online/digital approaches.

Screening and Immunisations

- Ensure as a first priority that screening services continue to be available for the recognised highest risk groups, as identified in individual screening programmes.
- Increase the delivery of diagnostic pathways (including endoscopy) to catch up with the backlog of those already in an active screening pathway, followed by the rescheduling of any deferred appointments.
- Antenatal and Newborn Screening Services must be maintained because this is a time critical service.
- Providers and commissioners must maintain good vaccine uptake and coverage of immunisations. It is also likely that the Autumn/Winter flu immunisation programme will be substantially expanded this year, subject to DHSC decision shortly.

Reduce the risk of cross-infection and support the safe switch-on of services by scaling up the use of technology-enabled care

- In response to Covid19, general practice has moved from carrying out c.90% of consultations with patients as face-to-face appointments to managing more than 85% of consultations remotely. 95% of practices now having video consultation capability live and the remaining few percent in the process of implementation or procurement of a solution. GP Practices should continue to triage patient contacts and to use online consultation so that patients can be directed to the most appropriate member of the practice team straight away, demand can be prioritised based on clinical need and greater convenience for patients can be maintained.
- Referral streaming of new outpatient referrals is important to ensure they are being managed in the most appropriate setting, and this should be coupled with Advice and Guidance provision, so that patients can avoid an outpatient referral if their primary care service can access specialist advice (usually via phone, video too).
- All NHS secondary care providers now have access to video consultation technology to deliver some clinical care without the need for in-person contact. As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure, and unless there are clinical or patient choice reasons to change to replace with in-person contact. Trusts should use remote appointments - including video consultations - as a default to triage their elective backlog. They should implement a ‘patient initiated follow up’ approach for suitable appointments - providing patients the means of self-accessing services if required.

NHS
Lincolnshire
Clinical Commissioning Group

Update to Lincolnshire CCG Board Board
System Covid 19 Phase 2 Response

APPENDIX 3

NHS
Lincolnshire
Clinical Commissioning Group

COVID 19 Timeline To Date

- 30 January, NHSEI declared this as a Level 4 National Incident. Incident Command Centres stood upacross Trusts and CCGs
- 17th March 20: Letter from Simon Stevens – free up maximum inpatient and critical care capacity, stress test plans for 'peak'
- 30 March 20: Lincolnshire system established NHS System Response Centre (SRC) and cellstructure
- 29th April 20: Letter from Simon Stevens - Second Phase Planning, 'safe re start' of services
- 6th May 20: Letter from Region – Phase 2 Plan submission & Key Lines Of Enquiry(KLOE) due 140520

Covid 19 Phase 2

Phase 2 Key Requirements:

- Safely Restore non COVID19 urgent services that have been stood down to date
- Assess if the system has capacity for non urgent routine elective care and ensure Independent Sector(IS) capacity is fully utilised
- Ensure all plans fully reflect Infection Prevention Control (IPC) guidance and Board Assurance Framework
- Plans need to be agreed with commissioners and be resilient to demand changes
- Clear communication plans with communities and stakeholders

NHS
Lincolnshire
Clinical Commissioning Group

COVID 19 Phase 2

Urgent Care	Lincolnshire Position as at 14/05/20
Increase the availability of booked appointments and open up new secondary care dispositions of Same Day Emergency Care (SDEC), Hot Clinics and Frailty to allow patients to bypass the emergency department altogether where clinically appropriate.	Service already in place, Implemented increased availability for services, but the access remains via A&E - Front Door navigator and Clinical Assessment Service (CAS) and book into the Urgent Treatment Centre (UTC)
Confirm that in the absence of face-to-face visits, primary and secondary care clinicians have a process to stratify and proactively contact their high risk patients.	In place
What have systems partners agreed / put in place to maintain discharge levels; ensuring that all admitted patients continue to be assessed daily for discharge	To ensure continuation of the following: 1) Streamlined referral processes; 2) Single Point of Access (SPA) for all referrals; 3) Trusted assessor documentation; 4) Collaborative system working; 5) Building relationships and standardising processes with out of county partners; 6) Embedding Home First ethos and Discharge To Assess (D2A)Model; 7) Follow-up of patients on pathway 0; 8) Daily review of medically optimised patients; 9) Community links to stranded patient reviews; 10) Aim to discharge patients within 3 hours of becoming medically optimised 11) Redesign medically optimised calls so that there is senior system wide leadership daily; 12) for ULHT to continue as owners and reviewers of SPA inbox; 13) ULHT discharge team extension of hours; 14) to continue with long length of stay patient reviews underpinned by system-wide collaboration.

COVID 19 Phase 2

Routine Surgery & Cardiovascular, Stroke	Lincolnshire Position as at 14/05/20
Provide urgent outpatient appointments at pre-COVID-19 levels.	Delivering 100% Pre Covid, Utilising technology enabled care wherever possible - telephone, VC
Provide urgent diagnostic appointments (including direct access diagnostics available to GPs) at pre-COVID-19 levels.	Delivering 100% Pre Covid, including GP Direct Access
Capacity for cardiology services for angioplasty and stents (PCI & PPCI)	Delivering 100% Pre Covid.
Secondary care capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.	Delivering 100% Pre Covid.
Capacity for stroke services for admission to hyper acute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.	Delivering 100% Pre Covid, Implementation of temporary hub and spoke model, with all hyper-acute admission to Lincoln site, will be maintained for Restore phase to maintain consultant rota As a system we are delivering 100% - interim pathway for some patients to be treated for Hyper acute at NWAFT and rehabilitation after 3 days to Pilgrim Hospital
Primary care clinicians to continue to identify and refer patients acutely to cardiac and stroke services	Remained fully open and continued referrals

NHS
Lincolnshire
Clinical Commissioning Group

COVID 19 Phase 2

Cancer	Lincolnshire Position as at 14/05/20
Local systems and Cancer Alliances must continue to identify ring-fenced surgical capacity for cancer, System cancer SROs must now provide assurance that these arrangementsare in place.	Moving to 7 day operating lists from 18 May, and then from 1 June green pathway potential enabling 4 theatres, 12h lists, 7/7
2WW Referrals, must be brought back to pre- pandemic levels at the earliest opportunity .	Current 50% Pre Covid. Meeting two week wait (2WW) demand, however 2WW referrals demand down by circa. 50% during Covid19. 80% of demand is being seen within 7 days. Communications in place
Cancer diagnostics (including direct access diagnostics available to GPs) must be brought back to pre-pandemic levels at the earliest opportunity .	Diagnostics is split mainly between Radiology (high volume and continued service) and Endoscopy (lower volume, stopped due to COVID), so overall figure would hide large variation. Dependent on referral volumes and national governing bodies advice (eg JAG)
Cancer treatment must be brought back to pre- pandemic levels at the earliest opportunity.	Current 75% Pre Covid. Dependent on referral volumes in to the Trust and any changes in treatment modalities in line with national, COVID19 clinical guidance may have a greater or lesser impact on our treated numbers.
Delivery of urgent and time critical chemotherapy	Current , Urgent 75% , Critical 100% of Pre Covid. Reduced activity due to social distancing, changes to clinical pathways in line with NICE guidance for chemotherapy regimes, based on clinical priority.
Plan to continue to deliver urgent and time critical radiotherapy	Delivering 100% Pre Covid
Please describe the system arrangements in place for oversight of the 62 Day and 104+ backlog – tracking and profiling?	All pts over day 62 are discussed in the weekly Cancer PTL meeting, chaired by the CSS Divisional Managing Director. All pts over 104 days are reviewed every week by the Lead Cancer Clinician with the Cancer Centre Manager

NHS
Lincolnshire
Clinical Commissioning Group

COVID 19 Phase 2

Mental Health, LD, Autism	Lincolnshire Position as at 14/05/20
Confirm your plan to make your 24/7 crisis lines permanent, with appropriate pathways in place for onward referral for children and adults.	All-age open access crisis services in place including 24/7 mental health liaison at Boston and Lincoln. 24/7 helpline launched 22nd March with pathways in place for Children and Young people (CYP). Out of hours CYP referrals are directed into LPFT SPA and handled by Child and Adolescent Mental Health Services (CAMHS). In hours CYP professional, family and service user helpline is in place 9:30 to 16:30. 24/7 Crisis vehicular response commissioned and fully operational.
Please confirm, for existing patients known to mental health services, current levels to continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding.	7 day Community Mental Health Teams (CMHTs) and Home Treatment services in place and new adult CMHT intensive case management model established.
Ensure that children and young people continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school.	Good links in place with local schools and other partners. Traditional referral routes remain open with self referral being promoted through the Healthy Minds emotional wellbeing service
Please detail plans to preparations for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan. This should include preparation for increases in numbers of patients with PTSD, complex trauma and bereavement.	24/7 telephone helpline established. Covid bereavement helpline established via St. Barnabas hospice. Recruitment to posts identified as part of community transformation (Long Term Plan) almost complete. Part of Mental Health System Population workstream

COVID 19 Phase 2

Mental Health, LD, Autism	Lincolnshire Position as at 14/05/20
hat enhanced psychological support is available for all NHS staff who need it, including processes to make sure that BAME staff are considered and protected.	LPFT staff wellbeing service is in place and being supplemented by a dedicated staff helpline during the Covid crisis LPFT staff wellbeing service is in place also: - Introduction of emotional wellbeing line, 'in the moment' support for all Lincolnshire NHS, CCG and GP surgery staff not just LPFT -All BAME staff have received a letter from their NHS Trusts outlining support with respect to risk management and general support. Trusts are also looking at the actual evidence on the impact of their staff.
Please detail the plans in place to segregate COVID-19 + patients, in mental health settings.	Utilisation of available ward space within Inpatient sites. Areas that can be isolated from rest of ward have been identified, these have in some instances ensuite facilities and individual bedrooms which helps facilitate isolation.
Maintaining reductions in Learning Disability Autism (LDA) in-patients numbers (all ages).	Local protocols relating to Care Education and Treatment Reviews (CETR) processes remain viable. Liaison services are still operating. Mental health and LD crisis services are still operating and able to avoid admission as well as support step down.
Please detail the current status of Learning Disabilities Mortality Review (LeDeR) – ensuring delivery of rapid review of deaths and continue or restart the plans for full LeDeR reviews.	All LeDeR review deaths are centraly allocated by the lead based within Lincolnshire CCG. This process has continued during the Covid-19 process.
Care (Education) and Treatment Reviews should continue, using online/digital approaches. Please confirm current percentage pending, and percentage delivered using digital.	CETR 100% delivered or in progress

NHS
Lincolnshire
Clinical Commissioning Group

COVID 19 Phase 2

Primary Care & Community	Lincolnshire Position as at 14/05/20
Please confirm a plan is in place to proactively contact high-risk patients with ongoing care needs, in particular, those in the 'shielding'. Ensuring they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary.	All practices have identified their high risk patients. Medication delivery arrangements are in place and home visits are provided where these are clinically required. Primary Care, Neighbourhood teams (including social prescribing) and the community and voluntary cell have worked together to ensure that the patients needs are identified and the appropriate support provided
Please confirm Community and general practice teams are undertaking a weekly virtual 'care home round' of residents needing clinical support.	Current 25% of Pre Covid , 100% by mid June, A key risk has been identified in some Primary Care Network(PCN) areas regarding primary care capacity to support the high number of care homes in the locality. We are currently establishing a cross agency working group to develop a mitigation plan in order to ensure that the key objectives are achieved for residents in these areas.
Please confirm patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.	Practices have used local media to make , alongside this we have worked with other partners and our communication and engagement team to ensure public information is widely available. 111 / local CAS have accurate information regarding service provision and are able to direct patients to the right service.
Please detail the plan for capacity to support the increase in patients who have recovered from COVID-19 and who having been discharged from hospital needing ongoing community health support.	LCHS undertook community capacity modelling including the acute surge modelling which informed our expected demand. This looked at community hospitals required bed numbers, activity expected through our urgent care clinical assessment services (CAS) and home visiting, community nursing and palliative care. Increased use of digital
Please confirm the essential community health services in line with national guidance continue to be provided fully, (with other services phased back in wherever local capacity is available).	Delivering 100% Pre Covid

NHS
Lincolnshire
Clinical Commissioning Group

COVID 19 Phase 2

Digital	Lincolnshire Position as at 14/05/20
GPs triage patient contacts and utilise online consultation	75 practices out of 86 have implemented, or are implementing text based on- line consultation packages. A further 2 are considering implementation
Referral streaming of new outpatient referrals using Advice and Guidance- (A&G) (access specialist advice via phone/video).	Not Currently Collaborating with system and primary care colleagues to scope implementation of technology enabled new referral streaming using 'Ask My Consultant' Pilot with 2 PCNs
Video or telephone appointments should be offered by default for all outpatient activity without a procedure (were practicable), and unless there are clinical or patient choice reasons to change to replace with in-person contact.	Circa. 50% of Outpatient (OPA) activity now by telephone consultation. Circa. 350 VC consultations undertaken in April 20
Use of remote appointments - including video consultations - as a default to triage the elective backlog.	Partial Booking Waiting List (PBWL) triage being undertaken across specialties with admin and clinical review, telephone contact and appropriate actions, i.e. discharge, Patient Initiated Follow Up (PIFU)
Implement a 'patient initiated follow up' approach for suitable appointments - providing patients the means of self-accessing services if required.	Low usage - Scoping to increase the use of PIFU across specialties

NHS
Lincolnshire
Clinical Commissioning Group

COVID 19 Phase 2

Areas of national focus	Lincolnshire Position as at 14/05/20
How many 'Bringing Back Staff' staff have been employed in system services to date?	9 (2 employed, 1 employment being processed and 6 have been contacted to establish their current position). It should be noted that some were offered positions but declined.
How many students have been employed in system services to date? And how many do you plan to use during restoration	126 plus Student Nurses /HCSW(Health Care Support Workers) - these are the Y2 student nurses who were already in the process of joining bank as HCSW - 51 contracted - 11 available. Future state unclear at present
How many COVID-19 volunteers have been deployed in the system services to date?	6 It should be noted that the national call for volunteers has been very successful in Lincolnshire and all LRF community and Volunteer cell requests have been met. Data is not available from the national pool
How many further COVID-19 volunteers are you planning to deploy during restoration?	0 at present. During the recent episode the anticipated surge was not as high as first thought and therefore demand has been met through redeployment of existing substantive workforce as well as use of bank. Future use of voluntary services will depend around service reconfiguration and how we commence essential services over the next few months and whether we experience a further surge. Our system is able to deploy Volunteers as required and this is being monitored.
What arrangements are in place to maintain clear operational oversight of services as they are reinstated and fully restored to identify and escalate any specific service issues?	Trust ICCs are accountable to their own trust board and have a range of cells along with clear Gold, Silver and Tactical command. The current Lincolnshire NHS response centre structure captures daily information through ICCs and Cells into the System Response Centre (SRC). The Incident Management Team (IMT) that oversees the SRC regularly reports into SET/LCB and directly into NHSEI in line with national requirements through ICCs. The Chief execs hold a daily call across the system

COVID 19 Next Steps

The planning aligned with the NHSE/I phases:

- Phase 1: Continue Effective management of COVID-19 (Now)
- Phase 2: Restoration (May – June)
- Phase 3: Recovery & Reset (July – March) – addressing long waits or any backlogs in line with new operating guidance for safe services – this work will start now and run concurrently with Phase 2
- Phase 4: Reset – Shaping the new Norm/ the new NHS (2021/22)

APPENDIX B

Title:	ULHT Covid-19 Restore Phase Plan – Executive Summary
Date:	2 June 2020

Author/Responsible Director: Simon Evans, Chief Operating Officer

Purpose of the report:

To provide summary of United Lincolnshire Hospitals NHS Trust response to the Covid-19 pandemic during the *Restore* phase.

The report is provided to the Board for:

Decision		Discussion	√
Assurance	√	Information	

Summary/key points:

This paper provides a summary of the Trust's response to the Covid-19 pandemic during the Restore Phase including high level descriptors of plans for Urgent and Emergency Care (UEC), cancer, elective care, maternity diagnostics and screening services.

The Restore phase will require step up of non-Covid-19 urgent care services as soon as safe to do so. Emphasis of the plan is on a safe restart with full attention to Infection Prevention & Control (IPC) as the guiding principle.

In addition, some elective care should be restarted based on the same IPC guiding principle but with priority being on cancer care and more urgent non-cancer elective care.

Beneficial changes that have been developed in the Manage phase should be 'locked in' and following assessment of risk, quality and equality impact should be continued on a more permanent basis.

The Trust is on standby and ready to deploy surge plans that were tested during the initial Manage phase of the pandemic response. Although these are not expected to be

deployed they are aligned to scenario plans and teams are briefed and prepared, should the need to deploy a surge response be required.

After regional review with regulators, the Trust remains well placed for restoring essential services, with some services already in place and functioning well. Some detail on the full restoration of surgical services is not yet available as options are developed. It is expected that these options will be ready to authorise and mobilise in early June.

Recommendations:

The Board are asked to accept this update, noting the nature of the current national level 4 incident, the nature of frequent new guidance and requirement for all plans to be flexible and responsive.

Strategic risk register	**Performance KPIs year to date**
Covid-19 Strategic Risk	All Standards

Resource implications (e.g. Financial, HR) Resource Implications are in line with authorisation SFIs and Covid19 operating parameters.

Assurance implications
This plan is a key component of the Trust's overall Covid-19 pandemic response campaign strategy, previously presented.

Patient and Public Involvement (PPI) implications In line with National Level 4 response, national guidance and PPI implications issued.

Equality impact Equality Impact Assessments are conducted on significant changes within the authorisation/governance system in place from the outset of the Covid-19 Level 4 Pandemic

Information exempt from disclosure No

Requirement for further review? Yes, further update to be provided July

1 Background

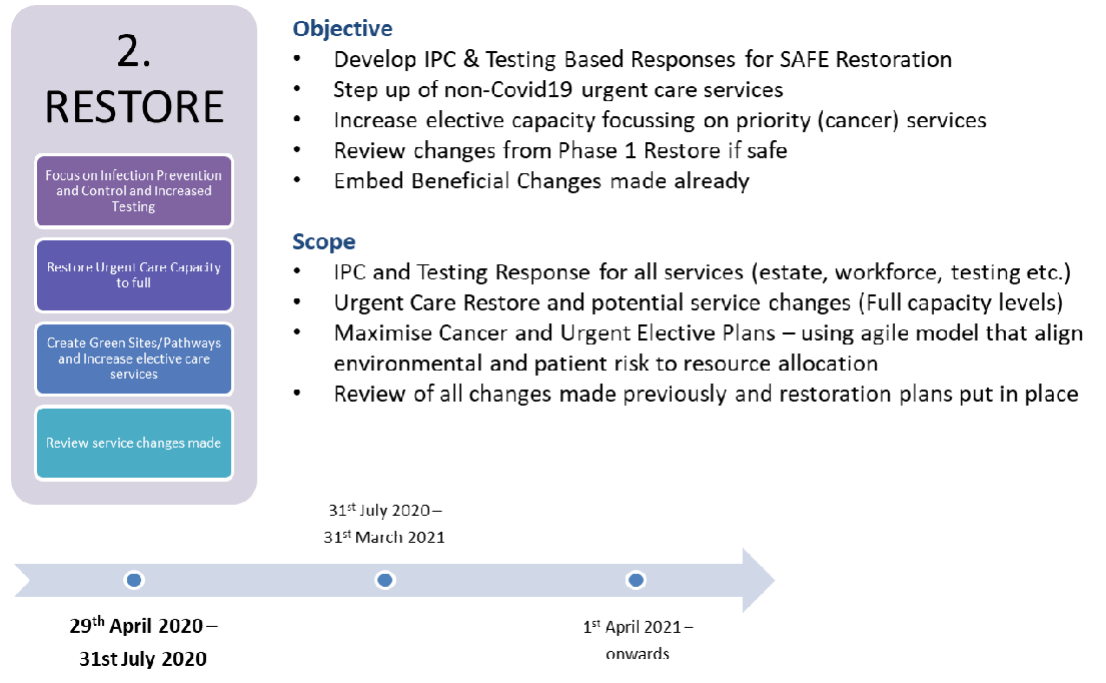
On 30 January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. At the same time Covid19 was confirmed as a High Consequence Infectious Disease (HCID) and the UK risk level was raised from moderate to high. On 3 March the Department of Health and Social Care issued the Coronavirus action plan; a guide to what you can expect across the UK. This reflected the strengthened legal powers announced by Secretary of State for Health and Social Care.

As NHSEI created national and regional Incident Command Centres (ICCs) and Incident Management Teams (IMTs) all trusts were tasked with enacting their own major incident plans and creating similar structures, 7 days per week and at a minimum 12 hours per day.

Nationally objectives of the respond to Level 4 National Incident were set as:

- Save Life
- Prevent Harm
- Protect the NHS

2. Restore Phase



2.1 Objectives:

The *Restore* phase will require step up of non-Covid19 urgent care services as soon as possible. This must be a safe restart with full attention to Infection Prevention & Control (IPC) excellence as the guiding principle. In addition, some elective care should be restarted based on the same IPC guiding principle but with priority being on P2-P3 cancer care and more urgent non-cancer elective care.

Beneficial changes that have been developed in the *Manage* phase should be 'locked in' and where necessary authorisation should be given to continue on a more permanent basis.

2.2 Timescales:

The *Restore* phase will take place from 28th April for a period up to 31st July 2020. As a Trust with comparatively less impact of Covid19 ULHT is well placed to restore many services to appropriate capacity swiftly.

2.3 Scope:

With planning complete on how and when surge responses could be put in place, the current position faced by the Trust and nationally is that the initial wave of Covid19 demand is subsiding. All modelling suggests that whilst subsiding, Covid19 will be a disease that will be in general population for many more months. During this phase focus will be heavily on infection prevention and control measures as well as use of testing services to create optimum levels of protection for patients and staff. Emphasis will be placed on the safe restoration of services and not to create additional risks to patients and staff.

3 Review of service changes

As part of the *Restore* plans the Trust has conducted a review of all service changes that have taken place during the Manage phase and considered those that could be safely reinstated or kept in place temporarily. These changes have been individually assessed for risk, quality and equality impact through the authorisation process previously described in the *Manage* phase. Sections 6 onwards in this report describe at a high level the approach being taken.

The table below identifies the level of restoration of service anticipated by the end of June 2020. ULHT plans alongside system restoration activities have been reviewed with regional regulators NHSE/I and assumptions tested to ensure that services are being safely restored.

Although many services are indicated at 100% levels it is important to note that these services make reference to essential services and do not include all services. Furthermore where services are described at less than 100% this will be in reference to services that contain a mixture of essential and routine services. Vascular services for example have both essential (urgent) services as well as planned routine services. It is these routine services that may not be in place by the 30th June, although they will feature in future *Recovery* plans.

Service	Anticipated Level of Service to Meet Demand by 30th June 2020	Comments
Neonatal Intensive Care	Delivering 100% Pre-COVID-19	
Adult Critical Care (for non COVID-19 indications)	Delivering 100% Pre-COVID-19	
Cystic Fibrosis	Delivering 100% Pre-COVID-19	Utilisation of technology enabled care - telephone, in line with NUH model of care delivery
Cardiac (Cardiology)	Delivering 50% Pre-COVID-19	Urgent cardiology services maintained, routine elective services to be increased through recovery phase
Specialised surgery in children	Delivering 75% Pre-COVID-19	Emergency surgery sustained 100%, limited elective through Restore phase

Service	Anticipated Level of Service to Meet Demand by 30th June 2020	Comments
Paediatric medicine	Delivering 100% Pre-COVID-19	Utilisation of technology enabled care - telephone
Specialised gynaecology services	Delivering 75% Pre-COVID-19	Full cancer unit service 100%, OP utilisation of technology enabled care - telephone
Vascular Services	Delivering 50% Pre-COVID-19	Urgent servcies maintained in line with Vascular Society guidance, increasing activity into the Restore phase in line with surgical prioritisation guidance
Specialised Neuro-rehabilitation	Delivering 100% Pre-COVID-19	Level 2 unit fully operational
2WW Referrals	Delivering 75% Pre-COVID-19	
Cancer diagnostics	Other - See Comments	Diagnostics is split mainly between Radiology (high volume and continued service) and Endoscopy (lower volume, stopped due to COVID), so overall figure would hide variation. Level of activity still subject to national governing bodies advice (eg JAG) and referral volumes.
Cancer treatment	Delivering 100% Pre-COVID-19	
Delivery of urgent chemotherapy.	Delivering 75% Pre-COVID-19	
Delivery of time critical chemotherapy.	Delivering 100% Pre-COVID-19	
Urgent radiotherapy?	Delivering 100% Pre-COVID-19	
Time critical radiotherapy?	Delivering 100% Pre-COVID-19	
Urgent outpatient appointments at pre-COVID-19 levels.	Delivering 100% Pre-COVID-19	
Urgent diagnostic appointments (including direct access diagnostics available to GPs)	Delivering 100% Pre-COVID-19	
Capacity for cardiology services for PCI and PPCI	Delivering 100% Pre-COVID-19	
Secondary care capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.	Delivering 100% Pre-COVID-19	Urgent service maintained fully
Capacity for stroke services for admission to hyperacute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.	Delivering 100% Pre-COVID-19	Implementation of temporary hub and spoke model, with all hyper-acute admission to Lincoln site, will be maintained for Restore phase to maintain safe medical provision

4 Infection Prevention and Control Approaches

The Trust will establish green (the term used for non-Covid) pathways/sites for cancer and elective surgery and non-surgical procedures. These pathways will be distinct from blue (the term used for suspected/potential or confirmed Covid) activity and based on the principles of ensuring the highest standards of IPC: minimising the risk of cross-infection, focused on environmental changes, hygiene, social distancing, screening and segregation of staff and patients.

5 Patient and staff testing

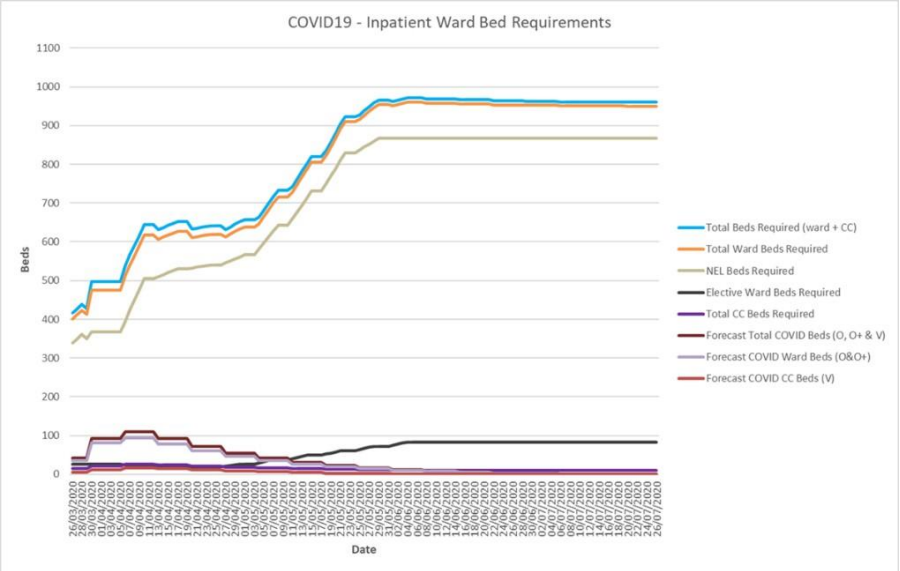
All patients undergoing cancer or elective surgery will be advised to self-isolate for 14 days prior to procedure and will be tested 48-72 hours prior. Patients testing positive will be rescheduled within a clinically appropriate timeframe and advised to follow the self-isolation pathway. Staff screening and testing will be managed by the Occupational Health Staff Testing Cell. Our approach to staff testing will continue in line with PHE guidance, including the adoption of the new antibody tests released in recent weeks. Full detail of how, and the level of testing will take place is still being developed.

6 Urgent and routine surgery and care

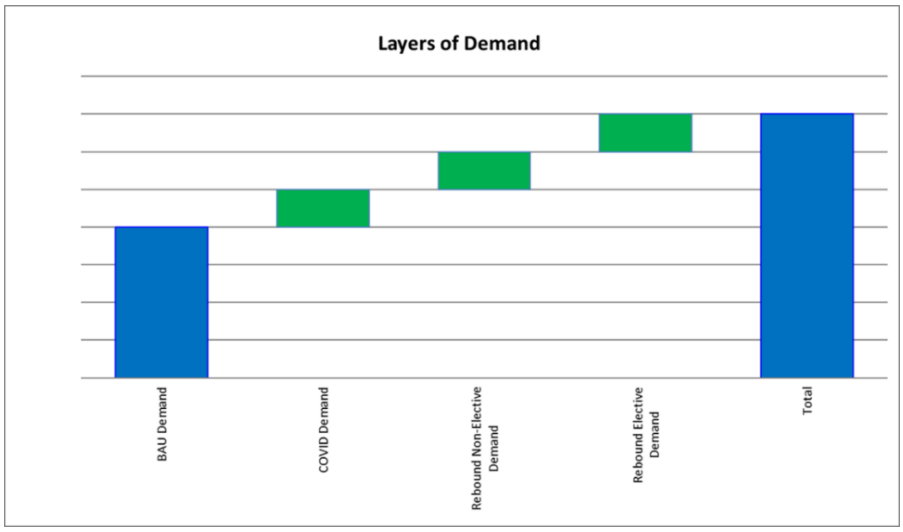
6.1 Urgent and emergency care:

The Trust's urgent and emergency care (UEC) activity has sharply reduced during the *Manage* phase with non-elective admissions at 42% of pre-pandemic average activity. This is likely to a combination of factors including changed healthcare seeking behaviour, reduced incidence of some presentations such as trauma and road traffic accidents and some care being provided through alternative routes.

Current local UEC demand modelling forecasts non-elective admissions to increase by 13.6% per week up to a normal level by the end of May. On to this we must factor a greater bed base requirement due to site configurations to maintain Covid cohort wards and distinct green pathways.



Scenarios have been developed that consider the potential "rebound" of increased demand on urgent care service generated by delayed attendance, deterioration due to delay in seeking medical assistance and postponed activity.



Plans for restoration therefore include scenarios that would utilise surge capacity responses in line with this timeframe should it be required.

6.2 Urgent outpatients and diagnostics:

The Trust continues to provide outpatient consultations for cancer and urgent patients utilising telephone and VC as default to reduce the risk of cross-infection, only offering face to face appointments where clinically required. We will continue to scale up our use of technology-enabled care at pace.

Currently circa. 50% of the Trusts maintained outpatient activity is being conducted over the telephone. This will increase further as more clinicians return to outpatient rotas and resume outpatient activity. The Trust offered VC appointments for the first full month in April and is planning to increase uptake of this at pace through the *Restore* phase.

Therapy outpatient services will ensure urgent patients have access to appointments through new referral triage and prioritisation, maximising the use of telephone and VC consultations, providing face to face clinic appointments only where clinically required following a risk assessment, and ensuring social distancing measures are in place.

The Trust continues to ensure access to urgent diagnostics in line with PHE and national body guidance whilst restoring diagnostics services for long wait patients where safe to do so.

Diagnostics have previously not been ring-fenced for cancer, in line with NHSEI best practice as issued at NHS Midlands & East Cancer Collaborative seminars. However, booking of cancer patients has always been given priority. Currently all diagnostics access is protected for emergency and cancer activity and this will continue. There is in place, the capacity to scan all current and forecast cancer and emergency patients, but not routine and direct access. Throughout the Covid period the Trust has consistently delivered 90-95% access within 7 days.

Endoscopy services nationally are guided by the British Society of Gastroenterologists (BSG) and Joint Advisory Group on GI Endoscopy (JAG) and plans will continue to adhere to their recommendations as and when these change. Endoscopy procedures are considered Aerosol Generating Procedures and current guidance requires significant change in practice that in turn impacts on capacity of the service. Specifically, the additional IPC controls and cleaning time required between patients. Current endoscopy capacity is reduced by 70% of normal activity. Demand management pathways for upper GI and lower GI introduced during the *Manage* phase are proving successful. The Trust continues to monitor and report weekly referrals, performance against DM01 standards and 7 & 10 day cancer standards.

6.3 Urgent surgery and non-surgical procedures:

The Trust will ensure sufficient capacity for urgent and time critical surgery and non-surgical procedures using Royal College of Surgeons (RCS) advice on surgical prioritisation. Green pathways will continue to be used however these pathways are currently extremely limited with mostly Level 2 and 3 (critical care level) surgical activity continuing through green pathways on Lincoln and Pilgrim sites. Restoration plans continue to be developed to increase surgical capacity by circa. 50% from June through the utilisation of additional theatres, extended operating sessions and 7-day working, amongst other strategies. Described in more detail later in this report, the Trust anticipates the use of Independent Sector capacity in Lincoln and Boston with much smaller elements in Nottingham. This will supplement the planned care green pathways in place at Boston and Lincoln.

6.4 Prioritisation and risk stratification:

The approach taken to prioritising elective care is based on clinical risk with the highest priority being cancer treatment, followed by clinically urgent, time critical non-cancer treatment. Only the appropriate levels of capacity for urgent groups across all specialties is in place the process of restarting routine electives will commence. Clinicians across all specialties are risk stratifying high risk patients and ensuring appropriate ongoing care plans are delivered.

6.5 Independent Sector Support:

The Trust will seek to make full use of NHS contracted independent sector hospitals in order to increase capacity available to treat cancer and elective long waits.

The system is contacting local Independent Sector providers on a regular basis to understand any surplus capacity by specialty available in the short term. This will be cross-referenced against known pressure points and long waiting patients. As an example, there are a cohort of long waiting patients for General Surgery and ENT which would be suitable for transfer into the independent hospitals. Priority will be given to urgent patients and long waiting patients first. The system is also requesting access to the weekly IS activity returns to understand activity and capacity opportunities. Activity levels are currently being scoped once capacity is understood.

7. Cancer

The Trust has maintained access to essential cancer surgery and other treatment throughout the pandemic in line with national guidance and in collaboration with the regional Cancer Alliance and provider partners. This will continue to ensure delivery of cancer surgery and treatment, making use of our independent sector contracts and local diagnostic capacity. Urgent action was taken in *Manage* phase to ensure the provision of 2WW appointments at pre-Covid-19 levels, using protected pathways.

Cancer referrals from MDT have significantly reduced during the *Manage* phase and it is anticipated that there will be an increase in 2WW clinic and oncology demand during the *Restore* phase. Monitoring of referrals and specialty activity continues and plans for cancer treatment capacity are adjusted accordingly.

Current available 2WW capacity is 100% of pre-COVID capacity but has not been required due to reduced demand. No 2WW capacity has been withdrawn during COVID, supported by use of technology enabled care (telephone, VC). May 2020 14-day performance is at its highest point since November 2017.

Oncology new and follow up outpatient clinic capacity has been maintained and will continue through the *Restore* phase through the adoption of telephone and VC clinics, with face to face appointments provided for patients requiring physical examination.

All chemotherapy clinics, except combined RT/chemotherapy regimens, are now being provided within a green pathway through Grantham District Hospital site and from the mobile unit delivering clinics from Skegness and Spalding, with a further mobile clinic planned to commence from Louth.

Radiotherapy will continue to be delivered from Lincoln County Hospital at reduced capacity to support social distancing and the safety of patients and staff. Demand management protocols are in place based on senior specialist clinician decision making in order to optimise utilisation of the available capacity and facilitate timely access to treatment.

8 CVD, heart attacks and stroke

Capacity is prioritised for acute cardiac interventions and cardiology services, urgent arrhythmia services, severe heart failure and valve disease. Stroke service capacity remains unchanged offering 24/7 access to thrombolysis and 7-day access to TIA Services.

The majority of elective cardiology operating ceased at the end of March with only PPCI and urgent elective device procedures continuing, alongside urgent echo diagnostics to support the cancer pathway. Waiting lists have not grown significantly due to the lack of other diagnostic testing being undertaken in cardiology during the *Manage* phase. The Trust has in place robust monitoring of current urgent, time critical and routine cardiology demand.

On 31 March, in order to maintain capacity, the Trust's stroke pathway was revised to a hub and spoke model, supporting a single consultant on call rota. All Hyper-acute strokes are currently conveyed to and received by our Lincoln site. Patients who self-present to our Pilgrim Hospital site showing symptoms of stroke are transferred to Lincoln. Robust monitoring and weekly reporting to Gold Command of stroke ambulance conveyance and admission activity is in place. This pathway will continue during the Restore phase while being under continual review.

9 Maternity

The Trust will ensure direct and regular contact with all women receiving antenatal and postnatal care, clearly explaining how to access scheduled and unscheduled care and reassuring women of the safest place to receive care. Our obstetrics units will be appropriately staffed including anaesthetic cover.

On 24 March, the Trust issued an interim standard operating procedure (SOP) for the management of Covid-19 in maternity services in line with RCOG guidance along with a minimum antenatal and postnatal pathway. This pathway included a reduction in face to face appointments for low risk women, special consideration of high risk and safeguarding concerns, and a temporary suspension of the home birth service.

Review of antenatal and postnatal appointments for low risk women will continue to reduce unnecessary face to face contacts, while our SOP for high risk women and safeguarding concerns will remain in place. This is in line with Royal College of Obstetrics and Gynaecology and Royal College of Midwifery advice. The home birth service was restored from 18 May 2020.

10 Screening and immunisation

The Trust will prioritise making screening services available for the recognised highest risk groups as identified in individual screening programmes. An increase in the delivery of diagnostic pathways initially focused on backlog clearance of those already in an active screening pathway will take place in the *Restore* phase.

10.1 AAA screening:

The AAA screening programme stopped screening on 16 March 2020 in line with PHE and Vascular Society guidance due to the assessed high risk to a vulnerable patient group. This has resulted in the Trust cancelling circa. 1000 screening appointments. All patients cancelled and all affected surveillance patients have been kept informed to enable full disclosure and ease stress surrounding their diagnoses. At the end of 2019, PHE approved the Lincolnshire AAA screening programme to start the 2020/21 cohort early on 7 January. This decision has supported restoration as the Trust was able to complete over 700 scans of this new cohort before the pandemic started in the UK – a significant proportion of the activity cancelled during the *Manage* phase.

10.2.1 Bowel screening:

The bowel cancer screening programme remains suspended nationally and the Trust continues to follow guidance set out by JAG and BSG. The Trust has a robust risk stratification process in place, patients are being closely monitored and, where intervention is required, patients are being referred accordingly.

10.3 Breast screening:

The breast screening service is currently suspended in line with national guidance. The high risk service is provided by Nottingham University Hospitals through a service agreement and this service has resumed.

10.4 Diabetic eye screening:

The DES programme stopped the majority of screening on 20 March due to the assessed high risk to this vulnerable group. Patients identified as at clinical risk have continued to be screened.

10.5 Newborn hearing screening:

Our Newborn Hearing Screening Programme will continue to be maintained. Outreach clinics were suspended from 1 April due to insufficient staffing availability and following PHE guidance. Since, parents have been offered screening for their babies while still an inpatient. We recognise the importance of maintaining the NHSP due to its time criticality and plan to re-instate outreach clinics at the earliest opportunity.

APPENDIX C

Meeting	*Public Trust Board*
Date of Meeting	*11 June 2020*
Item Number	*TBC*
Title	*Temporary Service Changes as a response to Covid-19*
Accountable Director	*Paul Matthew – Director of Finance and Digital*
Presented by	*Simon Evans – Chief Operating Officer*
Author	*Paul Matthew – Director of Finance and Digital* *Simon Evans – Chief Operating Officer*
Report previously considered at	*Private Trust Board* *2 June 2020* *Gold command* *22 May 2020*

How the report supports the delivery of the priorities within the Board Assurance Framework	
1a Deliver harm free care	*X*
1b Improve patient experience	*X*
1c Improve clinical outcomes	*X*
2a A modern and progressive workforce	
2b Making ULHT the best place to work	
2c Well Led Services	
3a A modern, clean and fit for purpose environment	
3b Efficient use of resources	
3c Enhanced data and digital capability	
4a Establish new evidence based models of care	*X*
4b Advancing professional practice with partners	
4c To become a university hospitals teaching trust	

Risk Assessment	*4558 – Local Impact of the Global Coronavirus (Covid-19) Pandemic* *The paper is in direct response to mitigating this risk.*
Financial Impact Assessment	*The changes proposed are a response to a Level 4 National Incident as such a FIA has not been considered.*
Quality Impact Assessment	*Completed – see appendix 3*
Equality Impact Assessment	*Completed – see appendix 4*
Assurance Level Assessment	*Significant*

Decision Required	*Approval from the Trust Board to proceed with the changes proposed, recognising that these are temporary and in response to the Level 4 incident response to the Covid-19 pandemic.*

Foreword

Across the NHS, a huge amount of work has gone into the response to the national level 4 Covid-19 pandemic in recent months, to ensure capacity for managing Covid-19 cases and the provision of safe environments for staff and patients.

Recognising that we are nationally past the first peak of infection, and as case numbers begin to decline, national guidance was recently issued requiring all NHS organisations to develop plans to restore some essential non-Covid-19 services.

These plans need to acknowledge that, although the number of cases nationally may be going down, we are a long way from being free of Covid-19 and it still poses a significant threat to patients and our staff. Therefore, putting in place measures to minimise hospital transmission of Covid-19 to protect patients and staff must be the priority in this next stage of our response. This will help to increase public confidence in accessing our services again.

As a Trust Board, we have a responsibility to the population of Lincolnshire to ensure we can provide the services that they need, in as safe a way as possible, as we progress through this national level 4 incident.

During the initial stages of this incident, many hospital services both locally and nationally were reduced very quickly in order to free up capacity to manage Covid-19 cases and to reduce the risk to patients of going into hospitals where Covid-19 patients were being cared for. This has resulted in a large number of appointments being deferred. As a result many more patients are now waiting for their care.

This includes some cancer surgery, clinically urgent cases and urgent diagnostic testing. If we don't act now, these waiting lists will only grow longer, and those patients whose procedures and investigations have been delayed could suffer harm as a result.

In planning for this next stage of our response, we must also bear in mind that whilst A&E attendances have been low during the initial phase of the pandemic, the demand for urgent care is now rising again and we must be in a position to continue to safely care for these patients too.

All this change needs to be made in line with the new world we are working in, with Covid-19 still circulating and at times still posing a threat to life. This should be expected for some time to come and at least the next 12 months.

Despite this, we need to make provision to expand our range of services, to ensure people do not suffer detriment as a result of delayed appointments or surgery, whilst still offering emergency care for those most in need and also preserving services for those who may have contracted Covid-19. This makes managing our hospitals even more complicated than in the past.

Taking all of this into account, we have assessed what services we can provide, and where, safely. The priority is maximising what we can offer to the people of Lincolnshire in a safe way for everyone.

We are recommending the temporary creation of a largely Covid-19 free Green site at Grantham and District Hospital for this next phase of the pandemic. This would mean an increase in elective patients at Grantham hospital, including transfer of chemotherapy, cancer surgery and other surgery from across Lincolnshire.

To support this, all patients must have a known Covid-19 status on admission to any ward on that site. Therefore, we would need to temporarily change the urgent care offer at the hospital from an A&E, open 8am-6.30pm, to a 24/7 walk-in Urgent Treatment Centre (UTC) and transfer unplanned admissions to our other hospitals. This is necessary to create isolated facilities and help us monitor and control the risk of infection.

We believe these temporary changes are the right approach to manage the pandemic in a way that best protects our patients and staff whilst delivering key services. These temporary changes will be in place starting from 22nd June until at least 31st March 2021.

Executive Summary

The aim of this paper is to:

- Summarise the case for the temporary reconfiguration of services provided by the Trust as part of the next stage of its response to the level 4 incident declared on 30 January 2020
- Describe the options considered and the preferred option
- Outline the legal basis for the change
- Describe the clinical leadership and governance established to oversee and enact the proposed changes
- Provide assurance that the quality and equality impact of the proposed changes has been considered

Enacting the proposed changes will drive the following improvements for the population of Lincolnshire:

Patients that require cancer surgery

The introduction of the Green site model – in addition to the existing Green pathways – will give ULHT the capacity to rapidly treat those patients waiting and protect the delivery of cancer surgery for all of Lincolnshire whilst minimising the risk of contracting Covid-19. Within 2-3 weeks of full implementation there will be no waiting list for cancer surgery and we will be able to continue to meet the demand for cancer surgery on an ongoing basis through the next phase of the pandemic. Only those cancer patients requiring high dependency or intensive care will continue at Lincoln or Pilgrim hospitals with the majority transferring to Grantham hospital.

Patients that require planned elective surgery

Planned elective surgery has been greatly reduced, resulting in significantly increased waiting times. The introduction of a Green site model will enable planned elective surgery to resume and prevent further deterioration of waiting times whilst permitting the treatment of clinically urgent cases. This means a continued low level of elective services at Lincoln and Pilgrim hospitals with operations greatly increasing at Grantham hospital.

Patients that require urgent diagnostic tests

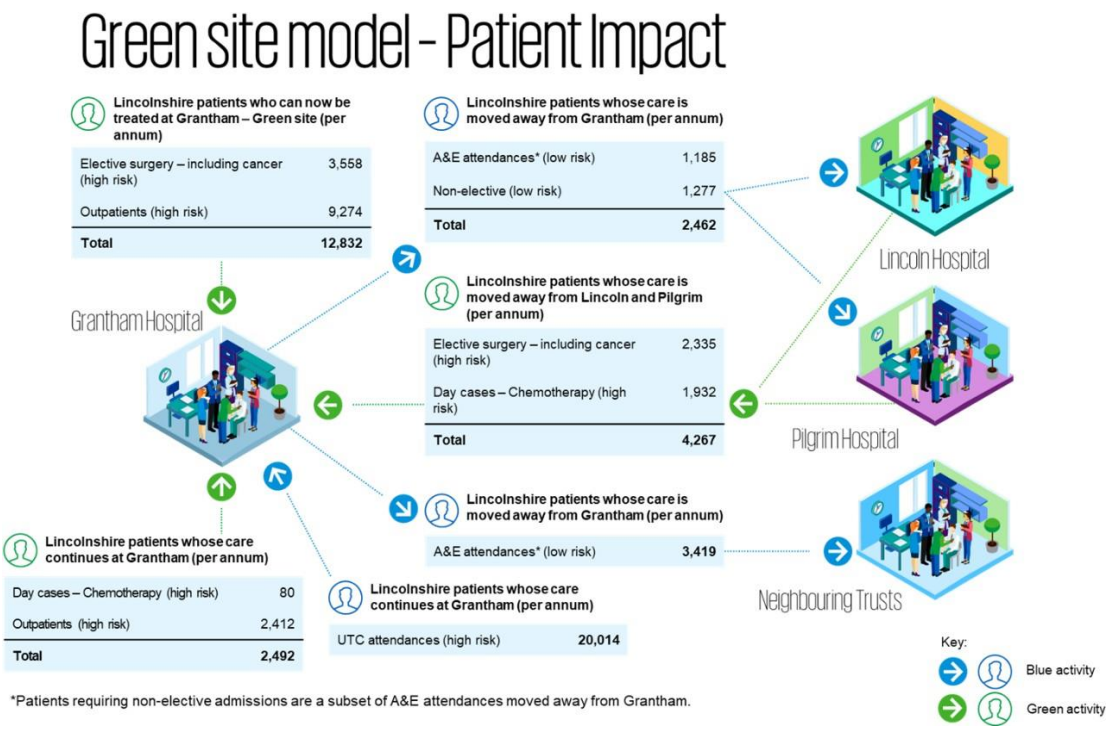
The introduction of a Green site model will enable urgent diagnostics to increase in a low risk environment where all patients, including those who may be vulnerable or susceptible to infection, can receive the necessary tests. This will ensure that patients will receive diagnostics in a timely manner, preventing further deterioration of waiting times and reducing the risk of delay in diagnosis.

The Green site model will support the majority of diagnostics required for cancer patients and urgent elective patients, whilst adhering to the Infection Prevention and Control design principles.

Increasing access to urgent care for patients

Delivering a Green site model in Lincolnshire requires all patients admitted to the site to be screened to minimise the risk that they may be Covid-19 positive. This is not possible for emergency admissions, and so the Green site model cannot support an A&E admission service on site. Furthermore, a Green site model cannot accommodate patients who have not been screened prior to accessing diagnostic services, which prevents a Green site from having an A&E service. However, in order to continue to provide access to urgent care services the proposed model would seee Grantham A&E converting to an Urgent Treatment Centre. Converting the service will incorporate the increase in operating hours to become a 24/7 walk-in function.

A summary of the likely patient impact is below:



** The numbers described in the above infographic are representative of known modelling assumptions at the point of production of this report. Throughout the Covid-19 pandemic both emergency and planned demand for services have changed much more than normal seasonal variation and, as such, whilst this has been considered it does reduce the accuracy of future forecasts.*

The Board is asked to formally approve the changes, noting that:

- These are temporary in nature and are within the authority of the ULHT Board to make given the emergency pandemic response. The timescale for the Green site is to implement from 15th June 2020, with the conversation of A&E to UTC on the 22nd June 2020 to last for the duration of Covid-19 to at least 31 March 2021. This timescale is subject to quarterly review and commencement of the changes will be phased.

- This is completely separate from the process to make any permanent significant changes to services, which would be led by the NHS Lincolnshire CCG, requires formal public consultation in line with national guidance and is within the authority of the CCG to decide.

- Registration of the change is also required to NHS England and NHS Improvement as part of Covid-19 incident management.

Introduction

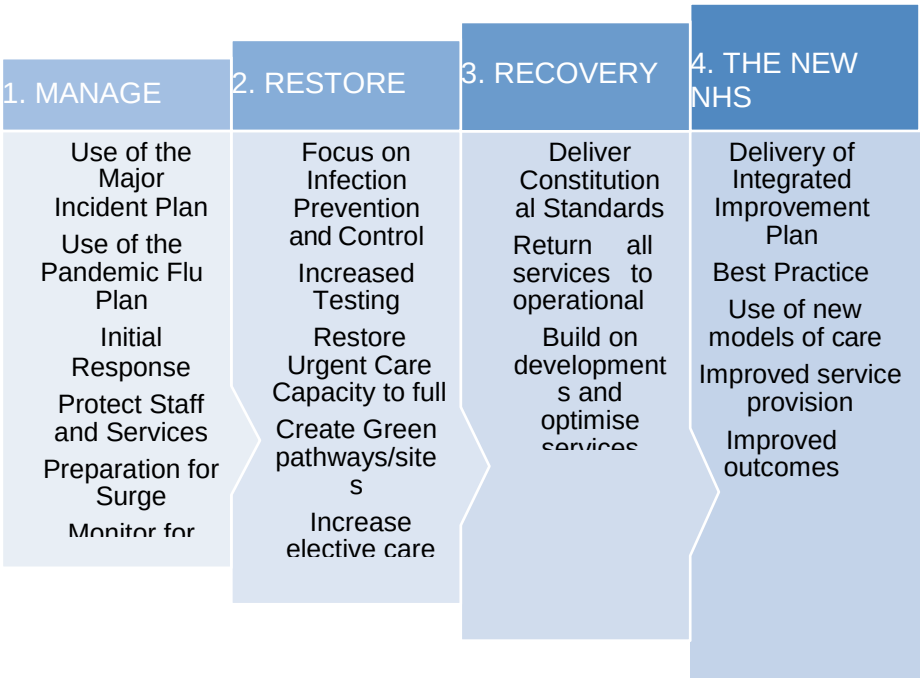
On 30 January 2020, a Level 4 National Incident was declared and at the same time Covid-19 was confirmed as a High Consequence Infectious Disease (HCID) and the UK risk level was raised from moderate to high. This triggered a national preparation and response to Covid-19 in the following four phases, beginning with the first Manage phase.

1. Manage – to 29 April
2. Restore – to 31 July 2020
3. Recovery – to 31 March 2021
4. The new NHS – 1 April 2021 onwards

Nationally, objectives of the response to the Level 4 National Incident were set as:

- Save Life
- Prevent Harm
- Protect the NHS

A high-level summary of each phase of the Covid-19 response is provided below:



Consequently, United Lincolnshire Hospitals NHS Trust (ULHT) as part of the first Manage phase, quickly repurposed services, staffing and capacity to treat and care for patients with confirmed Covid-19 infection.

A summary of the first Manage phase re-configuration by site is provided below:

Site	Function (High level)
Lincoln County Hospital	Blue site (for the treatment of patients with suspected Covid-19) with a discrete infection prevention and controlled (Green pathway) for any patients in need of urgent surgery, radiotherapy or interventional cardiology
Pilgrim Hospital Boston	Blue site with Green pathway for critical care surgery
Grantham and District Hospital	Blue site with urgent diagnostic services and no surgery
Louth Hospital, BMI Lincoln Hospital and Boston Ramsey Hospital	Currently ULHT and Independent Sector services are temporarily paused to support staffing at other sites.

The first Manage phase is now complete and provides the basis of a surge response that can be reactivated at any time if we experience any future spikes in Covid-19 cases. We are now in the second phase, Restore. The Restore phase will take place from 29 April 2020 for a period up to 31 July 2020. The options described in this paper are being reviewed and subsequently enacted in the Restore phase. However, it is anticipated that they will continue to be a feature of the recovery phase being in place for the duration of Covid-19 up to at least 31 March 2021.

A high-level summary of the Restore phase is set out below:

Objective

- Develop IPC & Testing Based Responses for SAFE Restoration
- Step up of non-Covid19 urgent care services
- Increase elective capacity focussing on priority (cancer) services
- Review changes from Phase 1 Restore if safe
- Embed Beneficial Changes made already

Scope

- IPC and Testing Response for all services (estate, workforce, testing etc.)
- Urgent Care Restore and potential service changes (Full capacity levels)
- Maximise Cancer and Urgent Elective Plans – using agile model that align environmental and patient risk to resource allocation
- Review of all changes made previously and restoration plans put in place

The challenge

There remains material uncertainty on how long the Covid-19 pandemic may last. Some experts in the field cite that the pandemic may last until 2022 and then stabilise as a new seasonal virus, similar to seasonal influenza.

As such, the challenge now facing ULHT as it begins the Restore phase and into the Recovery phase of its response to the outbreak is to maintain the capacity to provide high quality services for patients with Covid-19, whilst increasing other urgent clinical services and important routine diagnostics and planned surgery, for the population of Lincolnshire.

Case for change – What do we need to do?

In order to respond to the initial surge of Covid-19 patients, and reduce the chance of transmission, urgent and non-urgent elective services and routine diagnostics were stopped and treatment for some patients on the cancer pathway delayed.

Urgent surgery and diagnostic activity has continued through carefully planned Green pathways to minimise the risk of infection at Lincoln and Pilgrim hospitals.

As a direct result, the following has been observed:

1. **Cancer 62-day performance**

For a short period cancer surgery was stopped whilst the necessary preparation was undertaken to create discrete Green and Blue pathways. As such, a backlog of cancer patients has been created that now need to be operated on in the Restore phase.

The volume of patients previously treated with cancer surgery was 35 per week prior to the pandemic and since it began this has been less than 22 per week.

As at 5 May 2020, a total of 291 patients were on the waiting list, of which 203 patients (70%) are still to be offered a 'To Come In' (TCI) date. A breakdown is set out below:

Level of urgency	Number of patients on the waiting List	Number of patients on the waiting list with TCI date	Number of patients on the waiting list requiring TCI date
Level 1 (highest)	3	3	0
Level 2	202	82	120
Level 3 (lowest)	86	3	83
Total	291	88	203

The number of patients being referred in on a cancer pathway (also known as a 62 Day), having initially dropped to approx. 30% of pre-Covid-19 levels, is slowly beginning to increase and as at week ending 24 May was at 64% of the pre-Covid-19 baseline rates:

For the patients on cancer pathways there have been a variety of challenges around continuing on their journey. Some include availability of diagnostics, clinical risks around treatments, patient reluctance to attend for outpatient appointments and diagnostic tests or treatments. This may be due to recommended self-isolation, shielding or other risk concerns.

In order for services to respond effectively, address the backlog and treat all cancer patients in a timely way, the Trust needs to reinstate more capacity than was previously available for a period of time. All efforts should be put in place to prioritise this surgery, increase the capacity available and to protect patients from being further delayed by the impact of Covid-19.

Evidence produced through the early phases of the national response to Covid-19 indicates that patients operated on in hospitals who contract Covid-19 have an increased mortality rate. It is vital that we have solutions in place that minimise the chance of contracting Covid-19 in our hospitals.

2. Patients are nervous about seeking help or attending A&E when they need care

Like elsewhere in the UK, the NHS in Lincolnshire has seen a marked decline in the number of people seeking help, whether this be urgent care in A&E or a referral to a specialist. The table below illustrates this point.

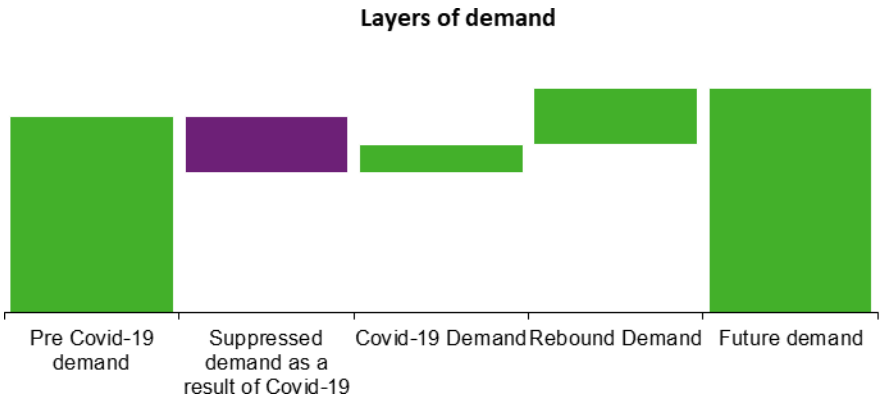
Attendances and admissions May 2020	% of normal (pre Covid-19) demand as at 1
A&E Attendances	64%
Non-Elective - 0 Day Admissions	64%
Non-Elective - 1+ Admissions	56%

Between 2 March and 24 May 2020, the emergency departments have had 10,701 fewer attendances compared to the same 12-week period last year. This shortfall in A&E attendances is broken down as follows:

Site	Lincoln	Pilgrim	Grantham	Total
1 March and 24 May 2020 – 12 weeks	1,673	5,145	3,883	10,701
Per week	139	429	324	892
Per day	20	61	46	127

The shortfall in attendances is even greater when Covid-19 related attendances are removed. This reduction is mirrored by a reduction in GP referrals on the 14-day (suspected cancer) pathway and for urgent assessment. The reasons for the sharp decline in patients seeking help are multifaceted, but concern regarding the risk of contracting Covid-19 in hospital features highly.

Clinical opinion is that this suppressed demand will reverse; with the majority of these patients presenting later (or rebounding). The quantum of this "Rebound" is difficult to predict as there is no precedent. However, a number of scenarios in each of the layers of demand are being modelled.



More broadly, the incidence of disease and morbidity in the population has not reduced. This prompts fears that this deferred demand will result in excess mortality, morbidity and harm from non Covid-19 causes if not addressed.

As such, there is a requirement in the Restore phase to build confidence in the ability to keep patients safe from Covid-19 in a hospital setting, knowing that urgent and emergency demand is likely to increase.

3. Planned elective and urgent diagnostic activity has reduced resulting in significantly increased waiting times

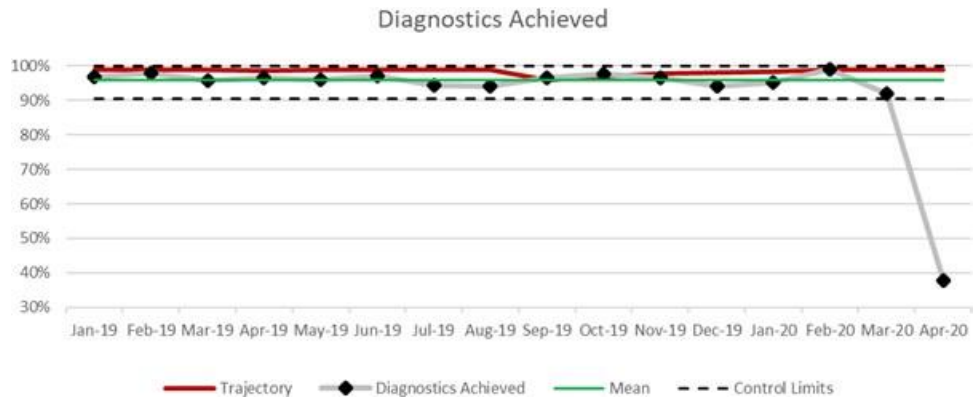
The total number of patients waiting more than 18 weeks on an 18-week (RTT) pathway has significantly increased –from 7,841 patients at week ending 22 March 2020 to 12,838 patients at week ending 17 May 2020 (an increase of 4,997)

Referral activity has significantly reduced – the number of patients on the diagnostics waiting list has reduced from 6,000 patients pre Covid-19 to 4,378 patients at the end of April (a reduction of 1,622)

Since the end of March 2020, reduced levels of routine and urgent diagnostics have been delivered, except for endoscopy which was stopped for a short period of time in line with national guidance. However, alternate diagnostic provision was delivered to those patients who were impacted.

Although the overall waiting list for diagnostic tests has reduced, there has been a significant increase in waiting times. The percentage of patients waiting less than 6 weeks from referral to diagnostic test (DM01 performance) has deteriorated significantly, from 99% in February 2020 (meeting the national standard of 99%) to 37% in April 2020. (a reduction of 67%)

The chart below represents ULHT's diagnostic waiting time performance from January 2019 to April 2020.



The majority of patients waiting over 6 weeks were within echocardiography and endoscopy diagnostic procedures. Endoscopy procedures are aerosol-generating and current guidance is impacting on service capacity due to Infection Prevention and Control (IPC) controls and cleaning time required between patients. Current endoscopy capacity is reduced by 70% of normal activity and is focused on cancer and urgent tests.

What do we need to do? – Conclusion

The Trust must safely and expediently resume surgical services. It must increase diagnostics alongside the response to lowering the risk of hospital-acquired Covid-19.

As such, the focus of the Restore and Recovery phases must be on the need to conduct planned care services in locations where the risk from Covid-19 is minimised to the lowest level possible.

This is particularly the case for patients who are vulnerable and may have compromised immunity, such as cancer patients who are at particular risk.

This assessment of the current challenges faced by ULHT in the context of delivering urgent elective services and urgent diagnostics to the population of Lincolnshire builds a strong case for change.

Any proposed solution to provide planned care in a hospital setting must reduce clinical risk, and that requires that the following three conditions are met –

1. **Infection Prevention Control (IPC) excellence –** Excellence in IPC is required to minimise hospital transmission of Covid-19 to protect patients and staff. In order to achieve this, careful planning, scheduling and organisation of clinical activity is required.

IPC excellence is achieved by evidencing full compliance to the national Infection Prevention and Control board assurance framework. This framework has been developed to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance that organisational compliance has been systematically reviewed.

ULHT has assessed the following within the Infection Prevention and Control board assurance framework (for detail – see Appendix 1):

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7. Provide or secure adequate isolation facilities
8. Secure adequate access to laboratory support as appropriate
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2. **Capacity to deliver at scale –** theatres, staffing and estate. Options for care delivery during this Restore phase must have sufficient capacity to treat cancer patients, those requiring care that is clinically urgent, and within a rapid timeframe. Thus reducing risk associated with delay.

3. **Future service resilience –** Amidst the material uncertainty of how long Covid-19 will last, the service will need to be resilient and capable of addressing ULHT's requirement over an extended timescale. As movements in and out of the county increase, a second wave of Covid-19 is plausible.

Any preferred options should meet these three conditions.

Options appraisal – What's the best way to meet these conditions?

The case for change sets out the requirement to resume urgent elective surgery and urgent diagnostics to protect patients from being further impacted by Covid-19.

An assessment was carried out by joint ULHT clinical and managerial teams to identify options to support resuming elective and planned care.

A high-level description of the options identified is set out in the table below:

Option	Description
Option A – No further change	Configuration of services remains as-is, no further steps taken to minimise the risk to patients with suspected cancer and requiring urgent elective intervention of cross infection from Covid-19.
Option B – Green pathway	Create a Green pathway for Covid-19 negative patients to support elective and planned care in a setting that minimises, wherever practicable to do so, the risk of cross contamination with Covid-19. This will be provided in conjunction with Blue pathways – care for Covid-19 positive patients. Blue activity would adhere to the same principles of IPC. Cohabitation of Green and Blue activity within a single site with some shared areas. Shared workforce for Green and Blue activity within a single site, with limited/no separation.
Option C – Green site	Convert a hospital site into a Green site. The Green site would support elective and planned care in a setting that aims to minimise the risk of cross contamination of Covid-19. Isolation of Blue activity from Green activity – no Blue activity (unplanned or otherwise) would be cohabiting with Green activity. Blue activity and Green activity are physically separated. Staff work in separate Green and Blue areas.

Assessment of the best way to meet these conditions

An assessment of each option was conducted against the 3 conditions. A summary of this assessment is set out in the tables below:

1. **Infection Prevention Control (IPC) excellence** – Excellence in IPC is required to minimise hospital transmission of Covid-19 to protect patients and staff. In order to achieve this careful planning, scheduling and organisation of clinical activity is required.

Option A – Do nothing	Option B – Green pathway	Option C – Green site
Absence of IPC excellence for non-Covid positive patients who require urgent elective care and/or urgent diagnostics leads to an increase in the incidence of Covid-19 in the population.	Blue activity would adhere to the same principles of IPC in preventing cross-contamination, but this activity is unplanned and less controllable. In addition, mixing staff between Blue and Green areas of hospitals leads to an increased risk of patients contracting Covid-19. Green and Blue pathways are for the purpose of undertaking clinical activity appropriately on a risk-based approach – standards of care are uniform across both pathways. Separate time slots and strict cleaning – Risk is minimised but not eliminated.	IPC excellence priorities and integrity can be fully met with Green site models as there is no mix of Blue and Green pathways. Clear inclusion criteria - limited to patients who are screened as Covid-19 negative, with strict social distancing applied. Isolated Blue activity from Green activity – Risk is further minimised (as compared to a Green pathway) but not eliminated.
Assessment: *IPC excellence – Condition not fully met*	***Assessment:*** *IPC excellence – Condition fully met*	***Assessment:*** *IPC excellence – Condition fully met*

2. **Capacity to deliver at scale** – theatres, staffing and estate. Clinical care provided during this Restore phase will be prioritised to treat cancer patients or those requiring care that is clinically urgent.

Option A – Do nothing	Option B – Green pathway	Option C – Green site
Absence of capacity to deliver care in a hospital setting for non-Covid-19 positive patients who require urgent elective care and/or urgent diagnostics leads to an increase in morbidity in the population. Patients' anxiety is not addressed	Theatres – Limited capacity as theatre environment restricted by which theatres can be isolated to maintain IPC integrity.	Theatres – All surgery can be planned in a theatre environment which can be isolated to maintain IPC integrity. Full theatre capacity can be realised, as all available capacity is allocated to Green service.
	Staffing – Robust screening, testing separate Green/Blue teams for sessions of care, unlikely to significantly increase workforce capacity.	Staffing – Robust screening with separate Green team. Support a return to work for staff who were risk assessed as high risk,

Option A – Do nothing	Option B – Green pathway	Option C – Green site
		thus increasing available workforce.
	Estate – Building could be physically separated into distinct Green/Blue areas with a defined point of access with Covid-19 checks and no contact with Blue staff and Blue patients. However, it is likely that complete separation will be challenging as common areas may still be shared with Blue staff and Blue patients. Patients concerns are partially addressed. Co-dependencies available on the same site but with Green/Blue split.	Estate – Building could be physically separated into distinct Green/Blue areas with a defined point of access with Covid-19 checks and no contact with Blue staff and Blue patients. Clear patient flow and site security No shared common areas with Blue staff and Blue patients, thus increasing available physical estate capacity for Green services. Increased Green area available addresses patient concerns to a greater degree than other options. Co-dependencies available on the same site but with Green/Blue split.
Assessment: ***Capacity to deliver at scale – Condition not met***	***Assessment:*** *Capacity to deliver at scale – Condition not fully met*	***Assessment:*** *Capacity to deliver at scale – Condition fully met*

3. **Future service resilience** – Amidst the material uncertainty of how long Covid-19 will last, the service will need to be resilient and capable of addressing ULHT's requirement over an extended timescale. As movement in and out of the county increase, a second wave of Covid-19 is plausible.

Option A – Do nothing	Option B – Green pathway	Option C – Green site
Absence of future resilience to deliver care in a hospital setting for non Covid-19 positive patients who require urgent elective care and/or urgent diagnostics leads to an increase in the incidence of disease and morbidity in the population (aggravated by a potential second wave)	A Green pathway may be suspended in the event of a surge response required for a second wave. As such, future service resilience is compromised amidst the material uncertainty of how long Covid-19 will be around.	A Green site can remain a Green site in a second wave, ensuring future service resilience. The Green site can transform into a dominant elective site throughout the duration of the Covid-19 pandemic.
Assessment: ***Future service resilience – Condition not fully met***	***Assessment:*** *Future service resilience – Condition not fully met*	***Assessment:*** *Future service resilience – Condition fully met*

What's the best way to meet these conditions? – Conclusion

A summary of the above assessment is provided in the table below:

Conditions	Option A – Do nothing	Option B – Green pathway	Option C – Green site
IPC excellence	*Condition not fully met*	*Condition fully met*	*Condition fully met*
Capacity to deliver at scale – theatres, staffing and estate	*Condition not met*	*Condition not fully met*	*Condition fully met*
Future service resilience	*Condition not fully met*	*Condition not fully met*	*Condition fully met*

The Green site option offers the maximum opportunity to protect patients and staff from hospital-acquired Covid-19. This approach to restoring urgent elective services and urgent diagnostics will ensure both speed and quality of access and provide patients and professionals with peace of mind. It also allows for isolated Blue activity from Green activity – conditional on the physical separation of building and no shared common areas where Green staff and Green patients mix with Blue staff and Blue patients.

As such, the proposed option is the introduction of a Green site for cancer surgery and urgent elective services and diagnostics.

Options appraisal – Where do we put it?

An assessment was carried out by joint ULHT clinical and managerial teams to identify options for a Green site in Lincolnshire which could support resuming elective and planned care in a setting.

A summary of the options identified is set out in the table below:

Green site options				
Lincoln	Pilgrim	Grantham	Louth	Independent sector (BMI Lincoln Hospital and Boston Ramsey Hospital)

Where do we put it? – Assessment

An assessment of each option was conducted against the aforementioned three conditions.

1. **Infection Prevention Control (IPC) excellence** – Excellence in IPC is required to minimise hospital transmission of Covid-19 to protect patients and staff. In order to achieve this careful planning, scheduling and organisation of clinical activity is required.

Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
IPC excellence priorities and integrity can be fully met as there would be no mix of Blue and Green pathways.	IPC excellence priorities and integrity can be fully met as there would be no mix of Blue and Green pathways.	IPC excellence priorities and integrity can be fully met as there would be no mix of Blue and Green pathways.	IPC excellence priorities and integrity compromised due to limited opportunity for social distancing.	IPC excellence priorities and integrity can be fully met as there would be no mix of Blue and Green pathways.
Assessment: *IPC excellence – Condition fully met*	***Assessment:*** *IPC excellence – Condition fully met*	***Assessment:*** *IPC excellence – Condition fully met*	***Assessment:*** *IPC excellence – Condition not fully met*	***Assessment:*** *IPC excellence – Condition fully met*

2. **Capacity to deliver at scale** – theatres, staffing and estate. Clinical care provided during this Restore phase will be prioritised to treat cancer patients or those requiring care that is clinically urgent.

Lincoln and Pilgrim

Should Lincoln or Pilgrim be chosen as the Green site, non-elective admissions (admissions to a ward that are unplanned and include emergency admissions) would be displaced at significant volumes per annum – ranging from 19,723 patients in Pilgrim to 29,743 patients at Lincoln. Comparatively, the 6,637 patients displaced from Grantham per annum is 22% of Lincoln's volume or 34% of Pilgrim's volume.

A breakdown of the non-elective admissions by site is provided below:

Site	Lincoln	Pilgrim	Grantham	Louth	ULHT Total
Total non-elective admissions	**29,743**	**19,723**	**6,637**	**2,756**	**58,859**
% of ULHT total non-elective admissions	51%	34%	11%	5%	100%

The patients admitted at Lincoln and Pilgrim hospitals from emergencies and un-planned routes could not be accommodated at any one hospital site. However, a redistribution of emergency and unplanned admissions from Grantham hospital could be accommodated at either Pilgrim or Lincoln sites, without exceeding safe occupancy levels. This is predicated on the reciprocal transfer of equivalent elective or planned patient admissions.

ULHT have already established limited Green pathways on Lincoln and Pilgrim hospital sites for cancer and urgent surgery. However, they cannot be expanded to meet the required patient need whilst meeting the set conditions. ULHT will continue to use these pathways for those patients requiring high dependency or intensive care post-operatively as this cannot be re-provided at an alternative green site. This is a risk-based approach compared with the implications of not operating.

Also, the urgent care response at Lincoln and Pilgrim is going to require increased physical estate, in order to comply with social distancing and IPC principles. An example of this is at Pilgrim where pre-op assessment clinic space is going to be re-tasked to support an increase in the size of the emergency department. Therefore, this will reduce the ability to deliver planned care at these sites.

Independent sector

Independent sector facilities in Lincoln (BMI) and Boston (Ramsey) will temporarily offer limited capacity to a small range of patients that can be treated, but they do not possess the necessary facilities to provide surgical services at scale.

Grantham and Louth

Louth and Grantham hospitals are considered as potential Green site models as these sites offer greater scope of services available, as they are larger than the Independent Sector sites.

Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
Theatres – 12 theatres of which 10 are currently designated for the Blue pathway. However, the theatre capacity for Blue pathway cannot be replicated or absorbed by any other site. As such, this would be detrimental to the wider population of Lincolnshire.	**Theatres** – 11 theatres of which 9 are currently designated for the Blue pathway. However, the theatre capacity for Blue pathway cannot be replicated or absorbed by any other site. As such, this would be detrimental to the wider population of Lincolnshire.	**Theatres** – 4 theatres, all of which are currently unused. All theatres can be used for planned surgery. A Green site can be delivered providing substantial cancer surgical capacity. No other site can provide the level of non Covid-19 capacity.	**Theatres** – 2 theatres of which all are currently unused. All theatres can be used for planned surgery. Impact on cancer and urgent care elective operating will be negligible as the types of cases that can be cared for in Louth is very limited. Likely <5 Cancer surgery operations/week. *(Future application of Louth Capacity will be of great benefit in the Recovery Phase once an approach to social distancing measures have been enacted.)*	**Theatres** – The independent sector has limited capacity to a small range of patients. BMI Lincoln Hospital – with only 1 theatre the hospital would not be able to offer the level of cancer surgery capacity required to address the current need. Boston Ramsey Hospital – smaller than BMI Lincoln Hospital and there is very limited scope to conduct cancer surgery.

Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
Staffing – Limited due to high vacancy rates	**Staffing** – Limited due to high vacancy rates. In addition, the high dependency on agency is a risk to IPC excellence.	**Staffing** – Core staffing model and baseline can support a Green site. This eliminates the reliance on agency and creates a lower risk Green area from an IPC perspective, whereby at-risk staff can return to work.	**Staffing** – Limited – small establishment who work with a specific subgroup of surgical patients only.	**Staffing** – Core staffing model and baseline can support a Green site Both BMI and Ramsey depend on NHS Surgeon and Anaesthetic workforce.
Estates – Separate site with single point of access. Clear patient flow and site security No shared common areas with Blue staff and Blue patients. Co-dependencies available on the same site.	**Estates** – Separate site with single point of access. Clear patient flow and site security No shared common areas with Blue staff and Blue patients. Co-dependencies available on the same site.	**Estates** – Separate site with single point of access. Clear patient flow and site security No shared common areas with Blue staff and Blue patients. Co-dependencies available on the same site.	**Estates** – Green site can be obtained with support from NHS Property Services Separate site with single point of access. Clear patient flow and site security No shared common areas with Blue staff and Blue patients. Co-dependencies available on the same site.	**Estates** – Separate site with single point of access. Clear patient flow and site security No shared common areas with Blue staff and Blue patients. Co-dependencies available on the same site.
Assessment: *Capacity to deliver at scale – Condition not fully met*	***Assessment:*** *Capacity to deliver at scale – Condition not fully met*	***Assessment:*** *Capacity to deliver at scale – Condition fully met*	***Assessment:*** *Capacity to deliver at scale – Condition not fully met*	***Assessment:*** *Capacity to deliver at scale – Condition not fully met*

Note 1: Independent sector - BMI Lincoln Hospital and Boston Ramsey Hospital

3. **Future service resilience** – Amidst the material uncertainty of how long Covid-19 will last, the service will need to be resilient and capable of addressing ULHT's requirement over an extended timescale. As movement in and out of the county increases, a second wave of Covid-19 is possible.

Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
The capacity for Blue patients cannot be replicated or absorbed by any other site, as such this would not ensure future service resilience.	The capacity for Blue patients cannot be replicated or absorbed by any other site, as such this would not ensure future service resilience.	A Green site at Grantham could remain a Green site in a second wave, ensuring future service resilience. The Green site can transform into a dominant elective site throughout the duration of the Covid-19 pandemic.	A Green site at Louth could remain a Green site in a second wave, ensuring future service resilience once social distancing measures have been enacted. The Green site can remain a dominant elective site throughout the later stages of the Covid-19 pandemic once social distancing measures have been enacted.	A Green site in the Independent sector could not remain a Green site as national contracting is due to end, as such this would not ensure future service resilience.
Assessment: *Future service resilience Condition not fully met*	***Assessment:*** *Future service resilience – Condition not fully met*	***Assessment:*** *Future service resilience – Condition fully met*	***Assessment:*** *Future service resilience – Condition fully met*	***Assessment:*** *Future service resilience – Condition not fully met*

Note 1: Independent sector - BMI Lincoln Hospital and Boston Ramsey Hospital

Where do we put it? – Summary

A summary of the assessment is set out in the tables below:

Conditions	Lincoln	Pilgrim	Grantham	Louth	Independent sector[1]
IPC excellence – protecting patients and staff	Condition fully met	Condition fully met	**Condition fully met**	Condition not fully met	Condition fully met
Capacity to deliver at scale	Condition not fully met	Condition not fully met	**Condition fully met**	Condition not fully met	Condition not fully met
Future service resilience	Condition not fully met	Condition not fully met	**Condition fully met**	Condition fully met	Condition not fully met

Where do we put it? – Conclusion

Grantham is chosen as the only viable option, as it has the ability to create a large-scale surgical service, whilst having the greatest level of IPC protection to patients and staff and provides future service resilience.

Furthermore, the assessment in this report indicates that Grantham is the only site where urgent care services can be provided whilst maintaining the greatest level of confidence of a non-Covid-19 Green service. i.e. the ability to separate patients with confirmed Covid-19 status from those that are undifferentiated.

Trust service configuration

This temporary service change is part of the Trust's broader response to Covid-19 and part of a holistic approach to Restore and Recovery phases.

A summary of re-configuration required by site is provided below:

Site	High level summary	Changes required from the existing reconfiguration
Lincoln	Blue site with Green pathway for Critical Care Surgery, Radiotherapy and Cardiac Surgery Only	Cease operating on all other cases other than critical care surgery.
Pilgrim	Blue site with Green pathway for Critical Care Surgery Only	Cease operating on all other cases other than critical care surgery.
Grantham	Substantially Green site with all services being devoted to elective/cancer care. Increase capacity. Isolated Blue UTC service.	Increase elective care beds and theatre capacity for cancer. Remove medical admissions and transfer to blue sites. Convert A&E to Urgent Treatment Centre ('UTC') and make physical estate changes to isolate from the rest of site. UTC isolation can be done in a way that removes staff/patient movement between Blue and Green areas *(see Grantham – Blue – Urgent Treatment Centre Overview Section of this report).* Level 1 unit although does not offer critical care can accommodate more surgical capacity that no other Green site has.
Louth	Green site once work has completed with NHS property services	Restart all ULHT services once physical changes have been made to support safe restart.
BMI Lincoln Hospital	Green site limited to elective services. Ophthalmology initially then orthopaedics.	Reopen as currently closed to support staffing at other sites
Boston Ramsey Hospital	Green site limited to elective services. TBC	Reopen as currently closed to support staffing at other sites

NHSE/I change protocols

The proposed change to a Green site at Grantham for elective services and diagnostics would ordinarily constitute 'service change' and require consultation under the public involvement and consultation duties of commissioners as set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs, and require the subsequent service change assurance process as detailed in the 'NHS Planning, assuring and delivering service change for patients' 2018 guidance.

However, these proposed changes are being made as part of the level 4 incident response and are deployed in response to Covid-19. As such, they are not subject to the usual legislative process.

The changes proposed are temporary in nature as part of the level 4 incident response. Any proposal to make them permanant would be subject to formal consultation.

This is completely separate from the process to make any permanent significant changes to services, which would be led by the NHS Lincolnshire CCG, requires formal public consultation in line with national guidance and is within the authority of the CCG to decide.

In addition, these changes will be subject to quarterly reviews against the aforementioned conditions and to ensure any and all alternatives for improvement of services are actioned.

NHSE/I change protocols and registration can be followed with cases being submitted so that the critical pathway for implementation date can be maintained. It is not anticipated that full implementation will be on 15th June 2020, but that the process will commence from this date.

The timescale for the Green site is the duration of Covid-19 – the Green site will be set up to at least 31 March 2021. As such, the Green site will be part of the Restore phase and the Recovery phase.

The changes proposed are a response to a Level 4 national incident, and as such this paper does not include financial considerations. This does not disregard the Trust's approach to financial governance and sound financial stewardship which are considered throughout the decision-making process.

Green site model - detailed design

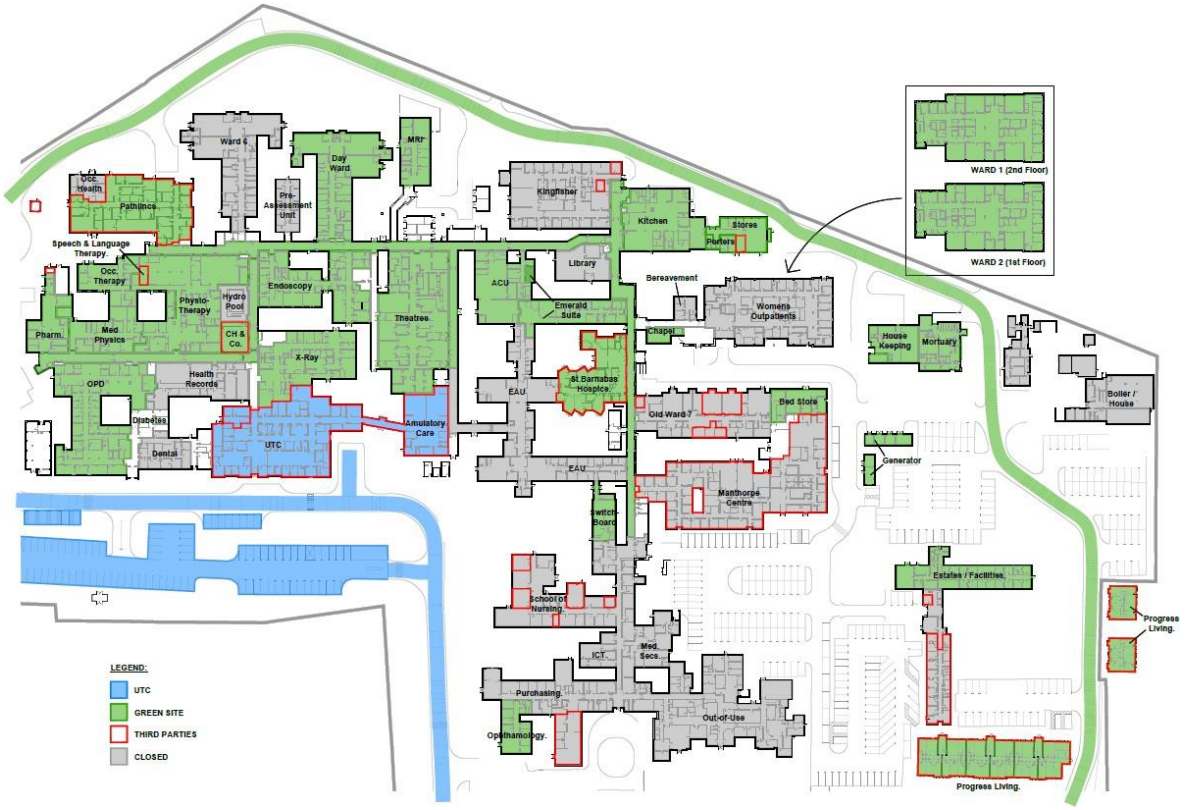
The proposal is for ULHT to establish a Green site at Grantham for elective and diagnostic activity (see Appendix 2 for detailed clinical model).

The three conditions mentioned earlier for a proposed solution require adherence to the following design principles:

- Eliminate the risk of nosocomial infection reducing chance of contracting Covid-19 in our hospitals.
- Access controlled by exemplary IPC and Personal Protective Equipment (PPE) compliance.
- Conform to all guidance and standards provided within the NHS IPC Board Assurance Framework with strict adherence to the NHSE Hygiene Code.

- Adhere to a strict and rigorous regime of monitoring and surveillance for Covid-19 of our patients and staff along with reinforcing social distancing and hand hygiene guidance. This will include the use of any new testing.
- Clinical care provided during the Restore phase will be prioritised to treat cancer patients or those requiring care that is deemed to be clinically urgent, ensuring support is in place to enable patients to comply with requirements - mental capacity, social and other factors.
- Maintain consistency in staff and equipment allocation and restrict movement of staff and equipment between different sites and areas which will support minimising the risk surface contact transmission accompanied by a rigorous cleaning regime.

An overview of the Green site with an isolated Blue UTC and associated car park is shown below:



The Restore phase will focus on cancer surgery and clinically urgent elective surgery and diagnostics.

The services provided at Grantham in this proposal have been assessed against the design principles. The services which will be included are as follows:

Specialty	Service
Surgery (day cases)	Cancer (theatre)
Surgery (day cases)	Clinic - cancer (dermatology)
Surgery (day cases)	Resus
Surgery (day cases)	Sepsis
Surgery (day cases)	Hospital at night
Surgery (theatres and clinics)	General surgery
Surgery (theatres and clinics)	Ear, Nose and Throat ('ENT')

Surgery (theatres and clinics)	Oral and maxillofacial ('OMF') (including skins)
Surgery (theatres and clinics)	Orthopaedics
Surgery (theatres and clinics)	Ophthalmology and orthoptics
Surgery (theatres and clinics)	Urology
Surgery (theatres and clinics)	Gynaecology
Surgery (theatres and clinics)	Breast
Surgery (theatres and clinics)	Colorectal surgery
Acute Care Unit (Level 1 care)	Acute Care Unit (Level 1 care)
Medicine	Ambulatory Care
Diagnostics	CT
Diagnostics	MRI
Diagnostics	Ultrasound
Diagnostics	X ray/Screening room hybrid
Diagnostics	Endoscopy
Diagnostics	Clinical engineering
Diagnostics	Ad hoc Complex hearing aid support
Clinical Support Services	Pathlinks
Pharmacy	Full Pharmacy Service
Back office functions	Switchboard
Outpatient Services	OPD Nursing
Outpatient Services	Access, Booking and Choice
Outpatient Services	Health Records
Outpatient Services	Outpatient Department Reception
Cancer Services	Hospice (St Barnabas)
Cancer Services	Chemo Suite/ Oncology and Haematology
Therapies	Physio – inpatient support
Therapies	Occupational Therapy – inpatient support

A number of services will be excluded as they do not currently meet the design principles. These are as follows:

Specialty	Service
Surgery (theatres and clinics)	Paediatrics – (Paediatric surgery will continue to operate on Green Pathways at LCH and PHB sites and would not change from Manage phase processes*)
Out-patient activity	Diabetes
Out-patient activity	Therapies
Out-patient activity	Upper GI
Out-patient activity	Cardiology
Out-patient activity	Endocrinology
Out-patient activity	Nephrology
Surgery (day cases)	Critical care outreach
Orthopaedics	Fracture follow up clinics
Orthopaedics	Elective clinics
Orthopaedics	X-ray guided injection lists
Orthopaedics	Ophthalmology - elective clinics
Orthopaedics	Outpatient injection lists
Urology	Uroflows
Surgery (theatres and clinics)	Orthodontics
Surgery (theatres and clinics)	Vascular
Back office functions	Outpatient Department
Back office functions	Procurement
Back office functions	Social services
Back office functions	Education team
Back office functions	Friends of Grantham
Medicine	Emergency Department
Medicine	Medical Ward Beds

Family health	Fertility
Family health	Antenatal
Family health	Urogynaecology
Family health	Colposcopy
Family health	Hysteroscopy
Family health	Maternity clinics
Family health	Maternity scanning
Family health	General gynaecology
Family health	Breast - Emerald Suite
Family health	Community paediatrics – Kingfisher
Family health	Community paediatrics - Day cases
Diagnostics	Nuclear medicine
Diagnostics	Cardiac & Respiratory Physiology
Outpatient Services	All outpatient services
Cancer Services	Palliative Care
Cancer Services	Abdominal aortic aneurysm ('AAA') screening
Therapies and Rehabilitation	Physiotherapy
Therapies and Rehabilitation	Occupational Therapy
Therapies and Rehabilitation	Dietetics
Therapies and Rehabilitation	Speech and Language Therapies
Therapies and Rehabilitation	Rehabilitation

* Paediatric services at Grantham are limited to Ootpatient services and do not include paediatric surgery. Paediatric surgery requirements to support safe care can only be offered at Lincoln and Pilgrim hospitals(such as facilities equipment and expertise in resuscitation) and, as such, Green paediatric pathways will be used at Lincoln and Pilgrim to continue urgent surgery.

This list will be reviewed regularly with services being permitted to operate on-site when they can demonstrate IPC compliance.

Services no longer continuing in the Green site will be relocated to alternative accommodation offsite, and staff will be redeployed where necessary. Delivery teams will work with all services and teams affected and will use the flexible and remote working solutions developed in the Manage phase of the response to the pandemic. Where these solutions cannot be deployed, accommodation options will be developed that reduce the distance of transfer, using other health and care sector facilities.

A rehabilitation inpatient unit will be established during the recovery phase to support rehabilitation of Green patients. This will provide inpatient services for confirmed Covid-19 negative patients from the Grantham area requiring step down care from Lincoln or Pilgrim hospitals.

The rehabilitation inpatient unit will "Go live" in October/November 2020 in the Recovery phase. This unit will be critical to winter planning in conjunction with the recovery phase.

Grantham – Blue – Urgent Treatment Centre (UTC) overview

The preferred Green site model at Grantham will include an Urgent Treatment Centre in an isolated Blue area.

It will be equipped to diagnose and treat many of the most common ailments people go to A&E for.

Patients may be referred to an urgent treatment centre by NHS 111 or by a GP. You can also just turn up and walk-in.

Conditions that can be treated at an urgent treatment centre include: *(* Please note this is not an exhaustive list)* :

- sprains and strains
- suspected broken limbs
- minor head injuries
- cuts and grazes
- bites and stings
- minor scalds and burns
- ear and throat infections
- skin infections and rashes
- eye problems
- coughs and colds
- feverish illness in adults
- feverish illness in children
- abdominal pain
- vomiting and diarrhoea
- emergency contraception

[1] *National Urgent Treatment Centre standards 2017*

Isolation can be achieved in a way that prevents staff crossing between Blue UTC and Green areas and does not compromise IPC principles.

The preferred model converts the A&E, currently open from 8am to 6.30pm, into a 24/7 walk-in UTC treating patients with a NEWS score of 4 and below and using existing x-ray imaging facilities dedicated to the UTC.

The conversion of the Grantham A&E to a UTC affords the options of having completely Green diagnostics and inpatient services.

Grantham – Blue – Ambulatory Care Unit overview

The preferred Green site model will retain an Ambulatory Care Unit in the isolated Blue area connected to the UTC. The Ambulatory Care Unit will be Consultant and ACP delivered.

The Ambulatory Care Unit offers same day care to patients at the hospital – providing early urgent diagnosis of an urgent clinical condition and treating patients with a NEWS score of 4 and below.

Patients are able to access the Ambulatory Care Unit via walk-ins or via GP referral. The unit will be open from 8am to 6pm – and will be staffed to 8pm to allow a buffer for all treatments to be completed.

[1] https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

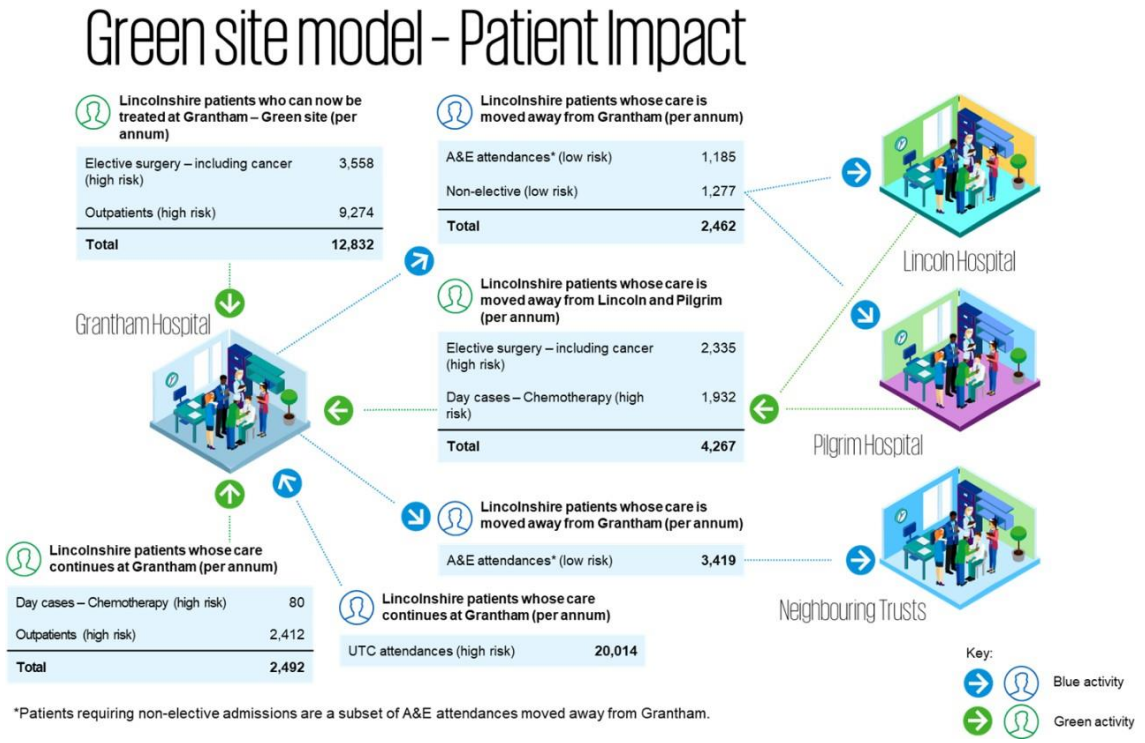
Patients are assessed, diagnosed, treated and are able to go home the same day - this affords patients the benefit of not being admitted into hospital overnight. Currently, on average 10 patients a day access the Ambulatory Care Unit.

Diagnostics services in Ambulatory will be limited to plain film x-ray and pathology. Ultrasound services are also being explored. Pathology services will have closed links to laboratories to protect the Green site status. As such, there will be no access to CT, MRI or other out-of-departmental service. GPs will therefore refer patients that require more than the diagnostics offered to a different acute site which could be; Lincoln, Pilgrim, Nottingham or Peterborough (dependent on the patient's location).

The potential for medical inpatient and diagnostic services to share Blue and Green services has been examined. This option failed to meet the IPC principles of a Green site.

Green site model – Likely patient impact

A summary of the patient impact of the Green site model is provided below:



** The numbers described in the above infographic are representative of known modelling assumptions at the point of production of this report. Throughout Covid-19 pandemic both emergency and planned demand for services have changed much more than normal seasonal variation and as such whilst this has been considered it does reduce the accuracy of future forecasts.*

Green site – Elective and diagnostic activity – Likely patient impact

Overall, the Green site at Grantham will positively impact the population of Lincolnshire. The case for change evidenced the requirement to temporarily reconfigure services to address the impact on patients as a result of the Covid-19 surge.

The following details how the drivers for change are addressed:

Cancer performance

The volume of patients treated with cancer surgery pre Covid-19 was 35 per week.

For a short period during the latter two weeks of April 2020, cancer surgery was stopped whilst the necessary preparation was undertaken to create discrete Green and Blue pathways. Since the beginning of May, with the introduction of Green and Blue pathways cancer surgery has increased from nil to 22 per week, however, further increases are restricted due to Green pathway capacity at Lincoln and Pilgrim.

The introduction of the Green site at Grantham, this will give ULHT the capacity– in addition to the existing Green pathways – to exceed the previous pre Covid-19 level and deliver cancer surgery for all of Lincolnshire – reducing waiting times and improving patient outcomes.

The Green site at Grantham will support delivery of all cancer surgical activity for patients across Lincolnshire that require Level 1 post-operative critical care. Within 2-3 weeks there will be no waiting list for cancer surgery.

That would be the case for the majority of patients needing surgery for breast, gynaecology, ENT/OMF and urology malignancies.

Patients needing high dependency and critical care post-operatively will continue to be operated on at Lincoln and Pilgrim through their Green pathways, as they are at present.

Chemotherapy will continue at Grantham and, as such, 80 haematology patients and oncology patients will receive treatment. Chemotherapy will also include patients from Lincoln and Pilgrim. As such, 1,932 haematology patients and oncology patients will move from Lincoln and Pilgrim to safely receive treatment at Grantham.

Planned elective

Planned elective surgery has ceased, resulting in significantly increased waiting times. The introduction of a Green site at Grantham will enable planned elective surgery to resume in the Restore phase and maintain the waiting list level ensuring that there is no further deterioration of waiting times.

The number of patients receiving elective surgery for the following specialities at Grantham; colorectal, urology, gynaecology, and cancer minor OPD procedures in dermatology and ENT/ oral Maxillofacial, will increase by over 3,500 patients per annum with Grantham as a Green site.

In addition, the number of patients receiving outpatients care can increase by over 9,000 patients per annum with Grantham as a Green site.

The proposal provides a benefit to all patient groups in an innovative way through providing the ability to continue with elective care in a controlled environment, to stabilise, and avoid the patient waiting list for elective treatments growing whilst we manage the Covid-19 situation.

To mitigate the impact of the extra travel requirement on patients, particularly those on the East Coast, ULHT is working with its partners to provide effective transport solutions. This is not expected to be a constraint on the deliverability of the model given recent experience in the Manage phase of response to Covid-19 pandemic.

Theatre capacity – The theatre capacity available in the Restore phase will only support cancer surgery and limited non-cancer elective surgery. The limited non-cancer surgery capacity will be sufficient to prevent further increase in waiting lists. More theatre capacity will be required to significantly reduce waiting lists.

Urgent diagnostics

The introduction of a Green site model at Grantham will enable urgent diagnostics to increase in a low risk environment where all patients including those who may be vulnerable or susceptible to infection can receive the necessary tests. The capacity will ensure that patients will receive diagnostics in a timely manner, preventing further deterioration of waiting times and reducing the risk of delay in diagnosis.

The Green site model will support the majority of diagnostics required for cancer patients and urgent elective patients, whilst adhering to the Infection Prevention and Control design principles.

Endoscopy – Endoscopy procedures are aerosol generating and current guidance is impacting on service capacity due to IPC controls and cleaning time required between patients. Current endoscopy capacity is reduced by 70% of normal activity and is focused on cancer and urgent work.

The demand management pathways for upper GI and lower GI introduced during the Manage phase are proving successful. Patients are currently scheduled for barium/CT CAP scans in the first instance and results are reviewed by a senior clinician to determine whether patients still require an endoscopy procedure. This will continue in the Restore phase.

Modelling indicates that the Green site will support endoscopy procedures for all cancer patients, whilst adhering to the IPC design principles, based on 12-hour sessions running 7 days a week.

Additional capacity is likely to be required, as due to IPC considerations the number of endoscopies performed cannot rapidly return to the pre Covid-19 level. As such, in the recovery phase, Louth will be operationalised as a Green endoscopy pathway.It is also possible that the Independent sector capacity can be utilised as needed.

Grantham – Blue – Urgent Treatment Centre – Likely patient impact

The conversion from an A&E to a UTC at Grantham will impact the population of Lincolnshire.

Lincolnshire patients whose care is moved away from Grantham (per annum)

The majority of patients (over 20,000 attendances per annum who attended the A&E) will be able to attend the UTC and will benefit from the increase in opening hours from 8pm to 6.30pm to a 24/7 walk-in service.

Nevertheless, 4,603 patients (12 per day) who attend Grantham A&E (19% of total attendances) will be treated at other hospitals as a result of the reduction of NEWS score – of these, 1,184 patients (3 per day), will be treated at Lincoln and Pilgrim and 3,419 patients (9 per day) will be treated at other neighbouring Trusts.

In addition, 1,560 patients (4 per day) of the 4,603 patients who will be treated at other sites will require admission at these other sites. Oof these 401 patients (1 per day) will be admitted and treated at Lincoln and Pilgrim and 1,159 patients (3 per day) will be admitted and treated at other neighbouring Trusts.

Transfers from Grantham as a result of A&E to UTC conversion and withdrawal of medical beds at Grantham

Some patients who attend the UTC will require admission and will be transferred to a different site, as the UTC would not support direct emergency admission to Grantham hospital. Due to the provision of the Ambulatory Care Unit, fewer patients will require transfer to another hospital site than without.

In total, 874 patients (3 per day) will be required to transfer to other sites, the majority of whom will be transferred to other ULHT sites. This represents an additional 20 patient transfers, as 854 patients were already transferred to other ULHT sites in April 2019 to March 2020 under existing protocols.

Re-routed admission from multiple non-A&E routes as a result of a withdrawal of medical beds at Grantham

A total of 1,198 admissions (3 a day) were made to medical beds at Grantham from multiple non-A&E routes between April 2019 and March 2020.

As medical beds will be withdrawn at Grantham, 476 patients will be treated at the Ambulatory Care Unit (largely GP referrals) and 772 patients will be re-routed and admitted at Lincoln. As previously described in this report, these volumes describe previous years' referral models pre Covid-19 and as such may be overstated.

Equality impact assessment and quality impact assessment have been completed and support this configuration (see Appendices 3 and 4).

Addressing the case for change

There will be no medical bed admissions at Grantham to adhere to IPC principles, and as such it would not be possible to have an A&E in the proposed configuration. Nevertheless, converting the A&E to a UTC maintains urgent care for the Grantham population which allows for colocation of a green site and urgent care.

Out of hours (OOH) services at Grantham hospital will continue to operate as part of the Blue – UTC footprint, and therefore patient pathways that involve accessing the existing OOH will be unaffected by changes.

Green site and Blue UTC – Staff impact

The Green site model at Grantham will impact staff at ULHT. The communications and engagement strategy contains detail of the internal communications and staff engagement actions, as staff morale and support is critical to the success of this temporary service change.

To reduce the footfall on the site and maintain IPC principles, a review has been undertaken to identify the staff that can be relocated elsewhere. In total, c.600 ULHT staff and an additional 50-75 staff members from third party tenants have been identified for relocation. Many of these staff are already working from home or have been redeployed as part of the Manage phase of Covid-19 response. The remaining affected staff will be supported in transition to work from home, from a different ULHT site or in the community as required.

In total, the initial configuration of the Green site and Blue UTC will require c.200 staff. This will increase as more services are initiated with the Green site IPC principles

The workforce will be supported by careful adherence to IPC principles and embedded culture of IPC excellence. ULHT will undertake the following reasonable and practicable steps to ensure that staff do not contract or convey Covid-19:

- Defined protocol for migration of staff between sites (especially surgical teams) to ensure no Blue to Green transfer on the same day.
- Screening by wellbeing assessment including temperature check at the start and end of each shift.
- Programme of random staff swabbing to screen for asymptomatic carriers – work is being undertaken to refine this approach.
- Risk assessment for staff not currently in patient-facing roles due to previous risk assessment to facilitate work at Green site.
- Swabbing if symptomatic or for contact tracing - adhere to the new National Test and Trace system.
- Maintain consistency in staff and equipment allocation and restrict the movement of staff and equipment between sites, accompanied by a rigorous cleaning regime that minimises the risk of contact transmission.
- Maintain the advice and guidance in respect of hand washing and social distancing.

The approach will be underpinned by education, training, awareness and compliance and will be consistent for all staff irrespective of the type of activity they are undertaking – Green and Blue.

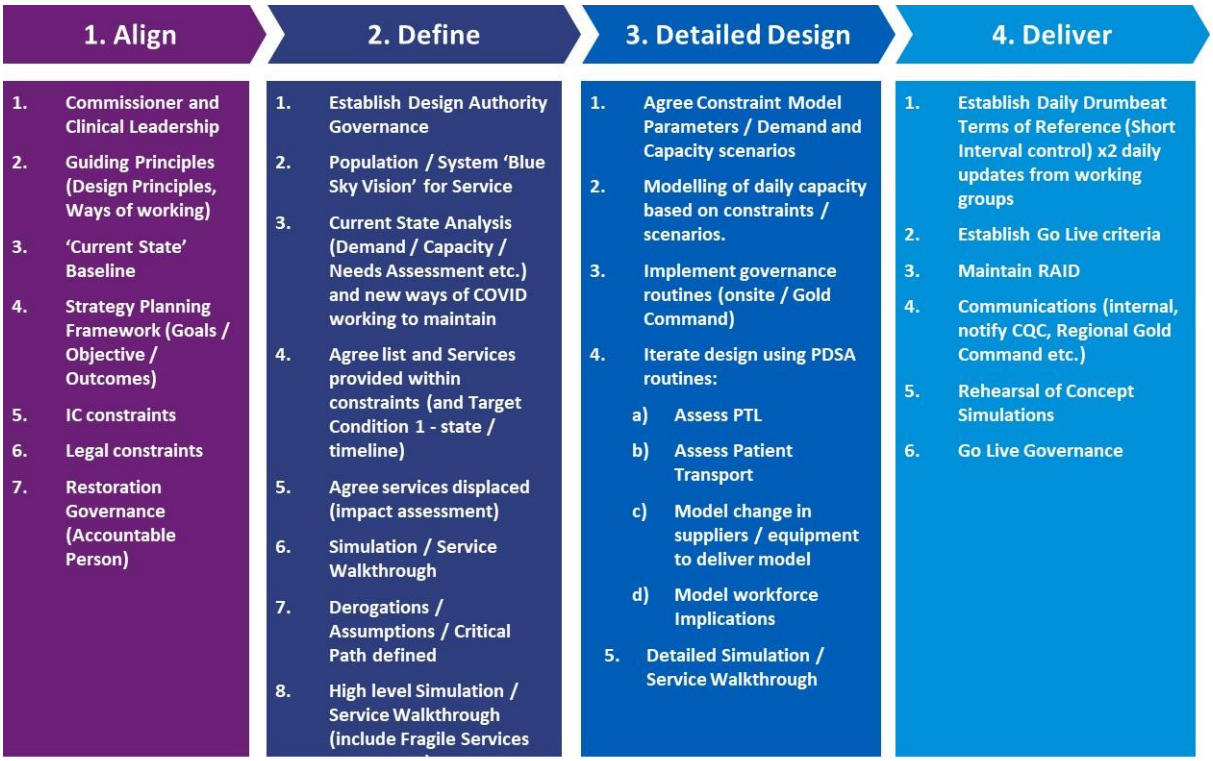
The proposal provides a benefit to staff from the perspective that it provides an opportunity for staff in vulnerable groups to return to work safely in a Green environment following a thorough risk assessment with the Occupational Health Department.

Under this proposal, staff who believe they are vulnerable are able to request a Risk Assessment via their line manager and also access Occupational Health support. Staff who are currently working at home due to the Covid-19 risks may be supported to return to work safely on a Green site, subject to a full risk assessment being completed by the Occupational Health Service.

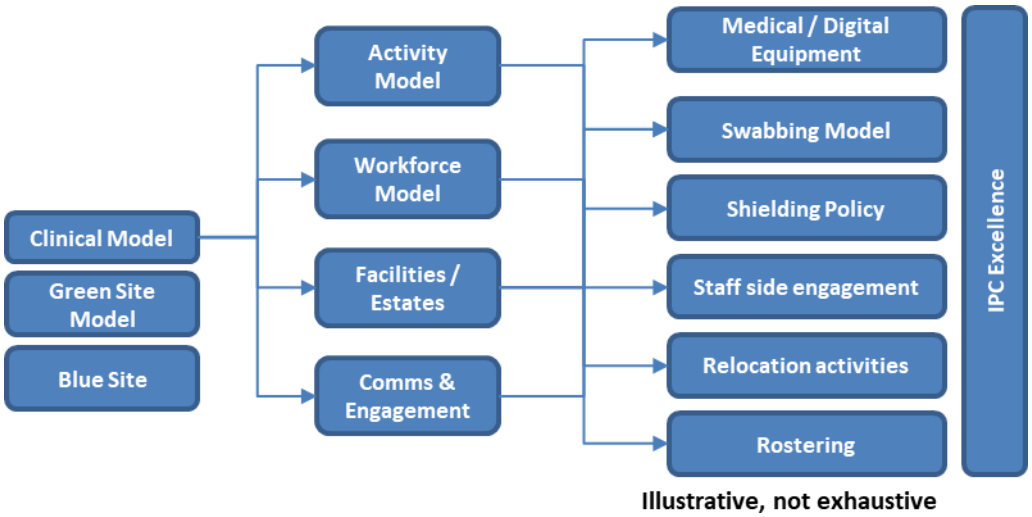
Implementation plan

A Task and Finish group, with programme support from KPMG, was established on 14 May 2020 to progress through to a start date of 15 June 2020.

The programme is to follow the following four key stages:



Programme overview



Programme Governance

Leadership

Leadership is provided by the following:

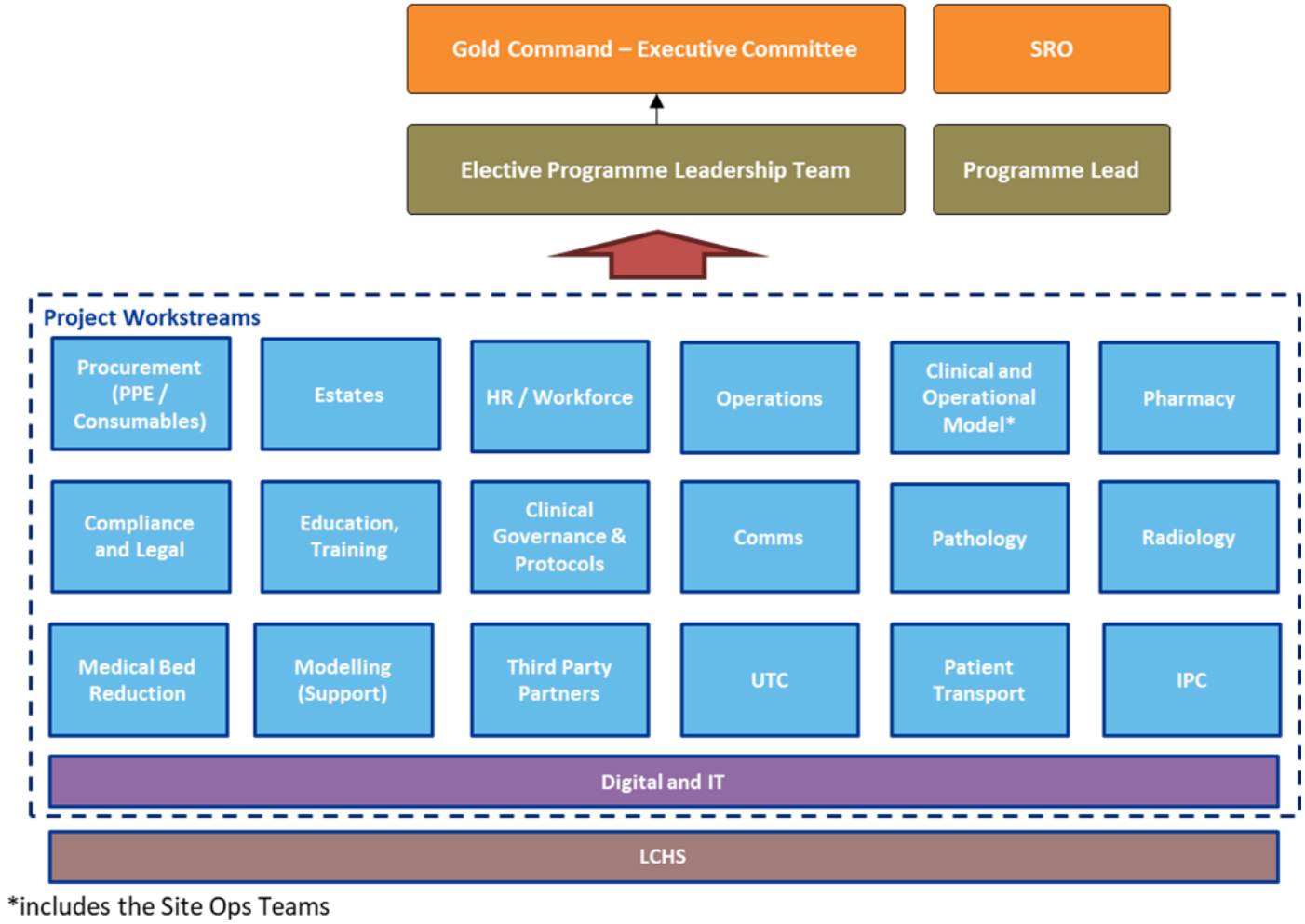
- Director of Finance and Digital / Senior Responsible Officer
- Chief Operating Officer / Restore Programme Lead
- Managing Director of Surgery / Programme Lead
- Clinical Director of Surgery
- Clinical Director Clinical Support Services
- Divisional Clinical Lead, Clinical Support Services
- Deputy Divisional Nurse, Lead Nurse Specialty Medicine
- Managing Director of Medicine
- Managing Director of Clinical Support Services
- Managing Director of Family Health

Programme Review

- The Programme Review is a meeting chaired by the Programme Lead.
- The Programme Review ensures that critical decisions are made on key problems that are raised from the Task and Finish group workstreams.
- Following the Programme Review, decisions and actions will be cascaded back to workstreams to action. Any critical decisions, issues, or risks will be raised from Programme level to Gold Command.
- The Programme Review occurs daily and will cover:
    - Workstream updates / review progress against plan (by exception)
    - Establish the week's key milestones
    - Cascade the week's key activities and meetings

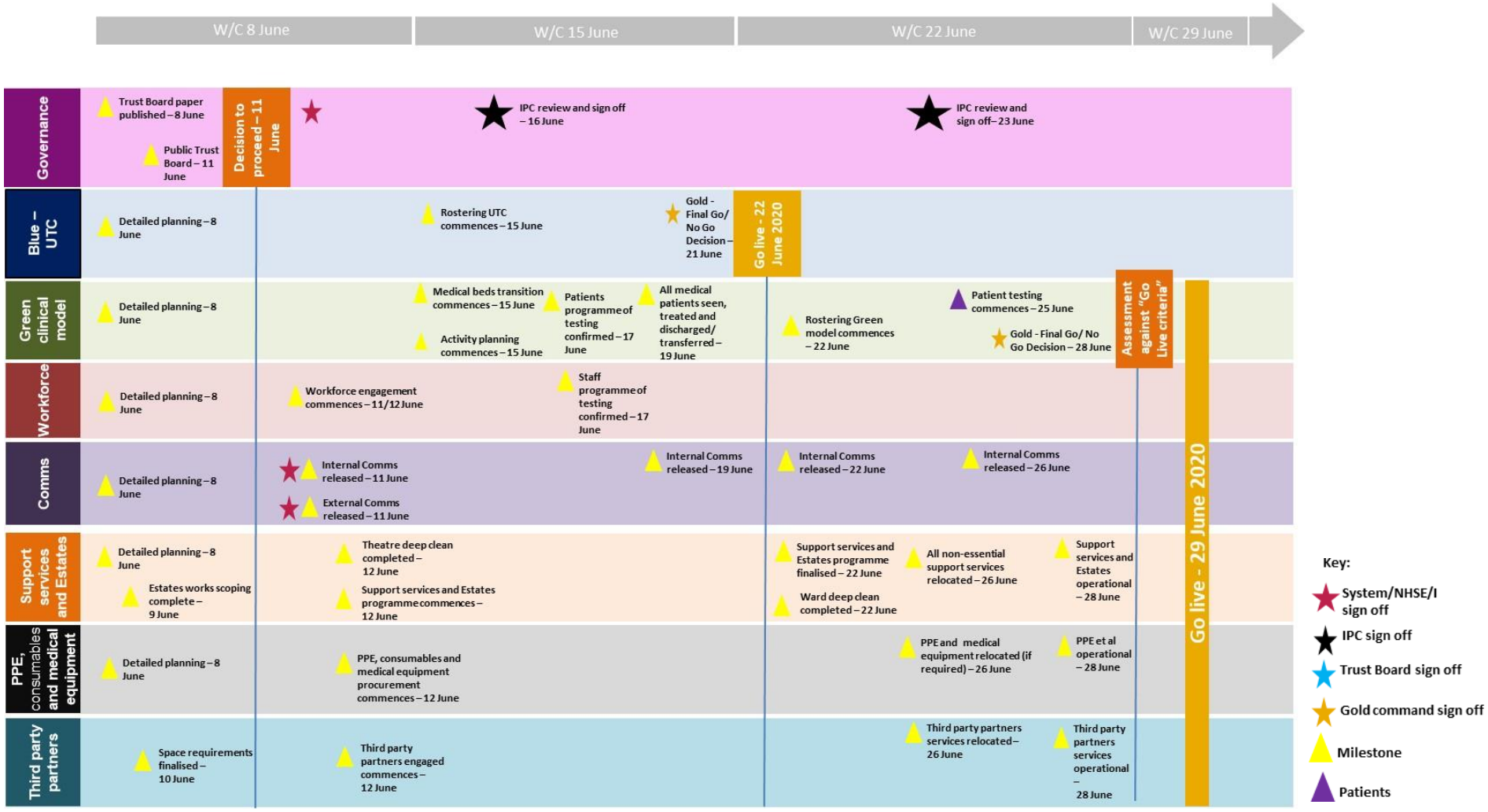
- Review critical milestones, risks, assumptions, issues and decisions to escalate
- Escalations and check in (driven by plan milestones) to Gold Command – with a minimum of 1 update per week.

Programme Structure



*includes the Site Ops Teams

Timeline



Patient-centred ◆Respect ◆Excellence ◆Safety ◆Compassion

Task and Finish Group update

All workstreams in the Task and Finish group are aligned and have commenced detailed planning. The workstream leads are awaiting the Trust Board decision to proceed in order to commence engagement with staff and third parties and completed this detailed planning ready for the start date of 15 June 2020.

A summary of work to date and next steps is provided in the table below:

Workstream	Work to date – 25 May 2020	Next steps
Green site – clinical model	- Green clinical model confirmed, including expected activity (See Appendix 2) - Staffing model (numbers and skill mix) confirmed - Modelling team has provided a prediction as to when all the outstanding Level 2 and 3 cancer surgery will be cleared	- Activity to be confirmed for outpatients, endoscopy and day case chemo - Modelling team to include urgent elective surgery - Confirm IPC – patient testing regime and demand - Communicate Clean IPC policy for movement of staff and equipment, ensuring Green site, maintaining key principles
Blue – UTC	- Blue UTC model confirmed - Modelling of displacement and transfers as a result of the conversion of the A&E to a UTC and withdrawing medical beds admission has commenced	- Staffing model (numbers and skill mix) to be confirmed to support 24/7 walk-in centre - Finalise medical beds "wind down" plan in transition period - Modelling of displacement and transfers as a result of the conversion of the A&E to a UTC to be completed
Workforce	- Identification of staff volume on Grantham site - Confirmation of staffing model and requirements across all staffing groups - Retraining requirements outlined - Review commenced with OCI Health for a return to work for staff groups that are shielding	- Commence engagement with clinical staff, admin staff, staff side and non-ULHT staff (who are on site at Grantham) after Trust Board decision to proceed - Confirm IPC – staff testing regime and demand
Communication	- A comprehensive Communications and Engagement strategy has been developed for staff, the public, the media and other third parties	- Commence communication and engagement after Trust Board decision to proceed

Estates	- Confirmed feasibility to isolate UTC from the Green site - Estates works required for Green site confirmed - Identified all third parties who occupy space at Grantham and which will require relocation - Staffing model confirmed - Site security requirement confirmed - IPC requirements on estates confirmed (e.g. fogging of theatres and wards)	- Confirm facilities and catering plans - Confirm emergency maintenance plan to ensure it preserves IPC integrity - Create signage around estates after Trust Board decision to proceed and engagement commences
PPE and consumables	- Commenced review of PPE requirements based on clinical model	- Finalise PPE requirements and scale supply to meet
Clinical Support Services	- Radiology and imaging – equipment identified for Green site and UTC - Pharmacy – confirmation of ability to support wards - Pathology – total capacity confirmed	- Radiology and imaging –confirm relocation of any diagnostics which will need to be completed on a different site - Pharmacy – ASEPTIC 7 day pharmacy to be confirmed - Pathology – align demand with capacity
Patient Transport	- Contract meeting with CCGs undertaken for initial scoping and confirmation of requirements	- Commence engagement with third party providers after Trust Board decision to proceed

Conclusion/Recommendations

Having considered all of the available options, the option that satisfies the full criteria set is the temporary change of services at Grantham as a Green site with a Blue isolated UTC. This is combined with the continued limited use of Green pathway services at Lincoln and Pilgrim hospitals for cancer surgery that requires high dependency or critical care facilities.

This paper has outlined the following:

- A summary of the case for the temporary change of services provided by the Trust as part of its response to the level 4 incident declared on 30 January 2020.
- The options considered and the preferred option.
- The legal basis for the change.
- The clinical leadership and governance established to oversee and enact the proposed changes.

This paper has also provided assurance that the quality and equality impact of the proposed changes has been considered.

Decision required

Approval from the Trust Board to proceed with the changes proposed and approval of the necessary work to deliver these changes, recognising that they are temporary and that any proposal to make them permanent will be subject to public consultation.

The timescale for the Green site is the duration of Covid-19 up to at least 31 March 2021. As such, this will be part of the Restore and Recovery phases. This timescale and the wider solution will be subject to quarterly review.

Appendices

Appendix 1: IPC assurance framework

COVID-19 IPC Board Assurance Framework

Appendix 2: Green site – clinical model

Green clinical model v.2.docx

Appendix 3: Quality Impact Assessment

Quality Impact Assessment.xlsx

Appendix 4: Equality Impact Assessment

EIA Rapid Service Change Impact Asses

Publications approval reference: 001559

APPENDIX 1

Infection prevention and control board assurance framework

4 May 2020, Version 1

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating

and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	All patients are screened on admission to the organisation. Those who are suspected COVID-19 are cared for in dedicated wards	Swabbing not a perfect method of screening	The Trust allows for other diagnostic evidence such as CT or X-ray and clinical picture to be considered pending re-testing
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Patients with suspected or confirmed COVID-19 are placed on dedicated wards or placed in isolation room on other wards if deemed clinically necessary	Asymptomatic cases have been detected	If an asymptomatic case is detected, close monitoring of contacts is undertaken
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	The Trust has been consistent in following national guidance on discharges and has supported social care discharges with a supply of PPE for 72 hours	Some initial gaps in notifying discharged patients with swab results	System now in place with Local Authority Public Health to notify post discharge patients of results
• patients and staff are protected with PPE, as per the PHE national guidance	The Trust has followed PHE national guidance throughout the pandemic	There have been occasions where supplies have been running low.	The Trust has sufficient supplies of all types of PPE and is building alternative and compliant PPE for future demand
• national IPC guidance is regularly checked for updates and any changes are	The Trust has subscribed to automated updates and has notified incident commanders at daily briefings with relevant		

effectively communicated to staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	updates cascaded through SBAR communication tool and live webinars Changes to PHE guidance are discussed with strategic commanders and any necessary adjustments or communications are agreed through daily meetings. The Trust BAF and risk register have been updated to reflect the current issues and signed off at subcommittee and board External additional support for non-COVID-19 IPC activity has been sourced by the DIPC.	This work is part of an ongoing refresh piece of all IPC functions & compliance with the hygiene code, currently assurance is limited	IPCT continue to monitor and manage HCAI cases including RCA investigations for alert organisms. Refreshed IPC group in place. Terms of reference approved and will be ratified by Quality & Governance Committee on 19 May 2020. Strengthened reporting arrangements in place
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat	Designated cohorting and isolation areas with specifically allocated teams to reduce the risk of transmission		

patients in COVID-19 isolation or cohort areas	These teams are further supported by IPCNs QM Clin Ed		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	All relevant housekeeping staff are trained to work in these areas. training sessions are recorded		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	In conjunction with IPC areas when identified, are cleaned in line with PHE guidance. Chlor Clean and HPV fogging	Historically there was no deep clean process in use	New process for deep clean currently being implemented with a defined deep clean schedule and accompanying SOP
• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Increased cleaning is in place across all sites/areas during this pandemic in line with the Deep cleaning protocol		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance	All Linen is treated as infectious and is managed using soluble laundry bags double bagged in a clear outer sack to be transported to the laundry. It is then		

and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	laundered as infectious laundry by the 3rd party laundry service		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Ongoing and strengthened accessibility to Antimicrobial Pharmacists for advice on antibiotics and infection management for all staff including junior doctors 7 day working PGME and pharmacy reminders, newsletters, tweets, very good uptake of this availability. C.Diff walk arounds halted, but have been taken over by phone calls to discuss patient where required with the lead consultant.	ASSG meeting cancelled in April as rooms bookings were over-ruled for COVID cells and other organisational purposes without options. ASSG held virtually in May. Productive but not quorate. Nothing to sign off but have progressed some actions and had opportunity for updates.	Direct contact from persons requiring ASSG input for antimicrobial stewardship, encouraged by request for virtual returns as enquired if anyone in group

	RCAs being held at Lincoln for all C.diff cases have antimicrobial input	Not got same assurance for PHB and GDH	New Antimicrobial Pharmacist at PHB will be assigned to pick these sites up for RCA input virtually with support of existing antimicrobial pharmacists if needed
	Antimicrobial stewardship and requests for advice. Virtual platforms used more frequently by pharmacists seeking advice on the wards – mobile, office line, skype, teams, whatsapp groups. Includes frequent requests for advice from Rowlands Outpatient Pharmacists. Comms sent out re availability over mon-sun have had good response and uptake.		
	PII audit(s) still prioritised and completed. Virtual communications with clinical teams and very good response. Confident no gaps in this assurance Repeat PII audit planned and will be prioritised despite pressures, with ward pharmacist involvement	Unable to complete PII investigation with Ribotyping, would be very helpful in drawing further conclusion and assurance for antibiotic prescribing assessment	
	Non-essential (or non-mandatory) Antimicrobial Stewardship audits halted to avoid risk to patient safety due to inaccessibility to patient medical notes and to reduce unnecessary footfall on wards. Junior doctor projects registered with Clin Governance largely concluded, some have actions of final report		

	remaining, which will be completed once pressures are manageable.		
	Ongoing contribution in virtual DTC, working to sign off guidelines related to antimicrobials, providing input in developing safe and effective documents, with feedback mechanisms. Rapid updates sent out around COVID and antimicrobial stewardship – evidences PGME emails, newsletter and pharmacy advice	Usually would be captured in team brief and educational update sessions	Provided updates by email instead. Working on further means of communicating these to increase awareness Sent updates to PGME and all pharmacy staff for sharing with all relevant staff
	Commenced work on an antimicrobial app procured by pharmacy, and being led by Antimicrobial Pharmacy team using STP funds. Collaborative effort captured in the 'long term plan' to improve AMS and support organisations across the patch. Will help with C.diff and ESBL bacteraemia rates related to correct antimicrobial use – governance process to be finalised via DTC before release/launch	COVID priorities have slowed antimicrobial team on antimicrobial guideline work COVID interruption of DTC and PACEF access pathways may impact on governance sign off, but will be pursued as virtual set up is formalised for these committees	Specific resource funded via SPT has been ring-fenced for populating the microguide app, pending governance sign-off, using existing Trustwide guidelines New antimicrobial pharmacist started Mid May will be part of effort to prioritise this work on guideline review
	Review of paediatric antibiotic guidelines out of date by 5 years. Commenced work on this but halted by COVID Review of adult antibiotic guidelines due this year and requires some updates to bring in line with NICE	Will need to secure microbiologist review and Pathlinks sign off	Antibiotic guideline review will also address some of the feedback from end-users where clarity was requested
	Surveillance continues	Extrapolation against occupied bed days and	Using various means and parameters for extrapolation to ensure good level of

		admissions may be skewed on system used for surveillance	confidence in surveillance and trends identified
	RECOVERY trial input including screening patients and advising on antimicrobial choices that have been made, next steps etc. Commas sent out via Trust, pharmacy, and STP		
	Follow up of patients with support of ward pharmacists, including complex patients on microbiology radar	Educational sessions for pharmacy teams halted, and will need to be re-developed depending on means of delivering them amid social distancing	All antimicrobial advice requests include educational aspect on rationale behind this advice and is acknowledged as being very helpful. Evidence of pharmacy colleagues applying this rational in their daily work, as notable difference in those who request advice frequently
	OPAT of patients where feasible	Some issues with premature and error in handover of patients amidst COVID rotas which could have impacted patient outcomes, and have required safety mechanisms to be used.	Tightened OPAT criteria to reduce risk of recurrence, at expense of delays to OPAT but important for patient safety
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	In line with national recommendations, the Trust suspended visiting with controlled exceptions i.e. end of life visiting	Some issues remain on rules for visitors bringing in patient possessions	The Trust has developed a protocol for acceptance of patient possessions
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Dedicated wards have been in use for both suspected and confirmed COVID-19 patients. The Trust has a place based approach to PPE precautions so all clinical areas take the same precautions regardless of the COVID-19 status of any patient		
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	There is a link on the Trust website front page taking the user to the national NHS COVID-19 page.		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	The status (known at time of transfer) of each patient is communicated to the receiving organisation. This includes when swab results are pending.	Initial gaps in communication were identified both for discharge home and to social care	Local Authority Public Health now communicate results to discharged patients. Discharge protocol in place
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection • patients with suspected COVID-19 are tested promptly • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Each ED has a designated streaming process for patients with suspected COVID-19. All patients admitted to ULHT are swabbed on admission. The Trust follows national guidance in relation to the management of patients who may have either a diagnostic or clinical presentation consistent with COVID-19. In these cases, patients are isolated and re-swabbed Patients attending for planned care appointments are requested to shield for 7 days prior to appointment. The patient is then swabbed 48hrs prior to the planned intervention. If the patient is positive or has symptoms consistent with COVID-19, they will be deferred and a new appointment made.	Some patients have tested positive but have been asymptomatic Atypical presentations can cause delays in diagnosis Some anecdotal evidence from a nearby Trust identified that some patients became symptomatic shortly after their procedure meaning they were likely positive during their appointment	Swab turnaround times are less than 24hrs meaning patients can be quickly isolated This has now been largely mitigated by the inclusive testing of all admitted patients All reasonable precautions are in place and are in line with national guidance
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	The Trust uses the published videos and posters provided by PHE to ensure that PPE is correctly used. There is a continuous programme of fit testing in all Divisions to ensure that staff can use all FFP3 mask types issued.	There is no control over the type of PPE received by the Trust from NHS Supply Chain including FFP3 masks. This means some risks exist of having sufficiently fit tested staff on a given mask type	The Trust is procuring reusable respirator masks that can be issued to individuals (400 + 23 Hoods). This will negate the need for high volume repeated fit testing
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	All staff who require fit testing attend training. The Trust uses the PHE videos and posters to assist with training relating to selection, donning and doffing of PPE	High FFP3 fit test failure rate in some areas. Lack of choice with masks further restricting fit tested staff available for a given shift	The Trust has purchased 2 quantitative fit testing kits. These kits can confirm a fit test pass or fail without the reliance on the human factor to smell/taste the fit test solutions
• a record of staff training is maintained	Staff fit testing records are held by Divisions and recorded on Health Roster	Health Roster does not include medical staff.	Evidence of fit trained staff held by clinical areas
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	While arrangements are in place (the published PHE guidance), the Trust has not yet introduced the reusing of PPE		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	The Trust is currently not reusing PPE however if needed, it would follow PHE published guidelines		

• adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	The Trust has consistently abided by the national PHE PPE guidelines and daily reports on PPE usage are supplied to the COVID-19 Tactical Cell The Trust has employed Personal Safety Champions (PSC) to visit all areas to ensure staff are adhering to hand hygiene, PPE, cleanliness and social distancing. Reports are provided daily The Trust has provided soluble red laundry bags to all staff who take uniform home to support safe laundering practices. Staff self-isolate and contact Occupational Health if they experience any symptoms consistent with COVID-19. The Occupational Health team also support national guidance in relation to symptomatic household contacts and support staff isolation.	There is still evidence of inappropriate PPE use however this has significantly reduced The PSC team work across all sites however out of hours is not fully covered.	Personal Safety Champions provide reports on challenges around inappropriate PPE usage and provide immediate training in the work place.
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate	Dedicated suspected or confirmed pathways have been established. This		

facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	starts at ED and is facilitated throughout the Patient stay. Designated suspected and confirmed COVID-19 wards have been identified. If a Patient needs care on their base ward, suitable isolation facilities are required. Patients identified with an alert organism or resistant organism are managed as per Trust policy.	Many clinical areas are in need of refurbishment Review of alert organism and Gram –ve BSI plans are in progress but not complete	Processes have been agreed (awaiting business case) for the complete refurbishment of 3 wards and environmental upgrades of a further 12 wards across the Trust External support for review of IPC function has been sourced by DIPC
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals	Molecular testing is undertaken within the microbiology section of Path Links laboratories which have UKAS accreditation and which are applying for an extension to scope for COVID-19 testing as part of the regional network. HCPC registered BMS staff are undertaking and overseeing the testing. Full validation and verification has been undertaken, and V&V documents, SOPs, training records and manufacturers' information documents are available on request.		

• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	PHE guidance is used as the framework for testing, although some locally arranged additional testing has been taking place. NHSE is co-ordinating across the MidE2 network. Current turnaround time is 13-18 hours from receipt of samples.		
• screening for other potential infections takes place	Demand management has been implemented according to national guidance, and according to the attached letter. Samples of limited clinical value are not being processed, but CPE screening and MRSA screening from high risk contexts is ongoing. We are reviewing the situation in light of "business as usual" guidance, balanced with the additional workforce pressures and demand upon the laboratory.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	The Trust provides daily updates (SBAR) and the Exec team host Facebook Live events to provide advice and information to staff. The Trust has also deployed Personal Safety Champions who visit all areas on all sites to ensure there is good practice on hand hygiene, PPE use, cleanliness and social distancing. The IPC team continue to support wards and	IPC policies need review to support staff. The Trust annual IPC plan and structure is in need of a review.	The DIPC has sourced an external support to review and refresh the Trust IPC policies. Systems and processes

	departments with regular visits to ensure that non-COVID-19 infections are properly managed. The Trust has subscribed to the automated PHE update system and once notifications are received they are reviewed and escalated to the DIPC and COVID-19 Gold command. Any necessary actions or adjustments are communicated as soon as practicably possible From the outset, the Trust has followed national PHE guidance on waste segregation. This is also in line with the national specification HTM 07-01 (Management of Healthcare Waste) PPE is stored centrally and controlled by the Trust procurement teams. There is a PPE 'hotline' so staff can access PPE stocks at short notice. A daily PPE stock report is produced which includes a tracker for each line item stating the number of days stock available.	There have been occasions when stocks of PPE have decreased to dangerous levels	The IPC and Procurement teams have worked to source alternative types of PPE (masks and gowns) that meet the same or better PHE standards. This has meant that stocks are more manageable.
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Appropriate systems and processes are in place to ensure:	As a Trust we are proactive in recognizing the risk to our staff of Covid19 and provide an action plan that is supportive of their		

• staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff that test positive have adequate information and support to aid their recovery and return to work.	physiological and mental health needs at this time. Individual managers are aware of the risk to our staff and provide time for conversation surrounding the anxieties this may cause for some staff signposting for additional support as required, seeking the advice from Occupational Health, where appropriate the counselling service and wellbeing service offered by the Trust. This includes BAME staff. All staff absence is recoded and on two data bases. All staff who are self-isolating will be contacted by their line manager OH and HR also Maintain contact with individuals considered at greater risk. All staff are offered a swab test. Priority is given to staff and Household members isolating for 7 and 14 days. All staff are called personally by a Nurse from Occupational Health to support them on having a confirmed positive test. They are offered support through wellbeing and counselling	Staff testing through national testing centres id difficult and appts and timeliness of results is poor	Staff are tested through in house NHS testing Labs commissioned for patient services managed by Occ/Health

APPENDIX 2

Clinical Model

IPC Excellence facility supporting a range of surgical activity including

- General Surgery
- Urology
- Breast Surgery
- Gynaecology

With smaller numbers of

- ENT
- OMF

Vascular Surgery and Paediatrics not supported in Restore at GDGH.

Casemix will vary weekly according to clinical prioritisation and be scheduled centrally in Restore.

Cohorting of specialty activity to provide speciality presence over several days to facilitate speciality cover for ward areas and support IPC excellence

A combination of day case and inpatient activity covering 2 28 bed areas, namely Ward 2 and Ward 1.

Green workforce supported by careful adherence to IPC principles and embedded culture of IPC excellence. Screening by wellbeing assessment including temperature check at start and end of each shift. Swabbing if symptomatic or for contact tracing. Programme of random staff swabbing to screen for asymptomatic carriers. Defined protocol for migration of staff between sites (especially surgical teams) to ensure no Blue to Green transfer on same day. Risk assessment for staff not currently in patient-facing roles due to previous risk assessment to facilitate work at IPC excellence site.

Medical cover provided by foundation grade doctors drawn from existing Grantham team. Existing Hospital at Night team to provide out of hours ALS cover with middle tier perioperative medical practitioner cover on call drawn from existing GS/Anaesthetic middle tier doctors. Speciality on call cover and arrangements for postoperative review of inpatients defined by individual specialities. Inpatients will require daily specialty review.

ACU functioning as 6 bed Level 1 postoperative care unit PACU (with outreach facility to support inpatient areas) Medical cover from on site anaesthetic staff (in hours) and middle tier perioperative medical practitioner cover on call drawn from existing General Surgery/Anaesthetic middle tier doctors. Defined SOP for escalation of ward patients into ACU and utilise existing SOP for transfer to L2 / L3 facility if required.

4 theatres operating 5 days a week initially with a view to 7 day working. Lists initially running from 09:00 – 18:00 (soft cap, intention to complete listed activity). Medical staffing of operating lists 8 – 18.00 to accommodate preop visits, consent etc. On call team for out-of-hours returns supported by on call non resident consultant anaesthetist and on call consultant surgeons as per agreed specialty models. Review of planned activity to ensure appropriate facilities (eg laser point), equipment (clinical engineering stream) and staffing skill mix.

Support in theatres from radiography for Urology, and occasional other use. Overnight on call radiographer required for ward / ACU (portable chest xray)
Radiology Support for breast surgery – wire guided and Sentimag machine

Histopathology function to support specimen processing from theatres

Chemical pathology function to support ward requests (including urgent out of hours), outpatient bloods and preassessment including phlebotomy

Haematology function to support ward requests, outpatient bloods and preassessment; blood bank to support elective surgery (including urgent out of hours)

Microbiology function to support ward, theatre and preassessment samples, including arrangements for urgent processing/transport of samples.

Clinical measurement function to support ward, outpatient and preassessment function with ECG.

Pharmacy function to support day case, inpatient and ACU areas and 4 theatres 5 days a week. Additional support for day case chemotherapy unit.

Preassessment function to support elective surgery including telephone assessment where possible. Includes arrangements for self isolation and swabbing (including home swabbing/CCG led swabbing).

Additional services in Green areas

Hospice	Utilises existing staffing arrangements
Day Case Chemotherapy	CSS managed; existing staffing arrangements; SOP needed for deteriorating patients
Endoscopy	CSS led; existing staffing arrangements; SOP needed for screening and for deteriorating patients
Outpatients including Emerald Suite	CSS led remote consultations and defined SOP for screening face to face attendances
Rehab Unit	Ward 6 area (following redevelopment) – therapy led facility for IPC green patients; level of nursing support to be defined. SOP to be defined for medical emergencies/deteriorating patient. Implementation later in Restore

Medical staff movement

Existing foundation tier to be reallocated to surgery (12 doctors) supporting ward work and overnight ward cover. Exception is 3 A&E F1s who will support UTC.
Model to be revisited for August rotation and numbers likely to reduce significantly
Existing Anaesthetic consultant and middle tier (14 doctors) supporting theatre activity. Anaesthetic consultant non resident on call supporting returns to theatre / PACU deterioration/transfer

Existing surgical middle tier (7 doctors) supporting theatre activity.
Anaesthetic and surgical middle tier supporting out of hours ward cover including PACU – this does not include the ST5's who support the Lincoln acute work. Workforce of 11 doctors (3 vacant posts at present)
Surgical consultants support theatre work along with visiting specialty teams. Post operative specialist cover defined by specialty.
Orthopaedic CONS and SAS reallocated to other sites / support OP activity at GKGH. Specialty to define.
Medical and speciality medical CONS, SAS, IMT and CT reallocated to other sites / support OP and endoscopy activity at GKGH. Specialties to define in conjunction with CSS.
A&E CONS and SAS support UTC model – any extra resource reallocated

Background Information and Sign-Off

APPENDIX 3

Please provide some supporting information in the table below:

Name of Scheme:	Green Pathway at Grantham to support 'restore' of Elective Surgery (Phase 1)
Reference:	QIA2020-X (to be numbered by PMO)
Division:	Trust Wide
Proposed Start Date:	June 1st 2020
Brief Description of service change:	Proposal to establish a "full green" site at Grantham for Elective & Diagnostic activity, with a single isolated "blue" service this being an Urgent Treatment Centre.
Is the Service change based on any national guidance received? **(if yes please state the name of the guidance in the opposite column)**	Yes
Is the Service change based on any local guidance received? **(if yes please state the name of the guidance in the opposite column)**	No
Names of those involved in completing the QIA / Risk Assessment:	Simon Hallion- Divisional Managing Director (Family Health) Mark Lacey - Divisional Managing Director (Surgery) Yaves Lalloo - Divisional Managing Director (CSS) Debbie Pook - Divisional Managing Director (Medicine) Julie Pipes - Assistant Director of Strategy & Planning

The National Operating Framework for urgent and planned services in hospitals

Divisional Authorisation			
Name	Signature	Position/Job Title	Date
Dr Grainne O'Dwyer		Clinical Director Surgery	
Dr Ciro Rinaldi		Clinical Director Medicine & CSS	
Dr Suganthi Joachim		Clinical Director Family Health	
Rosalyn Howie		Divisional Nurse Surgery	
David Cleave		Divisional Nurse Medicine	
Carl Ratcliffe		Divisional Clinical Lead CSS	
Executive Leadership Team Authorisation			

Name	Signature	Position/Job Title	Date
Dr Neill Hepburn		Medical Director	
Dr Karen Dunderdale		Director of Nursing	
		Gold Command	

Quality Impact Assessment										
	Yes/No (If Yes complete the following)	Risk Description	Initial Assessment				Post Mitigation			
			Impact	Likelihood	Consequence	Rating	Mitigations	Likelihood	Consequence	Rating
Impact on Duty of Quality (CQC/ Constitutional Standards)?	Yes - positive impact	N/A	Cancer wait targets and other constitutional standard targets (18 and 52 week waits) will be supported by this proposal as cancer patients and those defined as 'urgent' by the Royal College of Surgeons will be included in this	0	0	0	N/A			0
Impact on Patient Safety?	Yes	*There may be insufficient equipment, space and staff resulting in transfers from 'green' to 'blue'	The patient group being targeted for admission are already more vulnerable and compromised due to their clinical condition	4	4	16	*Assessment of space has been undertaken and advice sought from Infection Prevention and Control - area identified which is contained with minimal amount of cross over into 'blue' areas (see map) *Assessment of staffing levels and equipment needs confirming *Patients would not be transferred back to 'green'	1	4	4

Impact on Patient Safety?	Yes - potential for adverse impact	Medical patients who would have been admitted to the Grantham inpatient beds will under the green site model be redirected to A&E's at either Lincoln, Pilgrim or out of county to other acute service providers, and if admisson is required, will be admitted to one of these acute hospitals. In summary, the number of service users that will be displaced is as follows: • Of the 24,617 service users attending A&E at Grantham between April 2019 and March 2020, in the green site model, with an Urgent Treatment Centre located in a locked down area of the site, 4,611 (13 per day) service users would displaced to other hospital sites with a full A&E department. • The UTC would not support direct emergency admission to Grantham Hospital, as such patients who require direct admission via an A&E department will be transferred to a different site. Modelling shows that a an additional 847 patient transfers to other hospital sites per annum will be required, as 854 patients were already transferred to other ULHT sites between April 2019 to March 2020. • A total of 1,198 admissions (3 a day) were made to medical beds at Grantham from multiple non-ED routes between April 2019 and March 2020. As medical beds will be withdrawn at Grantham, these 1,198 patients will be re-routed and admitted at Lincoln.	There is a risk that this will place undue pressure on inpatient beds at Lincoln or Pilgrim Hospitals, and on the beds of out of county providers. This could have a knock on effect to the provision of elective surgery at these sites also	3	4	12	Intense work required with Lincolnshire Community Health Services to establish step up facilities in the community to minimise the number of patients requiring admission to acute hospitals.	2	4	8
Impact on Clinical Outcomes?	Yes - positive impact	The number of patients receiving elective surgery for Colorecta, Urology, OMF/ENT, Gynaecology and Dermatology at Grantham Hospital between April 2019 and March 2020 was 43 in total. This will be increased with Grantham as a “Green site”, to approximately 1,250 patients to receive elective (planned) surgical treatment at the Grantham Hospital site.	Cancer patients and those deemed clinically urgent will be able to receive the diagnosis / treatment they require which would impact positively on their outcomes & morbidity and mortality rates	0	0	0	N/A	0	0	0

Impact on Clinical Outcomes?	Yes - potential for adverse impact	Medical patients who would have been admitted to the Grantham inpatient beds will under the green site model be redirected to A&E's at either Lincoln, Pilgrim or out of county to other acute service providers.	There is a risk that outcomes of medical patients could be compromised if the redirection process and protocols are not clear and all stakeholders (EMAS, GP's, Primary Care, other Providers inside & outside of county, Community Care) are informed	2	5	10	Robust communication and engagement plan	2	4	8
Impact on Patient Experience?	Yes	*Patients unwilling to attend Grantham site due to concerns about the risk of contracting COVID *Patients unable to travel to Grantham due to transport availability Clinical services that will stop at Grantham will result in patients having to travel to other locations to access these services e.g. antenatal, nuclear medicine,AAA screening, Vascular, Fracture follow up etc	Patients requiring diagnostics / treatment are not accessing it which will impact on their outcomes, morbidity and mortality	3	4	12	* Established process to ensure timely and sensitive communication with patients by clinical teams about the reasons for the pathway changes and the risks / benefits and importance of attending the appointments offered *Monitoring of DNAs	1	4	4
Impact on Staff Experience?	Yes	*Staff unwilling to return to work within the 'green area' This proposal is likely to require transfer of staff from other sites to Grantham. Staff may not find this attractive.	Insufficient staffing on the green site. (this impact is not envisaged on the blue service)	4	4	16	Develop a workforce plan to reassure the staff of the precautions being taken to keep the green area, green. Emphasise that this is also part of their responsibility to keep it safe	3	4	12
Impact on Staff Experience?	Yes - positive impact	This proposal provides an opportunity for staff in vulnerable groups to return to work safely and in a controlled manner to a Green site		0	0	0		0	0	0

Risk Assessment Form				
What is the specific service change being proposed?	What is the increased risk (to patients, staff, visitors or Trust assets) as a result?	What can be done immediately to control this risk? (Attach documented new procedures, plans, etc.)	If these controls are in place, what is the level of risk? (See Risk Matrix tab)	What further action (if any) would be needed to improve control of this risk?
Proposal to create a "Green Site" at Grantham District Hospital for Elective & Diagnostic activity with a single isolated "blue" service in the form of a UTC.	Breakdown of employee / employer / staff side relations as a result of the changes and the requirement for staff to return to work within the 'green' areas	Discussion with Staffside	**12 - 16**	
	Patients that are awaiting diagnostic procedures or surgical interventions will have had their procedures delayed or deferred which could have led to a change in their clinical presentation and potentially poorer outcomes /increased complications.	Robust assessment of patients by clinical teams prior to procedures / interventions	**12 - 16**	
	Increasing activity will increase amount of PPE usage, linen, number of swabs required (staff and patients), surgical equipment & some surgical equipment may not be routinely used at the Grantham site	Scope requirements for each element	**4 -6**	
	Diagostic / support services (pharmacy, radiology, pathology etc) may not have the capacity to staff and support the expansion of services without compromising provision elsewhere	CSS involvement in the planning and assessment of impact	**8 - 10**	

	Potential for reputational damage, negative public comments and impact on reconfiguration of future services at Grantham	Develop a robust communication process as to the case for change. Engage all stakeholders in the Grantham area.	**20**	
	Potential that out of county Providers e.g. PSHFT, NUH, SFHT and EMAS will not support the proposal due to the impact it may have on their organisations	Engage with stakeholders, re-assure of the effort going into working with Lincolnshire community services to minimise impact	**8 - 10**	

Scoring Guide for Quality Impact and Risk Assessments

	Risk Ratings & Examples				
Risk type	**1-3 Very low risk** (minimal chance)	**4-6 Low risk** (<1% chance)	**8-10 Moderate risk** (1-10% chance)	**12-16 High risk** (10-50% chance)	**20-25 Very high risk** (>50% chance)
Harm (physical or psychological)	Extremely unlikely to result in severe harm to multiple individuals.	Unlikely to result in severe harm to multiple individuals.	Reasonably likely to result in severe harm to multiple individuals.	Quite likely to result in severe harm to multiple individuals.	Extremely likely to result in severe harm to multiple individuals.
Service disruption	Unlikely to result in noticeable disruption to any services.	Likely to result in noticeable disruption to one or more services.	Reasonably likely to result in temporary, unplanned closure of one or more services.	Quite likely to result in extended, unplanned closure of multiple services.	Extremely likely to result in closure of one or more hospitals.
Compliance & reputation	Unlikely to result in complaints or concerns raised.	Unlikely to result in multiple complaints, serious concerns or adverse media attention.	Reasonably likely to result in multiple complaints, serious concerns or adverse media attention.	Quite likely to result in a large number of complaints, serious concerns raised and sustained adverse media attention.	Extremely likely to result in a loss of public, commissioner and / or regulator confidence.
Finances	Unlikely to result in noticeable adverse financial impact.	Unlikely to result in significant adverse financial impact.	Reasonably likely to result in Significant adverse financial impact.	Quite likely to affect the ability of the Trust to achieve its annual financial control total.	Extremely likely to affect the long-term financial sustainability of the Trust.

Likelihood Score & Descriptor (with examples)				
1 Extremely Unlikely	**2 Quite Unlikely**	**3 Reasonably Likely**	**4 Quite Likely**	**5 Extremely Likely**

Unlikely to happen except in very rare circumstances. Less than 1:1,000 (<0.1% probability). No gaps in control. Well managed.	Unlikely to happen except in specific circumstances. Between 1:1,000 & 1:100 (0.1-1% probability). Some gaps in control; no substantial threats identified.	Likely to happen in a relatively small number of circumstances. Between 1:100 and 1:10 (1-10% probability). Evidence of potential threats with some gaps in control.	Likely to happen in many but not the majority of circumstances. Between 1:10 & 1:2 (10-50% probability). Evidence of substantial threats with some gaps in control.	More likely to happen than not. Greater than 1:2 (>50% probability). Evidence of substantial threats with significant gaps in control.

APPENDIX 4 - Rapid Service or Workforce Change Equality Impact Assessment Tool

This tool has been developed in response to the COVID-19 pandemic and the need for the NHS to respond by rapidly changing delivery of services or to the workforce by Silver / Gold commands whilst also maintaining our public sector equality duty under the Equality Act 2010 to show due regard for equality in decision making. Please complete all sections below. Instructions are in ***italics***. Email for all correspondence: email to tim.couchman@ulh.nhs.uk

A. Rapid Service or Workforce Change Details	
1. Description of change	As the Trust moves into the 'restore' phase of its response to the COVID-19 pandemic, it is imperative that time critical care pathways are restored safely as a matter of urgency. This equality impact assessment reviews the potential equality related impacts of a green / clean hospital being established on the Grantham Hospital site, with a "blue" service being an Urgent Treatment Centre that would be locked down from the remainder of the site, which would be "green" The green (clean) hospital is defined broadly by Infection Prevention and Control (IPC) as: • Clean patient • Clean team • Clean environment This is established through the rigorous application of targeted IPC interventions, which are further defined in the full business case. Where a green hospital is established, all blue / unclean activity on the site would cease. However, to provide access safely to urgent care for the residents of Grantham and the surrounding villages, , the proposal for Grantham Hospital site is to operate an Urgent Treatment Centre. This is classed as a "blue" service. The Urgent Treatment Centre will see and treat patients in the UTC, any patients requiring admission to an acute hospital will be transferred to either Lincoln or Pilgrim hospital will full IPC measures followed for the transfer. Grantham hospital would not admit any medical emergency or elective medical patients, there would be no medical inpatients on the Grantham site, and there would be no outpatient activity, including Diagnostic activity. Alternative locations in the Grantham area will be sought to provide a level of Diagnostic activity locally. This will ensure the Grantham Hospital "Green" status can be sustained. Outpatient activity at Grantham will transfer to the other Trust hospital sites. The effective implementation of a green site, would enable urgent cancer and elective services to be delivered safely (green) at Grantham Hospital. However, all services outside the green criteria would with the exception of the Urgent Treatment Centre.
2. Type of change	Partial stop and establishing a new pathway
3. Form completed by	Anthony Rosevear, Deputy Chief Operating Officer Tim Couchman, Equality, Diversity and Inclusion Lead Julie Pipes, Assistant Director of Strategy & Planning
4. Date decision discussed & agreed	tbc

This form is based on a template produced by Cambridge University Hospitals NHS Trust and used with their kind permission.

B. Equality Impact Assessment	
Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the Protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation ? Or other groups which can include, but not be limited to, people who are; carers, homeless, living in poverty, asylum seekers/refugees, in stigmatised occupations (e.g. sex workers), use substances, geographically isolated (e.g. rural) and surviving abuse	
1. How does this decision impact on protected or vulnerable groups? eg. their ability to access services and understand any changes?	Patients and Services Users: Age: • Lincolnshire has a higher population of people over 65 years of age compared with the rest of the UK (Census 2011: UK 16%; Lincolnshire 21%). • Older people in England are more likely to develop serious ill health and are more likely to have complex co-morbidities, which place them at greater risk of complications if they contract COVID-19. • Emerging data indicates that older people are disproportionately impacted by COVID-19. • Older people might have additional challenges in relation to transport, if elective surgery is moved away from their local hospital. Public transport from Grantham to Lincoln and Boston is not as comprehensive as it could be, and older people may find using public transport challenging. • People of all age groups will face additional challenges and negative impacts in accessing services no longer provided at Grantham Hospital (Emergency Care, Out-patient services, Ante-natal services, Young peoples' services etc). • People with Covid19 symptoms requiring admission to acute hospital will be diverted to one of the other ULHT hospital sites, Lincoln or Pilgrim both of which have higher intensive care facilities to treat patients with a higher acuity illness if required. This will increase likelihood of a positive outcome for this vulnerable group of people. • The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trust's current restrictions on visitors. • However, having elective surgery provided on a safer (green) hospital site will provide increased likelihood for a positive outcome, and reduced waiting times than if a green site was not established, for this vulnerable patient group using the service. Disability: • People with some long-term conditions (which would be classed as disability under the Equality Act 2010) are more likely to develop serious ill health if they contract COVID-19. • Emerging data indicates that some disabled people are disproportionately impacted by COVID-19. • People with Covid19 symptoms requiring admission to acute hospital will be diverted to one of the other ULHT hospital sites, Lincoln or Pilgrim both of which have higher intensive care facilities to treat patients with a higher acuity illness if required. This will increase likelihood of a positive outcome for this vulnerable group of people • The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trusts current restrictions on visitors. • The communication needs of people need to be assured in relation to access to healthcare in a new pathway. • Disabled people are more likely to access emergency services, out-patient clinics and the Kingfisher Unit. Therefore, a removal of these services from Grantham Hospital would negatively impact this group of people. • However, having elective surgery provided on a safer (green) site will provide increased likelihood for a positive outcome on this vulnerable patient group, with reduced waiting times than if a green site is not established Gender reassignment:

- As the Trust does not provide gender reassignment surgery or services, a neutral impact is envisaged.
- Trans patients will continue to be cared for in their chosen gender identity, in line with national NHS England Same Sex Accommodation policy.
- However, the mental health impact of 'social distancing' on LGBT+ people, who have a greater reliance on external contacts for advocacy and social contact in care settings needs to be understood and considered, alongside the Trusts current restrictions on visitors.

Marriage and Civil Partnership:

- A neutral impact is envisaged for this protected characteristic.

Pregnancy and Maternity:

- A green hospital site for elective surgery at Grantham, would mean that the current Ante-Natal and scanning services would cease on the Grantham site and people would have to travel to other hospital sites to access services and therefore a negative impact is envisaged.

Race:

- Emerging data and research indicates that people from Black, Asian and Minority Ethnic backgrounds are disproportionately affected by COVID-19.
- Whilst Lincolnshire does not have the large BAME communities as other urban areas in the Midlands and England, all BAME groups are still represented in the county.
- People with Covid19 symptoms requiring admission to acute hospital will be diverted to one of the other ULHT hospital sites, Lincoln or Pilgrim both of which have higher intensive care facilities to treat patients with a higher acuity illness if required. This will increase likelihood of a positive outcome for this vulnerable group of people
- People for whom English is not the first language may have less access to information about changes in service delivery.
- The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trusts current restrictions on visitors.
- However, having elective surgery provided on a safer (green) hospital site will provide increased likelihood for a positive outcome on this vulnerable patient group.

Religion or belief:

- A neutral impact is envisaged for this protected characteristic.

Sex:

- Emerging data and research indicates that men are disproportionately affected by COVID-19.
- Therefore, having elective surgery provided on a safer (green) hospital site will provide increased likelihood for a positive outcome on this vulnerable patient group.

Sexual orientation:

- A neutral impact is envisaged for this protected characteristic group.
- However, the mental health impact of 'social distancing' on LGBT+ people, who have a greater reliance on external contacts for advocacy and social contact in care settings needs to be understood and considered, alongside the Trusts current restrictions on visitors.

Other groups:

Carers:

- The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trusts current restrictions on visitors.

Geographical isolation:

- Some people might have additional challenges in relation to transport, if elective surgery is moved away from their local hospital. The population of Grantham will have additional challenges in relation to accessing the services that would cease being delivered at Grantham Hospital.
- The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trust's current restrictions on visitors.

Socially / economically deprived:

- Some people might have additional challenges in relation to finances, if elective surgery is moved away from their local hospital and if services currently provided at Grantham Hospital are relocated to other Trust sites.
- The mental health impact of 'social distancing' compounded by patients potentially being further away from their household needs to be considered, alongside the Trust's current restrictions on visitors, particularly for people experiencing social and / or economic deprivation.

Domestic abuse:

- It is recognised that people affected by domestic abuse are more likely to access help through locally provided services.
- Therefore, if the Trust only provides elective surgery at Grantham Hospital, people at risk of domestic abuse will no longer have access to help through the current local services.

<u>Staff:</u>

The emerging data and research, highlighted above, in relation to population groups disproportionately impacted by COVID-19 apply also to our staff groups. It is becoming clear that people from BAME backgrounds (race), older people (age), men (sex) and people with co-morbidities (disability) are being disproportionately affected by COVID-19. Therefore, if this is the preferred option, the creation of a green / safe hospital environment for people returning to work and other vulnerable groups is a potential positive impact in reducing risk infection for these groups.

If this is the preferred option, a full analysis of the staff impacted by the changes required, would be undertaken by the HR Business Partners and changes implemented according to the Trust's Management of Change Policy.

If this is the preferred option, staff who believe they are vulnerable are able to request a Risk Assessment via their line manager and also access Occupational Health support. If this is the preferred option as in interim solution for supporting the Infection Protection Control protocols and enabling patients to receive elective care safely, it will provide an opportunity for staff who are currently working at home due to the covid risks, to return to work safely on a Green site, subject to a full risk assessment being completed by the Occupational Health Service.

Further to the above, the following potential impacts need to be considered:

Age:

- The Trust has an ageing workforce profile. Therefore, older staff are likely to be impacted by change.

Sex:

- The Trust's workforce profile demonstrates that 80% of the workforce are women and 20% are men. Therefore, from a statistical perspective, women will be more impacted by change than men.
- Women are more likely than men to be in part-time employment, where potential changes to work patterns / bases could potentially have a negative impact on them.
- Women are more likely than men to have caring responsibilities, where potential changes to work patterns / bases could potentially have a negative impact on them.

Carers:

- All staff with caring responsibilities could potentially be negatively impacted if work patterns / bases are changed.

Economic:

- There is potential that lower paid staff could be disproportionately impacted by changes that have a significant economic impact on them. For example, with additional travel costs and time, right through to the proposed changes in their work being not viable and resulting in the loss of their employment.

The proposal provides a benefit to all patient groups in an innovative way through providing the ability to continue with elective care in a safe and controlled manner, to stabilise, and avoid the patient waiting list for elective treatments growing whilst we manage the Covid19 situation.

The proposal provides a benefit to staff from the perspective that it provides an opportunity for staff in vulnerable groups to return to work safely in a Green environment.

2. Number of patients that will be displaced from the Grantham site

Establishing a Green site at Grantham Hospital will result in a number of patients/service users currently accessing services at Grantham Hospital being displaced to either the Lincoln or Pilgrim sites

A&E-Impact

Activity modelling shows that a minimal number of potential service users will be displaced. Of the 24,617 A&E attendances from April 2019 to March 2020, 4,611 attendances (13 per day), would be displaced, of which 1,187 (3 per day) will be displaced to other UHLT sites and 4,424 (10 per day) will be displaced to neighbouring Trusts.

A summary of this is provided below:

Displacement Destination	Attendances per annum	Attendance s per day	% of total A&E attendances at Grantham in FY20
Other ULHT site	1,187	3	5%
Other neighbouring Trusts	3,424	10	14%
Total	**4,611**	**13**	**19%**

Displacement Destination	Attendances per annum	Attendances per day	% of total A&E attendances at Grantham in FY20
East Anglia NHS Trust – Peterborough	2,950	8	12%
Lincoln County Hospital	1,139	3	5%
University Hospitals Nottingham - Queens Medical Centre	469	1	2%
Pilgrim Hospital Boston	48	<1	<1%
NLAG – Scunthorpe, Kings Lynn FT and NLAG – Grimsby	4	<1	<1%
Total	**4,611**	**13**	**19%**

Acute Medical Admissions

In addition, a number of displaced service users will require admission to an acute hospital due to acute medical problems. Activity modelling has shown that approximately 33 patients per week will need admitting to an acute hospital that would have ordinarily been admitted to Grantham Hospital, this equates to approximately 1,716 per annum. These patients will be admitted to either Lincoln, Pilgrim, Peterborough or Nottingham hospitals depending on which A&E /UTC they present to.

Transfers from Grantham as a result of ED to UTC conversion and withdrawal of medical beds at Grantham

The UTC would not support direct emergency admission to Grantham Hospital (other than via A&E) as such patients who require admission will be transferred to a different site. Modelling shows that a minimal number of patients will require transferring to other sides to be admitted.

This represents an additional 847 patient transfers as 854 patients were already transferred to other ULHT sites in April 2019 to March 2020.

A summary of this is provided below:

Transfers destination (patients will be admitted for inpatient care at these sites)	Attendances per annum	Attendances per day	% of total A&E attendances at Grantham in FY20
Lincoln County Hospital	907	8	4%
Pilgrim Hospital Boston	680	6	3%
Other neighbouring Trusts	113	1	<1%
Total	**1,701**	**15**	**7%**

Re-routed admission from multiple non ED routes as a result of a withdrawal of medical beds at Grantham

A total of 1,198 admissions (3 a day) were made to medical beds at Grantham from multiple non-ED routes between April 2019 and March 2020.

A breakdown of these admission methods is provided below:

Admission Method Grantham in FY20	Non ED 'Emergency' admissions at
Baby Born at home as Intended	3
Emergency - Bed bureau	8
Emergency - Dom Visit	1
Emergency – GP	697
Emergency - OP Clinic	91
Other Emergency Admission	390
Other Immediate	4
Transfer of an Admitted Patient from another Hospital in an Emergency	4
Total	**1,198**

As medical beds will be withdrawn at Grantham, these 1,198 patients will be re-routed and admitted at Lincoln.

Patients will be admitted for inpatient care at these sites	Attendances per annum	Attendances per day
Lincoln County Hospital	1,198	3
Total	**1,198**	**3**

Outpatient activity

Based on January 2019 to December 2019 data – 2,810 first patient appointments for suspected cancer were provided at the Grantham Hospital site for a range of specialities, plus any follow up appointments for these patients. This outpatient activity will not continue at the Grantham site, it will resume at the Lincoln and Pilgrim Hospital sites

To support the reintroduction of cancer surgery at Grantham in the following specialities – colorectal, urology, gynaecology, haematology, and cancer minor OPD procedures in dermatology and ENT/ oral and maxillofacial activity will on resume on the Green pathways

	Lincoln and Pilgrim. This activity is summarised as follows and is based on January 2019 to December 2019 activity data: • 2,810 first patient appointments (and any follow ups for those patients) previously at Grantham will resume at Lincoln/Pilgrim. This is the equivalent to 234 a month, 59 a week and 8 a day. For the same period, there were c.15,000 first patient appointments for non-cancer related conditions, plus any follow up appointments for these patients. This outpatient activity will not continue at the Grantham site, it will resume at the Lincoln and Pilgrim Hospital sites.
3. Number of patients that will be displaced from Lincoln & Pilgrim sites to Grantham Hospital	The section above shows the impact of Establishing a Green site at Grantham Hospital on patients/service users currently accessing services at Grantham Hospital for outpatient appointments, and how these will be displaced to either the Lincoln or Pilgrim sites. This section shows the number of patients currently receiving elective treatment at Lincoln and Pilgrim hospital sites that will be displaced to the Grantham Hospital site for elective surgical treatment. The majority of surgical treatment for cancer will be performed at Grantham for the following specialities – colorectal, urology, gynaecology, and cancer minor OPD procedures in dermatology and ENT/ oral Maxillo Facial. Patients requiring level 3 critical care after surgery (around 6% of cancer patients) will be treated at either Lincoln or Pilgrim hospitals, but all other cancer patients for these specialities will receive surgical treatment at Grantham. In addition, a number of patients who require non-cancer surgery will also be treated at Grantham. The number of patients receiving elective surgery for these specialities at Grantham Hospital between April 2019 and March 2020 was 43 in total. This will be increased with Grantham as a "Green site", to approximately 1,250 patients to receive elective (planned) surgical treatment at the Grantham Hospital site. Query here about whether chemotherapy will continue at Grantham for Lincoln and Pilgrim patients, and if so, how many more patients will receive chemotherapy at Grantham, the numbers treated April 2019 to March 2020 indicate 80 Haematology patients and 43 Oncology patients received chemotherapy at Grantham.

C. Risks and Mitigations	
1. What actions can be taken to reduce/mitigate any negative impacts? (If none please state so)	Patients and Service Users: For all groups: • Review of the welfare payments in relation to increased costs to patients through the changes, particularly for the economically disadvantaged. • Review hospital transport policy for people impacted by the service changes, particularly those unable to arrange their own transport. • Proactive promotion of the Patient Support Service (led by Patient Experience Team) for people impacted by the service change. • Enhanced communication through the NHS Lincolnshire system in relation to the changes, with particular focus on accessible communication for vulnerable groups. • Enhanced focus on accessible communication for patients during their hospital stay (use of remote translation services for spoken languages and British Sign Language). Staff: For all groups: • Effective use of Risk Assessment for staff potentially impacted by change. • Effective and consistent implementation of the Trust's Management of Change Policy. • Effective engagement with Staff-side.
2. What data/ information do you have to monitor the impact of the decision?	Patients and Service Users: • Monitor activity levels of people accessing Emergency Services • Monitor EMAS service responses • Monitor the number of patients and service users who are going out of county to access services • Monitor patients using the Grantham green pathway • Monitor patients using the blue service (UTC) at Grantham • Monitor Datix reports Staff: • ESR data • Employee relations data • Staff Survey data (longer term)
D. Decision/Accountable Persons	
1. Agreement to proceed?	Yes / No *Delete as appropriate and add detail or rationale*
2. Any further actions required?	*Eg. risk to be added to COVID-19 Programme Risk Register ?*
3. Name & job title accountable decision makers	

4. Date of decision	

This page is intentionally left blank