1 Executive Summary

1.1 Introduction and background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Figure 1 – Summary of ULHT's key challenges

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

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

1.3 Acute Services Review (ASR) overview

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

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

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

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

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

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

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

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

1.4 Clinical services prioritisation

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

1.4.2 Following this review three categories of specialty were identified:

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

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

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

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

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

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

1.5 Options appraisal

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

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

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

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

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

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

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

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

Figure 2 – Long list of scenario-based options

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

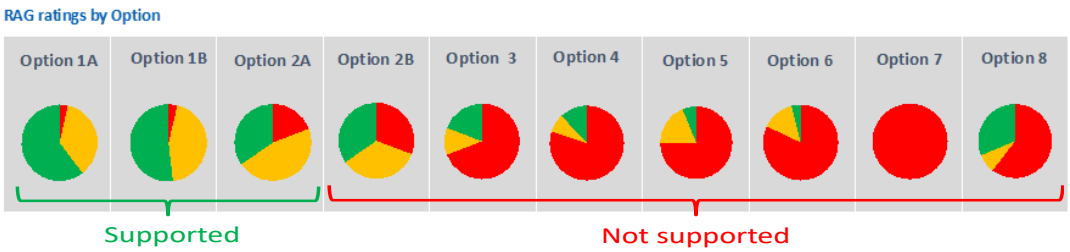
1.5.9 The anticipated impacts of change associated with each of the nine overarching scenario-based options was modelled. These were presented at a second Clinical Summit on 14 February 2018, which had over 55 key stakeholders and leaders present.

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

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

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

Figure 3 – RAG rating of options by Clinical Summit attendees



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

Figure 4 – Shortlist of scenario-based options

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

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

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

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

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

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

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

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

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

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

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

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

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

1.5.23 The review focussed on the clinical interdependencies and the totality of the changes proposed. Specifically, the clinical review team was asked whether it supported the ASR proposals based on clinical sustainability, workforce deliverability and improvements in clinical outcomes.

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

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

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

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

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

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

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

Figure 5 – Revised short list of six options

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

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

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

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

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

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

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

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

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

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

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

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

Figure 6 – Stakeholder options evaluation workshop

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

Note: figures have been rounded to nearest whole number

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

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

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

1.6 The preferred option

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

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

Figure 7 – Overview of Preferred Option changes

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

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

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

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

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

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

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

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

1.6.9 Through this exercise and in response to feedback received from the public the preferred option for Urgent and Emergency Care was developed so the proposed UTC at Grantham Hospital would be open 24 hours a day, 7 days a week and accommodate walk-ins throughout the opening hours.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.7 Orthopaedics service change proposal

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

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

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

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

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

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

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

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

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

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

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

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

Figure 10 – Overview of Orthopaedics service change proposal

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

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

Figure 11 – Orthopaedics summary EIA

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

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

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

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

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

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

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

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

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

1.8 Urgent and Emergency Care service change proposal

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

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

1.8.3 The unit would be a community-led service, however a medical workforce would be retained as part of the team and consultant oversight would be provided to the unit for governance and training purposes. The multi-disciplinary workforce would have the ability to manage all presentations, including those requiring stabilisation and transfer.

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

1.8.5 In response to feedback received from the public during the Healthy Conversation 2019 engagement events, the proposed UTC at Grantham Hospital would be open 24 hours a day, 7 days a week.

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

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

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

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

Figure 14 – Urgent and Emergency Care summary EIA

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

1. Longer travel requirements	• This will potentially be the case for some patients, however:
	  • They will be small in number and only those with higher acuity health needs
	  • Current exclusion criteria means this is already happening, refinement of this criteria will mean an additional small number of patients will travel longer
	• Estimated c.600 patients per year who are currently seen at Grantham A&E will be displaced to an alternative site.
	• This is equivalent to c2.5-3.0% of the current activity, and the displacement is due to their care needs being better met in a more specialised service at an alternative hospital.
	• Under the proposed changes it is estimated that of these displaced patients c.375 will travel over 45 minutes by car for A&E services, the travel time threshold set by the local health system for this type of activity. It is estimated that currently 21,500 people in Lincolnshire travel over 45 minutes to access A&E by car.
	• Given the acuity of patients who would no longer be seen at Grantham Hospital many are likely to travel by ambulance to an alternative site and therefore travel time could be less than 45 min.
		• No. For some patients there may be longer travel times, but this is balanced against ensuring those patients receive treatment in the right place first time.

2. Negative impact on health	• The majority of patients currently seen at the Grantham A&E will continue to be seen at the Grantham UTC. • Only a small number of patients will be seen at an alternative site and the basis for this is to ensure people get to the right hospital with the right facilities first time to ensure the best outcomes	• Yes. Proposed service should have a positive impact on health

3. Greater reliance on family and friends for increased travel needs
4. Greater reliance on public transport, which is perceived to be limited in accessibility
5. Concerns about costs of travel to and from hospital, especially at times of limited/ no public transport
	• If a patient is concerned about their health but it is not an emergency, patients should call NHS 111 or 'walk in' to the UTC. There is no change to this service. The proposed UTC will remain on the same site.
	• If a patient is concerned because they are clearly very ill, patients should call 999 and an ambulance will be sent and their condition will be assessed, so they are taken to the most appropriate place for treatment, meaning no increased demand for friends and family.
	• Friends and family of those admitted to hospitals further away will need to travel further – this is the current situation for cases covered by the exclusion criteria.
	• If a patient goes to the proposed UTC and needs to be moved to an alternative hospital site, travel arrangements will be made to transfer the patient, meaning no increased demand upon family and friends.
	• Some patients may potentially have a greater reliance on friends/family or public transport for travel support to return home. However:
	  • ULHT currently provides a patient transport service based on eligibility criteria; and
	  • Volunteer services currently provide patient transport services where confidence or mobility issues can make it difficult to attend hospital
	  • The impact of the proposed service change proposals on access, particularly on groups with protected characteristics, will continue to be explored and understood through consultation with the public and plans only finalised once that process is complete.
		• Yes. For some there may be a greater reliance on family and friends or public transport. However, NHS and voluntary sector patient transport services already exist to help in certain situations.
		• The proposed service changes do not make any changes to these patient transport services or associated criteria.
		• Plans to mitigate impact on travel and access will be finalised once the public has been fully consulted on any proposed service changes. These plans will need to be finalised in the context of existing local and national patients transport policies and criteria.

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

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

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

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

[3] Independent Reconfiguration Panel (IRP)

1.9 Acute Medicine service change proposal

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

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

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

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

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

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

Figure 16 – Overview of Acute Medicine service change proposal

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

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

Figure 17 – Acute Medicine summary EIA

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

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

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

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

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

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

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

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

1.10 Stroke Service change proposals

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

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

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

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

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

1.10.4 When the preferred option was presented to the East Midlands Clinical Senate it was praised by the panel and deemed to be well led clinically and from the evidence provided well researched. It was acknowledged the proposed reconfiguration would reduce unwarranted variation in outcomes and would ensure a more consistent achievement of clinical standards and national guidelines. The East Midlands Clinical Senate recommended the Lincolnshire STP proceeds with its proposal for stroke services to be consolidated at Lincoln County Hospital.

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

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

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

1.10.7 The service will link closely with Neighbourhood Teams, who will provide the requisite nursing, social care support and on-going 'self-care' options and support for stroke survivors. It will support community hospitals, which will be health & wellbeing hubs providing different levels of care under one roof, making the most effective use of inpatient and ambulatory services offered locally, including rehabilitation, reablement and palliative care services.

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

Figure 19 – Overview of Stroke Service change proposal

Stroke Services	
Current model **Hyper-acute and acute stroke services provided from Lincoln and Pilgrim Hospital**	**Proposed model** **Consolidate hyper-acute and acute stroke at Lincoln Hospital supported by enhanced community service**
• Sentinel Stroke National Audit Programme (SNAP) shows ULHT need to continue to improve performance at Lincoln County Hospital and Boston Pilgrim Hospital. • In addition, ULHT is not achieving required performance in 1 of 4 priority standards for 7-day services, for hyper-acute stroke: Clinical Standard 2 – *All emergency admissions seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital* • Recommended hyper-acute stroke units see no less than 600 strokes per year, as activity below this is not sufficient to ensure staff have enough clinical and institutional experience to maintain skills; Lincoln sees just over this, Pilgrim does not and is unlikely to over next 5-10 years • Currently significant gaps exist in workforce – both Lincoln and Pilgrim should have six substantive consultant posts however each only has one. Has not been possible to recruit substantively. • Current nursing vacancy at Pilgrim is 50% which has led to a reduction in open beds • Average length of stay is c.13.5 days against a best standard target of 7-10 days	• Evidence shows centralising hyper-acute stroke treatment on a smaller number of sites has considerable benefits including reduced mortality, faster recovery, shorter length of stay and improved workforce sustainability • Evidence shows patients treated in dedicated hyper-acute stroke units are more likely to survive and recover more quickly as these units are fully staffed and equipped and set up to deliver specialist care 24/7. • This also helps to address the significant workforce shortages and challenges in stroke by concentrating specialist stroke skills and expertise under one roof. • Supports improved performance against Sentinel Stroke National Audit Programme domains and priority standards for 7-day services • Enables a critical mass for stroke units well above recommended levels, which will support the delivery of improvements in quality and outcomes • Supports reduction in length of stay in acute hospital • Enables a concentration of multi-disciplinary teams on one hospital site to support performance and quality improvement • Supports reduction in heavy reliance on locums - increases chances of recruiting to substantive roles and having to spread limited staff across two sites

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

Figure 20 – Stroke Services summary EIA

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

3. Greater reliance on family and friends for increased travel needs
4. Greater reliance on public transport, which is perceived to be limited in accessibility
5. Concerns about costs of travel to and from hospital, especially at times of limited/ no public transport
	▪ Acute stroke services will be consolidated on the Lincoln Hospital site. A service will no longer be provided from Pilgrim Hospital
	▪ People currently receiving care at Pilgrim Hospital will on average experience an increase in travel time to an alternative hospital
	▪ The vast majority of patients admitted into an acute stroke unit are through an unplanned attendance and admission, and are therefore likely to present at hospital in an ambulance, as opposed to using their own transport
	▪ Upon discharge, if the patient has a health care need or meets the ULHT transport support criteria then transport will be provided on their return journey home and there will be no need for reliance on friends and family or public transport:
	  ▪ ULHT currently provides a patient transport service based on eligibility criteria; and
	  ▪ Volunteer services currently provide patient transport services where confidence or mobility issues can make it difficult to attend hospital
		• Yes. For some there may be a greater reliance on family and friends for transport. However, NHS and voluntary sector patient transport services already exist to help in certain situations.
		• The proposed service changes do not make any changes to these patient transport services or associated criteria.
		• Plans to mitigate impact on travel and access will be finalised once the public has been fully consulted on any proposed service changes. These plans will need to be finalised in the context of existing local and national patients transport policies and criteria.

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

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

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

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

1.11 Financial case

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.12 Enablers

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

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

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

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

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

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

1.13 Stakeholder engagement and governance arrangements

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

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

Figure 23 – Evolving ASR programme engagement

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

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

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

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

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

1.14 Conclusion

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

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

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

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

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

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

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

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