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

Open Report on behalf of Andrew Crookham
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**10 November 2021**
Subject:	**Lincolnshire Acute Services Review – Urgent and Emergency Care**

Summary:

On 13 October 2021 the Committee agreed its approach to its consideration of the NHS's consultation on the Lincolnshire Acute Services Review. This included consideration of two of the four strands of the review at this meeting, with the remaining two on 15 December 2021.

The Committee also established a working group, which would support the work of the Committee, and give detailed consideration of the consultation materials. As part of its consideration the Committee is requested to consider whether it wishes to highlight any areas, which the Working Group might explore.

The following NHS representatives are due to attend to present to the Committee:

- Dr Dave Baker, South West Lincolnshire Locality Clinical Lead, Lincolnshire Clinical Commissioning Group
- Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services NHS Trust

Actions Requested:

(1) To consider the details on the Lincolnshire Acute Services Review of Urgent and Emergency Care.

(2) To highlight any areas which the Committee's working group might wish to explore in further detail.

1. Background

On 30 September 2021, the consultation on the Lincolnshire Acute Services Review was launched. On 13 October the Committee considered an introductory item and agreed its approach to the consultation.

2. Urgent and Emergency Care

Dr Dave Baker, South West Lincolnshire Locality Clinical Lead, Lincolnshire Clinical Commissioning Group, and Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services NHS Trust, are due to attend the meeting to present information on Urgent and Emergency Care. To facilitate the Committee's consideration, pages 27-31 of the consultation document, which relate specifically to Urgent and Emergency Care, are attached as Appendix A to this report. Chapter 10 [Acute Services Review: Preferred Option – Urgent and Emergency Care] of the Pre-Consultation Business Case (PCBC) provides further detail and is attached at Appendix B. It should be noted that chapter 10 of the PCBC in turn refers to the following documents, all of which are available at: Pre-Consultation Business Case Appendices:

- Appendix N - Grantham and District Hospital Urgent Treatment Centre, Ambulatory Care Unit and Emergency Assessment Unit exclusion criteria
- Appendix H – Access Impact Analysis by Neighbourhood Team
- Appendix I – Quality Impact Assessments
- Appendix J - Equality Impact Assessment (EIA) Stages 1 and 2

At the Committee's last meeting on 13 October, when an introductory item on the Acute Services Review consultation was considered, more information was requested on the usage data for the Grantham Urgent Treatment Centre.

3. Consultation and Conclusion

The Committee is invited to consider the presentation on the detailed elements of the Lincolnshire Acute Services Review and highlight any areas which the Committee's working group might wish to explore in further detail.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Extract (Pages 27 – 31) from Lincolnshire NHS Public Consultation Document – Relating to Four of Lincolnshire's NHS Services – Urgent and Emergency Care at Grantham and District Hospital
Appendix B	Chapter 10 of the Pre-Consultation Business Case for the Lincolnshire Acute Services Review [Acute Services Review: Preferred Option – Urgent and Emergency Care]

5. Background Papers

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

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

Urgent and emergency care at Grantham and District Hospital

What are we asking you to consider?

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

- A 24/7 Urgent Treatment Centre (UTC) at Granthamand District Hospital

What are the services and how are they currently organised?

The primary role of an Accident and Emergency (A&E) department is to assess and treat people with major trauma, serious injuries and those in need of emergency treatment.

United Lincolnshire Hospitals NHS Trust (ULHT) currently provides A&E departments at Lincoln County Hospital, Pilgrim Hospital, Boston and Grantham and District Hospital.

The A&E departments at Lincoln County Hospital and Pilgrim Hospital, Boston are consultant-led 24 hour services that provide the full range of accident and emergency care, with support from 24/7 diagnostics and access to critical care.

However, the Grantham and District Hospital A&E department has for some time (since 2007/8) only dealt with a limited range of presenting emergency conditions. This is because of its small size, limited availability of specialist staff and limited range of 24/7support services to support very ill patients after they leave the A&E department.

This means the majority of patients treated at Grantham and District Hospital A&E department arrive with injuries or illnesses that can be safely treated at an Urgent Treatment Centre (UTC). As the service is supported by a skilled range of doctors, GPs, practitioners and nursing staff, it is able to provide an extensive range ofassessment and treatment that meets the needs of thelocal population.

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

If patients do present at Grantham and District Hospital A&E department with conditions that the hospital is not able to deal with, the skills and experience are there to manage the patient whilst transfer is quickly arranged to a more specialist unit for the appropriate treatment.

Prior to 2016 the A&E department at Grantham and District Hospital was operating 24/7 (dealing with a limited range of presenting emergency conditions).

Since 2016 it has been operating on reduced hours (currently closed between 6.30pm and 8.00am) due to difficulties faced by ULHT in safely staffing its A&E departments. This change did not impact on the limited range of emergency conditions the service could deal with

A summary of the current provision at ULHT's A&E departments is set out below.

Lincoln County Hospital	• Operates 24/7 • Services: Full A&E • Consultants: 24/7 • Doctors: 24/7 • Nurses: 24/7
Pilgrim Hospital, Boston	• Operates 24/7 • Services: Full A&E • Consultants: 24/7 • Doctors: 24/7 • Nurses 24/7
Grantham and District Hospital	• Operates 08:00-18:30 • Services: Not full A&E • Consultants: 14/7 • Doctors: 14/7 • Nurses: 14/7

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

In addition to the three A&E departments currently provided by ULHT, six Urgent Treatment Centres (UTC) are provided by Lincolnshire Community HealthServices NHS Trust (LCHS). These are located at:

- Lincoln
  located with A&E
- Boston
  located with A&E
- Louth
- Skegness
- Gainsborough
- Spalding

These urgent care services can treat a wide range ofconditions which are not critical or life threatening such as sprains and strains, suspected broken limbs and feverish illness in adults and children. They playa significant role in protecting A&E departments for those patients who really need them.

The Minor Injuries Unit service at Stamford Hospital (which is currently provided by North West Anglia NHS Foundation Trust is available to people in and around the Stamford area in the south of the county.

What are the challenges and opportunities for urgent and emergency Care at Grantham and District Hospital?

This section sets out the challenges and opportunities for urgent and emergency care and what we hope to achieve by making changes.

Challenges

- Nationally there is a shortage of emergency medicine (A&E) doctors, which means greater competition between hospitals for doctors and an over reliance on doctors employed on a temporary basis
- Emergency medicine doctors are very difficult to secure, which in turn can lead to medical staffing vacancies and risk to the quality of patient care. Ultimately this can lead to service and patient safety concerns – as experienced by Grantham and District Hospital A&E department when the opening hours were reduced
- There have been genuine efforts to recruit and retain staff to work in Lincolnshire's A&E departments but with limited success – the uncertainty over the future of the Grantham and District Hospital A&E has addedto the reluctance to join the county's team
- Independent clinically-led reviews have concluded that in the interests of safety the A&E department atGrantham and District Hospital should not re-open 24/7 unless sufficient staff can be recruited and retained on a long term and sustainable basis
- The A&E service at Grantham and District Hospital has, since 2007/8, only dealt with a limited range ofpresenting emergency conditions, and services are similar to that of an Urgent Treatment Centre (UTC) yet the description of the service as an A&E is still inplace
- Using a description of A&E for this service creates unrealistic expectations and misunderstandings aboutthe level of service that is and can be provided at Grantham and District Hospital

Opportunities

By making changes, we can look to ensure:

- High quality urgent care services are delivered at Grantham and District Hospital on a 24/7 basis in a sustainable was for the long term, by:
    - Making relatively small changes in the scope of safe and high-quality services, ensuring Granthamand District Hospital receives patients in line with its medical capabilities
    - Those few patients with the highest levels of needthat cannot be met at Grantham hospital receivecare in the most appropriate and safest place for them
    - Improve our ability to attract and retain talented and substantive staff to an effective, high quality,successful and sustainable service
- All patients see the right clinician for their needs, firsttime, 24/7, and therefore receive the best possible care, including not having to wait unnecessarily
- Patient health and the overall patient experience areimproved

The feedback from engagement about urgent and emergency care and how we have used it

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

Some consistent themes in relation to urgent and emergency care have been shared by the public and stakeholders throughout our engagement to date:

· The need to improve urgent and emergency care services across the entire county to deliver the best possible care for everyone

- Concern that the variety of urgent and emergency care service options across the county, with different names and specifications, was confusing and contributing to inappropriate use of services
- A clear desire that people should only use specialist A&E services when they are appropriate, to protect them for those requiring them
- Specific to Grantham and District Hospital:
    - A wish for 24/7 walk in access
    - Some concerns about increased travel time for local people if an A&E was no longer provided at the hospital
    - Some concern that other services at the hospital would be affected by not having an A&E department

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

In light of the feedback received in relation to urgent and emergency care we have considered how we can deliver a sustainable 24/7 walk in service at Grantham and District Hospital.

What is our proposal for change?

Our proposal for change is to establish a 24/7 walk in Urgent Treatment Centre (UTC) at Grantham and District Hospital, in place of the current Accident and Emergency (A&E) department.

The UTC would be provided by a community health careprovider, with existing doctors retained as part of the team and consultant (senior doctor) oversight provided to the unit. The multi-disciplinary workforce would havethe ability to manage all presentations, including those requiring stabilisation and transfer to an alternative hospital with the right skills and expertise.

It is anticipated this change would affect around 3% ofthose patients currently attending the Grantham and District Hospital A&E. This is equivalent to 2 patients a day, on average. These are patients who require onwardtransfer for immediate specialist care.

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

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

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

Support for change proposal to establish a UTC at Grantham and District Hospital in place of the A&E department

Support for change proposal	Stakeholder Workshop	Public Workshops
Agree (strongly/ tend to)	98%	84%
Disagree (strongly/ tend to)	2%	11%
Neither agree nor disagree	0%	5%

Impact Analysis

As we have developed our proposals we have considered the quality and equality impact of the preferred option for urgent and emergency care at Grantham and District Hospital.

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

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

Potential positive impacts

1. 24/7 walk in urgent care would return to Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term

2. The vast majority of patients (estimated to be around 97%) seen at the Grantham and District Hospital A&Edepartment would continue to be seen and treated at the 24/7 Urgent Treatment Centre (UTC)

3. The UTC would provide greater accessibility due to increased opening hours compared to the current A&E arrangements (currently closed between 6.30pmand 8.00am). Access to treatment would further improve for children because the UTC team would broaden to include community and primary care staff (eg. GPs) who are more experienced and familiar withtreating children than a traditional, non-paediatric A&E team.

4. Patients would spend less time in the UTC compared to an A&E department due to the different model of assessment and management it uses. Specialistfollow-up input would be arranged as required

5. The UTC would be provided by a community health service provider, which would support better integration with primary care and community servicesand the provision of care closer to home

6. For a small number of patients (estimated to be around 3%, which is equivalent to 2 patients a day on average) currently attending the Grantham and District Hospital A&E who wouldn't be able to have their care needs met by the UTC, care would be received at an alternative site with the right facilities and expertise to ensure better clinical care outcomes

Potential adverse impacts

1. For the small number of patients (estimated to be around 2 a day) with greater needs who wouldn't be able to have their care needs met by the UTC, treatment would be received at an alternative site with a full A&E service

   These patients would get the specialist input they require at the right time and receive the best possiblecare. However, it is acknowledged that needing to travel further for this care may be seen as an adverse impact by some people

   - Of those 3% of patients seen at an alternative site with the required specialist (A&E) services, it isestimated that if travelling by car around 60% of them would travel over 45 minutes (the thresholdagreed by the local health system for this type of activity). This equates to less than 9 patients a week. It is estimated there will be no increase in the number of patients travelling more than 60 minutes by car

   However, given the serious nature of the conditions these patients are expected to have, most are likely to travel by ambulance. This is whathappens now for those patients requiring a level ofemergency care that cannot be met by Grantham and District Hospital A&E

   - Of those attending an alternative site it is estimated around a third would attend Lincoln County Hospital and the remainder would attendhospitals out of the county, with the majority going to Peterborough City Hospital

   - The friends and family of those patients receiving treatment at an alternative hospital which better meets the patients care needs, may have to travel further to see them if they require specialist in-patient care

10. Acute Services Review: Preferred option – Urgent & Emergency Care

Note the case for change and proposed model of care described in this chapter are set against the current model of care (i.e. that provided before the COVID-19 pandemic and subsequent temporary changes).

10.1 Case for change

10.1.1 The United Lincolnshire Hospitals NHS Trust operates three Accident and Emergency (A&E) Departments: Lincoln Hospital (c.73,000 attendances per year) provides a full A&E, Pilgrim Hospital (c.55,000 attendances per year) which is also a full A&E and Grantham Hospital (c.29,000 attendances per year prior to the temporary closure) that has an exclusion criterion. Major trauma cases go to Queens Medical Centre in Nottingham.

10.1.2 The Grantham A&E department sees both adults and children, however because of its small size and availability of specialist staff exclusion criteria have been put in place. The A&E Department at Grantham Hospital has for some time only dealt with a limited range of presenting conditions.

10.1.3 The exclusion criteria have been in place for some time, since 2007/08, and following its introduction patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions have been taken by the ambulance service straight to neighbouring hospitals (Lincoln, Pilgrim, Nottingham or Peterborough) where more specialised services are located.

10.1.4 This exclusion list is well understood by the local healthcare system including primary care, community providers and the ambulance service. If patients do present at Grantham A&E with conditions the hospital is not able to deal with the capabilities and systems exist to manage the patient pending transfer to a bigger unit.

10.1.5 In the summer of 2016 concern was expressed by the emergency departments at Lincoln Hospital and Pilgrim Hospital about their ability to fill middle-grade medical rotas. A report to the ULHT Board described a number of reasons for this – a national shortage of emergency medicine doctors, insufficient doctors in training choosing to work at ULHT, an increasing reliance on locums and difficulty in securing the number of locums required to fill gaps in rotas consistently.

10.1.6 The report also stated that (at the time) there were four substantive consultants in post out of 15 funded whole time equivalent (wte) posts, with vacancies being filled by locums. Furthermore, there were 11.6 wte middle-grade doctors against the 28 funded posts. The reduced emergency staffing levels, combined with a reduction in skill mix of substantive staff, compromised the on-going provision of safe 24 hours, seven days per week A&E care across three sites. Although efforts were continuing to recruit additional staff, and various steps had been taken to mitigate staff shortages it was felt further action was required.

10.1.7 The ULHT Board agreed the additional risk to patients was too great to continue without further action and considered potential options to how best manage this situation. The Board agreed to implement a temporary overnight service closure at Grantham Hospital to support the staffing at the Lincoln and Pilgrim A&E departments, as releasing middle-grade doctors to work at these two sites would provide safer services for the Lincolnshire population as a whole. Prior to the temporary closure attendances there were on average 11 attendances between the hours of 23.00 and 07.00.

10.1.8 In August 2016 an initial three-month overnight closure of the Grantham A&E Department was introduced by ULHT taking it from a 24/7 service to 09.00 to 18.30 hrs seven days a week. In addition, an agreed threshold plan for recommencing services was agreed. The Lincolnshire A&E Delivery Board assumed responsibility for undertaking the monthly reviews with effect from September 2016 against a threshold of:

- No deterioration in the current consultant position; and
- Fill rate of at least 75 per cent (21) of the middle-grade establishment (28) on an eight-week prospective basis.

10.1.9 Representatives of Lincolnshire East CCG (the lead commissioner of services from ULHT) and NHS Improvement undertook a quality visit of the Grantham Hospital A&E and reported no concerns. Quality impact and equality assessments were undertaken and the Trust's decision was supported by NHS Improvement.

10.1.10 The ULHT Board met on 1 November 2016 and considered an updated report on the position regarding emergency care services. A number of expressions of interest in vacancies had been received but no appointments made while a further two-middle grade doctors were leaving the Trust. The Board considered options on how to proceed and decided to extend the period of closure to the end of February 2017.

10.1.11 The ULHT Chief Executive and Medical Director attended the Lincolnshire Health Scrutiny Committee again on 23 November 2016. It was reported that reducing the A&E department opening hours at Grantham Hospital had enabled the A&E department at Lincoln Hospital to be supported by up to an additional 85 hours per week by middle-grade and consultant staff from Grantham Hospital. No serious issues had been reported. A recruitment drive had indicated the potential to reach the necessary threshold but it was unlikely that sufficient new doctors would be in employment before January or February 2017.

10.1.12 The Health Scrutiny Committee concluded that the closure of A&E services between 18.30 and 09.00 at Grantham Hospital represented a substantial variation in the provision of health services for the area. It recorded it was not reassured that the required threshold of consultant and middle-grade doctors would be recruited by February 2017 and hence that A&E services would not be reinstated by this date, and therefore the closure between those times would be permanent. The Committee decided that the matter should be referred to the Secretary of State and letter of referral was sent on 15 December 2016.

10.1.13 The Secretary of State for Health passed the matter onto the Independent Review Panel (IRP) to undertake an initial assessment in accordance with its agreed protocol for handling contested proposals. The IRP responded to the Secretary of State on 22 March 2017 with the following advice:

- The IRP was content the closure of A&E services at Grantham Hospital between 18.30 and 09.00 represents a substantial variation in health care provision.
- The changes agreed by the ULHT Board in August 2016 and implemented in relation to the temporary closure at Grantham Hospital were done so on the grounds of safety.
- The situation raised a number of questions in relation to the true nature of emergency care provision at Grantham Hospital.
- The A&E service at Grantham Hospital has for some time (since 2007/08) only dealt with a limited range of presenting emergency conditions.
- The level of emergency service provided from Grantham Hospital prior to August 2016 was already more akin to that of an urgent care centre. Yet description of the service as an A&E or ED by the NHS and Health Scrutiny Committee continues today.
- This is not just about the appropriate use of terminology or signage but that unrealistic expectations and misunderstanding may have been allowed to develop about the level of service that can and should be provided at Grantham Hospital.
- Genuine efforts to recruit and retain staff to work in ULHT's departments continue but, thus far, with limited success. The IRP agreed that after six months (to date at the time) the closure of the A&E service at Grantham Hospital can no longer be regarded as a temporary measure and considered that it is not in the interests of patients that future discussions be conducted on this basis.
- The Grantham A&E service is demonstrably the smallest of the three A&E services provided by ULHT and deals with a limited range of presenting conditions. Consequently, taking account of the low level of activity through the night, the actual numbers of patients affected in terms of accessing A&E elsewhere is relatively small.
- That said the IRP accepts the issues that gave rise to the issue did not originate in Grantham and that there is considerable disquiet about the uncertainty among the residents of Grantham and the surrounding areas.

10.1.14 The IRP concluded that in the interests of safety the A&E service at Grantham Hospital should not re-open 24/7 unless sufficient staff defined by the threshold can be recruited and retained. It also stated that the time has come for an open and honest appraisal, both of the options for future emergency care delivery at Grantham Hospital and more widely across Lincolnshire.

10.1.15 Following the referral to the IRP, ULHT continued its effort to recruit staff and the closure of A&E services between 18.30 and 09.00 at Grantham Hospital was reviewed. A review in February 2017 concluded that the threshold to re-open the service full time had not been met but acknowledged there had been significant improvement in staffing levels.

10.1.16 It was agreed to increase opening hours by one hour (08.00-18.30) with effect from 27 March 2017 and to introduce a direct to admission pathway for selected medical patients conveyed by the ambulance service from 3 April 2017. These changes aside the closure would remain in place for a further three months. NHS Improvement confirmed that it had received assurance regarding the decision.

10.1.17 In November 2017, the ULHT Board considered re-opening the A&E at Grantham Hospital on a 24/7 basis. NHS Improvement requested the Board delay its final decision on whether to re-open the department for a period of one month to allow time for a safety review to take place.

10.1.18 This review was undertaken by the East of England Clinical Senate, with a final report being submitted to the relevant organisations on 14 December 2017. Key findings from the East of England Clinical Senate review were:

- The extensive list of exclusions currently in place would not be subject to any change should the decision to extend or change opening hours be implemented;
- The Trust advised that over half its emergency medicine consultant workforce were locums with most currently not on the GMC Specialist Register, and only a small proportion with specialist qualifications.
- Since the original workforce thresholds were set to inform whether the service could revert back to being 24/7, ULHT had reviewed its workforce requirements resulting in a significant uplift in its target establishment. This was supported by additional funding.
- It was acknowledged that if the original workforce calculation threshold (c.75% of the required minimum number of medical staff across all three sites) was applied to the new establishment of 38 middle-grade doctors across ULHT (rather than the historical figure) around 30 middle-grade doctors would be required (as opposed to the original 21). ULHT also had plans to increase middle-grade staffing to 44 across all three sites in April 2018.
- The current number of 22 middle grades (at the time), including locums, therefore only met 50% of the Trust's target establishment for April 2018 (44). It was also acknowledged that the heavy proportion of locums amongst the 22 middle-grade doctors meant this was a relatively unstable position.
- The panel advised the Royal College of Emergency Medicine provided a 'rule of thumb' guide for 'Medical and Practitioner Staffing in Emergency Department'. Using that guide would indicate that ideally 36 middle-grade medical staff would be needed (i.e. 12 middle grades at each of the three sites) to maintain safe, sustainable 24/7 cover.
- The panel learned that although there were currently around ten nursing vacancies across the three sites, an additional 20 nurses would be needed to reach the new uplift level, including 24/7 opening at the Grantham site.
- Despite having reached the previously agreed threshold of 21 middle-grade doctors, the Trust acknowledged that there was still significant performance challenge across the Trust's three A&Es, with particularly poor performance compliance to the four-hour performance standard and Friends and Family results.
- ULHT confirmed there had been no reported patient harm as a result of the closure; the CCG also confirmed that it was unaware of any harm resulting from the reduction of opening hours. The Trust also reported that there had not been any significant change in activity, nor had overall admissions increased. The data provided showed that since August 2016 there had been an average decrease in attendance to Grantham Hospital A&E or around 100 attendances a week, with no correlating increase at Lincoln or Pilgrim A&E.

- The panel heard that the Trust considered that having reached the 21 middle-grade doctors threshold across the three sites, it may be able to support three 24/7 rotas for A&E but had no certainty or confidence in how long it could be safely sustained. The Trust agreed that given the considerable vacancy gaps it may not be able to sustain sucha rota for longer than three to four months, and the dependencies for the sustainability were outside the Trust's control, including staff being maintained.
- The panel agreed that as middle-grade staff from Grantham Hospital were currently covering some of the workload created by middle-grade vacancies at Lincoln and Pilgrim Hospitals; re-opening Grantham Hospital A&E 24/7 would mean that this additional support to Lincoln and Pilgrim Hospitals would no longer be available.
- Evidence showed that the majority of patients presenting at Grantham Hospital A&E were 'type 3' patients, the department did not support patients of higher acuity. Althoughthe department did have a resuscitation area, any critical patients would always need tobe transferred. The panel heard the department had two beds in the Emergency Admission Unit 'ring fenced' for patients requiring transfer for more specialist care, or to another site, after the department had closed. The panel heard that although formal recording of number of transfers ceased in March 2017, bed managers reported the activity as low.
- The CCG had made reference to the potential to extending the opening hours at Grantham Hospital A&E to 21.00. ULHT reported that this would require new staff rotas to be extended to midnight or beyond that could be challenging to achieve on current staffing and rotas. ULHT advised that historically there were typically around 11 patientspresenting between 23.00 and 08.00 hours at Grantham Hospital A&E.
- Both the Trust and CCG agreed that, having taken a year or more to adjust to the change in opening hours, to temporarily reinstate 24/7 opening would likely result in confusion among the public, patients and staff. There was agreement that there was insufficient demand for a full medically led overnight A&E service and that until there wasa full establishment across ULHT, services were not stable on any of the three sites.
- The panel noted there had been no mention or reference to any discussion with other parts of the system such as out of hours, community care providers, GPs and primary care on managing the impact of change in opening hours. The panel found that Grantham Hospital hosted an Enhanced Out of Hours service (Kingfisher Suite) taking walk in minor injuries from 18.30 until 23.30hrs seven days a week and an Out of Hoursservice for minor illnesses with appointments accessed via 111 from 18.30 to 08.00hrs,although no mention had been made of this.
- The panel heard that there had been ongoing engagement and discussion with the CCG and local stakeholders including community group leaders and that there was a broad agreement that a 24/7 medically led A&E at Grantham Hospital was not a sustainable model, nor a model that was justified in view of the small number of patients per hour that previously attended overnight.
- The panel agreed that the terminology 'A&E Centre' could imply a full A&E facility and be confusing for patients. The panel noted the IRP had made comment that *"the level of emergency service provided from Grantham and District Hospital prior to August 2016 was already more akin to that of an urgent care centre"*. It made reference to use of appropriate terminology *and "unrealistic expectations and misunderstanding about the level of service that can and should be provided at Grantham hospital"*. The East Midlands Clinical Senate panel reiterated those concerns, although it did agree that Grantham Hospital did currently provide more than an Urgent Care Centre which tendedto be Primary Care led, but significantly less than an A&E would usually be expected to provide.

10.1.19 The panel concluded that there was no evidence that any extended opening, over and above the current level of provision of the A&E Department at Grantham Hospital would improve outcomes for patients. The panel also agreed extending the opening hours at Grantham Hospital would put further pressure on the ULHT's A&E nursing staff when there are already vacancies – this could further impact on the quality and safety of care provided.

10.1.20 Therefore, the recommendation was ULHT should continue to provide an A&E service at Grantham Hospital on the opening hours of 08.00-18.30, seven days a week. The panel also recommended that in order to make it clear for patients and the public the type of services available at Grantham A&E ULHT look to re-naming the department, and that the terminology 'A&E Centre' is not applied.

10.1.21 Since the time of the unplanned temporary closure at Grantham A&E ULHT has continued to work hard to shore up its A&E departments. This has included significant uplifts in target establishments of medical and nursing workforce supported by additional funding and significant recruitment activity including a variety of initiatives.

10.1.22 Despite this hard work and some success, significant issues in the medical and nursing workforce still exist today resulting in challenges with rota coverage, high vacancies and high agency usage across ULHT's A&E services (2019/20):

- Consultants: currently funded for 26 posts - 3 filled substantively
- Middle grades: currently funded for 52 posts – 27 filled substantively
- Remainder are either filled with locums or underqualified clinicians, or left vacant
- Vacancy rates, turnover and sickness are high.

10.1.23 These ongoing workforce challenges have continued to drive quality and performance challenges across ULHT's urgent and emergency services:

- 4-hour A&E performance - through 2019/20 ULHT performance did not go above 68%
- Poor performance against time to triage at Lincoln Hospital and Pilgrim Hospital;
- Poor performance against time to treatment across all three hospital sites;
- Poor performance against proportion of patients who left before being seen across all three sites
- Worsening picture of ambulance handover delays at Lincoln and Pilgrim Hospitals.
- Lincoln Hospital and Pilgrim Hospital urgent and emergency care services rated as 'Inadequate' in the most recent CQC inspection in 2019.

10.2 Grantham A&E service re-designated as a 24/7 Urgent Treatment Centre and 24/7 A&E services provided from Lincoln Hospital and Pilgrim Hospital

Overview

10.2.1 At the time of the ASR Programme commencing in early 2018 the partners in the Lincolnshire health and care system were already engaged in a significant dialogue in relation to the provision of urgent and emergency care across ULHT's three hospital sites (as set out in the case for change above).

10.2.2 This work was supported by a substantial amount of analysis, particularly in relation to the workforce. The conclusions and recommendations from this work were fed into the ASR programme and its option appraisal process.

10.2.3 The preferred option identified through the ASR options appraisal process for urgent and emergency care is to re-designate the Grantham A&E service as an Urgent Treatment Centre (UTC) and maintain 24/7 A&E services provided from Lincoln Hospital and Pilgrim Hospital.

10.2.4 The Urgent Treatment Centre would be developed in line with the nationally-defined criteria for UTCs, offering improved accessibility and pre-booking via NHS 111. As a minimum, the eight priority standards sought by NHSE would be delivered.

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

10.2.6 The multi-disciplinary workforce would have the ability to manage all presentations, including those requiring stabilisation and transfer. The workforce mix would be expected to include GPs, urgent care practitioners, middle grade doctors, medical trainees, nurses and clinical support. The mix and level of input will be reviewed and refined once the service is operational.

10.2.7 The ULHT Emergency Medicine consultant team would provide ten sessions (40 hours a week) to the unit from commencement. Their primary function would be to provide clinical oversight, training and governance in addition to providing supervision to the medical trainees in the unit. Cover would be provided on a rotational basis from across appropriate members of the permanent ULHT team, facilitating improved working relationships across all urgent care services in the county. The volume of consultant input to the service would be reviewed at three, six and 12 months post-commencement.

10.2.8 Ambulance arrivals would continue to be accepted. The clinical criteria for conveyance to Grantham by East Midlands Ambulance Service have been reviewed against the planned clinical acuity model for the Grantham Hospital site (described in the Preferred Option - Acute Medicine chapter). See Appendix N for revised exclusion criteria.

10.2.9 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 and accommodate walk-ins throughout the opening hours (though the preferred route of access will be via NHS 111, supporting early triage and pre-booked appointments – as per national UTC standards).

10.2.10 Home visiting through the Out of Hours service would also be offered by this team, supporting improved consistency of care.

10.2.11 Radiology access will be x-ray and CT over a 24-hour period and MRI access will be available Monday to Friday 09.00-17.00. Diagnostics would be supported by full laboratory access.

10.2.12 The table below sets out a comparison of the 24/7 Grantham A&E service as it was before the temporary closure and the proposed 24/7 Urgent Treatment Centre.

Figure 142 – Comparison of Grantham 24/7 A&E service and proposed 24/7 UTC

	24/7 A&E (as was)	24/7 UTC
Opening hours	• 24hrs a day 7 days a week *Av. 80 attendances per day (24hrs)* *Av. 11 attendances between 23.00-07.00*	• 24hrs a day 7 days a week
Acuity	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E • Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals	• Majority of patients presenting 'type 3' (other A&E/minor injury/walk in centre/urgent care centre) • Level of care provided more than an Urgent Care Centre but significantly less than an A&E • Exclusion criteria: Patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions taken by ambulance straight to neighbouring hospitals • Refinement of exclusion criteria to allow a larger proportion of frail and elderly patients from the geographic locality to receive inpatient care at Grantham and a small volume of higher acuity cases currently managed at Grantham to receive specialised treatment elsewhere
Workforce	• Consultants: 80hrs/week plus on-call evenings & weekends • Middle Grades: 24/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours	• Consultants: 40hrs/week no on-call evenings & weekends • Middle Grades: 16/7 • Nursing: 24/7 • GPs: 10 sessions a week in hours plus GP sessions out of hours *Planning assumptions: All subject to review and change once service is fully operational*
Diagnostics	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7	• X-ray and CT – 24/7 • MRI – M-F: 09.00 – 17.00 • Full laboratory access 24/7

Quality

10.2.13 Concerns have been expressed for a number of years regarding the clinical sustainability of ULHT delivering three 24/7 A&E medical and nursing rotas, one in each of its hospitals. This culminated in the implementation of a temporary service closure at Grantham Hospital to support the staffing at the Lincoln Hospital and Pilgrim Hospital A&E departments, as releasing middle-grade doctors to work at these two sites would provide safer services for the Lincolnshire population as a whole. In parallel there have been growing concerns regarding these services delivery and achievement of clinical standards.

10.2.14 The preferred option for urgent and emergency care provision across Lincolnshire is seen to provide a number of quality improvement opportunities:

- Given the medical workforce challenges and heavy reliance on locum doctors who are likely to represent a less stable workforce, will minimise additional pressures across the A&E system in Lincolnshire and patient risk.
- Minimise the pressure on ULHT's nursing staff, where there are already significant vacancies, and therefore impact on the quality and safety of care provided.
- Support a more consistent achievement of clinical standards, i.e. the NHS constitutional four-hour standard, time to triage at the Lincoln Hospital and Pilgrim Hospital sites and time to treatment across all three ULHT hospital sites.
- Redefining and refining the scope of safe and high quality services, ensuring Grantham Hospital receives an appropriate mix of patient acuity in line with its capabilities.
- Encourages integrated service delivery between primary care, community care and acute care providers.
- Aligns with NHS England and Improvements vision for urgent and emergency care patients, with more serious life threating emergency needs treated in centres with the very best expertise and facilities in order to reduce risk and maximise chances of survival and recovery.
- Promotes positive volume versus service provision balance in urgent care provision at Grantham Hospital between 23.00 and 08.00 hrs, compared to a 24/7 A&E service.

10.2.15 When the preferred option for urgent and emergency care was presented to the East Midlands Clinical Senate as part of the ASR programme's options evaluation process, the panel praised the Lincolnshire health system for its exclusion protocol, which was considered 'clear, comprehensive and excellent'.

10.2.16 Although caution should be exercised when comparing the proposed 24/7 UTC at Grantham Hospital identified through the ASR programme with the temporary UTC provided as part of the Covid-free 'Green' site at Grantham Hospital in response to the pandemic, the temporary changes do provide useful insights.

10.2.17 Key considerations to consider in the context of these insights is the proposed UTC model set out within this PCBC would be able to see patients with a higher level of acuity and additional pathways of attendances such as 111 appointments (much more in line with what was provided 'pre-covid', compared to the temporary UTC that was implemented. The temporary UTC was also operating in a 'constrained' COVID-19 environment which will have shaped patient behaviour.

10.2.18 A comparison of the performance of the temporary UTC at Grantham Hospital as part of the 'Green' site in August 2020 and March 2021 has been carried out, due to the length of time the temporary service was in place it is not possible to use comparable months. However, there is an assumption that given similar levels of isolation and lockdown that overall performance should not differ between months:

- August 2020
  - 90% of patients seen within their 15 minute clinical triage, of those averagingaround a 9 minute assessment
  - 98% of UTC attendances are discharged within the 4 hour target, of those averaging 102 minute attendance.
  - 5% referral rate to A&E

- March 2021
  - 91% of patients seen within their 15 minute clinical triage, of those averaging around a 9 minute assessment
  - 98% of UTC attendances are discharged within the 4 hour target, of those averaging 112 minute attendance.
  - 5% referral rate to A&E.

10.2.19 A comparison of the Friends and Family test performance showed:

- August 2020:
  - 357 responses
  - Recommended Score= 90%
  - Non Recommended Score = 4%
- February 2021:
  - 314 responses
  - Recommended Score = 93%
  - Non Recommended Score = 3%

10.2.20 A range of positive and negative feedback was received during the months of August 2020 and February 21:

- Positive:
  - "I honestly don't think you could have done better. Everyone was so understanding supportive and helpful. I never felt they were in a rush. They took time to talk to me help me relax and of course talked about what I should do etc the doctor who looked after me. Who I cant remember the name of was absolutely brilliant and the nurse Sally was as well"
  - "Just wanted to thank all the everyone involved from my visit to Grantham UTC this afternoon, from the Reception staff, to all the doctors, nurses and Healthcare assistants who treated and looked after me."
  - "It was my first experience using a UTC so had doubts but everything that was required was there, specialists were on hand, it was a good experience (that might have been the Entonox!!)".
- Negative
  - "A choice of hospital to travel to would of been better. Also I had arrived at Boston & Grantham hadn't released me. The notes didn't include everything as Id said been sent for a CT scan & they were not in the notes that I took with me"
  - "Staff excellent but the service they can offer has been stripped to nothing. Whats been done to Grantham A&E is criminal"
  - "The facility was great but the judgement or expertise was lacking. I needed to be admitted to hospital and drs at A and E where shocked I had been sent home two days before by Grantham. Bring back proper A and E at Grantham please I nearly died"

10.2.21 Based on both months of the Friends and Family Test it highlighted the following:

- Positive experience of UTC service, but mixed reviews as expected around the loss of an A&E.
- Lack of confidence or uptake in using the 111 service, but unlikely to use the service where a walk in option is available.
- A mixed understanding around how services operate and integrate in Lincolnshire, proving that there is still further work and collaboration to be made in the local area.

These insights will be taken forward into any final decision making.

Access

10.2.22 In 2019/20 Grantham Hospital A&E saw 23,134 attendances (opening hours 08.00-18.30), these patients largely came from Grantham and the surrounding area. The highest volumes of attendances per hour are first thing in the morning when the service opens at 8.00am, volumes per hour then steadily reduce through the day to when the service closes.

10.2.23 Under the proposed model of a 24/7 UTC at Grantham Hospital (and integrated community/acute medicine beds described later) the exclusion criterion for the Grantham Hospital site would be refined, meaning a relatively small number of patients currently attending the A&E, would not in the future. This would mean more patients going to the right place for care first time and minimising subsequent patient transfers.

10.2.24 It is estimated that with the refinement of the exclusions criteria, once fully implemented the preferred option to establish an UTC at Grantham Hospital will displace c.600 patients per year who are currently seen at Grantham Hospital A&E (based on 2019/20 activity). This is equivalent to c.2.5-3.0% 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. It is anticipated the majority of these patients will have a NEWS ≥7 with a low frailty score (<5), fractured neck of femur/femoral fractures or acute coronary syndrome.

10.2.25 Under the proposal it is estimated that the number of additional patients travelling over 45 minutes for non-elective care, the travel time threshold set by the local health system for activity of this type, is c. 375 (based on 2019/20 activity, c.435 forecast to 2023/24 - see Appendix H for breakdown by neighbourhood team). This is based on the assumption they travel to their nearest appropriate hospital by car and against a baseline of c.21,500 patients across Lincolnshire who currently travel more than 45 minutes to attend urgent and emergency care services by car.

10.2.26 However, in reality given the existing exclusion criteria and 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 their travel time could be less than 45 minutes. 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.

10.2.27 Approximately 33% of the patients would attend Lincoln Hospital and the remainder would attend hospitals out of county, the majority of these would attend North West Anglia NHS FT (58%) followed by Nottingham University Hospitals NHS Trust (9%).

10.2.28 The table below provides a summary of the estimated impact on the number of patients displaced and associated travel times by car when the preferred option is fully implemented (based on 19/20 activity and forecast 23/24 activity).

Figure 143 – Estimated displaced Grantham urgent and emergency care activity andimpact on travel times

	Grantham Hospital		LincolnHospital		Out of county hospital	
	19/20	23/24	19/20	23/24	19/20	23/24
UEC activity	-600	-694	197	228	403	466*
Travelling +45 mins.	+376	+435	16	16	360	419

** (19/20 c.350 to NWAFT and c.50 to NUH; 23/24 c.400 to North West Anglia NHS FT, c.65)*

10.2.29 During the various public engagement exercises that have taken place a number of people have raised some concern about travel times for urgent and emergency care if A&E services are no longer provided at Grantham Hospital.

10.2.30 However, it is not widely understood by the public that exclusion criteria have successfully existed for some time (since 2007/08) for the Grantham Hospital site to ensure the care it provides aligns to its size and the level of specialism it is able to deliver. As highlighted in the feedback provided by the Independent Review Panel (IRP) to the Secretary of State for Health in relation to the opening hours of Grantham A&E.

10.2.31 When necessary, under the current model patients are already taken by ambulance to alternative hospitals in line with the current exclusion criteria to ensure patients are treated at the most appropriate location to their needs. In addition, if patients self-attend at Grantham Hospital who fall into the exclusion criteria they are transferred to Lincoln Hospital to ensure they receive the clinical input they need.

10.2.32 Through the ASR programme public engagement events a common theme of feedback was a desire from the public for the Grantham A&E service to return to a 24/7 service following its temporary closure. In the original scoping of the Urgent Treatment Centre (UTC) option its planned opening hours were to be in line with the national principles and standards set for UTCs (open for at least 12 hours a day seven days a week).

10.2.33 However, in light of the feedback from the public further consideration was given to the opening hours of the proposed Urgent Treatment Centre at Grantham Hospital and the decision was reached for this proposed model to operate 24 hours a day, seven days a week. Therefore, implementation of the preferred model would increase overall access to patients compared to the reduced hours A&E service currently in operation.

10.2.34 Conversations are ongoing with Lincolnshire County Council regarding public transport and how it supports access to health services in the wider sense. The impact of the proposed service changes on access has been considered in the Equality Impact Assessment and this will be tested and explored further through consultation with the public before any plans are finalised.

10.2.35 These plans, for example, could include providing additional non-emergency patient transport such as cohorting appointments by postcode and providing a shuttle service. Any plans developed would need to be done so in the context of existing local and national patient transport policies and criteria.

10.2.36 In addition, through workshops with stakeholders proposals have been developed to improve support to patients with regards to travel in the broadest sense across Lincolnshire (i.e. not just relating to proposed service changes under the acute services review). These include:

- Ensuring a seamless process for advice, eligibility assessment and booking
- Improved coordinated way of ensuring the appropriate transport is arranged for discharges from hospital:
    - The default should be Non-Emergency Patient Transport Services (NEPTS) unless there is a ‘medical need’
    - Better planning and coordination with the family/patient early in a patients stay as an integral part of discharge planning
    - Coordination of NEPTS with potential other options through a single system approach to discharge planning
- Booking of clinics:
    - More proactive choices regarding clinic bookings should include a discussion on ‘how are you intending to travel’
    - Real time information to support administrators in understanding public transport should be easily accessible on their IT systems so that is the patient is travelling by bus and the first bus doesn’t arrive until 10:00 the patient is offered an appointment after this time
- Integration of CallConnect and NEPTS journey planning to reduce duplication
- Integration of systems to allow funded, non-funded and concessionary fares/bus passes to use multiple types of transport

Affordability and Deliverability

10.2.37 In 2015/16, the last full year the Grantham Hospital A&E Department operated as a 24/7 service, it saw 29,297 patients. In the same year the Out of Hours service based at Grantham Hospital saw 15,675 patients (70% from NHS 111, a further 17% from walk-ins and the remainder from other sources). Giving a total activity in 2015/16 of 44,972.

10.2.38 Based on historic growth rates in accident and emergency activity seen at Grantham Hospital it is estimated that if the A&E department was still operating 24/7 the activity levels in 2019/20 would be c.33,900. In 19/20 the activity volumes seen by the Out of Hours service on the Grantham Hospital site had reduced to 7,603 (70% of which was from NHS111, a similar proportion to 2015/16 just a smaller absolute number). If the estimated volume of activity in 2019/20 assuming the Grantham A&E was operating 24/7 is combined with the 2019/20 actual Out of Hours activity this would give an estimated total urgent and emergency activity of c.41,500.

10.2.39 To estimate the activity that would be seen at the proposed 24/7 UTC in 2023/24 an analysis has been conducted based on two scenarios:

- Scenario 1 – Demographic growth applied to 2019/20 A&E activity (assuming operating 24hrs/day) and Out of Hours Activity = 42,700
- Scenario 2 – Historic growth applied to 2019/20 A&E activity (assuming operating 24hrs/day) and assume 50% of drop in Out of Hours activity seen between 2015/16 and 2019/20 returns = 49,900

10.2.40 Through the ongoing planning and implementation of the Lincolnshire Integrated Community Care (ICC) clinical model a set of 'left shift' assumptions were developed to inform the system's planning. In relation to accident and emergency services a reduction of 10% of attendances has been assumed. This has been used as an additional sensitivity analysis on the expected number of attendances at the Grantham UTC.

10.2.41 The table below provides a summary of the estimated volume of activity at the proposed 24/7 UTC on the Grantham Hospital site when the preferred option is fully implemented. This includes a sensitivity analysis relating to the number of patients that would attend if the full impact of the 'left shift' occurs.

Figure 144 – Estimated future Grantham UTC attendance analysis

Attendees at the proposed Grantham Urgent Treatment Centre	15/16	19/20	23/24 Scenario 1	23/24 Scenario 2
Grantham 24/7 A&E attendances *Assuming 24/7 operation in 19/20*	29,297	33,900	-	-
Grantham OOH service	15,675	7,600	7,800	11,600
Grantham 24/7 UTC attendances	-	-	34,900	39,000
Total	44,972	41,500	42,700	50,600
Adjusted for displaced patients	-	-	42,000	49,900
Sensitivity analysis – reduction in 10% of attendances through ICC				
Grantham 24/7 UTC attendances	-	-	37,800	44,910

10.2.42 Within the original ASR PCBC and identified capital requirement, moderate capital investment was identified to address backlog maintenance and improve the functional suitability of the environment.

10.2.43 This would include some expansion into adjoining departments which are deemed underutilised, enabling a rationalisation of back office accommodation and increase in the amount of clinical floor space which enables a greater degree of privacy and dignity for patients.

10.2.44 These changes are still the longer term ambition, however they are not an immediate necessity to enable the transition from an A&E to UTC and this change can still happen without them. The activity forecast in 2023/24 under the higher activity growth scenario (Scenario 2) does estimate a level of activity greater than that seen when the A&E operated 24/7. If required there is the option to relocate the fracture clinic to provide additional capacity (supported through virtual fracture clinics and telemedicine) ahead of the expansion planned for the longer term.

10.2.45 A comparison has been made between this forecast activity and that seen by the temporary UTC implemented as part of the Lincolnshire health systems response to the COVID-19 pandemic. However, as previously highlighted this should be treated with caution due to the differences in the service provided and context it was operating.

10.2.46 The temporary UTC saw on average 72 patients a day, which would equate to 26,280 for a full year. This is below the forecast set out above, which could be expected given the proposed model will be able to treat more patients with higher acuity needs and provide more pathways such as 111 attendance.

10.2.47 The temporary UTC showed a consistent demand throughout the hours of 07:00-23.00, with small numbers of use in the remaining hours. Between the hours of 23.00-07.00 (included) the average attendance was:

- September 2020: c.5 patients
- March 2021: c.5 patients

10.2.48 Recruitment and retention of urgent and emergency staff has been a long-standing concern for ULHT, although Grantham Hospital has not had as many issues as Lincoln and Pilgrim Hospitals.

10.2.49 Historically there have been two A&E consultants who provide day-time cover to the A&E department. Under the proposed Urgent Treatment Centre model there would still be consultant support and input to provide vital leadership, clinical governance and training to all UTC staff, however this would reduce to 1.2 whole time equivalents.

10.2.50 The retention of Emergency Medicine Consultants is additionally required to provide supervision for medical trainees, who are to be retained as part of the UTC workforce. The consultant workforce will be ULHT employed and will undertake sessions at Grantham UTC on a rotational basis.

10.2.51 Initially a total of ten sessions of Emergency Medicine Consultant cover will be provided (equivalent to 40 hours a week). This will be reviewed at three, six and 12 months. Any future reduction would only be agreed if clinically appropriate, and where it would not adversely impact on overall service model delivery. In particular, the ability to retain middle grade staff and training placements.

10.2.52 During its review of whether the temporary closure of the Grantham A&E should be lifted and it go back to being a 24 hour 7 day a week service, the East of England Clinical Senate identified that using the Royal College of Emergency Medicine ‘rule of thumb’ guide 36 middle grade medical staff would be needed (i.e. 12 middle grades at each of the three sites) to maintain safe, sustainable 24/7 cover.

10.2.53 When the Grantham Hospital A&E operated 24 hours a day, seven days a week the service operated with six whole time equivalent middle grades providing the 24/7 middle grade cover. Under the proposed model it would operate with five whole time equivalent middle grades.

10.2.54 Given the workforce pressures and heavy reliance on locum doctors facing all medical grades in emergency medicine it would be very difficult to sustainability staff up to the ‘rule of thumb’ number identified by the Royal College of Emergency Medicine.

10.2.55 The proposed model being led by a community provider should also minimise the pressure on ULHT’s nursing staff, where there are already significant vacancies.

10.2.56 By implementing the proposed model of an Urgent Treatment Centre at Grantham Hospital it is believed the optimum balance of patient volumes, acuity, outcomes and resource will be achieved. Medical middle grades will support the UTC between 08.00 and midnight when activity is known to be at its highest and will not need to staff an on-call rota at night. When the A&E operated as a 24/7 service on average 11 patients a day attended between 23.00 and 07.00.

10.2.57 The table below sets out the workforce (funded establishment) of the Grantham Hospital A&E when it operated 24/7 together with the Out of Hours workforce, what the workforce currently is and the workforce for the proposed 24/7 Urgent Treatment Centre developed for planning purposes. The workforce model for the 24/7 UTC will be subject to ongoing review and refinement once the service is fully operational.

Figure 145 – Grantham UTC model workforce compared to A&E & Out of Hours model (funded establishment)

	A&E 24/7 & Out of Hours (WTE) *2015/16*	A&E (08.00-18.30) & Out of Hours (WTE) *2019/20*	UTC 24/7 (WTE)***
Medical			
• Consultants	2.0*	2.0	1.2
• Middle/Trust Grade	6.0**	5.0	5.0
• Foundation/Trainee	7.0	6.0	6.0****
• Admin	0.6	0.6	0.6
• GPs	10 sessions/week	10 sessions/week	10 sessions/week + OOH
ACP			
• Nurse ACPs	4.5	4.0	4.0
Nursing			
• Registered	24.5	19.0	25.5
• Nursing Associate	2.5	1.0	1.0
• Non Registered	10.0	7.5	14.0
• Receptionist	4.0	2.5	2.5
Out of Hours			
• GP	2.0	2.0	*Out of Hours will be integrated with UTC*
• Registered	6.5	6.5	
• Non Registered/ Clark	7.0	6.5	

** Consultants provided on-call cover overnight and at weekends*
*** Middle grades covered the whole out of hours rota between them – 'rule of thumb' guidance suggests should be 12.0*
**** Planning assumptions: All subject to review and change once service is fully operational*
***** Junior training posts will be retained, proposed model will offer a valuable and interesting environment. Ongoing engagement of HEE to ensure they remain supportive and posts will need to be considered in the context of the overall requirement/ need for these posts across the whole of ULHT*

10.3 East Midlands Clinical Senate recommendations and workforce improvements

10.3.1 The East Midlands Clinical Senate has been involved all the way through the options development and appraisal process for Urgent and Emergency Care. This included an independent clinical review where they were asked to consider whether there is a clear clinical evidence base underpinning the proposal.

10.3.2 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.

10.3.3 Through this review the East Midlands Clinical Senate supported the proposal for Urgent and Emergency Care and made no further recommendations other than not use the term 'UTC Plus'.

10.4 Quality and Equality Impact Assessments

10.4.1 A Quality Impact Assessment (QIA) has been completed for the proposed service change for stroke services to identify clinical risks to the reconfiguration. This has been completed using a standard template by the NHS Lincolnshire CCG Locality Clinical Lead and Medical Director for Lincolnshire Community Health Services NHS Trust.

10.4.2 The QIA for the service proposal:

- Identifies the key relevant quality measures for the areas of safety, clinical effectiveness, and patient experience;
- Identifies any risks to achieving an acceptable quality in these areas; and
- Presents mitigating actions.

10.4.3 A summary of the QIA for the proposed changes to urgent and emergency care services is set out below and the full version is included in Appendix I.

Figure 146 – Summary of QIA for proposed urgent and emergency care service changes

Area	Summary Impact(+ve & -ve)	Summary Actions
1.Quality		
Duty of Quality	▪ Presenting symptoms for a small no. of patients would indicate full A&E department required at a different site – resulting improved quality of care received ▪ Population need to understand what symptoms are appropriate for a UTC	▪ Comprehensive communication strategy and robust consultation process
Patient Safety	▪ Improve patient safety as ensures those with highest acuity needs go to right hospital first time ▪ Workforce capability/skills - Staff working in existing A&E Department as staff may need to transfer employment to a new provider	▪ Support offered to staff to facilitate the change
2. Experience		
Patient Experience	▪ Quality of service will remain high, and access will only change for a small proportion of current service users on the basis of appropriate clinical care ▪ Greater accessibility (opening hours) and a direct link with Primary Care and Community Services ▪ Positive impact on time spent by patients within department due to UTC model of assessment and management compared to UTC.	▪ Comprehensive communication strategy and robust consultation
Staff Experience	▪ Changes should make some roles more attractive to staff ▪ Stability and a confirmed long term service model should reduce anxiety among staff	
3. Effectiveness		
Clinical Effectiveness & Outcomes	▪ Optimise balance of access, cost and outcomes	

10.4.4 Quality for the domains of patient experience, patient safety and clinical effectiveness will be monitored and assured for United Lincolnshire Hospitals Trust (ULHT) through a combination of surveillance mechanisms throughout the Acute Services change and improvement program.

10.4.5 A system wide Lincolnshire Quality Surveillance Group is now meeting bi-monthly chaired by the CCG Director of Nursing with Clinical & Quality lead attendance from all Lincolnshire main providers (including ULHT and LCHS), NHSE/I including Specialised Commissioning, HealthWatch; HEE and Social Care. Any significant Quality concerns will be alerted and mitigated through the work of that forum.

10.4.6 Quality metric hard and soft intelligence for ULHT and LCHS is also considered through the CCG Quality and Patient Experience Committee (QPEC) that also meets bi-monthly as a sub-committee to the CCG Board. This committee will continue to consider Quality improvement requirements for ULHT, plus identifying any areas of Quality concern, where improvement action is required.

10.4.7 There are four dedicated CCG Quality Officers that work closely with ULHT, each with a focus on a respective hospital site. These CCG Officers are responsible for daily surveillance to identify any areas of Quality concern for ULHT, working with the Trust to secure improvements where required. This is through meetings with leads from relevant areas of the Trust, through attendance at the Trust's own Quality Governance Committee, via a regular CCG led Patient Safety Group and when indicated through Quality visits to the Trust as required.

10.4.8 There is also regular liaison between CCG Leads and their counterparts in the Trust to flag any areas of concerns plus now a regular system Clinical Forum that meets with ULHT attendance. There are similar quality monitoring processes for all Lincolnshire main providers, each having at least one dedicated Quality officer.

10.4.9 The lead CCG Quality Officer reports any concerns into QPEC and from a CCG perspective re: ULHT into the system Quality Surveillance Group. There is therefore an alerting system for any deteriorating quality areas for ULHT, which can be quickly identified for improvement, immediately if indicated.

10.4.10 Services undergoing any significant change will be monitored via the Trust's own Quality monitoring processes and also through the system and commissioner processes outlined above, to ensure as the change occurs and new service models become embedded that there are no deleterious effects on patient care at ULHT, LCHS or any other providers.

10.4.11 In addition the impact of any proposed changes on staff will be kept under ongoing review through the evaluation of measures such as the NHS Staff Survey, local surveys, absence rates, staff health and wellbeing, and retention rates.

10.4.12 As well as a QIA, a Stage 1 and Stage 2 Equality Impact Assessments (EIA) has also been completed for the proposed urgent and emergency care service changes.

10.4.13 Within the Stage 1 analysis the populations/groups defined by protected characteristics that were identified that may face adversity as a result of the proposed activity/project were; Age, Disability and Economically Disadvantaged.

10.4.14 To help address adverse impact on these groups The People's Partnership, on behalf of the then Lincolnshire Sustainability and Transformation Partnership (now Integrated Care System), carried out an engagement exercise to reach hidden communities between 5 and 25 March 2019.

10.4.15 Over 15 days 130 questionnaires were completed. These submissions received views relating to sensory impairment, physical disability, learning disability, mental health, carers, young people and families, older people, race, pregnancy and maternity and social economic deprivation.

10.4.16 In addition, through March to October 2019 all Lincolnshire health organisations conducted the *'Healthy Conversation 2019'* engagement exercise. Within this period there were a number of engagement opportunities including an ASR-focused survey, drop in events with lead clinicians and executives to discuss proposed service changes, dedicated locality workshops offering more detailed discussion opportunities and a direct response/query mechanism.

10.4.17 During this engagement period, accessibility issues were again taken into account and the survey and promotional materials were made available in different formats on request and translated into different languages. Our partner and stakeholder organisations also worked with us to promote the various ways the public could get involved and supported their groups and audiences to engage. This process yielded broader feedback, however, it is noted that the themes and concerns were similar.

10.4.18 Using the results of the engagement exercises and additional research the following themes were identified in the Stage 2 EIA:

- Age:
  - Older population: Longer travel requirements which is impractical; negative impacton health; concerns of greater reliance on family and friends for increased travel needs; reliance on public transport that is perceived to be limited in accessibility.
  - Younger population: Negative impact on health; reliance on hospital transport; longer travel requirements which is impractical; reliance on public transport, whichis perceived to be limited in accessibility.
- Disability:
  - Longer travel requirements which is impractical
  - Additional cost related to travelling services further away
  - Inability to drive especially if sight impaired or wheelchair user
  - Greater reliance on family and carers for increased travel needs
  - Negative impact on health and anxiety levels
- Economic Disadvantaged:
  - The specific engagement from The People's Partnership did not receive feedbackfrom groups with this protected characteristic
  - But the wider Healthy Conversation 2019 engagement identified that the possible negative impacts of this proposed change on deprived population include longer negative impact on health and stress levels, travel requirements and additional cost of this and specific concern about the costs of return travel from hospital, especially at times of limited/no public transport.

10.4.19 A summary of the EIA for the proposed changes to urgent and emergency care services is set out below and the full version is included in Appendix J.

10.4.20 The Equality Impact Assessment will continue to be developed and refined throughout the consultation period, drawing in feedback received through the process.

10.4.21 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 be finalised in the context of existing local and national patients transport policies and criteria.

Figure 147 – Summary of EIA for proposed emergency and urgent care service changes

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 c.2.5 – 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 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 an 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.

Note: 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.

10.5 Vignettes to demonstrate the positive impacts of the clinical model

Patient 1

10.5.1 A 62 year old male is brought to Grantham UTC by his wife with sudden onset of slurred speech and a left sided weakness in his arm. He has a history of hypertension and angina.

10.5.2 An immediate assessment reveals an irregular pulse, raised BP, dysarthria and paresis of the left arm. Capillary blood glucose is 7.8.

10.5.3 An immediate call is made to the Stroke Team at Lincoln. While awaiting ambulance transfer, the patient is given an immediate dose of clopidogrel and the GP record is accessed to establish past history, medication history and a log of any recent attendances. Blood samples are taken and if available, a CT brain is carried out on site at Grantham for review by the Stroke Team while awaiting arrival of the patient at Lincoln. Performing a CT should not delay transfer if an ambulance is immediately available.

10.5.4 Support is provided to the patient's wife to ensure she is aware of what is happening and she can either travel home herself or can be collected by a family member or friend.

10.5.5 Outcomes:

- This patient is either transferred back to Grantham Hospital for rehabilitation immediately following his specialist acute stroke intervention; or
- Receives assisted discharge home with support from the stroke discharge service.

Patient 2

10.5.6 A 44 year old male is brought to the UTC by his brother with worsening asthma following a lower respiratory tract infection.

10.5.7 The patient is triaged by a senior nurse, and immediately assessed as category 4 due to severe breathing difficulties.

10.5.8 The patient is transferred to an examination room and attended by a middle grade doctor. Treatment is commenced with oxygen and nebulisers. The patient fails to improve and a 999 ambulance is called, and due further rapid deterioration, a Same Day Emergency Care consultant is called to review the patient and on site anaesthetist is called to assist with airway management.

10.5.9 Outcomes:

- The patient is stabilised and an anaesthetist accompanies the patient in the ambulance transfer to Lincoln County Hospital Emergency Department.

Patient 3

10.5.10 An 86 year old female is brought to the Grantham UTC by ambulance with increased confusion, and a history of fall one week earlier. She is a resident of a local Care Home, taking multiple medication and has had three admissions to acute care with urosepsis in the past 12 months.

10.5.11 Clinicians working within the UTC have direct access to this patient's GP record and are able to establish pre-morbid health status and level of frailty. If necessary, there will be direct communication with the patient's integrated community team (ICT), care coordinator and family to establish whether acute escalation is appropriate.

10.5.12 Investigations including blood tests, plain film x-ray and, if felt appropriate clinically, a CT Head will be carried out within the SDEC on site at Grantham. There will be further liaison with the ICT to agree the best outcome for the patient.

10.5.13 Outcomes, following liaison with the ICT may be:

- Discharge back to Care home with additional ICT/therapy support
- Admission to an acute community bed on site for management of this acute event
- Short term admission or referral to the frailty unit to review holistic needs and prepare for safe discharge and/or palliative care.

Patient 4

10.5.14 A 67 year old male with worsening breathlessness and cough, known underlying COPD and cor pulmonale and lives alone attends the Grantham UTC.

10.5.15 The UTC clinicians have direct access to the GP record to establish previous history, medication details including allergies and what support is in place. They check if the patient is known to ICT and/or Specialist Community Teams (Respiratory, Heart Failure) so information can be gained about social circumstances and support needs.

10.5.16 The UTC clinicians undertake an assessment of health status to include blood testing, ECG and plain film X-ray. Advice is sought from the Respiratory Medicine Consultant if necessary and an appropriate management plan agreed based on the patient's medical and social needs.

10.5.17 Outcomes, following attendance may be:

- Discharge home with appropriate pharmacological treatment with additional social support (HART, ASC) from Specialist Nursing Teams and ICT and direct liaison with GP Practice to arrange a timely review at home
- Short term admission to an acute-community bed on the Grantham Hospital site until the patient can be safely discharged home
- Escalation to Acute Trust if deteriorating clinical condition and patient appropriate for critical care input.

NOTE: Patient 3 and 4 vignettes reflect full proposed acute medicine pathway at Grantham Hospital, which is described further in Chapter 11.

10.6 Assessment against tests for service change

10.6.1 In line with the guidance set out in *'Planning, assuring and delivering service change for patients'* published by the NHS in 2018, all proposals for significant service change must be assessed against the Government's four tests for service change and NHS England and Improvement's test for reductions in hospital beds.

10.6.2 The proposed change to re-designate the Grantham A&E service as an Urgent Treatment Centre (UTC) has been assessed against these tests. This assessment reflects and aligns to the description and narrative for the preferred option for urgent and emergency services set out in this chapter.

Test 1: Strong public and patient engagement

10.6.3 There has been strong ongoing engagement with the public throughout the life of the ASR programme and its predecessor programmes. The breadth and depth of this work is set out in full in the stakeholder engagement chapter later in this document with more detail provided in the detailed engagement reports in Appendices K and L. The focus here is therefore on the engagement relating to urgent and emergency care services.

10.6.4 During July 2018 a series of nine engagement events to discuss hospital service in Lincolnshire were held, each in a different area of the county. In total 170 members of the public were engaged across these nine events. The meetings were designed to focus on the case for change for particular health services and the possible solutions to the challenges faced. The main points made in relation to urgent and emergency care at these events were:

- The discussions around urgent and emergency care were largely focused on how best to relieve pressure on existing A&E departments.
- Although there was some initial uncertainty about the difference between emergency and urgent care, it was generally accepted that A&E is often used incorrectly, and that more education is required to guide patients to the most appropriate place. There was confusion around, for example, exactly how an Urgent Treatment Centre differs to an A&E, and when to call 111 rather than 999. Participants also wanted to see more education on opening hours to assist the public.

- Some thought the burden on A&E might be relieved by more accessible GP services with longer opening hours; more widespread use of Advanced Nurse Practitioners, pharmacists and paramedics to assess patients; or through the development of 'hubs' containing multi-disciplinary teams. Many participants supported the idea of accelerating the process of assessing, 'filtering' or triaging patients.
- There were also suggestions for streamlining and improving 'pathways' between primary and secondary care, for example, allowing GPs more opportunity to refer patients directly to a specialist ward (where appropriate), completely bypassing the need for the patient to attend a walk-in centre or A&E.
- Existing locations such as Lincoln and Boston were widely identified as preferred sites for the provision of A&E services, with either Grantham or Stamford as a third location (to give coverage to North, South and East). Although the appropriate number of A&Es for Lincolnshire was not discussed in detail, a few participants stated one site would not be enough.
- Participants in Grantham felt their local A&E had been penalised at the expense of Boston's and Lincoln's, wanted a return to a 24-hour service, and were resistant to services being concentrated in Lincoln. Elsewhere participants asked for the seasonal and tourist pressure on coastal areas (e.g. around Skegness) to be considered as part of any service design. There was also support for Gainsborough offering an MIU or urgent care. Some participants had a negative perception of current services and said they would rather travel out of the county to Nottingham or Peterborough.

10.6.5 As well as the stakeholder events a questionnaire was made available in online and paper formats to enable the public and other stakeholders to share their views. A total of 256 questionnaires were received between 11 July and 5 August 2018. Feedback from the public in relation to urgent and emergency services included:

- 72% of respondents were prepare*d* to travel under 45 minutes for urgent care (e.g. suspected broken arm); 22% were prepared to travel 45-60 mins; and 6% were prepared to travel over an hour.
- 92% of respondents were prepared to travel under 45 minutes for emergency care (e.g. suspected heart attack); 5% were prepared to travel 45-60 mins; and 3% were prepared to travel over an hour.
- When asked about a set of statements and which was most important in relation to urgent and emergency services 38% said 'I can access care when I need it and not just Monday – Friday 9am-5pm'.

10.6.6 In October 2018 four public options evaluation workshops were undertaken across Lincolnshire in Sleaford, Mablethorpe, Bourne and Gainsborough to enable members of the public to share their views on the options against the evaluation criteria and supported the ongoing process of developing the final options being proposed for consultation. At these events the proposal for Lincoln Hospital and Pilgrim Hospital to provide 24/7 A&Es and Grantham to be re-designated as an Urgent Treatment Centre were discussed.

- Overall, a substantial majority of participants (84%) agreed with the proposed changes to emergency and urgent care.
- Across all four of the groups, a majority of participants agreed with the proposed changes – although it is worth noting that a third (3 out of 9) participants disagreed in Bourne.
- A number of participants expressed support for a two-site model, suggesting that this would lead to a more streamlined service. However, they felt for the model to work successfully, the CCGs should undertake a campaign to improve public awareness of where to present, as there is currently much confusion that could worsen if the model changes.
- Furthermore, it was felt this should be accompanied by education over the term used: for instance, if Grantham is re-designated as an Urgent Treatment Centre without a clear explanation of its purpose, this could lead to some people continuing to treat it as an A&E.

10.6.7 In 2019 *Healthy Conservation 2019* was launched, which was an open engagement exercise to shape how the NHS in Lincolnshire takes health care forward in the years ahead. This included pre-consultation engagement on the emerging preferred options coming out of the ASR programme:

- In relation to urgent and emergency care services, and specifically relating to Grantham Hospital, key themes related to:
    - Distance and accessibility – treatment may be outside 'Golden Hour'
    - Transport – without a car access is difficult from other areas of the county
    - Grantham is on major road and rail links and needs an A&E open 24/7
    - New housing developments with increasing local population
    - Poor road networks and lack of public transport, especially in rural villages
    - Ambulance availability and response time concerns
    - Capacity issues – overburden on Lincoln Hospital
    - Inability to get back from hospital if taken by ambulance
    - Lack of transport to attend another A&E during the night
    - Service and staffing provision within the proposed Urgent Treatment Centre and how this may impact other hospitals
    - How any proposed changes might affect other wards and services at Grantham Hospital.
    - NHS support offered to disadvantaged patients, especially for travel and transport
    - Access to services and inadequate public transport (EMAS) service provision, performance and the 'golden hour'.
- Suggestions to overcome challenges included:
    - Upgrade other local community hospitals to provide urgent and emergency care
    - Urgent and emergency care services required 24 hour a day 7 days a week
    - Offer walk in service 24/7 with full resuscitation and imaging
- Feedback was also obtained from hidden and hard to reach communities relating to the impact on the protected characteristics groups and communities focussed around the longer distance need to travel and the challenges this could bring. This also highlighted restricted incomes and savings would be a barrier to travelling further and a need to rely on family members for transport or public transport and taxis with the associated cost and practicality implications. Being physically disabled or with mobility issues makes access more difficult.

10.6.8 Throughout the duration of the ASR programme there has been ongoing engagement with the Lincolnshire County Council Health Scrutiny Committee. Between May and October 2019, the Committee commented on each of the services within the scope of the ASR programme where an emerging preferred option for the future delivery of services had been identified. The Committee considered the change proposals for urgent and emergency care services on 15 May 2019 and submitted initial comments on the 23 May 2019.

10.6.9 These were:

- Acceptance that the introduction of urgent treatment centres (by autumn 2020) is a national initiative
- Need for 24/7 walk in access and proposals for Grantham Hospital should reflect this
- Concerns over continued absence of A&E facilities in Grantham and surrounding area overnight
- Need for list of services undertaken currently at Grantham A&E and proposed Grantham urgent treatment centre

Test 2: Consistency with current and prospective need for patient choice

10.6.10 The Department of Health guidance on this test sets out that a central principle underpinning service reconfigurations is that patients should have access to the right treatment, at the right place at the right time. Services should be locally accessible wherever possible and centralised where necessary.

10.6.11 The guidance goes onto state that in this context, local commissioners need to consider how proposed service reconfigurations affect choice of provider, setting and intervention; and that commissioners will want to make a strong case for the quality of proposed services and improvements in the patient experience.

10.6.12 The concept of services being locally accessible wherever possible and centralised where necessary is at the heart of the Lincolnshire Acute Services Review, and at the heart of the proposed urgent and emergency care model.

10.6.13 Implementing the preferred option for urgent and emergency care will reduce the number of hospital sites 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 the services provided and available to patients from each of the three hospital sites there will be minimal change.

10.6.14 This is due to the exclusion criteria that has existed at Grantham Hospital since 2007/08 due to its size and level of specialist services available. Under the proposed change to re-designate Grantham A&E to an Urgent Treatment Centre, the exclusion criteria will be refined, however it is estimated this will only impact on a small number (c.600 patients per year equivalent to 2.5-3.0% of the current activity seen) of higher acuity cases that clinically should receive specialist treatment elsewhere.

10.6.15 It should also be noted that given the proposal is for a 24/7 Urgent Care Treatment, more patients will be able to access the service than are currently able to under the reduced opening hours of the current A&E service.

Test 3: Clear clinical evidence base

10.6.16 The development of the case for change and preferred option for urgent and emergency care has had substantial clinical consideration and input from across the Lincolnshire health system:

- Concerns regarding sustainability of three 24/7 A&E services at each of ULHT's hospital sites expressed by clinical leads at Lincoln Hospital and Pilgrim Hospital.
- Development of options to address challenges faced in sustainability of A&E services led by ULHT Medical Director, supported by ULHT lead clinicians.
- In its review the Independent Reconfiguration Panel (IRP), which is supported by clinical experts, identified the A&E service at Grantham Hospital has for some time (since 2007/08) only dealt with a limited range or presenting emergency conditions and that the level of emergency service provided from Grantham Hospital is more akin to that of an urgent care centre.
- The IRP concluded that in the interests of safety the A&E service at Grantham Hospital should not re-open 24/7 unless sufficient staff defined by the threshold can be recruited and retained.
- The East of England Clinical Senate identified that based on the Royal College of Emergency Medicine 'rule of thumb' guide for 'Medical and Practitioner Staffing in Emergency Department', 36 middle-grade medical staff would be needed (i.e. 12 middle grades at each of the three sites) to maintain safe, sustainable 24/7 cover.
- The East of England Clinical Senate also identified the evidence showed that the majority of patients presenting at Grantham Hospital A&E were 'type 3', although it did agree that GDH did currently provide more than an Urgent Care Centre which tended to be Primary Care led, but significantly less than an A&E would usually be expected to provide.
- The East of England Clinical Senate panel concluded that there was no evidence that any extended opening, over and above the current level of provision of the A&E Department at Grantham Hospital (08.00-18.30 hours); would improve outcomes for patients.

10.6.17 The case for change and proposals for the future configuration of urgent and emergency care were tested through two ASR Clinical Summits with over 55 leads from across the system, facilitated by the East Midlands Clinical Senate.

10.6.18 The preferred option for the future configuration of urgent and emergency care services was identified through a clinically led options appraisal event attended by over 60 stakeholders – the conversations on urgent and emergency care services at this event were led by a ULHT urgent and emergency care consultant. At this event there was overwhelming support for this option with 98% of attendees either strongly or tending to agree it was the right way forward.

10.6.19 The identified preferred option for urgent and emergency care aligns with NHS England and Improvements vision for urgent and emergency care patients, with more serious life threating emergency needs treated in centres with the very best expertise and facilities in order to reduce risk and maximise chances of survival and recovery.

10.6.20 The presentation of the preferred option for urgent and emergency care services to the East Midlands Clinical Senate was led by local lead clinicians. The East Midlands Clinical Senate panel considered the exclusion criteria to be 'clear, comprehensive and excellent'.

Test 4: Support for proposals from clinical commissioners

10.6.21 The Lincolnshire CCG(s) have been main sponsors of the ASR programme since its inception. The members of all of the Governing Bodies recognise the case for change and accept that doing nothing is not an option.

10.6.22 Clinical leads from CCGs have played a key role in developing and refining clinical models, working closely with colleagues in the acute setting. This joint approach between clinicians in primary, community and acute care will continue into the public consultation meetings.

10.6.23 The four CCG Governing Bodies and 'Shadow' Joint Committee, as they were at the time, considered the outputs of the evaluation process and the independent reviews as the ASR programme developed.

10.6.24 The four CCG Governing Bodies, as they were at the time, agreed the original PCBC that set out the preferred option for the future configuration of acute services in Lincolnshire at their Governing Body meetings in October 2018. The proposed changes to go to consultation set out in this PCBC are the same as they were in the original PCBC.

10.6.25 Most recently the newly formed single Lincolnshire CCG Governing Body reviewed this PCBC on 22 July 2020 and gave its support to the proposed changes to be submitted to NHSEI to start its assurance process. An extract of the minutes of that meeting can be found in Appendix M.

Test 5: Capacity implications

10.6.26 It is widely acknowledged that the current Accident & Emergency (A&E) department at Grantham Hospital is underutilised and the proposed re-designation of this service into an Urgent Treatment Centre (UTC) can be achieved within the current footprint.

10.6.27 The total activity forecast to attend the proposed 24/7 UTC on the Grantham Hospital site by 2023/24 is c.42,000-49,900. In 2015/16 when the A&E operated 24/7 the total urgent and emergency care activity seen between the A&E and Out of Hours service on the site was 44,972, which is in between the forecast estimate.

10.6.28 When the sensitivity analysis of a 10% reduction in activity is applied, which is the aspiration of the impact of the Integrated Community Care (ICC) model the forecast activity at the 24/7 UTC in 2023/24 c.37,800 - 44,910.

10.6.29 Within the original ASR PCBC and identified capital requirement, moderate capital investment was identified to address backlog maintenance and improve the functional suitability of the environment.

10.6.30 This would include some expansion into adjoining departments which are deemed underutilised, enabling a rationalisation of back office accommodation and increase in the amount of clinical floor space which enables a greater degree of privacy and dignity for patients.

10.6.31 These changes are still the longer term ambition, however they are not an immediate necessity to enable the transition from an A&E to a UTC and this change can still happen without them. The activity forecast in 2023/24 under the higher activity growth scenario (Scenario 2) does estimate a level of activity greater than that seen when the A&E operated 24/7. If required there is the option to relocate the fracture clinic to provide additional capacity (supported through virtual fracture clinics and telemedicine) ahead of the expansion planned for the longer term.