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:	**15 December 2021**
Subject:	**Lincolnshire Acute Services Review – Acute Medical Beds at Grantham and District Hospital**

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 each of the four elements of the review in detail. The first two elements: stroke services and urgent and emergency care were considered on 10 November 2021. The remaining two elements are due to be considered at this meeting, with acute medical beds at Grantham and District Hospital as one of these.

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 further.

Actions Requested:

(1) To consider the detailed on the Lincolnshire Acute Services Review of Acute Medical Beds at Grantham and District Hospital.

(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 2021 the Committee considered an introductory item and agreed its approach to the consultation.

2. Acute Medical Beds at Grantham and District Hospital

The following representatives from the NHS are due to attend the meeting to present information on this topic:

- Dr Dave Baker, South West Lincolnshire Locality Clinical Lead, Lincolnshire Clinical Commissioning Group
- Dr Yvonne Owen, Medical Director, Lincolnshire Community Health Services NHS Trust.
- Pete Burnett, System Strategy and Planning Director, Lincolnshire NHS.

To facilitate the Committee's consideration, pages 32-36 of the consultation document, which relate specifically to acute medical beds at Grantham and District Hospital, are attached as Appendix A to this report. Chapter 11 of the Pre-Consultation Business Case (PCBC) provides further detail and is attached at Appendix B. It should be noted that chapter 11 of the PCBC in turn refers to the following documents, all of which are available at: Pre-Consultation Business Case Appendices:

- Appendix H – Access Impact Analysis by Neighbourhood Team
- Appendix I – Quality Impact Assessments
- Appendix J - Equality Impact Assessment

3. Consultation and Conclusion

The Committee is invited to consider the presentation on the detailed elements of the Lincolnshire Acute Services Review.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Extract (Pages 32 – 36) from Lincolnshire NHS Public Consultation Document – Relating to Four of Lincolnshire's NHS Services – Acute Medical Beds at Grantham and District Hospital
Appendix B	Chapter 11 of the Pre-Consultation Business Case for the Lincolnshire Acute Services Review

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

Acute medical beds at Grantham and District Hospital

What are we asking you to consider?

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

- Integrated community/acute medical beds atGrantham and District Hospital

What are the services and how are theycurrently organised?

Acute medical beds work alongside, but are separate from, Accident and Emergency (A&E) departments.

The primary role of these services is to provide assessment, investigation and treatment for patients with particular medical (i.e. not surgical) conditions suchas severe headache, chest pain, pneumonia, asthma or chronic obstructive pulmonary disease (COPD), who are referred by their GP or come via the A&E department.

In these services the care is provided by a multi-disciplinary team of doctors, nurses, therapists and support staff.

The acute medical beds team is responsible for coordinating initial medical care for all the patients theysee, whether they need a hospital stay or are able to return home after assessment and treatment in one of the walk in (ambulatory) units.

If patients do need a hospital stay they will either be admitted to an acute medical assessment bed or transferred to another specialist ward or department. This can sometimes involve patients being transferred between hospital sites to ensure they get to the team that provide the right care and treatment.

United Lincolnshire Hospitals NHS Trust (ULHT) currentlyprovides acute medical beds at Lincoln County Hospital,Pilgrim Hospital, Boston and Grantham and District Hospital.

In line with the limited range of presenting emergency conditions (as highlighted in the urgent and emergency care section) that Grantham and District Hospital A&E department can deal with, the level of care and complexity of patients seen by the acute medical beds service at this hospital is lower than that at Lincoln County Hospital and Pilgrim Hospital, Boston.

The reduced service available at the Grantham and District Hospital is well understood by the local healthcare system, including the ambulance service. If they assess a patient local 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 the right facilities and skills to care for them.

A summary of the current acute medical beds provision at ULHT's hospital sites is set out below.

Lincoln County Hospital	**A&E** · Operates 24/7 · Services: full A&E **Acute medical beds** · Same day emergency care · Medical emergency assessment unit · Medical emergency short stay · Acute medical short stay ward
Pilgrim Hospital Boston	**A&E** · Operates 24/7 · Services: full A&E **Acute medical beds** · Integrated assessment centre · Acute medical short stay ward
Grantham and District Hospital	**A&E** · Operates 08:00 – 18:30 · Services: not full A&E **Acute medical beds** · Emergency assessment unit · Acute medical short stay ward

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

What are the challenges and opportunities for acute medical beds at Grantham and District Hospital?

This section sets out the challenges and opportunities for acute medical beds and what we hope to achieve bymaking changes.

Challenges

- There is a rising demand for acute medical beds services and more patients have complex needs
- Our local acute medical beds services struggle to recruit enough doctors and nurses, which means:
    - We cannot consistently provide the level of service quality we aspire to
    - We need to fill vacancies with temporary staff, which itself is not always possible
    - There are increased service and patient safety concerns
    - In addition, Grantham and District Hospital faces further staffing challenges in this area as:
        - Its Accident and Emergency (A&E) department sees a limited range of presenting emergency conditions because of its small size and limited availability of specialist staff; which in turn means
        - Its acute medical beds service treats fewer patients with a lower level of care needs compared to Lincoln County Hospital and Pilgrim Hospital, Boston

Opportunities

By making changes, we can look to ensure:

- High quality acute medical services are delivered locally in a sustainable way for the long term
    - The volume and complexity of presenting emergency conditions at hospitals in Lincolnshire ismatched to the level of acute medical beds service provided at each site
    - Improving the ability of services to attract and retain talented and substantive staff through building a strong, high quality and successful service
- Patients who require specialist care are identifiedearly and attend the right service, first time and receive the best possible care
- Patient health and the overall patient experience are improved
- Better integration and collaboration with patients' GP surgeries and community teams

The feedback from engagement about acute medical beds at Grantham and District Hospital 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 acute medical beds, a number of which specifically relate to Granthamand District Hospital, have been shared by the public and stakeholders throughout our engagement to date:

- A need to keep medical treatment as local and easy to access as possible
- Concerns around distance and accessibility, poor public transport and access for patients or family who cannot afford the travel costs
- The ability of the ambulance service to transfer patients safely when required
- Specific to Grantham and District Hospital:
  - Acute medical beds at Grantham and District Hospital might take pressure off Lincoln CountyHospital and Pilgrim Hospital, Boston
  - Concerns around how any proposed changes might affect other wards and services at Granthamand District Hospital

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

What is our proposal for change?

Our preferred proposal for change is to establish integrated community/acute medical beds at Granthamand District Hospital, in place of the current acute medical beds.

The integrated community/acute medical beds would be delivered through a partnership model between a community health care provider and United LincolnshireHospitals NHS Trust. The care of patients would still be led by consultants (senior doctors) and their team of doctors, practitioners, therapists and nursing staff.

It is anticipated this change would affect around 10% of those patients currently receiving care in the acute medical beds at Grantham and District Hospital. This is equivalent to 1 patient a day, on average. These patients would receive care at an alternative hospital with the right skills and facilities to ensure the best possible outcome. We envisage the number of medicalbeds required at Grantham in this new model will not be reduced.

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 acute medical beds two solutions remainedfollowing the shortlisting of options:

- No provision of acute medical beds at Grantham and District Hospital
- Provision of integrated community/acute medicalbeds at Grantham and District Hospital

Attendees at the workshop were asked to think aboutthe advantages and disadvantages of the two options against agreed criteria.

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

Support for change proposals for acute medicalbed services at Grantham and District Hospital		
Support for changeproposal	Stakeholder Workshop	Public Workshops
Integrated community/ acute beds at Grantham hospital	85%	81%
No acute medical beds at Grantham hospital	9%	11%
No preference	6%	8%

Impact Analysis

As we have developed our proposals we have considered the quality and equality impact of the preferred change proposal for acute medical beds.

Through our equality impact assessment we identifiedtwo groups of people, one of which is defined by a protected characteristic, which may be more likely to be impacted positively or adversely by this proposal. These groups are age and those who are economicallydisadvantaged.

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. Acute medical beds provision would continue to be delivered at Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term – including a more sustainable medical and nursing workforce.
2. The majority of patients (estimated to be around 90%) cared for in the acute medical beds at Grantham and District Hospital would continue to becared for in the integrated community/acute medical beds
3. The preferred proposal for change would delivera more comprehensive local service provision at Grantham hospital, specifically in relation to the frail' population, thereby reducing pressure on acutehospital sites at Lincoln and Boston
4. The preferred proposal for change would enable Grantham and District Hospital to build a centre of excellence for integrated multi-disciplinary care(particularly for frail patients), which supports bothimproved community-based management of longterm conditions and reduced lengths of stay in hospital beds
5. An estimated 10% of patients (equivalent to 1 a day on average) currently cared for in the acute medical beds at Grantham and District Hospital would not beable to have their care needs met in the integrated community/ acute medical beds. Instead, they wouldreceive their care at an alternative site with the right facilities and expertise to ensure the best outcomes

Potential adverse impacts

1. For the small number of patients (estimated to be around 1 a day) with higher acuity needs who wouldn't be able to have their care needs met by the integrated community/ acute medical beds, treatment will be received at an alternative site with the facilities and skills to look after the most seriouslyill patients

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 patients seen at an alternative site, it is estimated that there would be no increase in the number of patients travelling more than 60 minutesby car, the threshold set by the local health system for this type of activity. However, given the serious nature of the conditions these patients are expectedto have, most are likely to travel by ambulance

- Of those attending an alternative site, it is estimated around 40% would attend Lincoln County Hospital. The remainder would attend hospitals closer to them,but outside 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.

11 Acute Services Review: Preferred option – Acute Medicine (including respiratory and cardiology)

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 service changes).

11.1 Case for change

11.1.1 There is an unequivocal case for change relating to acute medicine across the United Lincolnshire University Hospitals NHS Trust (ULHT). The ULHT acute medicine service including respiratory and cardiac services experiences significant workforce challenges in their ability to deliver a safe, quality service. It is widely recognised to be clinically and operationally unstable in its current form.

11.1.2 Across the ULHT acute medicine service there are significant recruitment and agency spend challenges, 50% of consultant posts are filled by locums at Lincoln and Grantham Hospitals (2019/20).

11.1.3 There is a 40% vacancy rate (out of 10 posts) for respiratory consultants across ULHT's three hospital sites, leading to reliance on agency staffing. There are no substantive respiratory consultants at Grantham Hospital, the service is currently led by an agency locum, and there are significant gaps in the respiratory consultant workforce at Pilgrim Hospital (2019/20).

11.1.4 There are longstanding issues with cardiology consultant recruitment at Pilgrim Hospital and a sub-optimal cardiology service at the hospital as it is unable to develop CT and pacing due to workforce challenges.

11.1.5 A key specific issue relating to Grantham Hospital is the sustainability of the acute medicine service as it has a selected medical 'take' (exclusion criteria) with low volumes compared to the other two ULHT sites.

11.1.6 Through the Acute Services Review (ASR) programme two alternative service delivery options for acute medicine across ULHT have been considered:

- No provision of acute medical beds at Grantham Hospital; and
- The provision of integrated community/acute beds at Grantham Hospital

11.1.7 To help inform the development of these options, as well as their appraisal, in August 2018 a Grantham Clinical Summit was convened to specifically consider the future of acute medical provision at Grantham Hospital.

11.1.8 A key part of this clinical summit was a clinical audit of acute medicine at Grantham Hospital. The purpose of the audit was to identify the clinical status (acuity) of current patients using the Grantham Hospital acute medical service provided by ULHT.

11.1.9 A small group of clinicians and managers conducted an audit on the Grantham Hospital site that comprised of two approaches:

- A review of one year of NEWS data for the period ending May 2018; and
- A review of a cohort of patients in the hospital (on that day) who had at some point or stillhad a NEWS ≥7 at any time during their stay.

11.1.10 NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice when patients present to or are being monitored in hospital.

11.1.11 The audit review of the one year of NEWS data showed:

- Total number of A&E attendances to Grantham of 23,463
- Total number of medical admissions to Grantham Hospital of 3,892
- Number of medical inpatients with a first NEWS ≥7 = 230
- Number of medical inpatients with a first NEWS ≥5 = 313

11.1.12 Following this initial audit the following observations were made:

- 36.1% of medical patients with NEWS of ≥7 on admission had subsequent score of ≤3.
- 82.4% of medical patients with NEWS of ≥5/6 on admission had subsequent score of ≤3.
- There are some patients currently admitted to Grantham Hospital that should be considered for exclusion now as it was considered a current concern e.g. severe asthma and overdose patients with a reduced conscious level.
- NEWS is the preferred method to assess acuity, however to improve selection of patients suitable for different care settings using NEWS combined with Frailty Scores would potentially be more robust e.g. a patient with a NEWS of 7 but a frailty score of ≥7 would not be for escalation to level 2/3 critical care and therefore would be appropriate to be seen and remain in a consultant supported community model. This was tested when the audit team reviewed the cohort of patients in the hospital (on that day).

11.1.13 The cohort of patients identified for review was agreed as any patient in the hospital on 3 August 2018 who had at some point or still had a NEWS of ≥ 7 at any time during their stay.

11.1.14 The audit team looked at the patients notes, discussed with nursing staff to identify the reason for admission, considered what had happened during admission, used clinical judgment on what clinical service was required to care for the patient and completed a frailty score (used Canadian Frailty Score). The results were:

- 17 patients were audited with an average age of 77 years
- 12 were not suitable for escalation, 2 were and 1 was unclear (2 were elective).
- The 2 elective patients were medically unwell as a result of surgery and were on the Acute Care Unit.
- 5 patients required specialist acute care based on the current exclusion criteria and the recommended additions to exclusions identified in the first part of the audit meant they should therefore not be on the Grantham Hospital site.
- 7 patients required general acute care which could be managed by consultant supported medical beds run by a community provider; 4 of these could potentially be discharged earlier with a community plan if new pathways were introduced.
- 2 patients required lower acuity care i.e. community hospital/neighbourhood team model or new pathway as part of neighbourhood team model.
- 1 patient was suitable for hospice bed.

11.1.15 On 17 August 2018 a second audit was completed on the Grantham Hospital site. This second cohort of patients identified for review was agreed as any patient in the hospital on 17 August who had a NEWS score of ≥5 at any time during their stay.

11.1.16 The audit team looked at the patient's notes, discussed with nursing staff to identify the reason for admission, considered what had happened during admission, used clinical judgement on what clinical service was required to care for the patient and completed a Frailty Score. The results were:

- 9 patients were audited with an average age of 82 years
- 6 were not suitable for escalation and 3 were for escalation
- 2 patients were transferred to Grantham from Lincoln Hospital stroke service for rehabilitation
- 4 patients required general acute care which could be managed by consultant supported medical beds run by a community provider; 2 of these could potentially be discharged earlier with a community plan if new pathways were introduced.
- 3 patients required lower acuity care, i.e. community hospital/neighbourhood team model or new pathway as part of a neighbourhood team model

- A summary of the NEWS and Frailty Score for all 9 patients at the time of their review were as follows:
    - All 9 patients had a NEWS score of ≤4
    - 2 patients had a Frailty Score of ≥7
    - 3 patients had a Frailty Score of 5/6
    - 2 patients had a Frailty Score of ≤3
    - 2 unrecorded

11.1.17 The recommendations from the audit were:

- The combination of the NEWS and Frailty Score provide a clear evidence base for identifying acuity; and
- To review the Grantham Hospital Exclusion Criteria and include respiratory distress, patients with reduced consciousness and non ST segment Elevation Myocardial Infarct (STEMI)

11.1.18 The discussions by system clinical and managerial leaders in relation to the audit findings were predominantly around making sure that patients get to the definitive treatment, first time whether that be Grantham Hospital or an alternative site. The acuity of the patient, using combined NEWS and the Frailty Scores, was agreed to be the way to accurately identify need.

11.1.19 There was also an agreed aspiration to reduce the number of intra hospital transfers to another site so demonstrating that the patient was getting to the definitive treatment site, first time. There was also acknowledgement that the number of transfers will never be a zero figure as some patients will deteriorate after admission; a declining figure should be the aim.

11.1.20 The conclusion drawn on NEWS and Frailty Scores, using the audit results and evidence, have been articulated into a clinical acuity model for the Grantham Hospital site.

Figure 148 – Grantham Hospital Clinical Acuity Model

Outline Assessment Criteria for Suitability for Grantham Hospital

For individuals assessed by a healthcare professional, including ambulance arrivals

- NEWS <7 would continue to be assessed and admitted to the site.
- NEWS ≥7 with a frailty score ≥5 (including admissions from nursing / care homes and housebound patients) to continue to be admitted to and assessed on the Grantham site as these patients would not normally be for escalation for intensive treatment.
- NEWS ≥7 but a frailty score of <5 (patients requiring escalation) – should go to the right site first time, or be transferred to an alternative site (i.e. Lincoln, Peterborough, Nottingham).

Where clinically and operationally appropriate patients will be given a choice about where they receive their care

For walk-ins

Staff in identified clinical teams at Grantham Hospital will retain the required skills to stabilise individuals who have deteriorated or who arrive as a walk-in and require emergency intervention prior to transfer. The admission criteria for Grantham is as detailed above, irrespective of arrival method; where clinically indicated, ambulance transfer to the most appropriate unit will be arranged.

11.1.21 Findings from the audit, that combined NEWS and Frailty Scores, were used to model and understand demand on services so new ways of working could be described. Taking the conclusions from the audit, demand was modelled through in terms of patient numbers, acuity and projected bed usage.

11.1.22 This was undertaken by analysing the non-elective medical admissions to Grantham Hospital from 2017/18 data across the following categories and the proportion of beds associated within each category at 92% occupancy:

- NEWS of ≥7 with any length of stay (LoS)
- NEWS 5-6 with any LoS
- NEWS ≤4 at 1 day LoS, 2-3 day LoS, 4-7 day LoS, >7 day LoS

11.1.23 Based on the clinical audit results and in consultation with the Grantham Clinical Summit members the following principles were proposed and agreed for acute medicine services at Grantham Hospital:

- Transfer to specialist site – A proportion of patients with higher acuity and lower frailty would transfer to a specialist site and this would be modelled using two scenarios at 50% and 25% transfers.
- Patients to remain at GDH – this would include the following:
  - A proportion of patients with higher acuity and high frailty modelled. These patients are not affected by the above scenarios
  - Lower acuity patients for the first 7 days of predominantly clinical need
- Alternative model of care would be developed for patient of lower acuity and longer LoS depending on social and clinical need i.e. > 8 days
- Alternative models of care would also be developed for lower acuity patients with 1-3 day LoS to avoid admission to hospital and enable assessment and discharge

11.1.24 Applying the above principles to the analysis, the demand for the various care settings was estimated. Two scenarios were modelled based on a proportion of patients that require escalation to a specialist site.

11.1.25 The second clinical audit on 17 August 2018 of 9 patients with >5 NEWS scoring suggested 3 patients of that cohort required escalation (33%) which is a good sense check however as the sample size is not significant two scenarios were developed:

- Scenario 1- 25% of patients with NEWS >5 are transferred to a specialist site and 75% remain at Grantham Hospital – assumed to be closest to reality and therefore the base case
- Scenario 2 – 50% of patients with NEWS >5 are transferred to a specialist site and 50% remain at Grantham Hospital

Figure 149 – Grantham Hospital demand modelling based on acuity model

Care Setting	Scenario 1	Scenario 2
Specialist site *Transfer to an alternative hospital site*	11%	21%
Beds run by community provider with predominantly clinical input *High Acuity beds*	60%	50%
Alternative model of care for low acuity longer LoS incl. rehab phase Lower Acuity beds	19%	19%
Admission avoidance / assessment	10%	10%
Total	**100%**	**100%**

1.2 Integrated community/acute beds provided at Grantham Hospital as part of an extension of the neighbourhood team

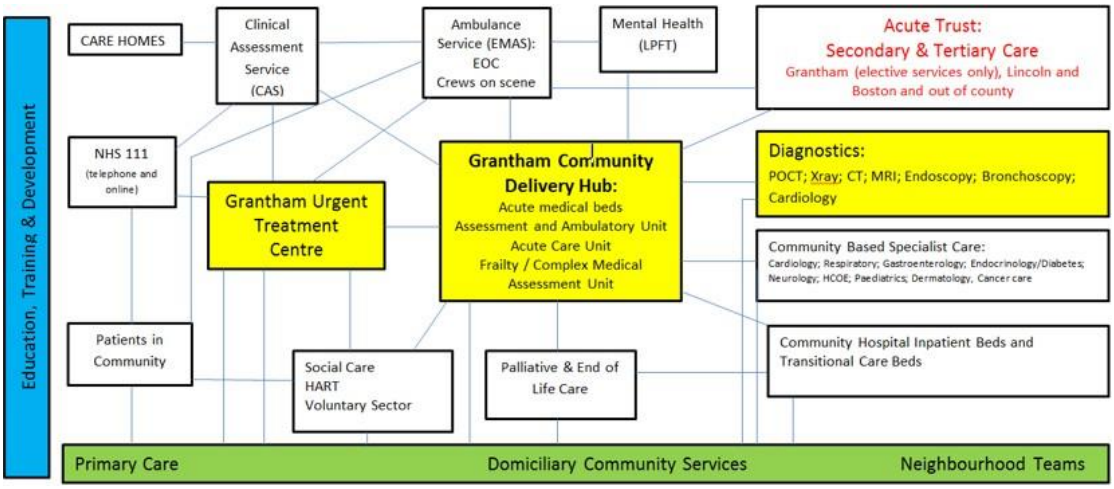
Overview

11.2.1 Through the ASR options appraisal process the preferred option identified for ULHT's acute medicine services was identified as the provision of integrated community/acute beds at Grantham Hospital as part of the neighbourhood team.

11.2.2 This innovative integrated community/acute model has been developed through extensive discussions by local clinicians, commissioners and provider organisations and reflects feedback received from the East Midlands Clinical Senate and takes into consideration feedback received during the various ASR public engagement activities.

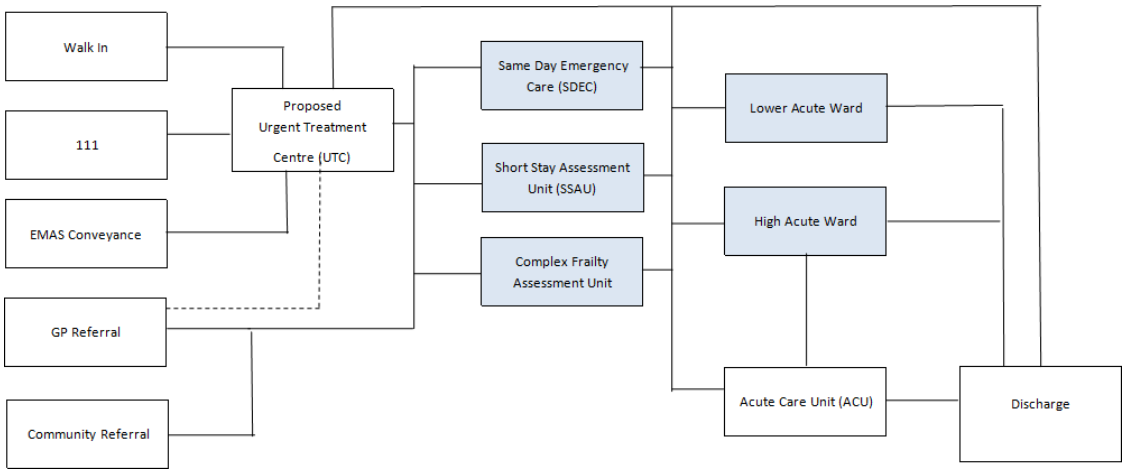
11.2.3 This model will see Grantham Hospital as a hub for supporting community teams and community services across the county, (including existing inpatient community hospital beds).

Figure 150 – Grantham Hospital's proposed acute medicine service within the wider system



11.2.4 The components of the proposed Grantham Hospital acute medicine service that underpin the community delivery hub are set out and described in the diagram below.

Figure 151 – Proposed Grantham Hospital acute medicine service



11.2.5 A description of each of the components of the proposed Grantham Hospital acute medicine service is set out in the table below.

Figure 152 – Proposed Grantham Hospital acute medicine service

Service	Provider	Description
Same Day Emergency Care (SDEC)	Community	Development in line with national directive to expand same day emergency care. Service would offer equivalent specification to that provided at Lincolnand Boston Hospitals. Service will be consultant-led with operating hours 08.00-20.00 7 days a week. This will replace the current Assessment and Ambulatory Care (AAC) service.
Complex Frailty Assessmen tService	Community	This will be an integrated model offering urgent and elective assessment, careand treatment from a multi-disciplinary team, including community-based careteams. Consultant oversight will be provided and provision will primarily be from the SDEC although it can be facilitated across the proposed Urgent Treatment Centre and into inpatient areas. Enhanced Assertive in-reach provision will be provided. Services operating hours will be 10am – 8pm, with an agreed 'cut-off' point earlier in the day for new admissions. The service will enable an integrated frailty service at the front door.
Short Stay Assessmen tUnit (SSAU)	Community	Care delivery model will be as per provision through the current Emergency Assessment Unit (EAU). Provision will transition to a community-provided service. This inpatient unit will offer initial assessment and care planning and short-stay (up to 72 hours) higher acuity care. The service will be consultant-led with frequent ward rounds.
Medical Wards - **High Acuity** - **Lower Acuity**	Community	A mixture of beds will be provided offering high and lower acuity. *High Acuity Beds* These will be consultant-led offering specialist care under a variety of specialties. Care will be provided following transition from EAU, step-down from ACU or step-up from lower acuity beds. Patients will be allocated under the care of the most appropriate consultant to support their needs, for example respiratory. Other specialities will support either on-site or remotely as required. This model offers greater flexibility in care provision and drives a more holistic approach to care. *Lower Acuity Beds* These will be nursing and therapy-led providing step-up from community services and step-down from higher acuity beds (at Grantham Hospital and other sites). They will also provide inpatient rehabilitation. *Overnight Medical Consultant Cover* The long-term vision is to support overnight medical consultant cover remotely facilitated by telemedicine, moved to with transitional arrangements
Acute CareUnit	Acute	This service is currently provided at Grantham Hospital and will continue. It is run by an acute provider, consultant-led and offers care for the highest acuitypatients at Grantham Hospital, primarily for post-surgical patients. The unit additionally supports medical inpatients requiring escalation via joint care.

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

Quality

11.2.7 The most significant quality benefit of the preferred option for acute medicine, as articulated by the East Midlands Clinical Senate during the review process, is it provides an *'excellent balance between access and sustainable long term outcomes'*.

11.2.8 The proposed model is ambitious in design, and will see more activity moving from a traditional acute setting into a community-led, integrated service in line with the Lincolnshire Integrated Care System (ICS) plans and supporting a greater number of individuals in receiving their care closer to home.

11.2.9 The proposal enables Grantham Hospital to offer services which may not be offered elsewhere and build a centre of excellence for integrated multi-disciplinary care, particularly for frail patients. This will offer some the opportunity to receive care at Grantham Hospital where this is not possible presently, expanding the geographic catchment for some services.

11.2.10 This new model offers a more comprehensive service provision for Grantham Hospital than currently provided, further reducing pressure on the acute sites at Lincoln and Boston (and those out of county) and enhancing the provision of community-based services, not just locally but across Lincolnshire.

11.2.11 This model will see Grantham Hospital as a hub for supporting community teams and community services across the county (including existing inpatient community hospital beds), reducing acute medicine admissions not just at Grantham Hospital but potentially across the county. This approach is very much in line with the feedback received from the public during the public engagement events.

11.2.12 The proposal sees a continuation of consultant specialists in acute medicine, general medicine, respiratory medicine and health care for the elderly based on-site at Grantham and providing support to the new model.

11.2.13 For other specialties, joint working between ULHT (or other acute providers, particularly for tertiary services) and community providers will facilitate specialist input; telemedicine facilities would support these interactions in the longer term.

11.2.14 The Same Day Emergency Care (SDEC) unit will offer an expansion of the current Ambulatory Assessment Unit (AAU), which is to be re-named in line with the national shift to 'Same Day Emergency Care'. The unit would receive referrals directly from the UTC, EMAS and primary / community care teams. The SDEC unit will be led by an Acute Physician team.

11.2.15 The new Complex Frailty Service will offer specialist care and support for elderly and frail patients, including those with complex needs. The team will offer a day assessment and care service, supporting frail/complex patients who require diagnostics, multi-disciplinary assessment, medical review, therapy and social service assessments. Patients referred electively to the team would have transport arranged to enable them to arrive in a timely manner at the start of the working day and have all the necessary assessments and interventions carried out before returning home at the end of the day. The service will also support an 'integrated frailty service at the front door approach'.

11.2.16 The Short Stay Assessment Unit (SSAU) would continue to provide the same function as the current Emergency Assessment Unit (EAU) offering short-stay spells for initial assessment and treatment for patients admitted through the UTC, and SDEC (where care cannot transition directly to the acute medical wards). The unit will be staffed by acute medicine physicians, supported by a team of medical trainees, ACPs and other healthcare professionals.

11.2.17 The SSAU would provide care for patients who meet the criteria for admission to Grantham and require a higher level of monitoring and/or care than can be provided on the medical ward.

11.2.18 Beds on the acute medical wards will be a mixture of high acuity and lower acuity, provided on a generic basis supported by medicine for the elderly, respiratory and other specialists. Patients will be allocated to the consultant with the most appropriate skills to meet the patient's medical needs.

11.2.19 There is no current intention to reduce the beds available on the site for medical inpatients. Retaining current provision is essential to supporting stabilisation of the wider system. However, ensuring only those that require an admission and reducing length of stay and delayed transfers of care will be a priority, thereby supporting a greater patient cohort.

11.2.20 Beds will additionally support current community hospital pathways, which are lacking within the south-western Lincolnshire geography.

11.2.21 The Acute Care Unit (ACU) would continue to be run by an acute provider, offering care for the highest acuity patients at Grantham Hospital. This consultant-led unit would be primarily for post-surgical patients, the unit would additionally support medical patients requiring escalation.

11.2.22 The implementation of the proposed model and development of a fully-integrated service at Grantham Hospital additionally offers opportunities to improve care across Lincolnshire, through the introduction of a number of consultant posts to the community provider structure and improved links with acute consultant teams.

11.2.23 Grantham Hospital will assume a new function as a community services hub for the county. In addition to overseeing pathways for outpatient and inpatient care at Grantham Hospital, the community-employed consultant team will support community-based specialist nursing teams, community hospital ward teams (at Skegness, Louth, Gainsborough and Spalding) and integrated neighbourhood teams across Lincolnshire. This new and innovative function will bring specialist knowledge and capability for care delivery directly into communities, with the following expected benefits:

- Improved community-based management of Long Term Conditions
- Reduced acute hospital admissions and length of stay
- Improved utilisation of community hospital bed resource
- Reduced length of stay in community hospital beds
- Improved accessibility to specialist advice for primary care and community-based teams
- Greater consistency in quality and delivery of care across all communities
- Opportunities for upskilling of specialist nursing teams

11.2.24 There is scope in particular to develop community respiratory services and community diabetes services, as well as enhancing the support offered to the frail elderly population.

11.2.25 This community function is expected to be delivered remotely, though potential for rotational posts for a variety of staff groups would facilitate positive working relationships between colleagues. It is expected that telemedicine (and technology generally) will support delivery, offering potential for video consultations and ensuring shared access to records.

11.2.26 As community-based and integrated care models are developed across the NHS, this innovative function will put Lincolnshire in a position to attract a high quality workforce into the future and to build further on current medical, nursing and AHP training provision within the county.

11.2.27 This new innovative model will also 'uncouple' ULHT from direct provision of non-elective care on the Grantham site so 'protecting' elective services from non-elective admissions at times of surge. ULHT becomes a key supporting partner for non-elective admissions.

Access

11.2.28 Grantham Hospital currently has 3,919 (2019/20) acute medicine admissions (3,858 non-elective and 61 elective) a year, plus a further 2,954 acute medicine day cases. These patients largely come from Grantham and the surrounding area. This is forecast to grow to 4,025 acute medicine admissions by 2023/24 (3,963 non-elective and 62 elective) plus a further 3,034 acute medicine day cases.

11.2.29 Once the preferred option to establish an integrated community/acute inpatient model for acute medicine at Grantham Hospital is fully implemented, c.385 patients per year (c.10% of current non-elective inpatient admissions) currently seen at Grantham Hospital would be displaced (based on 2019/20 activity). This displacement is due to their care needs being better met in a more specialised service at an alternative hospital – these are the patients identified in the audit of acuity of patients in Grantham Hospital medical beds as having higher acuity and lower frailty.

11.2.30 Under the proposal it is estimated that no more patients than currently do now will be travelling over 60 minutes for non-elective care, the travel time threshold set by the local health system for activity of this type. This is based on the assumption they travel to their nearest appropriate hospital by car and against a baseline of c.2,000 patients across Lincolnshire who currently travel more than 60 minutes to attend acute medicine services based on the assumption they travel by car.

11.2.31 However, in reality given the existing exclusion criteria and current usage of the Grantham Hospital site many of the patients who would no longer attend Grantham Hospital would actually travel by ambulance and therefore their travel time would likely to be less than 60 minutes.

11.2.32 Approximately 40% (c.150) of the patients would attend Lincoln Hospital and the others would attend hospitals out of county, with the majority going to North West Anglia NHS Foundation Trust (55%, c.210) followed by Nottingham University Hospitals NHS Trust (5%, c.25).

11.2.33 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).

11.2.34 This includes a sensitivity analysis relating to the number of patients that would transfer to a specialist site based on the scenarios defined in the Grantham Clinical Summit audit (set out in the case for change section above).

Figure 153 – Estimate of displaced Grantham Hospital acute medicine activity and impact on travel times

	Grantham Hospital		LincolnHospital		Out of county hospital	
	19/20	23/24	19/20	23/24	19/20	23/24
Base Case: Scenario 1 - 25% of patients with NEWS ≥5 are transferred to a specialist site (equivalent to 10% of overall activity)						
Acute Medicine Activity	-385	-396	149	153	236*	243*
Travelling +60 mins.	0	0	0	0	0	0
Sensitivity: Scenario 2 - 50% of patients with NEWS ≥5 are transferred to a specialist site (equivalent to 20% of overall activity)						
Acute Medicine Activity	-770	-792	298	306	472	486
Travelling +60 mins.	0	0	0	0	0	0

** (19/20 c.210 to NWAFT & c.25 to NUH; 23/24 c.220 to North West Anglia NHS FT, c.25 to Nottingham University Hospitals NHS Trust)*

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

11.2.36 However, it is not widely understood by the public that an exclusion criterion has successfully existed for some time (since 2007/08) for the Grantham Hospital site to ensure the care it provides aligns to its size and 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 (as described in the Preferred Option - Urgent and emergency care chapter).

11.2.37 In addition, under the current model, when necessary patients are transferred from Grantham Hospital to Lincoln Hospital to ensure they receive the clinical input they need, although numbers are comparatively small.

11.2.38 Under the proposed model of an integrated community/acute medicine model the exclusion criterion for Grantham Hospital would be refined, meaning a relatively small number of patients currently admitted to acute medicine services, would not be in the future. This would mean more patients going to the right place for care first time and minimising subsequent transfers.

11.2.39 However, it should also be noted the proposed model offers a more comprehensive service provision for Grantham and the surrounding areas and this will offer some the opportunity to receive care at Grantham Hospital where this is not currently possible. This is particularly true for the frail elderly population and aligns to the feedback and suggestions from the public engagement events.

11.2.40 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.

11.2.41 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.

11.2.42 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 if 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

11.2.43 Acute medicine is currently provided from three wards on the Grantham hospital site that have a combined capacity of 79 beds:

- Emergency Assessment Unit - 28 beds (19/20 non-elective av. length of stay = 2.8)
- Ward 1 - 28 beds (19/20 non-elective av. length of stay = 7.1)
- Ward 6 - 23 beds (19/20 non-elective av. length of stay = 5.6)

11.2.44 Based on the current activity levels and the current average lengths of stay across the wards the required bed capacity for acute medicine at Grantham hospital is estimated to be 73 beds, based on a 92% occupancy.

11.2.45 Of these it is estimated 63 are used for non-elective admissions and 10 for elective admissions and day cases. Based on the findings from the audit conducted as part of the Grantham Clinical Summit it is estimated the non-elective beds broadly split 2:1 high acuity to low acuity, so 42 high acuity and 21 lower acuity.

11.2.46 It is estimated that if the clinical model stayed as it currently is, based on ONS population based projections the required acute medicine bed capacity at Grantham Hospital would increase by 2 beds to 2023/24 based on a 92% occupancy rate.

11.2.47 However, under the proposed integrated/acute bed model it is estimated that c.10% of the current admissions will be cared for in a more specialist unit – Scenario 1 from the bed audit conducted. This would require a future bed requirement of 69 beds by 2023/24, which is comfortably within the current acute medicine bed capacity at Grantham Hospital.

11.2.48 This modelled base case scenario for the required acute medicine bed capacity at the Grantham Hospital site is believed to be a prudent one. Two sensitivity tests have been applied both of which result in a reduced medical bed requirement at Grantham Hospital:

- Within the current care model it is generally accepted that there is an opportunity for admission avoidance and length of stay improvements across the non-elective acute medicine admissions. This is supported by the findings of the clinical audit that identified 10% of patients audited could have had their admission avoided. This opportunity should be easier to realise given the integrated acute/community model and is a key focus of the Integrated Community Care (ICC) clinical model 'left shift'; and

- If Scenario 2 from the bed audit is modelled, i.e. 50% of patients with a NEWS ≥5 transferred to specialist site (equals c.20% reduction), then fewer beds are required on the Grantham Hospital Site.

11.2.49 This bed capacity analysis is set out in the table below.

Figure 154 – Estimated future acute medicine bed requirement analysis

Grantham acute medicine bed requirement under preferred option	Non-Elective		Elective		Day Case		Total	
	19/20	23/24	19/20	23/24	19/20	23/24	19/20	23/24
ONS based population projection								
Admissions	3,858	3,963	61	62	2,954	3,034	**6,873**	**7,059**
Acute medicine beds	63	65	1	1	9	9	**73**	**75**
High Acuity Beds	42	43						
Lower Acuity Beds	21	22						
Basecase: ONS growth & 25% with NEWS ≥5 transferred to specialist site (equals 10% reduction)								
Admissions	3,858	3,566	61	62	2,954	3,034	**6,873**	**6,662**
Acute medicine beds	63	59	1	1	9	9	**73**	**69**
High Acuity Beds	42	40						
Lower Acuity Beds	21	19						
Sensitivity 1: Basecase PLUS 10% admission avoidance / early discharge								
Admissions	3,858	3,170	61	62	2,954	3,034	**6,873**	**6,266**
Acute medicine beds	63	52	1	1	9	9	**73**	**62**
High Acuity Beds	42	35						
Low Acuity Beds	21	17						
Sensitivity 2: ONS growth & 50% with NEWS ≥5 transferred to specialist site (equals 20% reduction)								
Admissions	3,858	3,170	61	62	2,954	3,034	**6,873**	**6,266**
Acute medicine beds	63	52	1	1	9	9	**73**	**62**
High Acuity Beds	42	35						
Lower Acuity Beds	21	17						

11.2.50 Recruitment and retention of medical staff has been a long-standing concern for ULHT, although Grantham Hospital has not had as many issues as Lincoln and Pilgrim Hospitals. At Grantham Hospital the majority of consultant posts are held by permanent Trust employees offering a consistency of service and training provision. Though there has been an increase in agency cover for some specialties more recently.

11.2.51 A key specific issue relating to Grantham Hospital is the sustainability of the acute medicine service as it has a selected medical 'take' (exclusion criteria) with low volumes compared to the other two ULHT sites.

11.2.52 The move to a more generic provision of beds and therefore no longer having defined cardiology and gastroenterology inpatient beds on the Grantham Hospital site will mean amendments to the medical staffing structure will need to be made to support the proposed acute medicine model.

11.2.53 However, in practice a large proportion of the work carried out by this cohort of doctors is within the outpatient environment and so the impact is manageable. Given the focus on outpatient provision by these specialties at Grantham Hospital the cardiology and gastroenterology medical teams will remain under ULHT going forward.

11.2.54 Consultant-led provision will be maintained for the relevant specialties of acute medicine, respiratory medicine, and health care for the elderly, and those currently ULHT employed consultants providing these specialties on the Grantham site will be offered the opportunity to transition their employment to the new community provider. Arrangements for specialist provision outside of these specialties to provide advice and support would be discussed and agreed with the acute provider.

11.2.55 The middle grades, currently attached to these consultants would continue to support them and provide care as they currently do and would also be offered the opportunity to transition their employment to the new community provider. Core trainees and foundation doctors would remain part of ULHT to support required training needs, however stay aligned to the service as they currently are.

11.2.56 To support the middle grade rota the cardiology and gastroenterology middle grades currently supporting acute medicine would need to be replaced, likely with respiratory and health care for elderly medicine middle grade doctors. Cardiology and gastroenterology foundation doctors/trainees currently supporting acute medicine would be replaced, including by GP VTS, IMT and ACPs.

11.2.57 ULHT and the community provider would work together closely to establish the employment arrangements for the consultants and middle grades ensuring due consideration is given to the cover provided to the relevant rotas of each organisation and training requirements are appropriately met.

11.2.58 Consultant roles will vary to those in place at present as they will offer their specialist leadership for management of individuals within other community hospitals and residences across Lincolnshire, for example managing an exacerbation of a long term condition for an individual in a community setting, or offering education and guidance to nursing teams in community hospitals to improve quality of care delivery or alleviate the need for escalation into an acute bed.

11.2.59 The proposed integrated care model will introduce exposure to community-based services for the medical teams, particularly trainee roles, developing new specialists for the future with a more detailed understanding of the capabilities of community teams and the growing capacity for higher acuity care in the community. These posts would be ideal for GP trainees

11.2.60 The Complex Frailty Service will offer a further new function for the development of consultant (and junior) staff delivering the new model. Greater collaboration with the local Neighbourhood Teams and primary care colleagues will additionally be built into the delivery, with a shift in culture compared to current ‘acute’ care provision to a holistic approach, facilitated and delivered by a multi-disciplinary team.

11.2.61 The table below sets out the current acute medicine workforce (funded establishment) model at Grantham Hospital together with the workforce model developed for planning purposes under the proposed preferred option. The workforce model for the preferred option will be subject to ongoing review and refinement once the service is fully operational.

Figure 155 – Acute medicine workforce model (funded establishment)

Staff Group	Current configuration (wte)	Preferred Option (wte)*
Medical		
General / Acute Medicine		
• Consultants	3.0	3.0
• Middle/Trust Grade	2.0	2.0
• Foundation/Trainee	6.0	6.0
Respiratory		
• Consultants	2.0	2.0
• Middle/Trust Grade	1.0	1.0
• Foundation/Trainee	3.0	3.0
Health Care for Elderly		
• Consultants	2.0	2.0
• Middle/Trust Grade	2.0	2.0
• Foundation/Trainee	2.0	2.0
		PLUS
Gastroenterology	Majority of care provided in OP setting	• 1.0 additional consultant (to give a total of 8**)
• Consultants	3.0	• 3.0 additional middle grades, likely in respiratory medicine and medicine of elderly (to give a total of 8)
• Middle/Trust Grade	2.0	
• Foundation/Trainee	2.0	• Gastro and Cardiology Foundation/Trainee to be replaced including by GP VTS, IMP and ACPs
Cardiology		
• Consultants	2.0	
• Middle/Trust Grade	1.0	
• Foundation/Trainee	4.0	
Admin	14.0	14.0
Nursing (SDEC / Frailty Service / Ward)		
• Registered	49.0	49.0
• Nursing Associate	7.5	7.5
• Non Registered	37.5	37.5
• Ward Clark	5.5	5.5

**Planning assumptions: All subject to review and change once service is fully operational – optimal nursing skill-mix will be refined over time once service is fully operational to ensure alignment with patient need*
*** In line with the innovative acute/community model consideration will be given to one of the consultants being a non-medical consultant.*

11.2.62 Medical consultant on-call on site availability would initially be 24/7, however the ultimate vision is to retain medical consultant on site availability until midnight (possibly reducing to 10pm) and to transition to medical consultant cover being provided remotely from Lincoln or Pilgrim Hospital after this time, facilitated by telemedicine.

11.2.63 Overnight consultant on-call cover would only move to these arrangements once it has been demonstrated that this was a suitable model in terms of meeting patients' needs and there is no impact on training (working with Health Education England). This would be reviewed on a six monthly basis.

11.2.64 With a shift to a more holistic approach to care provision and the move to more generic inpatient provision, it is anticipated the consultants in the team will also have a specialist interest (one of which should cover diabetes).

11.2.65 For example, the consultant with a diabetes interest would play a valuable part in the new integrated diabetes pathway which has recently been agreed for roll-out across Lincolnshire by spring 2021.

11.2.66 The Health Care for the Elderly team will support inpatient, ambulatory and outpatient services. The team will be essential in leading an integrated community service, to include the delivery of the new Complex Frailty Service, the acute medical beds, neighbourhood teams and providing remote advice and support to community teams and hospitals across the county. This team will be pivotal in ensuring that individuals are able to be supported back to their own 'home' as quickly as possible, receiving ongoing support without the need for extended inpatient stays.

11.2.67 The retention of respiratory physicians is essential to support both inpatient and outpatient services. A large proportion of the acute patients have respiratory problems necessitating the continued provision of respiratory teams on the Grantham Hospital site.

11.2.68 Respiratory consultants would also support community respiratory teams across the county providing advice to the specialist respiratory teams and to prevent admissions to hospitals across the county.

11.2.69 Trainee roles offer significant value to the medical establishment, both financially and in terms of care delivery. With the exception of the withdrawal of cardiology and gastroenterology trainee posts, there are no plans at present to further reduce training posts at Grantham as part of the transition to the new model; indeed, it is hoped that improved opportunities for training support at Grantham could be offered.

11.2.70 As medical trainees proceed through their training pathways, posts must offer exposure to education and development opportunities. Trainees will be seeking opportunities to 'tick off' specific criteria defined within their training programme and future posts at Grantham will be need to offer clarity to applicants as to the value which can be added to their development pathway.

11.2.71 The CCG Clinical Lead, LCHS Medical Director, the medical team at Grantham and UHLT's medical training leads, are in discussion with Health Education England (HEE) with regards to the anticipated delivery of care in the future and the opportunities which will be available to trainees under the proposed model.

11.2.72 Discussions with HEE to date have been positive; there is an acknowledgement that the structures for specialist roles will develop over time as models of integrated care develop across the country, with a greater emphasis on holistic management and consideration of the functions of care which can be safely managed within an individual's own residence.

11.2.73 The placement of trainees for specialty roles within a community-based Trust will offer a variety of new experiences which may not currently be available. In addition to the hospital-based functions, we would expect the new provider to work alongside system colleagues to offer trainees opportunities to experience integrated urgent care and community-based care delivery (for example, the Clinical Assessment Service, or Neighbourhood MDTs). In the medium to long term, telemedicine delivery will additionally be a key function of training opportunity with the consultants' responsibilities for supporting community hospitals and community-based specialty teams (e.g. Respiratory).

11.2.74 In addition to the opportunities for speciality trainees, General Practice training opportunities are being discussed. There are not currently any GP trainees based out of Grantham's medicine services, though there are a small number of posts offered across ULHT sites. Medical teams from both Primary Care services locally and Lincolnshire Community Health Services (LCHS) consider that there could be scope for the provision of integrated trainee posts within the proposed Grantham model. The CCG are in contact with the local GP Training facility and are working alongside the ULHT training teams and appropriate GP training locations to explore these opportunities further, and Health Education England have approved four GP trainees from August 2020.

11.2.75 The current Advanced Nurse Practitioner team at Grantham Hospital provide a rotational service within A&E, ambulatory care and the emergency assessment unit. The team of four individuals work alongside the medical teams, offering support in the assessment, diagnosis and treatment of patients within their scope of work.

11.2.76 The expectation for the new model is that existing provision will be extended, offering a number of benefits:

- Roles integrated into community provision, supporting working across both a community base and hospital units / wards.
- Reducing medical workload and reliance. Supporting any gaps in junior medical staffing / medical trainees within the new model.
- Increased consistency in service provision.
- Specialist knowledge across a range of disciplines, offering high level intervention in non-medical areas, for example frailty specialist therapy assessment and care planning.

11.2.77 The volume and specialism of roles required will be reviewed as part of the overall workforce structure for the new model, taking into consideration the outcome of ongoing discussion with regards to medical trainees.

11.2.78 The development of rotational posts within the workforce model will be a key variation to the current model of care and will reinforce the integration between community-based and hospital-based service provision. Such opportunities for staff will facilitate the breaking down of the existing barriers in understanding of individual and service capability between acute and community care, which are so often cited as reasons for extended hospital stays due to 'risk' of discharge.

11.2.79 All staff groups will be encouraged to utilise opportunities to experience a variety of services and working environments to build a more detailed knowledge of the structure and capability of services within the locality (Grantham and Sleaford PCN / neighbourhood areas).

11.2.80 For medical trainees, whether specialist or general practice routes, the rotations will offer experience of the developing intermediate and urgent care provision, for example Clinical Assessment Service. There could additionally be opportunities for shared rotational posts with acute hospital sites (potentially both in and out of county). Should GP training posts be secured, these placements could offer rotation into General Practice, including new services as they develop within the local PCNs.

11.2.81 The combination of community and hospital experience which could be offered has great potential for newly training GPs, but also for doctors planning a career in hospital medicine, wanting a rural bias.

1.3 East Midlands Clinical Senate recommendations and workforce improvements

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

11.3.2 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.

11.3.3 Through this review the East Midlands Clinical Senate supported the proposal for Acute Medicine and made no further recommendations.

1.4 Quality and Equality Impact Assessments

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

11.4.2 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.

11.4.3 A summary of the QIA for the proposed changes to acute medicine is set out below and the full version is included in Appendix I.

Figure 156 – Summary of QIA for proposed acute medicine service changes

Area	Summary Impact(+ve & -ve)	Summary Actions
1.Quality		
Duty of Quality	▪ Will not effect the rights and pledges of the NHS Constitution. ▪ Will not effect the organisation's commitment to being an employer of choice. ▪ EIA completed.	
Patient Safety	▪ All patients cared for in most appropriate setting for needs. ▪ Integrated community/acute provision that safely meets patient's clinical needs and maintain access. ▪ Ambulatory and bed based care that meets patient's acuity. ▪ Shared integrated response on the site to deteriorating patients. ▪ Frailty expertise is fully developed in the local teams. ▪ Development of an integrated community/acute provision that safely meets patient's clinical needs and maintains access locally should address workforce challenges.	▪ Implementation needs to be completed through a sequence of changes to clinical practice and the workforce. ▪ Exclusion Criteria for site reviewed and implemented to ensure those people with high acuity and life threatening illness and injury go more specialist site first time to receive treatment ▪ Ongoing refinement of workforce model
2. Experience		
Patient Experience	▪ Highly likely new model will be able to meet the needs of a significant majority of patients, locally. For the small cohort of patients who will receive care further away this will be provided by a facility most appropriate to their needs. ▪ 'Uncouples' ULHT from direct provision of non-elective care on Grantham site so 'protects' elective services from non-elective admissions at time of surge. ▪ Integrated community/acute provision will allow for a service that safely meets patients' clinical needs and maintains access locally.	▪ Monitor performance ▪ Joint planning with Neighbourhood Integrated Care Team
Staff Experience	▪ Will support pressure currently experienced by ULHT with regards to significant workforce challenges in acute medicine ▪ Greater role for advanced clinical practitioners and physician posts	▪ Work with Health Education England on recruitment/new roles ▪ Ongoing monitoring of staff surveys ▪ Consultation with staff
3. Effectiveness		
Clinical Effectiveness & Outcomes	▪ Integrated community/acute model based on research, evidence and significant clinical engagement ▪ Greater integration between hospital and Neighbourhood Integrated Care Teams ▪ 'Uncoupling' ULHT from direct provision of non-elective care will enable elective admissions to be protected ▪ Current model has 'selected' medical take with low volumes, which creates sustainability challenges ▪ New care pathways developed for care of patients that better integrate care between acute and community setting ▪ Support improvements against constitutional standards	▪ Monitor clinical outcomes ▪ Joint planning with Neighbourhood Integrated Care Team

11.4.4 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.

11.4.5 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.

11.4.6 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.

11.4.7 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.

11.4.8 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.

11.4.9 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.

11.4.10 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.

11.4.11 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.

11.4.12 As well as a QIA, a Stage 1 and Stage 2 Equality Impact Assessments (EIA) has also been completed for the proposed acute medicine service changes.

11.4.13 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 and Economically Disadvantaged

11.4.14 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.

11.4.15 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.

11.4.16 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.

11.4.17 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.

11.4.18 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 impact on 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 public transport, which is perceived to be limited in accessibility; additional cost
- Economic Disadvantaged:
    - The specific engagement from The People's Partnership did not receive feedback from 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 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.

11.4.19 A summary of the EIA for the proposed changes to acute medicine services is set out below and the full version is included in Appendix J.

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

11.4.21 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 157 – Summary of EIA for proposed acute medicine 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.385 patients per year who are currently admitted to Grantham Acute Medicine beds will be displaced to an alternative site.
	• This is equivalent to c10% of the current activity, and the displacement is due to their care needs being better met in a more specialised service at an alternative hospital.
	• Under the proposed changes it is estimated that there will be no increase in the number of patients travelling more than 60 minutes by car, the threshold agreed for this type of activity
		• No. For some patients there may be longer travel times, but this is balanced against ensuring those patients receive treatment in the right place first time.

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

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

1.5 Vignettes to demonstrate the positive impacts of the clinical model

Patient 1

11.5.1 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.

11.5.2 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.

11.5.3 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.

11.5.4 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 2

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

11.5.6 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.

11.5.7 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.

11.5.8 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: These vignettes are also included in the Urgent and Emergency Care (UEC) chapter (Chapter 10) given the proposals for UEC and Acute Medicine at Grantham Hospital reflect a full integrated pathway.

1.6 Assessment against tests for service change

11.6.1 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.

11.6.2 An assessment against these tests for the proposed changes to Acute Medicine provision has been conducted and is set out below. This assessment reflects and aligns to the description and narrative for the preferred option for acute medicine services set out in this chapter.

Test 1: Strong public and patient engagement

11.6.3 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 acute medicine.

11.6.4 During July 2018 a series of nine engagement events to discuss hospital services in Lincolnshire were held, each in a different area in 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. In relation to urgent and emergency care and acute medicine the focus of the conversations were very much on urgent and emergency care service provision rather than acute medicine beds.

11.6.5 In October 2018 four public options evaluation workshops were undertaken across Lincolnshire in Sleaford, Mablethorpe, Bourne and Gainsborough to enable member 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.

11.6.6 At these events the potential options for the future provision of acute medicine services were considered, these being no provision of acute medicine beds at Grantham Hospital and the provision of integrated community/acute beds at Grantham Hospital.

- Overall, the vast majority (81%) of stakeholders thought the provision of integrated community/acute beds at Grantham Hospital satisfied the evaluation criteria significantly or somewhat better than the proposal to have no acute medical beds at Grantham Hospital.
- Only 11% of attendees thought that the proposal to have no acute medicine beds at Grantham Hospital better satisfied the criteria, and 8% reported they felt both proposals satisfied the criteria equally well.
- The provision of integrated community/acute beds at Grantham Hospital was felt best to satisfy all criteria, particularly; quality - 91%, access - 80% and affordability - 89%.
- There was little interest from participants discussing there being no provision of acute medicine beds on the Grantham Hospital site. They were much more focused on the feasibility of the integrated/community acute beds.
- The integrated community/acute beds proposal was considered beneficial in supporting better care pathways so long as an integrated, joined up network of services is created to enable satisfactory patient flow.

11.6.7 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 options in the ASR:

- In relation to acute medicine services care services, and specifically relating to Grantham Hospital, key themes related to:
    - Concerns around distance and accessibility, poor public transport and access and hardship to patients or family who cannot afford the travel costs
    - Needing to keep medical treatment local and easy to access, train staff in-house and more beds/staff needed at Grantham Hospital
    - Acute beds might take pressure of Pilgrim and Lincoln Hospitals and keeping as many services in Grantham as possible is important
- Feedback from a workshop held in Grantham relating to acute medicine services highlighted themes relating to:
    - 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’.

- 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 to proposed centres of excellence, such as for stroke services, and the associated increase in cost. This 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.

11.6.8 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 acute medicine on 18 September 2019 and submitted initial comments on the 24 October 2019.

11.6.9 These were:

- Initial preference for integrated community/acute bed model as a means of stabilising Grantham Hospital
- Welcome the involvement of local clinicians in development of options
- Different way of working by all staff involved
- Concern on availability of funding for integrated community/acute model, should it be required
- Medical admission to Grantham Hospital should continue on a 24/7 basis
- Plans for staff to be integrated, supporting both medical beds and urgent care noted
- Expectation for greater scope for children with more acute needs seen at Grantham
- More detail on how the integrated community/acute model would work in practice

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

11.6.10 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.

11.6.11 The guidance goes on to 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.

11.6.12 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 acute medicine service model for Grantham Hospital.

11.6.13 Implementing the preferred option for acute medicine will not reduce the number of hospital sites from which acute medicine is provided from (the number of providers is not reducing under the change proposals). However, for a small number of patients (c.385 patients per year) with higher acuity needs they will receive care specialist treatment elsewhere.

11.6.14 It should also be noted that the under this proposed model Grantham Hospital will be able to support a larger proportion of frail and elderly patients from the geographic area to receive inpatient care at Grantham.

Test 3: Clear clinical evidence base

11.6.15 The case for change and proposals for the future configuration of acute medicine were tested through two ASR programme Clinical Summits with over 55 leads from across the system, facilitated by the East Midlands Clinical Senate.

11.6.16 Subsequent to the ASR programme Clinical Summits and their initial outputs and conclusions a Grantham Clinical Summit was convened to specifically look at the provision of acute medicine services at Grantham Hospital. The clinical summit took place on 10 August 2018 followed by subsequent meetings and telephone conferences.

11.6.17 The summit comprised professionals from both acute and primary care including the Clinical Chair for South West Lincolnshire CCG, local GP lead, Medical Director for Lincolnshire Community Health Services NHS Trust, Medical Director of ULHT, Associate Medical Director ULHT, Consultant Nurse Cardiology/Associate Chief Nurse ULHT and Transformation Lead EMAS. In addition, external independent clinical expertise was provided by Dr Jay Banjeree Consultant in Geriatric Emergency Medicine at University Hospitals of Leicester NHS Trust and Chair of the Royal College of Emergency Medicine SIG in Geriatric Emergency Medicine.

11.6.18 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 conversation on acute medicine at this event was led by the Clinical Chair of South West Lincolnshire CCG who was instrumental in the Grantham Clinical Summit.

11.6.19 At this options appraisal event overall 85% of participants thought the proposal to provide integrated acute/community beds at Grantham Hospital satisfied the evaluation significantly better or somewhat better than no medical beds at Grantham Hospital. There was a strong preference across all criteria.

11.6.20 The presentation of the preferred option for acute medicine services to the East Midlands Clinical Senate was led by the clinicians who had led the Grantham Clinical Summit. Two presentations were given to the East Midlands Clinical Senate on the proposals, following the second presentation the clinical senate panel confirmed they were left with the impression that all system partners are engaged and cohesive with a clear vision for the future of medicine for Grantham Hospital.

11.6.21 The East Midlands Clinical Senate panel described the proposal as innovative and achieved an excellent balance between access and sustainable long term outcomes.

Test 4: Support for proposals from clinical commissioners

11.6.22 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.

11.6.23 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 care and acute care will continue into the public consultation meetings.

11.6.24 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.

11.6.25 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.

11.6.26 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

11.6.27 Acute medicine is currently provided from three wards on the Grantham Hospital site that have a combined capacity of 79 beds

11.6.28 Based on the current activity levels (19/20) and the current average lengths of stay across the wards the required bed capacity for acute medicine (elective and non-elective) at Grantham hospital is estimated to be 73 beds, based on a 92% occupancy.

11.6.29 Of these it is estimated 63 are used for non-elective admissions and 10 for elective admissions and day cases.

11.6.30 It is estimated that if the clinical model stayed as it currently is, based on ONS population based projections the required acute medicine bed capacity at Grantham Hospital would increase by 2 beds by 2023/24 based on a 92% occupancy rate.

11.6.31 However, under the proposed integrated/acute bed model it is estimated that 10% of the current admissions will be cared for in a more specialist unit. This would require a future bed requirement of 69 beds by 2023/24, which is comfortably within the current acute medicine bed capacity at Grantham Hospital.

This page is intentionally left blank