Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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Open Report on behalf of United Lincolnshire Hospitals NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**16 February 2022**
Subject:	**United Lincolnshire Hospitals NHS Trust – Reconfiguration of Urology Services Update**

Summary:

Since 9 August 2021, United Lincolnshire Hospitals NHS Trust has been operating a reconfigured urology service, whereby Lincoln County Hospital is due to receive all emergency urology admissions seven days per week (instead of both Lincoln and Pilgrim Hospital, as previously). The aim is to better manage elective urology procedures and reduce cancellations, which would in turn increase capacity and support the recovery of services post-Covid-19. This report provides an update on the service since its reconfiguration.

The report concludes that the expected benefits of the model and its wider impact will continue to be monitored, but it is difficult to draw conclusions given the limited amount of data available at this stage.

Actions Requested:

The Health Scrutiny Committee for Lincolnshire is requested to consider this paper as an update of the implementation of the new model for urology in Lincolnshire's hospitals.

1. Background

In early 2021, United Lincolnshire Hospitals NHS Trust (ULHT) highlighted the challenges facing the urology service across Lincolnshire's hospitals, and proposed a public engagement exercise to consult upon proposed changes to these services. The twelve week consultation began on 17 May 2021, and that included a discussion at Health Scrutiny Committee on 23 June and at the ULHT Trust Board on 6 July 2021.

On 3 August 2021, the findings of the consultation were presented to the ULHT Trust Board, and the proposed changes to the urology service approved, to start on 9 August 2022. At this time, there was also a request for a three-month review to ensure benefits were being realised and the project was delivering the expected outcomes.

2. The Model

Whilst previously the urology service within ULHT involved emergency urology patients being admitted to both Lincoln County Hospital and Pilgrim Hospital, Boston, the approved reconfigured model enabled Lincoln County Hospital to receive all emergency urology admissions seven days per week. The aim was to ensure that the other sites were better organised to manage the majority of elective urology procedures, thereby reducing elective cancellations, increasing capacity and supporting the recovery of services post-Covid-19.

Essentially, this approach planned to level the demand across the sites, creating enhanced patient choice and reducing patient wait times, while better meeting the needs of our emergency cases.

Under the current reconfigured model, Pilgrim Hospital continues to see emergency urology patients, but if the patient needs admission or surgery, they are transferred to Lincoln County Hospital if they are medically stable to do so. Where patients are too unstable for transfer, they are admitted to Pilgrim Hospital ICU and the urology consultant on-call will travel to Pilgrim Hospital as required to assess and support with the management of the patient.

3. Case for Change

Historically ULHT had struggled with delivering the optimal mix of capability, capacity and resources for urology across its hospital sites. Services tended to be delivered across all sites, however the rurality of Lincolnshire means that the distance between the sites and poor transport infrastructure limits opportunities for scale and networked ways of working. Over recent years ULHT has experienced pressure on elective beds due to a high volume of unplanned admissions.

Alongside this, prior to the service reconfiguration, high medical vacancies existed across ULHT in the urology (elective and non-elective) service (c.28% of medical posts vacant).

Data analysed between 2017 - 2020 inclusive show that, on average, five urology procedures were cancelled every day (c.1,900 annually). For the procedures that were cancelled by the hospital (i.e. not by the patient), around 25% were cancelled on the day and 10% due to lack of beds. Cancellation of surgery at any time leads to poor patient experience and satisfaction, and additional pressure on the waiting list. A cancellation on the day of surgery is extremely distressing for patients and their families.

The NHS Long Term Plan published on 7 January 2019 fully supports the split of elective and non-elective work onto different sites to drive improvements, and recognises that managing complex, urgent care on a separate dedicated site allows improved emergency assessment and better access to specialist care, so patients have better access to the right expertise at the right time.

On the basis of recommendations arising from the Urology Getting It Right First Time (GIRFT) visit, urology was selected for a major reconfiguration supported by the Integrated Improvement Directorate (IID) Delivery Team and KPMG, with strong executive sponsorship.

The GIRFT programme's national report into urology services, published in 2018, made a number of important recommendations around the delivery of emergency urological care. These include providing consultant delivered emergency care by reducing elective commitments when on call, reviewing workloads to ensure on-call arrangements are sustainable, and focusing available resources to ensure high-quality emergency care is available seven days a week. Most NHS organisations ensure that consultants are not on-call when delivering elective commitments to ensure prompt response to emergency care.

The current reconfigured model for urology services at ULHT was developed following an options appraisal with GIRFT clinical lead, Mr Simon Harrison, and supports the delivery of these recommendations. Support has been provided by the regional GIRFT implementation team throughout the project, through weekly meetings with the project team, and the current reconfigured model was presented to the GIRFT clinical leads on 23 July 2021. The team offered uniform support for the model.

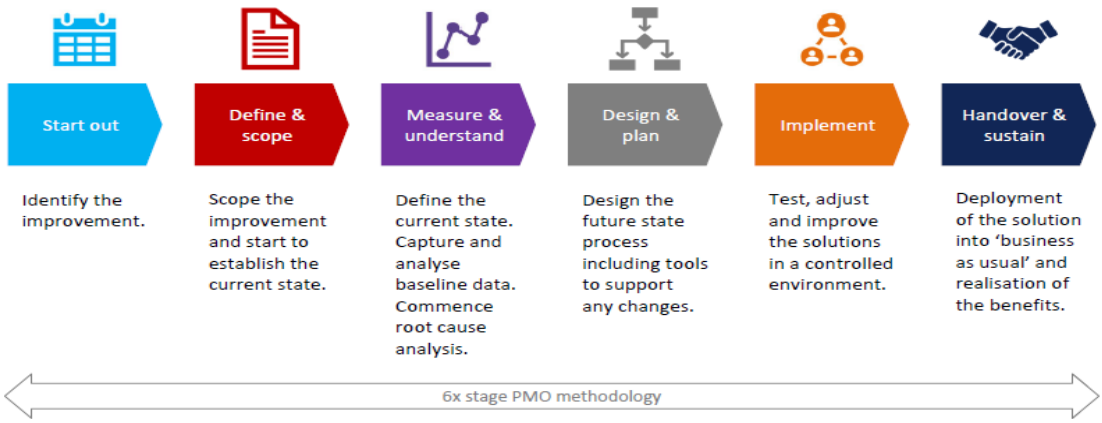
The key features of the reconfiguration include:

- Focus for acute urology at a single site emphasising increased same day care, acute lists and clinics
- Maintenance of diagnostic and outpatient activity across sites
- Increased non-complex elective procedures at Grantham and Pilgrim, with a focus on day case and short stay work but including specialist stone procedures.
- Retaining some complex major procedures at Lincoln County Hospital
- Single urology team with expanded consultant and SAS (specialty and associate specialist) doctors and a new tier of acute care practitioners. (ACPs)

Additionally, the project outcomes link directly to the Trust's 5 year Integrated Improvement Plan. At high level, the alignment to each of the strategy themes is as follows:

Patients	• Complaints, SI's and DATIX • Average length of stay (emergency) • Cancelled procedures • Cancer Performance (28 day) • Variation in cost per patient (Person Level Information and Costing Systems) • Procurement costs
People	• Staff engagement and medical vacancy rates
Service	• Financial performance • Agency costs • Service stability
Partners	• Collaboration with GIRFT – best practice alignment and delivery of GIRFT recommendations.

Delivery of the urology reconfiguration has been managed using the existing 6x stage project methodology with additional elements added to align with the Outstanding Care Improvement System (OCIS).



4. Benefits Realised to Date

Since go-live of the reconfigured service on 9 August 2021, the following benefits have been noted. More detail in these is available later in this report:

Benefit Theme	Progress to Date	Current Status
Deliver the change	Service now reconfigured following formal patient consultation. Service go-live 9 August 2021.	
Admissions	Total number of non-elective admissions downward trend since go-live. Ongoing monitoring of this metric in place.	

Benefit Theme	Progress to Date	Current Status
Voice of the Patient	Mechanism in place to capture feedback specifically on the reconfiguration. Overall, positive themes emerging from the feedback	
Staff engagement	Robust baselining of engagement taken pre-go live and also 3 months post go live. Opportunities exist to improve engagement. Action plan to be created based on the latest feedback.	
Staff vacancy rate	Medical vacancy rate now at 0 (compared to 28% before the reconfiguration.)	
Financial performance	The total investment into the service is £700k pa. Medical agency spend reduced to zero. To date, the overall pay savings reported amount to £9.4k, and this is expected to increase to up to £140k in this financial year now that medical agency has fully ceased.	
Collaboration with GIRFT	Endorsement of changes via the GIRFT clinical leads.	

A number of stakeholder experts have been involved throughout implementation of the new model, they are:

- GIRFT (Get it Right First Time)
- Patient Experience panel
- KPMG
- East Midlands Ambulance Service
- Lincolnshire Clinical Commissioning Group
- United Lincolnshire Hospitals NHS Trust Staff

In the original evaluation of the new reconfigured model, it was recommended that the trust adopts a reporting dashboard to track delivery of the key expected benefits, monitor desirable/undesirable impacts and drive performance improvements in terms of quality, safety, patient experience and use of resources.

These criteria were fully defined in the original Project Charter for the reconfiguration. This dashboard has now been created, therefore, performance against the KPI's is regularly monitored and performance against these are highlighted below in 'Benefits Matrix'. The dashboard aligns with the 'scorecard principle' adopted by the wider Outstanding Care Improvement System (OCIS).

	Expected Benefit Areas
Services	Medical agency spend reduction Procurement cost opportunities Reduction in service deficit against budget Sustainable financial service Urology assessment unit Improved flow from the Emergency Department

People	Improved engagement Training opportunity for SAS & ACP tier Reduced admin burden to manage rota and resource
Patients	Complaints, SIs and DATIX reductions Average length of stay reduction Direct access model for cancer pathway Continuity and consistency of care Increase in proportion of patients discharged from assessment unit Improved flow from Emergency Department Reduced waiting list and pathway times for cancer and Referral to Treatment Reduced cancellations on the day Reduction in non-elective admissions and overall bed usage
Partner	Alignment of solution with GIRFT recommendations and best practice guidance Increased support of Primary Care Work with system to provide best care for Lincolnshire patients

Benefits Matrix

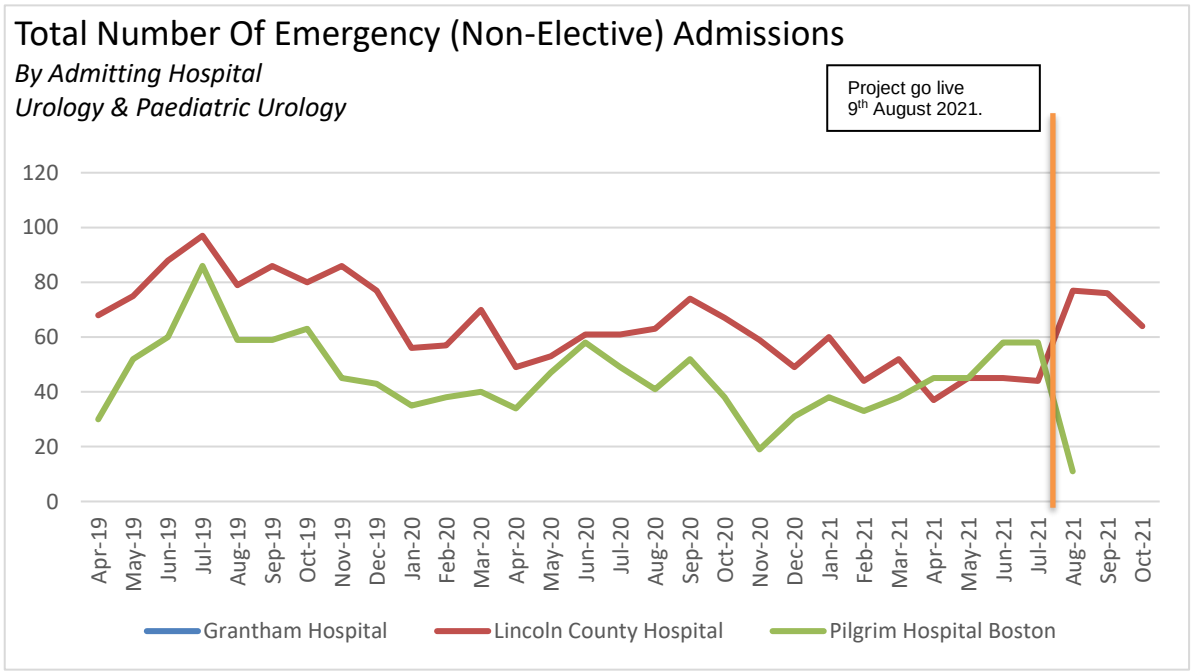
A comprehensive benefits matrix has been captured to support the reconfiguration. Below is a summary of the benefits matrix that continues to be used to manage and track the benefits of the reconfiguration.

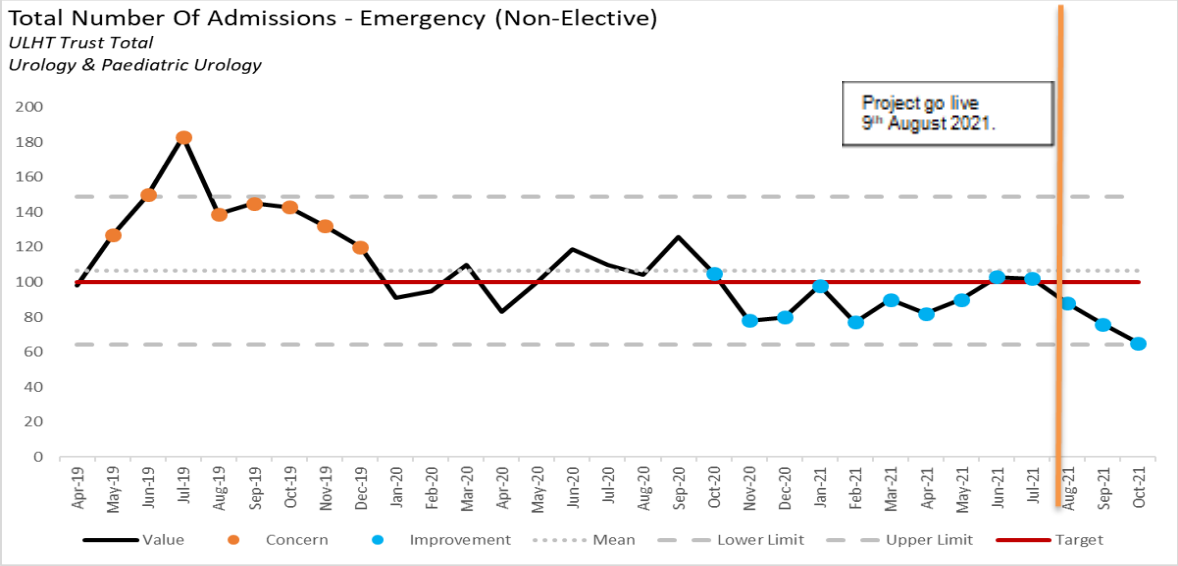
Benefit	Baseline	Opportunity statement	Current performance – NOV 2021	Current status	Quality	Operations	Workforce	Finance	GIRFT	Model Hospital	Benefit Realisation Period from go-live (May-21)
Medical agency spend	£100k / month	• c£300k annually • Reduce to zero by Sept-21	£0 spend on medical agency spend. All spend removed from early November 2021			X	X	X			Phase 1
Average length of stay	3 days	• Root cause understanding of ALoS metrics. Seeking to reduce non-elective admissions and overall bed usage • Increase in proportion of patients discharged from assessment units	Average length of stay remains the same but this is impacted by increased numbers of patients needing packages of care in order to be discharged.		X	X			X	X	Phase 2
Cancelled procedures	13% of EL and DC cases cancelled on same day.	• Reduction in cancelled operations. Target to be established once root cause and analysis completed. • 2019 baseline used – cancelled by the hospital (not patient)	August 13 September 24 October 13. Increase owing to level 4 pressure		X	X	X		X		Phase 2
Cancer performance (28d)	46%	• Direct access pathway model to reduce pathway duration • Improvement in 28d national standard performance • Standardise process • Focus on bladder and kidney pathway	50% Delay in implementing rapid diagnostic pathways due to governance sign off Issues owing to level 4 pressure		X	X					Phase 2
Indirect and PLICS data variation	Various	• Over the data, the total costs for all codes is £13.98m against an income of £11.10m yielding a delta of £2.88m • 80% of the loss (£2.3m) is attributed to 18 unique HRG codes (this accounts for 51% of the total volume of procedures)	Ongoing work being undertaken. Deep drive into areas of the specialty being undertaken which has identified potential for cost reduction per patient.		X	X	X	X	X	X	Phase 2
Procurement costs	£843k annual non pay costs.	• Note: £561k of the total non-pay costs relate to clinical supplies & services • At least £93k identify to date (urethroscope)	Delays in endourology procurement due to staffing issues with Procurement team		X			X			Phase 2

Benefit	Baseline	Opportunity statement	Current performance – NOV 2021	Current status	Quality	Operations	Workforce	Finance	GIRFT	Model Hospital	Benefit Realisation Period
Waiting list	December 2020	• 18 week RTT for ULHT is 60.8% (847 patients over 18 weeks) • Target to be identified following further investigation	• 18 week for RTT 64.44% (889 patients over 18 weeks Position expected to be higher but impact seen from level 4 escalations		X	X		X			Phase 2
Staff engagement	TBC	• Pulse survey issued Jan-21 to establish baseline. • Engagement plan to be developed to support outcomes	• Pulse Survey • Survey to be repeated in March 2022 owing to low responses			X	X		X		Phase 1
On-call provision	GIRFT	• Hot / cold site configuration will address the key concerns from GIRFT about reducing elective commitments for on-call consultants.	• Consultants no longer have elective commitments when undertaking on call		X	X	X	X	X		Phase 1
Emergency care provision	GIRFT	• Ensure high-quality emergency care is available 7-days a week • Explore options as part of a Urology Area Network (UAN)	• Emergency care is delivered on a 3 tier on call system 24/7 • Working in alliance with Leicester		X	X			X		Phase 2
Data integrity	GIRFT	• Review data collection • Improve coding accuracy • Increase income through accurate coding • Staffing costs per WAU	• This is ongoing with the support of Coding and Urology Clinical Leads		X	X	X	X	X	X	Phase 2

Non-Elective Performance

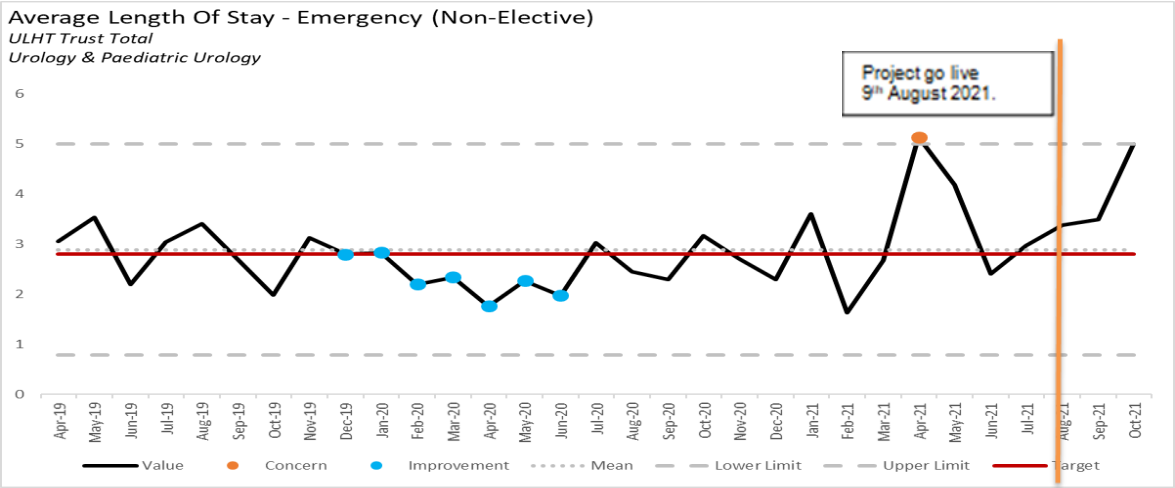
There was concern prior to the re-configuration that non-elective admissions would increase. The reconfigured service went live on the 9 August 2021. As you will see from the graphs below, admissions increased at Lincoln County Hospital once the reconfiguration commenced but are now significantly lower than what they were Trust-wide pre re-configuration. This trend will continue to be monitored through the scorecard.





Average Length of Stay Non-Elective

Average length of stay on the urology non-elective pathway has increased, as have all other specialties within ULHT. However, once the urology patients can all be placed on one ward (level 4 escalation permitting) the specialty is confident this will improve as we can then implement criteria-led discharge.



Quality Impact Assessment

The clinical risk analysis has directly fed into the Quality Impact Assessment (QIA). The QIA was signed off by the Trust's QIA Panel on 12 July 2021. A further update QIA and scorecard was presented on 17 November 2021 which received full support and final sign off. The QIA received high praise from the panel and commented that the level of detail and due diligence that has gone into the document is outstanding.

Patient Feedback

In order to capture patient experience information post go-live, the Project Team set up a Patient Experience Survey for Urology patients. This has been disseminated throughout the service for patients fit to sit and for inpatients. Staff have been encouraged to support patients with providing feedback through this forum. To date, as at 9/11/21, uptake has been three responses (one response from a patient who travelled from Pilgrim Hospital, Boston). It is work in progress given the current climate and winter pressures. Feedback shown below –

> *"The service was excellent; every stage of the procedure was explained thoroughly before proceeding"*
>
> *"The Urologist I saw today, I have seen before, very polite and knowledgeable"*
>
> *"The two paramedics on the ambulance were as efficient and attentive as the staff in the hospital. The staff in the hospital are magnificent under the conditions they work under, short staffed etc"*

Although patient survey responses have been low, no negative feedback via PALS or formal complaints have been raised.

Public/Patient Engagement

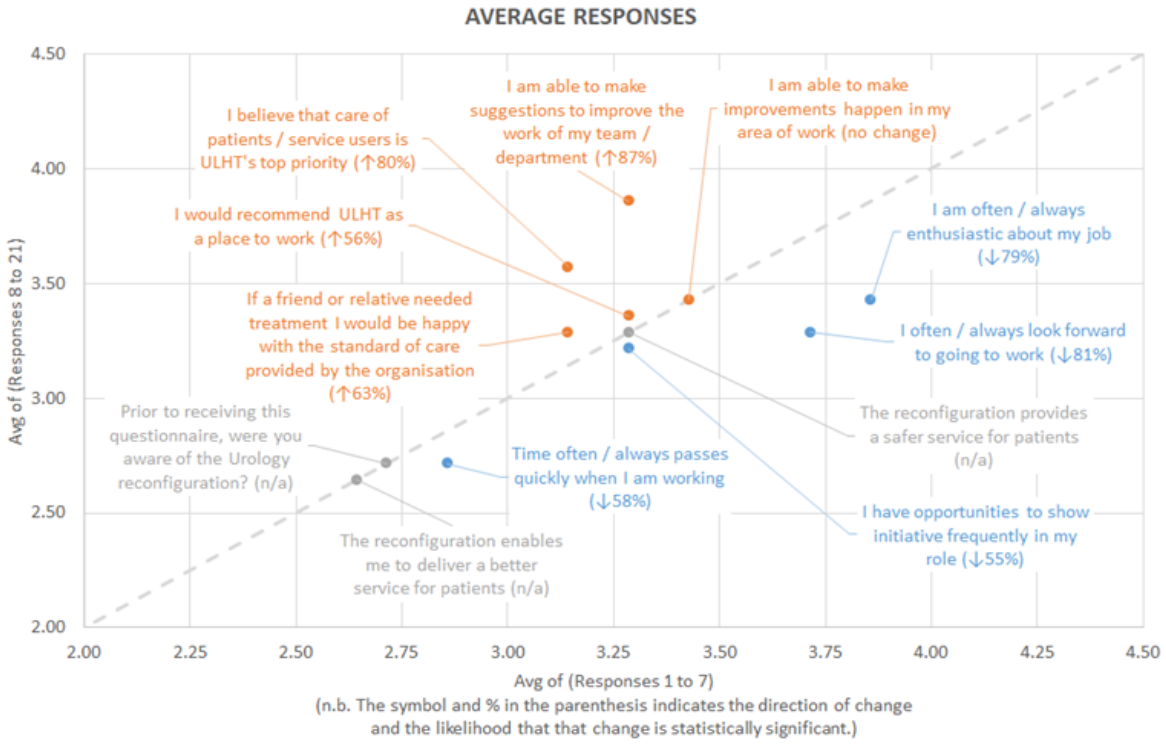
Prior to implementing the reconfiguration, we consulted with Lincolnshire patients over a twelve week period. This involved formal communications about the changes, focus group meetings with patients, clinicians and service leadership for patients to share their views about the proposed changes and to directly influence the reconfiguration model.

Positive Feedback	Concerns	Mitigation
Staff: complimentary about current staff, see the change as a vehicle to improved recruitment and specialists. Resource usage: general feeling that reconfiguration will positively improve access to resources / service. Patient experience: support for the separation of elective and planned activity. Feel this would result in a reduction in	Travel & transport: concern about delays in treatment due to emergency transport to another hospital site. concerns about how Boston-area patients would get back home after discharge from Lincoln hospital. Impact on other providers: EMAS ability to cope with demand.	Hospital transport on discharge will be provided for qualifying patients; for other patients, solutions including taxi provision will be explored on an ad hoc basis. EMAS are in full support of the proposal; modelling suggests the impact will be one additional transfer for admission per day

Positive Feedback	Concerns	Mitigation
cancellations of elective activity. Support a reduction in elective waiting times. Patients happy to travel for expert care. Activity: welcome increased elective activity at Pilgrim, Grantham and Louth hospitals	Patient safety: concern about risks connected with not receiving emergency care as quickly. Concerns about services being moved away from Pilgrim- disadvantaging population of Boston and the East Coast	The additional tier of on call provides enhanced access to specialist opinion through the SPOC. The provision of elective, diagnostic and specialist services at Pilgrim Hospital Boston will increase.

Staff Engagement

Staff were consulted via a questionnaire at the commencement of the project in order to obtain a baseline set of information in relation to staff satisfaction. The questionnaire has now been repeated post go-live in order to identify improvement or otherwise. Approximately 50 staff were consulted, and the response rate has been low. Analysis shown below.



For each question it is possible to compare our score from our first set of surveys (responses 1 to 7) to our score from our second set of surveys (responses 8 to 21), and say (mathematically) whether that score has remained the same, gone up, or gone down.

The responses shown in orange show an increase in positive responses to the questions, those in grey show a remaining consensus and those in blue show an increase in negative response.

The arrow and % at the end of the scatter chart points labels tell us first the direction of travel (the arrow; the text “no change”, an up-arrow, or a down-arrow) and how confident (the % calculated using a statistical test) we can be that the arrow is a true assessment of any change, rather than being simply due to random variation.

It is clear from the responses above that there is more work to be undertaken on improving ‘morale’ of our workforce, however, a higher sample of response would enable us to pin point any high levels of concern.

We plan to undertake a further survey in March 2022 and the in meantime are working with Organisational Development on improving team morale.

5. Finance

Prior to implementation there was a high reliance on agency medics. The investment into this service and improvements to the model of working was expected to improve recruitment and retention of staff. This included:

- Investment of 7.00 whole time equivalent Advanced Clinical Practitioners (ACP), who form part of the first on-call and reduce reliance on agency locums.

- Drive on substantive recruitment of medical staff, including an investment of budget from within the CBU to fund a 10th consultant post.

- Introduction of Core Trainees working across urology and orthopaedics at Grantham site, funded from within the clinical business unit.

The total investment into the service is £700k pa. Spend on medical agency was £780k in 19/20 and £1,153k in 20/21.

	Current Establishment			Future Establishment	
Cost Category	WTE	Cost 19/20 £k	Cost 20/21 £k	WTE	Cost £k
Consultants	8.00	2,143	2,313	10.00	1,682
SAS	8.80	948	992	8.00	878
Specialist Trainee	1.00	119	99	1.00	81
Junior Drs	7.00	325	358	8.00	373
ACPs	-	-	-	6.00	470
Total	24.80	3,535	3,762	33.00	3,484

Table showing current vs future costs of the medical workforce plus the ACPs. The future cost represents the model fully established with post-holders at 'top of scale' and without any premium costs from agency or extra duties.

As a result of these investments and the subsequent elimination of agency the specialty is expected to achieve a cost improvement of c£300k (full year equivalent).

As at October 2021, all posts are either filled or have a plan in place for a new staff member to join, and as such the agency has ceased as planned in early November. The 21/22 medical agency spend year to date is £300k.

To date, the overall pay savings reported amount to £9.4k, and this is expected to increase to up to £140k in this financial year now that medical agency has fully ceased.

The overall capacity and activity will stay the same with the reconfiguration. However, there is a potential income opportunity for reduced cancellations. Of approximately 500 cancelled operations per year, 17% were due to bed availability or unplanned surgeon absence. The reconfiguration could mitigate cancellations for these reasons and therefore there is an opportunity worth around £120k, using an average elective tariff. The expected benefit has not yet been quantified and thus far no benefit realised in relation to reduced cancellations.

Work continues on deep dives into cost variations using patient level cost information, with Finance working with the clinical business unit to identify opportunities for cost savings.

6. Key Risks/Issues

There are a number of potential issues to the continued success of the programme, which are listed below –

Issues							
Description	**Date Raised**	**Status**	**Owner**	**High Level Actions**	**Scoring**	**Impact**	**Latest Review**
Retention of Middle Grade Doctors	21/10/21	Open	Chloe Scruton	Working ongoing with HR to develop an individual development and training structure for each Middle Grade Doctor. Ongoing regular meetings with SAS doctors	2 (Low)	The impact is: We may not be able to fulfil the obligations of the rota in its entirety and may have to utilise agency staff De-stabilisation of service.	4/11/21
Compliance with the new service model by clinical staff – **all** urology patients being directed to LCH, without prior USPOC contact and agreement	19/8/21	Open	Chloe Scruton	Completion of statement of purpose to incorporate roles and responsibilities model – this will then become and official Trust document and communicated accordingly and will ensure absolute clarity in terms of all aspects of the service model for non-elective walk-ins at non-receiving sites (statement of purpose in final draft for the clinical business unit to verify and sign off). Good feedback from staff saying the service is much better. Keeping under review.	2 (Low)	The impact is: The flow of the patient pathway, and therefore the patient experience, may be compromised if the correct process is not followed, causing potential delay and inconvenience to our patients. Additional pressure on Lincoln County Hospital to accommodate non-urgent urology patients, sent in by Pilgrim, that should be seen and treated as usual within A&E.	4/11/21

Issues							
Description	**Date Raised**	**Status**	**Owner**	**High Level Actions**	**Scoring**	**Impact**	**Latest Review**
Establishment of Urology/Trauma Assessment Hub (UTAH) – delayed partly owing to the stand down of CRIG halting progression	16/9/21	Open	Chloe Scruton	Target was to open the UTAH during October 2021. Surgical assessment unit is being used as an interim measure. The business side of the report has been completed and this is now sat with nursing to complete their part. The stand down of CRIG has halted progress. Continuation of use of surgical assessment unit will need to continue. Action: seek acknowledgement from Project Sponsor of the delay with regard to this element of the reconfiguration and to potentially identify a solution to aid progression as quickly as possible Update: Excessive ambulance handover delays have highlighted the need to escalate the establishment of UTAH as part of the solution to remedy some relief on A&E. All money has been approved for estates. Nursing to addressed at CRIG early November. Potential start Jan 2022.	2 (Low)	The establishment of the UTAH is essential to ensuring improved patient flow and timely treatment in the right location. The status quo of using the surgical assessment unit will need to be maintained.	4/11/21

7. Conclusion and Next Steps

Expected benefits of the model and its wider impact are being monitored; however, it is difficult to draw conclusions given the limited amount of data available.

As expected, the medical agency doctor spend has reduced and it is anticipated that this trend will continue. Other metrics have been impacted by the significant urgent and emergency

care pressures that the Trust has experienced in recent months. The team intends to continue to monitor the data to determine any trends over a longer time period.

To ensure performance recovers and remains on track the urology department, along with Information Services, have implemented a dedicated dashboard (contained within the QIA in section 6) tracking key expected benefits. The aim is that this dashboard can be reviewed in real time to assess performance and give the CBU triumvirate team the ability to identify issues and rectify.

Additionally, a thorough lesson learned exercise has been carried out by the project team to ensure knowledge transfer is shared across the Trust.

- Implementation of Urology and Trauma & Orthopaedics Hub
- Recovery of Urology elective RTT and cancer KPI's in order to achieve target performance. Using C2-AI to ensure patients are treated in clinical priority order to optimise patient outcomes
- Ensure improved efforts to gain regular patient and staff feedback
- Present the current model, success and challenges at the Urology GIRFT gateway review in early 2022
- Implement criteria led discharge

The Trust Board of ULHT considered a paper which reviewed the service change to date (as above) on 7 December 2021, and agreed the continuation of the current model, based on the expected benefits of this model.

8. Consultation

This is not a consultation item.

9. Background Papers

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

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