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 United Lincolnshire Hospitals NHS Trust

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 May 2022**
Subject:	**United Lincolnshire Hospitals NHS Trust – Reconfiguration of Urology Services Update**

Summary:

A reconfiguration of urology services at United Lincolnshire Hospitals NHS Trust (ULHT) became effective on 9 August 2021, following a twelve week consultation period and a decision by the ULHT Board on 3 August 2021.

On 16 February, a report was submitted to this Committee on the progress with the intended aims of the reconfiguration, and it was agreed that a further report would be committee to this Committee in three months.

This report set outs improvements in performance, including a sustained and significant reduction in expenditure on agency staff. These improvements have been impacted by the significant urgent and emergency care pressures and progress will continue to be monitored.

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 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 included a discussion at Health Scrutiny Committee for Lincolnshire on 23 June 2021 and at ULHT's 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 2021.

An update was provided to the Health Scrutiny Committee on 16 February 2022 regarding the operation of the reconfigured service model, who requested a further update be provided in May 2022.

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 Intensive Care Unit and the on-call urology consultant will travel to Pilgrim hospital site 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 showed 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. Being cancelled 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.

Getting It Right First 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, who 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 successful embedding and operation of the model was noted at the GIRFT re-visit on 5 April 2022.

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; and
- a single urology team with expanded consultant and SAS (middle tier) colleagues and a new tier of acute care practitioners.

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 (28d) • Variation in cost per patient (PLICS) • 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.

4. Evaluation of Performance

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

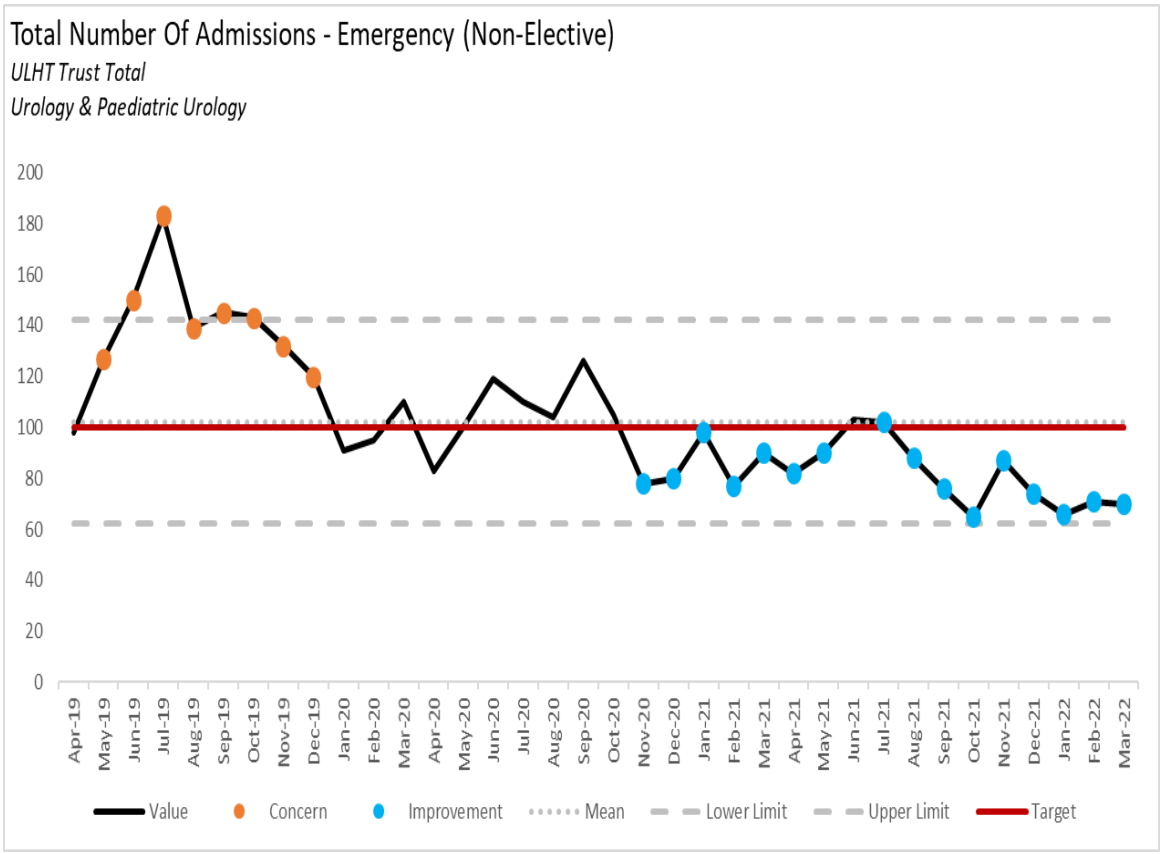
Patients	Complaints, SIs and DATIX reductions Average length of stay reduction Direct access model for cancer pathway Continuity and consistency of care Increase in proportion of patients discharged from assessment unit Improved flow from ED Reduced waiting list and pathway times for cancer and RTT Reduced 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

Performance Review

The following figures are taken from the Performance Dashboard with figures updated to March 2022

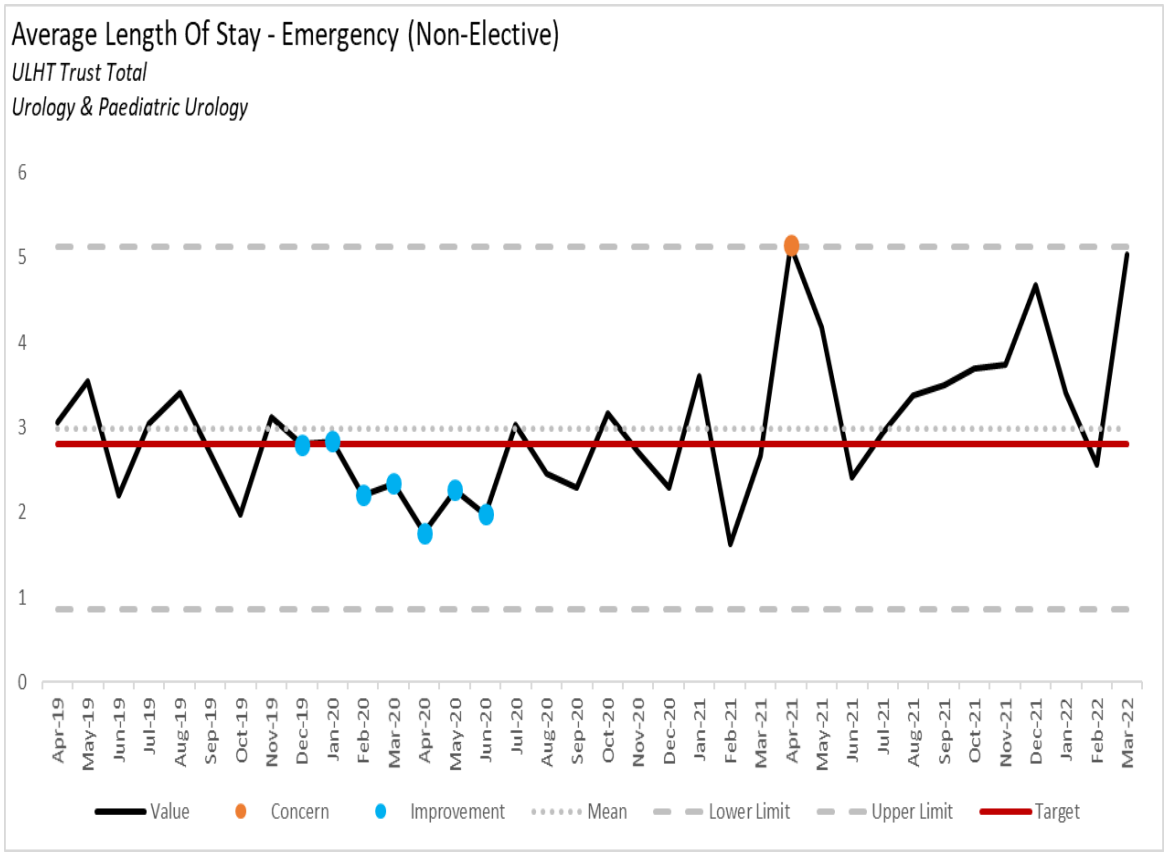
Non-Elective Performance

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 improvement has been sustained through to March 2022.



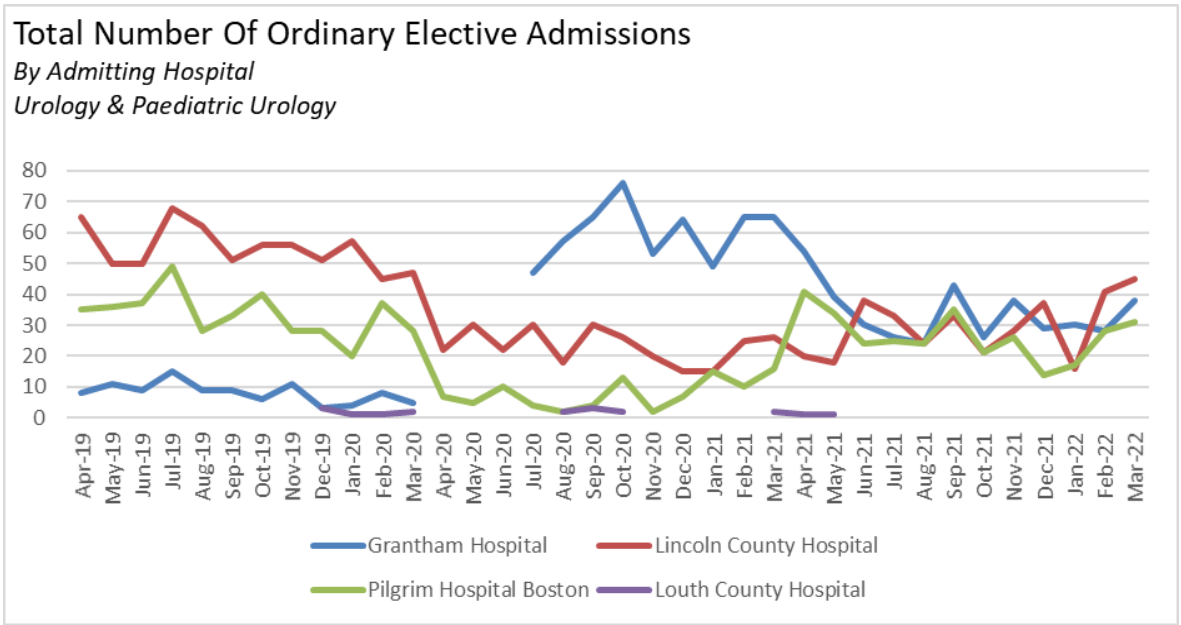
<u>Average Length of Stay Non-Elective</u>

Average length of stay on the urology non-elective pathway has increased, as have all other specialties within ULHT. In part the related to increased complexity with less complex patients being seen and discharged rather than admitted. It is anticipated that further improvement will occur following development of the Urology Assessment Hub



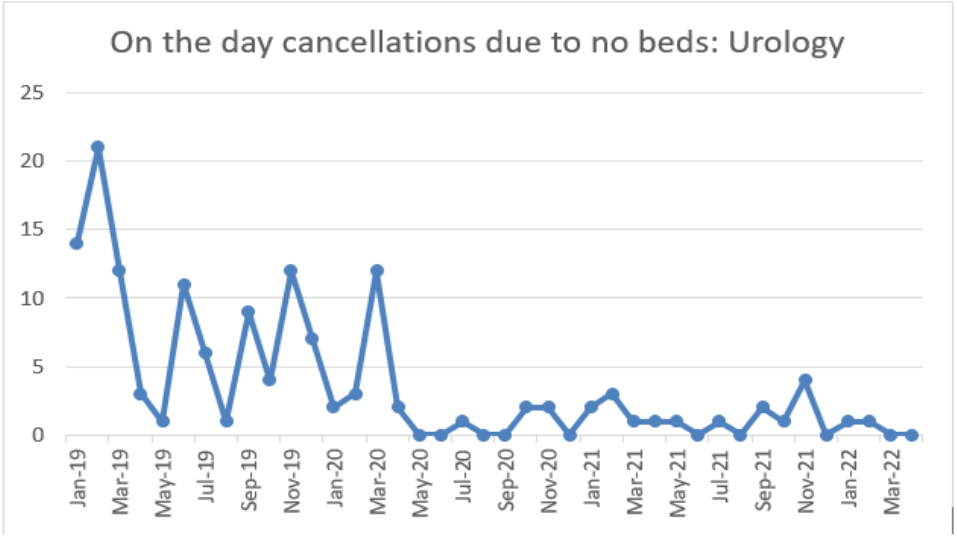
<u>Elective Admissions</u>

The elective admission profile has now reached a steady state following reconfiguration, with a balance of elective admissions across the three main sites: Lincoln is the focus for more complex and robotic work; Grantham provides lower complexity high volume work and Pilgrim delivers intermediate level activity including specialist stone surgery.



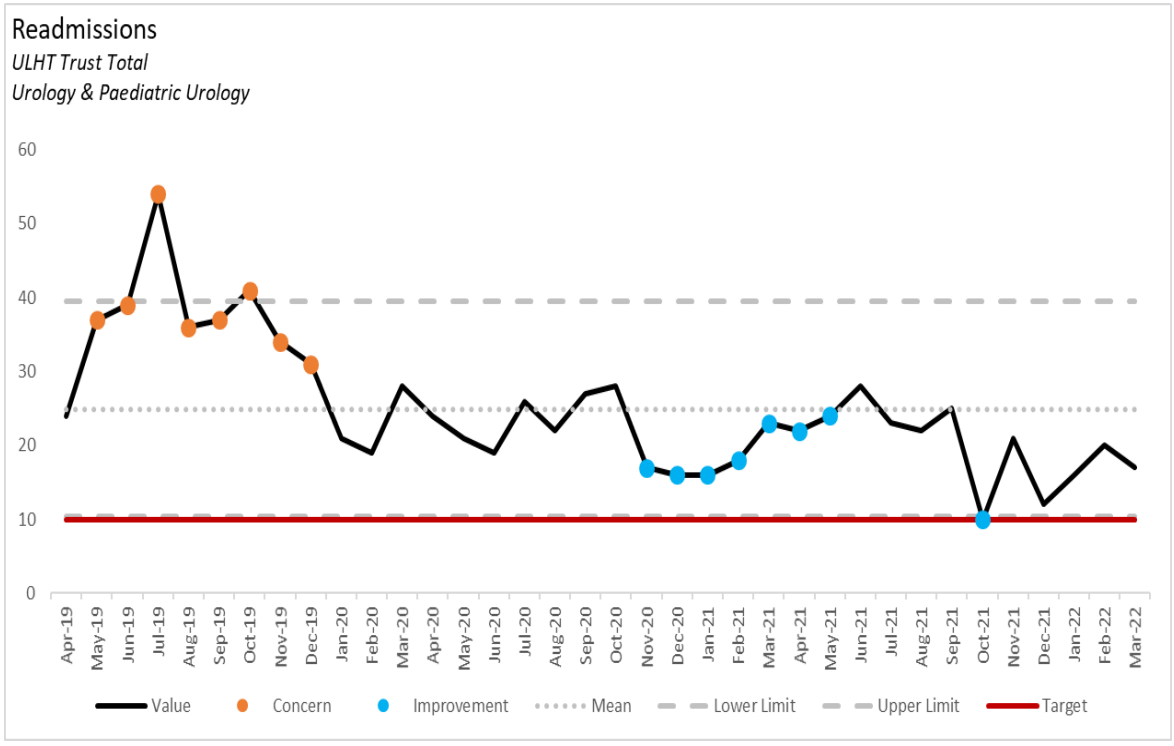
Cancellations on the Day – Non Clinical

The previous high levels of on the day cancellations have now been virtually eliminated; this has been achieved by a combination of increased activity through the Grantham site and protected capacity within the admission areas on the Pilgrim and Lincoln sites.



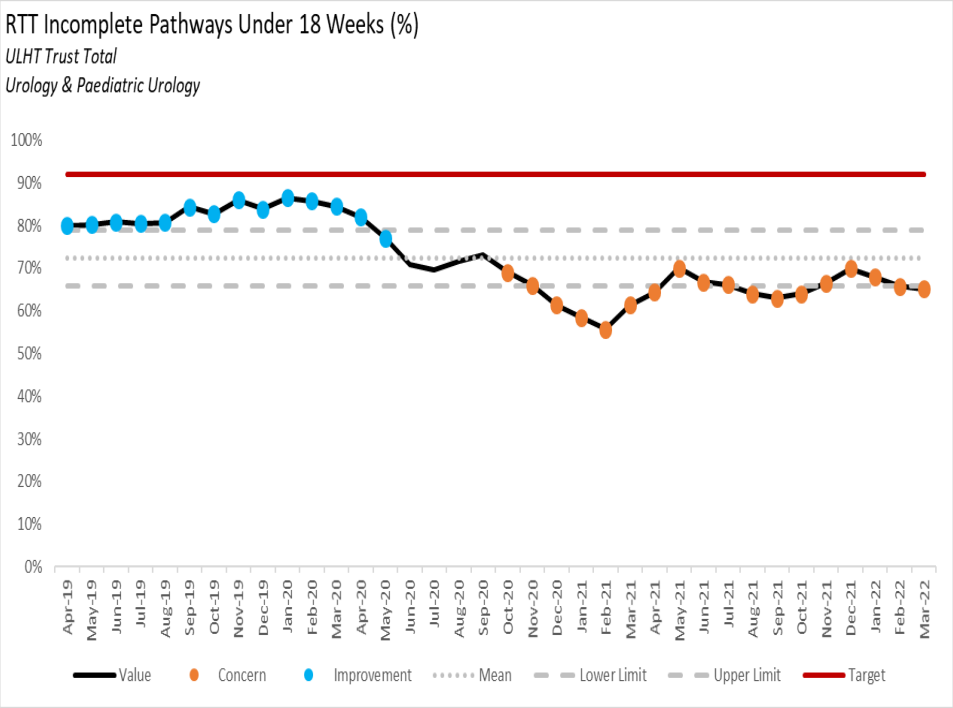
Readmissions

Readmission rates are an important quality indicator and have shown continued improvement through and following reconfiguration.



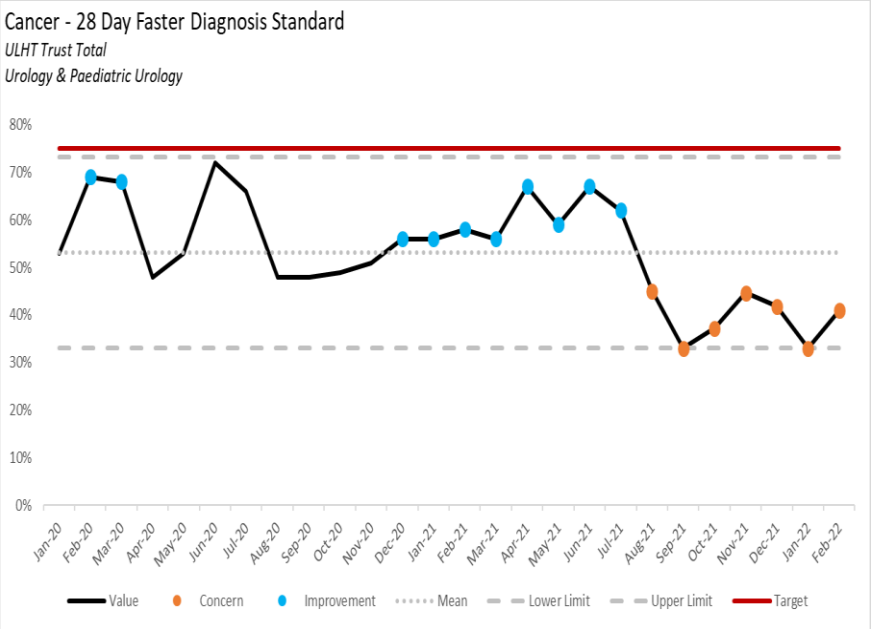
Referral to Treatment (RTT) Performance

In common with other specialties and other providers, urology continues to struggle with RTT performance, although the position remains static. However, the number of patients overdue on the partial booking waiting list has fallen significantly and the specialty has no patients waiting over 65 weeks for admission.



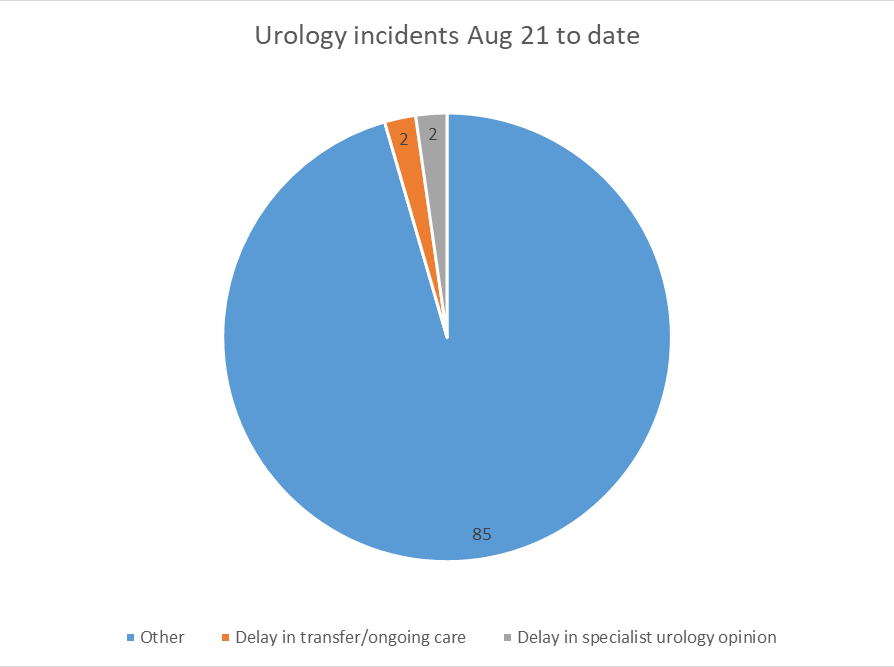
Cancer Faster Diagnosis Standard

The speciality has not achieved the faster diagnosis standard since reconfiguration. However expedited pathways have now been implemented for testicular and prostate cancer. Additionally the urology Acute Care Practitioners are now undertaking cancer diagnostic activity (cystoscopies and prostate biopsies) as part of their extended role which will see this position improve significantly through increased diagnostic capacity.



Urology Incidents

The speciality actively monitors adverse incidents relating to the specialty. 89 incidents were reported during the period from August 2021 to April 2022. Of these, two related to delay in transfer/ongoing care for emergency urology patients and two related to delay in receiving specialist urology opinion for inpatients at Pilgrim Hospital. Of these four, all were categorised as no or low harm on investigation.

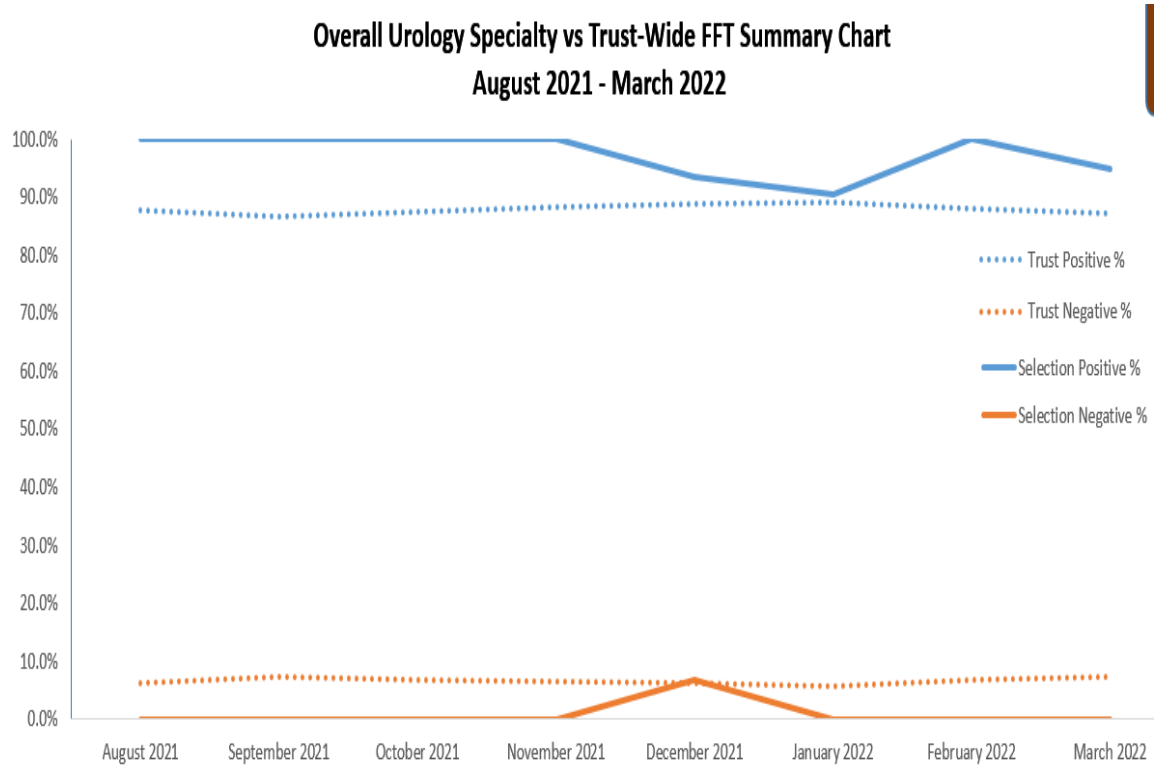


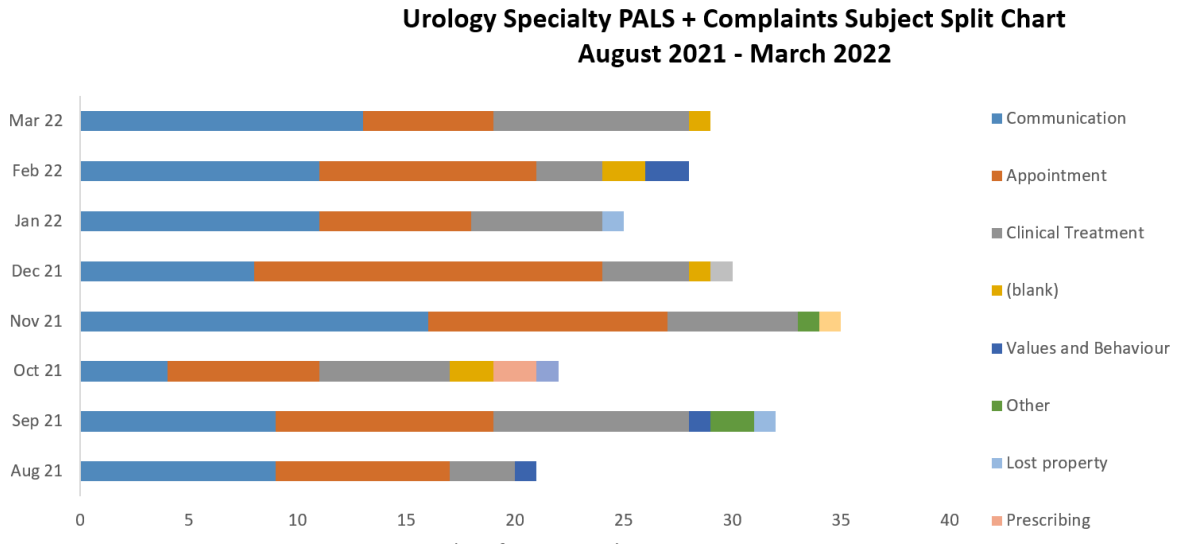
Quality Impact Assessment

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. The QIA is set out in Appendix A to this report.

Patient Feedback

The specialty continues to monitor patient feedback, including Friends and Family Test (FFT), compliments, PALS and complaints. The positive feedback on FFT sits above the Trust average, at 97% with only 1% adverse feedback. Analysis of complaints and PALS concerns shows the main areas of concern relate to communication and access to appointments, with no concerns relating to the service reconfiguration itself.





5. Public / Patient Engagement

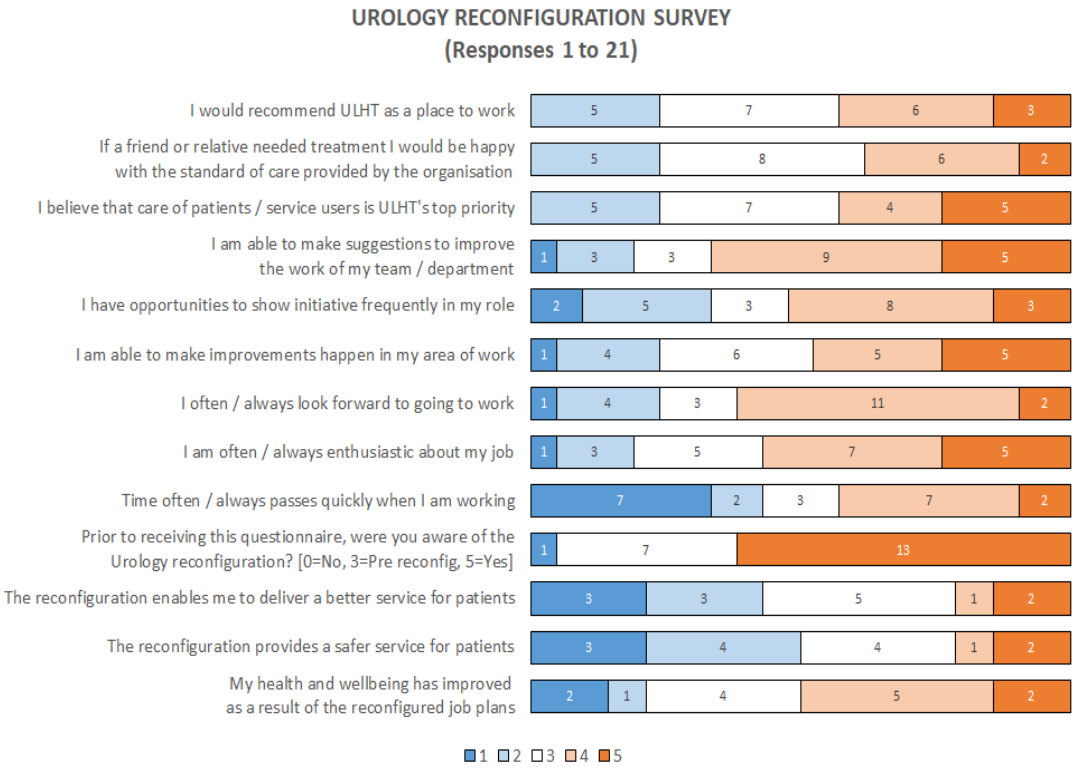
Prior to implementing the reconfiguration, we consulted with Lincolnshire patients over a twelve week period. This involved formal communications about the changes, focus group meetings with patients, clinicians and service leadership for patients to share their views about the proposed changes and to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

Positive Feedback	Concerns	Mitigation
Staff: complementary 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.	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.	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.
Patient experience: support for the separation of elective and planned activity. Feel this would result in a reduction in cancellations of elective activity. Support a reduction in elective waiting	Impact on other providers: EMAS ability to cope with demand.	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
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 and duty urologist at PHB. The provision of elective, diagnostic and specialist services at PHB will increase.

Staff Engagement

Although the next cycle of staff engagement is still underway, the specialty recognised the concerns previously expressed concerning the reconfigured model with particular reference to access to specialist urology opinion at sites other than Lincoln, especially Pilgrim Hospital. This was evident through the staff survey (below) and through concerns voiced at the Medical Advisory Committees. As a result, enhanced support, in addition to that offered by the urology single point of contact and on call consultant, is now provided on a daily basis at Pilgrim site through a "duty urologist" offering on site patient reviews and liaison where required with the on call team for ongoing management.



6. 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 WTE 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.

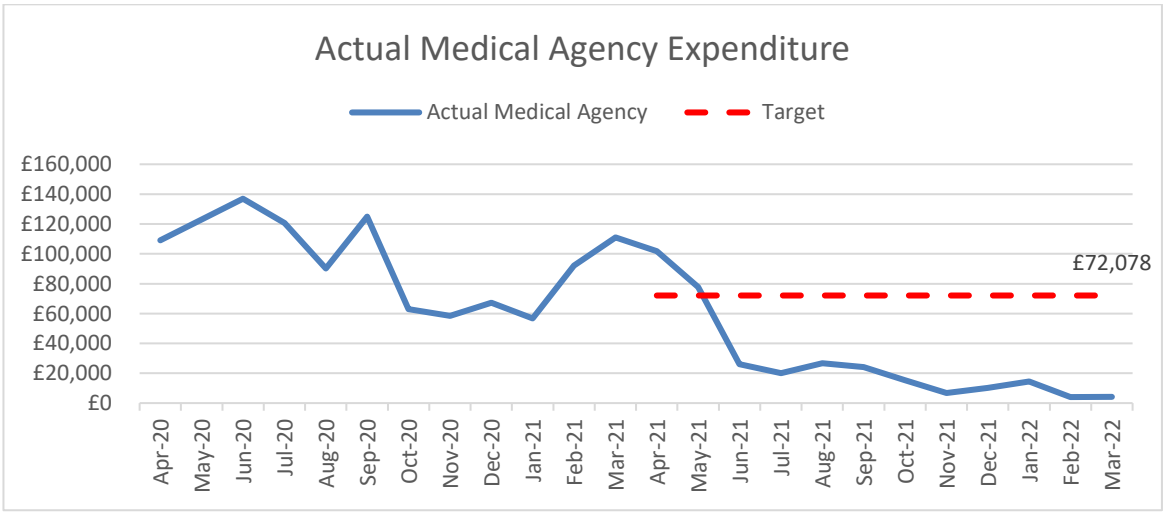
- Introduction of Core Trainees working across Urology and Orthopaedics at Grantham site, funded from within the CBU.

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.

Medical agency spend has been virtually eliminated through substantive recruitment.



As a result of these investments and the subsequent elimination of agency the specialty is was projected to achieve a cost improvement of £300,000 (full year equivalent): the actual realisation is closer to £160,000 as a result of extra duty costs incurred as part of the elective recovery programme.

7. Key Risks / Issues

There are a number of potential issues to the continued success of the programme identified. These are listed below: –

Issues *(An Issue has already occurred)*							
Description	**Date Raised**	**Status**	**Owner**	**High Level Actions**	**Scoring**	**Impact**	**Latest Reviewed**
Retention of Middle Grade Doctors	21/10/2021	Open	Sara Anscombe	Working ongoing with HR to develop an individual development and training structure for each Middle Grade Doctor. Ongoing regular meetings with SAS doctors Ongoing recruitment cycle	2 (Low)	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.	01/04/2022
Compliance with the new service model by clinical staff – **all** urology patients being directed to LCH, without prior USPOC contact and agreement	19/08/21	Open	Sara Anscombe	Completion of SOP 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 (SOP in final draft for CBU to verify and sign off) .	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 LCH to accommodate non-urgent urology patients, sent in by Pilgrim, that should be seen and treated as usual within A&E.	01/04/2022
Establishment of Urology/Trauma Assessment Hub (UTAH) – delayed partly owing to the stand down of CRIG halting progression	16/09/21	Open	Sara Anscombe	Although approved in principle and an area identified, funding to permit staff recruitment not yet agreed. Continued pressure on the surgical assessment area as a result.	3 (Moderate)	The establishment of the UTAH is essential to ensuring improved patient flow and timely treatment in the right location. The status quo of using SAU will need to be maintained.	01/04/2022

8. Conclusion and Next Steps

The model has now become embedded and accepted within the Trust as a safe and effective means of delivering urology services at United Lincolnshire Hospitals NHS Trust.

Metrics have shown performance improvements, although these have been impacted by the significant urgent and emergency care pressures that the Trust continues to experience. 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, monitor the dedicated dashboard (contained within the QIA) tracking key expected benefits. This dashboard is 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.

The outstanding actions for the project team are:

- 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

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

9. Appendices – These are listed below and attached to the report.

Appendix A	Quality Impact Assessment for the Reconfiguration of Urology Services at United Lincolnshire Hospitals NHS Trust

10. 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 United Lincolnshire Hospitals NHS Trust.

APPENDIX A

QUALITY IMPACT ASSESSMENT – UROLOGY SERVICES RECONFIGURATION

Programme/Project	**Urology Surgery Reconfiguration**
Scheme Overview	On the basis of recommendations arising from the Urology GIRFT visit, Urology was selected for a major reconfiguration supported by the Improvement Team and KPMG, with strong executive backing. The key features of the new configuration 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 LCH. Single urology team with expanded consultant and SAS numbers and a new tier of acute care practitioners. The current model of parallel working at the Lincoln and Pilgrim sites has caused some difficulties with onerous on call rota with frequent gaps which impact on our ability to provide a consistent and stable service for our patients. Alternating on call system at weekends has led to confusion in acute pathways, with many patients being redirected from one site to another. Financial impact through duplicate rotas, agency use and extra duties. Recruitment and retention problems, silo working and lack of whole team identity.
Quality Impact Overview	The new model will ensure the safety and well-being of clinical staff and will increase development and training opportunities for ACP's and middle grade doctors. This will stabilise our workforce, reducing reliance on agency staffing, ensuring consistency and safety for our patients. We will improve patient experience by ensuring efficient patient flow through the service, reducing unnecessary admissions, reducing same day cancellations of elective surgery, responsive ACP team (Urology Single Point of Contact USPOC) to ensure urology patients accessing the service through the ED route are seen and treated quickly and safely, without disruption to elective activity.
Quality Indicators	SI's (DATIX), Friends & Family Test, Complaints, Compliments, PAL's

Project Lead	Chloe Scruton, General Manager	**Division**	Surgery, Urology
Clinical Lead	Mr Andrew Simpson, Consultant Urologist and Deputy Medical Director – Clinical Effectiveness	**Stakeholder Engagement**	Neil Scott, Service Delivery Manager, EMAS; Patient Engagement Panel; internal meeting forums; project team membership and key contacts (including, CCG, Finance, GIRFT); public engagement exercise; HOSC
Senior Responsible Officer	Mark Brassington, Director of Improvement & Integration	**QIA Completed By**	Dawn Malloney, Project Manager, Delivery Team, IID
Financial Value	Projected year 1 service cost reduction of ~£300k	**Overall Risk Score**	12

Approved by Director of Nursing	Karen Dunderdale (remotely)	**Date**	12/07/2021
Approved by Medical Director	Andrew Simpson, Deputy Medical Director as Medical Director on annual leave	**Date**	12/07/2021

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Safety	Where a patient presents at A&E at a non-receiving site, consideration given to potential risk that a urology specialist will not be not available on site to provide immediate support	Negative	5	4	20	In the reconfiguration, 24 hour Single Point of Contact (USPOC) to ACP support based at LCH will be in place. The ACP's will have direct access to an on-call Consultant 24 hours. The USPOC will be able to provide immediate assessment and agree pathway for the patient remotely with the on-call Consultant. A Middle Grade doctor will available at Pilgrim and Grantham (during the day only) can attend to the patient if required.	1	4	4	We are measuring the number of patients admitted as a non-elective emergency (unplanned emergency), this measure supports the volume of emergency patients being treated and enables an understanding of capacity and demand for the urology service. We expect this number to decrease over a period of time as a sign of success	Assumption on benefits is a movement of demand into planned care. 08/21 figures show an overall Trust reduction in non-elective admissions, with an increase in LCH admissions and a reduction in Pilgrim admissions, which is what we would expect to see. We would expect to see a continued decrease in 09/21 figures when they become available. There have been no issues reported from Clinicians in relation to accessing the USPOC service. The Urology staff survey, due to be launched imminently, will provide further opportunity to gain insight to any issues.
Patient Safety	Delay to patient care - unable to contact USPOC in a timely manner	Negative	3	4	12	There is a dedicated mobile phone to USPOC and there have been no issues to date with contact. Backup is that the on-call consultant can also be contacted through switchboard	1	4	4	No issues reported by Clinical staff in relation to timely contact and support with USPOC. No impact on patient pathway/experience reported as a result of inability to access USPOC support/input.	There have been no issues reported in relation to contacting USPOC. The Urology staff survey, and patient experience survey, due to be launched imminently, will provide further opportunity to gain insight to any issues.

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Safety	Delay to patient care - EMAS unable to perform timely inter-facility transfer to LCH	Negative	2	3	6	EMAS protocol to prioritise based on condition. Consultant led decision to transfer based on severity of patient. Refer to existing Policy and Procedures for Patient Transfer CESC/2011/040. Engage with secondary patient transfer service (as a backup) TESL. Ongoing monitoring of the patient and clear engagement with ACPs to manage care of the patient in collaboration with the on-call consultant. EMAS document 'National Framework for Inter-Facility Transfers v0.8' provided by EMAS provides guidance on Inter Facility Transfers and timescales, including escalations.	2	3	6	Delay to patient care avoided owing to delay in patient transfer.	EMAS are not able to stratify transfers based on clinical condition to a suitable level for analysis of operational metrics impact. However, EMAS have reported that, on a combination of untoward incident reviews and staff feedback groups (alternate pathways in and out of hospital) there has not been any negative commentary or feedback raised. There have been no complaints in relation to delays in patient care and no SI's reported. The Patient Experience questionnaire, now launched for LCH 'fit to sit' patients, will provide more intelligence on this measure
Patient Safety	Insufficient bed capacity at receiving site - delays in patient care owing to patient flow at receiving site. Demand constraints at the receiving site.	Negative	3	3	9	Mitigated by ensuring 'protected' bed capacity at Digby Ward	1	3	3	ALoS by ward - measures demand. Excess bed days - beyond planned discharge. Expect to see decrease in ALoS. - success criteria - reduction in ALoS and no excess bed days being reported. Delays in admission avoided owing to sufficient bed capacity.	The protected bed status for Urology patients within Digby ward has not being able to be enforced owing the incident level 4 owing to the Covid pandemic. A move is now being made to revert back to normal protected bed capacity arrangements. Q3 & Q4 data will hopefully provide a more steady state picture in relation to the impact of reconfiguration. The ACP tier should facilitate timely discharge and improve ALoS, to facilitate bed availability.

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Safety	Any site - Delay in patient care - patient deteriorates post operatively and needs urgent urology attention.	Negative	4	4	16	24 hour Single Point of Contact (USPOC) to ACP support based at LCH (Resident), with direct access to an SAS doctor 24 hours and on-call Consultant 24 hours. SAS doctor available at Pilgrim (during the day only) and can attend if required. CT doctor based at Grantham 24 hours (Resident). Current state - Consultant non Resident overnight. No SAS or ACP presence.	1	4	4	Delays reduced and patient clinically optimised post operation in a timely manner	There have been no issues reported in relation to post op support
Patient Safety	Patient undergoing surgery within another speciality develops urological complication requiring urgent attention (non-receiving sites). Urology specialist not available for support	Negative	4	1	4	Access to 24 hour ACP via USPOC support. If urgent surgery required, on-call consultant would attend. Middle Grade doctor available at Pilgrim and Grantham (during the day only).	1	1	2	Patient receives timely intervention an no issues experienced by surgeon in accessing urology specialist support	There have been no issues reported in relation to post op support
Patient Safety	Patient not stable enough to transfer. Delay in consultant attending	Negative	4	2	8	Seek intensive care unit admission if at Pilgrim and on-call consultant to attend at site. If patient presents at another hospital site within ULHT, on-call consultant will attend	2	2	4	Proactive clinical decision making, rather than waiting for patient optimisation. Pre-emptive intervention on access of consultant to monitor patient conditions	No issues have been reported in relation to delays in oncall consultant attending to a patient at a site other than LCH. Frequency of occurrence for non-LCH attendance to be looked at - included in ACP reporting.
Patient Safety	Transfer of patients in a timely manner for time critical conditions (EMAS). Risk of patient dying during transfer. Based on past data, anticipated transfer requirement of 1 patient per day	Negative	1	5	5	Suitability for transfer is part of the pathway and will have been pre-assessed. If risk is deemed too high, patient will not be transferred as per existing Policy and Procedures for Patient Transfer CESC/2011/040.	1	5	5	No SI's reported in relation to a patient dying as a result of inappropriate transfer	No SI's have been reported

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Safety	Efficient access to urology specialist support	Positive	3	4	12	Implementation of 3 tier system and reconfigured on-call consultant rota will ensure direct access 24/7 to urology specialist	1	4	4	No incidents/issues/delays occurring that impact on patient safety, as a result of urology specialist support not being available	There have been no issues reported or concerns raised to date with regard to access to timely urologist specialist intervention. General feedback from staff on an ad-hoc basis is the reconfiguration is much better and works well. This will be verified further upon completion of the Urology staff survey
Patient Safety	Delays in accessing non-elective treatment/surgery	Positive	5	4	20	Dedicated on-call consultant will be available to attend to non-elective patients 24/7, as opposed to reliance on consultants performing elective duties to also respond to non-elective requests	1	4	4	Indicators that demonstrate improvement of patient flow through the service. No incidents/issues/delays occurring that impact on patient safety, as a result of urology consultant not being available to perform emergency surgical procedures	The level 4 critical incident status has had an impact on cancelled procedures. It is expected that once steady state is achieved the success of the reconfiguration will be reflected in the data that maps patient flow through the service.
Patient Safety	Same day cancellations of elective surgery	Positive	3	4	12	Same day cancellations will reduce as consultant with scheduled elective surgeries will not be required to cover on call	1	4	4	Demonstrate a reduction in number the of same day cancelled operations which will improve the safety and well-being of patients, acknowledging the distress this can cause patients and the potential associated safety risks	Awaiting recent figure for same day cancellations. Expected to see a drop post 9/8 go live, particularly for cancellation reason being no consultant available. (September increase - October coming back down again)

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Safety	Unnecessary admissions for urological conditions	Positive	4	3	12	Access to 24 hour ACP SPOC support will enable a treatment plan to be put in place and the patient is more likely to be discharged back home as opposed to admitted as a precaution	1	3	3	Reduce the number of unnecessary admissions occurring, which is in the best interests of patients.	The scorecard captures all types of admissions of which monitoring of emegency admissions is expected to reduce over time and more planned admission to take place as part of patient treatment plans. 08/21 figures already show a slight Trustwide decrease in non-elective admissions. It is expected that 09/21 data will show further reduction.
Public Image	Adverse publicity - making LCH main receiving site for non-elective	Negative	4	3	12	Members of the public can still present to any ED site with urgent urological condition and they will be seen and treated in accordance with the ACP/Consultant remote support. Full public engagement exercise running from 17 May to 23 July to ensure views are obtained.	2	3	6		No issues have been reported.
Public Image	Public concern about being transported from another hospital site to LCH if in need of urgent potential urological surgery	Negative	4	4	16	Patients will only be transferred under consultant guidance and if deemed suitable for transfer. They will not be transferred if any risk. On-call consultant will attend at site of patient. Full public engagement exercise running from 17 May to 23 July to ensure views are obtained.	1	4	4	Potential track through consultant decision - Proactive monitoring of patient experience through surveys. Success Criteria: positive patient survey results with regard to our pathways. Reduction of SI's and Complaints	To be evaluated on an ongoing basis following current launch of Patient Experience survey for LCH fit to sit patients

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Public Image	Public concern about reducing services at their local hospital	Negative	4	4	16	Elective capacity is remaining at all sites, decreasing slightly at LCH, but still retaining a large proportion. Capacity increasing at Grantham and Pilgrim. Change in non-elective is that EMAS will take patient straight to LCH from point of pick-up and walk-in's at other hospital sites will be transferred to LCH by EMAS, to be determined case by case by consultant. Benefits of this model are clear. Full public engagement exercise running from 17 May to 23 July to ensure views are obtained.	3	4	12		No issues have been reported.
Public Image	Risk of same day cancellations and faster access to non-elective support/treatment and surgery	Positive	4	4	16	Anticipated that access to care will be a priority for patients and that avoiding disruption to any planned surgery is positive. Full public engagement exercise running from 17 May to 23 July to ensure views are obtained.	2	4	8	Narrative & public consultation feedback	
Clinical Outcomes	Reduced length of stay for non-elective patients	Positive	4	4	16	Greater availability of staffing and will there be an assessment area that will increase the numbers of patients that are seen and discharged on the same day. Continuity of care due to single on call team, following up the patients and chasing up the discharge plan. Access to hot lists to deal with emergency surgery in a more expeditious way	1	4	4	Reduction of unplanned admissions which in turn should reduce overall ALoS due to reduction in the number of patients being admitted as an emergency	
Clinical Outcomes	Reductions in same day cancellation will improve outcomes for elective patients in terms of undisrupted care and impact on their wellbeing	Positive	3	4	12	Consultant performing elective duties will not be required to be on call. Therefore will not disrupt non-elective scheduled surgeries	1	4	4	Same day cancellation measures and number of planned admissions - we should see a reduction in same day cancellations and an increase on the number of planned admissions	

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Clinical Outcomes	Efficient and accurate diagnosis and treatment of patients attending ED with an urgent/non-urgent urological condition	Positive	3	4	12	Access to 24/7 USPOC ACP support will ensure the care diagnosis and treatment and plan for the care of the patient are performed efficiently and with accuracy, with a direct link to middle grade doctor and on call consultant support	1	4	4	Positive patient outcomes maximised as a result of early invention from specialist support	No issues reported. Patient survey results will provide further intelligence
Clinical Outcomes	Reduced elective and non-elective re-admissions following initial emergency admission	Positive	3	4	12	Hot list allowing for definitive treatment during first admission rather than requiring subsequent admissions	1	4	4	Manageable, reduced number of readmissions occurring and a general reduction month on month	
Clinical Outcomes	Avoidable admissions	Positive	4	4	16	Patients will not be admitted to hospital unnecessarily, as a precaution whilst obtaining urological clinical support. Better for the patient to be seen and treated without admission, avoiding unnecessary stress. Access to 24/7 USPOC support will avoid unnecessary delays in seeing and treating patients and will enable avoidance of unnecessary admissions that may be made as a precaution	1	4	4	Reduction in the number of emergency admissions, increased in planned admissions, understanding nature of internal transfer of patients from one consultant to another	Decrease Aug to October
Clinical Outcomes	Cancer surgical procedures	Positive	4	4	16	At present we operate a rota for LCH and a rota for Pilgrim. There is no cross-cover in place in the current model. Moving into the reconfiguration there will be cross-cover that has been reviewed within consultant job plans, therefore capacity will not be lost, creating better utilisation of theatre lists and clinics. Therefore cancer waiting times will be reduced and outcomes will improve.	1	4	4	Theatre utilisation available slots and slot management for theatres. Cancer waiting times RTT will support this as an evidence based outcome. Cancer 28 days measure and cancer 62 day measure. Measure of success: Better efficiency of theatre utilisation and a raising to the national target for RTT	

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Clinical Effectiveness	NICE Guidance	Positive	3	4	12	Reconfigured non-elective pathway to single acute site with hot list enables us to meet NICE guidance for the management of stones and ureteric obstruction, 48 hour standard	1	4	4	Operational internal monitoring against the principles of NICE Guidance	
Clinical Effectiveness	GIRFT Recommendations	Positive	2	3	6	The reconfiguration is based on GIRFT best practice pathways for urology	1	1	2	Operational GIRFT checkpoints and reviews. Measure of Success: GIRFT support for reconfiguration	Full GIRFT support provided. To be reviewed in January
Patient Experience	Complaints - same day cancellations	Positive	4	4	16	Reduction in complaints in relation to same day cancellation of elective surgery owing to reconfigured rota which avoids disruption of elective surgery.	1	4	4	Reduction of complaints and an improvement overall of patient experience as a result of a reduction in same day cancellations	
Patient Experience	Complaints about distance of travel, if mode is EMAS, from patients further south of the County, being transported up to Lincoln, for example, bypassing Pilgrim/Grantham	Negative	1	3	3	We may see this increase - patient consultation responses will enable us to review this and the number of complaints, post go-live, will be monitored as part of the performance dashboard	3	3	9	No complaints from patients in relation to access to service and distance of travel	The patient experience survey will provide us with more intelligence in relation to impact on patients as a result of travel/transfer requirements
Patient Experience	Lack of access to urology clinical advice, treatment and support, through the ED department.	Positive	4	4	12	Patients will experience improved access to urology clinical advice, treatment and support, through the ED department, avoiding longer wait times, through access to USPOC and on-call consultant availability	1	4	4	Patients do not feel agreived about excessive length of waits and are satisfied with the quality of service and care they receive	Patient experience questionnaire for LCH fit to sit patients - to be collated end October for initial feedback

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Patient Pathways	Unrefined Patient Pathway for non-elective surgical need	Positive	4	5	20	Non-elective clear patient pathways defined for non-elective patients presenting at ED (non LCH sites) and inpatient access to urology services. Supported by an operational roles and responsibilities document, providing clarity of process and ownership for the patient at each stage of the pathway. Inter-dependencies with EMAS are mapped in. EMAS have been fully engaged and consulted with in order to inform the clinical risk analysis and interdependencies with the pathway map.	1	5	5	No SI's occurring as a result of lack of clarity and ownership of the patient within the non-elective urology pathway	SI's. Case mix audit (now and then in 6 months or sample every 3-6 months)? (see what ACP's are collecting?). Clinicians point of view with regard to success. Patient experience questionnaire for LCH fit to sit patients - to be collated end October for initial feedback. Staff survey feedback.

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Accessibility	Access to transport post discharge	Neutral	2	3	6	Patients transported for urgent urological intervention, to LCH, from further points of the County, particularly south westerly and north easterly areas, may have concerns about getting home following discharge. Current position... PTS Contract, currently with TASL, specifies eligibility criteria in line with the DH Eligibility Criteria for Patient Transport Services published August 2007 which is detailed below:- • Where the medical condition of the patient is such that they require the skills or support of NEPTS service staff on/after the Journey and/or where it would be detrimental to the patients' condition or recovery if they were to travel by other means; • Where the patients' medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patients' condition or recovery to travel by other means; or • Recognised as a parent or guardian where children are being conveyed. No additional mitigation to current position.	2	3	6	Patients are not subjected to distress or concern in relation to how they will return home post attendance at LCH from further parts of the County.	No concerns raised to date - further analysis to take place once complaints information is available and following patient and staff surveys.
Accessibility	Access for friends and relatives to visit inpatients post admission for urgent urological condition	Negative	2	3	6	Inpatients at LCH who have been transported for LCH for urgent urological intervention, from further parts of the County, may have concern about accessibility for friends and family to visit owing to distance of travel. No mitigation	2	3	6	Patients are not subjected to distress in relation to isolation from friends and family owing to distance of travel	No concerns raised to date - further analysis to take place once complaints information is available and following patient and staff surveys. However, the visitors policy across the Trust currently governs this aspect.

Theme	Description	Impact	Likelihood	Severity	Score	Mitigation	Likelihood	Severity	Score	Measure of Success	Narrative: Benefits/ Impact
Inequalities of Care	Access to same level of care services across the County	Positive	4	3	12	All patients in Lincolnshire will be able to access a better quality service - all sites working to the same standards as opposed to working in silos. Variation in care will improve.	1	3	3	Patients are satisfied with the care and treatment received regardless of location of provision	
Staff Impact	Inability to recruit and retain substantive consultants and ACP's	Positive	4	4	12	The recruitment and retention of substantive consultants and ACP's is enabled and more attractive with the implementation of the new rota. This will provide a more stable working environment, allowing the development of working relationships, as opposed to reliance on agency staff	2	4	8	Workforce rotation and agency spend. Contribution to strategic outcome in reduction of agency spend. Sustainable resource and service.	Successful recruitment of Consultants, Middle Grade and ACP's - we now have a full compliment of clinical staff. 09/21 10/21 figures to follow - reduction in agency expenditure to be reported.
Staff Impact	Issues in relation to staff wellbeing, health and safety	Positive	4	4	12	The wellbeing of consultants, particularly in terms of fatigue and distances of travel, will be improved owing to the separation of duty between being on call and performing elective surgery.	2	4	8	Improved wellbeing of clinical workforce	Re-run of staff survey with regard to satisfaction - to be launched w/c 10 October
Staff Experience	Lack of training and development opportunities	Positive	3	4	12	The reconfiguration of rotas and rotation between hot and cold sites will enable ACPs and middle grade doctors to experience a broader range of conditions, treatments and surgeries, which will provide development and training opportunities, thus improving recruitment and retention	1	4	4	Clinical staff feel that they have development and training opportunities	
Staff Experience	Staff at Boston and Lincoln have a rotation 1 in 6 (weeks) on-call. Consultants and middle grades. Morale - affect on team having to come (travel)					1 in 6 is the mitigation to minimise travel for consultants to LCH (1 week is the designated on-call)				Reduction in issues being raise by consultants owing to excessive travel requirements in order to undertake on call duties	

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Staff Experience	Lack of clarity around roles and responsibilities in relation to the non-elective patient pathway	Positive	3	5	15	Clinical staff will benefit from a defined patient pathway for non-elective patients, which will also define processes, roles and responsibilities. This will provide surety around individual responsibilities and improve confidence in the effectiveness of the pathway model. This will also aide standardisation of procedures across sites.	1	5	5	Staff are clear about their roles and responsibilities and have confidence in the service they are providing, thus providing them with assurance and greater job satisfaction	SOP in the process of completion to formalise the pathway. This will be issued to staff to ensure full understanding and compliance with the requirements of the pathway, clarifying roles and responsibilities.
Targets/Performance	Finance - high spend on agency costs	Positive	5	3	10	The successful recruitment of Consultants and ACP's creates a reduction in medical agency spend across the urology service, with an estimated saving of £300k pa	2	3	6	Reduction in dependency on agency and temp cover thus reducing costs for the Trust and stabilising the service. Sustainable cost effective staffing/service model	09/21 10/21 figures to follow - reduction in agency expenditure to be reported.
Targets/Performance	Cancelled Procedures	Positive	2	4	16	Reduction expected. Reduces administrative burden, reduces wait times, reduce complaints, improved theatre utilisation	1	4	4	Reduction in same day cancellations with more emphasis on planned care	The level 4 critical incident status has had an impact on cancelled procedures. It is expected that once steady state is achieved the success of the reconfiguration will be reflected in the data. Reduction specifically in relation to 'no consultant available' and 'no beds available' to significantly reduce
Targets/Performance	Avoidable Admissions	Positive	3	4	12	Reduction expected. Improved utilisation of ward resources	1	4	4	Reduction in unplanned admissions which will ultimately reflect as a increase in planned care capacity	Trustwide non-elective admissions showing a slight reduction, with an increase at LCH and a decrease at Pilgrim, as expected. Further reductions expected to be realised when latest data becomes available

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Targets/Performance	Excessive length of stay & discharge rates	Positive	4	4	16	Reduction expected. Access to USPOC and better facilitated discharge/ward rounds	1	4	4	Gradual reduction of ALoS and to have the ambition to have 0 excess bed days being reported	To be evaluated when latest data becomes available to assess impact post 9/8/21.
Targets/Performance	Waiting Times/RTT	Positive	4	4	16	Reduction expected. Rota reconfiguration and USPOC covering both sites will ensure a reduction in disruption to elective activity, improved discharge rates, reduction in admissions, reduction in LoS, improved theatre utilisation, will allow an improved flow of activity and an increase in capacity.	1	4	4	Gradual reduction resulting in higher reporting reaching towards the 92% target. Main factors are the handling of referral ASI's and PBWL management	Incomplete pathways under 18 weeks RTT. Overall 92% target. Current 64/66%.
Equality & Diversity	Distance of travel for patients	Neutral	2	1	3	Elective capacity is remaining at all sites, decreasing slightly at LCH, but still retaining a large proportion. Capacity increasing at Grantham and Pilgrim. Therefore this reconfiguration is not increasing travel and patients can could still have the opportunity to choose location based on capacity (as happens now). The change in non-elective means that EMAS will take patient straight to LCH from point of pick-up. EMAS will also transport patients from non LCH sites as required. Patients can still walk in to any A&E. No mitigation - current PTS protocols apply.	2	1	3	No patients disadvantaged in terms of access to services as a result of the reconfiguration and increase in travel	An impact assessment study was undertaken scoping out the impact on local resident population and access to specific sites of treatment. Ask CCG to do a re-run 3 months post Go-Live