NHS
Lincolnshire
Clinical Commissioning Group

BOARD MEETING – PUBLIC

Date of Meeting:	25th May 2022	Agenda item:	12c

Title of Report:	Decision Making Business Case on four of Lincolnshire's NHS services
Report Author:	Pete Burnett, System Strategy and Planning Director Tom Diamond, Associate Director of Strategy
Lead Director(s):	CCG Executive
Accountable Officer:	John Turner, NHS Lincolnshire CCG Chief Executive
Attachments:	Appendix 1 – Acute Services Review Decision Making Business Case Appendix 2 – Appendices to the Acute Services Review Decision Making Business Case

1. Purpose of the Report (including link to objectives)

The purpose of this report is to seek **approval** for changes to four of Lincolnshire's NHS services as presented in the Decision Making Business Case (DMBC).

These changes have been developed under the Lincolnshire Acute Services Review (ASR) Programme and are recommended by the Chief Executive of the NHS Lincolnshire CCG, with the support of the CCG Executive.

As the Consulting Authority, the NHS Lincolnshire CCG Board is asked to **approve** key changes to the configuration of four NHS services.

2. Background

On the 29 September 2021 the NHS Lincolnshire CCG Board agreed to proceed to a period of public consultation on the proposals, as set out in the Pre Consultation Business Case, relating to four NHS services:

- Orthopaedics
- Urgent & Emergency Care
- Acute Medicine
- Stroke Services

This Decision Making Business Case is a technical document that follows the Pre Consultation Business Case (PCBC) and completion of the public consultation exercise.

The public consultation, which ran from 30 September to 23 December 2021, enabled a robust and detailed dialogue with an extensive range of stakeholders.

Listening to the views of those that responded to the consultation and working with partners across the Lincolnshire health system to consider the feedback has enabled the Chief Executive of the NHS Lincolnshire CCG, supported by the CCG Executive, to recommend proposals that:

- Deliver better outcomes and quality of care for patients
- Reduce waiting times to receive care
- Make it easier for staff to provide the best possible care to patients
- Make services more attractive so they can recruit and retain great staff dedicated to high quality care.
- Better use NHS funds, reducing spend on temporary staff

3. Recommendations

It is recommended that the NHS Lincolnshire CCG Board **approve** the proposed service changes:

- **Recommendation 1: Orthopaedics**
  - Consolidate planned orthopaedic surgery at Grantham and District Hospital, to establish a 'centre of excellence' in Lincolnshire.
  - Establish a dedicated day-case centre at County Hospital Louth for planned orthopaedic surgery.
- **Recommendation 2: Urgent and Emergency Care**
  - Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre (UTC).
- **Recommendation 3: Acute Medicine:**
  - Develop integrated community/acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.
- **Recommendation 4: Stroke Services**
  - Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service.

4. Finance, QIPP and Resource Implications

The financial and resource implications are presented in the Decision Making Business Case, these have been reviewed and agreed by the System Finance Leaders Group.

5. Legal/NHS Constitution Considerations

Legal advice was taken in relation to the PCBC, public consultation and completion of the DMBC. The main pieces of law that are applicable are the NHS Act 2006, as amended by the Health and Social Care Act 2012, and the Equalities Act 2010. A full legal review of the DMBC in consideration of the applicable law has been undertaken and confirms that the NHS Lincolnshire CCG has shown due regard to its duties.

Due regard means giving appropriate consideration in the circumstances. The duty should be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.

6.	Analysis of Risk including Assessments

Key risks associated with the proposed changes are included in the Decision Making Business Case.

If the change proposals are agreed these will be reviewed and developed further through implementation. An implementation risk register would be developed and managed by the relevant implementation group and it is proposed these would be overseen by an Implementation Oversight Group (IOG) made up of NHS commissioners and providers.

Please state if the risk is on the CCG Risk Register.

Yes		No	✓

7.	Outcome of Impact Assessments

The proposed service changes will deliver improvements in the quality of care and support reductions in health inequalities by delivering more equitable access to timely specialist interventions proven to improve patient outcomes.

The impact of the proposed service changes on protected characteristics has also been considered. The potential positive and negative impacts are the same for all groups, however the age, disability and economically disadvantaged groups have been identified as possibly being more likely to be impacted:

- Potential positive impacts have been identified in terms of improved care and outcomes, including more people benefiting from highly specialised interventions.
- Potential negative impacts have been identified related to access to services. Mitigations to support patients potentially impacted by the service change proposals have been included in the business case.

8.	Outline engagement – clinical, stakeholder and public/patient

Significant engagement with all stakeholder groups has occurred throughout all stages of the ASR Programme, covering:

- Broad engagement
- Pre-consultation engagement
- Public consultation

A full public engagement process was led by the NHS Lincolnshire CCG engagement team. Proposals have been subject to formal public consultation in line with the NHS Act 2006, as amended by the Health and Social Care Act 2012.

9.	Assurance Departments/Organisations who will be affected have been consulted

Insert details of the departments you have worked with or consulted during the process:

Finance	√
Commissioning	√
Contracting	√
Medicines Optimisation	
Clinical Leads	√
Quality	√
Safeguarding	
Other	√

10.	Management of Conflicts of Interest
None identified	

11.	Report previously presented at:
Not applicable	

12.	For further information or for any enquiries relating to this report, please contact
lccg.asr-enquiries@nhs.net	

Decision Making Business Case on four of Lincolnshire's NHS services

1. Purpose

The purpose of this report is to present the NHS Lincolnshire Clinical Commissioning Board (CCG) with the Decision Making Business Case (DMBC) for specific changes to four of Lincolnshire's NHS services, which have been developed under the Lincolnshire Acute Services Review (ASR) programme.

As the Consulting Authority, the CCG Board is asked to **approve** key changes to the configuration of four NHS commissioned services.

2. Background

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

ULHT provides services from hospital sites located in Lincoln, Boston and Grantham plus a fourth smaller site at Louth.

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

However this has led to a number of services becoming increasingly 'fragile' and struggling to be sustainable over a lengthy period of time with no obvious solution in the short to medium term, which has a consequence for service failure.

Key factors underpinning services becoming increasingly unstable and more challenging to sustain are:

- Vacancies and reliance on agency and locum staff
- Rota duplication across two or three sites
- Traditional workforce dependent on Doctors versus Advanced Care Practitioners (ACPs)

Which in turn results in:

- Poorer quality care and patient outcomes
- Longer waiting times for patients to be seen
- Delays for patients to receive treatment
- Clinical staff being over-stretched
- Higher financial costs incurred in an attempt to sustain clinical care

Acute service provision across Lincolnshire therefore needs to find the optimal configuration across the county to maximise clinical, operational and financial sustainability.

In August 2017 the leaders of the Lincolnshire health system agreed the need for a review of the current configuration of acute health services in the county.

The full scope of this review, known locally as the Acute Services Review (ASR), covered eight services; Acute Medicine, Breast, General Surgery, Haematology & Oncology, Orthopaedics, Stroke, Urgent & Emergency Care, Women's and Children's.

The aim of the ASR Programme was defined as a programme to develop a set of recommendations on the optimal configuration of acute hospital services across Lincolnshire to maximise clinical, operational and financial sustainability.

In November 2018 a Pre Consultation Business Case (PCBC) was submitted to NHS England for assurance, which set out a preferred option for the future configuration of all eight services within the scope of the ASR Programme. This business case identified a capital requirement of c.£52m (priced in 2018) to enable the proposed changes.

Through the first half of 2019 the availability of capital to enable the proposed service changes set out in the business case submitted to NHS England looked evermore unlikely.

In light of this, in November 2019 the Lincolnshire health system agreed to go into a 'production line' approach to progress the proposed service changes identified through the ASR Programme.

This approach was adopted to minimise delays to the delivery of patient benefits for those service change proposals that, if agreed, could be progressed with no/minimal capital or where sufficient capital could be secured for specific service changes.

Following consideration of the eight services within the scope of the ASR Programme, four services were agreed as the focus for a revised Pre Consultation Business Case (PCBC), the first under the production line approach:

- Orthopaedics
- Urgent & Emergency Care
- Acute Medicine
- Stroke

The PCBC details the work completed by the Acute Services Review (ASR) Programme and sets out recommendations on the proposed options for service change in the four areas set out above, including the identification of a preferred option.

Since the establishment of the ASR Programme, key elements around evidence development and assurance have been carried out including:

- Development of a case for change, new clinical models and potential solutions for review and consideration.
- Patient, public and stakeholder engagement:
    - The NHS in Lincolnshire has undertaken a wide variety of engagement programmes across the county, with a diverse range of staff, public and stakeholders.
    - This dialogue has been continuous since prior to the publication of the first Sustainability Transformation and Partnership (STP) five-year plan in 2016, and has played a pivotal role in developing the case for change, guiding and shaping the vision and underpinning the ASR planning process.
    - Engagement on the ASR Programme falls into three phases:
        - Broad engagement (2018)
        - Options engagement (2018)
        - Pre-consultation engagement (2019)
    - In March 2019 'Healthy Conversation 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 for all eight services in the Acute Services Review and ran through to October 2019.
    - Discussions of proposals with the Health Scrutiny Committee for Lincolnshire.
- Development and ongoing refinement of a Pre Consultation Business Case (PCBC) exploring the options for change.

- An assessment of the options for change, including a clinically-led stakeholder workshop and four workshops with members of the public.
- Regulatory and best practice assurance, including:
    - Two reviews of proposals by the East Midlands Clinical Senate.
    - Submission of the PCBC for regional regulatory assurance.
    - Independent assurance process by the Consultation Institute.
- National assurance approval of the PCBC.

The PCBC was approved by the CCG Governing Body on 29 September 2021 and it was agreed to proceed to a period of public consultation on the proposals as set out in the PCBC.

This Decision Making Business Case is a technical (DMBC) document that follows the Pre Consultation Business Case (PCBC) and completion of the public consultation exercise.

The public consultation, which ran from 30 September to 23 December 2021, enabled a robust and detailed dialogue with an extensive range of stakeholders and resulted in 3,044 questionnaire responses and 402 telephone surveys.

An independent organisation (Opinion Research Services) was commissioned to provide an independent analysis and report of the feedback received through the public consultation. (Appendix C of the DMBC).

The overarching conclusion of this independent analysis was there is broad support across all elements of the consultation for the need for change, and overall agreement with each of the four proposals.

There were however, two proposals where slightly more concerns were raised, and there was evidence of differing views between those living in different areas of Lincolnshire:

- A slight majority of consultation questionnaire respondents living nearest to Grantham and District Hospital disagreed with the urgent and emergency care proposal
- A majority of consultation questionnaire respondents living nearest to Pilgrim Hospital, Boston disagreed with the proposal relating to stroke services

Some equalities concerns were raised about or by particular groups or communities. They focused on travel and transport, particularly for those with limited access to private transport. Specific groups mentioned in this regard included: older people; people with disabilities and long-term conditions and co-morbidities; people living in rural and isolated communities, areas of deprivation or with low incomes; people living with disabilities and neurodiverse people.

Listening to the views of those that responded to the consultation and working with partners across the Lincolnshire health system to consider the feedback has enabled the Chief Executive of the NHS Lincolnshire CCG, supported by the CCG Executive, to recommend proposals that:

- Deliver better outcomes and quality of care for patients
- Reduce waiting times to receive care
- Make it easier for staff to provide the best possible care to patients
- Make services more attractive so they can recruit and retain great staff dedicated to high quality care.
- Better use NHS funds, reducing spend on temporary staff

This feedback and the further consideration and evidence compiled following the public consultation in response to it, together with the evidence contained within the PCBC, and have been brought together into a Decision Making Business Case (DMBC) which is put before the Board for decision.

3. Recommendations

Specifically, this DMBC document sets out the ask for the NHS Lincolnshire CCG Board, as the Consulting Authority, to **approve** key changes to the configuration of four NHS commissioned services across Lincolnshire.

This document and the recommendations within it have been underpinned by a clinically led review and evaluation process which considered the evidence collated in the Pre Consultation Business Case (PCBC), feedback received through the public consultation and the considerations of subject matter expert working groups to the consultation feedback received.

The NHS Lincolnshire CCG is grateful for all the feedback received and it fully acknowledges both the support and concerns for the four change proposals. Following an extensive programme of work to review the findings of the public consultation and ensure conscientious consideration of the feedback, the overarching conclusion of the subject matter expert groups and wider clinical leaders from across the county was the change proposals consulted on were still supported.

However, as set out in detail in the DMBC and highlighted here, through the review and consideration of the feedback a number of actions have been identified for implementation across all four services if the change proposals are agreed.

It is recommended by the Chief Executive of NHS Lincolnshire CCG, supported by the CCG Executive, that the NHS Lincolnshire CCG Board **approve** the following proposed service changes:

- **Recommendation 1: Orthopaedics**
    - Consolidate planned orthopaedic surgery at Grantham and District Hospital, to establish a 'centre of excellence' in Lincolnshire.
    - Establish a dedicated day-case centre at County Hospital Louth for planned orthopaedic surgery.
- **Recommendation 2: Urgent and Emergency Care**
    - Grantham and District Hospital A&E department to become a 24/7 Urgent Treatment Centre (UTC).
- **Recommendation 3: Acute Medicine**
    - Develop integrated community/acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.
- **Recommendation 4: Stroke Services**
    - Consolidate hyper-acute and acute stroke services on the Lincoln County Hospital site, supported by an enhanced community stroke rehabilitation service.

It should be noted that:

- The CCG Board is not bound by the recommendations or conditions put forward in this Decision Making Business Case. The CCG Board can choose to support, reject or amend the recommendations as members see fit.
- The proposals have been built on a solid base of clinical evidence and have been through rigorous clinical testing throughout the duration of the programme.
- The proposals have heard, considered and responded to the themes that emerged from public consultation.
- The proposals are assured by the East Midlands Clinical Senate.
- The proposals are recommended in order to improve patient outcomes and deliver against national clinical guidance.

The recommendations for each of the four services is set out below, together with an overview of key areas of consultation feedback, considerations given and identified actions if the change proposals are agreed. The full extent of consultation feedback, the consideration given and resulting conclusions and actions of the subject matter expert working groups should be read in full and can be found in the DMBC and its appendices.

Orthopaedics

Recommendation

Consolidate planned orthopaedic surgery at Grantham and District Hospital, to establish a 'centre of excellence' in Lincolnshire, and establish a dedicated day-case centre at County Hospital Louth for planned orthopaedic surgery. This reflects the orthopaedics pilot arrangements:

- Outpatients clinics would be unaffected.
- This would mean Grantham and District Hospital would not provide unplanned orthopaedic surgery.
- Lincoln County Hospital and Pilgrim Hospital, Boston would continue to provide unplanned orthopaedic surgery, and some planned orthopaedic surgery for high risk patients with multiple health problems, which is comparatively small in volume.

The CCG Executive have confirmed this proposal results in improved care (as demonstrated through the orthopaedics pilot evaluation) through:

- Reduced waiting times for planned orthopaedic surgery, which mean patients get seen quicker
- Reduced cancellations on the day of planned surgery due to a lack of beds
- Reduced length of stay following planned orthopaedic procedures (including United Hospitals Lincolnshire NHS Trust (ULHT) outperforming many other hospitals)
- Reduced numbers of Lincolnshire patients going to the private sector (often out of county) for planned orthopaedics procedures, funded by the local NHS
- Improvements in overall patient experience and satisfaction
- Removal of need for temporary staff to cover vacancies and services are more attractive to staff which supports long term sustainability

This has been evidenced further by ULHT currently being one of the best performing trusts in the midlands region in relation to waiting times for orthopaedics and providing 'mutual aid' to neighbouring trusts to support delivery of elective orthopaedic waiting lists.

The concerns raised by the public during the consultation in relation to unforeseen emergencies during planned procedures and the negative impacts on the quality and timeliness of emergency orthopaedic care are acknowledged, and were considered and reviewed by orthopaedic service leads as well as wider system clinical leads.

From an elective procedure perspective clinical review and discussions confirmed that since the pilot started in 2018 there has been only one patient who required transfer due to a post operation complication to Lincoln County Hospital, due to a suspected thrombolism, which demonstrated how robust the selection criteria for patients is.

With regards to emergency orthopaedic care it was confirmed by orthopaedic service leads that at the start of the pilot trauma lists were kept at Grantham and District Hospital as part of the model, however it was evidenced over time that these were not being utilised. Minor trauma cases that can be appropriately discharged home to have a semi-planned operative procedure on a later day at Grantham are, thereby keeping orthopaedic trauma patient transfers to a minimum.

Any additional demand on the emergency orthopaedic theatre lists at Lincoln County Hospital and Pilgrim Hospital, Boston is offset by theatre time freed up by the elective orthopaedic care going to Grantham and District Hospital and County Hospital Louth.

The concerns raised by the public during the consultation regarding increased travel and equity of access in a large rural county (particularly for groups such as older people, people on low incomes, those without access to private vehicles and people with disabilities) for planned orthopaedic procedures are acknowledged and were considered and reviewed by orthopaedic service leads as well as wider system clinical leads.

The conclusion of these considerations by clinical leads was the change proposals support timeliness of access. In addition it was identified:

- Currently patients actively choose to travel to other providers out of the county and the travel to the proposed orthopaedic model for Lincolnshire is no different to these, and therefore it is not a barrier to access.
- In terms of the patient pathway, patients will only have to travel once for the procedure and the pre and post-operative clinics will be at their local provider . Whereas if patients go out of county to the independent sector then pre and post-operative clinics will also be out of the county.
- More patients can receive their care in Lincolnshire.
- No formal complaints have been made during the orthopaedics pilot in relation to travel and transport.
- Non-emergency patient transport services in Lincolnshire will be able to provide transport for eligible patients who have a longer distance and journey time to attend for treatment at hospitals that are further away from their home and for the discharge from these hospitals.
- Working in partnership with all partners, particularly Lincolnshire County Council, to support and improve travel and transport solutions for health and care services in the widest sense is required, not just in relation to the four proposed services changes.
- The implementation of digital and virtual appointments will contribute to limiting the number of journeys.

It was recognised that for a small proportion of people who provided feedback through the consultation that the timeliness of ambulance response was a concern. East Midlands Ambulance Service (EMAS) has been fully engaged in the work and fully expect to be able to provide additional resources to mitigate the impact of the proposed care models. The business case provides resource to EMAS to mitigate the impact of the proposed changes on current ambulance response times.

The change proposal for orthopaedics is supported by the NHS Lincolnshire CCG clinical leads, who also identified a number of actions relating to implementation if the change proposal is agreed:

- A roadmap needs to be developed to ensure the vision of a ‘centre of excellence’ is fully realised
- Opportunities should be identified to increase the volume of planned orthopaedic activity at Grantham and District Hospital as this will further support the development of a ‘centre of excellence’
- Need to make sure there is not a distillation of orthopaedic skills at different sites in Lincolnshire

Urgent and emergency care

Recommendation

Establish a 24/7 walk-in Urgent Treatment Centre (UTC) at Grantham and District Hospital:

- This would be in place of the current Accident & Emergency (A&E) department.

The CCG Executive have confirmed this proposal results in improved care through:

- 24/7 walk in urgent care would return to Grantham and District Hospital through a high quality service delivered in a sustainable way for the long term
- The vast majority of patients seen at Grantham and District Hospital A&E department would continue to be treated at the 24/7 Urgent Treatment Centre (UTC)
- The UTC would provide greater accessibility due to increased opening hours compared to the current A&E arrangements (currently closed between 6.30pm and 8.00am).
- The UTC would support better integration with primary care and community services and the provision of care closer to home
- For a small number of patients (estimated to be around to be around 2 patients a day on average) currently attending the Grantham and District Hospital A&E who wouldn't be able to have their care needs met by the UTC, care would be received at an alternative site with the right facilities and expertise to ensure better clinical care outcomes
- Making sure patients get to the definitive treatment, first time whether that be Grantham and District Hospital or an alternative site.
- Reducing the number of intra hospital transfers from Grantham and District Hospital to another site, so demonstrating that the patient was getting to the definitive treatment site, first time.

The concerns raised by the public during the consultation in relation to the conditions that would be treated at a 24/7 UTC and that Grantham and District Hospital should have a 'full' Type 1 A&E and supporting hospital service provision area acknowledged. These have been considered and reviewed by urgent and emergency care service leads as well as wider system clinical leads.

In relation to the conditions that would be treated at a 24/7 UTC, clinical leads identified and agreed a number of key conclusions and actions for implementation if the change proposal is agreed:

- Grantham and District Hospital has had an exclusion criteria in place since 2007/08, and following its introduction patients with suspected heart attack, acute cardiology, surgical issues, multiple trauma, suspected stroke and a number of other conditions have been taken by the ambulance service straight to neighbouring hospitals where more specialised services are located. This exclusion criteria is well understood by the local healthcare system including primary care, community providers and the ambulance service.
- Under the proposed service change proposal the UTC would still have the ability to manage all presentations, including those requiring stabilisation and transfer to an alternative hospital with the right skills and expertise, as it does now.
- For the small number of patients that are currently seen by the A&E service that would receive their care at an alternative site, they would have a National Early Warning Score (NEWS) of ≥7 and a frailty score <5, and likely have an acute medical condition (e.g. severe sepsis, severe respiratory conditions), acute cardio syndrome or a complex trauma. This anticipated impact would be kept under ongoing review.

- A comprehensive communication plan would be rolled out for members of the public to make sure local residents are made fully aware of what services the 24/7 UTC would be able to provide. This will include a public facing document that clearly lists conditions that can be managed at the proposed 24/7 UTC, and be explicit about the red flags that should prompt 999 and includes information about diagnostics. This communication plan would be developed in line with the national requirement of the 'NHS 111 First' initiative.
- In addition, all relevant health and care providers including 111, East Midlands Ambulance Service Trust (EMAS), primary care and community providers need to be engaged and information provided detailing the full list of exclusion criteria for Grantham and District Hospital under the change proposals.
- When working up the detailed staffing model and rotas there needs to be:
    - Ongoing review and alignment of staffing model and ambulance conveyance arrangements for the Grantham and District Hospital site; and
    - Ongoing review of staffing models to ensure right staff skill mix is available and competent to stabilise and transfer patients whatever the condition that presents
- There needs to be ongoing review of ambulance transfer protocols and ensure clear process is in place, including risk assessment and mitigations.

With regards to Grantham and District Hospital having a 'full' Type 1 A&E and supporting hospital service provision, following a thorough review (of national guidelines and standards, independent clinical advice, current service provision, population growth data and the experiences of other health systems) the clinicians reaffirmed that a number of combining factors lead to the conclusion that a type 1 A&E department at Grantham and District Hospital that provides a full range of 'unselected' care and is supported by the required core set of specialties is not feasible. These are:

- The required staffing levels for a Type 1 A&E department and those specialities with clinical interdependencies that enable the ongoing provision of safe care;
- The availability of doctors and nursing to staff these services in a sustainable manner;
- The required scale of provision for these services to ensure staff maintain and continue to develop their skills and be attractive to staff to work in; and
- Even when considering the forecast growth for Grantham and the surrounding area, there will still not be sufficient scale to safely and sustainable deliver this level of care.

This review confirmed that the proposed service change is in line with national clinical guidance i.e. network arrangements where some acute hospitals (Lincoln County and Pilgrim Hospital, Boston) provide a broader range of specialist services to a larger population 'unselectively' and some (Grantham and District Hospital) providing a narrower range of services to a smaller population 'selectively' and work in close partnership with adjacent services to access specialist services not available on site.

From a clinical view it was identified that the population of Grantham and the surrounding areas has access to the services in the whole County, and implementing a Type 1 A&E in Grantham may harm more people than save, and splitting limited resources across multiple sites and services is not appropriate as there is a need for specialism to be concentrated in certain areas.

It is acknowledged that there are concerns about ambulance conveyance, including risk to life as a result of increased travel time. Clinicians have carefully considered this issue and identified:

- Under the current exclusion criteria, patients from Grantham and the surrounding areas with serious conditions such as heart attack, acute cardiology and suspected stroke and already taken straight to neighbouring hospitals where more specialised services are located. This exclusion criteria is well understood by the local healthcare system including primary care, community providers and the ambulance service.

- Under the proposed model of a 24/7 UTC at Grantham and District Hospital the exclusion criterion for the Grantham Hospital site would be refined, meaning a relatively small number of patients (2 a day on average) currently attending the A&E, would not in the future. Most of these are likely to travel by ambulance to an alternative site given their condition.
- Two key foundations of the proposed care model are to:
    - Make sure patients get to the definitive treatment, first time whether that be Grantham and District Hospital or an alternative site.
    - Reduce the number of intra hospital transfers to another site, so demonstrating that the patient was getting to the definitive treatment site, first time.
- The benefits of patients getting definitive treatment first time and the improved outcomes associated with this are seen to out-weigh the potential increases in ambulance travel time to alternative sites.

East Midlands Ambulance Service (EMAS) has been fully engaged in the work and fully expect to be able to provide additional resources to mitigate the impact of the proposed care models. The business case provides resource to EMAS to mitigate the impact of the proposed changes on current ambulance response times.

The concerns raised by the public during the consultation regarding travel and transport (particularly older people, people with disabilities, those from more deprived communities or living in rural areas) are acknowledged and were considered and reviewed by urgent and emergency care service leads as well as wider system clinical leads.

The challenges with the current county wide transport infrastructure were acknowledged by health system leads and key mitigations identified if the change proposal if agreed are:

- A high degree of confidence the changes will be fully and appropriately supported by EMAS.
- Non-emergency patient transport services in Lincolnshire will be able to provide transport for eligible patients who have a longer distance and journey time to attend hospitals
- Working in partnership with all partners, particularly Lincolnshire County Council, on wider transport plans
- Ensuring a clear and comprehensive communication plan with the public in terms of access routes and conditions treated by the proposed service

The change proposal for urgent and emergency care is supported by the NHS Lincolnshire CCG clinical leads, who also identified a number of actions relating to implementation if the change proposal is agreed:

- This is as much about a change in nomenclature as it is change from the current service provision. Communication with the public about the conditions that can be treated at the proposed service is key.
- A key requirement during the implementation phase would be to ensure the identified service provider has the capability to deliver the proposed model of care. This would need to be done in accordance with existing NHS contract and procurement regulations.

Acute medicine

Recommendation

Establish integrated community/acute medical beds at Grantham and District Hospital, in place of the current acute medical beds.

The CCG Executive have confirmed this proposal results in improved care through:

- Delivering a balance between access and sustainable long term outcomes for acute medicine services at Grantham and District Hospital.
- Supporting the majority of patients that currently receive Acute Medicine care at Grantham Hospital to do so in future, only c.10% of high complexity patients would be cared for at another hospital with the right facilities and expertise to ensure the best outcomes.
- Enabling Grantham Hospital to offer services which may not be offered elsewhere and build a centre of excellence for integrated multi-disciplinary care, particularly for frail patients.
- Delivers a more comprehensive service provision at Grantham Hospital, specifically in relation to the 'frail' population, thereby reducing pressure on acute sites in Lincoln & Boston.
- Grantham Hospital acts as a hub for supporting community teams and community services across the county, and improves accessibility to specialist advice for primary care and community-based teams
- Supports improved community-based management of long term conditions and reduced length of stay in hospital beds
- Supports a more sustainable medical and nursing workforce through new and innovative care models that offer sustainability, role variety and greater integration across pathways.

Key concerns raised by the public during the consultation that are acknowledged include:

- Placing elderly needs out of a secure hospital environment supported by specialist consultants or moving them to alternative hospital sites requiring considerable journeys with associated risk
- Adequate staffing, cost of implementing the changes and increased workload required
- Negative impacts on the quality of care provided, and the potential for increased pressure on other hospitals.
- Grantham and District Hospital should be a fully serviced hospital with acute medical beds.

These were considered and reviewed by the acute medicine service leads and wider system clinical leads.

Clinical and operational leads confirmed the service change proposal is to establish integrated community/acute medical beds at Grantham and 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 Lincolnshire Hospitals NHS Trust. The care of patients would still be led by consultants (senior doctors) and their team of doctors, practitioners, therapists and nursing staff. Workforce modelling for the Pre Consultation Business case identified an increased workforce requirement to deliver the proposed model of care.

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.

System leads confirmed there are no changes in the beds available on the site for medical inpatients. Retaining current provision is essential to supporting stabilisation of the wider health 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. The proposed integrated community/acute medical beds would continue to be supported by a Level 1 bed function on the Grantham and District Hospital site that would support medical patients requiring escalation.

Clinical leads confirmed there are a number of combining factors that lead to the conclusion that it is not feasible for the Grantham and District Hospital to be a fully services hospital with acute medical beds (see urgent and emergency care section).

It was also acknowledged that the East Midlands Clinical Senate strongly supported the proposed model – identifying it delivers a balance between access and sustainable long term outcomes for acute medicine services - and there is a strong clinical evidence base for it. Clinical leads identified the ongoing development of Integrated Care Systems and the advent of Primary Care Networks makes it stronger.

It was recognised that there are some concerns about an additional impact on East Midlands Ambulance Service (EMAS) to transfer people to the nearest hospital with an acute bed, and it was confirmed EMAS has been fully engaged in the work and fully expect to be able to provide additional resources to mitigate the impact of the proposed care models. The business case provides resource to EMAS to mitigate the impact of the proposed changes on current ambulance response times.

It is acknowledged that in the public consultation feedback there were few comments related to potential impacts on any specific demographic groups, with the exception of a small number of comments reiterating concerns about travel and access for groups without access to private transport.

It is also acknowledged that several respondents, including some NHS staff members, felt that the proposed move to integrated community/acute medical beds would benefit older and more frail patients by better integrating acute and community care for those patients who need the latter.

Positively in the consultation feedback, it was said that patients would be seen quicker, resulting in more efficient care, and they would benefit further by being discharged back into their community more quickly. Elderly or frail patients were highlighted as particularly benefiting from this.

In terms of access, clinical leads identified a distinction needs to be drawn between these proposals and those for urgent and emergency care as these are based on admitted patients. It was reiterated the proposals would support repatriation of patients from Grantham and the surrounding areas so they can receive care closer to home and, if implemented, there is a need to ensure alignment with wider system strategies for addressing digital poverty whilst exploring opportunities such as virtual wards.

It was also confirmed non-emergency patient transport services in Lincolnshire will be able to provide transport for eligible patients who have a longer distance and journey time to attend hospitals and ongoing joint working was required with Lincolnshire County Council on wider transport plans to continue to support those not eligible for patient transport.

Clinical leads confirmed that if the change is agreed, then key requirements for the implementation and delivery are:

- Detailed workforce planning to ensure the model attracts and retains the right workforce, and governance/accountability arrangements are clear between partner organisations delivering care
- Existing bed capacity is optimised and cohorts extended in line with detailed workforce planning

The change proposal for acute medicine is supported by the NHS Lincolnshire CCG clinical leads, who also identified a number of actions relating to implementation if the change proposal is agreed:

- Need to ensure recruitment to the model focuses on the whole workforce, irrespective of the stage of their career.
- The proposed model has to look to reach outside of the Grantham area and provide support to patients further afield.

Stroke services

Recommendation

Establish a 'centre of excellence' for hyper-acute and acute stroke services at Lincoln County Hospital site. This would be supported by increasing the capacity and capability of the community stoke rehabilitation service:

- This would mean hyper-acute and acute stroke services are no longer provided from Pilgrim Hospital, Boston.
- Transient ischaemic attack (TIA) clinics would be unaffected at Pilgrim Hospital, Boston.

The CCG Executive have confirmed (which has been informed through the temporary service change to consolidate hyper-acute stroke services on the Lincoln County Hospital site in light of Covid-19) the proposal result in improved care through:

- Tackling significant workforce shortages and challenges in stroke by concentrating specialist stroke and multi-disciplinary skills and expertise
- Reducing heavy reliance on locums by increasing chances of recruiting to substantive roles and having to spread staff across two sites
- Improved achievement against national stroke standards
- Enabling a critical mass for a stroke unit well above recommended levels
- Improved alignment with clinical interdependencies – Lincolnshire Heart Centre and Mechanical Thrombectomy services at Queens Medical Centre (QMC) in Nottingham

Key concerns raised by the public during the consultation that are acknowledged, and were considered and reviewed by the stroke service leads and wider system clinical leads relate to:

- Increased travel times to Lincoln County Hospital for emergency stroke care
- Concerns the proposal could widen health inequalities and negatively impact patients access as services would be removed from a deprived area.

Following thorough consideration by clinical leads from across the health system it was confirmed that it is the overall time from event to treatment by a skilled and dedicated workforce that can provide high-level Consultant led 7-day provision that has the greatest impact on quality of care and outcomes, not travel time. Faster access to high quality diagnosis and treatment at the acute site can offset longer travel times.

It was also confirmed that time spent in an ambulance can still be used to support the treatment of patients. Since the start of the temporary service change, a good joint working model has been established between ambulance paramedics and stroke Advanced Care Practitioners (ACPs) at Lincoln Hospital to review previous medical history and decision for treatment commences as soon as patients arrives at hospital.

It was acknowledged that East Midlands Ambulance Service (EMAS) has been fully engaged in the work and fully expect to be able to provide additional resources to mitigate the impact of the proposed care models. The business case provides resource to EMAS to mitigate the impact of the proposed changes on current ambulance response times. It was also noted that the Lincolnshire division of EMAS has the most efficient on scene time of all East Midlands divisions/counties helping to reduce overall call to definitive treatment timescales

Through the clinical consideration it was also acknowledged that the consolidation of cardiology services on the Lincoln County Hospital site to concentrate capacity, skills and expertise, in a similar way proposed for stroke, has demonstrated improvements in outcomes for all Lincolnshire residents.

Using the experience of the temporary service change of consolidating hyper-acute services on the Lincoln County Hospital site clinical leads have given thorough consideration to the impact this has had on the quality of care received by patients. This confirmed that:

- In 2021 Lincoln County hospital was one of the highest performing sites nationally in terms of national stroke performance standards.
- Patients from the Boston Hospital catchment area have been seen and scanned quicker, had more access to thrombectomy and were, on average, discharged sooner (compared to before the temporary change)

The Lincoln Hospital stroke service was able to deliver this level of performance whilst under a huge amount of operational pressure.

A conclusion of the clinical considerations was the temporary change to consolidate hyper-acute stroke care on the Lincoln County Hospital site has shown thrombolysis can be achieved providing a first-class service to stroke patients in the County regardless of where they live and that this is predicated on having the best expertise on one site that is clinically supported based on the evidence.

Through the clinical discussions it was confirmed that key factors contributing to the performance at Lincoln County Hospital was the stroke service on-call Advanced Care Practitioner workforce and co-location with cardiology services.

Co-location with the heart unit also has the benefit of using the Cath lab facilities to directly access acute imaging thus bypassing A&E and further reducing door to needle time/angiogram time.

The stroke team at Lincoln Hospital has also developed an excellent working relationship with the Queens Medical Centre (QMC) Nottingham thrombectomy team, and became one of the best referring sites in the region.

Since the service started in 2018 and up to April 2020, Lincoln Hospital had referred 19 patients for the procedure in Nottingham, compared to a single patient from the Boston Hospital site within the same timeframe. In 2021, 14 patients from the Pilgrim Hospital, Boston catchment area went to Nottingham for thrombectomy and 19 from the Lincoln County Hospital catchment area. This helps to emphasise the importance of team work in improving stroke care, and demonstrates the net benefit to more patients going to a single, better staffed site.

During the clinical discussions it was noted that the thrombectomy time frame has been extended to anything between 16 and 24 hours depending on the centre that takes the patient. Therefore, if a patient presents at Lincoln County Hospital and they have just missed the thrombolysis an angiogram can be undertaken and the patient transferred to Nottingham much quicker due to a refinement of the system over the last two years.

The clinical discussions confirmed the public's concerns about patients travelling further need to be recognised and, if the change is agreed, a communication and education strategy on the proposals, how to recognise stroke symptoms and how to access care needs to be put in place This should include a targeted, local bespoke communication and education strategy with a specific focus on the deprived areas with the longest travel times.

Concerns raised through the public consultation relating to stroke service staffing, particularly a single site at Lincoln County Hospital, and capacity at Lincoln County Hospital are acknowledged. As are the suggestion put forward to maintain two hyper-acute stroke units in Lincolnshire or consolidate hospital stroke services on the Pilgrim Hospital, Boston site.

Consideration by clinical leads confirmed the proposed service change to consolidate hyper-acute and acute stroke services at Lincoln County Hospital is supported by a workforce model that would see an increase in specialist stroke staff at Lincolns County Hospital, and ensure the unit is staffed according to agreed national guidelines for medical, nursing and allied health professional staff.

It was confirmed the capacity required at Lincoln County Hospital to meet the needs of the population have been developed based on analysis of demand and application of clinically evidence based assumptions with regards to pathways of care and outcomes for patients. The outputs of the proposed bed capacity model have been tested through sensitivity analysis.

It was acknowledged that through the proposal development process the workforce demand of multiple sites was considered against the supply of specialist workforce and ability to deliver consistent, equitable high quality care to all patients in Lincolnshire. This was re-considered following the consultation feedback and concluded the proposal to consolidate hyper-acute and acute stroke care at Lincoln County Hospital was the best possible option to deliver consistent care for all and make the best use of available workforce.

A single site can be staffed more effectively as currently there is not enough work for two centres, and if there is not the critical mass of patients it is unlikely that the organisation will be attractive to recruit and retain staff.

Previous considerations of the rationale for consolidating stroke services on the Lincoln County Hospital Site as opposed to the Boston Hospital, Pilgrim site were revisited and reaffirmed by clinical leads:

- Co-location with the heart centre supports an optimal front door service as it enables access to more important time critical interventions and has the benefit of using the Cath lab facilities to directly access acute imaging thus bypassing A&E and further reducing door to needle time.
- At Lincoln there is an established Advanced Care Practioner (ACP) service and pathway that was noted as a regional example of excellence by a Getting It Right First Time (GIRFT) review.
- Excellent working relationship with the Queens Medical Centre (QMC) Nottingham thrombectomy team, Lincoln County Hospital has become one of the best referring sites in the region.
- Experience has shown it is easier to recruit to Lincoln County Hospital compared to Pilgrim Hospital, Boston
- More Lincolnshire residents would receive their care out of the county if stroke services were consolidated on the Pilgrim Hospital, Boston site rather than at Lincoln Hospital.

Alternative suggestions put forward through the public consultation for stroke rehabilitation are also acknowledged. During the clinical discussions it was identified that approximately 49% of stroke patients are discharged from hospital within seven days. It was confirmed there is a very wide spectrum of rehabilitation needs for stroke patients and hospital is not the best place for a majority of these patients. The best place for rehabilitation is in the patient's own home and they can progress with the right level of support, the longer a patient stays in hospital the more deconditioned the patient becomes and is more dependent

The rehabilitation element was acknowledged as an important part of the whole process and the proposed Centre of Excellence is crucial to the development of community services.

It was acknowledged there are examples in other areas of healthcare where professions are worked across different pathways in order to achieve the right skill set, and this approach is being explored for the proposed stroke community rehabilitation model.

It was acknowledged the proposed community stroke model will attract staff bringing in a higher skilled workforce which will ultimately improve the patient outcomes and develop the multidisciplinary team approach.

The change proposal for stroke is supported by the NHS Lincolnshire CCG clinical leads, who also identified a number of actions relating to implementation if the change proposal is agreed:

- Need to ensure there is a robust and effective needs assessment prior to discharge that identifies the most appropriate location for rehabilitation.
- Need to ensure the enhanced community stroke rehabilitation service is:
    - Properly resourced to provide a high quality service and support appropriate discharge from hospital
    - Fully integrated with the hospital based stroke service to ensure safe discharge and appropriate skills development across the whole pathway
    - Considered in the context of a virtual ward model

Travel and transport

It is acknowledged that feedback on the consultation on the four service change proposals has identified travel and transport as a significant concern for patients and the public, as well as the Health Scrutiny Committee (HSC) for Lincolnshire.

This concern was generally expressed in terms of:

- The effect of the proposed changes on the ability of patients and their family/carers to access services that may be at a more distant site than currently.
- Hospital discharges in the evening or overnight when public transport tends not to operate creating an additional challenge for people without their own transport.

A Travel and Transport Report has been considered which contains an assessment of the current situation together with a set of enablers to help mitigate the impact of the proposed service changes on access. These enablers are:

- Emergency and Urgent Transport
- Non-Emergency Patient Transport
- Other Transport

Comments received from the consultation feedback indicated concerns about the impact on the ambulance service of the additional journey times associated with the proposals in the ASR. EMAS have been fully engaged in the ASR and fully expect to be able to provide additional resources to mitigate the impact of the proposed care models. EMAS have confirmed they are able to accommodate the additional small demand on their services.

Non-emergency patient transport (NEPTS) is provided for patients who meet the nationally set eligibility criteria for NHS funded patient transport services. This means Lincolnshire residents who meet the eligibility criteria receive free transport in the following situations; patients who are going to hospital for outpatient appointments, diagnostics, treatment or for admission, and for patients who are eligible for transport from hospital following outpatient, diagnostic appointments, daycase or inpatient care and treatment.

Non-emergency patient transport services will continue to be offered and provide transport for all eligible patients who have a longer distance and journey time to attend for assessment and treatment at hospitals that are further away from their home and for discharge from these hospitals.

The Lincolnshire health system is committed to using any revisions arising from the implementation of the national criteria, including any flexibility in those criteria, to the full for the benefit of patients in Lincolnshire.

The patient transport service is also required to signpost patients who do not meet the eligibility for patient transport to alternative transport providers.

Th ‘other transport’ category presents the most complex area for consideration as it covers transport and travel services that the CCG does not have a duty to provide.

Through the work completed to consider the travel and transport feedback received during the consultation it was identified a number of solutions already exist and strengthening the current arrangements is seen as central to tackling the challenges.

Opportunities to strengthen current arrangements include:

- Promoting the use of public transport options to try to reduce reliance on car usage
- Promote and use existing infrastructure wherever possible
- Making the best use of existing public transport facilities wherever possible – including engagement with transport operators to discuss how services could accommodate changing travel patterns
- Ensure users have clear and easily accessible information about public transport options to encourage uptake
- Tackling issues relating to expanding existing volunteer driver schemes

The NHS in Lincolnshire is committed to working in partnership with all partners, particularly Lincolnshire County Council, to support and improve travel and transport solutions for health and care services in the widest sense, not just in relation to the four proposed services changes.

This is being actively considered with the County Council and continuing to tackle this challenge is a priority for the Lincolnshire health system.

Irrespective of whether the change proposals are agreed the NHS in Lincolnshire will continue to work with Lincolnshire County Council and ensure joint working groups and forums are in place to improve travel and transport solutions for health and care services in the widest sense.

If the change proposals are agreed, this ongoing work between the NHS and Local Authority will be informed further through the monitoring of the transport impact overall, as well as on those groups with protected characteristics, by the service change implementation groups. This would include analysis and assessment to understand whether the changes are exacerbating inequalities and identifying mitigations.

4. Financial and resource implications

The economic and financial analysis has been developed by the Lincolnshire Integrated Care System (ICS) finance team, working with the relevant service leads and reporting to the ICS Financial Leaders Group (FLG). This group is chaired by the NHS Lincolnshire CCG Director of Finance.

Detailed financial planning was undertaken for the Pre Consultation Business Case (PCBC), and since its production the following activities have been undertaken:

- Updates to the financial context within which the Lincolnshire health system is operating
- Re-validation of the clinical model workforce requirements
- Consideration of the responses to consultation feedback by working groups to understand financial impact
- Review and update of financial risks
- Updated financial projections

The four services in the scope of this Decision Making Business Case (DMBC) are forecast to deliver a financial benefit of c.£1.9m in total by the time all the service changes are in place.

The table below provides a summary of the financial impact by service.

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

Three of the proposed service changes can be achieved without capital requirements, the one area that will require estates reconfiguration and associated capital is the consolidation of stroke services on the Lincoln County Hospital site, through the construction of an extension to the existing unit. Current cost estimates for this estates solution are £7.5m.

Following completion of the public consultation and consideration of the feedback the Lincolnshire ICS FLG re-assessed the affordability of the financial case for the four change proposals from financial sustainability and best use of capital resource perspectives.

The FLG has concluded that since preparing the Pre-Consultation Business Case there has been no material change in the proposals or the assumptions underpinning financial sustainability of the proposals. There are risks to the overall deliverability of the DMBC and they are set out in summary in the table below together with mitigations.

Risk	Mitigation
Delivery of financial benefit attributable to the replacement of interim and agency staff in the new models of care	Service stability and certainty along with improvements in the medical and nursing roles offered Orthopaedics – pilot has demonstrated positive benefits in relation to establishing a sustainable workforce
Repatriation of orthopaedics activity from the independent sector to improve utilisation of ULHT's cost base	Supported by the current pilot model, ULHT is one of best performing trusts in the region relating to waiting times for orthopaedics
Rise in inflation causing the cost of capital projects to exceed previous estimates	Initial estimates of impact of cost increases show an immaterial impact on revenue consequences If change proposals are agreed all capital planning assumptions would be reviewed as part of developing a Full Business Case (FBC)

5. Legal implications

The NHS Lincolnshire CCG has taken legal advice throughout the Acute Services (ASR) Programme, including the following key points:

Date	Advice provided
March 2021	Full review of Pre-Consultation Business Case and appendices
August 2021 – May 2022	Advice on governance for decision making, public consultation and requirements in relation to the Health Scrutiny Committee for Lincolnshire
May 2022	Full review of Decision Making Business Case and appendices

The table below outlines the legal duties that are applicable to the ASR and explains how the ASR Programme, the NHS Lincolnshire CCG and the proposals contained in the Decision Making Business Case (DMBC) have complied with those duties. This assessment has been completed independently by Capsticks Solicitors LLP.

It should be noted that the Health and Care Bill is currently passing through Parliament and includes significant changes to the legislation in respect of NHS commissioning. However, at the time that the Governing Body considers the DMBC the main duties that apply to the CCG are contained in the NHS Act 2006 as amended by the Health and Social Care Act 2012, and the Equalities Act 2010. Those duties will broadly continue to apply to Integrated Care Boards when they replace CCGs later in 2022.

Where the CCG is required to comply with duties to "have due regard" this involves a conscious approach and state of mind. The CCG cannot satisfy the duty by justifying a decision after it has been taken. The duty should be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.

Legal Duty	Evidence of compliance
NHS Constitution Section 14P of the NHS Act imposes a duty upon CCGs both to exercise their functions with a view to ensuring that health services are provided in a way that promotes the NHS Constitution and to promote awareness of the Constitution among staff, patients and the public.	A summary of how the change proposals promote the key principle of the NHS Constitution is outlined below: **1. The NHS provides a comprehensive service, available to all:** The change proposals improve consistent access to high quality healthcare for those in need of treatment. **2. Access to NHS services is based on clinical need, not an individual's ability to pay:** No restrictions will be placed on access to services based on an ability to pay. **3. The NHS aspires to the highest standards of excellence and professionalism:** Development of the change proposals has been clinically led and been based on establishing best practice clinical models based on the available clinical evidence. The change proposals have been scrutinised and supported by the East Midlands Clinical Senate. **4. The patient will be at the heart of everything the NHS does:** There has been extensive involvement of the public throughout the process to date.

	5. The NHS works across organisational boundaries: The change proposals seek to bring organisations together to work in a more integrated way to provide better care **6. The NHS is committed to providing best value for taxpayers' money:** The Lincolnshire NHS Financial Leaders Group has overseen the financial and economic aspects of the change proposals to ensure they are providing the best value for taxpayers' money **7. The NHS is accountable to the public, communities and patients that it serves:** Opportunities have been provided for the public and local elected members to provide input into the programme of work throughout its development
Duty to exercise functions effectively, efficiently and economically By section 14Q of the NHS Act each CCG must exercise its functions effectively, efficiently and economically.	• The change proposals look to improve the efficiency and effectiveness of how services are delivered. How the recommendations contribute to this are detailed in Chapters 2 to 5 of the Decision Making Business Case (and associated appendices). • Chapters 6 to 10 describe the approach to decision making, including the quality, access, clinical evidence base and affordability criterion and the assessment against these • Chapter 11 provides the detailed financial assessment of change proposals • Chapter 16 sets out the anticipated benefits that will be realised by proposed changes
Duty to secure improvement of service Section 14R of the NHS Act places CCGs under a duty to exercise their functions with a view to securing continuous improvements in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness. Quality of services comprises in particular outcomes which show effectiveness, safety and patient experience.	• The change proposals look to improve services for the local population. How the recommendations contribute to improved effectiveness, safety and patient experience are detailed in Chapters 2 to 5 of the Decision Making Business Case (and associated appendices). • Chapters 6 to 10 describe the approach to decision making, including the quality, access and clinical evidence base criterion and the assessment against these • Appendix G sets out the Quality Impact Assessments (QIAs) • Appendix J sets out the recommendations of the East Midlands Clinical Senate • Appendix L sets out the statements of support from providers
Duty to reduce inequalities Section 14T of the NHS Act provides that CCGs must, in the exercise of their functions, have regard to the need to:	• The change proposals look to promote more consistent access to high quality care. How the recommendations contribute to reducing inequalities are detailed in Chapters 2 to 5 of the Decision Making Business Case.

(i) reduce inequalities between patients with respect to their ability to access health services; and (ii) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.	• Chapters 7 to 10 set out analysis of change proposals including assessment against quality, access and clinical evidence base criterion • Appendix G and H set out the Quality Impact Assessments (QIA) and Equality Impact Assessments (EIAs) • The proposals will affect patient access to healthcare, with some patients having to travel further to access services. Chapter 5 of the Decision Making Business Case summarises the mitigations and conclusions in respect of travel and transport, and Appendix I sets out the Travel and Transport Report.
Duty as to patient choice Section 14V of the NHS Act imposes a duty on CCGs, in the exercise of their functions, to act with a view to enabling patients to make choices about aspects of the health services provided to them.	• Chapters 7 to 10 set out analysis of change proposals including assessment against choice criterion • Appendix M sets out the CCG's statement in relation to choice
Duty to promote integration Section 14Z1 of the NHS Act states that the CCG must exercise its functions with a view to securing that services are provided in an integrated way where this would improve the quality of the services, reduce inequalities in respect of access or reduce inequalities in outcomes.	• The change proposals look to promote integration. How the recommendations drive integration to improve the quality of services and reduce inequalities in respect of access and outcomes is detailed in Chapters 2 to 5 of the Decision Making Business Case (and associated appendices) • Chapters 7 to 10 set out the analysis of change proposals including assessment against quality, access and clinical evidence base criterion • Appendix G and H sets out the Quality Impact Assessments (QIAs) and Equality Impact Assessments (EIAs) • Appendix L sets out the statements of support from providers

6. Risk implications

Key risks associated with the proposed changes, and mitigations to these, are included in the Decision Making Business Case. If the change proposals are agreed these will be reviewed and developed further through implementation. An implementation risk register would be developed and managed by the relevant implementation group and it is proposed these would be overseen by an Implementation Oversight Group (IOG). As part of its establishment its relationship with existing Integrated Care System, commissioner and provider governance arrangements would be confirmed.

It is anticipated that the Implementation Oversight Group (IOG) would comprise a core membership of senior clinicians and officers from NHS commissioners and providers and service users. As required by the matters under consideration, relevant service implementation group leads would be invited to attend the IOG to discuss progress.

The organisations impacted by the changes and the NHS Lincolnshire CCG would continue to monitor the entirety of the core quality schedule through an established infrastructure in order to ensure that there is no unplanned adverse impacts in any areas of care provision.

7. Implications for equalities and health inequalities

An Equality Impact Assessment (EIA) is included in Appendix H of the Decision Making Business Case.

8. Implications for public involvement

A comprehensive engagement process has underpinned the Acute Services Review Programme, engaging clinicians, provider organisations and the local population.

A robust consultation exercise was undertaken between 30 September and 23 December 2021 to seek public responses to the change proposals to four NHS services.

Appendix A of the DMBC provides the communication and consultation activity report and Appendix C provides the independent report on the consultation responses.

9. Next steps

Up to this point the ASR Programme has developed with significant public involvement. If the change proposals are agreed, further engagement and scrutiny will continue to be sought, both leading up to, and as part of, the implementation process. This will help to ensure that the service changes and improvements proposed meet the needs of the Lincolnshire population.

If the service changes outlined in this business case are agreed by the Board of the NHS Lincolnshire CCG, they will be commissioned through contractual processes and be subject to procurement where appropriate.

Implementation will be driven by the responsible provider organisations, with commissioning support where necessary.

Health system partners have been fully engaged all the way through the process allowing for smooth implementation whilst the CCG functions transfer to the Integrated Care Board (ICB) which is expected from July 2022.

The ICB will oversee the strategic commissioning of the new model of care and implementation of the service changes, as the new NHS commissioning authority for the Lincolnshire health system.

10. Appendices

Appendix 1 – Acute Services Review Decision Making Business Case

Appendix 2 – Appendices to the Acute Services Review Decision Making Business Case

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